



FINAL REPORT

Summative Evaluation of the National Indigenous Critical Response Service



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MAY 2020

Document preparation

This document was prepared by Human Capital Alliance (International) Pty Ltd (HCA) for Thirrili Ltd.

Acknowledgements

We acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia. Australia is the only place in the world where Aboriginal and Torres Strait Islander Australians belong. There is no place in Australia where this is not true.

HCA would particularly like to acknowledge and extend their gratitude to the clients, community members and stakeholders who participated in the interviews that informed the evaluation and this report. Your willingness to contribute your time and share your perspectives and personal experiences were pivotal for undertaking the evaluation.

HCA would also like to thank the Critical Response Support Advocates (CRSAs) who assisted with coordination and liaising with interview participants. Your care and dedication to the people you support was undeniable.

Finally, we would like to thank Thirrili Ltd management for supporting the evaluation by fulfilling data requests and document requirements.

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Suggested citation:

Ridoutt, L., Cowles, C., Noel, J., Kelleher, K., Stanford, D., Williams, M. and Daley, D. (2020). *FINAL REPORT: Evaluation of the National Indigenous Critical Response Service*. Human Capital Alliance: Sydney.



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Human Capital Alliance (International) Pty. Ltd.
ABN 82 105 375 442
Unit 8.03 / 14 Kings Cross Road, Potts Point,
NSW Australia
Ph: +61 2 93808003
www.humancapitalalliance.com.au

Acknowledgements to Country

We pay our respects to the Aboriginal and Torres Strait Islander Elders, past present and future, on the Lands throughout Australia that the National Incident Response Service (NICRS) is tasked to support. We acknowledge the trauma that suicide and its aftermath bring to individuals, families and communities and recognise the power of Culture in the prevention and healing processes.

The team members for the evaluation included Aboriginal people belonging to the Dhungutti, Palawa, Wiradjuri and Anaiwan Nations and this report was prepared on Eora (Guringai and Gadigal), Darkinjung, Awabakal, Bundjalung and Ngunnawal Country.

Fieldwork for this evaluation was undertaken (either in person or by electronic means) with respondents on Whadjuk, Yamaji, Yawuru, Larrakia, Arrernte, Alyawarr, Gimuy-walubarra yidi, Wulgurukaba and Bindal, Yuggera, Kurna, Ngunnawal and Kulin Country. We thank the people from these and other Nations for their contributions to this process of reflection.

Key findings

The summative evaluation of the first three years (2017-2020) of development and implementation of the National Indigenous Crisis Response Service (NICRS) has found that the service is providing **valuable postvention support** to individuals and families (clients) who have recently experienced a suicide or other traumatic incident in their close family network. The evaluation found that there is support for the service, however all stakeholder groups agreed that there was **scope for improvement** in the way the NICRS is managed and delivered.

Clients reported that the NICRS Crisis Response Support Advocates (CRSAs – frontline staff) provided welcome and highly valued personal support and financial relief at a time of great stress and crisis. CRSAs reported that the role was generally rewarding but could be stressful and overwhelming. The long-term impact of the service on social and emotional wellbeing (SEWB) of clients could not be determined due to the outstanding need for established outcome measures and the immaturity of data collection processes at this point in the service's development.

The evaluation found that the service could be **improved by**:

- locating small teams of 2-3 workers in areas of known suicide 'hotspots'
- establishing stronger governance arrangements, including a strategic plan with outcome indicators and improve data collection processes to support quality improvement and future evaluation efforts.
- achieving greater consistency and clarity in the program's core guiding documents (i.e. the Model of Care and the Program Logic) and in the application of organisational policies, including the use of Emergency Relief Funding
- providing comprehensive, regular and systematic professional and emotional support, clinical supervision and cultural supervision for frontline workers (CRSAs and Coordinators), including by enlisting additional options to assist those staff in responding to 24/7 enquiries or calls for assistance and by strengthening the workforce's capabilities and capacity
- increasing efforts to build an understanding of, connection with and referrals to other services and community organisations in the client's local community and surrounding area
- planning, documenting and implementing throughcare plans that are co-designed with clients and developed in consultation with relevant local service providers and trusted (by the client) community Elders
- including of stronger and more explicit Aboriginal and Torres Strait Islander cultural and social and emotional wellbeing improvement practices built in service delivery patterns to provide leadership and modelling for best practice in the mental health sector more broadly.



Executive Summary

Overview

Since its establishment in 2017 and up to June 2019, the **National Indigenous Critical Response Service (NICRS)** provided postvention support to Aboriginal and Torres Strait Islander individuals, families and communities in response to 367 incidents (suicides or other traumatic events) in WA, NT, Queensland, SA, NSW and Victoria. At the time of the evaluation (2018-19) a network of approximately 12 (FTE) Critical Response Support Advocates (CRSAs) were employed to deliver the service. These frontline workers were supported by a team of approximately seven (FTE) management, coordination, cultural advisor and administrative NICRS staff positions. Clinical supervision and management support services were also contracted to support the CRSA team as required.

The national service is delivered by a newly established not-for-profit company, Thirrili Ltd., which is led by a Board of Aboriginal and Torres Strait Islander Directors and has been built during the initial program development phase. Thirrili is governed by a comprehensive set of organisational guidance documents, some of which **require review to support a clearer definition of the service goals and associated activities.**

The evaluation

The 2018-19 evaluation examined the NICRS from the period of establishment up to June 2019.

The objectives were to:

- demonstrate NICRS accountability in response to Indigenous Advancement Strategy (IAS) funding
- assess program quality, value & effectiveness
- identify opportunities for program improvement & re-design
- generate evidence to inform decision-making in line with the IAS Evaluation Framework.

A mixed methods approach was used to combine information from a literature review, review of program documents, interviews in WA, NT, Qld, and Victoria (14 Board and staff members, 18 clients, and 30 other service and community stakeholders) and NICRS program data. Information from these sources helped to understand how the service was operating, what it had achieved, and where there were gaps or a need for future adjustment.

The evaluation had ethical approval and was guided by a set of questions to look at relevance, effectiveness, efficiency, impact and sustainability of the service.

Effectiveness of the service

Clients and families consistently reported that **NICRS support was valuable** in their time of crisis many liked the confidentiality that an independent service could provide. Many service provider stakeholders confirmed that the service was **filling a service gap** in their geographic location.

Clients also highly valued receiving support from a service led by Aboriginal and Torres Strait Islander board and staff members and guided by values that align with their culture and approach to social and emotional wellbeing. However, it was clear that greater emphasis on implementation of the culturally focussed and place-based elements of the model would be appreciated.

Effectiveness of NICRS service provision could also be improved through careful consideration of the competencies required to undertake the challenging CRSA role – both in the initial recruitment process and in ongoing and professional development of staff (such as Mental Health First Aid and Accidental Counselling courses).

NICRS program activity identified throughout the evaluation can be summarised as follows:

NICRS PROGRAM ACTIVITY	
Number of service responses	Between commencement of the service and the last date of a reported incident in the Online Reporting System (ORS) data supplied to the evaluation team (23rd June 2019), there were 367 incident notifications . Of these, 275 incidents were responded to by the NICRS.
	NICRS 'cases' and 'clients' are created after being assessed for when a service should be provided. A total of 1,001 family members had been assisted in conjunction with all recorded cases to June 2019 where support was provided by NICRS.
Location of service responses	The largest proportion of total incidents notified (by place of incident) to the NICRS occurred in WA (40.5%, n = 363) followed by NT (26.4%) and QLD (23.1%), with SA (5.0%), NSW (3.0%) and Victoria (1.9%) presenting smaller numbers.
Types of incidents responded to / types of support provided	76% of incidents received a service and by definition, had therefore been considered 'in-scope' by NICRS staff.
	Suicides represent approximately 60% of all NICRS incidents. Incidents of completed suicide were those most likely to receive MICRS support (i.e. in nine out of every 10 cases); other types of incidents were slightly less likely to receive assistance.
	Where a service was provided, the most common type of intervention was an Emergency Relief Fund (ERF) payment (82.8%) followed by a referral (56.9%) and accidental counselling (22.1%).
Requests for services	The most common sources of request for assistance was the family (63%), service providers (39%) and community members (15%).
Nature of service delivery	Of the 275 incidents that received assistance (up to June 2019), 169 (61%) cases were responded to at least partially via face to face contact and most were supplemented by telephone contact. 96 (35%) of contacts were made only by telephone , with 4% involving 'other' contact.

Relevance of the service

Clients, other stakeholders and CRSAs reported that the **scope** and **application** of NICRS services were **not yet clear enough** – more explicit information and guidance was needed, including better elaboration and data collection around its culture-based approach. Many service providers and community representatives were not supportive of the ‘fly in, fly out’ service model for a region and strongly believed there was a need for a stronger emphasis on a **‘place-based’ approach** - to ensure that the service is well connected with local services and networks and has a good understanding of the context and needs of the local community. A more open, transparent and better documented service planning approach would help the process of co-design and engagement with clients, communities and local service networks, contribute to the creation of national suicide prevention resource mapping, and enable review and quality improvement.

Service reach

Rollout of the NICRS was **not achieved to all states and territories** (nor coverage of all priority areas within jurisdictions) within the initial three years as anticipated. This appears to have been an overly ambitious target which did not account for the intensity of effort that is required to achieve effective engagement in many communities.

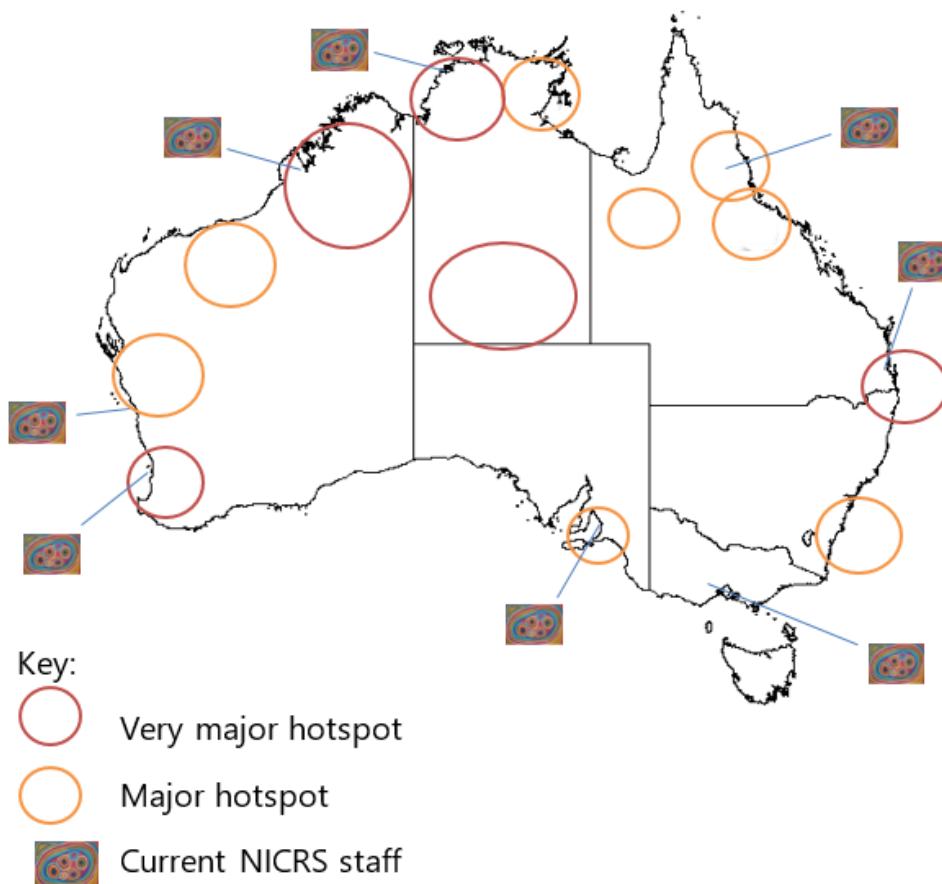


Figure 1: NICRS service delivery locations vs suicide hotspots

Measurement of the program's reach against national coronial data suggested that NT and WA have achieved significant reach while QLD and SA had much lower levels of reach.

Although some geographic spread of CRSAs has been achieved, the network of locations did not fully reflect the regions of Australia that appear to have been most significantly affected by suicide (both historically and more recently – see map below). Guidance to ensure greater consistency between locations and jurisdictions would assist CRSAs in their assessment and service response processes to incidents.

A more strategic and 'place-based' approach to prioritisation of local presence as well as more effective outreach and engagement strategies involving local communities are needed.

Sustainability of the service

The current dispersed approach of responding to individual incidents in many locations is **not a sustainable strategy**. It was found to be expensive, involved significant time commitments and was perceived as a 'fly in, fly out' model of care that did not engage effectively with the local community social and emotional wellbeing (SEWB) networks nor contribute to local capacity-building.

Providing **effective support and supervision** to CRSAs operating in isolation has proven difficult to achieve. Solo workers reported that it is often difficult to achieve work/life balance in meeting the support needs of the communities they serve. Long hours and extensive travel are regularly required, in sometimes potentially unsafe circumstances. The evaluation recommends management practice and service location changes to address these issues and to consolidate a more team-based approach to NICRS service provision.

Efficiency of the service

Consideration of overall expenditure in the program indicates an acceptable ratio of costs across direct, indirect and support-related costs, though support costs may be slightly high.

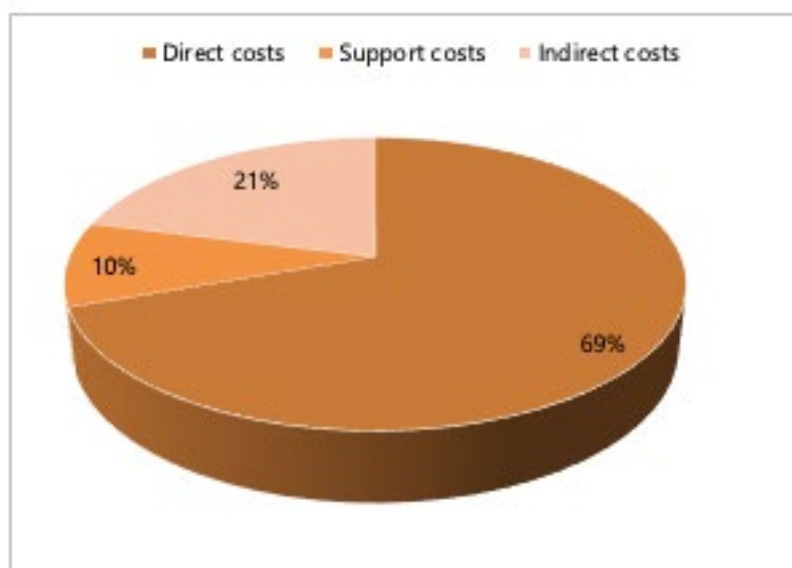


Figure 2: Distribution of total NICRS expenditure in FY2018-19 by type of cost (Source: HMA, 2020)

"They probably need to coordinate more through other services, refer people to other services." (Stakeholder)

Significant variation was identified in total costs associated with incidents:

- 'in scope' incidents ranged from \$2,873 to \$44,124
- 'out of scope' incidents ranged from \$982 to \$29,755
- total recorded ERF expenditure for all clients was \$131, 264. ERF per case ranged from \$50 to \$5,040 (31% of cases received <\$500 and 51% cases received > \$1,000)
- across cases where ERF was distributed, an average of \$863.58 was expended
- 38% of cases that involved more than 20 hours of CRSA support received over \$1,500 in ERF.

A preliminary Value for Money (VfM) assessment was undertaken by HMA management consultants in 2019-20, however, in the absence of clear agreed outcome measures and associated data there was insufficient information for a full VfM analysis at this stage of the service's development.

Impact of the service

Clients and stakeholders reported that, immediately after an incident, the service made an impact in their lives by assisting them emotionally and financially, but also in practical ways through advocacy support. In the short-term, at least, the service appeared to be having an impact on the stability of families, though there is significant scope for closer engagement with other local service providers and community organisations.

The long-term and broader impacts of the service, however, were not possible to objectively determine. This was primarily due to a **lack of objective measures or tools** to capture pre and post improvements in SEWB of clients and their families supported by the service. Improved data collection processes and analysis to support continuing quality improvement are areas of recommended focus for achieving a better understanding of how the service is being delivered and its impact. Closer **alignment of NICRS human resources to known areas of concentration**, or 'hotspots', of suicides is likely to result in better targeting of unmet demand for service.

Next steps for NICRS improvements

A recommendation by the evaluation team has been provided to reconstruct the model of care and outcomes measures. The intention of the example model provided is to highlight the way the broad outline of the service and the boundaries around the type and duration of support could be made clearer, as well as promoting long-term capacity building and community engagement in service locations.

"The emotional support provided to me by the service has been life changing, it's helped me to stay strong for my other children." (Client)

The service model has been reconfigured into a draft three-phased approach, as follows:



The evaluation identified that improvements are required to:

- strengthen the workforce's capabilities and capacity
- develop a governance framework that covers all levels of the NICRS including regular practice supervision and support of the CRSA workforce
- develop a strategic plan with agreed outcomes and indicators
- improve data collection processes to support quality improvement and future evaluation efforts.

Acronyms & abbreviations

ACCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
ACCCHS	Aboriginal Community Controlled Health Service
ACT	Australian Capital Territory
AMS	Aboriginal Medical Service
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
COAG	Council of Australian Governments
CQI	Continuous Quality Improvement
CRM	Customer relationship management
CRSA	Critical Response Support Advocates
ERF	Emergency relief funding
HCA	Human Capital Alliance
IAS	Indigenous Advancement Strategy
MSC	Most Significant Change
NGO	Non-government organisations
NIAA	National Indigenous Australians Agency
NICRS	National Indigenous Critical Response Service
NSW	New South Wales
NT	Northern Territory
ORS	Online Reporting System
PHN	Primary Healthcare Network
QLD	Queensland
SA	South Australia
SEWB	Social and emotional wellbeing
UWA	University of Western Australia
VfM	Value for Money
WA	Western Australia
WHO	World Health Organization

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1 The National Indigenous Critical Response Service

1.1 Background evidence

Aboriginal and Torres Strait Islander social and emotional wellbeing

Suicide rates among Aboriginal and Torres Strait Islander people are 24.1 per 100,000, compared to 12.1 per 100,000 overall in Australia in 2018 (ABS, 2019). In the five years from 2014–2018, intentional self-harm rates among Aboriginal and Torres Strait Islander people were 23.7 per 100,000 compared to 12.3 per 100,000 among the general Australian population (ABS, 2019).

It is in this context that Aboriginal and Torres Strait Islander people live today – often with strong sense of being Indigenous to Australia but experiencing many barriers to equity and equality. Whole families and communities as well as culture and the environment (Country) are affected across generations when a person passes away by suicide or other trauma.

The underlying factors for these statistics are complex and varied. Ongoing health inequalities (Markham & Biddle, 2018; Seccombe, 2018), poor levels of access to mainstream health services (Department of Health, 2017; Goodwin-Smith, et al., 2013) and under-developed Aboriginal and Torres Strait Islander workforces and capacity to deliver culturally safe services (Department of Health, 2017) are some of the factors affecting the health, social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Suicide prevention has become a major policy and service delivery focus in Australia's suite of mental health interventions. Postvention involves provision of support to individuals and/or communities after a suicide to assist in recovery and to help reduce the potential for further suicides. It is a relatively new but promising intervention and the specific literature and evidence relating to its effectiveness is only now emerging. In the context of suicide prevention and postvention, facilitating connection to and healing from culture is also now a well-recognised success factor in service delivery strategies, inspiring hope and promoting health social and emotional wellbeing.

A more detailed description of the research and policy landscape that is relevant to the National Indigenous Critical Response Service (NICRS) is at Appendix 1.

Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)

The 2015–17 ATSISPEP initiative was funded by the Australian Government to evaluate the effectiveness of existing suicide prevention services and programs. Three common principles appeared in ATSISPEP's overall recommendations for postvention support (Dudgeon et al., 2017):

- the importance of building on Aboriginal Community Controlled Health Services' existing mental health and SEWB services
- ensuring existing services and actions were respected and connected

- the provision of coordinated, timely and practical responses in communities and across regions.

ATSISPEP produced a *Recommended Service Model for Critical Responses in Indigenous Communities*, which included two major streams of connected activity:

1. Critical Response Stream
2. Community Development Stream.

That model, which was developed from ATSISPEP's expertise and community engagement, a roundtable and two streams of activity, has informed the development of the NICRS. It asserted the need for Regional Critical Response Advocates to facilitate the development of shared agreements, conduct community training and develop networks, with Community Level Functions identified prior to, in the short-term and after incidences (Dudgeon et al., 2017). The model also included a clear role and need for of national-level support agencies, including a National Leadership Role in Suicide Prevention, and a Centre of Best Practice in Indigenous Suicide Prevention (Dudgeon et al., 2017).

A pilot project to test the model's effectiveness was conducted (December 2015- December 2016) in three regions of southern WA where suicide was having ongoing impacts on local communities. This pilot operated from December 2015 to December 2016. The NICRS service model was strongly based on this pilot model but adopted a largely centralised national scope rather than the region-led approach suggested in the ATSISPEP model.

Success factors and quality indicators for postvention activities

Dudgeon et al. (2016, p. 16) also identified a range of success factors in suicide prevention, including postvention, for activities at three intervention levels¹:

- **Universal interventions:** Community-wide prevention actions through *primordial prevention* addressing risk factors for suicide and *primary prevention* to prevent a completed suicide or suicide attempt occurring
- **Selective interventions:** Aimed at groups identified at higher risk of suicide; evidence gathered by ATSISPEP indicated Aboriginal and Torres Strait Islander children and young people require specific attention, with responses tailored well to age groups generally
- **Indicated interventions:** Interventions with individuals identified as at risk of suicide, or who have attempted suicide

In addition to levels of intervention and success factors, ATSISPEP identified quality indicators for postvention activities according to six broad domains (Dudgeon et al., 2016, pp. 65-70).

¹ Although the primary focus of the NICRS is on Indicated interventions, its scope also includes selective identification of those who have been bereaved after an incident and may therefore require postvention support, as well as contributing to local and national efforts to address risk factors (such as through promoting the benefits of connection to culture for strength and healing), promoting coordination and raising community awareness of suicide prevention strategies through its work in communities.

1.2 Inception of the NICRS program

In December 2016, during the final stages of the critical response pilot project, \$10 million in funding was granted by the Australian Government, through the Safety and Wellbeing Program of the Indigenous Advancement Strategy (IAS), to develop and deliver the National Indigenous Critical Response Service (NICRS) – a suicide postvention service for Aboriginal and Torres Strait Islander communities across Australia.

The primary aim of this three-year funding investment was to set up a new postvention service with national reach. A clear secondary aim of the investment was to support the expansion of the national Aboriginal and/or Torres Strait Islander-led mental health and social and emotional wellbeing service delivery infrastructure. It also allowed transitional support to continue where needed for the initial clients, participating communities and service delivery staff of the critical response pilot project in southern WA, which has been described above.

The contract for this funding was initially held by the management consultancy firm, Healthcare Management Associates Inc. (HMA) during the establishment period of the new organisation (Thirili) during early 2017. The funding contract and funding were transferred to Thirili in April 2017 (Clear Horizon, 2018).

1.3 Description of the program

Program mission and philosophy

In addition to the guidance provided by the ATSIPEP initiative in the previous section, development of the NICRS program was also based on the World Health Organization (WHO) definition of postvention:

“Intervention efforts for individuals bereaved or affected by suicide [that] are implemented in order to support the grieving process and reduce the possibility of imitative suicidal behaviour.”

(WHO, 2014: pg. 37)

The NICRS program is guided by a comprehensive social and emotional wellbeing (SEWB) framework that is designed and implemented to support healing and is informed by the well-defined principles that are outlined the section above. This SEWB framework is embedded into the NICRS model of care and described in more detail below.

Program activities and objectives

Three key areas of NICRS program activity were funded to address the program goals of this national service, as summarised in Table 1.

Table 1: Key activities of the NICRS program

Key Activities	Objectives
Postvention & bereavement support services for Aboriginal & Torres Strait Islander families & communities	Enhance and provide critical response support to individuals, families and communities affected by suicide or other traumatic incidents, by providing practical support to individuals, families, and communities in a timely manner, where existing services may not be providing an adequate response.
Building community resilience & capacity to support prevention & provide postvention response services in Aboriginal & Torres Strait Islander communities	Identify local community needs and activities relating to prevention and postvention and support the development and implementation of a model that promotes better service system coordination and builds community capacity & resilience of Aboriginal and Torres Strait Islander communities affected by suicide related incidents and/or other highly traumatic critical incidents.
Systems change: Undertake stakeholder engagement at the National, State and Regional level	Improve the coordination of postvention response services for affected individuals and families, working alongside existing services that can provide support to the program and its aims.

It should be noted that the current evaluation scope has been limited to only **Postvention and bereavement support activities**, or “Stream one” support services, as delivered in WA, Northern Territory (NT), South Australia (SA) and Queensland (QLD). In interviews with NICRS management, though, it was noted that the service program situation is evolving such that different program ‘streams’ are merging. Thus, it is becoming accepted that individual and family-based support (Stream One or Postvention and bereavement support activities) can, and perhaps should, lead to broader community capacity building and population health type interventions. The evaluation team understood that this vision of service direction is still possibly evolving.

The objectives of the NICRS are broad and reflect the holistic Aboriginal and Torres Strait Islander definition of health which recognises that health is more than the physical wellbeing of an individual and that also includes the mental, emotional, social, environmental and spiritual dimensions connected to the whole community (National Aboriginal Health Strategy Working Party, 1989).

The NICRS objectives also align with concepts of multi-level empowerment in Aboriginal and Torres Strait Islander contexts, recognising that actions to promote an individuals’ wellbeing are required at multiple ‘levels’: for the individual, as well as the families to whom an individual is connected, communities in which individuals and families live, among services for support through culturally safe workforces, and in the systems that fund and shape service delivery (Jackson Pulver, Williams, & Fitzpatrick, 2019).

Expected outcomes and goals of the NICRS

The anticipated immediate, intermediate and longer-term outcomes and goals that have been defined for the NICRS are outlined in the formal program logic that was developed by Thirili in 2017 (Appendix 2) to assist with guiding service development and review.

The long-term **social goal** of the service is:

'Aboriginal and Torres Strait Islander communities have improved capacity to undertake healing postvention'

Immediate and intermediate outcomes are intended to contribute to three **program goals**:

1. *Improved understanding of the needs of Aboriginal and Torres Strait Islander communities when responding to suicide and other traumatic events and issues that affect them*
2. *Service and community systems have increased capacity to respond in culturally appropriate ways to support Aboriginal and Torres Strait Islander communities*
3. *Communities are receiving culturally appropriate, holistic and locally tailored program delivery.*

NICRS model of care

The NICRS model of care (see Appendix 3) follows an eight-step approach to guide engagement with families, the local community and local services. It is strongly aligned to the ATSIPEP-recommended model but does not follow every proposed aspect of that model. In particular, the NICRS model has a less structural focus on regional governance arrangements and the involvement of Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).

The NICRS model of care is underpinned by a SEWB framework that is designed and implemented to support healing. This framework has been extrapolated to guide the work of the Critical Response Support Advocates (CRSAs), who are the NICRS workers providing frontline services (see section *Critical Response Support Advocates* for more information about the role).

NICRS service process

The NICRS program aims to provide postvention *throughcare*, where individuals and families affected by suicide or other trauma are provided with coordinated and culturally responsive support for their *journey of healing*. Support is only provided on the invitation of individuals and families and postvention throughcare² plans can then be developed to ensure service clients live safe and meaningful lives. NICRS defines throughcare in this context as the *'... provision of coordinated and culturally responsive support to individuals and families affected by suicide or other trauma.'*

As outlined in the model of care diagram (see Appendix 2), support from the NICRS should be provided in an eight-stage process, commencing upon notification of an incident and seeking consent from the family to engage with those directly affected, providing a range of direct support,

² The term 'throughcare' is most widely used in the prisoner release context, but has been adapted to the purposes of the NICRS program.

generating comprehensive engagement with the local community and mental health service network, and continuing through to a carefully managed stepping back process.

Once the throughcare plan is implemented, the needs of the individuals and families should be assessed every three months to assess any emerging needs and to consider whether it is appropriate for the service to 'step back' from the clients. Stepping back occurs when increased resilience in the client/s and strong support systems are observed. According to the model of care, however, support from the service is not time-limited and client/s can still seek support from the NICRS.

The service is provided by a network of CRSAs located in identified areas of need throughout Australia, with coordination and support provided either from national or state/territory-based management and support staff. The service provision arrangements vary somewhat according to the requirements and infrastructure available in different jurisdictions and regions. Partnership with local organisations is a stated core value for the service's implementation process and this may result in some variation at the local level according to community needs.

1.4 Governance and staffing

Thirrili

Thirrili Ltd is a not-for-profit company limited by guarantee and a registered charity which was established during this initial phase of NICRS funding. Since registration of the company in early 2017, the NICRS program has been governed by the Thirrili Ltd Board of Directors.

The Board is currently made up of six Directors (including five from Aboriginal and/or Torres Strait Islander backgrounds), as follows:

- Tim Goodwin, Chair
- Dr Mark Wenitong, Deputy Chair
- Jacqui Flynn
- Indi Clarke
- Belinda Duarte
- Wayne Kinrade (Founding Thirrili Director and HMA Managing Director).

The stated mission of Thirrili, as the program's auspicing body, is:

'...to support social and emotional wellbeing of our people to stem suicide and trauma'.

Since it commenced its responsibilities in April 2017, the Board has overseen the establishment of approximately 60 organisational and service delivery policies to guide its operations. Appendix 4 provides a list of those policies (as provided by Thirrili staff to HCA during the evaluation period). These policies have been categorised as either core organisational policies or NICRS specific policies. The breadth of the list provides an indication of the degree of investment required during the funding period to support the establishment of Thirrili as a service provider.

