Suicide Prevention Australia

SUICIDE PREVENTION STANDARDS FOR QUALITY IMPROVEMENT

Edition 2

Suicide Prevention Standards for Quality Improvement Edition 2
is a product of Suicide Prevention Australia

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Editor

This edition of the Suicide Prevention Standards for Quality Improvement was edited by Lisa Mariah, Clarity Point.

Disclaimer

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INTRODUCTION

Background

Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With over 400 members representing more than 140,000 workers, staff and volunteers across Australia, we provide a collective voice for service providers, practitioners, researchers, local collaboratives and people with lived experience.

Suicide Prevention Australia supports and strengthens the services of our members by providing leadership, policy services, training and research support. We also act as an information channel between the sector and government.

There are many organisations and programs dedicated to preventing suicide and supporting those impacted by it, and they vary significantly in size, maturity and focus. The suicide prevention sector, state and federal governments, commissioning agents, and the Australian community at large expect these programs to be able to demonstrate safety, quality and efficacy. But there is no 'one size fits all'.

Quality accreditation for the sector

Suicide Prevention Australia partnered with people with lived and living experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Standards for Quality Improvement.

The accreditation process is designed to support the suicide prevention sector, offering a user-friendly, self-directed pathway relevant to the needs of a wide range of suicide prevention programs. It also acknowledges that providers are at different stages of maturity and program implementation.

Programs are measured against appropriate, necessary and relevant standards that set a nationally consistent quality benchmark. This supports community confidence in suicide prevention programs, especially for those seeking help for suicidal behaviour.

Quality accreditation also assists governments, Primary Health Networks, and other funders and commissioners to understand the breadth and depth of existing programs.

The Standards for Quality Improvement, 1st Edition (the Standards) were published in 2020. Suicide Prevention Australia conducted a minor review of the Standards in 2022, resulting in this update (Edition 2).

Eligibility

A suicide prevention program addresses, prevents and/or responds to suicidal behaviours and their impact on individuals, families, communities and the Australian population.

Recognition against the Suicide Prevention Standards for Quality Improvement (the Standards) is reserved for programs who are committed to positively contributing to suicide prevention in Australia. For programs to undertake accreditation against the Standards, the program's primary purpose must be suicide prevention or postvention.

If you are unsure whether your program meets these criteria or you wish to discuss eligibility for accreditation, contact Suicide Prevention Australia (qip@suicidepreventionaust.org).

Standards review – Edition 2

The Standards underwent a review in 2022 as part of Suicide Prevention Australia's continuous improvement framework. The review process involved consulting with organisations using the Standards (accredited or in progress), people with lived and living experience of suicide, and representatives from the Primary Health Network (PHN). This took place across five workshops, conducted online to allow participation from organisations and programs across Australia, as well as individual meetings with organisations who have successfully achieved accreditation.

The purpose of the review was to:

- Improve clarity and usability
- Identify challenges to implementing the Standards

Sector consultation overwhelmingly agreed the existing standards demonstrated the minimum requirements for safe, high quality and effective programs, and that the process – while challenging at times – was worth the effort dedicated to it.

Feedback also indicated that restructuring the contents of the Standards would support users in their accreditation and continuous improvement journey. The subsequent restructure in this edition includes regrouping some criteria and merging others, so they more clearly reflect program development and implementation. These changes have been mapped against the 1st Edition, for those who have been working with this earlier document.

Contributors to the review

Suicide Prevention Australia acknowledges the unique and important understanding provided by people with lived and living experience of suicide. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research.

Advice from the Lived Experience Panel and other individuals with lived experience helped guide the development and review of the Suicide Prevention Standards for Quality Improvement.

The following organisations implement suicide prevention programs and participated in the consultation workshops:

- Anglicare
- Beyond Blue
- CALM Consulting
- Connecting with People
- Eastern Health
- Ergonomie
- HealthWISE
- Hello Driven
- Iris Foundation
- Jesuit Social Services
- Kentish Regional Clinic
- Lifeline Direct
- Lifeline Macarthur and Western Sydney
- Lifeline Mid Coast
- LivingWorks Australia
- Love Me Love You
- Mind Blank
- OzHelp
- Parents Beyond Breakup
- Queensland TMHC
- Quest for Life Foundation
- Roses in the Ocean
- Stand Tall Australia
- Standby National
- Stride Mental Health Ltd
- Suicide Risk Assessment Australia
- WEHL
- Wellbeing Evolution Community
- Wellways – HOPE
- Wesley Lifeforce
- Youth Insearch Foundation
- Zero Suicide Institute

The following Primary Health Networks also provided feedback:

- Adelaide
- Brisbane South
- Central and Eastern Sydney
- Central Queensland, Wide Bay, Sunshine Coast
- Country SA
- Darling Downs and West Moreton
- Eastern Melbourne
- Gippsland
- Hunter, New England and Central Coast
- Murray
- Murrumbidgee
- Nepean Blue Mountains
- North Western Melbourne
- Northern Queensland
- Northern Territory
- South Australia
- South Eastern Melbourne
- South Eastern NSW
- Tasmania
- WA Primary Health Alliance
- Western NSW
- Western Queensland
- Western Sydney
- Western Victoria

STRUCTURE OF THE STANDARDS

There are six standards, each covering a defined area of program implementation. They are not designed to be a linear progression from Standard 1 to Standard 6, but connect with each other to form a strong quality framework.

These intersections are important, as no one function can operate successfully in isolation. They create a holistic framework that reinforces quality, however at times lead to unavoidable overlap when providing evidence to demonstrate how each standard is met. This is addressed as much as possible by providing a clear primary focus for each standard and criterion, and demonstrating how they strengthen and support each other.

Examples of intersections between standards

- Active and meaningful input from people with lived and living experience of suicide – those best placed to inform how a program can effectively support others in a crisis – (Standard 2) should also be present across all other standards.
- The program's framework (Standard 4) gives clarity to the program's aims and objectives (Standard 1) through needs analysis, whilst also supporting how the program is managed and delivered (Standard 5) by ensuring a robust framework for ongoing sustainability and a safe environment for all involved.
- Collaboration with others (Standard 3) builds connections and can increase the program's resources and knowledge base (Standards 4 and 5), while also provides opportunities for learning, sharing and continuous improvement (Standard 6) that benefit both the program and the sector as a whole.
- Training and education/communication and relevant across all standards.

More ways the standards intersect are described within the standards themselves.

Standards are made up of criteria: measurable components that, when assessed together, can determine whether the program meets the expected outcomes of that standard.

Each standard has:

- A brief, clear title
- An overall statement that describes what it is aiming to achieve
- An introduction, providing the 'why' for its inclusion
- Criteria that describe the specific components of the standard.

Each criterion includes:

- A title that identifies the area covered
- A statement that describes what the program looks like when this is in place
- Its context, and how it contributes to a quality program
- What to look for (guidance questions – see below)
- Evidence examples (documentation potentially relevant to the criterion – see below)
- Cross references – other closely connected criteria.

> The program has clear aims and objectives based on understanding community needs.

Example of statement for criterion 1.1 Program aims and objectives

What to look for

This section contains broad questions to guide your thinking about how the program reflects the intent of the criterion and the standard it relates to. Even if you are not directly responsible for part of the program's life cycle (e.g. you develop or deliver a program but not both), all criteria still need to be considered in a holistic approach.

Evidence examples

This section illustrates the types of documentation that may contain relevant evidence for each criterion, and are the primary focus when demonstrating how you address the standards for the online desktop audit. It is not an exhaustive list, nor are all examples relevant to all organisations – they are there to draw on when interpreting what to provide for your program's assessment.

Evidence comes in many forms and will vary depending on the program and the organisation(s) implementing it. There may be other evidence you believe contributes to how you have addressed each criterion.

Evidence may also be relevant to multiple criteria, such as a training log/register (or equivalent).

A note on language

This revision of the Standards uses plain language wherever possible, whilst understanding this is a sector with distinct terminology. Words and phrases that are sector specific or not part of the general vernacular are defined in the glossary – refer to this if you are unsure of how a word or phrase is being used.

Specific language use

There are certain terms that have been used throughout the Standards to represent more than one aspect. This is designed to increase readability and should be interpreted as below.

Term	Description
Suicide prevention	Includes both prevention and postvention programs.
Program	Includes both suicide prevention programs and services. 'Program' is mostly used as the overarching term to distinguish what is being assessed against these standards from the broader organisational setup, although there are times when an organisation's systems contribute to ensuring the program operates smoothly and effectively.
Program team	Includes: • The staff, volunteers, peer workers, people with lived and living experience of suicide, and/or contractors in designated roles • Partner organisations • Anyone else responsible for designing, implementing, delivering, reviewing and/or evaluating the program. These roles will often overlap.
Implementation	A catch-all word used throughout the standards to cover: • Designing or developing the program (identifying the need and building the program plan) • Implementing the program, as in the 'back-end' functions (such as managing risks, resources, etc.) • Delivering the program • Reviewing and evaluating the program There are times when these individual words are also used – this means the content is focusing in on that specific part of program implementation, such as directly interacting with participants during delivery. Implementation may or may not include delivering the program. This allows for programs that are developed with the intention of others delivering them, or when programs have been developed by others for you to deliver.

APPROACHING THE STANDARDS

The six standards document what is required to demonstrate a quality suicide prevention program or service.

It is the program, not the organisation, that is being assessed.

That said, there are broader organisational functions that are crucial to ensuring the program's success and sustainability, such as alignment with the wider strategic direction (Criterion 1.2), or how the program's workforce is built and managed (Criterion 5.1). In the context of these standards, an organisation's functions are relevant where they are part of implementing the program being assessed.

How you approach gathering your evidence is up to you, and should take into account the size, type and complexity of the program. You may consider:

- Reviewing all six standards together initially, to understand what evidence you can easily gather and where gaps are, then dive into detail after that
- Identifying which pieces of evidence may cover more than one standard (e.g. program plan, reports)
- Identifying which departments/individuals may have the information/evidence you need for different standards or criteria, and engaging them early in the process.

More information and guidance on the accreditation process can be found here:
https://www.qip.com.au/standards/suicide-prevention-australia-standards/

Evidence overlaps

There are certain documents, if comprehensive, that could provide evidence for multiple standards and criteria. They include:

- The program plan which may document:
  - Clear aims and objectives
  - Timelines
  - How people with lived and living experience of suicide inform the program
  - Strategies for collaborations/partnerships
  - Research into evidence-based strategies and considering what data and knowledge could be gained during the course of the program
  - Planned evaluation points throughout program implementation.

