8 FINDINGS: EFFECTIVENESS – OUTCOMES AND ACHIEVEMENTS

This chapter examines the outcomes and achievements of NSPP-funded projects to date. The first three sections contextualise the measurement of outcomes, as follows:

1. Need for outcome measures

2. Challenges of measuring outcomes for suicide prevention

3. Outcome measurement by NSPP projects.

The subsequent sections assess outcomes and achievements to date:

4. Achievement of project goals and objectives

5. Self-reported LIFE Action Area achievements

6. Unintended outcomes

7. Summary of key findings.

8.1 Need for outcome measures

Effectiveness is defined as the extent to which an intervention or program produces desired or intended outcomes[74]. Outcomes, in turn, include:

> …changes, results, and impacts that may be short or long term; proximal or distal; primary or secondary; intended or unintended; positive or negative; and singular, multiple, or hierarchical. Outcomes are enduring changes, in contrast to outputs, which are more specific.[75]

Outcome measurement must therefore consider different timeframes (long and short-term), whether outcomes are direct or indirect (proximal and distal), and the consequences of initiatives (primary/secondary, anticipated/unanticipated, positive/negative, single/multiple/hierarchical). These factors make outcome measurement complex and require that outcomes be measured at various stages throughout an initiative so that progress can be monitored.

Drawing on these two definitions, effectiveness can be condensed to two main questions:

Question 1: Did interventions/programs deliver what they said they would?

Question 2: What were the outcomes of these intervention/programs?

Outcome measurement is critical for funders and policy makers to assess the effectiveness of individual interventions and of the NSPP overall. Properly executed outcome measurement provides the crucial evidence needed to not only inform economic decisions regarding what interventions should be funded but also the appropriate level of funding to be allocated.

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[74] "Effectiveness is the extent to which an evaluand produces desired or intended outcomes. Effectiveness alone provides a poor assessment of overall evaluand merit or worth: It is possible for something to be 'effective' (ie,, produce desirable intended outcomes) but at the same time produce serious detrimental, if unintended, effects. It is also possible for an evaluand to be highly effective but extremely inefficient or overly costly. Claims of effectiveness require the demonstration of a causal link between the evaluand and the desired changes to show that they are, in fact, outcomes caused by the evaluand and are not coincidental changes." J Davidson, 'Effectiveness'.

[75] S Mathison, 'Outcomes'.

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While ensuring that funding is allocated to the most effective interventions, outcome measurement also provides safeguards that the 'do no harm' imperative presented in the LIFE Framework is adhered to and ensures that the best outcomes are achieved for persons using NSPP-funded services.

The absence of outcome measures make it problematic to establish 'what works for whom in what circumstances, in what respects, and how'. [76] As a result, funding decisions may be influenced by extraneous factors such as community or sector pressure, rather than being evidence-based.

The social and environmental factors related to suicide are complex and dynamic. This means that outcome measurement will always be challenging. While no perfect solution exists to overcome these challenges, the inherent benefits of outcome measurement to funders and policymakers, and to the projects implementing these programs, mean that outcome measurement is a critical area of activity in suicide prevention.

8.2 Challenges of measuring outcomes for suicide prevention

Outcome measurement is a challenge for many public health initiatives. This is largely because of the multifaceted nature not only of the initiatives but also of their outcomes (*Section 8.1*).

Suicide prevention is not exempt from these challenges. Indeed, it could be argued that outcome measurement is particularly challenging given that a determination of death by suicide involves establishing the:

- Mechanism, ie, how a person died

- Intent, ie, whether the death was accidental, homicide or from intentional self-harm (suicide).[77]

This, in essence, involves measuring motivation in an empirical way. This can be problematic, especially, for example, where death or injury from motor accidents[78] and drug overdoses is concerned. Furthermore, while completed suicide is the ultimate, distal outcome measure, other outcome measurements are also pertinent.

As outlined earlier (*Section 4.10.2*), difficulties in outcome measurement in the suicide context are further compounded by the following:

- Suicide rates may be influenced by many factors including a range of personal characteristics as well as socio-cultural factors such as economic conditions, stigma relating to mental illness and suicide, and access to means of suicide.

- Completed suicide is a statistically rare event. This makes it difficult to achieve the statistical power that is necessary to identify patterns and causation, or to draw conclusions about reductions in the suicide rate. This is particularly true in the case of subgroup analysis.