NICRS staffing structure

Under the oversight of the Board of Directors, the NICRS is managed by the Thirrili Chief Executive (via the co-held position of NICRS Project Director). A Chief Executive position reports directly to the Board. This position is responsible for developing and implementing a range of other activities

endorsed by the Board to promote Thirrili's formal objectives. This role has been established with dual responsibility for leading the NICRS in the role of Project Director (as described in the organisational structure at Figure 3 below).

The Chief Executive/Project Director role is supported by two Cultural Advisors (one in WA and one in Far North QLD), a Project Manager, several policy and administrative support positions, two Coordinator positions, and approximately 10 CRSA positions. The role of CRSAs is described in more detail in the next section.

Figure 3 below provides an indication of the current organisational structure of Thirrili and the NICRS program, including broad geographic locations and associated full time equivalent (FTE) allocations. Not all positions were filled at the time of writing this evaluation report. A table outlining the roles of each of these position types is at Appendix 5.

In addition to the Board and employee positions indicated in Figure 3, a psychologist is contracted to provide practice supervision to Thirrili employees on an individual (as needs) and group (monthly) basis. This contractor also assists with the development and review of organisational policies.

Critical Response Support Advocates (CRSAs)

CRSAs are the frontline staff who deliver the NICRS supports. The role of CRSAs is to provide postvention support that is informed by the key domains of the SEWB framework. CRSAs work closely with clients and respond to the SEWB needs of clients immediately after an incident notification has been made to the service.

A range of different protocols are applied by CRSAs depending on the context or age of clients to ensure all domains of SEWB are addressed.

Currently 10 CRSAs are employed to deliver the service in WA, NT, QLD, SA and Victoria. Three additional roles are still to be established in New South Wales (NSW), Tasmania and the ACT, either directly or via a sub-contracting arrangement. A position was created and briefly occupied in Victoria but is currently unfilled.

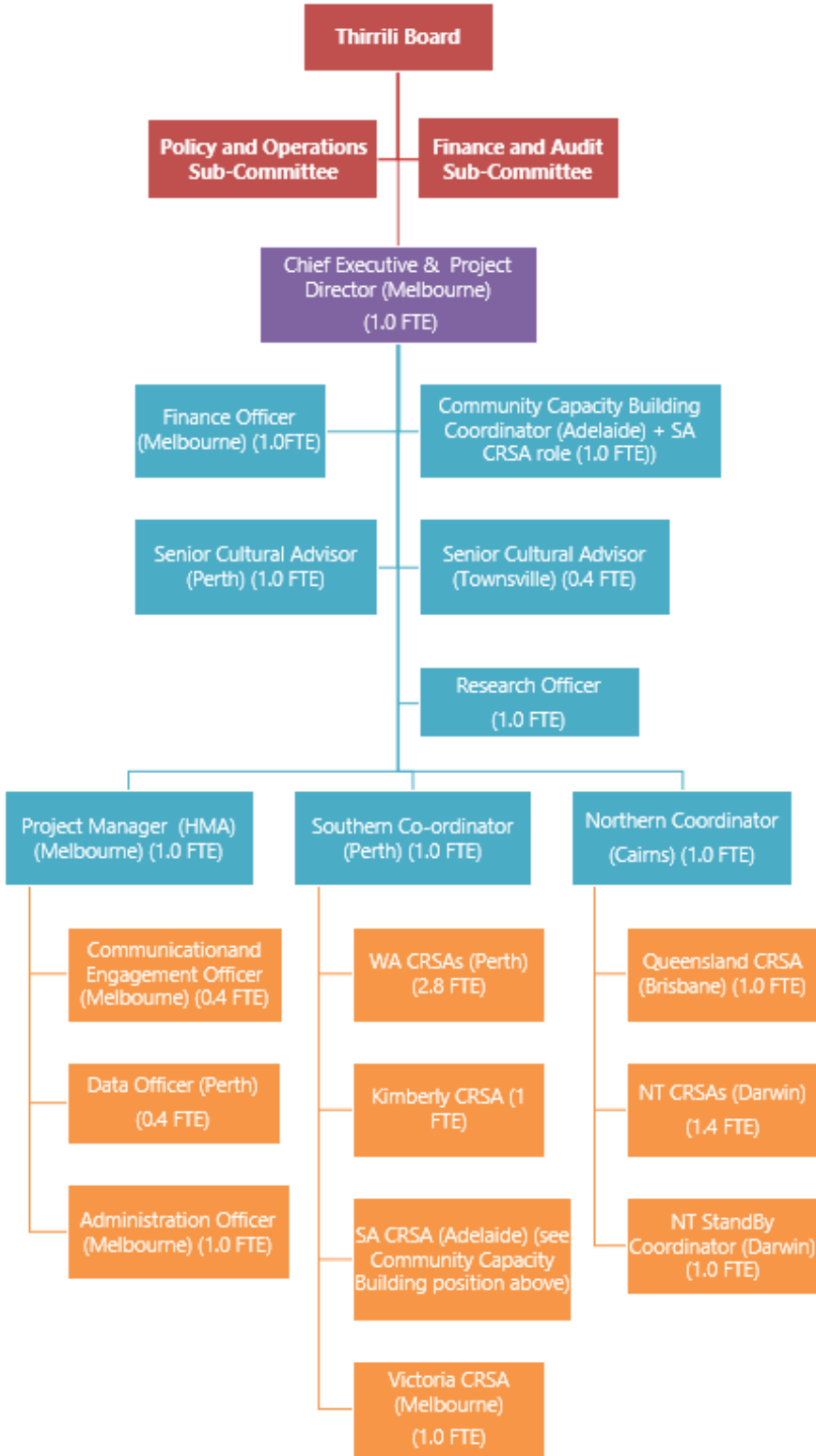


Figure 1: Thirili organisational structure

The current (as at March 2020) geographic distribution of the network of CRSAs is summarised in Table 2 below.

Table 2: Location and number of CRSAs

STATE	Number of staff (FTE)
WA	2.8 FTE CRSA positions based in Perth 1 FTE CRSA position based in Broome to service the Kimberley region – sub-contracted position to Kimberley Aboriginal Medical Services and provided in conjunction with StandBy The equivalent of 1 FTE position based in Geraldton to service. A sub-contract arrangement with Geraldton Regional Aboriginal Medical Service (GRAMS) pays for that service to deliver a NICRS type ³ service in the Gascoigne-Murchison region
NT	1.4 FTE CRSA positions based in Darwin 1 FTE StandBy Coordinator position based in Darwin
QLD	1 FTE position based in Cairns – now combined Northern Coordinator / CRSA position 1 FTE position based in Brisbane.
SA	1 FTE position based in Adelaide (combined position with national Community Capacity Building Coordinator role).

Additional NICRS service provision arrangements

In addition to its core NICRS service provision role in the NT, Thirili delivers the *StandBy - Support After Suicide* (StandBy) program, which is a national whole-of-population suicide postvention support service that has a complementary service model to the NICRS.

The StandBy service delivery role is undertaken on a sub-contracting basis on behalf of the not-for-profit community and social services organisation, United Synergies. The NICRS and StandBy programs are delivered in an integrated way and share a common referral email for stakeholders to contact the service in the NT. Standby was established in 2002 and has many resources, tools and programs that the NICRS team has available to them to draw upon in delivering postvention support.

As noted above, a sub-contract service provision arrangement has also been put in place with a local organisation in the Geraldton region. This arrangement with GRAMS is worth \$100,000.

³ The GRAMS service does not have a CRSA-centred response to a traumatic incident. The response is instead quite idiosyncratic and is more akin to the community capacity building actions of the NICRS 'Stream two'.

1.5 Planned service rollout

According to the NICRS funding contract, implementation of the service was expected to occur in three stages of rollout, as follows:

- Year 1 (2017) – NT, SA, and WA
- Year 2 (2018) – Victoria and QLD
- Year 3 (2019) – NSW, ACT and Tasmania.

The rollout has not fully proceeded according to the anticipated schedule, with Victoria only recently operationalised and NSW, ACT and Tasmania still waiting to be fully activated as at March 2020.

2 Evaluation of the NICRS

2.1 Objectives

The objectives of the evaluation were to:

- ▶ demonstrate NICRS accountability in response to IAS funding
- ▶ assess program quality, value and effectiveness
- ▶ identify opportunities for program improvement and design
- ▶ generate evidence to inform decision-making in line with the IAS Evaluation Framework.

2.2 Evaluation questions

The broad evaluation questions that were explored were:

- 1) Relevance – is the program relevant to the needs of families and communities?
- 2) Effectiveness – are objectives of the Program being met (in particular, the effectiveness of family and community interactions and the relationships with service providers)?
- 3) Efficiency – are resources being used efficiently?
- 4) Impact – what difference does the service make? Can the effects be attributed to the service or would they have occurred anyway (although not in a comparative framework using a no-intervention control group or other normative benchmark, which would have allowed causality to be determined more precisely)?
- 5) Sustainability – are the observed outcomes likely to produce ongoing results?

Detailed evaluation questions can be found in Appendix 6.

2.3 Data collection and analysis activities

A mixed methods approach was used for the evaluation to provide a comprehensive overview of the NICRS in relation to the outputs and intermediate outcomes detailed in the program logic (Thirilli, 2017).

Other aspects of the program logic, the relevance of the program and the way the program has been implemented, were previously addressed in the formative evaluation (Clear Horizons Consulting, 2018). However, as the NICRS is still only just over three years old, some implementation issues remain relevant and so are covered again in this report.

The specific evaluation methods employed were:

- *case studies* where a critical incident response has been initiated and followed through to at least Step 6 (that is, the development of a throughcare support plan) of the NICRS model of care (see Appendix 3). This involved interviewing clients, CRSAs, community members, local service providers and any other relevant stakeholders from the local area (see Appendix 7 for number and type of interviews)
- *analysis of 'Most Significant Change' (MSC) stories* developed by Thirrili to identify important elements of practice and response and discussed at monthly case conference meetings of CRSAs
- *analysis of the Online Reporting System (ORS)*, the NICRS program administrative data base collected by CRSAs
- *document review* – review of program documents such as evaluation reports, plans, policies and position descriptions.

More detailed descriptions of the evaluation methods can be found in Appendix 7. Further detail of the overall evaluation design is provided in the Evaluation Plan and the Evaluation Framework (HCA, 2019).

3 Profile of NICRS activity

As noted in the methodology section, data from the ORS database was analysed to understand the NICRS service activity during its initial 3-year period (January 2017 to June 30, 2019). In the sections below the service activity is described in terms of:

- Total incidents notified to the service
- Distribution of incidents by location of incident and location of home
- Distribution of incidents by incident type
- Distribution of incidents by gender and age
- Proportion of incidents that converted into cases.

3.1 Notified incidents

The earliest incident responded to by the NICRS was in December 2014 (although a response associated with this incident was not commenced until April 2019). This and several other incidents (10) pre-date the formal commencement of the NICRS; therefore, it is assumed that either the wrong date was recorded, or they were part of the previous pilot project. Alternatively, they were eligible incidents which had never been addressed in the previous absence of a NICRS type service⁴. The first recorded notification of an incident for the NICRS was in January 2017.

⁴ For instance, in one incident from the past involving 8 children, the family of the paternal side had reached out for support from the NICRS soon after it was formed. That incident was taken on in recognition of the significant impact that the incident still had on the family and the local community.

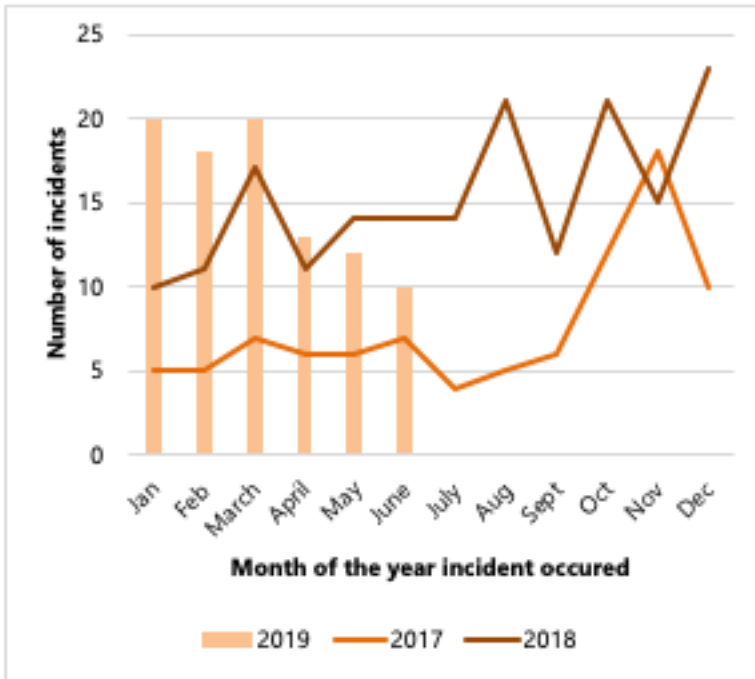


Figure 4: Distribution of NICRS notifications by year and month

Between commencement of the service and the last date of a reported incident in the ORS data supplied to the evaluation team (23rd June 2019), there were 367 incidents (plus five others with no date and 10 pre-2017) notified to the NICRS (Figure 4). The distribution of incidents was 91 in 2017, 183 in 2018 and 93 in 2019 (up until the end of June).

Using only the service years for which complete data was available (2017 and 2018); the months with the most incidents notified to the NICRS were October, November and December. This partially validates the commonly held perception that suicides are most prevalent around the end of year period. The months of January and February 2017 would have been affected by low numbers during the 'start-up' period (Figure 5).

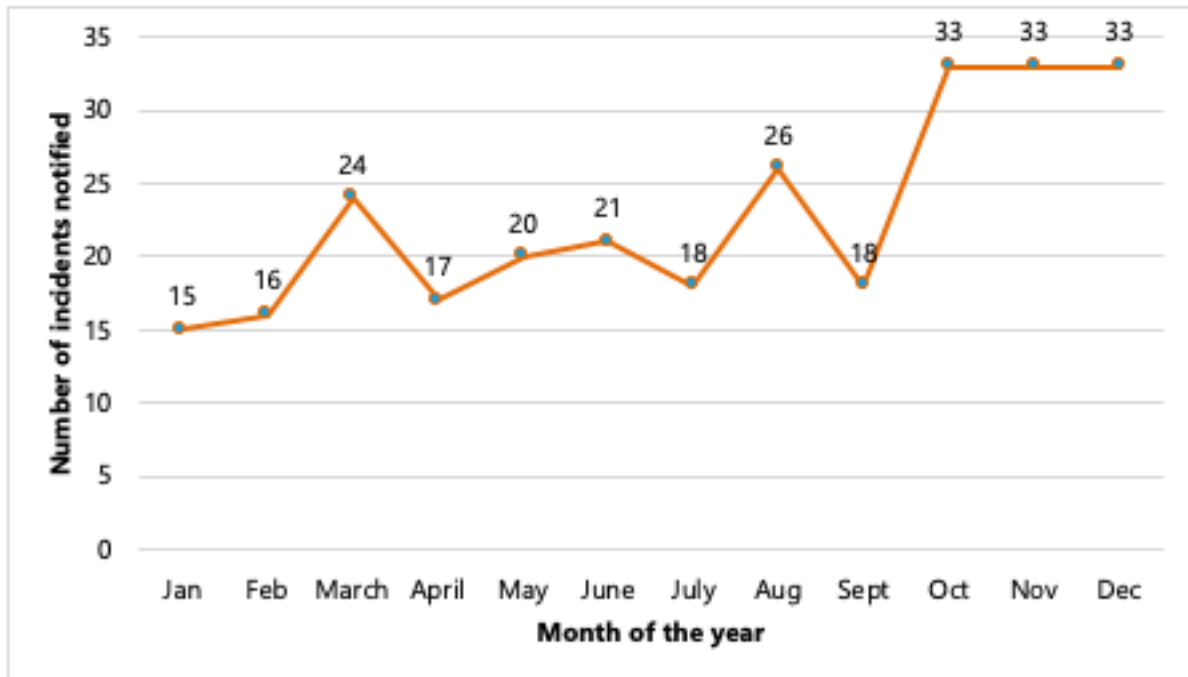


Figure 5: Distribution of incidents notified by month of the year (combined 2017 and 2018 data only)

3.2 The nature & location of notified incidents

The majority of incidents notified to NICRS resulted from a completed (57%) or attempted (16%) suicide. Just under one-fifth of the incidents (17%) involved a trauma resulting in death (Table 3). These results are similar to the findings by HMA (2020).⁵

Table 3: Distribution of notified incidents to NICRS by incident type (n = 367)

Incident type	Number	Proportion (%) of total incidents
Attempted suicide	58	15.8
Completed suicide	209	56.9
Other trauma involving a death	64	17.4
Other trauma not involving a death	36	9.8
Total	367	100

⁵ The HMA report analysed ORS data from a similar time frame (2017 to September 2019) focussing on some (but not all) of the same activity variables. The report also collected original data through a survey of CRSA activity and collated data from the NICRS accounts.

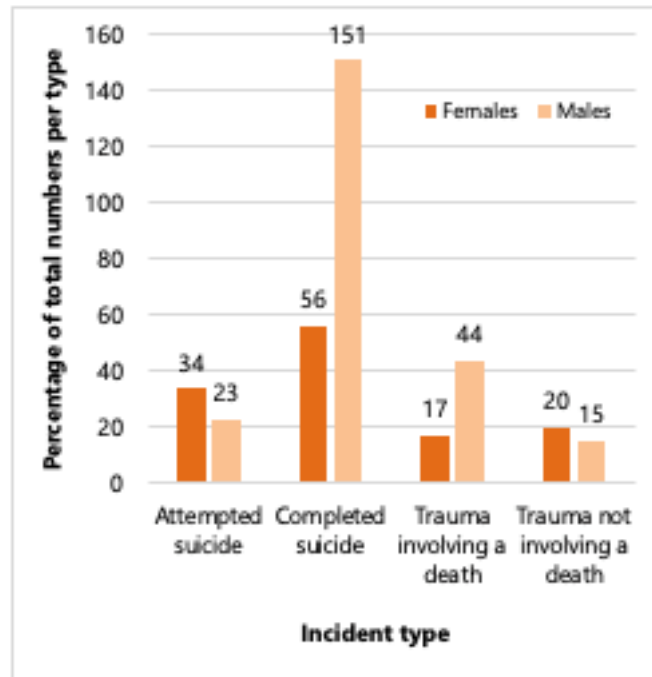


Figure 6: Proportional distribution of types of incidence by gender (n=360)

Most of the total incidents (64.7%, n = 360, five missing values) involved males⁶ but for each of the different incident types, the proportion varied. Completed suicides were proportionally much more undertaken by males (73%) whereas attempted suicides were more likely to be undertaken by females (60%). A similar pattern was observed for trauma incidences (see Figure 6).

Most incidents (70%, n = 306, 66 missing values) involved persons younger than 31 (Figure 7). Just over one-fifth of the incidents (20.5%) involved persons in the 31 to 40 age group.

⁶ After allowing for missing values, this finding is similar to the results found by HMA (2020).

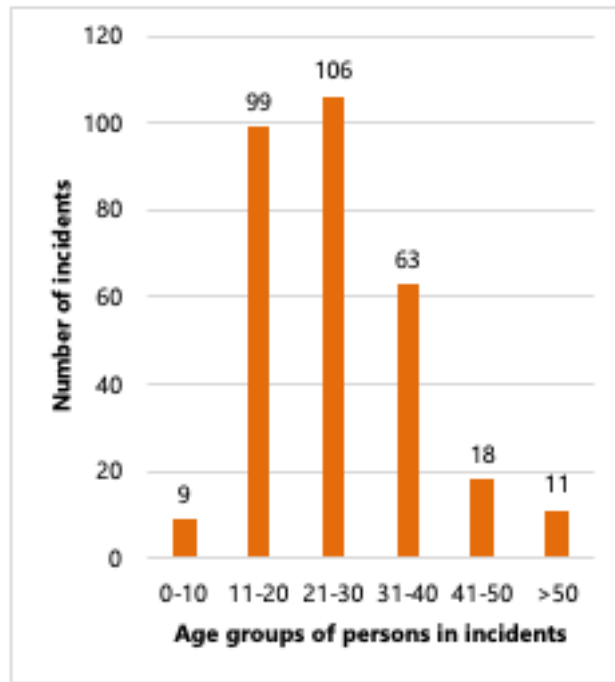


Figure 7: Distribution of incidents by age of person involved in the incident (n = 306)

The largest proportion of total incidents notified (by place of incident) to the NICRS occurred⁷ in WA (40.5%, n = 363). This may be a result of the history of the NICRS having been developed first in that state, including the running of the pilot project. Other prominent states/territories in this analysis were the NT (26.4%) and QLD (23.1%), with SA (5.0%), NSW (3.0%) and Victoria (1.9%) presenting smaller numbers. It is unclear why NSW and Victorian incidents were notified to the NICRS, and recorded even in small numbers, before July 2019 when there were no CRSA resources yet deployed in those jurisdictions. The place of the incident did not always coincide with the state/territory of residence of the person involved in the incident, although comparative analysis with the latter showed little difference.

The map at Figure 8 below provides an insight into the concentration of suicide incidents (so called 'hot spots') as recorded in the ORS (n = 210). Suicides represent approximately 60% of all NICRS incidents. By focusing on suicides only, a useful point of comparison with other available data sources is possible (see later section on 'Reach'). Of course, the distribution of suicide incidents according to ORS data will be strongly influenced by the process of staggered jurisdictional implementation.

⁷ The place of the incident did not always coincide with the State/Territory of residence of the person involved in the incident.

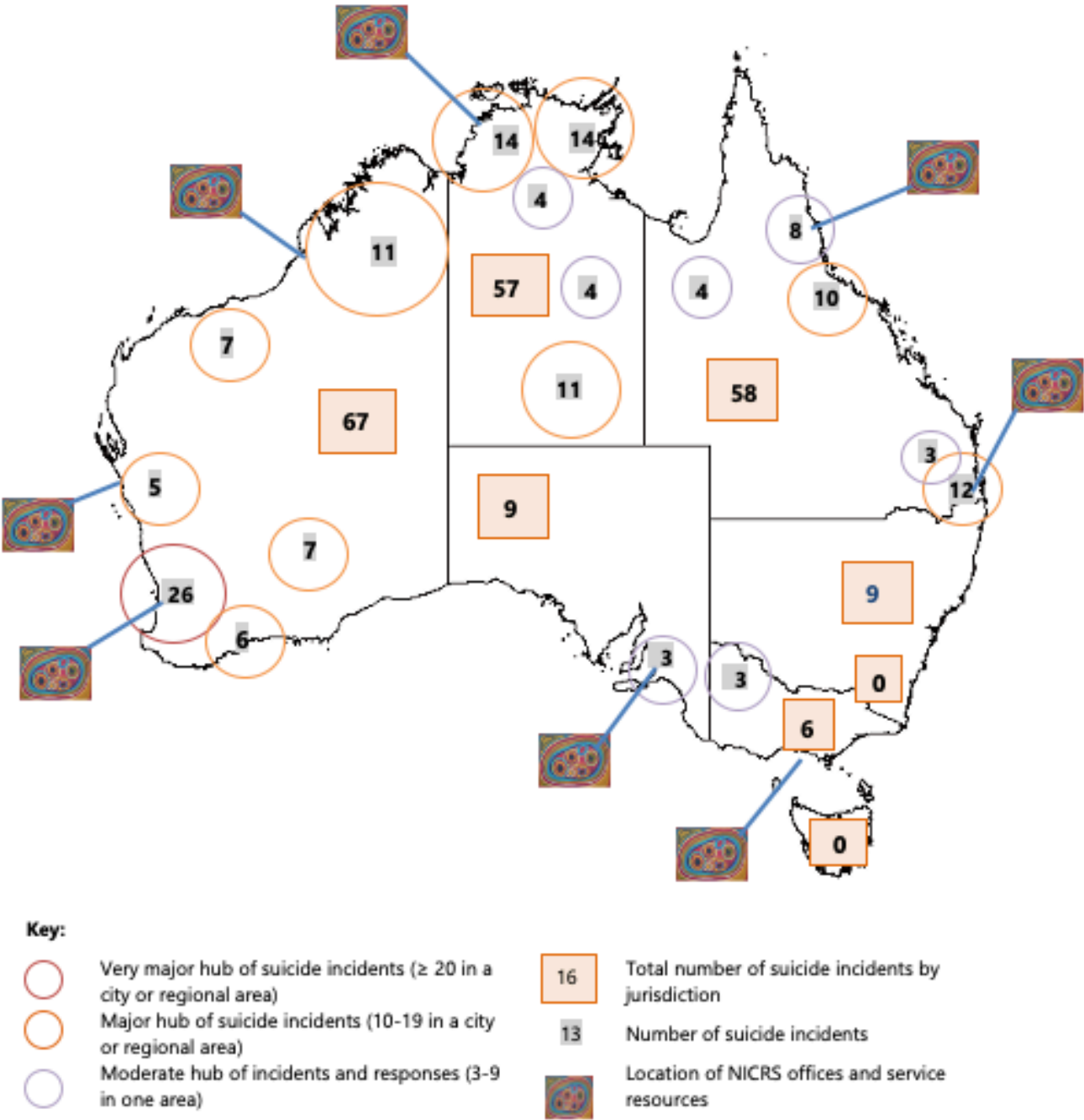


Figure 8: NICRS suicide ≥ 3 incidents by location and CRSA location⁸ (Source: based on ORS data)

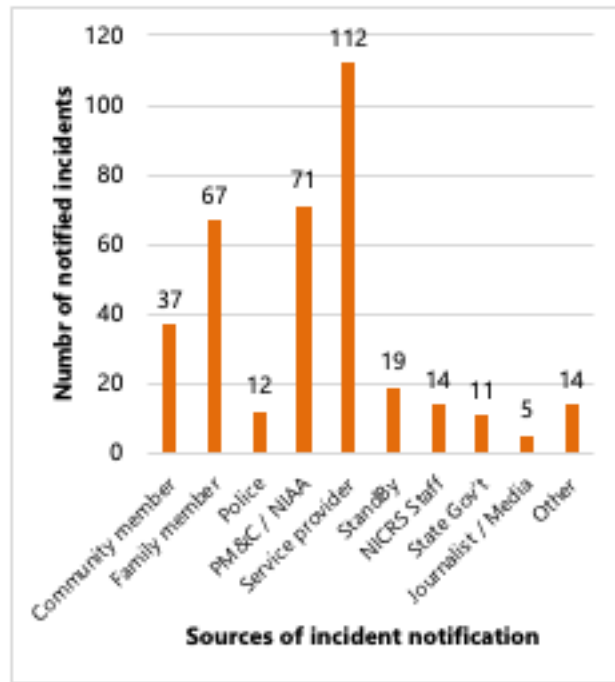


Figure 9: Distribution of notifications of an incident by source of the notification (n=362)

3.3 Source of notifications

The source of notifications varied but the most common source was service providers (30.2%, n = 362), PM&C/NIAA (19.9%) and family members (17.9%, see Figure 9). In the ORS Manual, the term 'informant' is used in lieu of 'notifier' or 'source of notification' and is defined as (p. 2):

"... the person who reports an incident to NICRS, or it may be someone we speak with in the community who is able to provide us with information about the deceased, the incident or the family of the deceased. They may be a police officer, a member of the community or a family member."

Under this definition an informant could be a reporter of an incident, a provider of information or maybe even the source of a request for assistance.

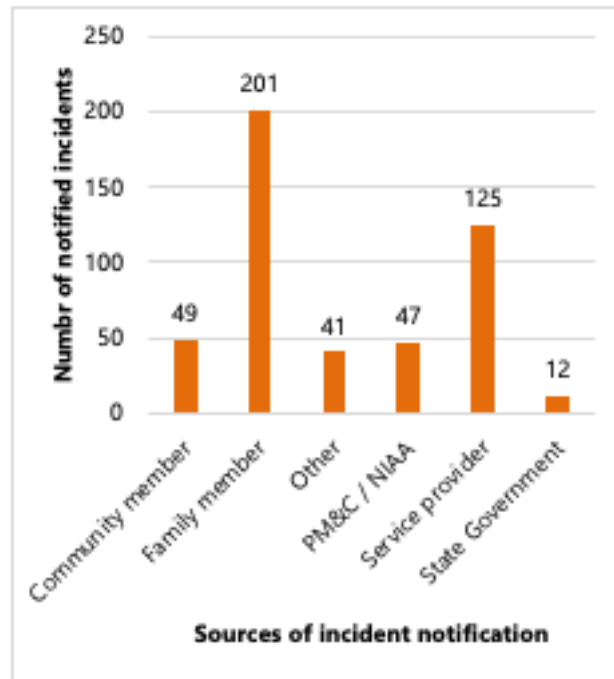


Figure 10: Distribution of incident by source of request for assistance (n = 318) - incidents with no request excluded

It is not precisely clear from the data dictionary how the source of notification or 'informant' is distinguished from another separate ORS data variable which identifies the source from which assistance was sought. For this variable, the more prominent source is a family member. NICRS management advised verbally that the latter variable captures data on actual requests for support.

The 'informant' source from which assistance was sought can often be the same as for notification but seems to be frequently different. This is to be expected as, following notification, enquiries are made by an allocated CRSA, both to validate an incident and to assess the need for assistance. In Figure 10, the main sources of request for assistance are identified. It should be noted in relation to this data that: a) 45 (12.4%) of the 363 notifications during the period January 2017 to end of June 2019 did not request assistance, and b) for many incident notifications, a request for assistance was received from more than one source, meaning more than one notification for a single incident is included. The most frequent 'informant' source of request for assistance was the family (63%), followed by service providers (39%) and community members (15%).