- Program logic, which describes how the program should work when executed correctly:
  - What the program is
  - What is needed to deliver it
  - How it is delivered
  - What it is expected to achieve, both short- and long-term
  - How this will be evaluated.

These and other broader documents may be referred to multiple times across different standards and criteria.

Accreditation process

Accreditation is based on successfully meeting the Suicide Prevention Standards for Quality Improvement, and demonstrating ongoing continuous quality improvement. Assessment is via a desktop audit.

Organisations have 12 months from registration to prepare for the external assessment. This includes submitting an internally driven self-assessment, often done around month eight. If successful, accreditation is awarded for three years from the date of the accreditation decision, with a review of the program's continuous improvement plan at around the 18 month mark.

Programs must be re-accredited every three years. If the program changes during this time it may need to be re-accredited earlier.

Accreditation is not transferable – if a program is 'onsold' (i.e. the purchasing organisation now owns the program) it will need to be re-accredited; accreditation is attached to the program owner.

If you believe a criterion does not apply to you (e.g. your program is very new and has not yet undertaken evaluation), discuss this with your accreditation contact.

SUMMARY OF THE STANDARDS

The revised structure still includes six standards, however the way they are grouped may differ from the 1st Edition.

1. Alignment	Clear 'line of sight' between the program's aims and objectives and those of the broader organisation (or partnership).
2. Lived and living experience of suicide	The voice of people with lived and living experience of suicide informs all aspects of the program.
3. Collaboration	Actively seeking and building relationships, partnerships and collaborations, both formally and informally.
4. Program framework	The 'behind the scenes' functions that wrap around the program when it is being delivered.
5. Program management	How the program is designed and implemented to ensure a safe and supportive environment for all who interact with it.
6. Program outcomes and knowledge sharing	How the program collects, analyses and learns from feedback, implementing those learnings to improve the program and inform the wider suicide prevention sector.

ALLIGNMENT

1

STANDARD 1. ALIGNMENT

The program has clear aims and objectives that align with the organisation's strategic direction to support ongoing sustainability.

Introduction

For a program to succeed the program team must be clear about:

- What you want the program to achieve (aims)
- What will enable it to be successful (objectives)
- What success looks like (outcomes)
- How you know you have succeeded (measures).

The program must also be able to show how it fits within the organisation's overall vision, mission, values and strategic direction.

This standard reflects the need for a clear connection between program and organisational goals, to support the program's ongoing sustainability. It ensures authentic, values-driven implementation that incorporates lived and living experience of suicide at its core.

1.1 Program aims and objectives

The program has clear aims and objectives based on understanding community needs.

Context

In planning and delivering a suicide prevention program, the program's aims and objectives must be clear, direct and agreed on by all involved. Aims and objectives may arise from:

- A recent event in the community
- Common trends in statistics
- External research
- Other drivers, such as government initiatives (see 4.1 Needs identification).

Clear aims keep the program team moving in the right direction, as stakeholders understand their purpose and how each step of the process contributes to what you want to achieve.

Objectives provide measurable targets that determine whether the program is on track. Quantifiable and time based objectives keep the program team accountable in delivering what is expected, and can provide a clear picture of the program's progress for funding bodies and/or external stakeholders.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. Are there clear aims and objectives and do they meet the need you identified for the program, and the outcomes you want to achieve?

b. Who was consulted in developing the program's aims and objectives? (e.g. program partners, people with lived and living experience of suicide, other key stakeholders)

c. When developing the aims and objectives, have you considered:
   - The program's purpose?
   - Who the program is intended for, and have they been included in defining the program's aims and objectives?
   - Where the program will be delivered?

d. Can the objectives be measured?

e. How are the program's aims and objectives continually monitored and reviewed?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Clear, documented program aims and objectives
- Clear, documented measures for the objectives
- How you communicate the program's aims and objectives to staff (new and/or existing), program partners and other stakeholders
- Policy/procedure/reports demonstrating that you monitor, review, evaluate and (where appropriate) improve the program's aims and objectives

Cross references

4.1 Needs identification

6.3 Evaluation and quality improvement

1.2 Organisational alignment

The program aligns with the organisation's vision, mission and strategic direction.

Context

To develop a clear purpose and direction an organisation needs to understand why it exists and what it wants to achieve. This is often articulated through one or more of the following:

- A mission statement that summarises what the organisation does, who it does it for, and the benefits these leads to
- A vision statement that describes the organisation's future once it is achieving its mission
- A values statement that defines the principles and ethics that guide how the organisation operates and how it expects staff and volunteers to act
- A strategic plan that documents the organisation's overall strategic direction, based on an understanding of the environment it currently operates in, how it expects this to change based on current trends, and what it wants to achieve over a specific time frame (e.g. 3-5 years with annual reviews to assess progress).

For a program to succeed, those responsible for executive oversight and program management need to see how the program fits within the organisation's broader direction, so they can provide support through planning and budgeting. A program that aligns with the organisation's mission, vision and values also gives it meaning for the team delivering it.

When a program is developed and/or delivered in partnership, partner organisations also need to reflect on and identify their shared vision and purpose and how the program aligns with this.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. Does your organisation have a clearly defined mission, vision and/or values?
b. Does the program align with these?
c. Does your organisation have strategic, operational and/or business plans?
d. How does the program support these broader organisational plans?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Documented organisational mission, vision and/or values statement(s)
- Ways in which these are communicated (e.g. discussed in team meetings, displayed in the workplace, available on your organisation's website)
- The organisation's strategic goals/direction
- Plans for strategic planning days held, that show how the program aligns with the broader direction
- Documented program/team goals that demonstrate alignment between the program and the wider strategic direction
- How alignment with the organisation's mission/vision/values/strategic plan is considered during program evaluation

Cross references

1.1 Program aims and objectives

6.3 Evaluation and quality improvement

LIVED & LIVING EXPERIENCE OF SUICIDE

2

STANDARD 2. LIVED & LIVING EXPERIENCE OF SUICIDE

Partnering with people with lived and living experience of suicide is embedded throughout the program.

Introduction

People with lived and living experience of suicide have experienced suicidal thoughts/ideation, survived a suicide attempt, experienced bereavement related to suicide, or cared for someone during a suicidal crisis.

They may be community members, program staff, volunteers, advocates, peer workers, or otherwise contributing to suicide prevention activities, either formally or informally. Their experience may be core to their understanding of themselves, or it may be less central; a part of their broader life journey.

> People who have experienced suicidal thoughts and/or been through suicidal crisis, are best placed to inform how we can best support others in crisis.
>
> People bereaved through suicide know what is and isn't useful when it comes to supporting them to understand and adapt to their 'new normal'.
>
> People who have cared for a loved one through suicidal crisis are acutely aware of [what] fear, helplessness and conflicting emotions feel like – and what helped them help their loved one.
>
> *'Lived Experience of Suicide'*, Roses in the Ocean

Drawing on the knowledge of those with lived and living experience contributes to safer and more effective suicide prevention programs, and is crucial to best practice in program implementation.

At the same time it is essential that any potential barriers to participation are addressed, and that an individual's contribution does not negatively impact their health and wellbeing. This is why training relevant to their role, and support where appropriate, are so important.

The program team may not know someone has lived or living experience of suicide; they may not share their experiences (e.g. a staff member or volunteer). Providing a safe environment will support their contribution as well, whether or not they disclose. (See Criterion 5.1 Staff support)

2.1 Lived and living experience of suicide

The direct knowledge and insights of people with lived and living experience of suicide are incorporated throughout program development, implementation and evaluation.

Context

People with a diverse range of lived and living experience perspectives should be involved in the program, from the initial idea through to evaluation and improvement. This includes:

- Co-creating and actively contributing to program design, development and implementation

Contributing to program delivery

- Providing input and/or feedback when evaluating and reviewing the program.

Providing appropriate training and support relevant to their role, to address barriers and minimise the impact on their health and wellbeing, are essential for genuine contribution.

Inclusive training and education for program staff and volunteers in how to encourage and engage people with lived and living experience of suicide in all aspects of the program is equally important.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. How are (or were) people with diverse lived and living experience of suicide involved in:
   - Designing (including co-designing), developing, implementing and delivering the program?
   - Evaluating, reviewing and improving the program?

b. How have contributors with lived and living experience of suicide been supported to participate at different stages of program implementation?

c. What training has been provided to support them in their role?

d. What training and/or other relevant support have they received in talking about suicide?

e. Have the program team received education and training in how to safely involve people with lived and living experience of suicide?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Program/delivery plans showing contribution from people with lived and living experience
- Terms of Reference for a lived and living experience advisory group
- Evidence that committee members, staff and/or volunteers are contributing their lived and living experiences of suicide to inform and improve the program
- Training resources / partnerships / agreements for:
  - In-house training provided by a trainer with lived and living experience of suicide
  - Training from an external provider with a reputation for quality and expertise in the area being trained (may include training for the program team, and/or program contributors with lived and living experience of suicide)
  - Relevant online training modules (e.g. as part of induction training)
- Records of training provided to contributors with lived and living experience of suicide, relevant to their involvement in the program
- Training log/register (or equivalent) documenting relevant training completed by staff/volunteers/contributors, such as:
  - Supporting the health, wellbeing, safety and inclusion of program contributors with lived and living experience of suicide
  - Individual training provided to staff/volunteers who requested additional support
- Educational material for staff, volunteers, and contributors with lived and living experience of suicide (e.g. safe language guide for staff, contributor guide on speaking about suicide)
- Processes that demonstrate the program environment encourages staff/volunteers/contributors to seek support or assistance safely and without fear of judgement

Cross references

Partnering with and contribution from people with lived and living experience of suicide is relevant across all standards, however connections with Standard 2 are strongest in:

4.1 Needs identification

4.2 Diversity and inclusion

5.1 Staff support

6.3 Evaluation and quality improvement

COLLABORATION

3

STANDARD 3. COLLABORATION

The program actively seeks partnerships and collaborations to support and improve program implementation.