- There is limited suicide data on specific target groups, data on protective and risk factors, pathways to suicide and mental health statistics. This creates difficulties in understanding the impact of programs on target groups.

- Ethical issues make it difficult to randomise people into those who receive help and those who do not. This results in having to use proxy measures in many suicide interventions. Again, problems with low prevalence problems in small subgroups apply.

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[76] R Pawson & N Tilley, *Realistic Evaluation*, Sage Publications, London, 2011.
[77] Australian Bureau of Statistics, *Suicides, Australia, 2010.*
[78] Australian Bureau of Statistics, *Causes of Death, Australia, 2011.*

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- Given that suicide prevention programs do not operate in isolation, attribution is difficult to determine.

Given the long timeframes between some interventions and outcomes (eg, interventions that involve building resilience), the long-term outcomes from programs cannot be measured without longitudinal studies.

Barriers exist in establishing longitudinal effects of programs on reductions in the suicide rate. Small program size and short program duration can diminish statistical power of studies and thus limit the ability to establish causation and assess the effects of the program.

The quality of suicide data is problematic, particularly in relation to timeliness, consistency of process across jurisdictions and improving the identification of Aboriginal and Torres Strait Islander peoples at the time of death.[79] Some have argued that ABS figures underestimate the total figures.[80]

Without appropriate outcome measurement, funders and policy makers may rely on anecdotal and other information to determine whether a program should be continued, expanded upon, refined or eliminated. Such evidence may not be fully representative of outcomes being achieved as projects are likely to present best case examples that may be atypical of the broader cohort(s) served. This not only hinders the extrapolation of findings from individual cases to the broader population but also renders comparison of achievements across projects impractical. Best case examples have clear value, particularly in terms of illustrating what could potentially be achieved, however failure to include negative cases limits the learnings that can be drawn from project experiences.[81]

8.3 Outcome measurement by NSPP projects

All projects are required to report output and financial data as part of their funding agreement and to submit regular progress reports. These progress reports were largely based on quantitative output and financial data, with narrative self-report used to describe the effects of activities. To date, outcome measurement involving validated tools has been rare among NSPP-funded activities. Furthermore, the dearth of validated and standardised tools limited the extent of comparison that could be made between projects engaged in similar activities across the program.

Projects that were required to undergo independent external evaluations under their funding agreement (see *Table 4-1*) tended to generate objectives-based evaluations[82] that addressed achievements relative to input and output objectives, rather than outcomes. Evaluations largely relied on consultations with key stakeholders (service users, community, etc.) as their primary source of data.

The following *Table 8-1* provides an overview of the evaluations conducted for the 47 projects that are both in-scope of the evaluation and that were operating at June 2013.

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[79] Australian Bureau of Statistics, *Causes of Death, Australia, 2011.*
[80] Williams et al, 'Accuracy of Official Suicide Mortality Data in Queensland'.
[81] S Funnell & P Rogers, *Purposeful program theory: effective use of theories of change and logic models*, Jossey–Bass, San Francisco, 2011.
[82] JM Owens, *Program Evaluation – Forms and Approaches*, 3rd edn, Allen & Unwin, NSW, 2006, p48.

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Table 8-1: External evaluation profile of projects

- 29 of 47projects (62%) had an external evaluation completed
- 31 independent external evaluation reports were generated, of which two projects each had two reports related to different aspects
- In addition one economic analysis was commissioned by the project, independent of their NSPP funding requirements
- These 31 evaluation reports were completed by:
  - Private consultants (15, 48%)
  - University (14, 45%)
  - Not for profit organisation (1, 3%)
  - Jointly between private consultant and project personnel (1, 3%)
- Three evaluations cited use of validated outcome measurement instruments:
  - Clinical Global Impressions Scale
  - Harter Social Acceptance Work Readiness Questionnaire
  - Kessler Psychological Distress Scale (K10)
- Various qualitative and quantitative data collection methods were used in these evaluations, including:
  - Customer satisfaction surveys
  - Social network analysis
  - Surveys
  - Participant observation
  - Document review
  - Case notes
  - Community visits
  - Focus groups
  - Semi-structured interviews
  - Key informant interviews
  - Review of output data
  - Un-validated quality of life measures.

As indicated above, only three validated tools were used, namely:

- Clinical Global Impressions Scale
- Harter Social Acceptance Work Readiness Questionnaire
- Kessler Psychological Distress Scale (K10).