3.4 Response to notifications

As noted above, not all notifications involved seeking assistance. Additionally, not all the incidents were responded to with an initial offer for assistance, as the matrix at Table 4 demonstrates. In 12.4% of cases an incident notification **was not** accompanied by a request for assistance (although a small proportion of these did subsequently receive support). In a further 12.4% of cases a request for assistance **was not** responded to positively that is no assistance was offered.

Table 4: Matrix of notifications vs assistance provided (n = 362)

	Assistance PROVIDED	Assistance NOT provided
Advocate assistance NOT requested	2 (0.5%)	42 (11.6%)
Advocate assistance REQUESTED	273 (75.4%)	45 (12.4%)

In order to determine whether a response to requested assistance is provided or not, each incident is classified according to whether it lies within the scope of NICRS practice.

Inclusion criteria include (HMA, 2020):

- concerns family members may be at heightened risk of suicide, e.g. they have lost family to suicide previously or suffer from mental illness
- the event involves the accidental or sudden death of a child under the age of 18
- there is a lack of services in the community able to provide support to individuals or family
- there is significant media interest in the event, which may place significant pressure on the family, and cause “shame” to the family, which may heighten the risk of suicide
- there is a high risk of vicarious trauma given the suicide or event occurred in a public place.

Incidents may be considered out of scope if:

- the incident was not a suicide or a non-fatal traumatic event⁸
- neither the deceased or any of the potential clients, including their children, identify as an Aboriginal and/or Torres Strait Islander person
- the incident relates to a murder, domestic violence or sexual assault as other services are available to support family members.

As noted in Table 4 above, 76% of incidents received a service and, had therefore been considered ‘in-scope’⁹ by NICRS staff. An analysis of ‘cleaned’ 2018 NICRS ORS data (HMA, 2020) found that the proportion of ‘in-scope’ incidents was 69%. The authors noted, though, that a number (indeed 17%)

⁸ The NICRS ORS Manual defines ‘Non-Fatal Trauma’ as ‘someone who has attempted suicide and is on life support or involved in a serious traumatic incident e.g. has been seriously injured in a traffic incident.

⁹ Note that the ORS data provided to HCA did not include a field that designated the scope detail, rather a field which designated whether a service had been provided or not was included in the data set.

of cases (namely, those incidents for which a service is eventually provided – see further detail below) involved incidents that had previously been designated ‘out of scope’ in the ORS.

Table 5 shows that incidents of completed suicide were those most likely to be aided (i.e. in nine out of every 10 cases), while other types of incident were slightly less likely to receive assistance.

Table 5: Distribution of advocate assistance provided by type of incident

CRSA assistance	Type of incident			
	Attempted suicide	Completed suicide	Other trauma involving a death	Other trauma not involving a death
PROVIDED	36 (80.0%)	172 (89.1%)	41 (78.8%)	24 (85.7%)
NOT Provided	9 (20.0%)	21 (10.9%)	11 (21.2%)	4 (14.3%)

3.5 Incidents translated into cases and clients

The process of deciding to provide a service in response to an incident creates NICRS ‘cases’ and ‘clients’. The ORS Manual makes a clear distinction between a ‘case’ and a ‘client’. A case is described as follows (p. 2):

“For each incident there can be one of more cases opened. Sometimes we can be supporting different parts of the family, and within each case there can be one or more family members (clients) we are supporting”

A client is a subset of a case and is “... the person or family we are supporting affected by a suicide or a traumatic incident.” Just as there can be more than one case per incident, there can be more than one client per case. In the example provided in the ORS Manual, a suicide incident leads to two cases - one case has three clients (the mother and sisters of the deceased), and a second case has one client that is the estranged father of the deceased.

Of the 275 incidents where a response to an assistance request was indicated as provided, the following number of cases were associated with the incidents:

- 174 incidents had one case (63%)
- 27 incidents created two cases each (10%)
- 6 incidents created three or more cases (2%)

There were 68 incidents (24%) associated with no cases and no clients. However, responses to other variables suggested at least one family member was being assisted in some cases. It may be that CRSAs completed this field poorly¹⁰.

¹⁰ NICRS management advised that the Online Record System was developed in 2 stages, and it was not until August 2018 that CRSAs began using the case capacity. If only post August 2018 records are analysed, the

The 174 incidents that had one case resulted in the provision of assistance for 187 clients, or on average 1.2 clients per case. All other cases – namely, those incidents with two or more cases per incident (33) - involved provision of assistance to 95 clients, or 2.9 clients per case.

A total of 1,001 family members were associated with the 275 recorded cases where NICRS assistance and support was provided (up to June 2019). There is, however, some suggestion by CRSAs and NICRS management that this data represents under-reporting of total client numbers.

When assistance was provided, it was most often directed to families (see Table 6) either 'directly' (58%, n = 275) or 'indirectly' (1.8%). In almost one-third of incidents (28%), assistance was directed towards the service provider, either alone or in conjunction with the client.

Table 6: Distribution of assistance from NICRS according to the recipient of the assistance (n = 275)

Recipient of assistance	Number	Proportion of total client incidents where assistance provided (%)
Direct to family	160	58.2
Direct to family and community	23	8.3
Direct to family and service provider/s	33	12.0
Direct to others	4	1.5
Direct to service provider/s only	46	16.7
Indirect to family	5	1.8
Indirect to others	4	1.5

Of the 275 incidents where assistance was provided (as recorded in the ORS up until June 2019), 169 (61%) cases were responded to through at least partially via face to face contact. Most often, this was supplemented by telephone contact. A total of 96 (35%) of contacts were made only by telephone, with 4% involving 'other' contact. It is not clear what 'other' constitutes.

Further detail on the types of assistance that have been provided is detailed in Section 6.3.

number of cases with missing values for case numbers only drops to 18%, suggesting recording of case data is still problematic.

4 Relevance of the service

Is the program meeting the needs of families and communities?

The findings indicated that postvention services are relevant to the needs of Aboriginal and Torres Strait Islander families and communities. Various clients and stakeholders cited the increasing need for communities to be supported due to the impact of suicide and trauma and viewed the service, or a service like the NICRS, as critical to providing an immediate response in times of crisis. However, many stakeholders felt that the relevance of the service was potentially being undermined by the 'fly in fly out' approach of the service which was viewed as unsustainable and disconnected with local communities.

There was limited engagement and partnerships between the service and relevant service providers and agencies, and communities and more meaningful and strategic engagement was viewed as an important strategy for improving the service to ensure a tailored approach for clients.

4.1 The service is relevant

The need for a postvention service

There was universal agreement from all clients and stakeholders interviewed for the evaluation that there was a critical need for a service like the NICRS.

"...there is no doubt in my mind that postvention of suicide and traumatic deaths is a much-needed service in the community. We need more of these services." (Stakeholder)

Many stakeholders felt that there were many initiatives currently in place addressing suicide prevention yet, limited work being undertaken in the postvention space. Stakeholders reported that communities needed more support because of the high number suicides being experienced and the lack of services to respond to communities in crisis.

"The service is needed because we don't know what's going to happen in terms of the next death and so the service needs to reach out and ask, 'what do you need?'" (Stakeholder)

Several stakeholders noted that many families and communities were in crisis and were often ill-equipped to deal with death, loss and grief.

"The service is really critical because there are many families that are devastated after deaths, but they don't have the capacity to deal with or understanding how to cope with loss." (Stakeholder)

It was also noted that a service like the NICRS was also needed to provide families with emotional as well as practical support.

"Nobody really caters for families left behind after a suicide, they get Centrelink but sometimes they might need a bit of a hand." (Stakeholder)

The need for the NICRS

There was strong consensus across all clients, stakeholders, and community members interviewed that there was a need for the NICRS and its model of care.

Many clients interviewed reported that without the service they and their families would not have received any support and they would have been left without support at a time of significant grief.

Case Study 1 – Western Australia

Leanne* became engaged with the NICRS following the death of her teenage son. At the time of the death she was also experiencing domestic violence and she still had other children who had high care needs.

Leanne had never heard of the NICRS but was contacted directly by one of the CRSAs and accepted their support. She was well connected in the Aboriginal community and also in her church community from which she derived a lot of comfort and she was happy to draw on community for practical help but appreciated the neutrality of the service.

"I knew I had someone to trust to turn to and talk to. I knew everything was confidential"

They assisted with costs associated with the wake as there was a lot of mob around for a couple of weeks, and food vouchers. The service provided Leanne with a lot of emotional support as well and facilitated counselling for her and her children. The service also assisted her in dealing with the Coroner who wanted to conduct an autopsy against her wishes. The NICRS advised Leanne of her rights and advocated by email on her behalf and the autopsy did not go ahead.

The NICRS also connected Leanne with housing services because she was keen to leave the area following the death. Through her own connections in the community she was also assisted with all of the logistics of moving in and out of a new home. Overall, Leanne was happy with the support she received from the NICRS and from the CRSAs.

"... just helped talking to them ... I congratulate them."

* not client's real name

Some clients and several stakeholders felt that where the service had been delivered it had been critical to supporting families cope with their grief primarily by supporting them with the logistical issues or practical support.

"...without the service we would not have had anywhere else to turn to for help." (Client)

In some instances, clients and stakeholders reported that there can be a reluctance to reach out for support from local providers or community services such as NGOs, ACCHS or local church communities because they prefer not to disclose their personal matters to other local people or services. In such cases, the clients viewed the CRSAs as 'neutral' players focussed on the needs of their family.

For some clients experiencing poverty and financial hardship the service was critical immediately after the incident to ensure they had money for travel (fuel or public transport), food, and bills or to manage costs associated with other family visiting for the funeral:

"If this service wasn't here my kids would have gone without decent meals with car repairs and funeral costs. I was also able to get vouchers ... my kids could use them to get lunchboxes and stuff for school." (Client)

It was also reported by several stakeholders that there was potential for the program to also respond to other family members who may be at risk of suicide:

"... they were able to provide the family with counselling, which was critical because we were worried that one of the siblings was at risk of suicide because they felt guilty about not doing more to stop the death." (Stakeholder)

4.2 Approach of the service

The interviews indicated that while a service like the NICRS was valued and sorely needed, many stakeholders felt that the national approach of the service was unsustainable and less effective in truly responding to the needs of *specific* communities and *specific* individuals affected by suicide and trauma.

At an individual level the NICRS seems to perform better. It was reported that CRSAs worked closely with clients to help them to identify their unique circumstances and support requirements, indicating that to some extent the service was adaptive to individual needs. But at a broad community level, the findings suggested that local communities did not appear to have a strong input into how the service was delivered or that the service was being delivered in a way that was adapted to and responded to specific community needs. The model of care does not seem to have been materially modified as a result of community (or stakeholder) feedback.

Across all jurisdictions visited, it was reported by most stakeholders, including from ACCHS, Primary Healthcare Networks (PHNs), and NGO services, that in most jurisdictions the service was viewed as a 'Fly-in-fly-out' (FIFO) model that was disconnected from local communities.

"...the FIFO model is frowned upon in communities, services need to have localised strategies to ensure community connection and understanding of local contexts." (Stakeholder)

These stakeholders argued that there was a need for a stronger emphasis on a 'place-based' or a local approach to ensure that the service was well connected with local services and networks and therefore had a good understanding of the context and needs of the local community.

Several stakeholders felt that the geographic areas NICRS staff were currently covering were too large, raising concerns about the ability and capacity of the service to develop relationships and to adequately respond to local needs. The travel required to respond to the large areas was also viewed as a significant workplace health and safety risk for NICRS staff.

Immediate and practical support, such as food and petrol vouchers provided by the service, was regarded as valuable for families. However, many respondents felt that, without a local 'presence,' that the service was limited in providing meaningful and sustained support, particularly after a funeral when emotional support was often most needed.

"...need to cultivate relationships on the ground. I'm happy with idea of immediate 'practical' support but need to support also post funeral..."

Some stakeholders suggested a place-based approach could be achieved by training or building the capacity of local people or community leaders to provide immediate support or to act as 'community connectors' for the service. However, some stakeholders felt that the funding and resources of the service should be localised and distributed to community controlled organisations that were already servicing and connected with local community.

It was evident that stakeholders' opposition and dissatisfaction with the current national approach of the model was having a direct impact on the implementation of the service. Some stakeholders indicated that they were reluctant and cautious to engage with the service because of the aforementioned concerns. In one jurisdiction, one important stakeholder organisation reported that a decision had been taken to actively refuse engagement and support of the NICRS. Analysis of ORS data (see later section for more details) indicated that of 275 incidents between January 2017 and June 2019 that turned into cases, only 33% of those cases resulted in a referral, suggesting the capacity to form locally relevant service provider relationships might be limited. The situation is worse in the case of referrals to an ACCHS. Only 14% of the 275 cases ended in a referral to an ACCHS.

4.3 Reach of the service

An estimate of the reach of the NICRS program can be obtained by comparing notifications for completed suicides with the actual number of suicides as estimated through analysis of coronial¹¹ data (analysis undertaken by Thirrili Ltd, 2019).

Table 7 shows the comparison between NICRS reported notifications for completed suicides in 2017 and 2018 (the two completed years of data) and the suicides in those years as reported in the Thirrili Ltd (2019) analysis. The comparison is undertaken by jurisdiction.

Table 7: Comparison of number of NICRS notifications (for completed suicides) with suicides by year and by jurisdiction

Points of comparison	Year	State/Territory			
		WA	NT	SA	QLD
Number of notified incidents to NICRS	2017	21	20	4	10
	2018	27	27	3	25
Estimated no. of Indigenous suicides* (Coronial data)	2017	31	22	9 / 117**	112
	2018	40	22	3 / 133**	51
Estimated reach (NICRS / Coronial)	2017	68%	91%	44% / 3%	9%
	2018	68%	123% ¹²	100% / 2%	49%

¹¹ Coronial data has long been understood to underestimate deaths by suicide, but it provides the most meaningful benchmark.

¹² Difficult to explain a greater than 100% reach, but it could be because Coronial figures were wrong and/or because some non-Indigenous clients were included in the notifications, the result of the close association in the NT between NICRS and Stand-up.

* Includes 'Unlikely to be known' which are believed to be mostly Indigenous

** There are large numbers of 'Unlikely to be known' in the SA coroner numbers

The program reach measured in this way suggests that NT and WA (the two earliest implemented jurisdictions) have achieved significant reach (being notified of well over half of total incidents to almost all incidents) while QLD and SA, depending on how the coroner statistics are interpreted, have much lower levels of reach. This could be explained by the later commencement of program activity in those two sites but also the lower level of resources.

4.4 Engagement and relationships with stakeholders

Increased promotion of the NICRS is needed

Interviews with clients and stakeholders strongly indicated that greater promotion of the NICRS was required to increase the profile and awareness of the service. While the service is delivered nationally, it was evident from interviews that the purpose and function of the NICRS was at best unclear, and at worst, in some areas, the service was altogether unknown.

A key step of the NICRS model of care is to develop a throughcare support plan for individuals and families. This planning involves identifying clients' priorities and local services and supports available to assist them following a suicide or traumatic event.

Evidence from the analysis of the MSC stories collated by the NICRS, and some interviews with CRSAs and stakeholders indicated that CRSAs were working with a range of services and supports for clients. This included support to access safe and stable housing by liaising with relevant agencies, financial and unemployment advocacy with Centrelink and other government agencies, and legal support representation by helping to liaise with local police and Coroner's Court.

However, there was limited evidence from the stakeholder and client interviews, in all the sites visited, that the NICRS was well known to other relevant agencies. This included agencies that would likely be referrers to the service such as local ACCHSs, government services or relevant NGOs.

Several stakeholders interviewed had little or no knowledge of the service. Some stakeholders with no knowledge of the service expressed concern about the ability of the service to effectively respond to community needs without being properly linked and engaged with other services and providers:

"How will you find out about people who are suicidal or are suiciding in the community if you're not linked into the local services both Aboriginal and non-Aboriginal?" (Stakeholder)

One service provider stakeholder who had limited knowledge of the program reported being unclear about the referral process to the program:

"How do they get their information about suicides or trauma events? It's not clear how they could know" (Stakeholder)

Many clients and stakeholders, across all locations, stated that greater promotion of the service was needed to ensure communities could access support:

“Yes, for sure, more Aboriginal families could use this service. I think that they need to advertise this more. Everyone’s on Facebook and advertising it this way would be a great way to get the service there. I think if they could focus on the Aboriginal Facebook pages. They have always been a good support to us.” (Client)

One stakeholder, who was not aware of the program in their local area, felt the service could be useful for the community if it were easy to access:

“It would be great to know more but how does this work. Our families are already going through the process of mourning and we are adding to this by a process that’s all this red tape. Sometimes, it may not be helpful. If the process was as simple as, ‘Hey, this family had a suicide within their mob, lets help them,’ and it’s easy, that is fine.” (Stakeholder)

Greater promotion of the service was also viewed as an important strategy by some stakeholders to set community expectations about what support the service could provide.

“The service needs to put themselves out a bit more, getting out in the community, going to NAIDOC events, coming out and talking with local community. Maybe should do some advertising that says this is what we offer.” (Stakeholder)

In some areas it was reported that there was a lack of clarity around what families could expect to receive from the service; in some locations it was reported that some families received the Emergency Relief Fund (ERF) and others did not, which resulted in some communities feeling let down and unsupported by the service.

“People might say, ‘I’ll never ask again because I got knocked back’, so it needs to be clear about the support – how long do people receive support for? How long do you stay on the list? Just got a be more open conversation about what to expect, like, “We can have a yarn and get you this or that’.”

Many stakeholders also reported that wider promotion of the service to local service providers and stakeholders was also important to ensure that the purpose and function of the NICRS was well understood and to ensure that the service was embedded within broader systems and networks.

“The service needs to be doing more promotion with the hospital, police station, Facebook, through the AMS, just something that says who they are and what they do.” (Stakeholder)

Increased strategic engagement with local stakeholders is needed

The ORS data suggests that, broadly, the service was engaging at an operational level with a variety of service providers and stakeholders. Yet, interviews with stakeholders in all case study locations indicated that there was limited coordinated and strategic engagement by CRSAs and the NICRS with local service providers and stakeholders. In three jurisdictions, several stakeholders expressed a strong desire to engage and work with the service but reported engagement was yet to eventuate.

Other stakeholders, with some knowledge of the service viewed the NICRS either as a disconnected adjunct to services or had a limited understanding of the purpose and function of the program, how referrals occurred or how clients were supported.

It was reported by CRSAs that referrals to other service providers may not occur for a range of reasons, and ultimately depended on the needs of clients. A common issue that was noted in some

areas, by CRSAs and some stakeholders, was that clients and their families were sometimes unwilling to engage with local ACCHS or be referred to other services and supports. This meant it could be difficult for CRSAs to effectively refer clients to appropriate services.

While the ORS data does indicate that referrals were being made by CRSAs, in at least two locations there was limited evidence that CRSAs had strong working relationships and networks, or if they were attending interagency meetings with other services and agencies that could be relevant for clients' needs¹³. Across all locations, the client and stakeholder interviews also indicated that, overall, engagement and referrals with other services and supports appeared to be largely *ad hoc* rather than part of a coordinated response. In one location, this point was specifically highlighted by one stakeholder as a key area of improvement for the service.

"They probably need to coordinate more through other services, refer people to other services."
(Stakeholder)

There was some evidence at two locations, as reported by stakeholders, that the NICRS was attempting to engage and increase the service's presence with interagency forums. Yet, overall, stakeholders, including PHNS, ACCHSs, mental health NGOs and government agencies, across most of the locations reported that greater strategic engagement was required by the NICRS to improve collaboration and coordination of supports for clients.

"There could be a lot more strategic collaboration ... look more carefully at how the two services could work more mutually beneficially." (Stakeholder)

¹³ The distant location of CRSAs from the point of service, given the vast areas they are required to cover, to some extent obviates against any significant 'local' networking. It was noted that originally the NICRS had been intended to set up in more specific regions, but agreement on selection of the regions could not be obtained and so a broader jurisdiction level brief eventuated. A review of this approach, perhaps with a focus on 'hot spots', would be appropriate.

5 Effectiveness of the service

Have the objectives been met?

The evaluation indicated that the service is highly valued for the emotional, financial and advocacy support clients received. For many clients, it appeared that the service was effective in providing them with personalised support, particularly ERF support.

However, it was likely that effectiveness of the service was being undermined by a lack of consistency, accountability and governance processes and clarity of vision of the service. Information from the document review, interviews and analysis of the ORS data suggested that policies and procedures were not being properly translated into practice, which was affecting the direction of the service. This was resulting in inconsistent practice in the way the service was being delivered and managed, and confusion and frustration for clients and stakeholders, particularly in regard to allocation of ERF.

Greater governance of the service overall is required, to ensure a clear vision and purpose of the service, to ensure continuous improvement and accountability, and to ensure that support for clients is timely and coordinated.

5.1 The service is valued

Interviews with clients and many stakeholders indicated that overall, the service was highly valued. Clients reported that they valued the personalised and responsive support provided by CRSAs and several clients stated that without the NICRS they would not have received any support.

"... [the CRSA] gives us the best service and does far more than all the organisations around here put together. I really think the service needs to keep going cause without them I don't know where we would be." (Client)

The most common forms of personalised support that were valued by clients about the service were financial, emotional and advocacy support.

The financial support offered to clients assisted with alleviating financial stress from costs related to travel, groceries and sometimes funerals, or not being able to work following an incident. For several clients, this form of support was viewed as one of the key practical forms of support they valued most.

"The financial help when I needed things and wasn't able to work... [the CRSA] was able to reach out and speak to everyone I couldn't, such as my boss, etc. and explain what was happening and what I needed. So that was really helpful. [CRSA] also spoke to my real estate as well." (Client)

"They provided support for the funeral. Food vouchers – and that really helped me... Another organisation will help me move out, clean inside your house and clean up the yard. That takes a lot of stress off me." (Client)

"We would have been in trouble as there is no service around like the service she does. I don't know what we would have done it would have been far more stressful then it was without their financial support." (Client)

Emotional support provided by CRSAs in the initial contact with clients was also highly valued by several clients. It was evident that some clients and stakeholders viewed the service as a valuable counselling service.¹⁴

“For me it was just having someone to talk to when I needed to talk.” (Client)

Several clients reported being referred and supported to access counselling services once other pragmatic issues, such as funeral arrangements or dealing with the Coroner’s Court, were resolved.

Case study 2 – Northern Territory

Maureen* received support from the NICRS after a traumatic incident involving her child during a time in her life when she was living in an unfamiliar place with no networks. The service was pivotal in helping her to organise rental properties, liaising with government services, referrals for counselling services and travelling around the area.

The CRSA facilitated connections to services and provided various forms of assistance during the time that Maureen was living away from her home country. These supports were highly valued by Maureen who regarded the support as critical.

However, difficulties arose for Maureen when she returned home with her family and she was left with little support and no handover or follow-up by the NICRS. She was still trying to cope with the incident and needed professional counselling and support. She also had limited access to services and support and was living in an area with limited phone coverage.

While she did not receive follow-up support from the service when she moved, Maureen was still extremely positive about the support and personal connection she had with the service through the CRSA. She also strongly believed that that the service was needed and was supportive of its continuation and expansion.

Some clients also reported accessing the service and maintaining contact with CRSAs for ongoing emotional support or to troubleshoot issues, which provided a sense of stability and security in their lives. Several clients appreciated that the CRSAs were always available to talk over the phone, even after some months, when they were feeling low or were going through a challenging period in their life because of the incident.

“I went through a bad stage... didn’t know what I was doing with my life and was feeling really down. I scrolled through my phone and found [CRSA’s] number and texted [the CRSA] and they called me. I know that when I need [CRSA], they are there even just for a yarn. [The CRSA] really cares about us as a family and we feel that support...” (Client)

Advocacy support provided through the service was also highly valued by clients. Most of the clients interviewed required some form of support to liaise with police, government agencies, or real estate agencies, immediately after, but in some cases for several months following the incident. Clients talked about being overwhelmed with grief and feeling incapable of advocating for themselves or their families immediately after an incident. CRSAs were therefore seen to play an important role to represent clients and advocate for their needs with police, housing matters, employment and welfare benefits.

¹⁴ This is not meant to be a primary NICRS intervention. This issue is discussed later.

5.2 Consistency of the service

The document review of the policies, operational guidelines and position descriptions indicated that a comprehensive range of documentation to support implementation of the NICRS has been developed. Overall, this documentation was well prepared to support good organisational practice. However, the following observations are worth noting:

- there is little in the policy framework that describes and/or prescribes culturally specific approaches to service provision and organisational operation
- there is little in the policy framework that addresses the challenges and risks of CRSAs operating in isolation
- few operational guidelines were provided to the evaluators – for example, no clear guidance was available to describe the competencies required of CRSAs or other service delivery staff and managers
- operational decision-making was often allocated to the Project Director position, with few effective delegations
- not all NICRS staff positions (including key contracted roles) have position descriptions and, where those descriptions do exist, some are either very brief or overly voluminous – the associated potential for lack of role clarity is high and this could be observed in the qualitative data.

It was clear from the interviews with clients, NICRS staff and stakeholders as well as the ORS data that there was a lack of clarity at the operational level of the service. Collectively, this data revealed that policies and procedures were not being properly translated into practice, therefore affecting the direction of the service.

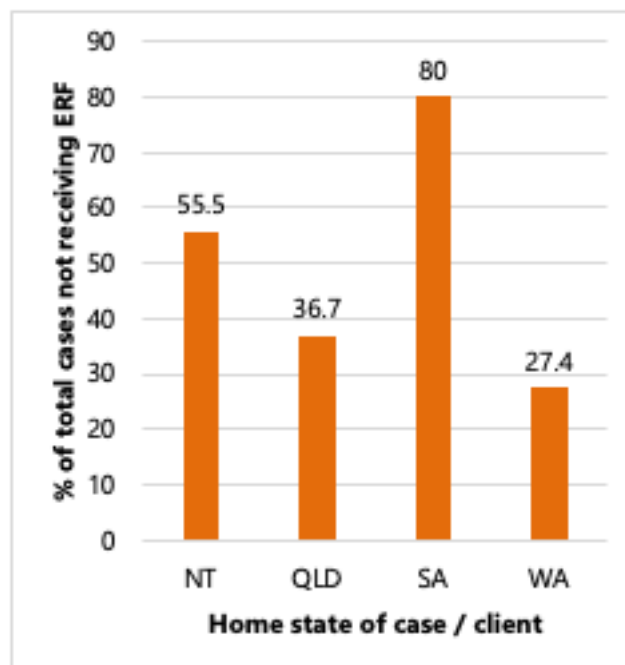


Figure 11: Proportion (%) of clients not receiving ERF support by home state / territory (n= 181)

One good illustration of the disconnection between policy and practice is inconsistent allocation of ERF, an issue that is reported in several sections of this report. Clients and stakeholders alike

reported being unclear and confused about how, when and for what reasons funds were allocated. There were reports that some families appeared to receive more funds than others or that there were discrepancies about what items would be funded. In some locations it was reported that ERF funds had been approved for funeral costs, yet the ERF policy specifically states that funeral costs should not be covered.

The degree of inconsistency in the use of the ERF is quantitatively revealed in the ORS data by analysis of its application between the jurisdictions (Figure 11). WA clients were more likely to receive an ERF amount, with only 27% not receiving ERF support. At the other end of the spectrum, most clients in SA (80%) and NT (56%) were not being offered ERF support at all. To some extent these inter-jurisdictional differences hide the within-jurisdiction differences that are likely to be more obvious and therefore could be more confusing to clients (and partner stakeholders). For instance, in WA, after a long period where the ERF was liberally administered, a new approach was introduced in late 2019 that placed considerably more restrictions on its availability. This change appeared to have been derived more from a philosophical rather than financial perspective.

A second illustration of the disconnection between policy and practice was in the role of the CRSAs. It was apparent from the interviews with CRSAs that there was inconsistent practice by CRSAs, both across and within office locations, leading to perceived inconsistency in the implementation of the service. Although there were detailed position descriptions and operational guidelines potentially available to guide NICRS staff practice, the interviews indicated that there was considerable variability in how CRSAs supported and responded to clients and therefore how that guidance was being accessed and applied. In one location it was reported that a CRSA was yet to be provided with a formal position description. It was also reported that CRSA-type duties were being undertaken by managers and Coordinators, presumably leading to further potential for inconsistency of practice.

Some CRSAs described taking a more intensive and reactive approach to their roles, making themselves available at all hours of the day, while others reported adopting a less intensive approach. Some CRSAs described providing 'accidental counselling' (at least) when clients called during a bad stage and clients and stakeholders similarly viewed the NICRS as a "counselling service". Several clients also reported having the perception that CRSAs had paid for food or fuel for clients from their personal finances. Collectively, these reports suggested that some CRSAs were unclear about their professional boundaries and the core functions of their role.

The interviews also indicated that there was variability in how the ORS was being utilised; several CRSAs reported that they had not been formally trained in using the system. Analysis of the ORS confirmed that there were numerous inconsistencies in how data was entered.

The issue of comprehension and activation of the established model of care and associated consistency of care requirements is further explored in Section 10.

5.3 Governance and accountability

Governance requirements

In the previous (5.2 Consistency of the service) it was noted that there is a disconnection between policy (as expressed in the model of care and several policy and procedure documents) and actual

practice in the field. This is leading to significant breaches in the fidelity of the operationalisation of the NICRS model of care. This suggests there has been a breakdown in 'clinical' or practice governance arrangements. Clinical¹⁵ governance is defined by the Australian Commission on Safety and Quality in Health Care (2017) as:

"... the set of relationships and responsibilities established by ... an organisation between its ... governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good ... outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services"

Clinical or practice governance fits within a broader organisation governance framework and all the levels mentioned in the above quote – the Board, executive management, operational management and workers – are integral to accountability for quality of care. In Figure 12, a typical set of elements of a governance framework is provided.



Figure 12: Typical elements of an organisation governance framework

Limited levels of accountability

Based on interviews conducted with various stakeholders, Board members, executive staff and operational personnel (CRSAs and Coordinators), there appeared to be no structured and cohesive

¹⁵ This term is not particularly suitable for the services provided by NICRS, but the concepts still apply.

governance framework that routinely assessed and managed risk, monitored performance or ensured the safety and productivity of the workforce.

