7 Findings: Appropriateness

7 FINDINGS: APPROPRIATENESS

This chapter examines whether the range, funding and design of projects are appropriate to meet the desired outcomes.46

Sections 7.1 and 7.2 examine the appropriateness of the mix and funding of NSPP projects across Australia. Data presented in Section 7.1 is based upon responses to the Project Survey and the MDS data collected.

The remaining nine sections examine the extent to which the project activities align with the evidence base, as articulated through the peer review literature. Findings are based on a thematic analysis of the qualitative data provided by projects.

In these sections, a summary of the current evidence/best practice (derived from the Literature Review, see Appendix E) is presented in relation to each parameter of appropriateness. A brief description of NSPP-funded activities under each parameter is then provided and the appropriateness of these activities is assessed in relation to current evidence of best practice.

7.1 Mix of projects

The evidence suggests that multilevel interventions are the strategy of choice for suicide prevention.4748 The following Figure 7-1 provides a geographic overview of project activities at a state/territory and national level. The state level profiles reflect the number of projects that are active in each state. Projects that have a multi-state component are included in the profile of each individual state/territory in which they operate.

Four key observations are evident from the map at Figure 7-1:

- Activities are directed across all LIFE Action Areas across all states and territories
- A mix of universal, selective and indicated approaches have been used in each state/territory
- The majority of state/territory level project activities had a local geographical reach
- National level projects also showed activities across all LIFE Action Areas and a mix of universal, selective and indicated approaches were evident.

State/territory and national level activity by target group is shown in the subsequent Figure 7-2.

---

46 "To evaluate appropriateness, one of two comparisons is made. The program may be compared to the needs of the intended clients, using any of the techniques of needs analysis. Alternatively, the program can be evaluated in terms of its compliance with process. In health for example, some evaluations focus on appropriate care, including treatment of conditions (heart disease) or events (childbirth). Appropriateness can be determined through expert review of individual cases". PJ Rogers, 'Evaluation', in S Mathison (ed), The Encyclopaedia of Evaluation, Sage Publications, London, 2007, p.31.


7 Findings: Appropriateness

Figure 7-1: National and state/territory project profiles

Data sources:
Funding amounts: DoHA Project Data.
Project details: NSPP Survey.

Northern Territory
10.3 Age-standardised suicide rate
$4,460,715 funding 06/07-12/13
Project Approach: Life Action Areas:
1 Universal 2 Local 2 LAA1
3 Selective 3 LAA2
1 Indicated 1 LAA4
1 State-wide 1 LAA5
2 LAA6

Western Australia
13.1 Age-standardised suicide rate
$13,235,694 funding 06/07-12/13
Project Approach: Life Action Areas:
1 Universal 4 LAA1
5 Selective 6 LAA2
3 Indicated 5 LAA3
1 Local 4 LAA4
5 State-wide 5 LAA6

South Australia
12.0 Age-standardised suicide rate
$982,097 funding 06/07-12/13
Project Approach: Life Action Areas:
0 Universal 1 LAA1
2 Selective 2 LAA2
0 Indicated 2 LAA3
1 Local 1 LAA4
1 State-wide 1 LAA5

Tasmania
14.1 Age-standardised suicide rate
$7,083,907 funding 06/07-12/13
Project Approach: Life Action Areas:
1 Universal 2 Local 2 LAA1
4 Selective 3 LAA2
2 Indicated 1 Multi-state (WA/Qld)
1 Multi-state (WA/Qld)
1 LAA4
2 LAA4
1 LAA5
4 LAA6

Queensland
12.4 Age-standardised suicide rate
$18,007,776 funding 06/07-12/13
Project Approach: Life Action Areas:
3 Universal 8 LAA1
8 Selective 8 LAA2
5 Indicated 10 LAA3
9 Local 10 LAA4
7 LAA5
1 Multi-state (WA/Tas)

New South Wales
8.6 Age-standardised suicide rate
$9,890,062 funding 06/07-12/13
Project Approach: Life Action Areas:
1 Universal 4 LAA1
5 Selective 6 LAA2
6 Indicated 5 LAA3
4 Local 4 LAA4
4 LAA5
1 Multi-state (ACT)

Australian Capital Territory
9.9 Age-standardised suicide rate
$2,047,858 funding 06/07-12/13
Project Approach: Life Action Areas:
0 Universal 1 LAA1
1 Selective 1 LAA2
1 Indicated 1 LAA3
1 Project Reach: 1 LAA4
1 State-wide 0 LAA5
1 Multi-state (NSW) 1 LAA6

