Evaluation of Suicide Prevention Activities

Final Report
January 2014
Acknowledgments

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>AHA</td>
<td>Australian Healthcare Associates</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AOD</td>
<td>Alcohol and Other Drug</td>
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<td>ASPAC</td>
<td>Australian Suicide Prevention Advisory Committee</td>
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<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<tr>
<td>CCBTP</td>
<td>Community Capacity Building and Training Project</td>
</tr>
<tr>
<td>CO</td>
<td>Central Office (Department of Health and Ageing)</td>
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<tr>
<td>DASS</td>
<td>Depression Anxiety and Stress Scales</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing (Australian Government)</td>
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<td>DNA</td>
<td>Department of Health and Ageing National Alignment</td>
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<tr>
<td>EDR</td>
<td>Evaluation Data Report</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent (staff)</td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners</td>
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<tr>
<td>LAA</td>
<td>LIFE Action Area</td>
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<tr>
<td>LGA</td>
<td>Local Government Authority</td>
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<tr>
<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
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<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
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<tr>
<td>MSSI</td>
<td>Modified Scale for Suicidal Ideation</td>
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<tr>
<td>NGO</td>
<td>Non-government organisation</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>National Suicide Prevention Program</td>
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<td>National Suicide Prevention Strategy</td>
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<td>National Youth Suicide Prevention Strategy</td>
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<tr>
<td>PAI</td>
<td>Principals Australia Institute</td>
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<tr>
<td>RD</td>
<td>Research and Development</td>
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<td>STO</td>
<td>State or Territory Office (Department of Health and Ageing)</td>
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<td>TATS</td>
<td>Taking Action to Tackle Suicide</td>
</tr>
<tr>
<td>VOIP</td>
<td>Voice Over Internet Protocol</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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1 Executive summary

1 EXECUTIVE SUMMARY

Australian Healthcare Associates (AHA) was appointed by the Australian Government Department of Health and Ageing (DoHA) in May 2012, to undertake the Development and Implementation of an Evaluation Framework for Suicide Prevention Activities (the Evaluation). The Evaluation assessed activities funded under the National Suicide Prevention Program (NSPP) and selected elements of the Taking Action to Tackle Suicide (TATS) package, over the seven-year period from 2006-07 to 2012-13.

This Final Report presents the Evaluation results and findings.

1.1 Introduction and background

Suicide is a significant public health problem, both in Australia and internationally. Suicide-related behaviour, both fatal and non-fatal, has substantial emotional effects on family, friends, peers, and general community, and from an economic point of view, places a considerable burden on health care resources. Pathways to suicide are often complex and multi-faceted, and prevention strategies therefore encompass a wide range of approaches.

In Australia, the National Suicide Prevention Strategy (NSPS) provides the platform for national policy on suicide prevention. One component of the NSPS is the Living Is For Everyone (LIFE) Framework which provides the overarching evidence-based strategic policy framework for suicide prevention in Australia. Originally developed in 2000 and updated in 2007, the LIFE Framework outlines the vision, purpose, principles, action areas and proposed outcomes for suicide prevention in Australia. In September 2011 the LIFE Framework was adopted in all jurisdictions as Australia’s overarching suicide prevention framework.

The NSPS is operationalised through the National Suicide Prevention Program (NSPP). This Australian Government program provides funding to a range of projects, including local community-based projects as well as national projects that take a broad population health approach to suicide prevention, including research. Drawing upon the priorities set out in the LIFE Framework, the NSPP funds universal, selective and indicated suicide prevention activities.

The Taking Action to Tackle Suicide (TATS) package was part of the Australian Government’s response to the Senate Community Affairs References Committee Inquiry into Suicide in Australia and was introduced as a 2010 election commitment. The TATS package provides further support for suicide prevention through universal and population-wide approaches and through community-led responses.

The central aim of the NSPP/TATS program is to reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour in Australia.

As indicated above, this Evaluation examined activities funded under the NSPP and selected elements of the TATS package, over the period from 2006-07 to 2012-13.

1.2 Objectives of the Evaluation

The Evaluation analysed NSPP/TATS-funded project activities from 2006 to 2013 and had two broad objectives:

- Evaluate existing activity under the NSPP and new activities funded under the 2010 TATS package, in order to determine appropriateness, effectiveness and efficiency of these activities within the broader policy context.
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- Inform the evidence base for future policy direction and implementation of suicide prevention activity and to create and put in place a comprehensive evaluation framework for ongoing use.

This Final Report presents:

- Introduction (Chapter 2), background and policy context (Chapter 3) and details of the evaluation methods adopted (Chapter 4)
- Profile of the in-scope NSPP/TATS-funded projects (Chapter 5 and Appendix A), plus a snapshot of project activities over the six months to March 2013 (Chapter 6)
- Findings in relation to the appropriateness, effectiveness and efficiency of the specified projects (Chapters 7 to 10)
- The policy context for the NSPP and findings relating to the alignment and integration of the NSPP with other suicide prevention efforts underway in Australia (Chapter 11)
- Suggestions to improve outcome measurement of suicide prevention activities (Chapter 12) and an overall summary of findings, suggested improvements and conclusions (Chapter 13).

Chapters 5 to 11 each conclude with a summary of findings.

1.3 Methods

The Evaluation employed a mixed methods approach, using both quantitative and qualitative data sources. Information was obtained from:

- Project documentation/data submitted to DoHA by funded organisations, as part of DoHA’s contract management of the 49 projects evaluated. This includes funding agreements, progress reports, final reports, internal evaluations and external evaluations
- An online survey developed by AHA that was completed by projects, comprising a mix of closed questions, rating scales and open-ended text responses
- Workshop consultations with project representatives conducted late in 2012
- Consultations with key stakeholders including:
  - State/territory government representatives responsible for developing/implementing jurisdictional suicide prevention strategies (referred to as jurisdictional suicide prevention representatives)
  - Peak body representatives
  - Suicide prevention experts
- Consultations with representatives from DoHA Central Office (CO) and State and Territory Offices (STO) that are responsible for administering NSPP-funded project activities (referred to as DoHA STO/CO representatives)
- Published evaluation reports of the Access to Allied Psychological Services (ATAPS) Suicide Prevention service initiative) and MindMatters
- Data collected and submitted by 47 projects for the six month period October 2012 to March 2013, using the Minimum Data Set (MDS) developed and implemented by AHA.

All information was systematically analysed, including thematic analysis of narrative data. A range of descriptive statistics was generated from the quantitative data analysis. The development of findings
1 Executive summary

was supported by the Stage 2 Literature Review (Appendix E), which enabled project activities to be considered in light of the evidence for best practice.

Throughout the Evaluation, an advisory group provided critical feedback regarding the direction of the evaluation and the findings.

1.4 Caveats and limitations

A number of limitations and caveats apply to the findings presented in this Report, particularly in relation to internal and external data. Internal data limitations include incomplete data, the relatively short timeframe of the Evaluation, and the absence of quantifiable outcome measures. External factors relate to the significant challenges involved in evaluating suicide prevention programs which are well recognised in the sector including the fact that suicide is a statistically rare event, attribution is difficult and issues related to the quality and timeliness of suicide data.

1.5 Summary of findings

Key findings are outlined below, under the headings of appropriateness, effectiveness and efficiency. Findings are also presented regarding the position of the NSPP in Australia’s suicide prevention efforts.

1.5.1 Appropriateness

This report demonstrates that 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 occurred at state/territory level but also within individual projects.

Overall, project activities 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 (Section 6.6.2). However, other non-NSPP-funded initiatives (which are not part of this Evaluation) may be filling these gaps.

A mix of universal, selective and indicated approaches was evident in project activities. A number of NSPP-funded projects used universal approaches to address media reporting of suicide and mental illness, awareness-raising and promotion of help-seeking.

Gatekeeper training and community capacity-building activities were among the selective approaches reported by the projects; however, there was considerable variation in the way these services were delivered across target groups and settings. While only one project targeted the 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 the ATAPS Suicide Prevention service initiative (see Chapter 11) and the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Program.