Introduction

High quality programs are not designed or implemented in isolation. They involve engaging with a wide variety of individual and group stakeholders[1], including:

- People with lived and living experience (including co-designing or co-creating programs)
- Partner organisations
- Program staff/volunteers, program participants and families/others
- Funding bodies
- Peak bodies
- Local councils and government departments
- Community organisations
- Suicide prevention networks
- Primary Health Networks
- Commercial businesses and suppliers
- Consultants
- Tertiary organisations and research bodies.

Partnerships and collaborations can be formal or informal, and although specific stakeholders may vary at different points, they enable a program to achieve greater reach, share knowledge and expertise, and use resources, funds and materials more efficiently.

Authentic collaboration and engagement opens opportunities for continuous quality improvement at all stages of program implementation, and contribute to high quality outcomes.

1 In Standard 3 the term 'stakeholder' refers to any individual or organisation the program partners or collaborates with, whether formally or informally, to implement a program. It includes targeted and/or ongoing relationships that further the program's aims.

3.1 Partnerships and collaborations

Partnerships and collaborations are well planned, clearly communicated and have a common purpose. They support and improve program implementation.

Context

Partnerships must have a common, agreed purpose that aligns with the program's objectives. Whether formal or informal they should be well planned, with documented objectives and clear communication paths; i.e. they must have a reason for being.

Each arrangement should reflect the unique blend of knowledge and resources it creates, with appropriate processes and procedures to manage it over time. This includes how conflict is managed, and an exit strategy if the partnership/collaboration no longer serves its intended purpose.

More formal types of partnerships include:

- Written agreements, including partnership agreements
- Memorandums of Understanding (MOUs)
- Joint ventures

Informal partnerships, collaborations and networks cover a wide variety of relationships that may not have formal written agreements. They should still be clearly identified, planned and managed to ensure they contribute positively to the program's objectives, both when establishing and over time.

Collaboration contributes to best practice

When:	To ensure:
Designing a program	Its aims, objectives and desired outcomes are best suited to the program's target population
Implementing a program	Safeguards are in place that support ongoing program sustainability
Delivering a program	It is delivered safely and effectively for all involved
Seeking feedback, evaluating and reviewing the program	Improvements are well informed

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:
(Note: informal partnerships/collaborations may not have the same level of written documentation, but many of these questions should still be considered to ensure they are suitable for the program.)

a. How have you identified relevant stakeholders?
b. Have you assessed the value a relationship with each stakeholder brings to the program?
c. For partnerships and collaborations with other groups/organisations, have you confirmed their mission, vision, values and strategic directives align with the program's purpose and objectives?
d. Is there a clear purpose for the partnership/collaboration and do all stakeholders agree with it?
e. Are discussions and negotiations around partnering and collaborating transparent?
f. Have you confirmed each partner's capacity to deliver on the partnership's requirements?
g. Are conflicts of interest identified prior to partnering with others, and when they arise during the partnership?
h. What processes are in place to resolve conflict with partners, stakeholders and other collaborators?
i. Have you considered and agreed on an exit strategy for the partnership if it is not meeting its intended purpose?
j. What communication strategies do you use to ensure ongoing engagement with partners and collaborators?
k. How do you monitor and manage the partnership/collaboration?
l. How do you identify, communicate and monitor agreed performance indicators in formal partnerships?
m. How are collaborations and/or partnerships communicated to other stakeholders?
n. How do you communicate the value of existing and potential relationships to your program team?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Policy and/or procedure for identifying, engaging, monitoring and reviewing partnerships and collaborations (formal and informal)
- Evidence of how this policy/procedure is communicated to the program team and relevant stakeholders (e.g. during induction, in emails, via intranet/website, as part of engagement process)
- Policy and/or procedure for partnering/collaborating/co-designing/co-creating with people with lived and living experience of suicide
- Training log/register (or equivalent) for engaging and understanding the needs of various stakeholders
- Evidence of how stakeholders are engaged (e.g. meetings, networks, forums, emails, relevant marketing material)
- List of existing stakeholders and where/how they contribute to the program (e.g. document, spreadsheet, CRM software, or equivalent if not centrally gathered)
- Partnership agreements and/or MOUs that clearly articulate their purpose, mutual expectations, roles and responsibilities, communication and feedback channels, as well as how conflicts of interest are identified and addressed, how conflict is managed, and how the agreement may be dissolved
- Evidence of how these partnership agreements/MOUs have been developed collaboratively to ensure mutual agreement
- Communication framework/strategy for partnerships (e.g. documented in agreement/MOU, how you keep open communication channels with informal partnerships/collaborations)
- Other forms of communicating stakeholder engagement (e.g. newsletters, website)
- Partnership/stakeholder meeting records
- Evidence of monitoring effectiveness and outcomes of partnerships/collaborations

Cross references

1.1 Program aims and objectives

2.1 Lived and living experience of suicide

6.1 Feedback

6.3 Evaluation and quality improvement

PROGRAM FRAMEWORK

4

STANDARD 4. PROGRAM FRAMEWORK

The program's functions ensure high quality implementation.

Introduction

A program framework includes all the 'behind the scenes' functions that wrap around a program when it is being delivered. It is a key structure in implementing any suicide prevention program, and its elements are crucial for ensuring ongoing program sustainability.

The framework ensures that:

- Community needs have been clearly identified and are reviewed over time
- The program understands and addresses diversity in its target community/communities
- Program risks are identified and well managed
- The resources the program needs to meet its purpose and outcomes are well managed.

Each of these elements must be reviewed regularly, and be flexible enough to change and improve where needed. This ongoing management is equally relevant to new and existing programs.

4.1 Needs identification

Community need for the program is researched, identified, assessed, and regularly reviewed.

Context

In the context of these Standards, a 'need' is something that is identified as missing (but necessary) in the scope of currently available programs and services for an existing cohort. This gap could be within a specific geographical community (e.g. a regional or rural local), for a particular cohort (e.g. First Nations people, youth, people with disability), or in a variety of other areas.

Needs are not just identified when a program is being initially considered; it is important to maintain a holistic view of community needs and how they can change over time. Programs must adapt to these changes.

Identifying and assessing needs is a deliberate and systematic process that occurs:

- During initial program planning to confirm there are unmet needs and determine how best to meet those needs
- When implementing and evaluating existing programs to ensure they still meet the needs they set out to address.

There are multiple ways of identifying needs, and processes should appropriately reflect the target community/cohort. Processes should, however, include some form of:

- Collecting information and data
- Engaging and consulting with members of the target group and other interested parties
- Analysing, evaluating and reviewing information gathered to determine how best to meet the ongoing needs of the target group.

A need may also be identified by an external party (e.g. a government body or other funding provider). It is still important for the program to understand the identified need so it can be effectively addressed.

Evidence-based or evidence-informed?

Evidence-based programs are developed using research conducted through validated scientific processes, and research is usually ongoing during program delivery to ensure it remains current. Evidence-based approaches are very detailed, however they can also be restrictive and time-consuming, often requiring extensive resources and funding.

Evidence-informed programs use tested and proven research shared by other organisations/programs. Evidence is collected and considered, then used to inform the program's development in conjunction with available expertise and resources.

Evidence-informed approaches enable organisations in the suicide prevention sector to deliver safe programs without considerable research investment – the research has already been done.

Not all programs can draw on relevant evidence – some are new or unique, meeting a very specific need. However, making the most of relevant evidence from similar research can strengthen the program as a whole.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. How did you identify the need for this suicide prevention program in the community?
b. What consultation has taken place to determine and/or clarify the need?
c. What information/data has been gathered and analysed to support or verify the need?
d. What evidence exists that the program (or a program like it) would address the identified community need?
e. Have you considered relevant local, national and international evidence?
f. How have you assessed the quality of the information/data/evidence available?
g. Have you identified gaps in what is currently available? How does your program addresses these gaps?
h. Have you confirmed the program does not duplicate an existing program?
i. Are there other programs that may be meeting this need that could be adapted for use in this community?
j. How might this program affect other programs in the community?
k. How do you assess the ongoing need for the program?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Documented needs analysis/assessment for the program
- Review of existing information/evidence supporting the identified need
- Evidence of consultation with stakeholders to identify/assess needs
- Evidence of consultation with people with lived and living experience of suicide to identify/assess needs (e.g. interview results/reports)
- Surveys undertaken within the community (e.g. online, by phone), and/or analysis/ reports on information gathered
- Face-to-face or online community focus groups (e.g. questions asked, the cohort who contributed, reporting afterwards)
- Consultation with relevant local community groups (e.g. those with a shared interest in the proposed outcomes)
- Consultation with local councils, relevant government departments, and/or Primary Health Networks
- Study outcomes and final reports of past programs delivered in the community or to the same target population
- Statistics from related studies or from government data (e.g. census data) that identify relevant populations at risk

Cross references

3.1 Partnerships and collaboration
4.2 Diversity and inclusion
6.2 Data collection and storage
6.3 Evaluation and quality improvement

4.2 Diversity and inclusion

The program reflects the diversity of the target community/communities and is inclusive in the way it is implemented and delivered.

Context

Most programs have a predefined target group (e.g. young people, single parents, members of specific communities), however within any group participants can vary, and all must feel safe and welcome.

Both physical and non-physical considerations should be addressed, including:

- Access for people with physical disabilities
- Safe and inclusive language, imagery and spaces
- Sufficient privacy
- Appropriate physical, emotional and verbal interactions, both with the program team and other participants.

Certain cohorts have been historically excluded from many services, or had recurring negative experiences, and providing safe spaces for them is particularly important. These include:

- People with disability
- Members of the LGBTIQA+ community
- Aboriginal and Torres Strait Islander people
- People with lived and living experience of suicide
- People with other mental health considerations, including trauma
- People from culturally and linguistically diverse (CALD) backgrounds
- Certain age groups, especially youth and older people.