Victoria
9.6 Age-standardised suicide rate
$6,237,074 funding 06/07-12/13
Project Approach: Life Action Areas:
3 Universal 2 LAA1
4 Selective 3 LAA2
1 Indicated 4 LAA3
2 Local 2 LAA4
1 Multi-state 1 LAA5
3 Local 4 LAA6
1 State-wide 4 LAA6
7 Findings: Appropriateness

Figure 7-2: National and state/territory projects by target group

Data sources:
Figures for all target groups except “People at risk (no previous attempt)” and “Those engaged with the justice system” are based on the NSPP Survey.
Figures for the target groups “People at risk (no previous attempt)” and “Those engaged with the justice system” are based on MQS data collected after the NSPP survey.
7 Findings: Appropriateness

While it is clear that NSPP-funded activities address multiple target groups in each jurisdiction, as shown in the map at Figure 7-2, a number of gaps are evident at a jurisdictional level. These gaps are summarised in Table 7-1 below.

### Table 7-1: Jurisdictional gaps in the range of groups targeted

<table>
<thead>
<tr>
<th>Target group</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>Qld</th>
<th>SA</th>
<th>Tas</th>
<th>Vic</th>
<th>WA</th>
<th>Nat.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereaved</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Men</td>
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<td></td>
<td></td>
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<tr>
<td>Children</td>
<td></td>
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<td>Youth</td>
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<tr>
<td>Indigenous</td>
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<td></td>
<td></td>
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<tr>
<td>Mental illness</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Previous attempt</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Self-harm</td>
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<tr>
<td>Rural and remote</td>
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<tr>
<td>LGBTI</td>
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<td>CALD</td>
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<td>Refugee</td>
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<tr>
<td>Older people</td>
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<td></td>
<td></td>
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<tr>
<td>AOD problem</td>
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<tr>
<td>Whole community</td>
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<td></td>
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<tr>
<td>Workforce settings</td>
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<tr>
<td>Redundancies</td>
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<tr>
<td>Natural disasters</td>
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<td></td>
<td></td>
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<tr>
<td>People at risk*</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice system*</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The shaded boxes indicate that a particular group was not listed in the survey responses as a specific target by any of the project active in that jurisdiction.

*Figures for the target groups “People at risk (no previous attempt)” and “Those engaged with the justice system” are based on MDS data collected after the NSPP survey.

The groups that emerged as being most consistently absent as project targets at jurisdictional level are LGBTI, CALD, refugees and people affected by natural disasters.

It should be noted that these gaps are based on an analysis of data from the Project Survey, as the survey accounts for project activity across the life of the Evaluation. There are some inconsistencies between the gaps identified above and those emerging from analysis of the MDS data. As outlined in Section 6.6, the MDS analysis indicated that there were no group or individual activities for the following target groups:

- People who have self-harmed (ACT)
- Rural and remote communities (ACT)
7 Findings: Appropriateness

- LGBTI populations (SA, WA, NT)
- CALD communities (SA, WA, NT, ACT)
- Refugee communities (SA, WA, NT, ACT)
- Older people (ACT)
- People living with an alcohol or other drug problem (ACT)
- People affected by workforce redundancies (ACT)
- People affected by natural disasters (SA, WA, ACT)
- People at risk (no previous attempts of suicide or self-harm) (ACT, NT)
- People engaged with the justice system (Qld, NT, ACT).

Overall, the MDS data suggests that there is greater coverage of target groups across populations than reported in the survey.

As outlined in Section 5.3, multiple approaches were often evident within projects and a mix of individual and group level activities were provided. Overall, NSPP-funded projects are engaged in activities that are consistent with current best practice, in that they are providing a range of multilevel interventions.

Two caveats apply to this finding. First, the extent to which the particular mix of projects can be considered appropriate needs to be interpreted with caution. While the jurisdictional level analyses provides some indication of the LIFE Action Areas and target groups covered, this activity is based on the number of projects that were active in each jurisdiction.