Several projects used indicated approaches which 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.

Importantly, none of the NSPP-funded projects reported using activities or approaches that were identified in the peer review literature as potentially harmful. Survey responses from funded organisations indicated that research and evidence were used in project design and implementation for
1 Executive summary

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.

NSPP project funding per capita varied considerably between jurisdictions. However, 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. Jurisdictions with the greatest need (ie, highest age-standardised suicide rate) were therefore recipients of the highest funding per capita.

1.5.2 Effectiveness: outcomes and achievements

Effectiveness is defined as the extent to which an intervention or program produces desired or intended outcomes.\(^1\) Assessing the effectiveness of NSPP activities was hampered by a general absence of quantifiable outcome measurement by NSPP-funded organisations.\(^2\) As addressed in Chapter 10, outcome measurement is not something that funded organisations have engaged in to any great extent to date. This issue is not unique to the NSPP and has been a challenge for suicide prevention activities throughout Australia and internationally. Routine progress reports submitted by funded organisations were largely based on quantitative output and financial data, with narrative self-report used to describe the effects of activities. Outcome measurement involving validated tools has been rare among NSPP-funded activities. Even in cases where independent external evaluations had been undertaken, most reported on the achievement of project objectives rather than on short, medium or long-term outcomes.

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.

Most projects reported having achieved their objectives. While a lack of outcome data made it difficult for projects to demonstrate their effectiveness, a diverse range of activities and a wide range of project achievements were cited. The MDS identified that 16,222 individual client contacts/activities and 2,428 group activities occurred over the six months to March 2013.

The LIFE Framework lists a number of LIFE Action Areas that describe the intended effect of the NSPS. Projects’ achievements related to these LIFE Action Areas were assessed using documentation/reports and survey responses from funded organisations. Based on this data, self-reported achievements were demonstrated across the full range of LIFE Action Areas, particularly in relation to:

- Improved understanding of imminent risk and how best to intervene (particularly through gatekeeper training and community awareness approaches)
- Improved access to support for people at risk of suicide and, in some cases, improved knowledge, attitudes and help-seeking behaviours of those at high risk
- Improved community strength through capacity-building approaches, particularly for some well-defined target populations
- Provision of information about suicide prevention
- Improving the profile of risk and protective factors at the individual level.

\(^2\) Outcomes 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.’ S Mathison, ‘Outcomes’, in S Mathison (ed), The Encyclopedia of Evaluation, Sage Publications, London, 2007, p.288.
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Although significant achievements have been identified, it should be noted that it is not possible to determine the extent to which the NSPP-funded activities have impacted on rates of suicide.

The documentation/reports and survey responses submitted by funded organisations indicate areas with scope for improvement. These areas include:

- Limited opportunities exist for funded organisations to share strategies/best practice
- There was little evidence that regionally integrated approaches were operating
- The ability to achieve long-term, structural change was beyond the scope of many projects. Many projects reported that this partly due to the short-term nature of NSPP funding
- Many project representatives expressed a desire for greater support to evaluate their activities
- Limited access to information and data about suicide prevention activities.

1.5.3 Effectiveness: enablers and barriers

Project representatives identified several enablers that contributed to the success of projects. Relationship building between service providers and other stakeholders was reported to be vital but time-consuming and sometimes complicated by a lack of clarity around roles and responsibilities.

Recruiting and retaining appropriate staff was identified as important. Maintaining strong relationships within the project staff team and providing staff with adequate support was a high priority for many projects. Where difficulty was encountered with staff recruitment or retention, this presented a significant barrier. Most problems were reportedly due to the short-term nature of NSPP funding or insufficient funding to deliver the number, range, intensity or geographical coverage of services needed.

A further barrier to program effectiveness was difficulties experienced in engaging with some target groups due to:

- Competing priorities within settings such as schools and workplaces
- Social stigma relating to suicide which resulted in a reluctance to talk about suicide or seek help
- Time and distances required to attend meetings/appointments.

Project representatives reported that a number of project-specific design issues had impacted effectiveness, and that sub-optimal data collection and evaluation had limited their ability to measure effectiveness.

Project representatives were asked to provide suggestions for improving project effectiveness. The most commonly cited responses were:

- Improved collaboration with, and coordination between, funded organisations
- Providing support for organisations to improve capabilities in project development and evaluation
- Larger funding amounts and longer funding periods.

1.5.4 Efficiency

Efficiency was examined from an operational perspective, as follows:

- Analysis of the apparent cost efficiency of projects, by relating costs to outputs (ie, hours of service delivered) to calculate and compare average cost per hour.
- Sustainability of projects.
1 Executive summary

- Potential efficiency improvements, based on consultations with project representatives and the Department.

This analysis found that:

- The average cost per hour of service provision varies across projects
- Projects that provide relatively more hours of direct service provision (to individuals or groups) tend to have a lower cost per hour and hence appear to be more efficiently delivering services
- Projects that spend relatively more time on travel and event/activity planning, appear to have higher costs, ie, travel and event/activity planning appear to be key driver of costs.

In relation to sustainability, more than half of the projects indicated that they receive no funding other than through the NSPP (Section 0). The vast majority of project representatives do not believe their project would be sustainable without continued NSPP funding.

Project representatives reported high levels of satisfaction with the level of communication and responsiveness of the DoHA officers responsible for the administration of their project. There were some suggestions for improving DoHA administration of projects, related primarily to improvements in contract management and data collection and storage.

STO and CO staff believed that the DoHA National Alignment (DNA) changes will lead to more efficient administration of the NSPP projects, however these benefits have not yet been realised.

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. This highlights the need for a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia in order to determine the economic benefit of prevention, to help inform future investment decisions.

1.5.5 Positioning the NSPP in Australia’s suicide prevention efforts

The NSPP represents one component within a complex range of suicide prevention activities in Australia. While it was outside the scope of this Evaluation to map these in detail, a desktop review of two initiatives was undertaken; namely the ATAPS Suicide Prevention service initiative and the MindMatters initiative. MindMatters was a national mental health promotion program for secondary schools that addresses some of the risk and protective factors for suicide. Review of previous evaluation reports for these two initiatives indicated that:

- The ATAPS Suicide Prevention service initiative is an appropriate and effective suicide prevention intervention. The efficiency of the program has not been established due to a lack of data.
- MindMatters has had high levels of uptake and acceptance across Australian schools and appears to be an appropriate intervention. The evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of the program.

Through interviews, stakeholders expressed a range of views regarding the positioning of the NSPP in Australia’s suicide prevention efforts. The following findings emerged:

- People working in the suicide prevention sector held mixed and sometimes confused views of what the NSPP is. Many did not see the NSPP as a distinct component of the Australian Government’s activity around suicide prevention, and several confused the NSPP with the NSPS or the LIFE Framework.
1 Executive summary

- Communication and leadership between DoHA, the jurisdictions, states and territories and the sector was seen as an area for improvement, to ensure the NSPP is integrated with other suicide prevention activities in Australia.

- Some stakeholders argued that suicide prevention is too strongly linked to a mental health agenda, at the expense of a broader social determinants approach.

- Stakeholders felt that most of the funded NSPP projects would not be able to continue in the absence of NSPP funding, and that the impact of this would be felt by service users at the local level.

- Stakeholders stressed the importance of a strong and continuing Australian Government commitment to suicide prevention.

- The concept of setting a national suicide reduction target was raised by several stakeholders; however details of what this target should be or how it should be set were not specified.

1.6 Opportunities for program improvement

Based on the findings of this Evaluation, including consultation with stakeholders, the following opportunities for program improvement are presented for consideration, under the headings of effectiveness, efficiency and appropriateness.

<table>
<thead>
<tr>
<th>Effectiveness</th>
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<tbody>
<tr>
<td>1. Positioning suicide prevention</td>
</tr>
<tr>
<td>Suicide prevention should be promoted as a whole-of-government and whole-of-community endeavour that stretches beyond the domain of mental health/illness.</td>
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</table>

2. Evaluation

All Australian Government-funded suicide prevention activities should be rigorously evaluated, with adequate support, access to expertise and resourcing to do this. Where possible, the findings from these evaluations should be made available in the public domain.