This evaluation was not intended to undertake an organisational review, so precisely pinpointing the cause, or causes, of the breakdown in organisational and clinical governance is difficult. This task is made more challenging by some key internal stakeholders interviewed perceiving that the service was well established, with a clear management system and accountability mechanisms in place, while others expressed the view that the NICRS was still in a development phase as reflected by governance issues and procedural impacts.

From the evaluation perspective three examples can highlight the nature and dimension of governance concerns:

- (1) a finding from the interviews, ORS data and the document review was that outcomes, for clients and the service, were not being routinely captured and measured. This lack of outcome measures is discussed in more detail in Section 8.3. The lack of mechanisms in place to measure outcomes at the client level in relation to nationally-based standards of practice, begged the question as to how decisions were being undertaken to effectively 'handover to local services for ongoing support and meeting of specific needs' or what assessment was being made to facilitate 'Step back' from clients.
- (2) It is identified as a key, realistically a critical, element of the model of care, yet there is not strong evidence to show that *throughcare plans* are being routinely drafted, or for perhaps many incidents, drafted at all. Adherence to a throughcare planning model is stipulated in NICRS policies and part of funding agreements. A related documentation issue relates to the writing of case records. A 'Case Records Policy' provides some guidance on how to prepare client notes on needs and care/support tasks, and within that policy is an 'audit checklist template' to assess the quality of a sample of case notes. The evaluation team was advised the audit process had never been undertaken.
- (3) The CRSA role is challenging and the capability and capacity of CRSAs to perform their role well is a major area of risk. Yet there was no evidence that CRSA competence was adequately assessed at the point of recruitment or that learning needs were addressed at induction or subsequent professional development interventions. Managers and CRSAs themselves acknowledged differences between CRSAs in types and levels of competence, but only limited structures were in place to overcome possible skill deficiencies.

Another example is the inconsistent allocation of ERF (noted previously). Based on the client interviews, there was no doubt that ERF was often a major enabler for NICRS engagement with families and communities (and a recurrent need expressed by clients) but the discrepancies in allocations and variation in approved usage highlights a lack of internal oversight and accountability.

Limited Continuous Quality Improvement (CQI) and quality control

Interviews with stakeholders and clients indicated that in the initial period of establishment of the service there was significant fluidity in response decisions, most notably, in apparently *ad hoc* allocations of ERF which appears to have been intensified by highly personality-based casework approaches. The NICRS has been operating for almost four years yet it was apparent there remains a high level of fluidity and inconsistency in how incidents are being responded to and how clients are

being supported, even in the oldest service areas. As noted in a previous section, it is not evident that CRSAs were following established NICRS protocols or policies.

Interviews and the document reviews also indicated that there had been little, if any, casework review and no analysis (systematic or otherwise) of the ORS data to identify practice outcomes, critical incident markers, or assessment procedures.

The levels of practice and professional supervision afforded to CRSAs also emerged from the interviews as an area of significant risk for the organisation, especially at the organisation governance level. It was not clear if staff were trained in risk management procedures or emergency distress technology. Yet, it was apparent that most CRSAs were operating as a travelling case worker (much like a disability contract worker or family behaviour support officer) without being tethered to clear protocols, or procedures that ensured duty of care for clients or safe working conditions for CRSAs.

Lack of clarity of management roles

During interviews with CRSAs and Coordinators in the various jurisdictions in which NICRS operates, it was apparent that operational management roles within the organisation were extremely confused and did not appear to follow predictable lines of reporting or accountability.

The evaluation team was informed that changes introduced in late 2019 and continuing into 2020 resulted in the establishment of two state/territory-based Coordinator roles. Establishment of the two Coordination roles appears to have 'regionalised' the allocation of caseloads and management of CRSAs, however, this also resulted in a much larger geographic coverage by the Coordinators. For example, the Perth-based WA Southern Coordinator, who is responsible for all of WA, SA and other 'southern' area cases and staff, encompasses the largest proportion of NICRS incidents based on the ORS data. This Coordinator is also responsible for direct supervision and line management of the Perth-based CRSAs (see previous section Governance and staffing).

While the commitment of the Coordinators is not in question, it was not clear to the evaluation team what specific training or additional management support was provided to undertake these complex roles. According to the job description they are meant to provide mentoring support to CRSAs by having regular catch up sessions to review their cases and discuss matters where they need advice and support; provide debriefing support following a critical incident response; and support CRSAs access psychological and cultural mentoring to promote self-care as required. There was no evidence that this level of support was being offered, especially as the Coordinators were still required to maintain some caseload.

Through various interviews a dislocation of management lines of authority was uncovered. It was reported that Coordinators or CRSAs were often bypassed by stakeholders who would instead liaise directly with the executive level of Thirrili to resolve issues such as ERF allocation. It was reported that this often-undermined line management and it affected the ability to maintain consistency in service delivery decision-making.

A good example of this dislocation of management lines and authority is the regional partnership with GRAMS which has operated for the past year through a direct funding grant from Thirrili to GRAMS. The WA Coordinator has no direct linkage with this service. In fact, this lack of coordination is now structural as it was openly stated by GRAMS workers that they do not contact the WA NICRS Office, instead dealing directly with National Office via the CEO.

It was also apparent from the interviews and the document review that internal Thirrili management roles were also confused as on-the-ground staffing was not reflected in operational guidelines or policies developed in Head Office. One key example highlighted through the interviews was the policy requirement for two CRSAs to attend critical incidents (at least until assessment and planning has been undertaken). However, compliance with this policy is often not possible as most CRSAs are not co-located in one area or region. The majority of CRSAs operate fundamentally as lone service providers with the possible support of a fellow CRSA to attend crisis incidents only if travel is approved from another office or aligned with existing workload.

Queensland is the clearest example of this issue where only two CRSAs are based in what can be viewed as the most decentralised state. With one based in Brisbane and the other fulfilling a dual role as CRSA/Northern Coordinator, these staff were undertaking NICRS activities on a solo basis regularly. The lack of connection with regional service supports and potential partner agencies, as reported in a previous section, only serves to exacerbate this situation. This has direct implications for worker safety, risk management and long-term impacts on staff.

5.4 Support services provided

Duration between notification and response

The model of care document (Thirrili, n.d.) does not prescribe the time that may elapse between a notification (advice) of an incident and the response to the client from an allocated NICRS CRSA. However, the Response Assessment policy (Thirrili, 2018) outlines the following requirements:

“The CRSA who receives a notification is responsible for advising the National Coordinator and NICRS Project Officer within 10 minutes of the notification, ... recording information collected in the initial notification stage in the ‘Incident file’ within one hour of notification, ... and actively seek to contact family member(s) (potential client/s) to explain the role of NICRS and the nature of the support NICRS can provide (ideally within 3 days of verification) ...”

Incidents were most often advised to the NICRS within a few days of occurring (Figure 13). Almost half (48%, n = 364) were referred to the NICRS on the same day the incident occurred, while nearly three-quarters (73.4%) were advised to the NICRS within three days. The average time for advising was 27 days, although if anomaly records (greater than 100 days, likely the result of a data entry error or a ‘left-over’ case from pre the NICRS program) are removed the average is reduced to 4.5 days.

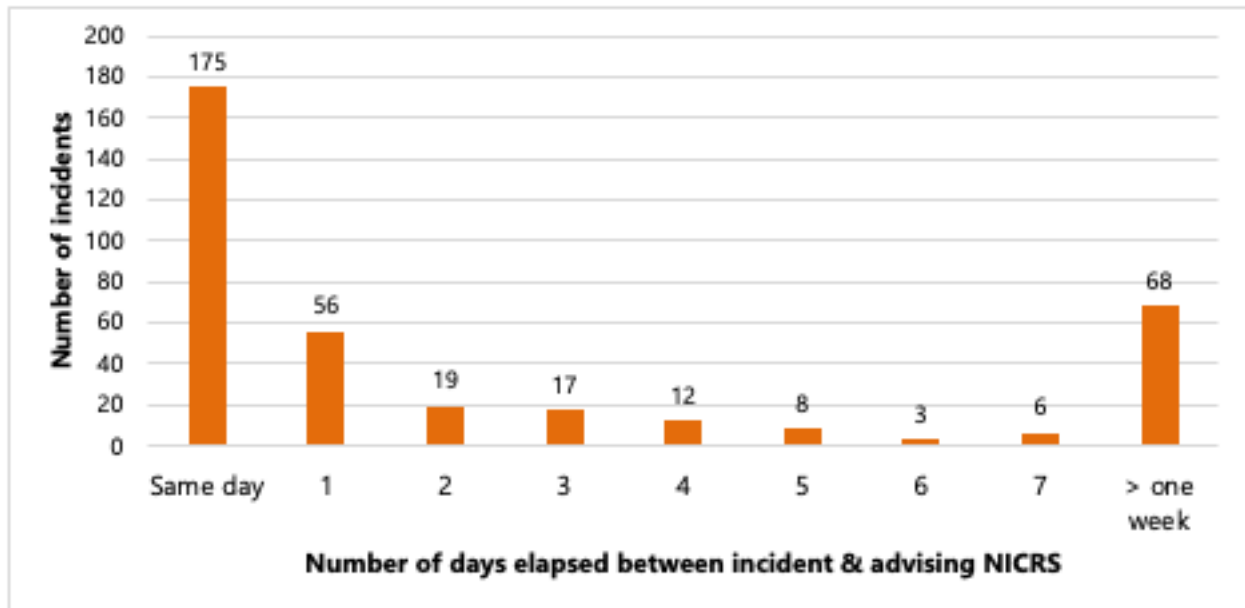


Figure 13: Distribution of cases advised to the NICRS by days elapsed since the date of the incident (n = 364)

Type of support provided

There were no direct records kept in the ORS of the type of intervention undertaken by CRSAs with clients, other than in the case notes. However, some indication of the interventions undertaken could be derived from the field 'Summary of Advocate actions'.

For the purpose of the evaluation, new fields were created by the evaluation team and completed based on the data in the 'Summary of Advocate actions' field. The constructed 'Type of intervention' fields allowed for three types of intervention; ERF, accidental counselling¹⁶, referral and other, although no 'other' type of intervention was found¹⁷. More details on interventions could potentially be obtained from the case notes and throughcare plans but this was not considered as part of the original evaluation method. Ethics approval was therefore not obtained to access these documents.

Data extracted from the 'Summary of actions field' indicated that not all of the 275 cases (or incidences) where a service was noted in the ORS as being provided was actually delivered; at least not financial, or accidental counselling, or a referral. In fact, in 41% of cases where the ORS indicated a service response had been provided, there was no evidence in the summary notes that a service had been provided. Reflecting on the earlier reporting of translation of incidents into cases, the findings have been summarised in Figure 14.

¹⁶ An '[Accidental Counsellor](#)' can be anyone who is not employed as a trained counsellor, but often finds themselves placed in a counselling role by accident. Accidental Counselling is most common for those in the role of teacher, youth worker, team leader, aged care professional, chaplain or complementary health practitioner. Definition adapted from one provided by ACWA.

¹⁷ It is accepted that this data, based as it is on a summary, may not be completely accurate. However, some attempt was made to analyse the service inputs to cases in lieu of recorded data.

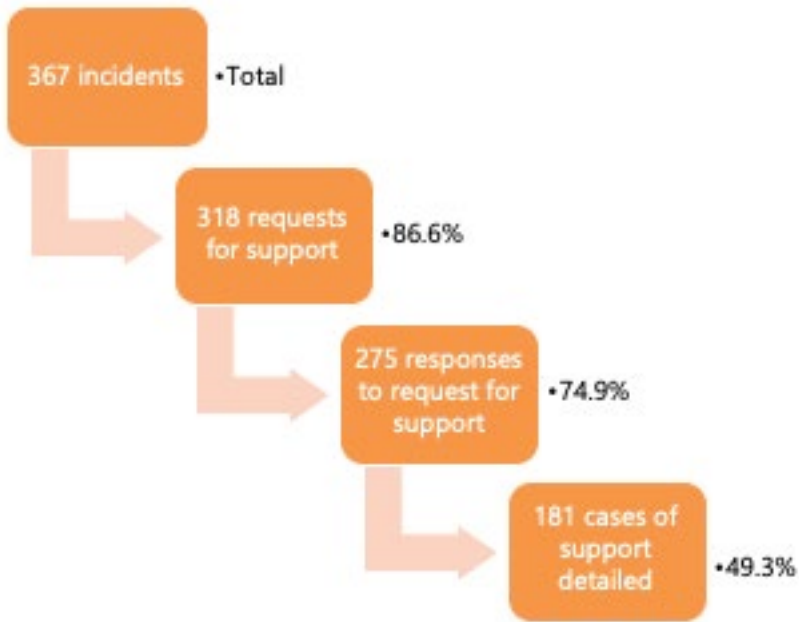


Figure 14: Number of incidents that translate to cases support by the NICRS (n=367)

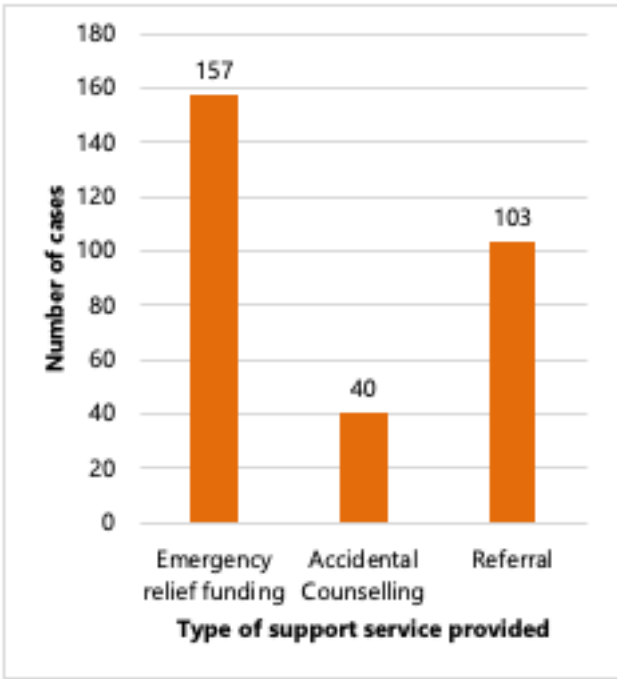


Figure 15: Distribution of cases where support provided by type of service provided (n = 181)

Where a service was provided, the most common type of service was ERF (82.8%, n = 181) followed by a referral (56.9%) and accidental counselling (22.1%; see Figure 15). Based on the ORS data, 94 (34.2%, n = 275) of the incidents where a response to a request was provided received no apparent recorded support.

Use of Emergency Relief Funding (ERF)

The ERF amount distributed to any single case ranged from \$50 to \$5,040. One third of the cases received \$500 or less (30.9%, n = 152, see Figure 16) but over half of the cases received more than \$1000 (50.7%).

The total ERF distributed across cases was recorded at \$131,264.11. The average level of ERF support across all cases (including those that did not receive ERF) was \$654. The average amount of ERF was \$863.58 for all the cases where ERF was allocated (n=152).

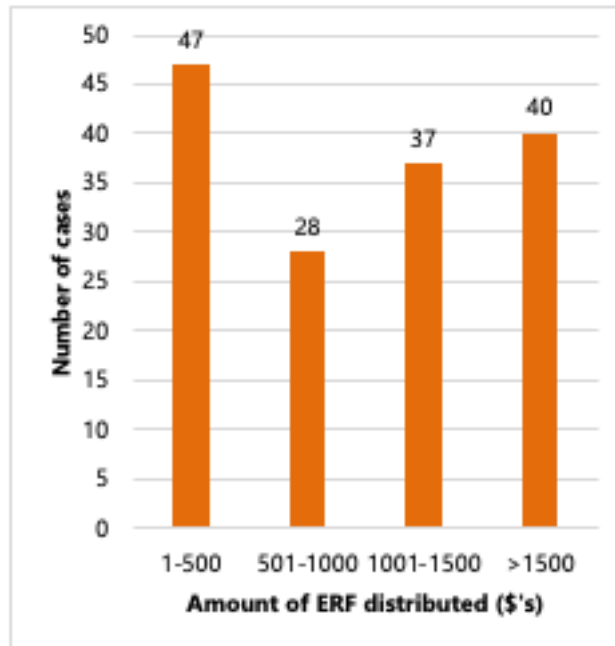


Figure 16: Distribution of ERF amount across cases by size of distribution (n = 152, missing values)

The amount of ERF per case appears to be strongly linked to the amount of time CRSAs spend with clients providing support (Figure 17). Thus, clients who received over 20 hours of support were also more likely to receive above \$1,500 in ERF; just fewer than 40% received that level of funding. Conversely, clients that received limited support time, less than five hours, were less likely to receive larger amounts or any ERF. Over 70% of clients who received five hours or less CRSAs support did not receive ERF. It was not possible to explore with the current data whether the low levels of ERF support were because those clients did not need support in general, or whether the low ERF support amounts were a consequence of low contact levels. Some clients, however, did receive high ERF amounts and had low levels of recorded support hours.

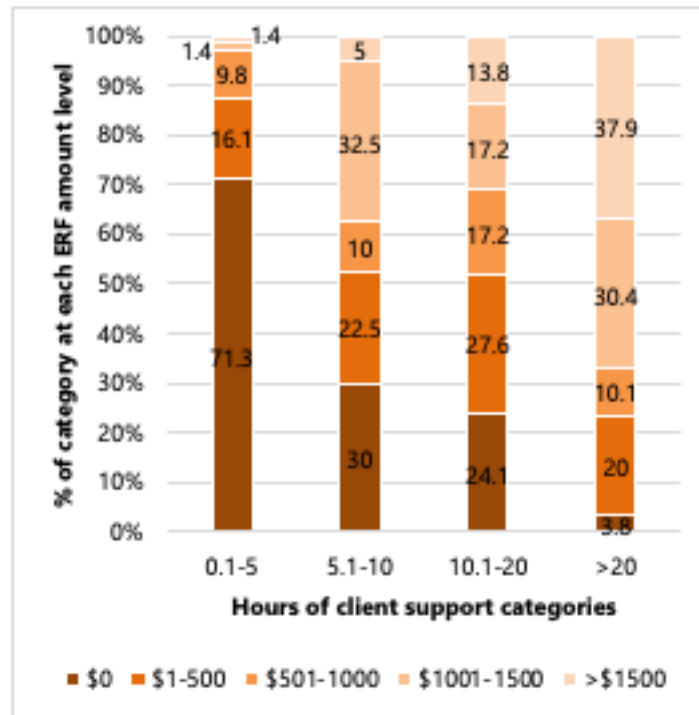


Figure 17: Distribution of ERF amounts by level of hours of CRSA support (n = 275)

Financial support available through the ERF was highly valued by all clients interviewed, yet some clients and several stakeholders noted that there was a lack of consistency, clarity or transparency in relation to the amount of financial support available. Interviews with CRSAs and the data reported above suggests almost that different 'policy' approaches to the ERF pertained in different states and even within states over time.

Clients and stakeholders also reported that there were often delays with approvals for financial support which could increase the client's frustration and undermine confidence in the service:

"I also felt the red tape would delay the process sometimes in being able to get help... and sometimes it takes a few days. It makes it harder for [the CRSA] to do their job when they have three to four days to wait for an answer back to be able to provide that support to the family."
(Client)

Several stakeholders and CRSAs also reported that it was critical to manage client and community expectations in relation to the amount of financial support, yet it was evident that such information was possibly not being consistently communicated or financial support was not being consistently allocated. The program ERF policy states:

"A maximum of \$1,500 per family can be spent for families who are directly engaged with the Critical Response Support Advocates, unless additional funds are approved by the Project Director (for the purpose of providing Emergency Relief, family means immediate family only)."
(NICRS Emergency Relief Fund Policy)

Some clients reported that \$1,400 was available to each family annually, others reported expecting more financial support than they received because they were aware of other families receiving more

than \$3,000 in financial support (note above some cases, which may involve more than one client, received more than \$1,500). One client reported receiving financial support for a holiday. In other cases, due to a lack of clarity around what the service could provide, the provision of financial support could increase tensions within families if there were concerns that some family members should not be able to access funds. Overall, it was evident that allocation and use of the funds needed to be clarified.

Referrals from NICRS

The ORS data indicates that where a request for service was responded to between January 2017 to June 2019, 180 (65%, n = 275, see Figure 18) cases involved at least one service provider in some form. How these other service providers were involved was not clear from the data but it could have been to seek information, assist them to provide support, work together to develop an intervention strategy or to accept a formal referral from NICRS and provide subsequent support to the NICRS client.

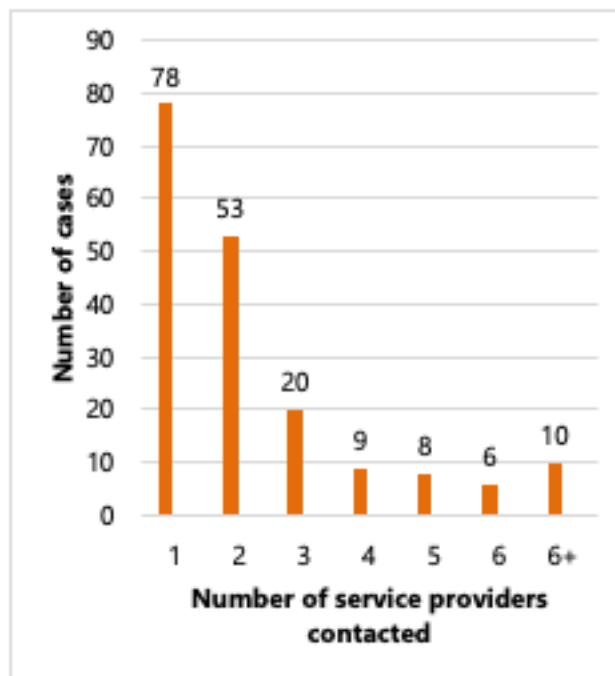


Figure 18: Distribution of cases by the number of service providers contacted (n = 180)

Most cases involved only one or two service providers contacted (43%, n = 180), but some cases had as many as 10 services providing support to a client. NICRS management advised that they believed data on service providers was likely to be under reported (Figure 18).

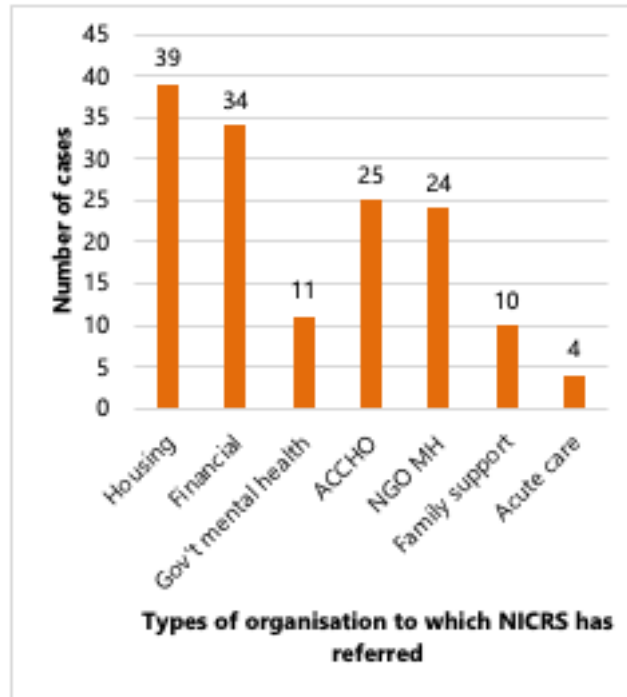


Figure 19: Distribution of cases by types of organisation to which NICRS has referred (n = 275)

Data from the constructed 'Type of intervention' fields showed that few of the service provider contacts made resulted in a formal referral (103 or 37.5% of cases where a response was provided; n = 275, see Figure 19).

Based on the referral data extracted from case summaries the key service providers appear to be (Figure 19):

- housing authorities (14.2%, n = 275)
- child protection agencies / family support services (3.6%)
- Aboriginal medical services (9.1%)
- mental health services (government and NGO) (12.0%)
- financial services (10.9%)

There are many reasons why referrals might be lower than expected. Several CRSAs intimated that referrals often could not be made in the absence of adequate and relevant service providers and / or client reluctance to be referred. However, several service provider stakeholders, many of whom would be a logical partner or referral agency for NICRS, noted NICRS's poor promotion and networking efforts. In most locations NICRS had not attended interagency meetings, suicide prevention groups or service network forums – NICRS was either unknown in many areas, despite a strong physical and case presence, or remained an enigma without any clear referral pathways or interagency referral mechanisms (either for notification or coordinating case support).

Accidental counselling

Accidental counselling was a feature of 40 cases (14.5%, n = 275), although the qualitative data findings suggest this is an underestimate.

6 Efficiency of the service

Are resources being used efficiently?

Evaluation findings indicated that the service is needed and is potentially filling a gap in services for communities. It also does not appear to be duplicating other services in case study sites visited and several clients reported that without the service they would not have been able to cope following an incident.

Analysis of NICRS service data revealed considerable variation in the extent of services delivered between both clients and locations, suggesting that the reasons for such variation should be carefully monitored and considered in future. Approximately 50% of CRSA time is spent in direct client communication, with a number of other service categories registering low or no activity - the balance of service activities provided by CRSAs may require closer scrutiny to ensure effort is as closely aligned to program goals as possible.

6.1 Is the NICRS duplicating services or filling gaps?

As outlined in Section 4, the NICRS service is highly valued by most clients interviewed for the evaluation. Interview findings also indicated that the NICRS does not appear to be duplicating existing services with most clients, NICRS staff and other service providers indicating that they believed there was a strong demand for this type of postvention service. This provides a strong indication that the NICRS is filling a significant service gap that would otherwise exist for its client group.

There was also some evidence, for some clients, that access to a service that was separate from the local ACCHS service infrastructure allowed families privacy and some level of anonymity that was highly valued when dealing with sensitive, traumatic incidents. As a separate service, the NICRS was also viewed to offer support to clients in ways that other services could not such as liaising with police and coroners' courts and other support services. With this support in place some clients reported that they had more emotional to deal with other arrangements related to the funeral.

Despite the independence of the service being valued by some clients, there is however some evidence (as noted in Section 4) that efficiency of the NICRS could be improved through increased engagement by CRSAs with local service networks. Interviews with clients and stakeholders indicated that awareness of the service needed to be increased to improve awareness of the availability of the service and to improve understanding of what the service offered. Increased engagement could also improve understanding and knowledge of the capacity of local services to ensure that coordinated and planned support is provided to by the NICRS to clients.

The evaluation also indicated that closer engagement with other services and networks in local communities would also increase the scope for NICRS services to be better aligned with the boundaries of other services. And, given the specialised nature of the NICRS, closer and sustained engagement could also provide opportunities for the NICRS to contribute to better understanding of postvention care and the strategies that have the best impact.

6.2 Duration of critical response contact

Each incident response was monitored in terms of CRSA time commitment, even those for which no response was ultimately provided¹⁸. Just over half (50.8%, n = 386¹⁹) of the cases (see Figure 20) consumed less than five hours of CRSA time. Another 28% consumed between five and 20 hours, while the remained (21.2%) required more than 20 hours of CRSA time. Eight cases have so far taken over 100 hours, with one case having consumed over 300 hours.

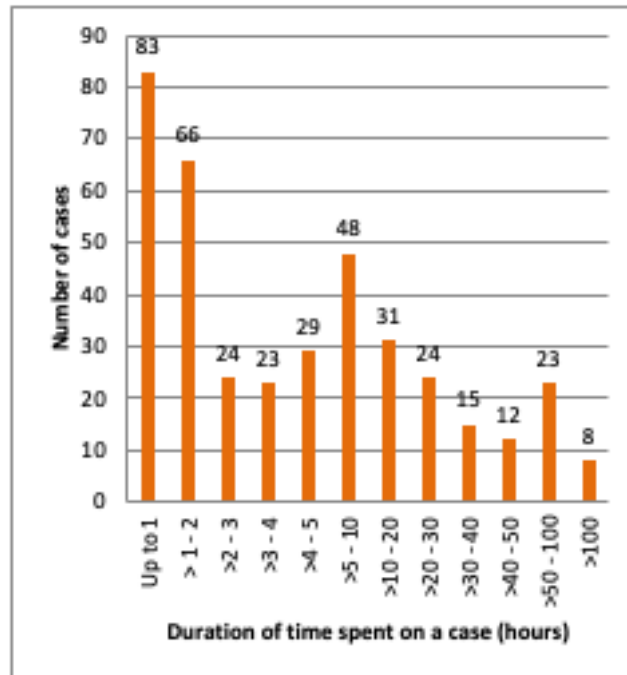


Figure 20: Distribution of all cases by hours of CRSA time consumed

Of the 94 incidents that did not ultimately receive any CRSA support, most (77 or 82%) received less than 5 hours of CRSA time. Oddly though, 15 (16%) received between 5 and 20 hours and two received even more hours. The average hours spent on incidents that did not convert into cases was 2.8, while the average hours spent on cases where support was provided was 21.

6.3 Use of CRSA time

Based on data collected by HMA (2020) from a survey of CRSA time usage over a fixed four-week period, Figure 21 shows what types of direct care activities CRSAs, on average, undertook with clients. A large proportion of time is spent supporting clients through face to face contact²⁰ (25.9%) and via telephone/video contact (23.9%). That is almost half their time is spent in conversation with clients, during which presumably needs are being assessed, some education is being provided

¹⁸ It is assumed that time is spent 'researching' a decision to respond to a request or not.

¹⁹ As noted above, a number of incidents have more than one associated case. For some of these cases the time spent is not split between cases but duplicated and so in the calculation duplicates were removed.

²⁰ Travel time to get to face to face conversations is not included in this figure.