Second, the gaps in target group coverage need to be interpreted with caution. This is because gaps at state or territory level may be addressed by:

- National NSPP-funded projects.
- Whole-of-community projects. For example, projects that target hard to reach groups such as farmers or rural men generally may do so through whole-of-community projects rather than through projects that overtly target farmers or rural men. Activities may be delivered though community events such as Country Women's Associations, banking groups, and agricultural shows who by virtue of familial, community or business connections serve as gatekeepers to these hard to reach groups
- Non-NSPP-funded activities. For example:
  - Gaps evident in relation to mental health and AOD may be covered through specific mental health and AOD funding
  - Suicide prevention activities occurring at state/territory level that are not funded by NSPP may be addressing these gaps. This issue is discussed in detail in Chapter 11.

### Key findings

- Overall, the NSPP-funded projects provide a range of activities across the LIFE Action Areas, using a mix of approaches and targeting a broad range of groups known to be at higher risk, as advocated in the LIFE Framework. Importantly, this mix not only occurs at state/territory level but also within individual projects.
7 Findings: Appropriateness

7.2 Equity of NSPP funding across regions

The 49 projects included in this Report are those that were funded at June 2011. Over the seven years from 2006-07 to 2012-13 these projects were allocated NSPP funding totalling $96.8 million. These projects represent a subset of total NSPP projects and funding of $120.1 million over this period (see Section 5.1).

This section examines the equity of this project funding across regions over the period 2006-13. Analysis of NSPP funding is presented relative to each state/territory by:

- Population
- Age-standardised suicide rate.

Two projects operated across multiple state/territories. For the purposes of this funding analysis, their funding was allocated between each state/territory-based on advice from the projects about the geographic reach of their activities. Funding for national projects was not allocated to states/territories. Accordingly, it is important that care is taken in interpreting the following jurisdictional funding comparison, as apparent gaps (ie, relatively low NSPP funding for a jurisdiction), may in fact be addressed by national projects.

The following Table 7-2 identifies the NSPP funding per capita and the age-standardised suicide rate for each jurisdiction and in total for Australia. The purpose of this analysis is to examine whether funding appears to have been appropriately targeted to the needs of jurisdictions, based on their relative population and age-standardised suicide rate.

### Table 7-2: Project funding per capita and Age-Standardised Suicide Rate, by jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Population 2012</th>
<th>Funding 2006-07 to 2012-13</th>
<th>Funding per capita</th>
<th>Age-standardised suicide rate 2007-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>376,500</td>
<td>$2,047,858</td>
<td>$5.44</td>
<td>9.9</td>
</tr>
<tr>
<td>NSW</td>
<td>7,314,100</td>
<td>$9,660,962</td>
<td>$1.32</td>
<td>8.6</td>
</tr>
<tr>
<td>NT</td>
<td>236,300</td>
<td>$2,468,715</td>
<td>$10.45</td>
<td>19.3</td>
</tr>
<tr>
<td>Qld</td>
<td>4,584,600</td>
<td>$18,007,776</td>
<td>$3.93</td>
<td>12.4</td>
</tr>
<tr>
<td>SA</td>
<td>1,658,100</td>
<td>$982,097</td>
<td>$0.59</td>
<td>12.0</td>
</tr>
<tr>
<td>Tas</td>
<td>512,200</td>
<td>$7,083,907</td>
<td>$13.83</td>
<td>14.1</td>
</tr>
<tr>
<td>Vic</td>
<td>5,649,100</td>
<td>$6,237,574</td>
<td>$1.10</td>
<td>9.6</td>
</tr>
<tr>
<td>WA</td>
<td>2,451,400</td>
<td>$13,235,694</td>
<td>$5.40</td>
<td>13.1</td>
</tr>
<tr>
<td>Subtotal</td>
<td>22,782,300</td>
<td>$59,724,585</td>
<td>$2.62</td>
<td></td>
</tr>
<tr>
<td>National projects</td>
<td>$37,091,816</td>
<td>$4.25</td>
<td>10.6</td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>22,785,500</td>
<td>$96,816,401</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

2. Source: DoHA Project Data.
7 Findings: Appropriateness

NSPP project funding per capita varied considerably between jurisdictions. The national average was $4.25 per capita of which $2.62 was for state/territory specific projects and $1.63 per capita was for national projects. Jurisdictional level funding ranged from $0.59 per capita in South Australia to $13.83 per capita in Tasmania.

South Australia, Victoria and New South Wales had relatively low funding per capita ($0.59, $1.10 and $1.32 respectively), and Northern Territory and Tasmania had relatively high funding per capita ($10.45 and $13.83 respectively). Overall, jurisdictions with lowest per capita funding tended to be those with the lowest age-standardised suicide rates 2007-11 while conversely, those with the highest per capita funding tended to be those with the highest age-standardised suicide rates 2007-11.