The fact that two of the three tools cited were clinical tools highlights that:

- Individual level interventions are generally more easily assessed using validated tools than group/community activities
- Suicide is often perceived predominantly in mental health terms; a perception that fails to acknowledge the complex array of personal, social and community factors that need to be

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considered in suicide prevention and overlooks an extensive range of suicide prevention activity that aims to address these factors.

This focus on validated tools in this section should not be interpreted as diminishing the 'merits in multiple methods, marrying quantitative and qualitative data'.[83] The use of both quantitative (validated and/or standardised tools, as appropriate) and qualitative data sources are strongly advocated for further NSPP evaluations (see *Chapter 12*).

However, it should be recognised that the diverse range of methods used by projects in their evaluations limits comparisons that can be made across projects. The use of bespoke tools (such as customer satisfaction and general surveys) restricts inter-project comparisons if these tools are not standardised across projects. Without common domains or measures, the relative achievement of different approaches cannot be ascertained. It is noted that bespoke tools were used in situations where validated tools currently exist.

This dearth of comparative outcome data has restricted not only the extent to which the effectiveness of the NSPP could be evaluated in this current report, but also the range of economic analysis that could be conducted.

Strategies to improve outcome measurement are identified in *Chapter 12*.

Key findings

- Outcome measurement using validated tools is rare among NSPP-funded activities. A range of quantitative and qualitative information was collected; however the dearth of validated and standardised tools limited the extent of comparison that could be made between projects engaged in similar activities across the program.

- The absence of quantifiable outcome data restricted not only the extent to which the effectiveness of the NSPP could be evaluated in this current report, but also the range of economic analysis that could be conducted.

8.4 Achievement of project goals and objectives

A wide range of activities were delivered by NSPP projects, as detailed in *Chapters* 5 and 6. MDS data illustrates the intensity of project activity over the six month period of data collection to date. A total of 16,222 individual activities and 2,425 group activities were reported.

A diverse range of process-related goals was cited in the project documentation/data for the 49 projects evaluated. Most projects, including those still in their infancy, reported having achieved their objectives.

The range of self-reported achievements included:

- Development of collaborative arrangements.
- Involvement of community and family.
- Quantity of individuals and families that the project had been in contact with.

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[83] Pawson & Tilley, *Realistic Evaluation.*

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- High levels of satisfaction with training activities or resources, and evidence of knowledge or attitude change as a result of training level of community awareness of the project. In some cases projects reported that they had become well known in the community they served, and word of mouth meant that advertising of events became increasingly unnecessary as people brought family, friends or colleagues along to events. As described in *Section 5.9*, 65% of projects reported very high levels of community acceptance.

- Training of workers to recognise at risk colleagues and workers' improved capacity to respond.

- In one community, the establishment of a drop in centre has provided a very positive space for young people who would otherwise have nowhere to go to seek support and assistance for LGBTI issues.

- Reports that suicide was talked about more readily in the community; thereby generating increased awareness and improved knowledge of how to access help when required. In some communities, people were interested in learning how to help and suicide had become 'everyone's business'.

- Increased numbers of calls to crisis lines in line with promotional activities.

Setting easily achievable goals and taking one step at a time emerged as a strategy that worked well in these suicide prevention projects. Several projects commented that the project goals or timeframes they had listed early in their inception phase were unachievable and reported that they had later modified these goals to reflect the real life difficulties of implementing projects of this nature in communities. It was often reported that in many communities, connections first needed to be forged and trust built before work could commence on specific suicide prevention activities.

Projects reported that they aimed to provide holistic, coordinated outcomes and flexible service delivery within their staffing and budgetary limitations. Developing linkages between organisations, people and communities were high priority areas of work for many projects, with 92% of projects reporting that they collaborated with other organisations (see *Section 5.10*), and extensive referral networks were developed (see *Section* 0). The degree to which consumers experienced seamless, coordinated service delivery, could not be measured as consultations with consumers was not within the scope of this evaluation.

Key findings

- Most projects, including those still in their infancy, reported having achieved their objectives.

- Developing linkages between organisations, people and communities were high priority areas of work for many projects, with 92% of projects reporting that they collaborated with other organisations, and that extensive referral networks were developed.

8.4.1 Perspectives of DoHA grant administrators

Representatives from DoHA Central Office (CO) and State and Territory Offices (STO) that administer the NSPP-funded projects were given the opportunity to comment on how project impacts and outcomes were reported.