This is not an exhaustive list, and it is not expected that the program team will develop resources that are not relevant to participants. However, to ensure a safe and inclusive environment it is important to conduct appropriate research and consultation, provide culturally appropriate content, and be aware of the intersectionality within a target group – an older person may also be a member of the LGBTIQA+ community; a young male may also be part of a CALD family; a mother with post natal depression (and lived and living experience of suicide) may also have a vision or hearing disability.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

(*Note: Consider what is relevant to the program's target group, taking into account intersectionality)*

a. Is the program accessible to all participants?
b. How has the program considered the different needs and diversities of individuals, communities and cultures?
c. Has consultation taken place to capture relevant expertise and advice to ensure the program appropriately addresses diversity and inclusivity?
d. Are the program's resources developed in a way that ensures they are suitable for the intended participants, and for the program team?
e. Are there processes in place to accommodate the needs of participants with disability?
f. Is the program inclusive for those who identify as gender and/or sexuality diverse?
g. Is the program informed by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)?
h. Are there processes in place to accommodate people from culturally and linguistically diverse (CALD) backgrounds?
i. Are there processes in place to accommodate the needs of participants who are ageing?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Demographic data on the target group, including intersectionality where relevant, that clearly informs program implementation (e.g. documented in program plan)
- MOUs, meeting records, advisory committee terms of reference that demonstrate consultation with relevant experts and advisors to address diversity and inclusivity
- Involvement of community groups, local organisations, peak bodies and/or government departments for relevant demographics
- Marketing plan/strategies that demonstrate reach into diverse populations (e.g. ads in public transport stations rather than expensive magazines)

Evidence examples (cont.)

- References to how diversity and inclusion have been considered and incorporated into program implementation:
  - Program times that reflect the target group's availability, e.g. during school hours for parents, outside business hours for workers
  - Program entry costs that do not exclude participants with limited financial resources
  - Presentation methods (such as in person or online) that best suit the target group
  - How the program team reflect the target group's needs (e.g. female domestic violence survivors may feel more comfortable around female staff/volunteers)
- Examples of resources developed for the program that are suitable for the target group, taking intersectionality into account:
  - Making them available in different formats (e.g. languages other than English, simplified English, e-reader compatible, hard copy)
  - Incorporating safe language relevant to the target group(s)
- Program staff/volunteer support:
  - Policy/procedure for supporting diversity when hiring new program staff or engaging volunteers
  - Cultural competence training for the program team
  - Safe language guidelines relevant to the target group(s)
- Physical location and infrastructure used for program delivery is fit for purpose (e.g. disability access, automatic doors, accessible bathrooms for disability and for all genders, private space for prayer where this is a common requirement for the target group)
- Administrative documents and forms that use safe language (e.g. appropriate gender/pronoun and 'Next of kin' options in registration forms)
- Program delivery techniques that suit the target population (e.g. a presentation given to the workforce at a coal mine would differ from a session run at a primary school)

Cross references

4.3 Risk management
4.4 Resource management and sustainability
5.1 Staff support
5.3 Safe language
5.4 Crisis support

4.3 Risk management

Program risks, including financial risks, are identified, assessed and managed.

Context

Identifying and managing risk contributes to a program's ability to function and supports its ongoing sustainability. All program staff/volunteers are responsible for managing risks, although the level and type of responsibility will vary depending on their role.

Risks can include:

- Financial
- Reputational
- Human resources, including worker screening, onboarding and training, and workplace health and safety (incorporating infection control)
- Business continuity
- Participant satisfaction

Understanding the program's identified needs, as well as the diversity of the target group, are important factors when assessing risks. Also, including program partners, people with lived and living experience of suicide, and other stakeholders can help identify risks that may not be obvious from 'inside' the program.

Early risk assessment informs decision making and program development, but risks can also change over time, especially as programs mature and improve to meet community needs. Therefore risk management must be an ongoing part of program implementation.

Financial risks should consider the guidelines laid out in funding agreements (where relevant), address fraud, corruption and conflict of interest, and ensure compliance with Australian Accounting Standards.

Despite risk management strategies, unforeseen circumstances will arise during program implementation. By training staff to understand and identify risks, and keeping risk an active conversation, unanticipated risks can be recognised and responded to appropriately to prevent future issues or incidents.

Not all risks can be completely avoided, but if they are managed appropriately they can be considered a calculated or acceptable risk.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. How are risks identified within the program?
b. Does your risk management process include both existing and potential/future risks, including risks that could impact the program's ongoing sustainability? (e.g. funding not being renewed at the end of the current funding body agreement)
c. Have you identified different categories of risk (e.g. financial, reputational, workplace health and safety, business continuity, external factors, etc.)
d. Have you defined what 'likelihood' and 'consequences' mean for each category? (These will vary, i.e. the level of financial risk may define the accepted level of financial loss, whereas work health and safety may define levels of physical/psychological injury)
e. Have you identified the level of risk the program can manage to remain sustainable?
f. Are there timelines in place for addressing/reducing unacceptable risks?
g. How are financial risks addressed (e.g. financial sustainability, oversight and reporting responsibilities/delegations, legislative compliance, fraud, and conflict of interest)
h. What education/training have the program team undertaken to understand their role in risk management?
i. What processes are in place to regularly identify, monitor and review risks?
j. Do program team members contribute to the risk register and its review?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Risk management policy/procedure that includes:
  - How and when risks are identified, documented, reduced/managed, monitored and reviewed
  - Who (by role) is/are responsible for risk management, categories and/or actions (e.g. program manager may oversee the program's financial/reputational risks; HR manager oversee work health and safety risks; all staff identify and report risks)

Evidence examples (cont.)

- How risk related policies/procedures are made available to:
  - The program team (e.g. during program induction, via intranet/shared drive)
  - Program partners and other relevant stakeholders
- Active risk register that includes potential risks and how risks are reduced or managed
- Documented risk matrix relevant to the program's scope, and how it is implemented
- Documented risk tolerance statement
- Meeting records where program risk management has been discussed (including agreed actions and who is responsible for them)
- Action plans for addressing risks, including work related hazards
- Training log/register (or equivalent) documenting program staff training (relevant to their role) in:
  - Risk management
  - Preventing and reducing program related workplace hazards
  - Work Health and Safety Officer training (where relevant/required)
- Policy/procedure for managing financial fraud and corruption (including checks and balances, conflict of interest and reporting) that would impact the program's ongoing sustainability, and how this is communicated to the program team, program partners, and other relevant stakeholders
- Financial delegations of authority, and how these are communicated and managed
- Active conflict of interest register for partner organisations, collaborators, and any one else who may need to declare a potential or actual conflict of interest
- Program budget, program report, annual report or other evidence that the program maintains sufficient financial resources to ensure program is implemented sustainably
- Reports of audits undertaken on the program's risk management system, financial management, and/or allocation of funds against funding agreements

Cross references

3.1 Partnerships and collaboration
4.1 Needs identification
4.2 Diversity and inclusion
4.4 Resource management and sustainability

4.4 Resource management and sustainability

The resources needed to implement the program are well managed and support ongoing sustainability.

Context

To implement a program as intended requires resources, including:

- Funds to cover program costs
- Staff, time and expertise (internal and external)
- Physical resources (e.g. equipment, venue(s) to deliver the program, etc.)
- Program collateral (marketing/promotional, manuals, handouts, etc.).

Planning ahead for resources ensures that the program's feasibility has been considered, both during development and as the program matures and improves. Including program partners, staff/volunteers and other stakeholders in developing and reviewing the program's resource needs and budget ensures expectations are realistic.

Underestimating can lead to:

- Understaffing
- Unsuitable space to implement/deliver the program
- Subpar collateral and/or support
- Inability to fully implement the program

Overestimating can lead to:

- Unrealistic costings
- Overspending or unnecessary spending
- Lost or reduced support from funding bodies

Resources may be sourced in a variety of ways:

- Leveraging existing organisational resources (e.g. reception or program staff, desk space, computers/printers, relevant collateral from past or other programs)
- Engaging with community organisations for cost-effective meeting/program delivery spaces
- Seeking assistance from past or current partner organisations
- Applying for funding.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. What resources do you already have available to develop/implement the program?
b. What additional resources do you need?
c. How will/do you allocate resources (including financial) to ensure the program is fully implemented?
d. What are the program's ongoing and/or recurring costs?
e. Do you have sufficient funds to cover the resources required?
f. Do you have existing partnerships that could contribute resources?
g. Are there other organisations you could partner with to access certain resources?
h. Are there local organisations who could provide additional resources such as venues?
i. Have you identified and documented the roles, responsibilities and expertise you need to implement the program, and put together a program team who can deliver on the program's aims?
j. Does your program team include people with lived and living experience of suicide?
k. Does your program require an employed/paid workforce? Could it include volunteers?
l. What training resources do you have (or need) to support the program team?
m. Have you considered potentially hidden financial costs, such as the administrative cost to engage volunteers (e.g. induction, training, supervision and insurance)
n. What strategies are in place to ensure ongoing resource availability/sustainability?
o. How do program staff know what resources are available to them (including budgets)?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- A documented resource plan that outlines the resources (physical, human, time, knowledge/expertise, and financial) required to safely and effectively implement the program
- Collaborator/stakeholder engagement in developing/reviewing resource plan
- Staffing plan for the program, including roles and responsibilities
- Process/procedure for identifying resources and where they could be sourced (e.g. existing internal resources, partner/community resources, purchasing)
- Assessments completed of resources already available within the organisation or with program partners (including reusing existing resources/collateral from past or related programs)
- Documented engagement with other organisations to seek further resources (meeting records, emails, management/stakeholder reports)
- Fundraising planning, promotional material, stakeholder reports, public communications (e.g. website, assessments of potential funding/grant sources)
- Volunteer planning, recruiting promotions, public communications (e.g. website)
- Financial management systems/processes/procedures that document how financial resources are identified and sourced to support the program's activities
- Reports demonstrating that resources are monitored/reviewed to ensure sustainability
- Training log/register (or equivalent) documenting program staff training in efficient resource and/or financial management (relevant to their role)

Cross references

3.1 Partnerships and collaboration

4.3 Risk management

5.1 Staff support

5.4 Crisis support

6.3 Evaluation and quality improvement

PROGRAM MANAGEMENT

5

STANDARD 5. PROGRAM MANAGEMENT

The program is designed and implemented to ensure safe, accessible and supportive delivery.

Introduction

Standard 5 covers how the program ensures a safe and supportive environment for participants, the program team, and any other stakeholders, particularly when the program is being delivered.

People with lived and living experience could be within any of these groups.

Program management includes how the program:

- Supports the program team to implement and deliver a safe, accessible and high quality program, including supporting their own health and wellbeing
- Manages and maintains privacy and confidentiality for individual program participants
- Uses safe language, both when referencing or discussing suicide, and for specific communities who are at higher risk of experiencing stigma and/or harm
- Provides readily accessible information about crisis services and help-seeking whenever suicide is referenced or discussed

It is about managing, promoting and maintaining safety for everyone who interacts with or participates in the program.