Key findings
- NSPP project funding per capita varied considerably between jurisdictions.
- In general, jurisdictions with the lowest funding per capita were those with the lowest age-standardised suicide rate and those with the highest funding per capita were those with the highest age-standardised suicide rate. Those jurisdictions with greatest need (highest age-standardised suicide rates) were therefore the recipients of highest per capita funding.

7.3 The evidence base for suicide prevention

The evidence base for effective suicide prevention activities is small but growing. Despite these limitations, the literature provides information (primarily based on evidence from systematic reviews of suicide prevention interventions) on what works, or what is likely to work.4950515253

The remaining sections in this chapter consider the extent to which the suicide prevention activities funded through the NSPP are aligned with the evidence base, as articulated through the peer review literature.

7.4 Higher risk groups

A summary of the higher risk groups identified in the peer-reviewed literature is provided below.

Table 7-3: Higher risk groups

<table>
<thead>
<tr>
<th>Summary of current evidence/best practice54</th>
<th>A number of at-risk sub-groups have been identified. These include but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- people with physical illness</td>
</tr>
<tr>
<td></td>
<td>- people with a history of suicide related behaviour or self-harm</td>
</tr>
<tr>
<td></td>
<td>- people with mental illness</td>
</tr>
<tr>
<td></td>
<td>- Indigenous populations</td>
</tr>
<tr>
<td></td>
<td>- lesbian, gay, bisexual and transgender and intersex (LGBTI) populations</td>
</tr>
<tr>
<td></td>
<td>- Culturally and Linguistically Diverse (CALD) populations</td>
</tr>
<tr>
<td></td>
<td>- older adults</td>
</tr>
</tbody>
</table>

50 van der Feltz-Cornelis et al, ‘Best Practice Elements of Multilevel Suicide Prevention Strategies’.
51 Mann et al, ‘Suicide Prevention Strategies’.
52 Nordentoft, ‘Crucial Elements in Suicide Prevention Strategies’.
53 DoHA, LIFE: Research and Evidence in Suicide Prevention.
54 DoHA, LIFE: Research and Evidence in Suicide Prevention.
7 Findings: Appropriateness

### Summary of current evidence/best practice

- men
- people with substance misuse problems
- rural and remote populations
- youth
- people who have been bereaved by suicide
- people engaged with the justice system
- people who are divorced, widowed, separated or single
- people who are unemployed or with low socioeconomic status
- people who are socially isolated or who lack social support

Given the higher prevalence of suicide in these groups, it makes sense that suicide prevention strategies include a focus on these populations.

The NSPP-funded projects include a focus on most of the target groups listed above, albeit with some jurisdictional gaps as identified in Section 7.1. While other higher risk groups, such as people who are divorced, widowed, separated or single, or people who are unemployed are not specifically listed as targets for any of the projects, it is reasonable to assume that they will be covered by a number of projects.

### Key findings

- Overall, NSPP-funded projects address most of the recognised target groups. Some gaps are evident at state/territory level in terms of the number of projects and the reported coverage of higher risk groups.

#### 7.5 Aboriginal and Torres Strait Islander populations

Since the 1970s, rates of suicide in Indigenous communities have shown a marked increase and are now disproportionately high. In 2012 the age-standardised death rate for suicide was 2.5 and 2.4 times higher for Aboriginal and Torres Strait Islander males and females compared with non-Indigenous males and females.55

This target population therefore requires specific consideration. Understanding Indigenous suicide requires an understanding of the complex historical, political and social context of contemporary Aboriginal life.

Identified factors that contribute to high levels of suicide in Indigenous populations include:

- Exposure to known environmental risk factors (including poverty, poor education, poor employment prospects, limited access to services, living in rural or remote communities, domestic violence or abuse, alcohol and other drug abuse).
- Many people have been exposed to suicide, which can lead to situations of ‘bereavement overload’ where suicidal behaviours can become socially contagious.
- Ever-present trauma and grief as a result of continuing loss and traumatisation from past dislocation and mistreatment.
- Disproportionately high numbers of Aboriginal and Torres Strait Islander people in Australian prisons.
- Relatively poor health compared with the wider Australian community.