3. Improving outcome measurement

A range of factors at project and national level need to be considered to improve outcome measurement and thus facilitate a greater range and depth of evaluation of NSPP activities.

Project-level considerations include: capacity building; oversight and information sharing regarding the use of appropriate qualitative and quantitative tools/measures; and expanding collaborations/partnerships between projects and the research sector to bridge the evidence-practice gap. Outcome evaluation at the macro level (state/territory/national level) is a matter for public health specialists, not individual projects.

At a national level, the key considerations are data related and involve inclusion of suicide attempts (not just completed suicides) as outcome measures, improved data linkages and ongoing improvement of suicide death data.
# Executive summary

## Efficiency

4. *Economic Analysis*

A detailed independent economic assessment is needed of the cost of suicide and attempted suicide in Australia in order to determine the economic benefit of prevention, to help inform future investment decisions.

5. *Administration*

Consideration should be given to administering NSPP funding through a single office in order to improve efficiencies and reduce duplication and fragmentation of suicide prevention efforts.

6. *Funding*

Funding surety would assist projects with recruitment, expansion and sustainability. An open and transparent tendering process would ensure that innovative suicide prevention approaches are supported alongside established programs.

## Appropriateness

7. *Strengthening DoHA’s role*

Opportunities for strengthening the Australian Government’s role in leading and coordinating suicide prevention activities across Australia should be explored. This includes considering:

- Better coordination between federal and jurisdictional suicide prevention activities
- Mechanisms for improved communication and information-sharing between all stakeholders in the suicide prevention sector
- A stronger role for the Australian Government in setting and disseminating the policy agenda (through appropriate consultation)
- Improved coordination, facilitation and funding of strategic, translational research that addresses the key evidence gaps in suicide prevention. Opportunities include:
  - Exploring the most appropriate strategies for those who are at immediate risk
  - Better understanding community risk and protective factors
  - Determining the most effective ways to build community and individual resilience
  - Exploring opportunities for measuring outcomes.

8. *Areas for continued work*

Continued work aimed at improving public awareness about mental health issues, encouraging help-seeking behaviours and reducing stigma is important. Community development in this area provides impetus for social change and the challenging of social norms.
1 Executive summary

1.7 Conclusions

The overall objective of the Evaluation was to inform the evidence base for future policy direction and implementation of suicide prevention activity, and to put in place a comprehensive evaluation framework for ongoing use. This Report provides an analysis of the appropriateness, effectiveness and efficiency of NSPP-funded projects from 2006 to 2013.

The initial retrospective evaluation of the projects encountered many data limitations that were addressed through obtaining more comprehensive data about project activities from the MDS (Chapter 6 and Appendix C) and through in-depth consultations with key stakeholders. Direct engagement with funded organisations has been one of the strengths of the current Evaluation and differentiates it from prior evaluations where such engagement was not possible.

As a result, this Evaluation represents the most extensive evaluation of NSPP-funded activities to date, and provides government with a solid foundation upon which to base future program-related decisions. Data derived from the MDS has been particularly valuable in this regard. Prior to the implementation of the MDS, existing project data could only be used to generate a broad overview of project activities. While areas of activity could be established, the scale of this activity was absent. Likewise, a refined analysis of activities could not be undertaken including participant demographics, target groups, and referral pathways, for example.

This Report is based on MDS data for only a six month period (October 2012-March 2013), however the 16,222 individual client contacts/activities and 2,428 group activities recorded for that period provides an essential baseline for future measures. The Department’s decision to extend MDS data collection for a further 12 months to May 2014 means that comparable data on NSPP-funded activities will ultimately be available for a 20-month period.

Despite these achievements and advances, information gaps still remain. This is particularly true in relation to outcome measurement. While the MDS has contributed greatly to the process evaluation of the NSPP, outcome measurement represents the next major frontier for NSPP evaluations. Without outcome measurement, the question of ‘what works for whom in what circumstances, in what respects, and how’ remains unanswered. So too do questions of economic efficiency.

Consequently, at this time it is not possible to assess whether alternative configurations of suicide prevention activities funded under the NSPP would be beneficial. This Evaluation found that the current community-based approach appears to be responsive to local need. However the absence of outcome measurement has impeded comparison of this approach with potential alternative future strategies, such as:

- Smaller number of larger programs
- Different mix of larger and smaller programs
- Delivering services and influencing behaviour through online mediums, including social media.

Implementation of outcome measurement needs to be a facilitated process. Capacity building at project level is essential in terms of the selection, administration and analysis of appropriate outcome measures and tools. First, a body of work needs to be undertaken in consultation with project representatives to compile a taxonomy of appropriate tools and where needed, develop additional tools (quantitative and qualitative).

Such a task is beyond the remit of individual funded organisations. Although this would represent an additional cost to government, the returns in terms of national consistency in measurement and
1 Executive summary

comparability across projects would be great. Importantly, it would provide the information on which to base decisions about which projects should be continued, expanded upon, refined or eliminated; something which this current evaluation lacks the outcome data to do. Incorporation of appropriate outcome measurement would also enable learnings from the NSPP to inform the international evidence base.

Nonetheless, despite these information gaps at project level, this Evaluation provides important insights for decision makers. Recent evidence of what works is summarised and consolidated in the literature reviews, while the extent of community support for NSPP projects serves as a strong indicator of the perceived appropriateness of suicide prevention activities at local level.

1.7.1 Concluding observations

The social and environmental factors related to suicide are complex and dynamic. As a result, outcome measurement will need to evolve as new risk and protective factors are identified and new programs and initiatives are implemented in response. Key emerging areas include the impact of social media and the internet on suicide and self-harm risk. These impacts may be negative (eg, through exposure to methods of self-harm or suicide) or positive (as a medium for service provision for some groups). Age appropriateness of social media and the internet as modes of service delivery will need to be considered, particularly where older age cohorts are involved.

Policy and funding changes also add to the dynamic landscape of suicide prevention in Australia. The introduction of Australia's first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is one such example. With this development comes the question of whether projects targeting Aboriginal and Torres Strait Islander populations are now more appropriately the domain of the new Strategy rather than the NSPP. This highlights the need to regularly review the range of projects that remain under the NSPP, as policy and funding changes occur.

Going forward, organisation funded to undertake suicide prevention activities, the government funding these activities and ultimately those at risk of suicide, can mutually benefit from the opportunities for program improvement identified in this report.
2 Introduction

2 INTRODUCTION

Australian Healthcare Associates (AHA) was appointed by the Australian Government Department of Health and Ageing (DoHA) in May 2012, to undertake the Development and Implementation of an Evaluation Framework for Suicide Prevention Activities (the Evaluation). The Evaluation pertains to activities funded under the National Suicide Prevention Program (NSPP) between 2006 and 2013 and selected elements of the Taking Action to Tackle Suicide (TATS) package, details of which are provided in later sections of the report.

This Report presents an analysis of NSPP-funded project activities from 2006-13. This chapter sets out the following:

1. Contextualising the Report within the overall Evaluation
2. Evaluation questions addressed in the Report

2.1 Contextualising the Final Report within the overall Evaluation

This Final Report is a subset of Stage 3 of a three-stage Evaluation:

Stage 1: Development of an Evaluation Framework
Stage 2: Mid-term quantitative and qualitative assessment of NSPP projects funded from 2006-07 to 2010-11

Overall, this three-stage Evaluation had two broad objectives:

- Evaluate existing activity under the NSPP and new activities funded under the 2010 TATS package, in order to determine the appropriateness, effectiveness and efficiency of these activities within the broader policy context
- Inform the evidence base for future policy direction and implementation of suicide prevention activity and to create and put in place a comprehensive evaluation framework for ongoing use.