5.1 Staff support

The program has clear systems and processes to support staff and volunteers.

Context

Suicide prevention programs differ greatly in their design and implementation, but it is the program team that puts into action all the work that went into its development. This includes the managers, staff and volunteers who contribute to implementation.

The program team may also include staff from multiple organisations with different HR systems, as well as volunteers, contractors and other external individuals who do not neatly fit within the organisation's systems.

For a program to achieve its intended outcomes it must have a team that is appropriately skilled, trained, resourced and supported. Human resource (HR) and work health and safety processes may be part of the broader organisational structure, however they also underpin an effective program team and contribute to quality program management.

This criterion ensures the program has appropriate processes in place to support team members in achieving the program's aims. It includes:

- Recruitment, induction and orientation
- Training
- Workplace safety and self-care
- Managing change

Support can take many forms, such as:

Formal	Informal (or less formal)
• Supervision processes (peer, professional or clinical supervision) • Further training/professional development • Employee Assistance Program (EAP)	• Mentoring • Peer support • Individual reflective practice • Self-care strategies

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

Recruitment, induction and orientation

a. What processes are in place to ensure program roles are filled by suitably skilled, qualified and experienced individuals?
b. Are volunteers appropriately assessed to ensure they have the capacity to fulfil roles and responsibilities?
c. How do you communicate roles and responsibilities to program team members?
d. What processes are in place to ensure program team members receive induction and orientation relevant to the program and their role/responsibilities?
e. How is recruitment, induction and orientation coordinated when the program includes team members from multiple organisations (e.g. partnerships)?

Training

f. What processes are in place to ensure program staff undertake regular education and training appropriate to their role and responsibilities?
g. What training documentation is available to support orientation and ongoing education for program team members?
h. Have you reviewed/analysed the program team's training needs in the last 12 months?
i. If a program team member is not fulfilling their role adequately, are there processes in place to review and support their performance?

What to look for (cont.)

Workplace safety and self-care

j. What processes are in place to ensure a physically and psychologically safe working environment? (See also 4.2 Diversity and inclusion)

k. What processes are in place to support a culture that is informed and inclusive of people with lived and living experience of suicide?

l. Do program team members understand self-care and its importance?

m. What tools and resources are available to program team members to support self-care?

n. Are program team members encouraged to create a self-care plan (if they wish to)?

o. Are there processes in place to support self-care while delivering the program?

p. How can program team members communicate their need for support (particularly during delivery)?

q. Are line managers / supervisors trained to recognise when program team members may require additional support?

r. What processes are in place to support program team members after difficult and/or challenging events?

s. Have you considered/implemented an Employee Assistance Program (EAP)?

Managing change

t. What processes are in place to update roles/responsibilities as the program changes?

u. How are changes communicated and program team members trained/supported to adjust to the changes?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

(Note: the program may leverage organisational policies, processes and procedures to support the program team)

Recruitment, induction and orientation

- Policy/procedure for program staff recruitment, selection and induction (including due diligence checks such as safety screening, reference checks, confirming qualifications)
- If a partnership, documentation that demonstrates how recruitment, induction and orientation are coordinated across partnering organisations (where relevant)
- Position/role chart that identifies relationships between roles and reporting lines (e.g. a program equivalent of an organisational chart)
- Meeting records where roles/responsibilities are/were discussed
- Program work plans
- Program induction checklist and/or resources
- Program induction/orientation plan(s) that reflect individual roles and level of participation in the program, such as:
  - Detailed induction/orientation for employed team members, relevant to the program, their role and their responsibilities
  - Group induction/orientation for program volunteers with lower or minimal hours/ participation that covers the basics of workplace health and safety, reporting lines, self-care, and their responsibilities within the program
  - Group or individual induction for people with lived and living experience of suicide, so they can share their story safely (the level of induction and ongoing training/support will depend on the individual – they may be new to sharing or already have extensive skills and experience in presenting)
  - Brief, one-on-one induction for contracted speakers before their presentation

Training

- Program training plan (including refresher training) and/or examples of training resources (online modules, partner resources, OH&S manual, operational manual)
- Training log/register (or equivalent) documenting ongoing program team training (individual and/or group training)

Evidence examples (cont.)

- Policy/procedure for personal development, supervision and performance management for program team members
- External/specialist organisations engaged to deliver training (e.g. self-care, workplace diversity and inclusion, fire training)

Workplace safety, support and self-care

- Policy/procedure for supporting and promoting workplace health, safety and self-care, which may include:
  - Peer support processes
  - Opportunities for individual debriefing following a stressful/traumatic event (where appropriate)
  - Flexible workplace arrangements
  - Employee Assistance Program (EAP)
- Self-care resources offered/provided to program team members (e.g. included in induction pack and/or readily available as needed)
- Ongoing education/training/resources for program team members on workplace safety, support and self-care
- Strategies implemented by the program team that encourage self-care and a no-blame workplace culture
- Team meeting records where professional development and/or workplace safety, support and self-care are/were discussed

Evidence examples (cont.)

- Processes, procedures and/or collateral that encourage and support program team members to prioritise self-care, whatever that looks like for them (including intentionally transitioning out of the program if this is the best option for the individual)
- Resources/collateral containing help-seeking information for program team members
- Policy/procedure for reviewing performance for individual program team members

Managing change

- Policy/process/procedure for reviewing program roles (when, why, how, and how changes are communicated to program team members) (See also 4.4 Resource management and sustainability)

Cross references

3.1 Partnerships and collaboration
4.2 Diversity and inclusion
4.4 Resource management and sustainability
6.3 Evaluation and quality improvement

5.2 Privacy

The program has processes in place to ensure privacy and confidentiality are respected and maintained, and personal information is protected.

Context

'Privacy and confidentiality' refer to respecting and protecting information about individuals participating in the program, including:

- Their personal information (i.e. information that can identify them, which is protected through the Australian Privacy Principles in the *Privacy Act 1988* (Cth) – see glossary for definitions of personal and sensitive information)
- Information they share about their life, experiences or circumstances
- Information they share about themselves during consultation, feedback, surveys, evaluation, research, etc. (see note below)

It also includes respecting privacy and confidentiality for the program team, volunteers, collaborators/contributors with lived and living experience, and program partners.

Privacy and confidentiality can be straightforward, such as not repeating a personal story shared in confidence. It can also be complex, subtle and nuanced, such as understanding in what situations and with which people an LGBTIQA+ person has shared their identity and where it is unsafe for them to do so (e.g. a young person may want you to use they/them pronouns generally, but she/her pronouns when talking to their parents as they have not disclosed their non-binary identity to their family). (See also 4.2 Diversity and inclusion)

Privacy also has limitations, such as disclosures of suicidal plans or intent to harm others, and it is imperative that participants clearly understand these limitations.

Note: Criterion 5.2 Privacy covers the program's privacy systems and practices generally, aligning with the Australian Privacy Principles and Duty of Care protocols. It is about maintaining privacy and confidentiality for the individual. **Criterion 6.2 Data collection and storage** focuses on protecting *collections* of data/information (such as client management systems, survey/research data, etc.), as well as reportable privacy/data breaches.

These two criteria are closely aligned, but cover different aspects or privacy.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. How has privacy been defined, and do you include a privacy statement on your website?
b. Do program team members understand their responsibilities under the Privacy Act, including in the Australian Privacy Principles?
c. How does the program manager keep up to date with changes to privacy legislation?
d. How are privacy processes and practices reviewed?
e. What processes are in place to ensure privacy and confidentiality are managed and maintained, including consent to share personal information where appropriate?
f. How are these processes communicated to program team members, partners and other stakeholders? (e.g. training, education, memos, posters)
g. What processes are in place to ensure participants are informed of why you collect their personal information, and how it will be used and stored?
h. How do you communicate to participants that privacy has certain limitations (e.g. disclosures of suicidal ideation/plans or intent to harm others)
i. What elements/practices do you have in place to protect privacy? e.g.
    - Positioning computer screens so they cannot be seen by unauthorised individuals (staff or visitors) when personal information is visible
    - Partitions to allow for more private conversations
    - Sound proofing in consulting rooms where clinical services are provided
    - Proof of identity before allowing access to personal information (e.g. a participant requesting access to the information you hold about them)
j. How are people identified when personal information is being communicated, without impacting privacy/confidentiality?
k. How do you promote and encourage privacy/confidentiality to different stakeholders?
l. How do you communicate the importance of maintaining privacy and confidentiality to program participants, and educate them in maintaining others' privacy?
m. What processes are in place to prevent and respond to privacy/confidentiality breaches during program delivery (or elsewhere)? (See also 6.2 Data collection and storage)

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Policy/procedure that clearly defines how the program manages and maintains privacy and confidentiality, in line with current legislation, including how you:
  - Collect, store, use and share participants' personal information
  - Obtain and document consent to collect and share participants' personal information
  - Manage and communicate confidentiality limitations
  - Confirm identity of program participants when they contact the organisation requesting information (steps that are reasonable in the circumstances)
  - Ensure your procedures/practices remain consistent with any changes to privacy legislation
- Training log/register (or equivalent) documenting privacy and confidentiality training, including common privacy issues and confidentiality limitations
- Privacy and confidentiality resources, including limitations to confidentiality
- Privacy Collection Statement (collecting, sharing and using information, as well as limitations to privacy/confidentiality) posters, leaflets for participants, included as part of registration process, and/or accessible on the program's website
- Duty of Care Statement (if it includes limitations to privacy/confidentiality)

Cross references

3.1 Partnerships and collaboration
4.2 Diversity and inclusion
4.3 Risk management
6.2 Data collection and storage

5.3 Safe language

The program uses safe language throughout implementation and delivery.

Context

The way we talk about suicide, mental illness and social and emotional wellbeing can either support a person or contribute to stigma and alienation, particularly for those with lived and living experience of suicide. Part of creating a supportive environment is understanding and using safe language.

Safe and inclusive language when discussing or communicating about suicide is fundamental to suicide prevention programs, and the program team, partners and other stakeholders must know how to use it.

Useful safe language resources

- *Life in Mind's* digital portal that provides translated evidence, policy, data and resources in suicide prevention and hosts the National Communications Charter. *Life in Mind* has a directory of suicide prevention organisations.
- Mindframe's *Language Guide*
- Conversations Matter's resources for safe and effective community discussions
- Roses in the Ocean's *Talking about Suicide, A Guide to Safe Language*

See Bibliography for links

Beyond safe language to support people with of suicide, there are community-specific safe language guidelines and/or protocols that apply to particular target groups, such as people with disability, the LGBTIQA+ community, and others. Also consider the most effective or appropriate language to use with subgroups such as single fathers or young children.