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7 Findings: Appropriateness

- Lack of access to culturally appropriate services.
- Loss of cultural identity and cultural disintegration.\(^{56}\)

<table>
<thead>
<tr>
<th>Summary of current evidence/best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions that show promise in suicide prevention in Aboriginal and Torres Strait Islander populations include:</td>
</tr>
<tr>
<td>- Gatekeeper training to improve skills in risk assessment and working with highly distressed individuals(^{57})</td>
</tr>
<tr>
<td>- Community-based strategies that aim to promote resilience and strengthen protective factors</td>
</tr>
<tr>
<td>- Proactive bereavement support to contain suicide clusters</td>
</tr>
<tr>
<td>- Sport or apprenticeship-based suicide prevention programs for Indigenous youth</td>
</tr>
<tr>
<td>- Community healing approaches that include traditional cultural approaches(^{58}^{59})</td>
</tr>
<tr>
<td>- Efforts to improve ‘cultural continuity’ by preserving and rehabilitating traditional cultures may be protective against youth suicide in particular.(^{60})</td>
</tr>
</tbody>
</table>

Findings in relation to NSPP-funded activities

As indicated in Sections 6.4.8 and 6.5.10, Aboriginal and Torres Strait Islander people accounted for 14.7% of individual activity participants and 19.4% of group activity participants, which exceeds the proportion of Aboriginal and Torres Strait Islander people in the Australian population. This over-representation is entirely appropriate, given the extremely high rates of suicide in this population. Indeed, as outlined in Section 3.9, NSPP-related activity represents only one part of a concerted national response to address the disproportionately high rates of suicide in Aboriginal and Torres Strait Islander populations.

NSPP-funded projects that target Aboriginal and Torres Strait Islander communities reported use of a number of the promising interventions outlined above. These include gatekeeper training, community-based approaches to promote resilience and community healing approaches that promote cultural practices and cultural continuity, such as ‘return to country’ trips. Most of these interventions were developed using extensive community consultation which helped improve cultural appropriateness.

While a number of the projects that targeted Indigenous Australians included bereavement support as a key activity, it is not clear whether this was sufficiently flexible or adequately resourced to be able to be responsive to suicide clusters.


\(^{58}\) K Kolves, A Milner, K McKay & D De Leo (eds), *Suicide in rural and remote areas of Australia*, Australian Institute for Suicide Research and Prevention, Griffiths University, Mt Gravatt, 2010.


7 Findings: Appropriateness

Key findings
- NSPP-funded projects that target Aboriginal and Torres Strait Islander communities reported using culturally appropriate interventions that included gatekeeper training, community-based approaches to promote resilience and community healing approaches that promote cultural practices and cultural continuity, such as 'return to country' trips.

7.6 Universal approaches

Drawing on the peer-reviewed literature, a summary of the current evidence/best practice related to universal approaches is provided below.

<table>
<thead>
<tr>
<th>Summary of current evidence/best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is good evidence that universal approaches aimed at reducing access to the means of suicide (such as firearms, pesticides, or building barriers at jumping sites) are effective suicide prevention strategies.</td>
</tr>
<tr>
<td>There is promising evidence for the effectiveness of media guidelines for appropriate reporting of suicide as a universal approach to suicide prevention.</td>
</tr>
<tr>
<td>There is some evidence for universal approaches involving awareness-raising aimed at improving knowledge or literacy about mental illness or suicidal behaviour. However, it has been suggested that generic population-based approaches are less likely to be effective than programs that target more specifically-defined sub-groups. Awareness-raising approaches need be coupled with accessible, appropriate services.</td>
</tr>
</tbody>
</table>

Findings in relation to NSPP-funded activities

None of the in-scope NSPP-funded projects specifically aimed to reduce access to means of suicide. Improving safety at 'hot spots' became a key component of the TATS package, which was released in 2010 in response to *The Hidden Toll*, the report on the Senate Inquiry into Suicide (see Section 3.4 and 3.5). Projects funded to address hot spots are not part of this Evaluation.

Two projects focussed on improving media reporting of suicide and mental illness.

Awareness-raising and promotion of help-seeking was evident at two levels within the NSPP-funded projects. Two projects had a primary focus on awareness-raising and promotion of help-seeking on a national scale while a number of other projects included awareness-raising in specific settings as a component of their activities.