Throughout this Evaluation, an advisory group provided critical feedback regarding the direction of the evaluation, the components of the evaluation framework and evaluation findings. The advisory group comprised the following members.

Table 2-1: Advisory Group

<table>
<thead>
<tr>
<th>Member</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Ian W. Webster</td>
<td>Chair – ASPAC</td>
</tr>
<tr>
<td>Professor Jane Pirkis</td>
<td>University of Melbourne</td>
</tr>
<tr>
<td>Barbara Hocking</td>
<td>ASPAC member, former CEO of SANE</td>
</tr>
<tr>
<td>Associate Professor Maggie Jamieson</td>
<td>Former ASPAC member and CEO of Lifeline</td>
</tr>
<tr>
<td></td>
<td>Associate Professor in Public Health, University of Canberra</td>
</tr>
<tr>
<td>Professor Graham Martin</td>
<td>University of Queensland</td>
</tr>
<tr>
<td>Noel Muller</td>
<td>Consumer representative on National Suicide Prevention Working Group</td>
</tr>
</tbody>
</table>
2 Introduction

2.2 Evaluation questions

Key evaluation questions related to program appropriateness, effectiveness and efficiency were developed for the overall Evaluation. These questions are shown in Appendix B.

2.3 Scope of this Final Report

This Final Report focuses on 49 national and local projects funded through the NSPP/TATS package between 2006-07 and 2012-13. A list of these projects is provided in Appendix A, along with a summary of each individual project. All 49 projects were funded at June 2011 and two subsequently ceased to receive funding. NSPP/TATS funding to all projects totalled $120.1 million between 2006-07 and 2012-13, of which the 49 projects evaluated received $96.8 million (81%).

Funding is provided through the NSPP for community-based projects that deliver activities at a local and national level, and other national core activities that have a whole-of-population focus. As part of the NSPP funding appropriation, funding was also allocated to several projects that indirectly support the ongoing delivery of other projects/activities funded under the NSPP. These include funding to support the broader alignment of suicide prevention activity nationally. These alignment activities have their own evaluation data collection processes. Where necessary and as appropriate, the NSPP Evaluation has been able to access such processes.
3 Background and policy context

3 BACKGROUND AND POLICY CONTEXT

The last two decades have seen a number of major policy developments in relation to suicide prevention in Australia. This chapter outlines the policy context, investment and evidence underpinning the NSPP.

3.1 Suicide in Australia

The costs of suicide to individuals and society are enormous. In Australia, suicide represents the fifteenth leading cause of all deaths, with 2,273 deaths from suicide registered in 2011.\(^3\) Given the complexities of data collection relating to suicide and issues of under-reporting,\(^4\) these figures are considered to be an underestimate of actual rates.

The number of suicide deaths recorded annually remained relatively stable from 2001-10, with the lowest number (2,098) recorded in 2004 and the highest number (2,457) recorded in 2001. Over these ten years, suicide accounted for between 1.6% and 1.9% of all deaths annually. However, the age-standardised suicide rate has decreased from 11.4 deaths per 100,000 population per year in the period 2001-05\(^5\) to 10.6 deaths per 100,000 population per year in the period 2007-11.\(^6\)

Suicide remains the leading cause of death for all Australians between 15-34 years of age, despite decreases in the suicide rate over the past decade. Males were between three and four times more likely than females to die from suicide in the period 2001-10. Rates of suicide also differed between states and territories, with particularly high rates in Tasmania and the Northern Territory. Rural areas were found to have higher suicide rates than capital cities.

Suicide rates for Aboriginal and Torres Strait Islander peoples are approximately twice those of non-Indigenous Australians, and rates are particularly high for younger Aboriginal and Torres Strait Islander people.\(^7\)

3.2 Policy milestones

The following sections outline the key developments in Australia’s national approach to suicide prevention. An overview of dates and milestones is provided in Table 3-1 and details of key developments are discussed in chronological order in the sections that follow.

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\(^{7}\) Australian Bureau of Statistics, *Suicides, Australia, 2010*. 
### 3 Background and policy context

#### Table 3-1: Milestones in suicide prevention policy

<table>
<thead>
<tr>
<th>Year</th>
<th>Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>National Youth Suicide Prevention Strategy (NYSPS) introduced</td>
</tr>
<tr>
<td>2000</td>
<td>National Suicide Prevention Strategy (NSPS) introduced</td>
</tr>
<tr>
<td></td>
<td>LIFE Framework produced</td>
</tr>
<tr>
<td>2006</td>
<td>National Suicide Prevention Program (NSPP) commenced</td>
</tr>
<tr>
<td>2007</td>
<td>LIFE Framework updated, and suite of resources released</td>
</tr>
<tr>
<td>2008</td>
<td>Australian Suicide Prevention Advisory Council (ASPAC) established and first NSPS Action Framework (2009-10 to 2010-11) developed</td>
</tr>
<tr>
<td>2010</td>
<td>Senate Community Affairs References Committee Inquiry into Suicide in Australia conducted and report released (The Hidden Toll: Suicide in Australia)</td>
</tr>
<tr>
<td></td>
<td>Announcement of Taking Action to Tackle Suicide (TATS) package</td>
</tr>
<tr>
<td></td>
<td>Continuation and expansion of the ASPAC</td>
</tr>
<tr>
<td>2011</td>
<td>Announcement of Delivering Mental Health Reform budget package</td>
</tr>
<tr>
<td></td>
<td>Release of the Roadmap for National Mental Health Reform 2012-2022</td>
</tr>
<tr>
<td></td>
<td>Development of National Aboriginal and Torres Strait Islander Suicide Prevention Strategy</td>
</tr>
</tbody>
</table>

Each of these key developments is summarised in the following sections.

### 3.3 National Suicide Prevention Strategy

With the development of the National Youth Suicide Prevention Strategy (NYSPS), Australia became one of the first nations to take a nationally coordinated approach to suicide prevention. Operating between 1995 and 1999, the NYSPS was replaced in 2000 by the National Suicide Prevention Strategy (NSPS). The NSPS not only expanded the focus on suicide prevention activities across the life span but also included consideration of specific at-risk groups.8

The goal of the NSPS is to reduce deaths by suicide and suicidal behaviour by:

- Adopting a whole-of-community approach to suicide prevention in order to extend and enhance public understanding of suicide and its causes
- Increasing support and care available to people, families and communities affected by suicide or suicidal behaviour by funding and evaluating initiatives which enhance or inform the establishment of better support systems.

The main objectives of the NSPS are to:

- Build individual resilience and the capacity for self-help
- Improve community strength, resilience and capacity in suicide prevention
- Provide targeted suicide prevention activities
- Implement standards and quality in suicide prevention

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8 Department of Health and Ageing, LIFE: Research and Evidence in Suicide Prevention, DoHA, Canberra, 2007.
3 Background and policy context

- Take a coordinated approach to suicide prevention
- Improve the evidence base and understanding of suicide prevention.\(^9\)

The NSPS has four interrelated components:

- **LIFE Framework**: sets an overarching evidence-based strategic policy framework for suicide prevention activities
- **NSPS Action Framework**: provides a work plan for national leadership in suicide prevention and policy
- **National Suicide Prevention Program**: the Australian Government funding program dedicated to suicide prevention activities
- **Mechanisms to promote alignment with and enhance state and territory suicide prevention activities**: includes progressing elements of relevant frameworks, such as the Fourth National Mental Health Plan 2009-14.

Each of these components is described below.

### 3.3.1 The LIFE Framework

Originally developed in 2000 and updated in 2007, the LIFE Framework provides the operational framework for the NSPS.\(^{10}\) It outlines the vision, purpose, principles, action areas and proposed outcomes for suicide prevention in Australia. In September 2011, the LIFE Framework was adopted in all jurisdictions as Australia’s overarching suicide prevention framework.