(about postvention reactions) and accidental counselling occurring. The other main areas of time allocation are to follow-up (11.2%) and providing advocacy to gain access to services (11.8%). Minimal time was recorded as being spent on developing throughcare plans (0.5%), providing funeral assistance (0.8%; despite this being constantly raised in CRSA and stakeholder interviews as a key postvention issue) and emailing clients (0.8%).

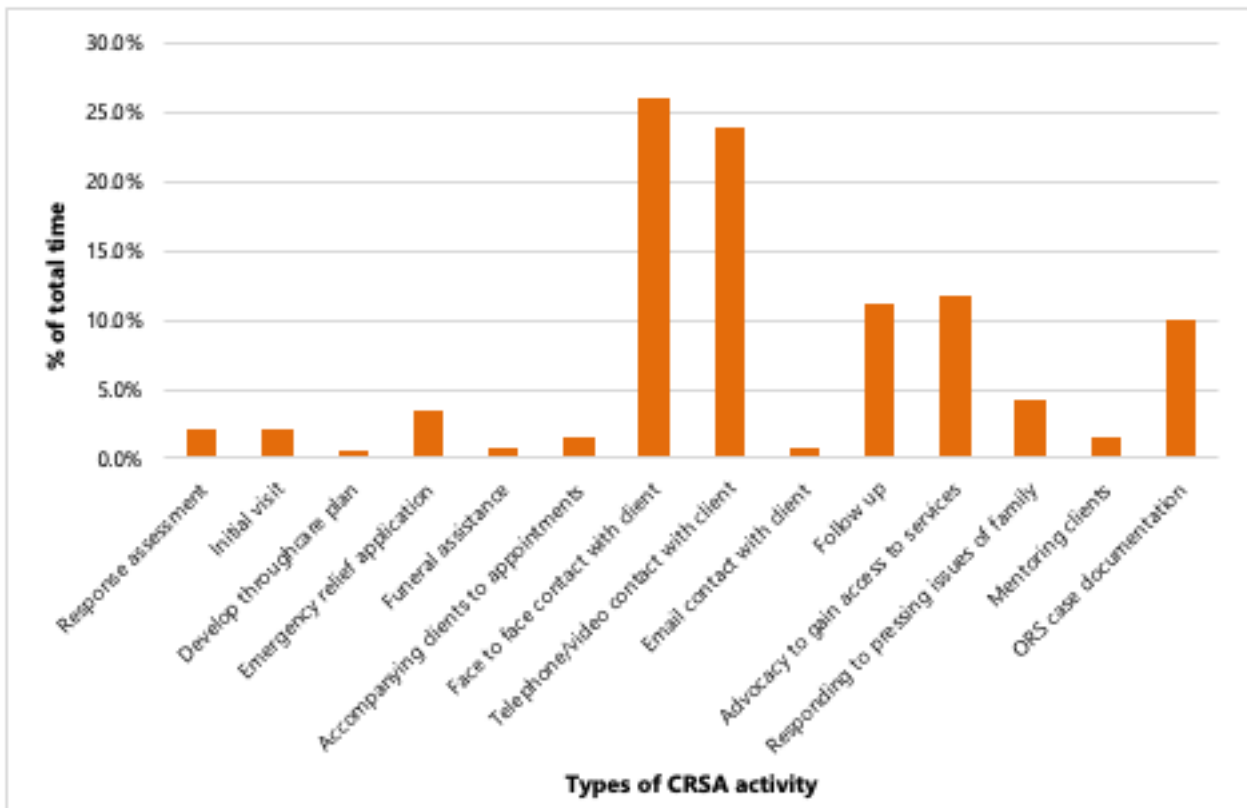


Figure 21: Proportion of CRSA time spent on various direct client support activities (source, HMA, 2020)

Several direct support activities had no time logged against them over the survey period, these included:

- tracing family members
- emergency relief assessment
- emergency relief – purchase of goods
- financial assistance (Centrelink, financial counsellors)
- support to repatriate body (although this was noted by GRAMS as something they routinely assisted with)
- social media contact with client
- prison visit
- cultural activities
- healing activities.

7 Impact of the service

What difference did the service make? Can the effects be attributed to the service or would they have occurred anyway?

Clients and stakeholders reported that, immediately after an incident, the service appeared to be making an impact in clients' lives by assisting them emotionally and financially, but also in practical ways such as through advocacy support. In the short-term, at least, the service appeared to be having an impact on the stability of families. The long-term and broader impacts of the service, however, were not possible to objectively determine. This is primarily due to a lack of objective measures or tools being utilised by the service to capture pre and post improvements in SEWB of clients and their families supported by the service.

7.1 Subjective impressions

Most clients interviewed for the evaluation reported that they valued the financial and emotional support from the service to maintain their relationships and support their families, with some clients reporting that the support they received was pivotal in building their resilience:

"The emotional support provided to me by the service has been life changing, it's helped me to stay strong for my other children." (Client)

Some stakeholders reported that, immediately after an incident, the service made an impact in client lives by assisting them emotionally and financially, but also in practical ways through advocacy support. CRSAs similarly reported that they were having an impact on the stability of families' lives by assisting with housing, employment and welfare issues or developing clients' confidence and capacity to advocate for themselves with other services and agencies.

Analysis of the MSC stories indicated that, from the perspective of CRSAs, the positive impacts of the service included:

- capacity building of clients – developing confidence, self-esteem and empowering clients to advocate for themselves
- enabling connections with family and culture to reduce isolation
- stability for families where alternate safe and secure housing was able to be put in place
- ongoing support and advocacy with government agencies to reduce stressors and negotiate for family reunification
- working collaboratively with other suicide prevention, aftercare and postvention services.

The scope of this evaluation did not include review of the formal community capacity-building (or Stream 2) of the NICRS program activities, however, there was some evidence, primarily from the stakeholder interviews, that there had been little investment of effort to date by NICRS staff in capacity-building type activities into their program of work. The majority of service provision had been focussed on direct client support rather than networking or other forms of engagement related to build capacity in either postvention service provision or in culturally appropriate strategies for support.

7.2 Objective measurement

The above information gathered from clients, CRSAs and engaged stakeholders provides some indication that the service was having a positive impact, at least in the initial period of support, for clients. However, in the absence of plans (that have stated client objectives), objective tools or measures, or structured client feedback mechanisms, it was not possible to definitively determine the immediate, intermediate, or long-term impacts of the service.

A core element of the model of care is the development of a 'throughcare plan'. The NICRS model of care (Thirrili, 2018) defines **Postvention Throughcare** as:

"Provision of coordinated and culturally responsive support to individuals and families affected by suicide or other trauma... we work to enable families to access social and emotional wellbeing services to support them in their journey of healing and over time live safe and meaningful lives in the context of urban and remote settings. Simultaneously we work with the Traditional Owners, local communities and service providers to ensure individuals and families are well supported."

On the invitation of the client, CRSAs assess their needs regarding:

- emotional health
- cultural and spiritual health
- physical health
- social, family and community health

Based on the needs identified, a throughcare support plan is developed "... to strengthen individual and/or families social and emotional wellbeing to support their journey of healing" (Thirrili, 2018).

However, there was no clear evidence from any of the interviews, MSC stories, ORS data or document review that throughcare plans were being routinely and formally prepared nor implemented for any clients in any jurisdiction. A survey of CRSA time allocation over a four-week period in 2019 (HMA, 2020) showed that less than half a percent of their total time was spent on 'developing [a] throughcare plan' - a seemingly totally inadequate time allocation to prepare a structured plan with clear [client] objectives and a strong understanding of the strategies to be followed.

Throughcare support plans could provide individual client objectives (e.g. link to a specific service provider, negotiate rental assistance, re-integrate a child into school, facilitate contact with an affordable funeral director, etc.) that could be used to determine the immediate impacts of the service by comparing what support clients should have received against what they actually received, and what objectives of support were intended and were they achieved.

In the absence of widely developed and used throughcare plans, there is also no evidence that the needs of clients being assessed - emotional, cultural, physical and social - is through the use of objective tools despite numerous tools to measure these aspects available, some of which have been developed specifically to be culturally acceptable. It is therefore unclear how clients' needs are documented when they commence with the service or how CRSAs assessed when it was appropriate to 'Step back' (Step 8 of the model of care) from clients - presumably after there has been sufficient

change in their emotional, social or physical wellbeing. Within the NICRS management and staff there appears to be a level of resistance to the use of objective tools, particularly the common psychometric means of measuring mental ill health (e.g. K10 for depression, Living in Community Questionnaire (LCQ) [AMHOCN, 2015] for measuring of social inclusion and recovery). This resistance is based on a view that they are “culturally inappropriate” or that they are too “clinically oriented” and therefore not relevant to the task of the CRSA and the objectives of the NICRS.

Data collected through such processes could assist with measuring intermediate impacts such as strengthened resilience and social and emotional wellbeing, or long-term impacts, such as whether communities are receiving a culturally appropriate and holistic service. However, without data collected through such processes or mechanisms, it was difficult to determine the intermediate impacts or long-term impacts of the service.

7.3 Process of data collection

Operation of the NICRS model of care requires the capture of a range of data types. A significant amount of this data is sensitive personal data and an appropriately secure mechanism has been adopted to hold this information

Nevertheless, there are issues with the process of data capture. It was clear from both the qualitative data and the ORS data analysis that this system is not operating optimally to capture all types of data. These deficiencies are resulting in significant data gaps and delays of data entry.

8 Sustainability of the service

Are the observed outcomes likely to produce ongoing results?

As a national service, the NICRS aims to support clients across a variety of locations in metro, regional, rural and remote areas in Australia. However, the evaluation findings suggested that current staff resources may be inadequate to rapidly respond to incidents, to meet a broad cross section of social, emotional and cultural needs, or to cover large geographic distances and regions across and within jurisdictions. The evaluation also suggested that limited formal workplace induction, training, clinical and cultural supervision processes were in place to support staff to manage complex and safe working conditions. With limited support and limited staff resources, the safety of staff and clients is potentially being compromised, which in turn may be impacting on the sustainability of the service.

8.1 Adequacy of staff resources

Qualitative data analysis suggested that more staff were needed to respond more swiftly to incidents and to provide support to clients and families, who were all experiencing high levels of psychosocial complexities. The reality of this situation can be tested in several ways:

- Is there an unmet demand?
- Is there a delay between incident notification and NICRS response?
- Staff workload
- Staff overtime
- Are cultural requirements being met?

Unmet demand

A common way of services managing demand is to apply filters to service access, for example for mental health services to accept only seriously ill clients, or in emergency departments to triage cases and refer some to GPs. The possible mechanism for this in the NICRS is the classification of incidents as to whether they are 'in' or 'out' of scope. Reasons apparently are provided for the scoping decision in the ORS, but this data was not made available to the evaluation team. The fact that a reasonable proportion of 'out of scope' incidents ended up receiving a service, though, suggests that this mechanism is not used to control demand.

Another possibility is that service levels might vary between client types, with some client categories receiving less service than others, and therefore representing a sub-population with unmet demands.

A small analysis of cases in WA, where the service has operated the longest, shows that the average case in Perth and towns in the Perth environs received on average 45.8 hours of CRSA support. All other WA cases outside of Perth on average received only 28.6 hours of CRSA support (just over 60% of what Perth clients receive). In addition, much more of the support provided for cases outside of Perth was given via telephone only, or telephone and face to face combined, whereas most support given to Perth cases was provided face to face. This provides some evidence of unmet demand.

Time delay to response

Several clients who were interviewed reported experiencing a delay of several days before a CRSA responded in person to an incident:

"It took them about five days to make contact with me after I initially called them." (Client)

It is difficult to assess the validity of any suggestion of a significant delay between date of notification and date of first contact with client since the latter data is not collected in the ORS. The evaluation team attempted to assess this issue by constructing a date of first contact field from data in the 'Case summary' field. In this way, 91 case records were able to be constructed with a notification and first contact date, but two outlier cases were rejected because they had excessive numbers. Based on the remaining 89 records, the average time between notification and first contact was 13.6 days.

This data certainly needs to be gathered more rigorously in future. But if this figure is accurate then the delay would appear to suggest staff resources inadequacy – or inefficient procedures for allocating incidents to CRSAs.

Staff workload

It was evident from the qualitative data that clients and stakeholders were concerned about the capacity of the service to respond to more cases or to continue supporting existing cases. One stakeholder reported not referring all potential cases to the service due to concerns about capacity; several clients also reported being restrained about calling on CRSAs for support, either because they were conscious of their high caseload or because they knew it might take time for them to respond:

"The worker is amazing ... I am always supported and respected...they are so busy and always honest about when and how long it will take to help... [the CRSA] was spread really thin."
(Client)

Based on ORS data, it is difficult to determine an average caseload for CRSAs over the duration of the program so far (at least until June 2019), especially given the variation in staff numbers. But assuming²¹ there were between two to three CRSAs in 2016, five in 2018 and seven in 2019, the average number of **cases** being assisted by each CRSA would be between 24 and 30 per annum, the average number of clients would be between 15 and 28 per annum, and the average number of family members would be between 50 and 150 per annum. It has been pointed out elsewhere that some cases are quite long in duration (one to two years) and that CRSAs could be supporting clients for the (unclearly defined) "long haul". The HMA (2020) analysis of CRSA workload based on a survey of their time allocation found on average they managed 15 **incidents** (per CRSA) per month and they had an average of 12 open **cases** per month. They noted significant variation between CRSAs in caseload, ranging from 3 per month to 31 per month.

Without an established norm of what an appropriate caseload should be, it is difficult to interpret this data regarding staff resource adequacy.

²¹ This allows for several positions being vacant for periods of time.

Staff hours

From the interviews, it was also unclear what backup support was provided to CRSAs to ensure they were working reasonable hours and to take holiday or sick leave. The HMA (2020) analysis of the CRSA survey of time spent data indicated that 96% of CRSA total work time was spent working during standard hours of 8 am to 6 pm, Monday to Friday²². The survey was undertaken during February to May, which does not include the period of the year with the greatest number of new incidents (namely, the Christmas/new year period).

Cultural appropriateness

Several clients and stakeholders also explicitly stated that greater availability of male and female CRSAs in each location was required to ensure that clients had the option of speaking to a male or female. Some interviewees noted that such an approach would be in keeping with the culture of their community:

"The grandfather was happy to talk to [worker] but they probably didn't get as much information as they could've about how he was feeling if he was speaking to a male worker..." (Stakeholder)

"I think it would be good if the females could have an option of a female worker and males have a male worker. That fits culturally with our mob." (Client)

8.2 Geographic distribution of staff

Impressions from qualitative data

It was evident from analysis of the qualitative data that the geographic areas that current staff were required to cover were too large and were unsustainable for the safety of CRSAs and the resources of the services.

Several clients and many stakeholders expressed concern about the distances CRSAs were required to travel in their work; in some instances, it was reported that CRSAs appeared fatigued and overworked:

"... [the CRSA] appeared very overworked – they said they had been working 14 days straight and they seemed tired and fatigued...this is very unsafe for anyone." (Stakeholder)

"I think we need more workers as one person cannot possibly long-term cover that huge area and not be spread too thin." (Client)

As most of the CRSAs were expected to cover large geographic regions, it was evident from the interviews that there was a prevailing understanding and acceptance that CRSAs were expected (even required) to work within a 'solo worker' model rather than as part of a team approach or integrated partnering approach. It was reported that this 'solo worker' model was reinforced at the management/coordination level, with one CRSA being informed during their initial job interview:

²² It is unclear if this data includes or excludes CRSA time spent handling the emergency telephone number.

“If you can’t do this job on your own you are the wrong person for the job”. (CRSA)

There were several instances reported of back-up support being provided for CRSAs in the form of other NICRS staff travelling to a location to manage a new or complicated case, independent of the ‘local’ CRSA who had received the notification. There was limited evidence that case coordination or team-based case management planning was being consistently implemented.

One exception to this solo and dispersed approach was evident in the NT office, where the service was delivered in conjunction with the StandBy service. This co-location arrangement appeared to enable a team-based approach and more effective cross-organisational resource allocation. It also appeared to enable an approach that ensured that the NICRS partnered better with local services. In other locations, the team-based approach was not apparent unless the CRSA or Coordinator leveraged personal relationships and networks.

Despite the large and remote geographic areas CRSAs were expected to cover (including in the NT), it was not evident that CRSAs had access to personal distress devices, mandated safety check-in processes or reporting arrangements in the field. Given the highly emotional and often highly volatile community settings in which suicide and traumatic events occur, it is highly likely that CRSAs were being exposed to unsafe working conditions.

It was reported by NICRS managers that some attempt was being made by the service to rectify staff safety issues, whereby a policy change was enacted that required a minimum of two workers to respond to a notification. However, several CRSAs reported that very often it was not possible to comply with that policy because in most cases they were dispersed across large geographic areas and not co-located with other colleagues.

Service implications of geographic deployment

A survey of CRSA time allocation over a four-week period in early 2019 (HMA, 2020) showed that a large proportion of indirect client support time (see Figure 22) was spent travelling to visit clients (50.8%) and on logistics (e.g. scheduling of appointments and organising travel). This means that travel and organising travel on average took up nearly one-fifth (18.3%) of total CRSA time.

Based on 2018/19 financial accounts for the NICRS, ‘indirect costs’ accounted for 21% of total costs (see Section 9 and Figure 23 for more details). Indirect costs, that is overhead costs such as administrative, finance or communication activities, rent and utilities, are those accrued because of providing services but do not ‘directly’ provide service. In theory, the lower the level of indirect costs the better, since that implies a greater proportion of resources going into direct care.

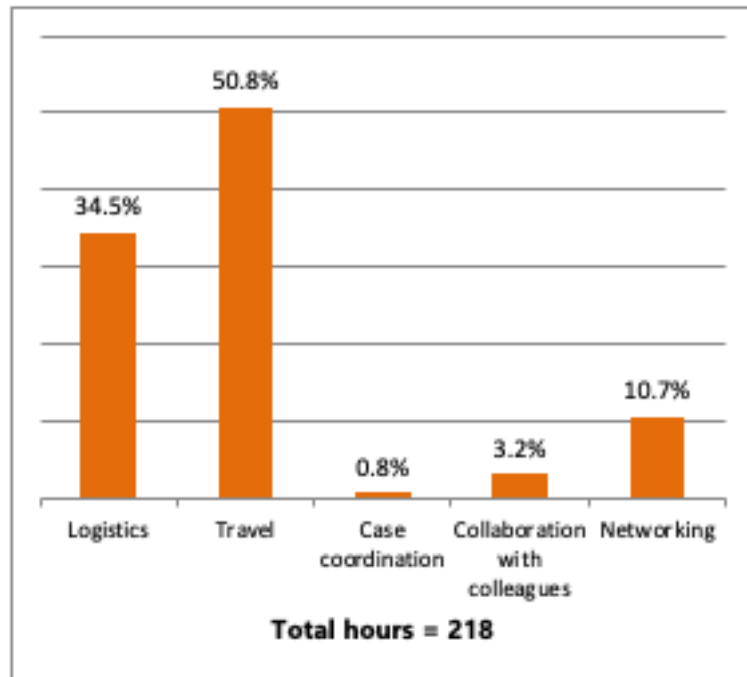


Figure 22: Allocation of CRSA time across different 'Indirect' service-related activities (Source: HMA, 2020)

8.3 Staff training and support

Induction

Combined with the MSC stories, interviews with clients, stakeholders, and CRSAs underscored the commitment and dedication of CRSAs to supporting clients and their families. However, there was also a strong indication from those interviews that there was insufficient support and training of the CRSAs to meet the complex needs of their clients.

During the evaluation period, changes were undertaken to Coordinator positions and this change was reported to have increased the internal focus on staff capacity and support. However, prior to this change it was reported that several CRSAs had not been trained to use the ORS and consequently had no experience entering and maintaining client data of assigned cases. It was further reported that training had since commenced but was being conducted 'in-house' between team members and was dependent on other CRSAs' time availability to provide individual support and guidance. There was also some indication that this process was a longstanding, if not widely undertaken, practice.

There was other evidence that staff had limited access to formal orientation and induction processes or assessments of their initial competency at the time of recruitment to meet minimum capability levels. Some staff reported undertaking personally sourced and funded education to develop what they regarded as fundamental skills for their role once they were familiar with their role.

The insufficient formal or systematic induction processes suggest that policies for induction and staff training were not being well translated into practice, with the likely consequence that staff would be inconsistently interpreting policy and practice guidelines – leading to idiosyncratic approaches once they were in the field. Additionally, without formal induction processes it was

unclear if introductions to service protocols such as risk assessments, personal safety training, distress protocols and equipment, and high-risk environment situational awareness training had been consistently implemented for all staff members.

Training and supervision

There was some indication from the qualitative data analysis and a review of policy documentation that CRSAs were undertaking relevant training and had some access to both practice²³ and cultural supervision. However, information from the CRSA interviews, indicated that these opportunities were irregular rather than available in a structured and systematic manner.

Appropriate training

As previously discussed, while the service is not a healing or counselling service *per se*, it was apparent that some CRSAs were undertaking a counselling role with clients, at least during the immediate response but also on an ongoing basis in some cases – far more than would be appropriate to be termed ‘accidental counselling’²⁴.

Some CRSAs acknowledged the delicate and fine line between accidental counselling and counselling proper but argued the difficulty of referring clients when: a) sometimes they did not want to speak to other services (for instance, because of a past bad experience), or b) no service is easily accessible, or c) they could be in denial about needing counselling support:

“I initially said no to the counselling – yeah good for the kids but not for me. But I do need it. Me and the kids need counselling. They directed me which way to go.” (Client)

But in some cases, discussed with CRSAs and/or clients, it was not actually clear why clients were not being appropriately referred to counselling support, particularly after a period had passed and clients still reported calling CRSAs to just ‘talk’.

Given this *de facto* counselling role that CRSAs appeared to be undertaking, there was limited evidence that CRSAs were sufficiently trained or supervised to provide counselling support. At the time of the evaluation, at least two CRSAs interviewed were undertaking a Diploma or Certificate IV level qualification in Mental Health; another CRSA already held an appropriate tertiary level qualification.

Practice supervision

Interviews with CRSAs and management confirmed that clinical supervision delivered by an Indigenous clinical psychologist via a monthly Zoom video conference was available to all CRSAs. It was reported in the interviews that the supervision model was not intended to be individual clinical supervision and was primarily an informal monthly “catch up” in which the ‘big issues’ are discussed.

²³ This term, given the nature of the CRSA role, is used here instead of the term ‘clinical’ supervision.

²⁴ In an earlier section (5.4) it was noted that in just less than one quarter of cases where a service was provided ‘accidental counselling’ was employed as an intervention. As noted in that section the interviews with CRSAs seemed to indicate the practice was higher.

Common discussion topics were reported to include self-care and setting boundaries, the issue of 'case closure' and the associated need to prevent dependency developing in the client relationship.

While these critical issues were reported to be raised by CRSAs, it was not evident from interviews with CRSAs, clients (nor analysis of the ORS data) that the current level or format of clinical supervision was sufficient to assist CRSAs to sustainably manage their role. The incidence of 'accidental counselling' described above was one example of CRSA practice that the current model of clinical supervision was not sufficient to address. It was also indicated that some CRSAs were 'holding onto' clients - even in NICRS offices with multiple FTEs where there was potentially more capacity to implement a team approach - rather than making appropriate referrals. This example points to a possibly insufficient level of guidance and supervision within and between CRSA practice.

A lack of formal or regular supervision processes was indicated by the reported expectation that CRSAs were responsible for seeking support if they needed to supplement the monthly catchups, rather than formal 'check-in' processes being in place. Additionally, it was not evident that CRSAs had access to structured case review processes to inform, assess or justify case closures or reductions in contact requirements.

It was also reported that it was assumed (by managers) that Coordinators were providing the direct operational supervision and personal practice supervision. And, given that CRSAs were not raising significant issues, it was also assumed that Coordinators were conducting supervision effectively. However, neither of the current Coordinators interviewed, nor the previous Coordinators, reported any training or procedures being provided that would facilitate their competence to undertake practice supervision for staff.

Cultural supervision

Cultural supervision is a key element both of the NICRS program rationale and its model of care. A form of cultural supervision is provided to CRSAs via a Cultural Adviser role, which originated in WA. This was recently supplemented by an additional QLD-based role. No position description existed for the initial Cultural Adviser position, but a brief and quite non-specific description had been prepared for the second role (see Appendix 5).

The Cultural Adviser role was regarded as critical by CRSAs and Coordinators, the majority of whom were Aboriginal people themselves. However, these staff members reported that there was a high level of concern that general cultural governance and advice for service operation was a greater need, compared with the provision of specific cultural practice advice and local understanding for individual clients, families and communities. This interview data suggested that some re-alignment of effort would be helpful.

It was evident that the Cultural Adviser role activity was primarily focussed on the second arm of cultural input as described above and reported to be available to CRSAs on an 'as needed' basis. Staff reported *ad hoc* engagement with the Cultural Advisers, based on either their personal connections and or their needs. Some CRSAs reported high levels of satisfaction with this process, whereas others tended instead to rely on their own personal cultural resources and Elders to inform cultural practice and understanding.

The aspect of Thirrili as an organisation assuring Cultural Safety in the workplace or in practice deliberations was not raised at all in interviews. This would be a key area of improvement, to

incorporate into NICRS cultural supervision arrangements in parallel with (but complementary to) clinical supervision and support actions. An effective combination of these two distinct and important aspects of staff supervision is essential, given the diversity of cultural practice, nuanced cultural relationships and widely differing and specific cultural needs of families and communities in trauma encountered by NICRS staff members.

The nature and level of practice and cultural supervision provided to CRSAs remains unclear and cannot be regarded as being delivered in a systematic or organised manner.

9 Costs of the service and value for money²⁵

A VfM analysis was undertaken by HMA by looking at the costs of service delivery in the first three years of operation. The analysis indicated that 'direct costs', such as salaries, was found to be the most significant area of cost for the service. The analysis also provided some indication that costs differed by type of incidents and types of support, with 'incidents with evidence of clear activity' and 'client support' being the most significant costs for the service. However, without routinely collected data on outcomes of the program, it was not possible to accurately assess the VfM of the service.

9.1 Total costs

The total budget the NICRS received for its first three years of service delivery was \$10 million (from December 2016 until December 2019 and extended to March 2020). For the 2018-19 financial year, HMA (2020) estimated the total expenditure to be \$3,287,954. They broke this total expenditure down into three categories - 'direct' costs, 'support' costs, and 'indirect' costs, as shown in Figure 23. Direct costs were found to be the most significant cost category (69.6%).

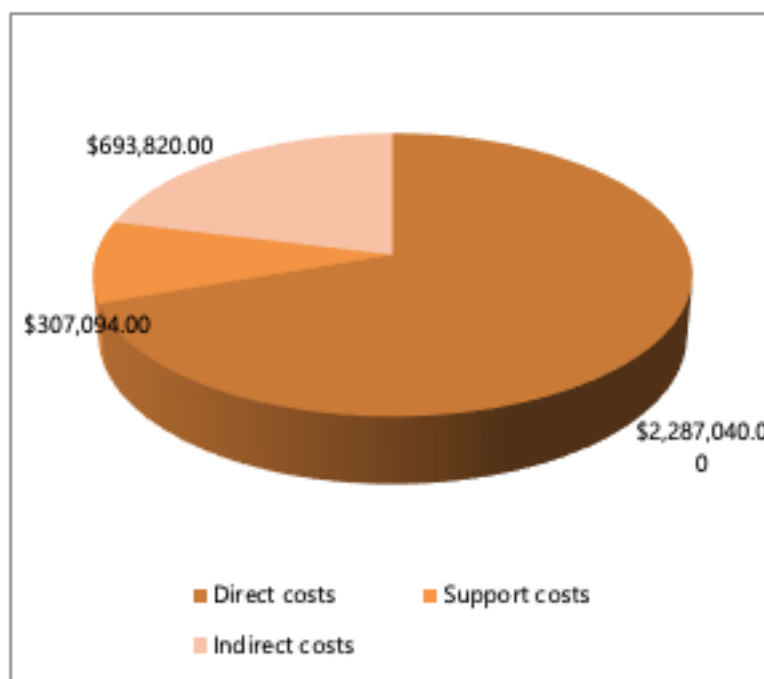


Figure 23: Distribution of total NICRS expenditure in FY2018-19 by type of cost (Source: HMA, 2020)

Direct costs were defined as being salaries and other costs (e.g. systems development) directly associated with delivering services. So, for instance, CRSA salaries and their immediate supervisors were included in 'direct' costs. Only part of the cultural advisor and manager salaries were included as direct costs, but parts of these roles were also included in support and indirect costs.

²⁵ Most of the findings for this section are based on data in a companion study undertaken by HMA (2020)

Support costs were defined as those costs that facilitated direct service delivery, such as professional development, cultural advice and data collection support.

Indirect costs were primarily defined as synonymous with standard overheads, including management, finance / accounts and communications related salaries plus office related costs (rent, utilities) in six sites and support for governance arrangements (Thirrili Board, NICRS Reference Group, etc.). Indirect costs account for 21.1% of total costs. This is a little higher than conventionally accepted levels (namely 15%; see Brewer, 2018) but within the range of administrative cost proportions for non-government organisations. In any case, the use of an 'overheads' ratio to total costs is considered controversial (Brandt, 2013).

9.2 Unit cost per incident

As noted in an earlier section, widely varied CRSA and other activity accompanies individual incidents, with CRSA hours in particular ranging from less than one hour to over 300 hours.

HMA (2020) tried to conceptualise this level of variation from a cost perspective by classifying incidents into three broad categories: 'Incidents with evidence of clear activity', 'Incidents classified as out of scope', and 'In-scope incidents where no action was taken'. All three of these incident categories attracted an average unit cost - \$25,349, \$1,567 and \$5,426, respectively. In Table 8, a further breakdown of costs within these broad categories is provided.