Many expressed concern that the existing reporting mechanisms (through the EDR form, progress reports and final reports) did not adequately capture data on outcomes and impacts, which meant that in some cases it was difficult to justify whether projects should continue to be funded.

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Their assessments of project outcomes and achievements were therefore largely based on word-of-mouth reports from project staff or other stakeholders and the content of the progress and final reports.

> **Key findings**
>
> - DoHA staff that administer the NSPP-funded projects expressed concern that the existing reporting mechanisms (progress reports, final reports) did not adequately capture information about project outcomes and impacts.

8.5 Self-reported LIFE Action Area achievements

As outlined in *Section 5.5*, projects reported that activities occurred across all six LIFE Action Areas. Multiple LIFE Action Areas were being addressed by most projects.

Overall, self-reported achievement scores differed little across the 19 components of the LIFE Action Areas, with average scores per component ranging from 3.41 and 4.06 (see *Figure 5-3*). This suggests that project staff consider that they are effectively targeting their suicide prevention work to the LIFE Action Areas.

The data suggests that LIFE Action Area 5.2 (Systematic, long-term, structural interventions), which achieved an average score of 3.06, may be an area requiring more attention. This finding may be partially explained by the short-term nature of NSPP funding and the limitations this imposes on achieving long-term or structural change.

Drawing on the project documentation/data, the following provides illustrative examples of the self-reported achievement of objectives for each of the six LIFE Action Areas.

LIFE Action Area 1: Improving the evidence base and understanding of suicide prevention

Understanding of imminent risk and how best to intervene

This outcome was primarily addressed through 'gatekeeper training' including training aimed at first responders such as police and other emergency services personnel. Some school-based training interventions also addressed these issues.

Understanding of whole-of-community risk and protective factors, and how best to build resilience of communities and individuals

Most projects with a community focus reported some achievement in this regard. Some projects demonstrated considerable effort to understand the unique needs of the population they served (eg, understanding the particular areas of vulnerability/distress for young people from refugee backgrounds or Indigenous people). This was achieved through extensive stakeholder involvement in the development of strategies to ensure appropriate interventions.

Other projects improved understanding of risk and protective factors through community capacity-building and training activities which meant that that the community as a whole was better equipped to respond to risk of suicide.

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The extent to which projects contributed to the evidence base, particularly in relation to how best to build community and individual resilience, is difficult to ascertain due to the variable availability and quality of existing project evaluations. Communications with project stakeholders highlighted the need for greater opportunities for information sharing among projects about what strategies they have found to be effective. A number of project representatives noted that the opportunity to meet representatives from other projects during the August 2012 workshops held to develop the MDS was very beneficial, as it provided an opportunity to interact with their peers and share information.

Application and continued development of the evidence base for suicide prevention among high-risk populations

Based on the current literature on suicide prevention, a strong evidence base does not exist for many of the interventions that are currently funded under the NSPP. This is not to say that these interventions are not effective. As discussed in *Section 4.10*, lack of evidence is one of the key evaluability issues that apply to suicide prevention activities generally. It would therefore be erroneous to equate lack of strong evidence with ineffectiveness.

Many of the projects reported that they were responding to perceived community need or working with a model that had been evaluated as effective in another setting. Others described a process of continual review and evaluation which enabled activities to be refined.

Improved access to suicide prevention resources and information

Provision of suicide prevention resources and information formed part of the activities of most projects. This was achieved through training, workshops, other promotional activities (eg, talks to community groups), development of websites, or provision of print resources. Other ways that projects achieved this outcome included dissemination of research on suicide prevention, and by encouraging/reminding journalists of the need to include helpline numbers when publishing media articles relating to suicide or mental health.

Key findings

- 'Gatekeeper training' including training aimed at first responders such as police and other emergency services personnel and school-based training interventions, were the main strategies used to develop understanding of imminent risk and how best to intervene.

- Most projects reported they were responding to perceived community need or working with a model that had been evaluated as effective in another setting.

- Provision of suicide prevention resources and information was part of the activities of most projects. This was achieved through training, workshops, other promotional activities (eg, talks to community groups), development of websites, provision of print resources, research dissemination and encouraging publication of helplines in media articles.

LIFE Action Area 2: Building individual resilience and the capacity for self-help

Section 5.5 shows that LIFE Action Area 2 represented the LIFE Action Area that projects considered they were making the greatest progress. Self-reported achievements for Action Area 2 are described below.