The LIFE Framework is based on the premise that in order to reduce suicide rates, activities should occur across eight overlapping domains of care and support, as described below:

- **Universal interventions** target whole populations, with the aim of reducing risk factors and enhancing protective factors across the entire population. Typically such approaches include (but are not restricted to) reducing access to means of suicide, improving media reporting of suicide and providing community education about suicide prevention.
- **Selective interventions** target subgroups whose members are not yet manifesting suicidal behaviours, but exhibit proximal or distal risk factors that predispose them to do so in the future. These may include gatekeeper training or programs that involve screening those thought to be at elevated risk.
- **Indicated interventions** are designed for people who are identified through screening programs or by clinical presentation as already beginning to exhibit suicidal thoughts or behaviours, and may include psychological or pharmacological treatment of underlying mental disorders.
- **Symptom identification** involves knowing and being alert to signs of imminent risk, adverse circumstances and potential tipping points by providing support and care when vulnerability and exposure to risks are high.
- **Finding and accessing early care and support** when treatment and specialised care is needed. This is the first point of professional contact that provides targeted and integrated care, support and monitoring.


3 Background and policy context

- **Standard treatment** when specialised care is needed to manage suicidal behaviours and comprehensively treat and manage any underlying conditions, improve wellbeing and assist recovery.

- **Longer-term treatment and support** which entails continuing integrated care to consolidate recovery, reduce the risk of adverse health effects and prepare for a positive future.

- **Ongoing care and support** involving professionals, workplaces, community organisations, friends and family to support people to adapt, cope and build strength and resilience within an environment of self-help.

The LIFE Framework also sets out six action areas and related outcome areas for suicide prevention activity, as follows (Table 3-2).

**Table 3-2: LIFE Action Area Outcomes**

<table>
<thead>
<tr>
<th>LIFE Action Area</th>
<th>LIFE Action Area Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the evidence base and understanding of suicide prevention.</td>
<td>1.1. Understanding of imminent risk and how best to intervene.</td>
</tr>
<tr>
<td></td>
<td>1.2. Understanding of whole-of-community risk and protective factors, and how best to build resilience in communities and individuals.</td>
</tr>
<tr>
<td></td>
<td>1.3. Application and continued development of the evidence base for suicide prevention among high-risk populations.</td>
</tr>
<tr>
<td></td>
<td>1.4. Improved access to suicide prevention resources and information.</td>
</tr>
<tr>
<td>Building individual resilience and the capacity for self-help.</td>
<td>2.1. Improved individual resilience and wellbeing.</td>
</tr>
<tr>
<td></td>
<td>2.2. An environment that encourages and supports help-seeking.</td>
</tr>
<tr>
<td>Improving community strength, resilience and capacity in suicide prevention.</td>
<td>3.1. Improved community strength and resilience.</td>
</tr>
<tr>
<td></td>
<td>3.2. Increased community awareness of what is needed to prevent suicide.</td>
</tr>
<tr>
<td></td>
<td>3.3. Improved capability to respond at potential tipping points and points of imminent risk.</td>
</tr>
<tr>
<td>Taking a coordinated approach to suicide prevention.</td>
<td>4.1. Local services linking effectively so that people experience a seamless service.</td>
</tr>
<tr>
<td></td>
<td>4.2. Program and policy coordination and cooperation through partnerships between governments, peak and professional bodies and non-government organisations.</td>
</tr>
<tr>
<td></td>
<td>4.3. Regionally integrated approaches.</td>
</tr>
<tr>
<td>Providing targeted suicide prevention activities.</td>
<td>5.1. Improved access to a range of support and care for people feeling suicidal.</td>
</tr>
<tr>
<td></td>
<td>5.2. Systemic, long-term, structural interventions in areas of greatest need.</td>
</tr>
<tr>
<td></td>
<td>5.3. Reduced incidence of suicide and suicidal behaviour in the groups at highest risk.</td>
</tr>
<tr>
<td></td>
<td>5.4. Improved understanding, skills and capacity of front-line workers, families and carers.</td>
</tr>
<tr>
<td>Implementing standards and quality in suicide prevention.</td>
<td>6.1. Improved practice, national standards and shared learning.</td>
</tr>
<tr>
<td></td>
<td>6.2. Improved capabilities and promotion of sound practice in evaluation.</td>
</tr>
<tr>
<td></td>
<td>6.3. Systemic improvements in the quality, quantity, access and response to information about suicide prevention programs and services.</td>
</tr>
</tbody>
</table>
3 Background and policy context

3.3.2 Groups at higher risk of suicide

Certain groups are identified in the LIFE Framework\(^{11}\) as being at higher risk of suicide (acknowledging that this is not an exhaustive list):

- Men aged 20-54 and over 75
- Men in Aboriginal and Torres Strait Islander communities
- People with a mental illness
- People with substance use problems
- People in contact with the justice system
- People who attempt suicide
- People in rural and remote communities
- Gay and lesbian communities
- People bereaved by suicide.

3.3.3 The NSPS Action Framework

The NSPS Action Framework is developed by the ASPAC in collaboration with DoHA, and has two primary purposes:

- To help ASPAC plan and manage the provision of confidential advice to the Australian Government on strategic direction and priorities in relation to suicide prevention and self-harm
- To help DoHA plan and manage the implementation of the National Suicide Prevention Program.

The Action Framework, which is reviewed periodically, provides targets and cross-government departmental directives to implement suicide prevention activities.

3.3.4 National Suicide Prevention Program

The third component of the NSPS is the NSPP, which is the Australian Government funding program dedicated to suicide prevention activities. The NSPP funds local community-based projects as well as national projects that take a broad population health approach to suicide prevention, including research. Drawing upon the priorities set out in the LIFE Framework, the NSPP funds universal, selective and indicated suicide prevention activities. The first competitive grants round for the NSPP started in 2006.

Funding under the NSPP is provided to support suicide prevention activities that will contribute to outcomes specified in the LIFE Framework. The central goal of the LIFE Framework is to reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour in Australia. Suicide prevention activities, programs and interventions aim to build:

- Stronger individuals, families and communities
- Individual and group resilience to traumatic events
- Community capacity to identify need and respond
- The capacity for communities and individuals to respond quickly and appropriately
- A coordinated response, providing smooth transitions to and between care.

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\(^{11}\) DOHA, *LIFE Framework*, p.32.
3 Background and policy context

The NSPP also contributes funds to other large programs including the Access to Allied Psychological Services Additional Support for Patients at Risk of Suicide and Self-Harm Project (ATAPS Suicide Prevention service initiative) and the MindMatters initiative.

3.3.5 Mechanisms to promote alignment with and enhance state and territory suicide prevention activities

The fourth component of the NSPS aims to enhance alignment (thereby promoting synergies and reducing duplication) between the NSPS and state/territory suicide prevention activities by progressing the relevant actions of related national frameworks, such as the Fourth National Mental Health Plan 2009-14.

3.4 Senate Community Affairs References Committee Inquiry into Suicide in Australia

Growing recognition of the high personal, social and financial costs of suicide led to the commissioning of the Senate Community Affairs References Committee Inquiry into Suicide in Australia. The committee’s report, The Hidden Toll: Suicide in Australia, was released on 24 June 2010. Its recommendations, which covered all aspects of suicide prevention, are summarised below:

- Improve the accuracy of suicide statistics through standardising coronial reporting and process and police reporting
- Provide suicide awareness and prevention training for frontline staff, workers in community organisations and other gatekeepers
- Improve assessment, care, continuity of care and follow-up care in the health setting for people who have attempted suicide, have suicidal ideation or have an existing mental health problem
- Undertake long-term suicide awareness campaigns including targeted approaches to high-risk groups
- Encourage responsible reporting of suicide in the media
- Ensure affordable access to telephone crisis services
- Reduce access to means for suicide
- Add suicide prevention measures at suicide hotspots.