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61 Beautrais et al, ‘Effective Strategies for Suicide Prevention in New Zealand’.
62 Mann et al, 'Suicide Prevention Strategies'.
63 Nordentoft, ‘Crucial Elements in Suicide Prevention Strategies’.
64 van der Feltz-Cornelis et al, ‘Best Practice Elements of Multilevel Suicide Prevention Strategies’.
7 Findings: Appropriateness

Key findings

- NSPP-funded projects included a number of projects that used universal approaches to address:
  - Media reporting of suicide and mental illness
  - Awareness-raising and promotion of help-seeking.

7.7 Selective approaches

Drawing on the peer-reviewed literature, a summary of the current evidence/best practice related to selective approaches is provided below.

<table>
<thead>
<tr>
<th>Summary of current evidence/best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is good evidence that selective strategies that aim to improve the ability of medical practitioners in primary care to recognise and treat depression can result in lower suicide rates.</td>
</tr>
<tr>
<td>Gatekeeper training programs that focus on enhancing the skills of community, organisational and institutional gatekeepers (such as people who work in schools, prisons, workplaces, etc.) have been shown to be effective selective approaches in improving the identification and referral of people at risk of suicidal behaviour.</td>
</tr>
<tr>
<td>A range of community capacity-building approaches have also been identified as being promising selective approaches. These include screening for depression or suicide risk (for example, in schools, universities or primary care settings), crisis centres and crisis helplines, and support for people who have been bereaved by suicide.</td>
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</tbody>
</table>

Findings in relation to NSPP-funded activities

A number of projects reported including gatekeeper training (either of professionals or other community members) as one component of their activities. Only one NSPP-funded project (local) specifically supported medical practitioners to better recognise and treat depression and suicide risk.

More than half of the funded projects reported undertaking some form of community capacity building. These activities included provision of crisis lines/crisis centres, services for those bereaved by suicide and screening/identification of people who may be at risk. Considerable variation existed in how these activities were delivered between target group and settings (eg, workplaces, schools, drop-in centres).

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65 Beutrais et al, ‘Effective Strategies for Suicide Prevention in New Zealand’.
66 Mann et al, ‘Suicide Prevention Strategies’.
67 Nordentoft, ‘Crucial Elements in Suicide Prevention Strategies’.
68 van der Feltz-Cornelis et al, ‘Best Practice Elements of Multilevel Suicide Prevention Strategies’.
7 Findings: Appropriateness

Key findings

- While gatekeeper training and community capacity-building activities were among the selective approaches reported by the 49 projects, considerable variations exist in how these activities were delivered between target groups and settings. Services for people bereaved by suicide featured prominently. While only one project targeted knowledge and awareness of medical practitioners, there are a number of other initiatives that support GPs to better identify and refer suicidal patients to appropriate care. These include initiatives such as the ATAPS Suicide Prevention service initiative (Section 4.8) and the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Program.

7.8 Indicated approaches

Drawing on the peer-review literature, a summary of the current evidence/best practice related to indicated approaches is provided below.

Summary of current evidence/best practice

There is promising evidence that improving support for people after suicide attempts may be an effective indicated strategy. Interventions include improving access to and coordination of mental health services.

There is some evidence that pharmacotherapy for mental illness as an indicated approach may reduce suicidal behaviour, despite controversies surrounding potential adverse effects of some classes of medication.

For people with mental illness, psychotherapy and psychosocial interventions have also been shown to be appropriate indicated approaches. In some studies these interventions have demonstrated a reduction in suicidal behaviour, either alone or in combination with medication.

Findings in relation to NSPP-funded activities

As indicated in Section 0, the NSPP-funded projects received referrals from, and made referrals to, a wide range of other organisations. Several projects aimed to improve access to care and support pathways for people following suicide attempts (for example, by improving transition from the emergency department to primary care or community mental health services).

Few of the in-scope NSPP-funded projects had a specific focus on pharmacotherapy, psychotherapy or psychosocial interventions for people with diagnosed mental illness. However, the ATAPS Suicide Prevention service initiative (Section 4.8) included these types of interventions.

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[70] Mann et al, ‘Suicide Prevention Strategies’.
[71] Nordentoft, ‘Crucial Elements in Suicide Prevention Strategies’.
[72] van der Feltz-Cornelis et al, ‘Best Practice Elements of Multilevel Suicide Prevention Strategies’.

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7 Findings: Appropriateness

### Key findings
- Several projects used indicated approaches aimed at improving access to care and support pathways for people following suicide attempts (for example, by improving transition from the emergency department to primary care or community mental health services).