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Improved individual resilience and wellbeing

Improved individual resilience and wellbeing was demonstrated by a number of projects, particularly those with an individual or community focus. Several projects demonstrated improvements in:

- Interpersonal and school functioning
- Self esteem
- Health and wellbeing
- Personal behaviour strengths.

The ability to develop positive coping strategies which could be employed in times of adversity was emphasised, as were behavioural actions to reduce risk factors and strengthen protective factors. These included:

- Talking to a family member or friend about mental health and/or suicide
- Visiting websites of services or contacting services/helplines directly
- Raising issues/concerns with health professionals.

In addition, there were anecdotal reports of clients 'bouncing back more easily', as well as documented improvements in 'positive connection to their identity' (for LGBTI clients). A key finding from a service delivering support to people bereaved by suicide was that the service led to improvements in clients' measures of 'happiness' and 'vitality' such that their grief experience was 'normalised' to levels similar to those of people who had experienced a recent non-suicide trauma or loss.

An environment that encourages and supports help-seeking

The extent to which the NSPP-funded projects promoted an environment that encourages and supports help-seeking was mixed. A number of projects facilitated help-seeking by promoting services (eg, formal counselling services or informal support groups) and improving referrals to services. There is also evidence that population-wide social marketing approaches have been effective in promoting help-seeking. For example, a key message of RUOK? Day (2010 campaign) was 'It's OK to admit that you are not coping', and this reportedly resulted in a spike in referrals to SANE Australia.

Nevertheless, encouraging help-seeking is a challenging goal that hinges on broader socio-cultural factors including stigma and social norms. It may also be affected by the extent to which services are perceived to be appropriate or helpful (eg, LGBTI, Aboriginal cultural appropriateness), and for some groups in particular, cultural norms around stoicism and independence (eg, men, and rural men in particular).

> **Key findings**
> - Improved individual resilience and wellbeing was demonstrated by a number of projects, particularly those with an individual or community focus.
> - The extent to which the NSPP-funded projects promoted an environment that encourages and supports help-seeking was mixed.

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LIFE Action Area 3: Improving community strength, resilience and capacity in suicide prevention

Improved community strength and resilience

It is difficult to determine the extent to which the funded projects improved community strength and resilience. Improved cohesion and resilience was reported in some well-defined target populations, eg, certain projects targeting Aboriginal and Torres Strait Islander people in rural/remote Australia. While many of the projects undertook training, education, workshops and others focused on improving community networks (through support groups, camps and a range of recreational activities), the extent to which these resulted in meaningful changes in community strength and resilience cannot be measured based on the existing documentation or data sources.

Increased community awareness of what is needed to prevent suicide

Many of the projects achieved improved community awareness of what is needed to prevent suicide. Strategies used to do so included training (particularly gatekeeper training) workshops/conferences, provision of information through a range of media and strengthening referral pathways. As previously suggested, more support for information sharing between organisations delivering suicide prevention programs is likely to assist with achieving increased community awareness.

Improved capability to respond at potential tipping points and points of imminent risk

A range of projects improved capabilities to respond at points of imminent risk through providing access to counsellors/support (notably to high-risk groups, such as people who had been recently bereaved) and through gatekeeper training and improvements to referral pathways. Several projects that undertook training of frontline workers reported that participants had improved their skills and confidence in interacting with people at imminent risk of suicide.

Key findings

- Improved cohesion and resilience was reported in some well-defined target populations (eg, certain projects targeting Aboriginal and Torres Strait Islander people in rural/remote Australia)

- Many of the projects improved community awareness of what is needed to prevent suicide

- Limited opportunities existed for projects to share strategies/best practice

- A range of projects improved capabilities to respond at points of imminent risk through providing access to counsellors/support.

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Local services linking effectively so that people experience a seamless service

The development of partnerships and linkages was an important component of almost all projects. In the survey, 92% of projects reported that they collaborated with other organisations (*Section 5.10*) while the MDS data revealed extensive referral networks (*Section* 0) From the pre-existing project documentation/data, it was evident that this was also one of the most challenging tasks for many projects. In some cases partnerships were formalised through Memoranda of Understanding while in other cases they were less formal in nature. Examples of cross-sector collaborations included partnerships between police and mental health services, and between ambulance services and bereavement services.