In addition, the Committee made a number of specific recommendations to include interventions and resources for high-risk groups, to improve the effectiveness of existing interventions and to expand reach. These recommendations included:

- Improve evidence on the efficacy of suicide prevention interventions and access to this evidence
- Increase funding through the NSPP for research and evaluation of suicide prevention interventions
- Improve coordination of programs and services through a National Suicide Prevention Strategy that involves participation and funding from all levels of government and collaboration with community stakeholders and service providers
- Explore the benefits of an external governance and accountability structure for national suicide prevention

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12 Senate Community Affairs References Committee, The Hidden Toll: Suicide in Australia, Commonwealth of Australia, Canberra, 2010.
3 Background and policy context

- Increase funding of programs and support for people at risk of suicide
- Establish a Suicide Prevention Foundation to encourage and direct funding from all sectors into suicide prevention awareness, research, advocacy and services
- Provide longer funding cycles for suicide program funding to assist in success and stability
- Establish targets to reduce the suicide rate.

The Inquiry raised a number of issues in relation to the NSPS and the NSPP, including:

- The NSPS has resulted in fragmented services for those at risk of suicide, and there is no agency at the national or state/territory level with the mandate to address suicide and suicide prevention. For example, responsibility for mortality data collection, morbidity data collection, funding for program initiatives, research, services, advocacy, and self-help/support groups rests with different groups/organisations.
- More substantial collaborative structures and mechanisms are needed to better link up all levels of government, stakeholders, communities and consumers.
- The NSPS is not a National Strategy because it was not a formal agreement signed by all governments (this occurred subsequently in September 2011 through the Australian Health Ministers Conference (AHMC)).
- There was uncertainty over whether the LIFE Framework constituted ‘The Strategy’ or was a ‘supporting resource’.
- The Inquiry recommended that an aspirational target for the reduction in suicides be set as part of the strategy.

3.5 Taking Action to Tackle Suicide

The Commonwealth Response to The Hidden Toll: Suicide in Australia was tabled on 24 November 2010 and included details of the TATS package. The TATS package provides further support for suicide prevention through universal and population-wide approaches and through community led responses. This investment seeks to strengthen and further build on proven strategies in suicide prevention in the following four areas:

1. More frontline services and support for those at greatest risk of suicide:
   - More community-based psychology services (through expansion of ATAPS Suicide Prevention service initiative (see Chapter 11)

2. More services to prevent suicide and boost crisis intervention services:
   - Boost capacity of crisis lines
   - Mental Health First Aid training for frontline community workers
   - Infrastructure for suicide hotspots
   - Community prevention activities for high-risk groups (including Indigenous people; men; lesbian, gay, bisexual, transgender and intersex (LGBTI) people; and families bereaved by suicide)\(^{13}\)
   - Outreach teams to schools through the headspace School Support program

3. Target men who are at greatest risk of suicide:
   - Expansion of the National Workplace Program delivered by beyondblue

\(^{13}\) Includes $6 million quarantined for community-based prevention activities for Aboriginal and Torres Strait Islander peoples.
3 Background and policy context

- Increased helpline capacity
- Targeted campaigns on depression and reducing stigma

4. Programs to promote good mental health and resilience in young people:
   - Expansion of the *KidsMatter* primary school program
   - Additional services for at-risk children through the ATAPS child mental health service
   - Online mental health and counselling services.

For the period 2011-12 to 2015-16, the total investment under the TATS package is $292.4 million.\textsuperscript{14} The TATS package funding represents an additional funding source to the NSPP, which fills some of the gaps in the NSPP that were identified through the Senate Inquiry into Suicide. In some instances, the TATS package has provided additional funding to NSPP-funded projects. This includes $4.8 million to expand the Wesley LifeForce project, and $6.9 million to improve access to bereavement services through the StandBy Suicide Bereavement Response Service. In addition, $1.1 million was provided to the National LGBTI Health Alliance to deliver the MindOUT! project.

A number of other recommendations from the report on the Senate Inquiry into Suicide have also been acted upon by the Australian Government. These include the development of a suicide prevention strategy for Aboriginal and Torres Strait Islander communities (see Section 3.9) and alignment of state/territory suicide prevention strategies to the LIFE Framework under the auspice of the Australian Health Ministers’ Conference.\textsuperscript{15}

3.6 Implementation of the 2011 Delivering National Mental Health Reform package

In the May 2011-12 Budget, the Australian Government announced a reform package for mental health services worth $1.5 billion over five years, focused on five key areas:

- Better care for people with severe and debilitating mental illness
- Strengthening primary mental health care services
- Prevention and early intervention for children and young people
- Encouraging economic and social participation, including jobs, for people with mental illness
- Improving quality, accountability and innovation in mental health services.

The package has a focus on reducing gaps in the provision of care and support and maximising social and economic participation by people with mental illness, and includes:

- $571.3 million for better coordinated services for people with mental illness
- $220.3 million to strengthen primary care and better target services to those most in need (this included additional funding for the ATAPS service initiative, and funding to develop e-mental health services)
- $491.7 million to expand services for children and young people.


3 Background and policy context

The reform package also focuses on improving coordination between state/territory governments and the Australian Government in providing services. This was formalised in August 2011 when the Council of Australian Governments (COAG) agreed to develop a new National Partnership Agreement on Mental Health.\(^{16}\) It also provided funding to establish the National Mental Health Commission, which, is charged with influencing reform within the suicide prevention sector as well as the mental health sector.\(^{17}\)

3.7 Formation of the National Mental Health Commission and publication of its first Report Card

Australia’s first National Mental Health Commission was established on 1 January 2012. It is independent and reports directly to the Prime Minister. The Commission’s vision is for all people in Australia to achieve the best possible mental health and wellbeing. The Commission aims to work across all sectors and settings that promote mental health and prevent mental illness and suicide. As such, its reach extends beyond government programs and beyond the health sector. The Commission has three primary strategies:

- Reporting on how the mental health system is performing and the contribution other sectors are making to people’s lives. A key initial focus was the creation of a data set for the *National Report Card on Mental Health and Suicide Prevention*\(^{18}\) (Section 3.7.1).
- Providing independent advice (in the form of reports, submissions, studies and commentaries) to make visible the evidence, build capacity, guide investment decisions and improve systems and supports.
- Collaborating with government agencies, community-based and private sector providers, businesses, employees and workforce representatives in order to develop a shared vision, align actions, share learnings, measure progress, and ensure consistent communication about mental health and suicide.\(^{19}\)

3.7.1 A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention

In 2012, the National Mental Health Commission released *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention* (the 2012 Report Card)\(^{20}\). In the first of what will be annual Report Cards, the Commission presents a ‘big picture’ case for change and identifies four key priority action areas:

- Mental health must be a high national priority for all governments and the community
- A complete picture of what is happening needs to be provided and changes need to be closely monitored and evaluated

\(^{20}\) NMHC, *A Contributing Life*. 
3 Background and policy context

- Agreement needs to be reached on the best ways to encourage improvement and get better results.
- Analysis of the gaps and barriers to achieving a contributing life needs to be undertaken and Australia’s direction agreed on.

Based on these four action areas, a number of recommendations are made to achieve the vision of a contributing life for people with mental health difficulties, their families and supporters. While all the recommendations are relevant to suicide prevention, one has suicide as its specific focus:

Recommendation 10: Prevent and reduce suicide, and support those who attempt suicide through timely local responses and reporting.

Two actions are proposed to work towards this recommendation:

- Develop local, integrated and more timely suicide and at-risk reporting and responses, ie, coordinated, community-based, culturally appropriate, early response systems and suicide prevention programs.
- Programs with a proven track record (which are evidence-based) must be supported and implemented as a priority in regions and communities with the highest suicide or attempted suicide rates.21

3.8 Release of the Roadmap for National Mental Health Reform 2012-2022

The Roadmap for National Mental Health Reform (the Roadmap)22 represents the vision of the COAG in relation to mental health reform. The Roadmap emphasises that the voices of consumers and carers should be heard, and that policy should be guided by and respond to people’s lived experience. The priorities of the Roadmap are to:

- Promote person-centred approaches
- Improve the mental health and social and emotional wellbeing of all Australians
- Prevent mental illness
- Focus on early detection and intervention
- Improve access to high quality services and supports
- Improve the social and economic participation of people with mental illness.