#### 7.9 Approaches which may be harmful

The peer-reviewed literature points to some interventions which may potentially be harmful. It has been suggested that the following approaches be avoided until there is clear evidence that their use is both beneficial and without risk. These include:

- School-based programs that focus on raising awareness about suicide
- Public health messages about suicide (due to a fear of normalising suicide)
- ‘No-harm’ or ‘no-suicide’ contracts in mental health settings
- Recovered or repressed memory therapies.

### Findings in relation to NSPP-funded activities

While several NSPP-funded projects are based in schools, these appear in most instances to focus on competency development and skill enhancement rather than awareness-raising alone. This approach has some support from the literature. Please note that MindMatters, which is a large-scale school-based intervention, is discussed in detail in Section 11.4.

Based on the available information, no projects appear to be advocating ‘no-harm’ or ‘no-suicide’ contracts, or recovered or repressed memory therapies.

### Key findings
- None of the NSPP-funded projects reported use of activities or approaches that were identified in the peer-reviewed literature as potentially harmful.

#### 7.10 Use of research and evidence in project design and implementation

Through the survey, project representatives were invited to provide insight into how their projects had been developed, including the extent to which evidence was used in the development of strategies. Of the 45 responses received, the following themes featured:

- For more than half the projects, an evidence-based rationale was provided for the specific population subgroup that the project targeted, citing published evidence of the suicide prevalence rates and risk factor profiles.
- For eight projects, explicit reference was made to the evidence base as articulated in the peer-reviewed literature for the interventions implemented.

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73 Beautrais et al, ‘Effective Strategies for Suicide Prevention in New Zealand’. 
7 Findings: Appropriateness

- Explicit reference to the LIFE Framework, and the evidence that underpins it, was made for five projects.
- For five projects, a process of ongoing development and refinement as a result of pilot testing and regular evaluation was described.
- In five cases, community consultation led to the identification of gaps in service delivery, or assisted in the development of culturally appropriate interventions for specific settings.
- Three projects were adaptations of overseas initiatives, for which they claimed evidence of effectiveness had been established.

Key findings

- The survey responses indicated that research and evidence was used in project design and implementation for the majority of projects. The range of activities reported included a mix of innovative and established evidence-based activities in terms of target groups, settings and approaches.
7 Findings: Appropriateness

7.11 Summary of key findings

- Overall, the NSPP-funded projects provide a range of activities across the LIFE Action Areas, using a mix of approaches and targeting a broad range of groups known to be at higher risk, as advocated in the LIFE Framework. Importantly, this mix not only occurs at state/territory level but also within individual projects.

- Overall, NSPP-funded projects address most of the recognised target groups. Some gaps are evident at state/territory level in terms of the number of projects and the reported coverage of higher risk groups; however, it is recognised that this does not preclude the existence of such activities funded through different strategies.

- NSPP project funding per capita varied considerably between jurisdictions.

- In general, jurisdictions with the lowest funding per capita were those with the lowest age-standardised suicide rate and those with the highest funding per capita were those with the highest age-standardised suicide rate. Those jurisdictions with greatest need (highest age-standardised suicide rates) were therefore the recipients of highest per capita funding.

- NSPP-funded projects that target Aboriginal and Torres Strait Islander communities reported using culturally appropriate interventions that included gatekeeper training, community-based approaches to promote resilience and community healing approaches that promote cultural practices and cultural continuity, such as ‘return to country’ trips.

- A number of projects used universal approaches to address:
  - Media reporting of suicide and mental illness
  - Awareness-raising and promotion of help-seeking.

- While gatekeeper training and community capacity-building activities were among the selective approaches reported by the 49 projects, considerable variations exist in how these activities were delivered between target groups and settings. Services for people bereaved by suicide featured prominently. While only one project targeted knowledge and awareness of medical practitioners, there are a number of other initiatives that support GPs to better identify and refer suicidal patients to appropriate care. These include initiatives such as the ATAPS Suicide Prevention service initiative (Section 4.8) and the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Program.

- Several projects used indicated approaches aimed at improving access to care and support pathways for people following suicide attempts (for example, by improving transition from the emergency department to primary care or community mental health services).

- None of the projects reported use of activities or approaches that were identified in the peer-reviewed literature as potentially harmful.

- The survey responses indicated that research and evidence was used in project design and implementation for the majority of projects. The range of activities reported included a mix of innovative and established evidence-based activities in terms of target groups, settings and approaches.