The extent to which the linking of services led to provision of a seamless service cannot be measured based on existing project documentation or available data. While examples of improved referral pathways as a result of partnerships and linkages were described, cases in which services did not work together effectively were also recounted. The reasons for ineffective partnerships and collaborations included lack of shared vision, competing priorities, or perceived competition for clients or funding (these are described in more detail in *Section 9.2.4)*. In cases where these barriers occurred, the client journey may have been impeded.

Program and policy coordination and cooperation, through partnerships between governments, peak and professional bodies and non-government organisations

There is evidence of a shared vision and cooperation between policy stakeholders in relation to suicide prevention. This has been demonstrated through the efforts to align the NSPS with other Australian government initiatives as well as state/territory suicide prevention strategies (although, as outlined in *Chapter 11*, there is room for improvement in this regard).

However, at the project level, many project representatives indicated that they lacked knowledge about other suicide prevention projects. Others reported feeling isolated and expressed a desire for support and advice from other services grappling with similar problems (particularly in relation to community engagement and evaluation).

Regionally integrated approaches

Although data was not specifically collected about the extent to which regional integration occurs, there was little evidence that there were regionally integrated approaches operating.

Key findings

- While high levels of partnerships and linkages were reported in the survey, this was an area of challenge for many projects.

- Policy stakeholders had significant shared vision and cooperation in relation to suicide prevention. However, many project staff reported a lack of knowledge about other suicide prevention initiatives.

- There was little evidence that there were regionally integrated approaches operating.

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Improved access to a range of support and care for people feeling suicidal

The majority of funded projects undertook activities to improve access to support and care for people feeling suicidal. These activities addressed the needs of a range of high-risk groups and demonstrated that a wide range of services were available (although not for all risk groups in all areas). A wide range of approaches were used to promote these services, which increased the likelihood of uptake. While it is not possible or practical to quantify how many of the recipients of these services were feeling suicidal, most projects had an appropriate focus on the groups known to be at higher risk. Of note are several projects that have developed partnerships to increase access to referral to services through innovative pathways – for example through linkages between agricultural sector organisations and mental health services.

Systemic, long term, structural interventions in areas of greatest need

As discussed in *Chapter* 5, the body of NSPP-funded projects covered the majority of target groups and geographical areas of need. The extent to which the interventions can be described as systemic, long-term or structural is variable. Projects which focused on collaboration, partnerships and linkages (eg, improving referral practices from the hospital to community sector, or partnerships between the funded organisation and Youth Diversion programs) have potential to be sustained beyond the life of the funding period.

Similarly, projects that focused on training and upskilling (eg, through train the trainer approaches) are more likely to have long-term effects compared with, for example, approaches relying on passive dissemination of information (provided that those trained are able to enter or remain in the workforce). A number of projects, while addressing areas of need, acknowledged that systemic, long-term change was beyond their scope given the short-term nature of the NSPP funding.

Reduced incidence of suicide and suicidal behaviour in the groups at highest risk

Based on the information available for this review, it is not possible to evaluate the extent to which the projects reduced the incidence of suicide or suicidal behaviour in the groups at highest risk. While several projects reported improvements in knowledge, attitude and behaviours relating to suicide prevention, and others showed decreased levels of suicidal ideation, distress, anxiety and depression (in some cases assessed with validated tools such as the K10+), data on the incidence of suicide and suicidal behaviour before or after the interventions was not collected.

Project reports included comments from project participants that suggested that involvement in the project may have deterred them from attempting suicide. For example '*I could not have made it through without your support*'; '*I didn't realise how close I was to committing suicide before receiving counselling*'. See *Section8.2* for a discussion of challenges relating to measuring the impact of programs on the suicide rate.

Improved understanding, skills and capacity of front-line workers, families and carers

A number of projects addressed the aim of improving the understanding, skills and capacity of a range of workers including teachers, health professionals, police, community workers and Aboriginal Health Workers. In many cases the training programs used were established and well-researched programs (such as ASIST and SafeTALK). Other projects have targeted community groups, people bereaved by

suicide and other high-risk groups. A number of projects reported high levels of satisfaction with training or workshops, as well as positive changes in knowledge and attitudes.

Key findings

- The majority of funded projects undertook activities to improve access to support and care.

- The ability to achieve long-term, structural change was beyond the scope of many projects. Many projects reported that this was partly due to the short-term nature of NSPP funding.

- Several projects demonstrated improvements in knowledge, attitudes and behaviours of groups at high risk, but the extent to which this translated into reduced incidence of suicide or suicidal behaviour is not known.