The Roadmap is accompanied by a set of Preliminary Performance Indicators to monitor progress across governments. The National Mental Health Commission (Section 3.7.1) is responsible for evaluating the Roadmap. The implementation of the Roadmap will be articulated in the successor to the Fourth National Mental Health Plan, which will be developed by the COAG Working Group on Mental Health Reform that has been established as part of the Roadmap. It is intended that the successor to the Fourth Plan will reflect the high-level aspirations and strategies in the Roadmap and convert them into more concrete medium-term outcomes.23

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21 NMHC, A Contributing Life.
3 Background and policy context

3.9 Development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

Recommendation 27 of the Senate Inquiry into Suicide report, *The Hidden Toll: Suicide in Australia* (see Section 3.5), called for the development of a separate suicide prevention strategy within the NSPS for Aboriginal and Torres Strait Islander communities. This recommendation was supported by the Australian Government. The Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group was subsequently established to provide input to the development of the strategy and to provide advice on priorities for the $6 million of funding provided through the TATS package that was quarantined for Aboriginal and Torres Strait Islander suicide prevention initiatives.24

In June 2012, the Minister for Mental Health and Ageing announced the appointment of the Menzies School of Health Research to develop Australia’s first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. To inform the development of the Strategy, 14 community consultations were held across Australia, a national expert workshop was attended by peak bodies and key stakeholders, and 48 contributions from community members were received via a dedicated website. The development of the Strategy was overseen by the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group. The commitment to develop the Aboriginal and Torres Strait Islander Suicide Prevention Strategy was part of the Government’s response to the Senate Inquiry into Suicide in Australia.

On 23 May 2013 the Strategy was released, supported by funding of $17.8 million over four years (2013-14 to 2016-17). The funding will support the establishment of local suicide prevention networks and a centre of best practice to support and prioritise local, community-led activities, and share knowledge in suicide prevention for Aboriginal and Torres Strait Islander peoples across Australia. These activities will be developed in close consultation with Aboriginal and Torres Strait Islander communities and will implement key elements of the Strategy. The ministerially-appointed Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group will guide the development of program guidelines and implementation of key recommendations from the Strategy.

3.10 State/territory level suicide prevention policies

A range of suicide prevention policies exist at state/territory level. As indicated in Table 3-3, these are aligned with the LIFE Framework, although the priorities for action and the operationalisation of the strategies vary between jurisdictions.

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3 Background and policy context

Table 3-3: State/territory level suicide prevention policies

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Policy</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>NSW Suicide Prevention Strategy 2010-2015</td>
<td>Aligned with LIFE Framework.</td>
</tr>
<tr>
<td>WA</td>
<td>WA State Suicide Prevention Strategy 2009-2013</td>
<td>Aligned with LIFE Framework.</td>
</tr>
<tr>
<td>SA</td>
<td>SA Suicide Prevention Strategy 2012-2016: Every life is worth living</td>
<td>Aligned with LIFE Framework. Also includes priority focus on issues affecting regional South Australians and targeted postvention activities.</td>
</tr>
<tr>
<td>Vic</td>
<td>Mental Health Reform Strategy 2009-2019: Because mental health matters</td>
<td>This document states that Victoria’s Suicide Prevention Action Plan 2006 will be renewed and updated with reference to the LIFE Framework.</td>
</tr>
<tr>
<td>Tas</td>
<td>Tasmania’s Suicide Prevention Strategy 2010-2014: A strategic framework and action plan</td>
<td>Lists five key action areas that are broadly aligned with the LIFE Framework and other relevant state-level policies. There is a strong focus on primary prevention and community involvement.</td>
</tr>
<tr>
<td>NT</td>
<td>NT Suicide Prevention Action Plan 2009-2011</td>
<td>Lists six key action areas, which although differently worded, are similar in intent to those of the LIFE Framework. One action area specifically relates to partnerships with Indigenous people. The roles of various government departments in addressing goals are described.</td>
</tr>
<tr>
<td>ACT</td>
<td>Managing the Risk of Suicide: A suicide prevention strategy for the ACT 2009-2014</td>
<td>Comprises 56 activities to be implemented by 22 agencies, aligned under the LIFE Action Areas.</td>
</tr>
</tbody>
</table>

3.11 Scope, findings and learnings from previous NSPS/NSPP evaluations

Elements of the NSPS and the NSPP have been evaluated in recent years. An overview of these evaluations is provided below and the implications of these findings for this Evaluation are discussed in later chapters.

3.11.1 Learnings from Suicide Prevention Initiatives Project evaluation

The Learnings from Suicide Prevention Initiatives Project evaluated the first wave of NSPP-funded suicide prevention projects (to December 2005). The project involved a desktop review of the 156 funded projects. The evaluators found that the projects reached a broad range of target groups in a range of settings, and employed a range of approaches. The projects achieved improvements in knowledge about risk and protective factors for suicide, social connectedness and mental health literacy, and reductions in depressive symptomatology.

26 Some of these 156 projects have continued to operate during the timeframes for the current evaluation; others had been completed by 2005; and others were completed subsequently.
3 Background and policy context

Factors considered important in project success included: understanding contextual factors, investigating participants’ needs, drawing on sound evidence, developing multi-faceted strategies, garnering stakeholder support and employing capable staff. Projects' sustainability was found to be constrained by their short-term funding. A key recommendation was that processes to promote project evaluation should be strengthened, ideally through a common evaluation framework, to enable more rigorous assessment of the effectiveness of the NSPP. The authors also called for improved communication between projects to provide a forum for applying learnings.

The Learnings from Suicide Prevention Initiatives Project authors highlighted a number of key challenges to their evaluation that meant their findings needed to be interpreted with caution. These included:

- Variability in report quality, sub-optimally designed evaluations and reliance on largely qualitative data sources restricted the range of analysis possible, which made comparisons between projects impossible, and limited the development of conclusions
- Consultations with project representatives and state/territory-based DoHA personnel were outside the scope of their evaluation. The authors reported that such consultations would have provided insights to barriers and enablers to project implementation at project level and would have clarified the overarching approaches to implementation and evaluation in each jurisdiction. Important contextual information was absent from their evaluation as a result.

3.11.2 Evaluation of the National Suicide Prevention Strategy

The Evaluation of the National Suicide Prevention Strategy – Final Report was also produced in 2006. This report provided a high-level evaluation of the NSPS as a whole, including its governance structures and administration, as well as a review of the appropriateness, effectiveness and efficiency of the funded projects. The evaluation report concluded that while the NSPS is widely supported and perceived as an appropriate and necessary strategy that addresses an ongoing community need, there was scope to further refine its governance structures and processes.

In relation to the effectiveness of specific projects, the report concluded that while some gains were made in terms of capacity building (at an individual and service level), help-seeking, referral, and risk and protective factor profiles, there was little evidence available to indicate whether any NSPS-funded project had led to reductions in suicide or self-harming behaviour. Consistent with the Learnings from Suicide Prevention Initiatives Project, the authors highlighted the need for a stronger evaluation framework to enable more rigorous evaluation of the effectiveness of the NSPS and its funded projects.

Although the methodology for this evaluation included stakeholder consultations and written submissions in addition to a review of project documentation, the authors identified a number of methodological challenges including:

- The small number of completed national and ‘cluster’ evaluations of NSPS projects available for review (‘cluster’ evaluations in this context refers to groups of community-based projects in a particular state or territory)
- The limited corporate knowledge regarding the life of the NSPS among certain stakeholders
- The limited availability of outcome data concerning the community-based projects.

3 Background and policy context

3.12 Summary of policy context

From the policy developments outlined above, it is evident that suicide prevention in Australia is receiving increasing levels of attention by governments. The key messages relating to suicide prevention across the key Australian Government documents and the state/territory policies are largely consistent, albeit with different emphases on particular target groups (eg, rural men) or different approaches (eg, development of community action plans) depending on local factors. For the most part, jurisdictional policies are consistent with the themes outlined in the LIFE Framework. While there is a strong focus on the link between mental illness and suicide within more recent policy documents such as the Report Card and the Roadmap, there is also growing recognition of the broader social and economic factors that are implicated in suicide, and of the need for whole-of-government and whole-of-community responses.