Guidelines/literature may not be available for all target groups, however it is important to understand the power of language, and the words that can both create and undermine a safe environment.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. Have program team members:
   - Received training in using safe language in suicide prevention?
   - Understand and apply safe language guidelines for suicide prevention?

b. Are participants educated on the safe language guidelines for suicide prevention?

c. Have any additional safe language requirements been identified and implemented for the program's target group(s)? (See also 4.2 Diversity and inclusion)

d. What other language guidelines or protocols would ensure your program is safe and inclusive for all participants? (e.g. when working with young people or children)

e. Do your internal and external documents and communications accurately reflect safe language guidelines relevant to your program and its target group(s)?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Policy/procedure for implementing and practicing safe language, including how internal and external documents/communications are reviewed before release to ensure appropriate safe language use
- Safe language is embedded in:
  - Internal program documentation (e.g. program/implementation/delivery plan, or excerpts)
  - Staff training modules (beyond specific training in using safe language)
  - Promotional material for target communities/groups
  - Resources provided or made available to target communities/groups (e.g. information sheets, workbooks)
  - The program's website (or equivalent), social media platforms and other online/ interactive communications
  - Presentation material for program delivery (e.g. PowerPoint handouts)

Evidence examples (cont.)

- Training log/register (or equivalent) documenting relevant safe language training provided to team members, including induction and refresher training:
  - For discussing or communicating about suicide (all programs)
  - When delivering programs to specific target groups, such as people with disability and/or the LGBTIQA+ community (where relevant) *(Note: this may also be part of cultural competence training)*
- Internal language guide that defines appropriate use of language/terminology across internal documents (e.g. policies/procedures) and external material (e.g. program marketing collateral and participant resources)
- Staff communications and/or records of open discussions around using safe language
- Posters, quick reference guides, online resources and other collateral explaining the importance of safe language and how to use it, tailored to different target groups (e.g. team members, participants, specific communities)
- Program material (presentation slides, workbooks, handouts, etc.) that show how program participants are educated in using safe language

Cross references

2.1 Lived and living experience of suicide

4.2 Diversity and inclusion

4.3 Risk management

5.4 Crisis support

The program includes clear help-seeking and crisis support pathways in implementation and delivery.

Context

Suicide prevention programs are often delivered to vulnerable people who may at times be in distress or experiencing a crisis. Including information about crisis services and help-seeking whenever suicide or self-harm is referenced or discussed encourages individuals to seek help and support when they need it.

Information about crisis services and help-seeking should be readily available when delivering suicide prevention programs. It should contain a variety of contacts and be available in multiple places, including being able to access it anonymously.

Help-seeking information should be:

- On your website
- In all program collateral
- In videos and online clips
- Attached to advertising campaigns
- Included in media releases/stories (media coverage must adhere to national guidelines for safe reporting, portrayal and communication about suicide)

Help-seeking and crisis support pathways include:

- 24/7 crisis support lines
- Downloadable resources
- Texting services
- Online forums
- Counselling services

Crisis services and help-seeking information must also reflect the needs of your program's target group, e.g. if your program participants include people from the LGBTIQA+ community, services and information provided should be either specifically targeted to this group, or at least known to be welcoming and safe.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. Have you sought input/feedback from people with lived and living experience of suicide regarding the most appropriate types of help-seeking and crisis support information for your target group?

a. How have you made sure your program team understands the importance of making help-seeking and crisis support information easily accessible to anyone who may need or want it?

b. How do you make sure all program team members, partners, contractors and other stakeholders are aware of the help-seeking and crisis support services available (locally, online, and/or target group/community specific)?

c. Do program team members know how to recognise and respond to participants (or others) who may be in distress?

d. What referral pathways does your program have in place for providing help-seeking information?

e. How is information about help-seeking and crisis support services:
   - Made available to program participants?
   - Made easy to access?
   - Promoted and displayed in the workplace and where the program is being delivered?
   - Included on all program collateral, including external communications?

f. How do you ensure any media coverage promoting the program includes appropriate help-seeking and crisis support information?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Policy/procedure/protocols (or equivalent) documenting how, where and when you promote/include information about help-seeking and crisis support services
- Excerpt from program plan that identifies how you provide information about help-seeking and crisis support services to program participants
- Training log/register (or equivalent) documenting help-seeking and crisis support training for program team members, including induction and refresher training
- Training modules/presentations/slides demonstrating training in:
  - Why providing information about help-seeking and crisis support services is important
  - Help-seeking and crisis support information relevant to the program
  - Recognising and responding to potential suicidal behaviour (where relevant)
- Posters, flyers, handouts and other collateral that promote help-seeking and crisis support services (workplace collateral as well as participant-facing)
- Presentations, workbooks and other program collateral that promote/include information about relevant help-seeking and crisis support services for participants
- Marketing/promotional material, media releases and other external communications that include information about relevant help-seeking and crisis support services for media agencies to promote

Cross references

2.1 Lived and living experience of suicide
4.1 Needs identification
4.2 Diversity and inclusion
4.3 Risk management
5.1 Staff support
5.3 Safe language

PROGRAM OUTCOMES & SHARING KNOWLEDGE

6

STANDARD 6. PROGRAM OUTCOMES AND KNOWLEDGE SHARING

The program seeks feedback, collects and analyses data, and uses the knowledge gained to both improve the program and to inform the wider suicide prevention sector by sharing what is learnt.

Introduction

A program cannot confirm quality implementation from just the research conducted during its initial development. Ongoing review and evaluation is required for a program to continuously improve and adjust to the changing needs of participants and/or target communities.

The wider suicide prevention sector is also constantly changing to grow its knowledge, understanding and available expertise, and programs must keep up with this.

A suicide prevention program has a responsibility to:

1. Learn and continuously improve, so that participants achieve the best outcomes possible
2. Contribute to the sector's knowledge base, so it can grow in understanding and expertise

Standard 6 includes how the program:

- Seeks and uses feedback at multiple points in the program's implementation (not just delivery, although this is a crucial feedback point)
- Collects and stores the data/information it receives from feedback and research, so that it can be used in meaningful ways
- Analyses and evaluates this feedback/information to inform both program improvements and the sector as a whole

6.1 Feedback

The program seeks and makes use of feedback to inform development, tailor implementation, and improve outcomes.

Context

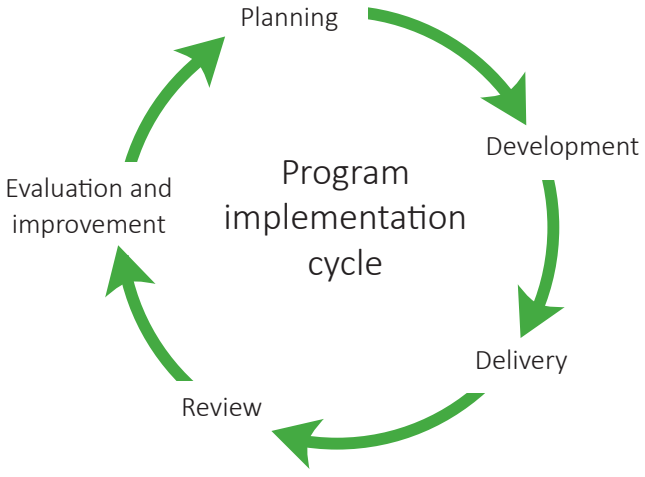
Wherever possible a program should be developed and implemented in collaboration with others, and seeking feedback is an essential component of this.

A high quality program must be flexible, with the ability to continuously improve and adapt to changing community and sector needs. This means listening to, and then acting on, feedback from a wide range of sources, including:

- Program participants
- People with lived and living experience of suicide
- Program partners and other collaborators/stakeholders
- Community members/organisations (particularly if the program has a specific target group)
- Program team members
- Suicide prevention sector networks
- Funding bodies

Whether positive or negative, feedback must be received in a constructive and open manner, and with a mindset of 'How can we do this better?'.

Feedback processes should be embedded throughout the program implementation cycle.



Note: Cycle stages are not equal in size, complexity or effort, and programs will vary in how long it takes to move through each.

How feedback is sought and where will vary depending on the stage the program is in. It can come through:

- Formal feedback surveys (written, verbal or online)
- Focus groups
- Informal discussion
- Suggestion boxes
- Social media posts/responses
- Other sources

Feedback can also identify where other areas and processes require additional attention. It may initiate change, or it may be part of planned evaluation processes (see 6.3 Evaluation and quality improvement). Continuous quality improvement allows a program to constantly adapt to best suit the needs of those who contribute to and participate in the program.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

a. How do you collect feedback?
b. Who do you collect feedback from?
c. Do you seek feedback using a variety of methods, formats and platforms?
d. Are your methods for collecting feedback tailored to be appropriate to the stakeholder group(s) you want to engage?
e. How can feedback be given anonymously?
f. How do you record feedback and acknowledge contributors?
g. How do you use feedback to improve the program's processes and practices?
h. How are complaints about the program resolved promptly and appropriately?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

- Policy/process/procedure that includes:
  - Who you collect feedback from
  - How, what, when and where feedback is collected
  - Who is responsible for managing feedback and complaints received
  - How a person/stakeholder can give feedback or make a complaint anonymously
  - Protocols for ensuring there are no negative repercussions for a person providing feedback or making a complaint
  - How improvements made based on feedback are communicated back to contributors
- Training log/register (or equivalent) documenting program team training and refresher training in responding to and managing feedback they receive (relevant to their role)
- Survey templates/forms (electronic, hard copy and/or online) that are user friendly and reflect the needs of the target group
- Feedback/complaints page on program's website
- Communications, posters and/or flyers for focus groups
- Program delivery collateral provided to participants on how to give feedback and/or make a complaint
- Pre/Post program surveys (templates or de-identified completed surveys)
- Feedback mechanisms (where relevant) for:
  - Program team members
  - Partner organisations
  - Other stakeholders and collaborators
  - The wider suicide prevention sector
- Team meeting records where the program team / managers discussed feedback adn decided on follow up actions

Evidence examples (cont.)