Table 8: Estimated average cost of different types of incident (Source, HMA, 2020)

Broad Incident category	Incident type	Average cost per incident (\$'s)
Incidents with evidence of clear activity	Limited initial input / no ongoing support	2,873
	Extensive initial input / no ongoing support	8,524
	Limited initial input / limited ongoing support provided	6,085
	Limited initial input / extensive ongoing support provided	30,888
	Initial extensive input with periodic / limited ongoing engagement	34,336
	Consistent extensive ongoing support provided	44,124
Incidents classified as out of scope	No further action taken	920
	Extensive support provided	29,755
	Some support provided	1,286
In-scope incidents where no action taken	No details available or unable to locate client(s)	1,456
	Other services providing support	1,660

9.3 Cost per type of support

Earlier descriptions of NICRS activity suggested that most activity was being directed towards support for individual clients (that, is, what the NICRS defines as 'Stream 1' or 'Postvention and bereavement support') and much less effort is directed towards community and systems level ('Stream 2' or 'Community capacity building') action. This is reflected in the service costs calculated by HMA (2020) based on service support type, as shown in Table 9.

Table 9: Distribution of NICRS costs according to type of support (Source, HMA, 2020)

Support type	Description	Total cost (\$)
Client support	Support to individuals, families and communities affected by suicide or other traumatic incidents	1,972,773
Community capacity building	Building local community capacity to respond to critical incidents	657,591
Systems change	Systems change by improving the coordination of postvention response services through capacity building	657,591

9.4 Value for money

A VfM analysis of the NICRS was requested in the original evaluation brief, but it was never agreed as to how the analysis was to be undertaken (or even if it was feasible). The NSW Government (2016)²⁶ defines VfM as follows:

"... value for money is the differential between the total benefit derived from a good or a service against its total cost, when assessed over the period the goods or services are to be utilised ..."

A simpler way of understanding VfM, especially as an evaluative question, is how well resources are used and whether the resource use is justified (King, 2018).

There is increasing scrutiny on VfM especially for evaluating not-for-profit programs where the concern is that invalid conclusions from VfM will arise if assessment is tied to a narrow set of indicators devoid of any evaluative judgement (King, 2018):

"... for example, by emphasising the most readily quantifiable measures rather than the most important (but harder to quantify) aspects of performance, or by focusing on the quantification

²⁶ <https://www.procurepoint.nsw.gov.au/policies/nsw-government-procurement-information/statement-value-money>

of outputs and outcomes at the expense of more nuanced consideration of their quality, value, and importance.”

A VfM analysis can be undertaken at different stages of the project results chain and associated logic of inputs, outputs and outcomes/impact. These elements are outlined in Figure 24, which captures the three major dimensions of VfM.

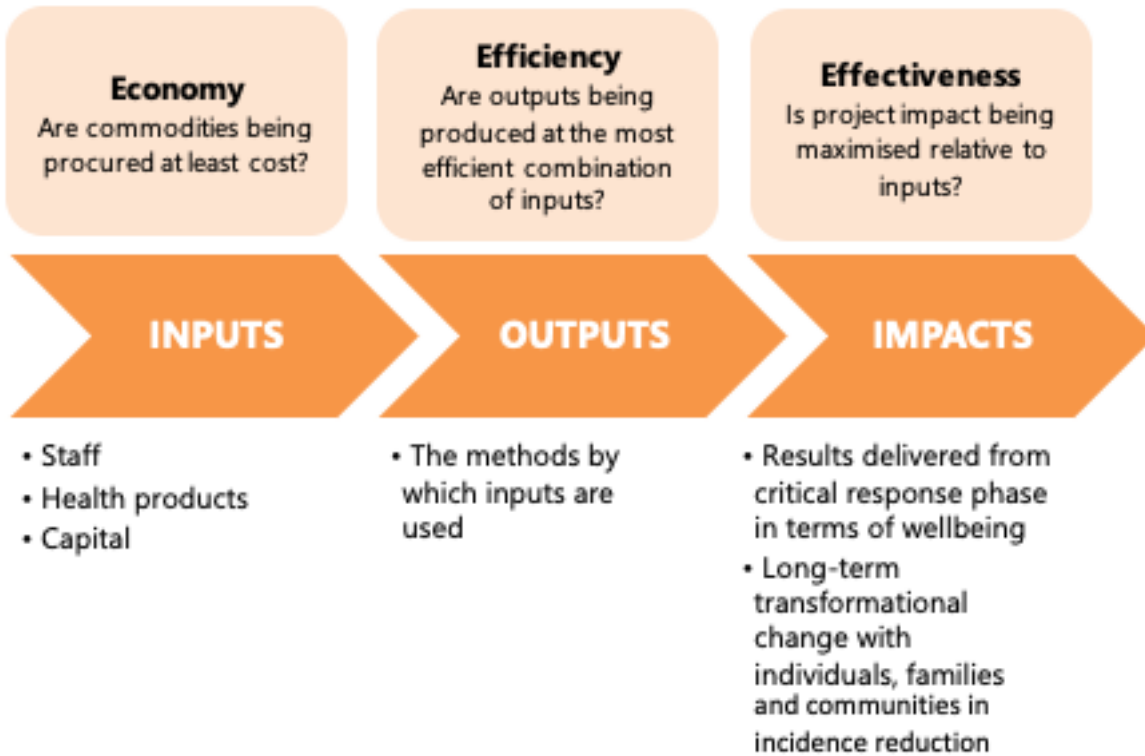


Figure 24: Value for Money and the Results Chain

It might be possible, in future evaluations if appropriate data is collected, such as the cost analysis data gathered by HMA (2020) and qualitative data in this evaluation, to make VfM judgements on the ‘economy’ and ‘efficiency’ aspects of NICRS operations. Explicit criteria and standards (of performance) would need to be agreed upon. VfM of ‘effectiveness’ would also still require agreement on the outcomes of the program and then routinely collecting data on those outcomes.

10 Discussion

10.1 Model of care

Implementation of the model

The findings from the evaluation indicated that the current NICRS model of care was not being uniformly adopted and that there was a lack of systems and mechanisms in place to support consistent implementation of the service. It was evident that implementation was breaking down at several steps of the published eight-step model and that there are few (if any) tools in place to monitor progress along the 'journey of healing' that underpins the model. This appears to be resulting in a lack of clarity for CRSAs, clients and stakeholders about the purpose and scope of the service and is potentially undermining broader confidence in the effectiveness of this national service.

The evidence gathered through the evaluation indicated that the service was valued by clients and viewed as a critical service by almost all interviewed participants. The immediate and practical support provided by the service, such as ERF for food and transport or advocacy, and liaison with key services was highly valued by clients and stakeholders. But the findings also indicated that there was a significant lack of clarity amongst clients, stakeholders and CRSAs about the purpose of the service, what the service was providing and how long support could be expected.

The evaluation findings strongly indicated that a key contributing factor for inadequate implementation or execution of the model was a lack of supportive systems and infrastructure available to CRSAs and ineffective translation of policies into practice. For example, there was no evidence that CRSAs were using the assessment tool provided in the ORS Manual (Appendix 1 of that document) to execute Step 3 (collect detailed information) and Step 5 (identify needs) of the model. There was also limited evidence that CRSAs had access to forms or templates to develop throughcare plans²⁷ (Step 6), or customer relationship management (CRM) systems to set electronic reminders for regular reviews, or that formal processes were in place to assess when it was appropriate to 'Step back' (Step 8) from clients. At best, this has resulted in some clients receiving support longer than may be necessary. But at worst, many clients have not been properly followed up and have been left without ongoing support. Overall, it is possible that some clients have received inequitable and possibly inappropriate levels of support.

Improving the supportive systems and infrastructure of the service is therefore paramount in order to ensure policies and procedures are translated into practice. It should then follow that the model would be uniformly implemented across the jurisdictions, while still allowing for some local customisation (for instance in response to more localised cultural practice).

²⁷ Appendix 2 of the ORS Manual provides a simple template for development of a 'Case Management Plan'. This is probably inadequate for proper throughcare planning.

Restructured model of care

In addition to ensuring there are supportive systems and infrastructure for the service, reviewing and revising the current model of care may also be warranted to support consistent implementation of the model.

Review of the literature suggest that the current model of care is in line with current understandings of postvention models. However, it was evident from the evaluation that the current description of the model is insufficiently clear and that some elements of the model are ambiguous in ways that were potentially impacting upon implementation.

Based on these collective findings, an example of how the model of care might be revised has been developed by the evaluation team to assist the Board's deliberations on this issue. The intention of this example model is to point out how a broad outline of the service and the boundaries around the type and duration of support could be made clearer, as well as promoting long-term capacity building and community engagement in service locations.

The model has been reconfigured into a three phased approach as follows:

1. **Preparation phase** - this is a major data collection phase involving assessment of service scope, incident information collection, client data collection and obtaining consent for service engagement; in parallel, this is a time for research and networking in relation to the local community and its cultural and service resources so that the CRSA is well prepared to enter a co-design process for a throughcare plan that connects the client with local support infrastructure – this phase may last from only a matter of hours after notification or for a period of days or weeks, depending on the client and family's preferences for engagement.
2. **Critical response phase** – in this phase clients are provided with support immediately after an incident and for up to three months; during this time it would be expected that CRSAs have assessed client needs using standard tools and checklists, provided postvention information (StandBy has a number of appropriate resources that could be adapted for NICRS's target audience; including by translation into appropriate language) and made appropriate referrals and connections.
3. **Ongoing support phase** – in this phase clients are supported for up to one year to ensure they remain connected with services and supports. After one year, CRSAs will continue to follow-up with clients at key anniversaries, etc., by setting reminders in a CRM system for two to three years. In this ongoing phase Coordinators and CRSAs would also undertake a 'population health response' to build the capacity of communities through education, community development activities and cultivation of relationships with relevant networks, which is analogous with Stream 2 of the current NICRS approach.

An outline of the suggested model revision, for discussion within NICRS, Thirrili and trusted stakeholders, is provided in Figure 25. Only phases 2 and 3 are included. A set of potential outcome measures for each phase have also been included to provide an indication of the types of outcomes that would be expected for each phase. This list is by no means exhaustive.

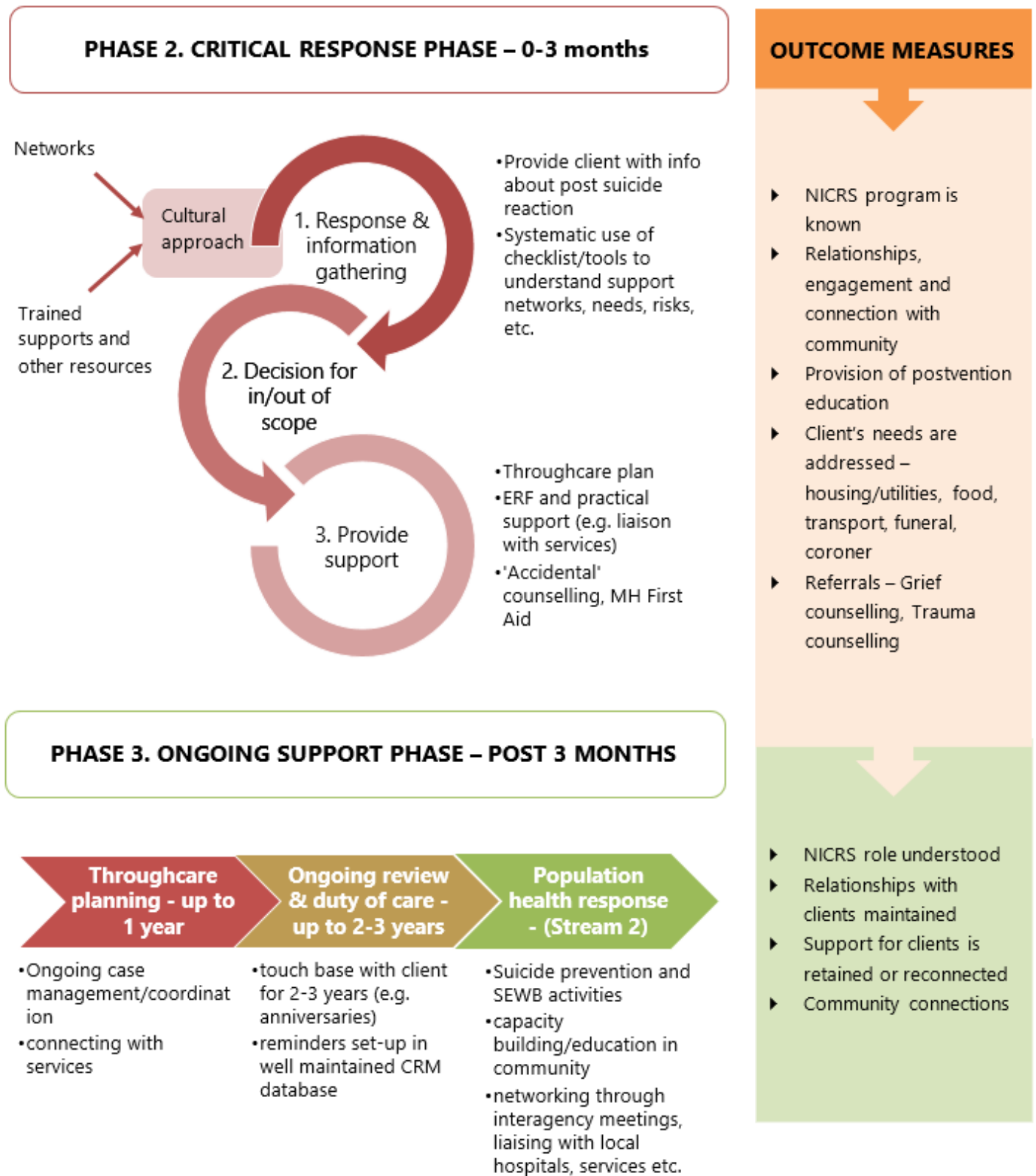


Figure 2: Reconstructed model and outcome measures developed by the evaluation team

10.2 Governance of the program

Within Thirili (and more specifically the NICRS), despite the findings that organisation governance needs to be improved, there are many of the elements of a sound governance structure.

There is a Board of Directors that meets regularly and is comprised of Directors of appropriate skill and experience. There are many policies and procedures documents that cover most areas of the organisation's financial and human resources operations, client and external partner relationships and legislative requirements. There is a management structure in place that should be able to support the frontline staff perform their roles. There is a model of care document that, despite the thoughts canvassed in the previous section, provides some direction. There is a program logic that identifies the 'vision' for the service and provides outcomes to potentially measure performance and hold various levels of the organisation to account.

Despite all these elements being in place, the practice (clinical) governance remains deficient. There appears to be a lack of frameworks and structures that can integrate all these elements into cohesion, thereby acting to ensure governance functions at the different corporate / cultural, managerial, operational and practice levels. The two missing pieces of work appear to be:

- a governance framework
- a strategic or business plan.

While both are document-based tools, it is important to consider them more as bodies of work that need to be undertaken by all the internal stakeholders (Directors, managers, workers) and, where appropriate, with engaged external stakeholders. It is the work to develop these documents which will be important and make the difference in how they are used and contribute to governance improvement.

Other than promoting the use of collaborative and appreciative inquiry processes to develop those tools (and especially the strategic and business plan), the evaluation team has no prescriptive suggestions as to how these documents should take shape. However, the following areas appear to be vital to consider and to have covered in any new governance arrangements:

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ <i>Workforce capacity</i> ▪ <i>Workforce capability</i> <ul style="list-style-type: none"> ○ induction, education and training ○ practice and administrative supervision | <ul style="list-style-type: none"> ▪ <i>Workforce health and safety</i> <ul style="list-style-type: none"> ○ site visit procedure ○ psychological support ▪ <i>Strategic planning</i> <ul style="list-style-type: none"> ○ clear vision and expectations ○ performance indicator ▪ <i>Service planning and operations management.</i> |
|--|--|

Workforce capacity

In Section 9 the capacity of the current CRSA resources to adequately cover all incidents that occur in each of the jurisdictions within which the NICRS is operating was questioned. From a governance perspective, further research needs to be undertaken into the workforce requirements needed to deliver the contracted level of services at the agreed level of quality.

Workforce requirements are dictated by the work that must be performed, so this research will need to be preceded by service planning decisions with regard (at least) to:

- the model of care (whether this be the current model or a revised model)
- the scope the services (whether it is national or a more regional focus on 'hotspots')
- the deployment of resources (the current distribution vs more cluster-oriented)
- the operational processes to be adopted (continuation of sole practice or more focus on teams; level of flexibility according to incident contexts).

In the short-term there appears to be enough evidence to accept that the NICRS is under-resourced for the task it has been set. This represents a governance risk to either service reach or service quality – or both. The solution choices are to increase the CRSA resources (which would require additional funding) or to tailor services to better fit available resources by reducing the service scope in one or more of the following ways:

- limiting the model of care (a focus only on the critical response, and limiting the duration of service contact to less than 6 months)
- restricting the target population (for instance, focus only on completed suicide incidents)
- reducing the geographical footprint (i.e. focus service delivery on regions or communities where needs are the highest²⁸).

Workforce capability

The CSAs are the key asset of the NICRS and it has been pointed out on a number of occasions in this report that, collectively, their commitment to the clients they serve and their desire to provide the best possible outcomes for their clients is undoubted. All stakeholders interviewed had praise for the CSAs and nothing but respect for the way they are approaching the challenges of their role.

There is great variation in the educational background and life experiences of the CSAs. This variation can be a positive if it is well utilised (for instance, through effective teamwork), but can be a threat to good governance if minimal competence requirements are not possessed by individuals. Apart from the job descriptions, there seems to be no specification of the minimum competencies required of CSAs. This is a gap in governance infrastructure that needs to be rectified and then CSA skills should be audited against the minimum requirements. Based on the understanding that has been reached of the CSA role, the evaluation team considered the following competency areas to be important for inclusion in any minimum competency set:

- understand loss and grief ... not just through personal lived experience
- understanding of what psychosocial support means
- accidental counselling and assertive referral
- case work and care coordination
- trauma-informed care
- understanding of the need for, and use of, service level data

²⁸ A decision would need to be made whether to focus on locations with the highest absolute numbers of incidents (efficiency) or the highest proportion of incidents (equity).

- ability to use data to inform practice
- networking and building partnerships.

Depending on how the model of care evolves, additional basic competencies in population health and community development would be advantageous but could be possessed within a team rather than by each CRSA individually.

From a governance perspective, achieving a competent workforce starts with recruiting people with the necessary skills. This might not necessarily have always been the case with NICRS recruitment practice, which means that strong induction processes are required. These strong induction processes do not seem to have happened - this situation must be rectified by putting in place a three month induction process of classroom-based and on-the-job training that includes (at a minimum) orientation to the CRSA role and the model of care, a full introduction to the ORS and why it is important, and use of key NICRS assessment and planning tools (e.g. to undertake a needs assessment, determine client scope, complete the throughcare plan).

Further skills development will invariably be required, even for a CRSA recruited with most of the minimum competency requirements. This can be done primarily through on-the-job training, which has been shown should account for 70-80% of all work-related learning (see Figure 26). Structured learning on the job can be achieved through peer review of cases, buddying up with other competent CSAs, being asked to undertake specific projects, and/or researching the ORS data (for instance, analysis related to a CRSA's own caseload)



Figure 26: A balanced Learning & Development framework – the 70/20/10 model

Coaching from a practice supervisor or external clinical supervisor (for instance, through the processes conducted by the contracted psychologist) can also support and direct the learning. Some skills will need to be developed off-the-job through structured (short or longer) recognised courses; for instance, in order to develop case work or accidental counselling skills.

Individual CRSA learning needs are best identified through the implementation of structured practice requirements and administrative supervision and performance management arrangements (see below). Practice supervision needs to be proactive and not just occur when an individual CRSA "feels the need" for it. From a governance risk perspective, supervision for all CSAs should include (at a minimum):

- routine conversations on selected cases (including peer review)

- regular audit of a sample of throughcare plans and case notes
- monitoring of caseload (including equitable distribution between CRSAs)
- supervised client interactions
- routine review of client outcomes
- observation of ORS data entry
- routine checks of wellbeing.

A key question for practice supervision is to identify where in the organisation responsibility for it lies. It has been assumed that practice supervision will primarily be undertaken by the two Coordinators. However, as pointed out earlier, the current Coordinators seem to [still] have a client caseload which will distract them from any significant supervision responsibilities. As well, neither of the current Coordinators profess to have the requisite skills to perform practice supervision confidently and competently now. Those skills, though, could be developed. There is then the additional question of how much of the practice supervision load should also be shouldered by the Project Manager, whose role currently seems to be more concerned with administrative supervision, and the Cultural Advisors, whose input is currently mostly focused on specific client-related operational issues. Ideally, a practice supervision arrangement should be designed that is highly structured and properly implement but does not place all the responsibility for supervision onto one or two persons.

Workforce health and safety

Several CRSAs were found to be working in situations that put their physical and mental health at risk. It appears that they often travel, alone, to community situations which are often highly emotional and often highly volatile following a suicide or murder and may have limited local service provider or community support. And, given that all of the current CRSAs have some level of lived experience with suicide, they can possibly be re-traumatised or, if consistently confronted with cases in an unsupported manner, be affected by vicarious trauma.

The evaluation indicates that a significant governance risk exists that a CRSA will become ill or injured, with subsequent negative impact on the other CRSAs, the reputation of the organisation and the financial burden of a long-tailed worker's compensation claim. A full health and safety risk assessment needs to be undertaken on all identified hazards and risk management strategies developed and put in place at the upper level of the hierarchy of control, then consistently monitored operationally. In the meantime, the following risk management measures can be specifically considered:

- deploying and locating CRSAs into teams so that no client face to face work is ever undertaken solo
- providing access to personal distress devices
- providing training in personal safety and use of equipment and environment situational awareness
- introducing mandated safety check-in processes or reporting arrangements for when CRSAs are in the field
- providing training in risk assessment.

Strategic planning

- Clear vision and expectations
- Performance indicators

In several sections of the report so far, the lack of clarity amongst CRSAs of the operational requirements of their role and the place of their role in the broader scheme of NICRS activity has been described. This lack of clarity occurs despite the existence of a model of care document and a large number of policy and procedure documents. It would be easy to attribute this situation to the inability of 'middle' management to translate policy down to the CRSA level, but the problem appears more systemic than that.

A clear vision for all managers and workers starts with the Board of Directors and the CEO and is conveyed to workers through a strategic or business plan and then embedded into documents that should be commonly available to and used by CRSAs (such as the position description; individual, team and organisation performance indicators; and standard operating procedures). Constructing a strategic or business plan, initiated by the Board but engaging the input of managers and workers, is a priority for Thirrili. This plan will set the expectations on all levels of the organisation.

The vision and expectations can be reinforced by clear and measurable performance indicators that apply to CRSAs, managers and the organisation (Board) and that relate directly to the outcomes (immediate, intermediate and long-term) to which the strategic plan makes a commitment.

Organisations increasingly tend to rely on a comparatively small number of dashboard-type performance indicators for focus. Most indicators established at the Board level assume that outcomes must be achieved at lower levels. Isolating the performance indicators with most meaning to NICRS's vision, developing a way to measure performance achievement, and then establishing a means to routinely collect data on performance will be the key aims of this.

These performance indicators should be developed internally (perhaps with reference to trusted stakeholders like NIAA) but a draft list of performance measures from which to draw possible suitable options is provided below. These draft measures were developed with the assistance of examples of good governance frameworks (DSS, 2011; Arguden, 2010) to address some of the relevant quality indicators for suicide intervention activities that were outlined in the ATSSISPEP Final Report (Dudgeon, et al., 2016). Although not an exhaustive list, possible measures might include:

- service is linked into a wide range of formal and informal early notification systems
- education material has been made available to community leaders and other service providers on SEWB and postvention strategies and options have been explored for collaboration
- contact lists, service maps and community roles prepared in each community setting
- situational analysis (including service and community mapping) is: a) commenced during the Preparation phase for all communities contacted and b) completed for all approved cases during the Critical Response phase
- Board and staff members understand the linkages between the program logic and service activities
- Throughcare plans are a) developed and b) implemented

- referrals have been made for counselling and medical treatment for appropriate clients
- clients informally assessed as being at risk of suicide given warm referral to suitable available mental health service
- service locations have an established community engagement process in place to guide local NICRS service provision and networking
- cases have involved active planning for coordinated throughcare involving other relevant service providers
- cases have involved active involvement and capacity building for clients' carers, family and kin in developing throughcare plans
- number of suicides/suicide attempts within 28 days of incident/ commencement of NICRS support
- cases have a minimum of 90% of ORS fields completed
- ORS data is regularly analysed in conjunction with feedback from clients and local service providers and relevant secondary data sources
- secure data system is regularly reviewed and maintained, and service protocols are in place and followed to ensure confidentiality and secure storage
- staff have had a skills audit undertaken and professional development plan agreed and activated
- clinical staff meet relevant professional accreditation requirements and address professional development needs for their current and/or anticipated role in the service, in consultation with relevant manager/s
- partner agencies reporting satisfaction with the contribution of the service providers to integrated service delivery.

A sound information system is required to make data for most, if not all, of these potential performance indicators accessible to the Board, managers and workers. Currently the ORS is intended to provide that function, but it has limitations. These limitations and how they might be overcome are discussed below.

Service planning and operations management

Improved service planning should result from the development of a strategic and business plan and if managers are properly held accountable through performance indicators for its implementation. Of concern, though, is that under the current iteration of the organisational structure, there are three key management levels – the CEO / Director, Project Manager, and two Coordinators. Almost all of the interface with CRSAs under this structure lies with the Coordinators.

Several CRSAs offered the view that an 'operations manager' position was required - one that would spend a lot more time in the field supporting [and supervising] Coordinators and interfacing directly with CRSAs to ensure policy and procedure are being clearly articulated and translated appropriately into operational practice. Such a position, possibly in lieu of the Project Manager role, might result in a more even distribution of accountability across the layers of governance between the Board and the CRSAs.

10.3 Service resources location

In earlier sections it has been noted that:

- (1) CRSAs spend a significant amount of their time travelling or arranging travel to meet with clients
- (2) they are often required to travel to client locations alone because it would not be feasible to bring a companion CRSA from another part of the jurisdiction or another jurisdiction
- (3) many stakeholders have argued that CRSAs need to be located closer to their client's communities in order to be able to form stronger understanding of, and relationships with, those communities, and
- (4) the current CRSA resources are likely insufficient to implement the model of care nationally.

Many stakeholders offered the opinion that the NICRS would be better delivered on a regional rather than national basis, and that this would improve the service delivery practice, reduce occupational health and safety risks to CRSAs, and make service delivery more efficient. NICRS management advised that indeed the original idea for the NICRS service was for it to be delivered regionally in collaboration with the Aboriginal Community Controlled Health sector, but such collaboration had been difficult to facilitate. It is perhaps time to reconsider the pursuit of a more regionalised service model.

Figure 26 shows the distribution of completed suicide incidents across Australia based on coronial suicide data between 2003 and 2018 (HMA, 2019). It mirrors an earlier figure (Figure 6) that was based on suicide incident notifications to the NICRS. Both the figures (Figure 6 and 25) provide a basis for examining how and where NICRS services might be regionalised. The key regions where high levels of suicide incidents occur (i.e. 'hot spots') are:

- The Kimberley
- Alice Springs / Central Australia
- Darwin
- Brisbane
- Perth.

Other major hubs of suicide incidents are:

- Perth
- Geraldton
- Pilbara
- Maningrida / Nhulunbuy
- Cooktown
- Mt Isa
- Townsville / Palm Island
- Cairns
- Mackay
- Sydney
- Adelaide.

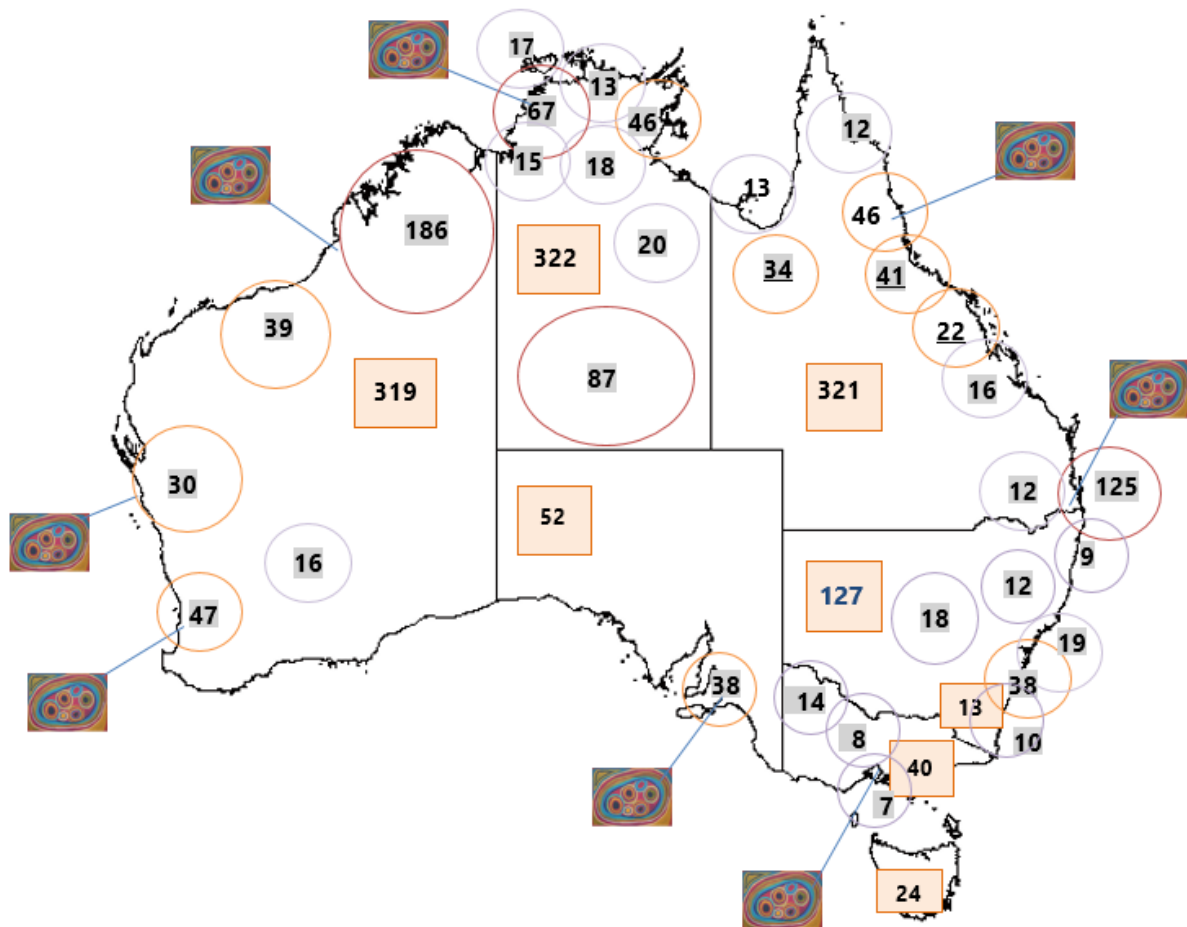


Figure 27: Coronial suicide data 2003-18 – Aboriginal & Torres Strait Islander people by location of suicide, top 10 LGAs by jurisdiction ≥ 5 per location³⁰ (Source: Thirilli Ltd., (2019). National Coronial Information Service Suicide Data Analysis)

Key:

- Very major hub of incidents and responses (≥ 50 in a city or regional area)
- Major hub of incidents and responses (21-49 in a city or regional area)
- Moderate hub of incidents and responses (5-20 in one area)
- 16 Jurisdictional total incidents
- 13 Number of suicide incidents
- CRSA location (incl. combined roles)

Currently resources are located in Adelaide and Melbourne that do not coincide with ‘hot spots’, while the Pilbara, Townsville / Palm Island, Maningrida / Nhulunbuy and Sydney all require services from remotely placed CRSAs. Based on this data alone (and one can accept that many other considerations might need to be considered), teams of CRSAs (i.e. no less than two) should be placed in the Kimberly, Darwin, Central Australia and Brisbane. If funds permitted, then teams could also be located in North QLD and Perth.