- A number of projects undertook activities that improved the understanding, skills and capacity of front-line workers, families and carers.

LIFE Action Area 6: Implementing standards and quality in suicide prevention

Improved practice, national standards and shared learning

The LIFE Framework emphasises that suicide prevention programs need to reflect the evidence of what does and does not work, and to communicate this effectively to the point of need. A number of examples of improved practice at a project level have been identified in this Final Report. In some cases, projects reported that activities have been refined in light of evaluation or review. Processes have also been undertaken to document best practice, for example by capturing the insights of senior workers and formalising processes in manuals or policy documents.

Several projects demonstrated commitment to shared learning. This was achieved through development of partnerships and networks, presentations at meetings and conferences and development of resources.

In addition, there is evidence of stakeholders in suicide prevention sharing knowledge via the physical and online communication channels provided through the LIFE Communications program, however, there is arguably scope for this to improve, given that many project representatives reported limited awareness of other suicide prevention activities underway.

Improved capabilities and promotion of sound practice in evaluation

Evaluation reports for 37 projects were supplied for this evaluation (see *Section 4.2*); however the quality of the reports was variable with many being largely descriptive in nature. In addition, inadequate project evaluation was listed as a shortcoming for a number of projects, with staff often indicating that they felt they would benefit from more evaluation advice and expertise through the NSPP (see *Section 9.3.3*). These findings suggest that there is scope to better support project staff to improve evaluation capabilities.

Systemic improvements in the quality, quantity, access and response to information about suicide prevention programs and services

To date, information about suicide prevention programs and services generated at a project level has been channelled centrally to DoHA as part of projects' regular reporting requirements under funding

agreements. Analysis of this aggregate data has not been made available in the public domain or to funded projects (although there is potential for this with the MDS). While several projects focused on disseminating information about suicide prevention programs and emerging research, there is arguably scope to improve the consistency and systemic nature of information provision.

Key findings

- A number of projects demonstrated a commitment to shared learning and several projects were funded to either conduct or disseminate research. However there is scope to improve communication between projects.

- Evaluations were not a requirement under all project funding agreements. This has implications for the level of systemic improvements that could be achieved.

- Many project representatives expressed a desire for greater support to evaluate their activities.

- Analysis of aggregate data generated through the NSPP has not as yet been made available in the public domain or to projects funded.

8.6 Unintended outcomes

To understand what works in what situations, it is important to review both the intended and unintended outcomes of interventions.[84] This section reviews the unintended outcomes of NSPP-funded activities. A thematic analysis of project documentation and free-text responses within the MDS identified a number of unintended outcomes, both positive and negative, that impact the assessment of program effectiveness. The unintended outcomes are outlined below.

8.6.1 Positive unintended outcomes

Three main categories of positive unintended outcomes were identified:

- Positive reciprocity
- Extended reach and/or goal expansion
- Adverse community circumstances leading to project 'down time' which can be used to project advantage.

Positive reciprocity

Positive reciprocity was demonstrated when project participants/recipients or other stakeholders 'gave back' to the project in some way. Examples include:

- Project recipients became volunteers for projects
- Project participants contributed (unplanned) interviews to enrich the content of DVDs
- Commercial organisations and celebrities provided pro bono assistance with suicide prevention media campaigns
- Grateful recipients of counselling raised funds for service providers.

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[84] Funnell & Rogers, *Purposeful Program Theory.*

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Extended reach and/or goal expansion

A second positive unintended outcome was observed for several projects which reported wider reach than intended or expansion of goals. Examples include:

- More people were trained than originally anticipated

- More referrals were received than expected (including for example, people who had been bereaved longer ago than expected, and more referrals via word of mouth than expected)

- Supporting young people to deal with their mental health issues resulted in some cases, in them being more able to engage in school and/or training programs although these outcomes were not particular targets of the program

- In one case, a project assisted with the emergency response to a flood. This included connecting the community with service providers, but for a different purpose than originally intended.

Adverse circumstances leading to project 'down time'

In some projects, adverse natural circumstances such as fires, floods or the rainy season can lead to the project workers having time to review materials, create new networks or support people and raise profile in ways that are not part of usual business. Not being physically able to conduct visits or workshops may mean there is time for advocacy or education work that may not be achieved whilst 'usual business' takes precedence.