- Results (anonymous or de-identified) and/or reports of feedback sought from:
  - Program participants
  - People with lived and living experience of suicide
  - Program partners and collaborators
  - Other relevant stakeholders/groups
- Program feedback and complaints log/register (or equivalent) that facilitates reporting of, and responding to, positive and negative feedback
- Reports from feedback log/register reviews
- Quality improvement register/plan for the program that demonstrates actions taken from feedback

Cross references

2.1 Lived and living experience of suicide
3.1 Partnerships and collaboration
4.1 Needs identification
4.2 Diversity and inclusion
4.3 Risk management
6.2 Data collection and storage
6.3 Evaluation and quality improvement

6.2 Data collection and storage

Data/information collected reflects and supports the program's functions and outcomes, and is stored securely.

Context

Every program collects, stores and uses data in some way. It may come in many forms and from many places, and is part of all stages of program design and implementation. It is particularly important when delivering, reviewing and evaluating the program, as these are often the times when the greatest quantity of data and/or information is managed (see 6.3 Evaluation and quality improvement).

Data	Raw facts, measurements, statistics, observations, perceptions, etc. (quantitative and qualitative) that are relatively meaningless on their own, but can be sorted, analysed and interpreted to be useful
Information	Tangible insights or facts derived from data
Knowledge	A collection of information that can be used to support learning, understanding, improving, and more effective decision making

Accurate data is the foundation of useful Information, which generates knowledge to inform both the program and the broader suicide prevention sector.

Data can be used to create meaningful information to:

- Identify target communities and groups
- Assess the program's progress
- Identify whether the program has achieved key deliverables and/or intended outcomes
- Monitor the program's impact
- Understand more deeply the types of participants who have engaged in the program
- Identify opportunities for improvement through feedback (see 6.1 Feedback).

Any data collected should have a clear purpose, such as to:

- Provide services to participants
- Provide progress reports to stakeholders (including funding bodies)
- Develop milestone and/or financial reports for funding bodies
- Confirm whether the program has achieved its intended outcomes and positive impacts
- Ensure continuous quality improvement

All data/information collected, stored, used and/or created – through registration forms, spreadsheets, feedback, qualitative/quantitative measures, financial reports, progress reports, or other – should be clear, accurate, and protected from disclosure and misuse.

Data gathered should always follow agreed guidelines, and wherever possible be comparable to other relevant data sets for research and comparison. Consistent definitions support this, particularly when recording and entering data.

Permissions and authorisations must also be in place that identify and limit who can access, sort, correct and share data associated with the program.

Data breaches

A data breach occurs when personal information held by a program (often electronically) is accidentally disclosed, lost, or accessed without permission. This includes personal information covered in Criterion 5.2 Privacy (predominantly collected and used during service delivery), but also includes any personal information gathered as part of developing, implementing, reviewing and evaluating the program.

As data breaches are mostly caused by malicious or criminal attacks as a result of cyber incidents and/or human error[1], suicide prevention programs must protect the data they are responsible for.

Data breaches likely to cause serious harm must be reported to the Office of the Australian Information Commissioner (OAIC), under the *Privacy Act 1988* (Cth) and the *My Health Records Act 2012* (Cth).

> **Note:** **Criterion 6.2 Data collection and storage** focuses on protecting *collections* of data/information (such as client management systems, survey/research data, etc.), as well as reportable data breaches. It is closely aligned with **Criterion 5.2 Privacy,** which covers the program's privacy systems and practices more generally.

1 Report from the Office of the Australian Information Commissioner (OAIC)

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

Collecting and using data

a. What data do you collect (relevant to program planning and implementation) in each stage of your program?
b. What other relevant data do/could you collect that could be beneficial to the sector's wider knowledge base? (e.g. specific demographic data)
c. What definitions and rules do you use when collecting and sorting data?
d. How do you use (or plan to use) the data you collect?
e. How is data used to monitor the program's effectiveness?

Data protection and data breaches

f. What federal, state and/or territory data protection legislation are you required to comply with (or is best practice) for data privacy and protection? (e.g. the *Privacy Act 1988* (Cth); data protection at a state or territory level, health records protection where relevant)
g. What physical protections do you have in place to ensure data security? e.g.
    - Computers, laptops and hard drives securely stored
    - Controlled access to areas where records are kept
    - Hard copy documents kept in locked filing cabinets (e.g. original research/survey responses containing personal information)
h. What electronic systems do you have in place to protect data security? e.g.
    - Password, firewall and antivirus protection on all computers
    - Two factor authentication (TFA) at login
    - Files are encrypted before transferring to other stakeholders
    - Limited access to data and personal information based on predefined role authorities
    - Offsite backups for secure data recovery following a disaster or emergency
i. How do you ensure program staff understand and protect data/information?
j. How are incidents resulting in data breaches responded to, reported, managed, and prevented from recurring?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

(Note: data collection may form part of your funding requirements and could inform your evidence here)

Collecting and using data

- Policy/process/procedure for collecting and and using data, including verifying data accuracy
- Section of Privacy Statement that shows how data and personal information is protected
- Program plan (or excerpt) identifying what data the program collects, how it is measured (qualitative and quantitative), and what it is (or will be) used for
- Records of meetings with partner organisations where data collection was planned and/or reviewed to ensure its relevance and usefulness for all partners
- Sorting and/or measurement tools for data (where appropriate)

Data protection and data breaches

- Policy/process/procedure for securely storing and maintaining data, including safely transferring and/or transporting data/information (may be part of above policy)
- Policy/process/procedure for identifying, managing, reporting, reviewing and evaluating data breaches (may be part of above policy)
- Legislation register/list that demonstrates understanding of the program's data security compliance requirements (including reportable data breaches)
- Training log/register (or equivalent) documenting program team training and refresher training in maintaining data security and managing data breaches (relevant to their role)
- Data breach incident register
- Action plan / improvement plan that addresses identified data security issues and/or data breaches

Cross references

5.2 Privacy

4.2 Diversity and inclusion

4.3 Risk management

6.1 Feedback

6.3 Evaluation and quality improvement

The program is evaluated against the intended outcomes, and this knowledge is used to improve the program and contribute to the sector's shared knowledge base.

Context

Program evaluation provides an opportunity to ensure the program is achieving its intended outcomes, and to make changes and improvements where needed. It occurs regularly throughout program implementation, although the types of information gathered and evaluated may differ depending on what the program is seeking to learn at that point.

Feedback from participants, stakeholders and program team members can be used to inform planned evaluations, or could activate an impromptu evaluation on specific program elements.

Planned evaluation points

Initial planning	To confirm that what is being created reflects what the program is setting out to achieve
Development	To ensure the program's viability and ongoing sustainability *(This may include reviewing/evaluating the program's resources to ensure it does not run short)*
Delivery	To determine its effectiveness for participants and/or the target group, and guide improvements *(This may be done at multiple points during program delivery)*
Completion	To confirm whether the program has achieved its intended outcomes *(This may be at the end of a delivery cycle (where there will be a new intake of participants, such as educational programs), or when the program has a predefined end point (such as a research or pilot program))*

Evaluation points must be carefully considered:

- If done too often, there may not be enough data collected each time to give an accurate indication of the program's effectiveness. This can lead to incorrect assumptions based on skewed data
- If not done often enough, easily fixed or serious issues with the program may go unnoticed, negatively impacting the program's participants and intended outcomes.

Resource levels will influence what data/information available to assist in evaluating the program, so evaluation should be factored into budgeting. Other requirements, planned outcomes and physical impacts are also factors to consider.

For programs with an end date, the final evaluation will determine how successful the program was in meeting the intended outcomes. It will also highlight any changes that should be made if the program was delivered again at a different time or place, or within a different environment. This knowledge contributes to improving the suicide prevention sector as a whole.

Sharing knowledge

Knowledge and learnings from evaluations should be shared with all relevant stakeholders, although this may vary depending on what was evaluated. It may include:

- The program team
- Partners, collaborators and other external contributors
- The wider organisation (where organisational systems can be improved)
- Program participants, as part of closing the feedback loop (see 6.1 Feedback)
- Funding bodies and/or relevant government departments
- The broader suicide prevention sector.

Benefits of sharing knowledge and learnings

- Know how to improve both existing and future programs
- Learn from mistakes so they are not repeated
- Create a platform for co-operation where there are common goals
- Uncover other community issues that could be addressed in potential future programs
- Foster an environment of collaboration and support across the suicide prevention sector

Knowledge and information can be shared in numerous ways, including:

- By direct communication with relevant stakeholders
- Through the program's website and/or social media channels (or social media more broadly)
- Via news/current affairs outlets
- In industry journals
- Through presentations at sector forums or conferences.

Not all knowledge gained from programs will be new; some information will reiterate or support existing knowledge, or in some cases refute past findings. However, reviewing, evaluating and continuously improving the program is crucial for ongoing sustainability and, ultimately, the program's success in achieving its intended outcomes.

What to look for

Guiding questions to consider when looking at how your program, whether new, existing or long established, addresses this criterion:

Evaluation and internal improvement

a. How have you planned for and incorporated evaluation in different stages of the program, including identifying what information you are gathering and what you want to learn from it?
b. What types of data, information and measurable objectives do you use to evaluate the program's achievements and effectiveness?
c. How do you involve stakeholders in evaluations, including people with lived and living experience of suicide?
d. Who is responsible for implementing evaluation and quality improvement processes?
e. Would it be useful for the program to be externally evaluated?
f. How do you manage impromptu evaluation (initiated based on feedback or when an unexpected issue is identified)?
g. How do program participants contribute to evaluations?
h. What opportunities are there for program team members to contribute to evaluations?
i. What do you do with evaluation results?
j. Who needs to be consulted and/or included in quality improvement processes? (e.g. program staff, partners, people with lived and living experience of suicide, stakeholder groups, broader organisational staff)

Knowledge sharing and sector improvement

k. Do you have a plan for how you share knowledge generated from the program? (i.e. when, how, who with, for what purpose)
l. How do you share information from program evaluations and outcomes with relevant stakeholders? Is this regular, at milestone points, or at other predetermined times (such as partner/collaborator meetings)?
m. How do you share program findings in public and/or professional forums?
n. Is the knowledge/learning generated from the program in a format that can be used to inform future programs?
o. How has (or could) knowledge/learning generated from the program added to the sector's knowledge base?