Locating CRSA resources in teams closer to hotspots would support more effective implementation of the example revised model of care, especially during the **ongoing support phase**, where community level / population health intervention would be envisaged. By locating CRSAs in teams,

the processes of practice supervision and workforce capacity building could be better supported. Finally, greater efficiency in the use of CRSA resources should result.

A variation on the 'hotspot' location of CRSA resources would be to adopt more of a 'hub and spoke' deployment approach. In this construct, the 'hubs' could be more regionally-based deployments of CRSAs, and the 'spokes' would be 3-4 members (or more) of hot spot communities trained to be first responders to incidents as well as trained connectors or links to those communities to support the NICRS regionally-based CRSA resources to provide an intervention. Standby in the NT has tentatively started to develop this type of model by training community members in selected Central Australia communities. In any of these variations, where possible, team composition should also reflect male and female workers to address the gender-sensitive service delivery requirements that have been discussed earlier.

10.4 Data collection for the program

Data quality concerns

The quality of the ORS data was raised in the discussion of the method (see Appendix 7) and in various other sections. The quality of the data is compromised from several directions but some of the main factors are:

First, current, and past, CRSAs have admitted to not placing sufficient importance at all times on the data entry for the ORS. This is a common problem that arises in social welfare organisations when program activity data is to be entered by direct care workers. Workers invariably preference the care work over what they see as the 'administrative' work (Nonprofit Hub, 2019) and some comments were made that the ORS was only really well maintained during a period when a dedicated officer (rather than the CRSAs) was doing the data entry. At best, the consequence of this general reluctance was tardy data entry; at worst, retrospective data entry has led to inaccuracies in the activities captured and/or missing data since memory fades and workers move on. After reviewing the data, the evaluation team has formed a strong suspicion that some (perhaps a significant amount) of NICRS activity has not been recorded.

Second, it was reported through the interviews that Coordinators had historically received little or no training in ORS system management and consequently could only provide limited direct support for CRSAs. Several CRSAs interviewed also indicated their understanding of the ORS was poor.

Third, during the early days of the program implementation, prior to the ORS becoming fully established, some cases were provided services without being properly recorded. This problem has continued to varying degrees because data fields have continually been added, and some critical fields were not added to the database until late 2018.

Fourth, the ORS Manual (NICRS, 2018), meant to be an aid to data entry, has been described by CRSAs as difficult to understand, a sentiment reflected as well by the evaluation team.

Compounding the effect of the above issues on the data quality, the ORS data set is incomplete – that is, not all the data required to monitor implementation and support continuous improvement is either required to be entered by CRSAs or is entered in a way that is easily accessible to analysis.

Some key service variables that need to be monitored but currently are either absent or difficult to access (this is not an exhaustive list) are:

- the time of the first client contact is difficult to determine
- inconsistency in the reporting between cases and clients
- needs of clients are not recorded except in case notes
- whether a throughcare plan was created
- objectives of the throughcare plan are not recorded and nor is the achievement (or not) of those objectives
- the types of intervention, other than ERF, are difficult to discern and inaccessible for analysis. For instance, there is no recording of accidental counselling (other than in case notes) nor of actual referrals attempted. There is no detail on the types of referrals attempted or the outcomes.
- other service providers involved in cases are not named or categorised (e.g. ACCHOs, NGO, government mental health services, etc.)
- the amount of time spent on cases is not amenable to analysis
- case closures are not recorded.

To undertake the analysis reported upon in earlier sections, the research team attempted to retrospectively create several data fields that would allow analysis of some key program implementation variables, particularly the referral to and use of other service providers, the time spent on cases, and the interventions employed for cases / clients. This was done by extracting information from the summary case notes, but these notes clearly presented limitations and required some researcher judgement to be exercised.

From a governance perspective, the inability to easily and reliably access data which monitors critical service activities and processes severely undermines governance intentions. How can a CRSA's service to a client be monitored and a CRSA be held accountable for the quality of that service if there is no record of the client's needs having been assessed, no record of a throughcare plan and no accessible record of what interventions were provided? Even if these documents exist, it is inappropriate for monitoring and continuous improvement processes for this data to be 'buried' in several separate documents.

Outcomes data

Arguably though the most important data variables missing from an organisation governance perspective are those variables to measure outcomes. In section 8.2 the absence of quantitative outcomes data was discussed and the objection of many internal stakeholders to clinical psychological assessment tools noted.

The search for suitable quantitative measures of service outcomes, that would support a more rigorous governance framework, needs to be undertaken with both internal stakeholders (CRSAs and managers) and external stakeholders (Thirili Board and NIAA) to find measures that are

practical, culturally appropriate and satisfy the needs of external stakeholders that funds are achieving value for money. The evaluation team is reluctant to put forward suggestions, but some discussion is provided below of the possibilities.

Dudgeon et al. (2016) offered a set of objective measures that might be culturally appropriate. These were itemised in Section 10.2.

In the area of more structured assessment tools, one stakeholder interviewed was using in her own service, and keen to recommend the use of by NICRS, a tool developed some years ago by the Menzies School of Health Research called the *Strong souls assessment tool*²⁹. *Strong souls* was developed as a measure of social and emotional wellbeing (SEWB) for use with Aboriginal and Torres Strait Islander populations. Other stakeholders pointed to the use of the *Westerman Aboriginal Symptom Checklist – Adults (WASC-A)*, which has been validated (Bright, 2016), but can only be used under licence. Both these tools were specifically designed for use with Aboriginal populations.

In a study of postvention clients undertaken by StandBy (Gehrmann, et al., 2018) the following tools to measure aspects of wellbeing or “how clients were travelling” were employed:

- Suicide Behaviours Questionnaire-Revised (SBQ)
- Grief Experience Questionnaire (GEQ)
- De Jong Gierveld Loneliness Scale (DLS)

The use of these tools though was not extended to the StandBy project site in the Kimberly, where a high proportion of the population is Aboriginal, because “... *there were significant differences in the way in which the StandBy model was being delivered within that region.*”

One stakeholder with good insights into the NICRS program suggested rather simpler outcome measures be adopted in line with the immediate ‘critical response’ ambitions of the service. Their suggestions included checking for the following outcomes:

- stable housing
- problems have been identified and a plan is in place as to how they are to be addressed
- counselling for trauma is in place
- care for different health and welfare issues is being coordinated

In theory these outcomes should be prescribed in throughcare plans and the attainment of these outcomes (and how attainment was measured) could be included in the plan.

Another source of thought is the program logic (NICRS, 2017) which underpins the service design and should inform the governance framework. Within the critical response, individually targeted

²⁹ This tool has never been validated for a clinical setting. It is described in Menzies School of Health Research [Strong souls assessment tool](#)

postvention activity of the program logic there are two immediate and two intermediate outcomes prescribed as follows:

- Aboriginal and Torres Strait Islander families receiving culturally appropriate postvention response
- Local services being supported to provide response
- Local services providing improved coordinated and culturally appropriate response
- Services and community working more closely together on postvention support

These could be used to determine what could be observed that would indicate these outcomes had been satisfied.

The process of data collection

As outlined above, the NICRS service model can be largely divided into three distinct phases, all with associated data requirements. Phase 1, as indicated in Figure 28 below, is an intensive data collection phase and a large proportion of that data is likely to be sensitive. This data therefore requires the protection of the secure entry environment. But this phase also occurs largely prior to service engagement with the client and family, with many details required for the NICRS to be able to decide whether the case is suitable for its services (that is in-scope and no other existing service able to satisfy needs). Further details will almost certainly emerge over the course of an active case, but these can be added incrementally under secure circumstances.

By contrast, the Phase 2 objective of preparing a postvention throughcare plan in partnership with clients (and their family) and the local community and service network requires a quite different approach to data. This is the point where personal information meets the process of identifying and documenting relevant local resources then activating that local network. There is a definite need for effective and secure ways to link the two datasets as needed but this community information remains restricted in its purpose if it is contained only in the secure database.

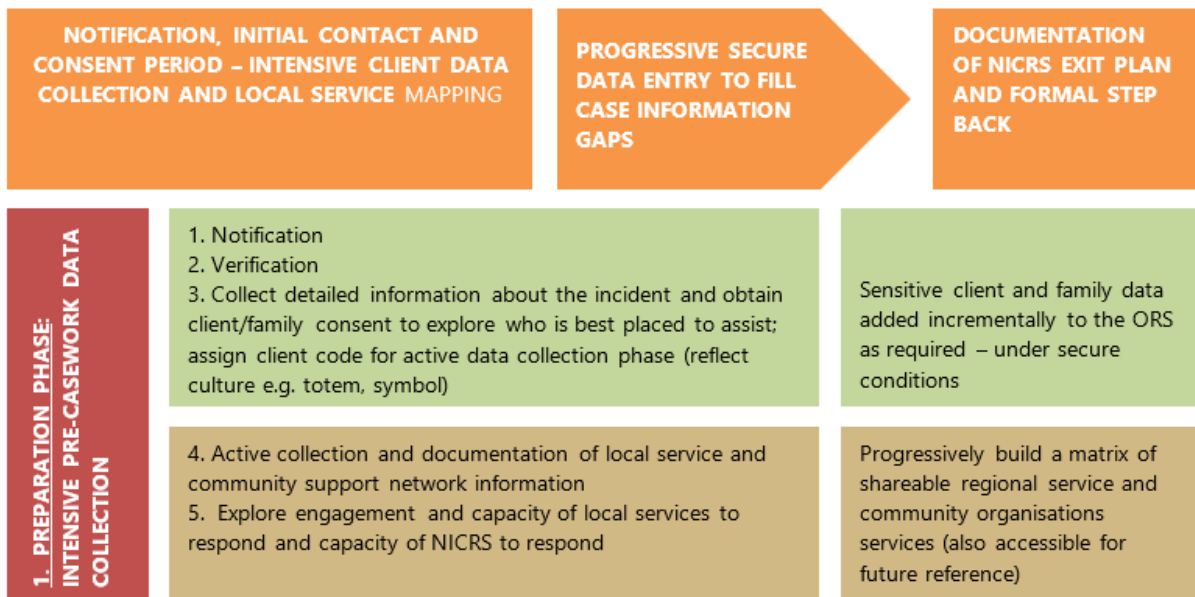


Figure 3: Phase 1 data collection requirements within overall model of care

In addition to facilitating communication and capacity building for the clients, adoption of a more visual data collection tool would be helpful as a prompt for ensuring all potential sources of support have been considered for the throughcare planning process while at the same time building a service database for current and future reference. An example of a more dynamic approach to these issues of data collection and facilitation of engagement is provided at Figure 29.

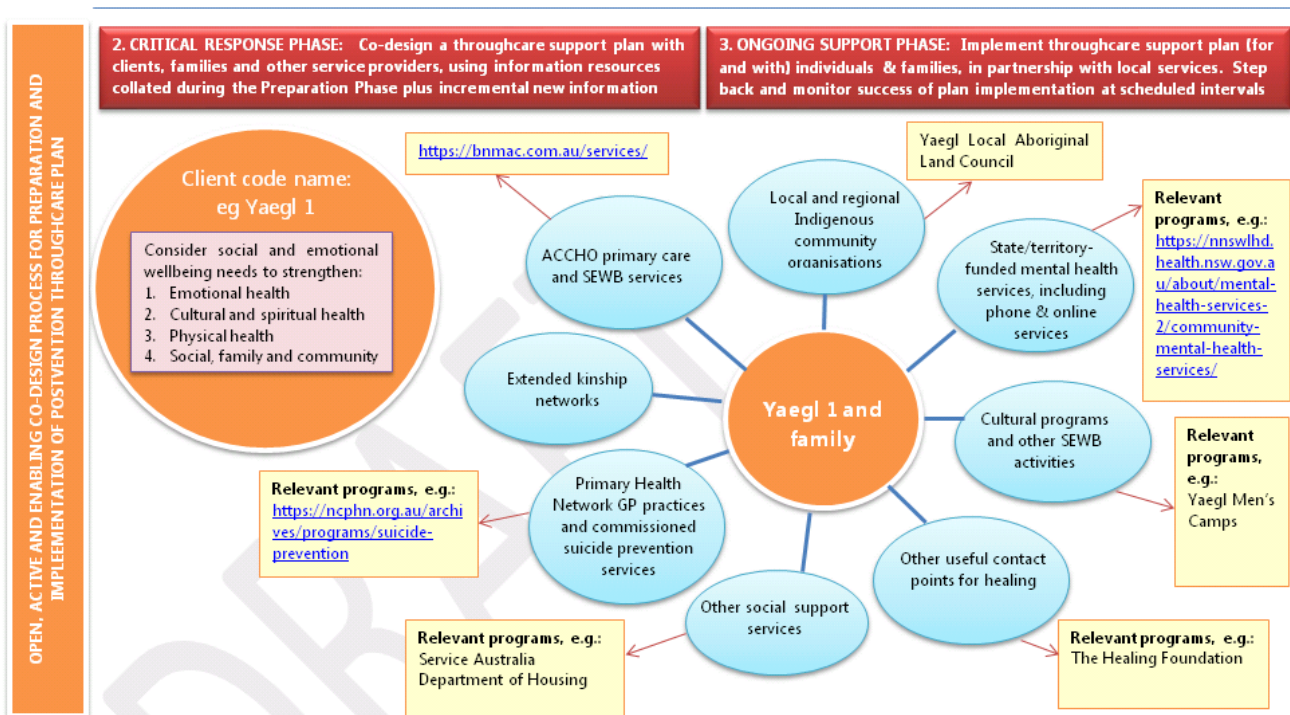


Figure 4: Draft tool to promote comprehensive and co-designed throughcare planning

Creation of this collation of local information resources also provides an obvious opportunity for the NICRS to develop a visual database of suicide and SEWB support resources across the country in the course of their everyday practice. This more interactive process would also address the current observed deficit in capturing data about what has been done with the assistance of the NICRS to connect and activate postvention supports for Aboriginal and Torres Strait Islander communities throughout Australia.

10.5 Conclusion

The evaluation confirmed postvention services were viewed as essential for Aboriginal and Torres Strait Islander people to provide support post suicide and trauma confirming the relevance of the NICRS. For many clients interviewed for the evaluation, the NICRS service was reported to be highly valued, particularly due to the practical support offered, such as the provision of ERF funds, which could help to alleviate short-term stress during a period of grief, confusion and instability. The evaluation also indicated that NICRS staff, the CRSAs, were highly valued and highly regarded for the emotional, financial and advocacy support they provided to clients and their families.

Yet, it was evident that the effectiveness, efficiency, impact and sustainability of the service are potentially being compromised. This appears to be primarily related to inconsistent implementation of the model, limited governance processes, location of the service and insufficient appropriate data collection of the service. The evaluation findings suggest that the service is attempting to build on individuals and families' strengths, that it has demonstrated cultural respect for its clients, the community and other service providers, and that it is aiming to work collaboratively. However, further work is required to ensure that the service is implemented as intended to definitively make a positive contribution to the lives of current and future generations of Aboriginal and Torres Strait Islander people.

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Appendix 1: Detailed background evidence

The need for suicide postvention services

Suicide rates among Aboriginal and Torres Strait Islander people are 24.1 per 100,000, compared to 12.1 per 100,000 overall in Australia in 2018 (Australian Bureau of Statistics (ABS), 2019). For all, approximately three quarters of suicides are by males and a quarter by females. There are also important differences for Aboriginal and Torres Strait Islander people compared to the general population in relation to age and location (ABS, 2019).

In the five years from 2014–2018, intentional self-harm rates among Aboriginal and Torres Strait Islander people were 23.7 per 100,000 compared to 12.3 per 100,000 among the general Australian population (ABS, 2019). Aboriginal and Torres Strait Islander were again disproportionately over-represented and younger when self-harming.

The underlying factors for these statistics are complex and varied. Ongoing health inequalities (Markham & Biddle, 2018; Seccombe, 2018), poor levels of access to mainstream health services (Department of Health, 2017; Goodwin-Smith, et al., 2013), and under-developed Aboriginal and Torres Strait Islander workforces and capacity to deliver culturally safe services (Department of Health, 2017) are some of the factors affecting health, social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

The report *Indigenous lived experience of suicide: Literature review* discusses these and other experiences of Aboriginal and Torres Strait Islander people and highlights the need to for more support services, and the need for mainstream and Aboriginal and Torres Strait Islander sectoral development (Dudgeon, et al., 2018).

It is in this context that Aboriginal and Torres Strait Islander people live today – often with strong sense of being Indigenous to Australia but experiencing many barriers to equity and equality. Whole families and communities as well as culture and the environment (Country) are affected across generations when a person passes away by suicide or other trauma.

There is still limited evidence from rigorous research or program evaluations to inform postvention services for Aboriginal and Torres Strait Islander people, and in Australia, postvention is mostly considered in the context of suicide prevention. A range of gaps in postvention services for Aboriginal and Torres Strait Islander people have been identified by Dudgeon et al. (2017) and include limited resources for ‘after hours’ support when services are closed, range and complexity of needs, complex trauma and financial challenges, few health and needs assessment tools for use with diverse Aboriginal and Torres Strait Islander people, and minimal training, support and networking for staff, and too few experienced staff.

What is postvention?

Postvention is generally defined as a direct form of support for individuals bereaved by suicide or other traumatic critical incidents such as suicide attempts or murder. Among Aboriginal and Torres Strait Islander people, postvention support is ideally also for families and community members of the deceased (Dudgeon, et al., 2017).

Postvention is also considered a suicide prevention strategy, including preventing people bereaved by suicide or other critical incidents themselves considering, attempting or completing suicide or other types of trauma (Dudgeon et al., 2017). A small range of literature examines suicides occurring in clusters, as well as in peaks at particular times, including among Aboriginal and Torres Strait Islander people (Hunter, et al., 2001; McCalman et al., 2010). However, postvention literature is minimal, and while some articles provide descriptive localised information, there are few studies assessing effectiveness in achieving postvention outcomes or long-term impacts generally or among Aboriginal and Torres Strait Islander people.

Postvention is most often described as practical assistance to individuals and families of the deceased, particularly by connecting them to other individuals and community agencies for support (Institute ref). For example, among Australians in general,

“Some of the most remarkable postvention responses are when practical assistance is provided by individuals and local organisations to the sad aftermath of suicide: dealing with police, the Coroner’s Court, administrative messes and the personal upheavals left behind.”

(Emeritus Professor Ian W Webster, cited in Australian Institute for Suicide Research and Prevention, 2017, p. 5)

However, actual postvention needs of individuals are not well-identified in research-based literature, nor are strategies or tools for identifying needs. Postvention is often linked to suicide prevention programs, policies and research. Both are complex, with multiple risk factors relating to social conditions and developmental issues that emanate from pre-conception, childhood and youth, and occur across the lifespan (for example, Zubrick et al., 2014).

Postvention programs on their own are considered unlikely to be effective because risks for suicide are often broader, with long-term factors to address, including that there are “community settings with high multiple risks” (Department of Health and Ageing, 2013, p. 22). There are a small number of theories on suicide bereavement including the Tripartite Model of Suicide Bereavement (Sands, 2009); and Post-Traumatic Growth (Zięba, et al., 2019). However, it should be noted that these theories have not been developed with Aboriginal and Torres Strait Islander people cultures and histories in mind.

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy does, however, describe people bereaved by suicide as “important catalysts for change to services and policies” (Department of Health and Ageing, 2013, p. 19). Community-oriented postvention programs have included training and support for community service providers, community members and family members, coordinated action to work with and follow-up with individuals in high-risk settings; as well as build the capacity of community-based services to maintain targeted preventive activities (Department of Health and Ageing, 2013).

Postvention initiatives

Policy context of postvention programs

Official calls to action to address suicide prevention in Aboriginal and Torres Strait Islander communities are present in a number of key national and state/territory reports, plans, policy and commissioning frameworks that have been published over the past decade or more.

However, there is currently no national key document or strategy about postvention among Aboriginal and Torres Strait Islander people or communities. There has been an increasing mention of postvention in most national and state strategies, plans and reports since the Inquiry into Suicide in Australia by the Senate Community Affairs References Committee's *The Hidden Toll: Suicide in Australia* (2010), and some acknowledgement of the disproportionate impacts of suicides on Aboriginal and Torres Strait Islander communities.

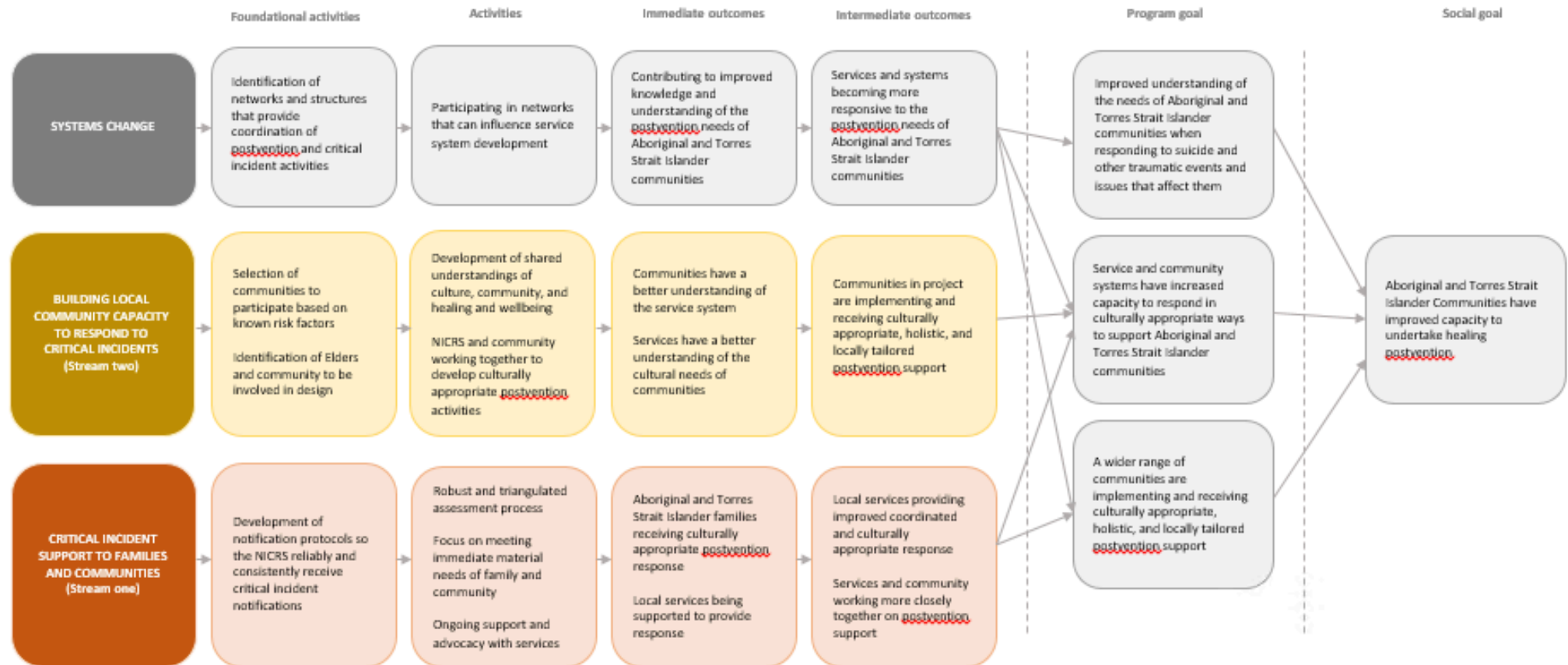
The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (Commonwealth of Australia, 2013), its implementation plan (Department of Health, 2015) and the *Closing the Gap Framework* (Department of Prime Minister and Cabinet, 2019) all have relevance to postvention. They all incorporate commitment to reducing developmental and social risk factors for illness and disadvantage, as well as strengthening community capacity to create conditions in which health occurs.

Other postvention initiatives

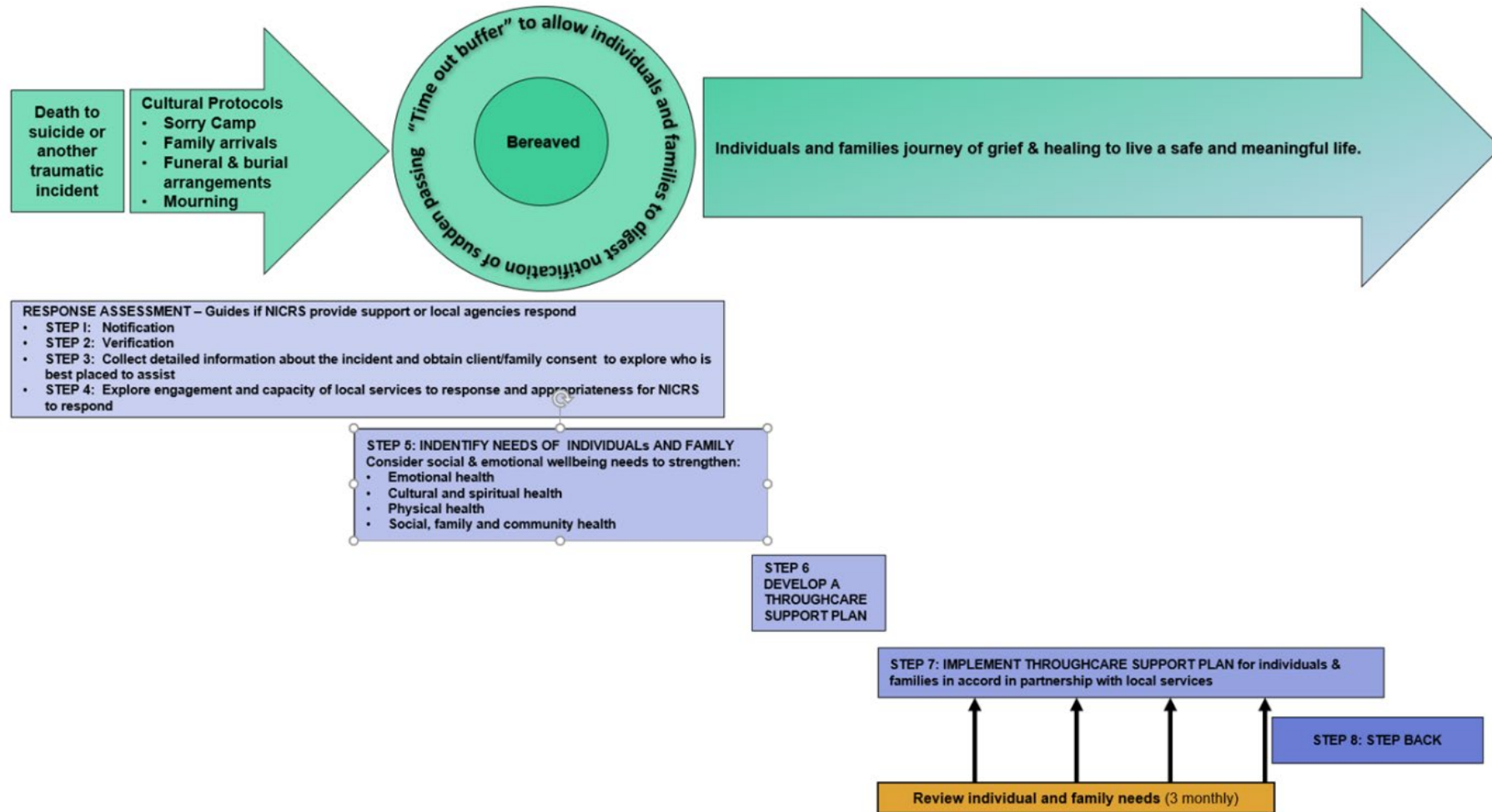
There is increasing awareness and action in relation to suicide prevention broadly, yet that the postvention space is still in a development phase. A handful of other postvention actions have been initiated in Australia and, while not specific to Aboriginal and Torres Strait Islander people, they provide some indication of how postvention has been addressed:

- **Postvention Australia Guidelines** - developed in 2017 by the Australian Institute for Suicide Research and Prevention
- **StandBy** – an Australian Government-funded initiative delivered by United Synergies that was established in 2002; provides support for individuals, families, friends, schools, workplaces and community groups, with a follow-up timeframe of one-year post-suicide. StandBy has links for support around Australia, including to the NICRS and 24/7 telephone numbers
- **Living Beyond Suicide** – delivered by Anglicare SA, the program works with police and ambulance services attending each suicide, to connect with families of the deceased. Staff visit within hours and across days, providing practical, needs-based support
- **Living is For Everyone (LIFE) Framework** – developed in 2007 by the Australian Department of Health, the framework was one of a series of suicide prevention initiatives beginning in the 1990s that provided national policy direction based on population health approaches, evidence-based materials for health planners, and practical resources for community members.