In some cases, waiting for a new staff member to be appointed can also be a time for reflection and reorganisation, planning and materials review. Although there may be interruption to service provision at these times, the opportunity for reinvigorating aspects of the project was sometimes welcome.

8.6.2   Negative unintended outcomes

Two main types of negative unintended outcomes were identified:

- Stigma
- Encouraging better help-seeking behaviour leading to inability to meet need.

Stigma

Stigma, which projects identified as a key barrier to help-seeking, is not only a recognised barrier in suicide prevention but also in mental health and other areas of the health and human services systems.[85] In some cases, projects reported that their activities may unintentionally result in an increased experience of stigma for participants involved.

Several organisations, which provided suicide prevention services at, or close to a Probation and Parole Office or a mental health organisation, reported that there was a perception among the public that all service users had been involved with the criminal justice system or had a mental illness. They suggested that as a result some people may have been reluctant to use the services because of this perceived association.

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[85] World Health Organisation, *Public Health Action for the Prevention of Suicide: A Framework*, World Health Organisation, Geneva, 2012.

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8 Findings: Effectiveness – Outcomes and achievements

Encouraging better help-seeking behaviour leading to inability to meet need

Several projects provided information about the need to be careful about service promotion and generating high community expectations that could not be met. For example, some projects reported knowing there was a need for services in neighbouring areas but were unable to meet expanded need within current budgetary constraints. As a consequence, they had to limit promotion of activities to specific geographical areas or target groups.

8.7   Summary of key findings

- Outcome measurement using validated tools is rare among NSPP-funded activities. A range of quantitative and qualitative information was collected; however the dearth of validated and standardised tools limited the extent of comparison that could be made between projects engaged in similar activities across the program.

- The absence of quantifiable outcome data restricted the extent to which the effectiveness of the NSPP could be evaluated.

- Most projects, including those still in their infancy, reported having achieved their objectives.

- Developing linkages between organisations, people and communities were high priority areas of work for many projects, with 92% of projects reporting that they collaborated with other organisations, and that extensive referral networks were developed.

- DoHA staff that administer the NSPP-funded projects expressed concern that the existing reporting mechanisms (progress reports, final reports) did not adequately capture information about project outcomes and impacts.

- 'Gatekeeper training,' including training aimed at first responders such as police and other emergency services personnel and school-based training interventions, were the main strategies used to develop understanding of imminent risk and how best to intervene.

- Most projects reported they were responding to perceived community need or working with a model that had been evaluated as effective in another setting.

- Provision of suicide prevention resources and information was part of the activities of most projects. This was achieved through training, workshops, other promotional activities (eg, talks to community groups), development of websites, provision of print resources, research dissemination and encouraging publication of helplines in media articles.

- Improved individual resilience and wellbeing was demonstrated by a number of projects, particularly those with an individual or community focus.

- The extent to which the NSPP-funded projects promoted an environment that encourages and supports help-seeking was mixed.

- Improved cohesion and resilience was reported in some well-defined target populations (eg, certain projects targeting Aboriginal and Torres Strait Islander people in rural/remote Australia).

- Many of the projects improved community awareness of what is needed to prevent suicide.

- Limited opportunities existed for projects to share strategies/best practice.

- A range of projects improved capabilities to respond at points of imminent risk through providing access to counsellors/support.

- While high levels of partnerships and linkages were reported in the survey, this was an area

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of challenge for many projects.

- Policy stakeholders had significant shared vision and cooperation in relation to suicide prevention. However, many project staff reported a lack of knowledge about other suicide prevention initiatives.

- There was little evidence that there were regionally integrated approaches operating.

- The majority of funded projects undertook activities to improve access to support and care.

- The ability to achieve long-term, structural change was beyond the scope of many projects. Many projects reported that this was partly due to the short-term nature of NSPP funding.

- Several projects demonstrated improvements in knowledge, attitudes and behaviours of groups at high risk, but the extent to which this translated into reduced incidence of suicide or suicidal behaviour is not known.

- A number of projects undertook activities that improved the understanding, skills and capacity of front-line workers, families and carers.

- A number of projects demonstrated a commitment to shared learning and several projects were funded to either conduct or disseminate research. However there is scope to improve communication between projects.

- Evaluations were not a requirement under all project funding agreements. This has implications for the level of systemic improvements that could be achieved.

- Many project staff expressed a desire for greater support to evaluate their activities.

- Analysis of aggregate data generated through the NSPP has not as yet been made available in the public domain or to projects funded.

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