Evidence examples

This is not a definitive list, but designed to provide ideas you can build on. There may be other evidence you believe contributes to how you address this criterion.

(Note: evaluation may form part of your funding requirements and could inform your evidence here)

Evaluation and internal improvement

- Policy/process/procedure for conducting evaluations and communicating/sharing findings, including how key stakeholders contribute
- The following may be part of the broader program plan, or separate evidence:
  - Evaluation plan that includes when and how evaluation takes place
  - Review/evaluation schedule demonstrating a cyclical process (planned and undertaken regularly or periodically, not just one-off)
  - Measurable objectives used for evaluation
  - Key questions used to guide program evaluations
  - Program team members responsible for conducting evaluations
- Baseline data used for comparison, which may be sourced from:
  - Needs identification
  - Participant pre-registration survey
  - Past program outcomes
  - ABS/Census data or other reliable sources
- Data/information collection tools such as surveys, questionnaires and/or checklists (templates or samples of de-identified completed forms) (see also 6.1 Feedback)
- Questions used in evaluation meetings, forums and/or focus groups
- Review/evaluation records (project plans, meeting records)
- Contribution to evaluations from partner organisation(s)
- Evaluation reports, recommendations and/or outcome reviews
- Report (or excerpt) from external evaluation(s)
- Improvement plan, register, or other demonstrations of improvements made based on evaluation results

Evidence examples (cont.)

- Meeting records or other demonstrations that improvements have been discussed, implemented and monitored
- Review conducted on improvements made against objectives to confirm whether they have contributed to project outcomes

Knowledge sharing and sector improvement

- Knowledge sharing/communication plan, including what, how and with whom you share information, knowledge and learnings from the program
- Evaluation results/reports provided to stakeholders (or similar communications) that demonstrate transparency and accountability
- Participant case studies
- Published articles and/or relevant journal contributions
- Program evaluations published on the program's website
- Forum/conference records documenting program presentation topic (e.g. conference overview/program)
- Forum/conference presentations or papers
- Stakeholder meeting records where evaluation results were discussed
- Any other examples of open knowledge sharing

Cross references

1.1 Program aims and objectives
3.1 Partnerships and collaboration
4.4 Resource management and sustainability
6.1 Feedback
6.2 Data collection and storage

GLOSSARY

Anonymous	A person who is not identified by name or any other identifiable features.
Bereavement	A period of loss where grief and mourning are experienced.
Co-design	Engaging people with lived and living experience of suicide in the process of designing a program.
Co-creation	People with lived and living experience of suicide play a central role in program implementation from beginning to end.
Conflict	A difference in views or a serious disagreement between two or more parties.
Conflict of interest	A situation where a person's professional decisions may be influenced by their personal interests.
Consultation	The process of asking advice or seeking counsel from another person or community who has expertise in a particular area or has a stake in the issue.
Continuous quality improvement	A leadership and management method used to assess and improve quality. It: • Defines quality in terms of consumer perceptions of service • Analyses systems – not people or things • Promotes partnerships with internal and external suppliers and stakeholders • Uses accurate data to analyse processes and to measure improvement • Involves staff in systems analysis and improvement • Sets up effective, collaborative meetings and communication processes • Trains managers in leading the improvement process • Engages staff in the improvement process • Achieves improvement through incremental steps • Links evaluation to planning. *(Source: QIP)*
Crisis support	Short term support that centres on providing people with assistance, non-judgemental support and resources in a time of urgent need.
Crisis support service	A service where people can obtain personal help when they are in urgent need due to an internal or external crisis or emergency.

Culturally appropriate	Providing services in a way that recognises and is compatible with the person's cultural values, beliefs, and needs. This includes the person's race, culture, language or ethnic background, religious or spiritual beliefs or principles, gender identity, age and sexuality.
Culture	The actions and symbols that different groups of people use to articulate or express their identity, often in relation to specific traditions of ethnicity, race, language, religion, occupation or social relations.
Data	Raw facts, measurements, statistics, observations, perceptions, etc. (quantitative and qualitative) that are relatively meaningless on their own, but can be sorted, analysed and interpreted to be useful. (See also: *Information*, *Knowledge*)
Duty of care	A moral or legal obligation to ensure the safety or wellbeing of others.
Evaluation	The process of making judgements about the value or success of a program or service, usually by assessing whether specified goals, objectives or strategies are achieved. There are three levels of evaluation: • Process evaluation is used early in program implementation and/or delivery and measures strategies, such as who the program is reaching • Impact evaluation measures whether the immediate effects of the program have been reached (objectives) • Outcome evaluation measures the long-term effects of the program (goals).
Evidence	Documentation that demonstrates the program meets the specific requirements for a criterion in the Suicide Prevention Standards for Quality Improvement. Types of evidence will vary depending on the program and the organisation(s) implementing/delivering it.
Evidence-based strategies	Any concept or strategy that is derived from or informed by objective evidence.
Exit strategy	A plan intentionally developed in advance that defines how/when a situation or partnership should be ended, and what may prompt termination.
Goals	Particular endpoints or achievements that are considered desirable. Planners and managers use goals to guide planning, allocate resources, and monitor and evaluate the impact of a program/service.

Implementation	A catch-all word used throughout these standards to cover: • Designing or developing the program (identifying the need and building the program plan) • Implementing the program, as in the 'back-end' functions (such as managing risks, resources, etc.) • Delivering the program • Reviewing and evaluating the program.
Information	Tangible insights or facts derived from data (see also: *Data*, *Knowledge*)
Intersectionality	The ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation. *(Source: Victorian Government website)*
Knowledge	A collection of information that can be used to support learning, understanding, improving, and more effective decision making. (See also: *Data*, *Information*)
LGBTIQA+	The abbreviated term for Lesbian, Gay, Bisexual, Transgender, Intersex, Queer and Asexual people. The term is often used to refer to the gender, sexuality and relationship diverse community as a whole.
Lived and living experience of suicide	A person who has experienced suicidal thoughts, survived a suicide attempt, cared for a loved one through suicidal crisis, or been bereaved by suicide. *(Source: Roses in the Ocean)*
Memorandum of understanding	A nonbinding written document that states the responsibilities of each party to an agreement, in the absence of an official contract.
Mission statement	A short, formal statement detailing the goals and values of an organisation, program or service.
Needs assessment / needs analysis	A formal, documented process that focuses on how a program addresses (or will address) the needs of a person, community or group.
Negotiations	The action or process for reaching an agreement between two or more parties.
Not-for-profit	An organisation that is not intended to make a financial profit.

Participant	The recipient of a program or service (e.g. a member of a support group for people who have lost a family member due to suicide).
Peer worker	People who identify as having lived or living experience of mental ill-health and/or suicide (or other experiences like drug and alcohol issues) who are employed, either paid or volunteer, in designated roles in the public or non-government sector and use their common experience to support and inspire hope and recovery in others.

Personal and sensitive information	The *Privacy Act 1988* (Cth) defines personal information as information or an opinion that identifies an individual, such as name, address, email address, phone number.
	Sensitive information is a special category of personal information and includes:
	• Information or an opinion about an individual's:
	  • Racial or ethnic origin
	  • Political opinions or membership of a political association
	  • Religious beliefs or affiliations
	  • Membership of a professional or trade association
	  • Philosophical beliefs
	  • Sexual orientation or practices
	  • Criminal record.
	• Health information about an individual, which generally means:
	  • Personal information about an individual's health, illness, injury or disability (e.g. a medical diagnosis)
	  • Personal information about health services provided to an individual, or the individual's expressed wishes about the future provision of health services to them.

Policy	A framework of principles that guide decision making and activity.
Postvention	A program or service that supports people after the death of someone due to suicide.
Procedure	A set of instructions to make policies and protocols operational.
Program logic	What a program will do and how it will do it (see Introduction for more detail).

Program team	Includes: • The staff, volunteers, peer workers, people with lived and living experience of suicide, and/or contractors in designated roles • Partner organisations • Anyone else responsible for designing, implementing, delivering, reviewing and/or evaluating the program. These roles will often overlap. The program team may also include students, carers and voluntary members of the governance structure.
Review	The act of carefully examining the quality of something through critical appraisal and inspection.
Risk management	The process of identifying, analysing and evaluating possible risks to the organisation and its partners, program team members, and people who participate in the program. It includes developing and implementing strategies and treatments to control, reduce or eliminate risks.
Risk matrix	A method for evaluating both the probability and severity of a specific action or inaction that is expected or anticipated to occur. It is used to determine the level of each identified risk (e.g. high/medium/low risk) which then guides how it is managed.
Risk register	A tool (often a document, spreadsheet or application) used to identify potential program/service risks. It contains information to assist in analysing risks, planning responses, and monitoring and controlling them. It may also include the risk owner, response plan, updates, etc.
Safe environment	An environment (physical or virtual) where people feel protected and not exposed to discrimination, negative judgement, risk or danger.
Stakeholder	A person, group, community or another service provider with a legitimate interest in the program. Stakeholders may include a local community, people with lived and living experience of suicide, special needs groups, other organisations providing related services, funders or sector networks.

Stigma	A negative attitude, idea or perception of social disapproval about a mental, physical, or social feature of a person or group of people. In the suicide prevention sector stigma can stop a person seeking help when they need it.
Strategic plan	A process where an organisation identifies its vision, goals, and objectives. May also be called strategic directives.
Suicidal crisis	A situation of emergency where someone is attempting, considering or planning suicide.
Suicidal ideation	A process in which a person thinks about, considers, or plans suicide. Suicidal ideation ranges from passing thoughts to extensive thoughts, through to detailed planning.
Suicide prevention	A collection of efforts to reduce the risk of suicide, which may occur at the individual, relationship, community, and/or society level.
Suicide prevention program	A program that provides specialised support to individuals with the intention of preventing suicide, assisting those who are at risk of suicide, or supporting individuals who have been affected by suicide.
Target group	A particular community or group identified as a program's intended audience.
Values statement	A declaration of an organisation's core principles.
Viability	The ability for a concept or plan to work successfully with undue restraint or impending failure.
Vision statement	A declaration of an organisations' objectives and what it wants to achieve.
Vulnerable	Exposed to the potential of being harmed, physically, psychologically or emotionally.
Work health and safety	Protecting the safety, health and welfare of people engaged in work or employment (including volunteers). It includes identifying and mitigating work-related risks in consultation with program team members, creating safe work practices, and establishing a safe workplace.

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