Appendix 2: NICRS program logic



Appendix 3: NICRS model of care



Source: NICRS Model of Care, v1.0

Appendix 4: Thirrili organisational policies

This is the list of organisational policies provided to HCA as the guiding policies for Thirrili as at February 2020. The colour coding provides an indication of: a) core foundational policies for Thirrili, and, b) policies specific to the NICRS.

Policy type	Policy name	Core	NICRS
Human resources	Supervision policy		✓
	Learning and development policy		✓
	Management responsibilities policy		✓
	Equity and diversity policy	✓	
	Recruitment policy and procedure	✓	
	Police check policy and procedure	✓	
	Working with Children/Vulnerable People Check	✓	
	Leave Policy (including Cultural Leave)	✓	
	Professional development		✓
	Probation policy	✓	
	Disciplinary policy and procedure	✓	
	Complaints and Grievance Policy	✓	
	Code of conduct - Staff		✓
	Conflict of interest	✓	
	Professional Development and Performance Reviews Policy	✓	
	New Employee Induction	✓	
	Facilities and resources	Bullying and Harassment Policy	✓
Family violence leave		✓	
Asset policy including assets register		✓	
Environmental policy		✓	
Investment policy		✓	
Financial delegations		✓	
Financial controls policy		✓	
Business credit card policy		✓	
Purchasing and Expenses Policy (Reimbursement of expenses)		✓	
Bank Account Policy		✓	
Compliance with legislation and regulations	Client management and data security to ensure confidentiality and privacy (third party data sharing)		✓
	Legislative and regulatory compliance policy	✓	
	Privacy policy	✓	
	Client and Board confidentiality	✓	
	Reporting serious wrongdoings policy	✓	
Schedule of Employment Related Compliance Requirements	✓		

Policy type	Policy name	Core	NICRS
Safe systems of work	Child safety (includes Mandatory Reporting) - Child Protection		✓
	Health safety and wellbeing policy	✓	
	Hazard identification and management policy	✓	
	Manual handling policy	✓	
	Workplace inspections procedure	✓	
	Managing threats, aggressive behaviour and violence		✓
	Accident/ injury/ incident/ hazard investigation policy	✓	
	Home visits policy		✓
	Safe driving policy		✓
	Office security policy	✓	
	Emergency – high risk fire policy	✓	
Marketing	Emergency management policy and procedure	✓	
	Media Policy	✓	
	Social Media Policy	✓	
Culturally effective practice	Policies relating to use of interpreters		✓
	Risk Management Policy	✓	
Risk management	Home visits policy		✓
	Safe driving policy		✓
Essential elements of a robust wellbeing governance framework	Office security policy	✓	
	Emergency – high risk fire policy	✓	
	Emergency management policy and procedure	✓	
	Continuous Quality Improvement Policy	✓	
	Case conference policy		✓
	Wellbeing Governance (Clinical Governance)		✓
	Mentoring Policy (relating to cultural and wellbeing supervision)		✓
	Mentoring framework		✓
	Response Assessment Policy (criteria for prioritisation)		✓
	Employee Wellbeing (Employee Assistance Program and External Supervision)		✓
	Supervision policy		✓
Learning and development policy		✓	
Management responsibilities policy		✓	
Client File Documentation including Audits (Case Records Policy and Audit)		✓	

Policy type	Policy name	Core	NICRS
	Client Consent to share Information (and forms)		✓
	Complaints policy / Complaints resolution policy	✓	
	Quality and Safety Incident Investigation Policy	✓	
	Access to Client Files Policy		✓
	Client rights		✓
	Access and Eligibility Policy		✓
	Emergency Relief Policy		✓
	Rostering Policy		✓
Miscellaneous	Development of Policies Policy	✓	

Appendix 5: NICRS position descriptions

Position	Role description
Chief Executive/ Project Director	<p>Role Description from Project Manager, March 2020</p> <p>Key responsibilities of the role include:</p> <ul style="list-style-type: none"> • Leading the project team to achieve the strategic objectives of the project. • Day to day management of all project staff. • Leading development of a culturally responsive model which promotes better service system coordination and promotes community capacity and resilience for Aboriginal and Torres Strait Islander communities affected by suicide related incidents and / or other highly traumatic critical incidents. • Liaising with key stakeholders in Aboriginal communities and service providers involved in providing critical responses. • Providing support as required in enhancing critical responses to Aboriginal and Torres Strait Islander suicide events or circumstances that could trigger suicide • Fostering an action learning culture that supports the development of an evidence base on effective interventions to reduce Aboriginal and Torres Strait Islander suicide rates. • Assuming responsibility to ensure systems and processes are in place to ensure a healthy organisational culture. • Ensuring appropriate risk management policies and processes in place. • Liaising with and reporting to the NIAA. • To continually develop their own and their team members' skills and knowledge to assist the project achieve its mission.
Senior Cultural Advisor	<p>Wording from Position Description</p> <p>The Senior Cultural Advisor and Mentor will be responsible for the provision and delivery of high levels of culturally sensitive and culturally strengths-based advice and support to Thirrili projects and personnel.</p> <p>Where assigned, to act as both a cultural mentor and peer support to Thirrili project workers and in particular to the Critical Response Support Advocates of the National Indigenous Critical Response Support Service.</p> <p>To assist in the cultural learnings and professional cultural development of the NICRS' Critical Response Support Advocates based in (State/Territory).</p>
Project Manager	<p>No formal Position Description available</p> <p>The Project Manager has supported the Project Director through:</p> <ul style="list-style-type: none"> • documentation of the service model, service delivery policies and organisational policies to support the delivery of responsive services • supporting development & training around use of the Online Records System • preparing papers for the Board and subcommittee meetings, and • human resources management, and complaints and grievance officer. <p>The Project Manager currently manages the Communications and Engagement Officer, the Data Officer and the Administration Officer.</p>

Position	Role description
<p>Senior Research and Policy Officer</p>	<p>Wording from Position Description</p> <p>The role of the Senior Research and Policy Officer will involve:</p> <ul style="list-style-type: none"> • preparing policy papers and discussion papers for the endorsement of Thirrili Board to guide directions in the development of the NICRS, in particular, service delivery directions, and advocacy for systemic change to address the contributing factors associated with the high rates of suicide amongst Aboriginal and Torres Strait Islander communities • working closely with the Chief Executive Officer to advocate for: <ul style="list-style-type: none"> ○ systemic change in the area of child protection ○ greater focus in suicide prevention responses for young women, ○ greater focus on addressing the social determinants of health contributing to suicide and ○ strengthening the social and emotional wellbeing of communities affected by high rates of suicide. • build strong partnerships with other research institutions such as Lowitja Institute, Healing Foundation and Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention • preparing presentations for the Chief Executive as well as making presentations at National and State /Territory Conferences to inform service providers about the work of the NICRS in providing postvention support, and building postvention capacity in communities • reviewing policy directions and the literature and providing advice to the National Coordinator, Critical Response Service, and the Community Capacity Building Project Officer to inform the development of our services • support quality improvement initiatives and program evaluation activities of the NICRS through: <ul style="list-style-type: none"> ○ analysis of program data to identify client needs and report on program achievements, and ○ analysis of client feedback with the view to strengthening service delivery.
<p>Community Capacity Building Coordinator</p>	<p>No specific role description provided beyond the CRSA role description.</p>
<p>Contract psychologist</p>	<p>No Position Description available. Wording provided by Project Manager, March 2020.</p> <p>This role is an important role in supporting good wellbeing governance across the organisation (often known as clinical governance). Currently the psychologist leads monthly case conferences which all CRSAs are expected to attend. She has also recently commenced providing clinical supervision to the CRSAs and StandBy Coordinator in the NT, and provides individual support as required to team members. We are currently reviewing the needs for clinical supervision across the organisation.</p>

Position	Role description
	<p>The psychologist has provided support on an as needs basis in relation to the development of service delivery policies and informed the development of the information gathering tools which supports workers identification of client need, case management plan tool, and case note form. At the annual 2019 staff retreat, she provided significant professional development for CRSAs in the role of supporting clients which included issues around: Good clinical governance and case management; self-care; and mandatory reporting.</p> <p>In the last month, she has reviewed all our service delivery policies, which are in the process of being approved by the Chief Executive or the Board, as appropriate, and we have engaged her to develop a number of other policies that we have identified as needed.</p>
<p>Finance Officer</p>	<p>Wording from Position Description</p> <p>The role of the Finance Officer is to provide high level financial and associated administrative support to Thirrili Ltd, and encompasses undertaking tasks and activities related to:</p> <ul style="list-style-type: none"> • Accounts – invoicing, purchasing, payment processing, reconciliations including bank reconciliations, and monitoring and reporting on expenditure. • Payroll – records and processing. • Emergency Relief Fund – processing of monies, liaison with general stores to purchase goods, maintaining records and reporting. • Policy and Procedures – assistance with the development, review and implementation of best practice policies and procedures related to financial management; and • Reporting – provision of monthly financial reports for managers, quarterly reports for Board Finance and Audit Committee, monitoring of accounts, and recommendations to strengthen organisational efficiency and financial systems.
<p>Administration Officer / Data Officer (WA)</p>	<p>Wording provided by the Project Manager, March 2020.</p> <p>The Data Officer prepares the monthly reports for National Indigenous Australians Agency (NIAA). These monthly reports are provided to the Chief Executive to review and finalise before submitting to NIAA.</p> <p>Wording from Position Description</p> <p>This administrative role involves:</p> <ul style="list-style-type: none"> • provision of high-level administrative and secretarial support to the organisation and its programs • provide direct support of the Chief Executive in her role as Project Director of the NICRS, in regard to auditing client data & preparing reports for the Chief Executive • take responsibility and be accountable for their work, including timeliness, responsive and quality support to the executive team.
<p>Communication and Engagement Officer</p>	<p>No formal Position Description available. Wording provided by the Project Manager, March 2020.</p> <p>The Communications and Engagement Officer played key roles in developing the organisations, website, circulating information about the service to stakeholders,</p>

Position	Role description
	preparing submissions for the Chief Executive to key government reviews, which supported our advocacy and systems change work.
Administration Officer (Central Office, Melbourne)	<p>Wording from Position Description</p> <p>This administrative role involves:</p> <ul style="list-style-type: none"> • provision of high level administrative and secretarial support to the organisation and its programs, including assistance to the executive team • direct support, assistance and management of the Chief Executive’s diary and scheduling • providing secretarial support to organisational committees • establishing, implementing and coordinating organisational and office management systems to ensure the smooth and effective business operations • managing all staff travel, and • take responsibility and be accountable for their work, including timeliness, responsive and quality support to the executive team.
National Coordinator	<p>Wording from the Project Director, March 2020</p> <p>The two Acting Coordinators of the NICRS provide leadership to the CRSAs across the jurisdictions. The Acting Southern Coordinator supports CRSAs in the West and South of Australia (Western Australia, South Australia and Victoria), while the Acting Northern Coordinator supports CRSAs in Queensland and Northern Territory, as well as the NT StandBy Coordinator.</p> <p>Wording from the National Coordinator Position Description</p> <p>Key responsibilities of the Acting Coordinators include:</p> <ul style="list-style-type: none"> • Lead and support the delivery of culturally sensitive and timely critical response to people bereaved by suicide or experiencing a similarly traumatic event in and • Coordinate and support Critical Response Support Advocates (CRSA’S) through: <ul style="list-style-type: none"> ○ Assessment of existing and new incidents whether they are ‘in’ or ‘out of scope’ & if the NICRS should respond & allocate cases to the appropriate CRSA ○ Monitor & coordinate casework load for each CRSA ○ Provide initial support and agreement of Emergency Relief requests from CRSAs for consideration and approval by the Chief Executive ○ Provide mentoring, and support to CRSAs in the delivery of critical response by having regular catch up sessions with CRSAs to review their cases, and discuss matters where they need advice and support ○ Provide debriefing support following a critical incident response as required and support CRSAs access psychological and cultural mentoring to promote self-care as required and where appropriate. <p>The National Coordinator Critical Response Support Advocate will be the line manager of the Critical Response Support Advocates.</p>
CRSA (Levels 4-6)	<p>Wording from the Position Description (Level 4, i.e. entry level)</p>

Position	Role description
<p>(Level 4 position description provided as an example – minor distinctions have been created between this one & Levels 5 & 6 PDs for advancement purposes)</p>	<p>To act as a local response contact point for critical incident needs and support achievement of the service’s mission by working with local communities and service providers to:</p> <ul style="list-style-type: none"> • enhance critical responses to suicide events, trauma or circumstances that could trigger suicide or other traumatic events by the provision of practical support to individuals, families and communities, • strengthen local service system coordination and promote community capacity and resilience, and • contribute to strengthening the knowledge base of effective approaches in supporting families and communities impacted by suicide or other trauma-related events. <p>To be responsible for delivery and implementation of tasks and activities under Stream 1 and Stream 2 related to the jurisdiction in which they are based.</p> <p>To act as a local response contact point for critical incident needs, and as required, provide practical support to individuals, families and communities.</p> <p>Support achievement of Stream 2 objectives by working with local communities and service providers to:</p> <ul style="list-style-type: none"> • enhance their delivery of local critical responses to suicide events, trauma or circumstances to provide practical support to individuals, families and communities • strengthen local service system coordination and promote local community capacity and resilience, and • contribute to strengthening the knowledge base of effective approaches in supporting families and communities impacted by suicide or other trauma-related events.
<p>Standby Coordinator</p>	<p>Wording from the NT Standby Coordinator Position Description</p> <p>The StandBy Coordinator is responsible for:</p> <ul style="list-style-type: none"> • ensuring that StandBy is implemented in line with the StandBy Model • supporting people, families and groups in crisis and/or affected by traumatic events using psychological first aid or crisis intervention approaches • effectively promoting the benefits of a service to engage stakeholders and increase uptake by community members • presenting community education workshops and speaking at public events and network meetings • maintaining a high level of understanding of current trends which impact and relate to the StandBy program and general areas of suicide, loss, bereavement & trauma. • initiating, planning and implementing annual activities or short-term projects • engaging and working collaboratively with relevant individuals, stakeholders and groups of diverse backgrounds, abilities, ages and genders. This includes being secretariat for an Advisory Group that provides strategic input on community needs, emerging issues and service delivery • recruiting and leading the virtual casual Crisis Response Team including maintaining engagement of team members in remote locations, ensuring alignment with service delivery Model, and ensuring they access supervision per the StandBy Supervision Framework

Position	Role description
	<ul style="list-style-type: none"> • problem solving, prioritising competing demands and synchronising various tasks to achieve outcomes and meet due dates • using various methods to collect evaluative feedback from participants / stakeholders • inputting data in database programs, analysing data to identify inaccuracies, variations and trends and write progress reports, & • Managing their personal self-care.
<p>Kimberley CRSA</p>	<p>Wording from the Kimberley CRSA Position Description</p> <p>The Critical Response Support Advocate will be responsible for leading the delivery and implementation of tasks and activities under the NICRS and Kimberley Postvention Response Service in close working relationship with the StandBy Coordinator.</p> <p>The CRSA will act as a local response contact point for critical incident needs &, as required, lead local critical responses to suicide events, trauma or circumstances that could trigger suicide or other traumatic events by the provision of practical support to individuals, families & communities, & support staff attending incidents with them.</p> <p>The primary responsibility to the CRSA is to make contact with the affected family members to understand their needs, be their advocate & take responsibility to connect affected individuals & families with support services & regularly check-in with those affected to ensure they continue to be supported in all phases of their grief.</p> <p>It is expected that CRSA will be well versed in the services and organisations within the State/Territory they are located in, and will develop a positive reputation and relationship with services, the Police, Department of Prime Minister and Cabinet staff in local areas and State/Territory Department Officers.</p> <p>The CRSA will support achievement of community capacity objectives by working with local communities and service providers to:</p> <ul style="list-style-type: none"> • enhance their delivery of local critical responses to suicide events, trauma or circumstances to provide practical support to individuals, families and communities • strengthen local service system coordination and promote local community capacity and resilience, and • contribute to strengthening the knowledge base of effective approaches in supporting families and communities impacted by suicide or other trauma-related events.

Appendix 6: Evaluation questions in relation to the postvention & bereavement services

Key Evaluation Area	Key Stakeholders whose view should be sought on KEAs					MSC document review	ORS data interrogation
	Individuals and families	Local Aboriginal service providers	Local mainstream service providers	CRSAs	Community members		
1. RELEVANCE – Is the program meeting the needs of families and communities?							
1.1 What input do families and communities have over how NICRS is delivered and does NICRS adapt service delivery to respond to unique family and community needs? If so, how?	✓	✓	✓	✓	✓	✓	–
1.2 Is NICRS working appropriately with Aboriginal and Torres Strait Islander services and mainstream services in local communities? If 'yes', how? If not, why?	✓	✓	✓	✓	✓	–	–
1.3 Is NICRS working appropriately with individuals and families to enable honest and open communication? If not, why? What could be improved?	✓	✓	✓	–	–	–	–
2. EFFECTIVENESS – Have the objectives been met?							
2.1 To what extent are Aboriginal and Torres Strait Islander communities and the services working in the communities that received NICRS support aware of the NICRS? How did the program communicate information about itself to communities and was this effective?	✓	✓	✓	✓	✓	✓	–
2.2 Is NICRS effective in assessing and responding to need at the family and community level?	✓	✓	✓	–	✓	✓	–
2.3 Were families, communities, and services happy with the support they received from NICRS? If 'yes', what did they find most effective about the support they received? If 'no', what was the main issue?	✓	✓	–	–	✓	✓	–
2.4 What elements of NICRS constitute good practice in culturally appropriate service delivery?	✓	✓	–	–	✓	✓	–
2.5 What are the barriers and enablers to engaging with families and how does the model of care address these factors? Why do some families seek support but others don't?	✓	–	–	✓	✓	✓	–
2.6 To what extent are local health, social and emotional wellbeing, and crisis support services aware of the NICRS? How did the program	–	–	–	✓	–	–	✓

Key Evaluation Area	Key Stakeholders whose view should be sought on KEAs					MSC document review	ORS data interrogation
	Individuals and families	Local Aboriginal service providers	Local mainstream service providers	CRSAs	Community members		
communicate information about itself to local services and was this effective?							
2.7 Is NICRS working appropriately with Aboriginal and Torres Strait Islander services and mainstream services in local communities? If 'yes', how? If not, why?	-	-	-	✓	-	✓	✓
2.8 Do families and communities feel well supported by an appropriate 'network' in dealing with ongoing post incident issues?	✓	✓	-	-	✓	✓	-
2.9 Have there been instances where the NICRS has not had the capacity to adequately respond to the needs of communities?	✓	✓	✓	✓	✓	-	✓
2.10 What are the barriers and enablers to delivering coordinated care with other service providers?	-	-	-	✓	-	-	-
3. EFFICIENCY – Are resources being used efficiently?							
3.1 Does the NICRS duplicate other services in communities where it has worked?	✓	✓	✓	✓	✓	-	-
3.2 How does the NICRS add value to or leverage off existing services?	-	-	-	✓	-	-	-
3.3 Does the NICRS fill a gap in services for communities?	✓	✓	✓	✓	✓	-	-
4. IMPACT – What difference did the service make? Can the effects be attributed to the service or would they have occurred anyway?							
4.1 What impact has NICRS had on strengthening social and emotional wellbeing (SEWB) and supporting healing as a result of?	✓	✓	-	✓	✓	✓	-
4.2 What impact has NICRS had on improving the capacity of local mainstream services to provide culturally appropriate postvention services?	-	-	✓	✓	-	✓	-
4.3 To what extent does the NICRS build on strengths, demonstrate cultural respect and involve collaboration in such a way as to make a positive contribution to the lives of current and future generations of Indigenous Australians?	✓	✓	✓	✓	✓	✓	-
4.4 To what extent do families and communities feel more resilient and confident in their wellbeing?	✓	-	-	-	-	✓	-
4.5 What other impacts has the NICRS had on clients and communities receiving the service or	✓	-	✓	✓	-	✓	✓

Key Evaluation Area	Key Stakeholders whose view should be sought on KEAs					MSC document review	ORS data interrogation
	Individuals and families	Local Aboriginal service providers	Local mainstream service providers	CRSAs	Community members		
local services? What would be the impact if the service was not available?							
5. SUSTAINABILITY – are the observed outcomes likely to produce ongoing results?							
5.1 What length of time is NICRS support needed to provide support to families?	✓	–	–	✓	–	✓	✓
5.2 Is there any evidence of systems change at the community or regional level as a result of the NICRS program activities?	✓	✓	✓	✓	✓	✓	–

Appendix 7: Detailed evaluation method

Case study selection

Selection of case studies

The case studies were randomly selected through a three-step sampling process:

1. An initial group of cases were identified for possible investigation by NICRS management. All cases selected involved clients that were deemed to be 'well progressed' in terms of their recovery, which included clients:
 - who had been engaged with the NICRS for at least 6 months (that is, at least 6 months since the incident), ideally up to 12 months?
 - were assessed as emotionally capable, by the CRSA through ongoing engagement with client, to reflect on the support and assistance received
 - had previously expressed their willingness to share their story outside of the NICRS.

A total of 125 eligible, or appropriate, cases were identified by NICRS across the four evaluation jurisdictions as follows:

Table 10: Number of initial eligible cases for case studies

Evaluation jurisdiction	Number of eligible cases
WA	70
SA	2
QLD	31
NT	22
Total	125

2. This list was provided to the evaluation team (with case ID number, incident geographic location type, client age and gender and residential postcode details only) to undertake a stratified (by geographic location and state) random sampling and select up to 24 case studies. The evaluation team used randomly generated numbers to select initial case ID numbers. To maximise efficiency of the data collection process, two or three additional cases were selected in the same or nearby residential postcodes using a judgement sampling technique. Criteria used in the judgement process, primarily to ensure diversity in the case population, included gender and age.
3. Identified clients were then confirmed with Thirrili to be emotionally stable and able to participate and then the relevant CRSA was contacted to assist with the client contact and provide information to facilitate the interview process.

This method of case study recruitment attempted to find a balance between minimising on the one hand the risk of re-traumatising clients and on the other hand the risk of bias in case study selection. The case study sample population numbers are noted in Table 6 by jurisdiction:

Table 11: Number of cases selected through sampling method

Evaluation jurisdiction	Number of clients interviewed
WA	5
SA	-
QLD	8
NT	5
Total	18

Interviews with individuals and families supported by NICRS

A total of 18 client interviews were undertaken across three states and territories. Due to the small sample size, difficulty contacting and remoteness of eligible clients in SA, interviews with clients were not pursued in this state.

Client interview subjects tended to be the immediate family of the person who died through suicide or affected by other trauma but also included other extended family members if they were particularly close (for instance a close cousin³⁰). Interviews with clients/families were the most sensitive and accordingly were afforded a special protocol (see Evaluation Plan; HCA, 2019).

The evaluators approached each case through the CRSA most relevant to each selected case that provided relevant background information about the client/family including the nature and course of the response, the service providers involved and the current situation of the family. The CRSA also advised on how to approach the family, whether an interpreter was required, the length of time NICRS had been supporting the family, and where appropriate, introduced the evaluators.

A semi-structured interview was conducted to seek clients' views on how the NICRS had helped support the client's practical needs and facilitated access to other services. Interviews were conducted face to face and arranged at a location nominated by the client to ensure they felt comfortable and safe. A schedule was used to guide the interviews and permission sought to both record the interviews and take written notes.

Interviews with CRSAs and Thirrili staff

A total of 14 interviews were conducted CRSAs, Coordinators, Board members and Thirrili staff including the CEO. An overview of the number of interviews by staffing category are provided in the table below.

³⁰ A trauma event depending on the age of the individual can affect more than the immediate or even extended family. Fellow members of a football team or workplace can also be impacted. The NICRS service though tends to focus only on the immediate family to provide support.

Table 12: Number of interviews with Thirrili and NICRS staff

Stakeholder	Number
CRSAs (including two former employees) – WA, NT and QLD	9
Cultural Adviser	1
CEO	1
Clinical Support Officer	1
Board Members	2
Total	14

A significant amount of phone contact occurred with CRSAs in WA and QLD prior to the case study site visits to prepare for the visits. While on site, the opportunity for both structured and more informal conversation was made available. During more structured and formal discussions, a set of simple questions was used as a broad guide for interviews.

Stakeholder interviews

A total of 31 interviews were conducted with a broad range of stakeholders based in QLD, NT, WA and Victoria. The purpose of the interviews was to understand the relationships and coordination between the service and service providers and other stakeholders. The following table provides an overview of the type and number of stakeholders.

Table 13: Number of interviews with stakeholder groups

Stakeholder type	Number of interviews
Local Aboriginal provider (including ACCHSs/AMSSs, NGOs)	13
Referral service/provider (including police, governments services, counselling services)	9
NIAA officers	2
Government agencies and networks (PHNs, health departments, community departments)	6
Total	30

Stakeholders were identified in collaboration with the local CRSA, or through local research by the evaluation team, and contacted by the evaluation team to participate in face to face or phone interviews. Interviews were guided by an interview schedule template.

Most significant change (MSC) stories

The MSC technique is a form of participatory monitoring that supports internal evaluation and quality improvement processes (Dart and Davies, 2003). It helps to gather information on impact and outcomes that can be used to assess the performance of the program as a whole and guide service improvement. Application of the technique to NICRS involved (1) the 'participant' (a CRSA)

being interviewed for 15 minutes by the NICRS Head Office Research Officer to identify their significant change story for a client generated by their work, and (2) documentation of the story by the Research Officer, CRSAs and the National Coordinator each month to identify areas for quality improvement.

The MSC stories are discussed at the monthly case conference meeting of CRSAs³¹.

A total of 19 MSC stories were provided to the evaluator by NICRS and analysed through thematic analysis. Thematic analysis focussed on developing an initial set of themes to understand:

- the perceived impact that CRSA work has on NICRS clients
- the ways that clients are being supported
- how and when change occurs as a result of their work.

The analysis also looked at common themes across the stories to identify the common concerns or issues for which clients are being supported as well as other contextual issues such as psychosocial issues and the geographic locations of clients.

Online Reporting System (ORS) data

The NICRS provides monthly reports to NIAA on the NICRS notified incidence and the response to incident notifications. This data, in the ORS, can be obtained on a unit record basis. The fields or variables in the database include:

1. Date and Time of incident
2. Date advised of incident
3. Incident type
4. Gender of injured or deceased person
5. Age of injured or deceased person
6. Location of incident (by state/territory and IAS Region, now the NIAA)
7. Individual's home location
8. Advocate assistance requested
9. Assistance requesters (family, community member, service provider, NIAA, state government, Local Education Officer, Other)

³¹ The MSC technique was introduced to the NICRS after the first evaluation undertaken by Clear Horizons. The technique ideally gathers stories from a range of stakeholders (including possibly clients and service providers) and the more significant of the stories [based on the effects on the lives of the beneficiaries] are selected by (all) the stakeholders and in-depth discussions of these stories takes place. It is not clear how stories were selected and / or the extent to which stories are discussed by stakeholders, even those internal to the NICRS.

10. Recipient of assistance (Direct to family, Direct to family and community, Direct to family and service providers, Direct to service providers only, Direct to others, Indirect to family, Indirect to others, No assistance provided)
11. Response type (Face to face and phone, Other)
12. Emergency relief amount provided
13. Number of cases
14. Number of family members being assisted
15. Numbers of service providers contacted by the advocate
16. Numbers of service providers assisting the family
17. Type of service providers
18. Summary of advocate action taken (provided as memo text and extracted from more detailed case notes)
19. Approximate total hours committed to an incident / case

Data is recorded in the ORS by CRSAs and reviewed by the NICRS Project Director, before an automated report extract is generated and sent to NIAA electronically. Data entry is guided by a User Manual that was produced by the vendor that constructed the ORS and the Project Manager.

The evaluation team requested de-identified unit record data for analysis. NICRS provided a data file of 393 records dating from the commencement of the service in January 2017 to 30th June 2019 with all the above fields. Some additional fields, such as case closure and incident assessment (in or out of scope) were not included in the data file. The data extracted for analysis was similar to that of a companion study by HMA (2019) which covered the period of January 2017 to December 2019 and included 438 records, although findings in the HMA report focused mostly on 114 'clean' records from the 2018 calendar year.

The data provided required extensive 'cleaning' to remove duplicate records, complete where possible blank fields, and resolve contradictory field entries. For example, response to the field 'Have services been provided' might have a 'No' response, but another field, for example the 'Amount of ERF' might have an amount clearly indicating a response was provided. In addition, a number of calculated fields were constructed to facilitate analysis. These included constructing year and month fields from date fields, hours of service fields, and specific intervention fields.

Despite extensive efforts to clean the data, its quality remained uncertain. An attempt was made to improve the usability of the data by applying filters to ensure consistency, but this was not always successful. The findings accordingly in this evaluation report, where they are based on ORS data, should be interpreted with caution.

ORS data was analysed using simple descriptive frequency distributions and, where possible, cross tabulations.



May 2020