Given that the NSPP and TATS are one component within what can be described as a somewhat crowded policy environment (see Chapter 11), the extent to which suicide-related outcomes (in particular, rates of self-harm and suicide) can be directly attributed to the NSPP/TATS specifically is limited.
4 Methods

4 METHODS

In this chapter, details of the methods used to conduct the Evaluation are presented.

4.1 Background and data sources

This Report was preceded by a Mid-term Assessment Report and Interim Analysis Report. In order to obtain the information required for the desktop review, DoHA requested that all 49 projects (see Appendix A) provide DoHA with copies of appropriate project documentation/data related to their NSPP-funded activities conducted during the period 2006-11. This was to include funding agreements, progress reports, final reports, internal evaluations and external evaluation reports, if applicable. The documentation/data was then forwarded by DoHA to AHA for analysis. The information provided is summarised in Table 4-1.

In June 2013, DoHA provided updated financial data for each project showing payments by the Department in each financial year, taking into consideration project underspends and contract variations. This updated data provided the basis for all financial analysis presented in this Final Report.

This Report builds on the Mid-term Assessment Report and Interim Analysis Report, and incorporates a range of additional data sources, including:

- Project documentation/data from July to December 2012
- Project survey
- Minimum data set
- Stage 2 Literature Review
- Stakeholder consultations
- Desktop review of ATAPS Suicide Prevention service initiative and MindMatters initiative evaluations.

4.2 Pre-existing project documentation/data

The project documentation supplied by DoHA comprised the following.

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29 Not all projects were required to undergo an external evaluation under the terms of their funding agreements.
4 Methods

Table 4-1: Pre-existing project data

<table>
<thead>
<tr>
<th>Type of documentation</th>
<th>No. of projects</th>
<th>No. of documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding agreements, including deeds of variation</td>
<td>49</td>
<td>173</td>
</tr>
<tr>
<td>Progress reports</td>
<td>36</td>
<td>89</td>
</tr>
<tr>
<td>Final reports</td>
<td>41</td>
<td>61</td>
</tr>
<tr>
<td>Internal evaluation reports</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>External evaluation reports</td>
<td>31</td>
<td>37</td>
</tr>
<tr>
<td>Evaluation Data Reports (EDRs)*</td>
<td>24</td>
<td>Not Applicable**</td>
</tr>
<tr>
<td>Financial reports</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Other documents (eg, newspaper articles, project newsletters,</td>
<td>25</td>
<td>105</td>
</tr>
<tr>
<td>memorandums of understanding, progress reports for earlier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>periods)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* EDRs were Excel templates provided to projects by DoHA. These templates were designed to capture activity level data across a range of individual and community initiatives. EDRs were scheduled for completion on a monthly basis for submission later as part of progress/final reports.

** EDRs were not collated and analysis of these did not constitute a significant component of our methods, therefore the number of individual documents received has not been counted.

4.3 Documentation/data quality: implications

An initial review of the documentation/data provided by DoHA identified some challenges. These challenges not only had implications for the extent of analysis which could be conducted but also highlighted limitations with existing data collection to support the implementation of the Evaluation Framework in subsequent stages of the Evaluation. The following issues were highlighted:

- Data quality and availability was inconsistent across projects
- Due to the small number of EDRs received, access to disaggregated activity level data was limited
- Information regarding target groups and geographical coverage was limited
- Data collection categories that were in use showed a lack of alignment with key external data sources such as the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS) or the National Health Data Dictionary (Version 15)
- Activities under LIFE Action Areas were not clearly articulated
- Important contextual information was absent for many projects, for example, issues/challenges encountered during the start-up phase, externalities such as non-NSPP funding, volunteer staff inputs and local factors were not always in these reports
- Evaluation reports were not available for all projects as not all projects were required to conduct evaluations under their funding agreements. The quality of the evaluation reports received was variable.

These findings highlighted the need for more consistent and comprehensive data collection in the overall Evaluation. A Minimum Data Set (MDS) was developed by AHA for this purpose (Appendix C), informed by the initial documentation/data review and by the needs of the Evaluation Framework. The
4 Methods

The first draft of the MDS was presented to project representatives at workshop consultation forums held throughout Australia in August 2012 at which all 49 projects were represented.

These consultations, in turn, highlighted a further range of issues that needed to be considered in both the Mid-term Assessment and the broader Evaluation. These issues included:

- Individual projects engage in multiple LIFE Action Areas and use multiple approaches and are therefore not easily clustered for analysis purposes
- Not all projects were required to complete EDRs. Narrative-style reports were the norm for many projects, thus restricting the level of statistical analysis possible
- Project staff expressed concern that reliance on pre-existing data for the Mid-term Assessment might not provide a comprehensive picture of their activities, achievements, and the overall journey of their projects. In particular, concerns were raised regarding:
  - Whether AHA was in receipt of a complete set of reports/documentation. Until that point, all communication with the projects had been through a third party (either DoHA Central Office or State/Territory Office). Project representatives were concerned that reports/documentation may have been overlooked.
  - Reliance on existing reports/documentation could mean that important contextual information relating to the development and evolution of projects could be lost.

In response to the issues raised during these forums, an online survey (Appendix D) was developed by AHA to address the gaps in the pre-existing data and to provide projects with the opportunity to provide direct input to the Mid-term Assessment. Further refinement of the MDS was also undertaken following feedback from project representatives at the workshops (see Section 4.8 for details of the final MDS).

Additionally, based on the feedback obtained at the workshops and discussions with DoHA, the list of high-risk groups identified in the LIFE Framework (Section 3.3.1) was expanded in both the survey and MDS to include:

- Children
- Youth
- People with a mental illness
- People who engage in self-harm
- People from Culturally and Linguistically Diverse backgrounds (CALD)
- Refugees
- Older people
- People with Alcohol and other Drug (AOD) problems
- Workforce settings
- Communities that experience redundancies
- Communities that experience natural disasters.

4.4 Project survey

A mix of closed questions, rating scales and open-ended text responses were used in the survey (Appendix D) to address the following key areas of enquiry:

- Changes to aims and objectives
4 Methods

- Activities and strategies
- Target groups
- LIFE Framework Action areas
- Resourcing, including supplementary funding sources
- Staffing
- Collaborations
- Sustainability
- Progress towards achieving LIFE Action Area Outcomes
- Program administration.

The survey was circulated on 18 October 2012. A total of 25 surveys (51%) were returned by the closing date (31 October 2012). Follow-up with projects increased the response rate to 96% response, with 47 of the 49 projects submitting surveys.

To generate a complete data set for analysis purposes, pre-existing data was used by AHA to construct survey responses for the two non-responding projects. There is some missing data in these responses.

4.5 Stage 2 literature review

The development of findings in this Report was supported by the Stage 2 Literature Review (Appendix E). The aim of this review was to describe the evidence base for effective suicide prevention initiatives, so that the NSPP-funded projects could be considered in light of the evidence of best practice. The Stage 2 Literature Review built on the literature identified in the Stage 1 review, which placed Australia’s suicide prevention efforts in the context of international strategies and policies.

Lessons learned from the literature helped to identify:

- Gaps in the current systems of delivery and evaluation
- Possible improvements to how suicide prevention activities are delivered and evaluated in Australia.

4.6 Stakeholder consultations

Stakeholder consultations were conducted with the organisations/representatives listed in Table 4-2. The consultations involved semi-structured interviews held either by phone or face-to-face, to explore questions relating to efficiency and policy alignment. In addition, several written submissions were received addressing the same questions. Consultations were not undertaken with service users as this was not within the scope of this evaluation.
Table 4-2: Stakeholder consultations

<table>
<thead>
<tr>
<th>Name/organisation</th>
<th>Method of consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peak bodies</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol and other Drugs Council of Australia</td>
<td>Telephone</td>
</tr>
<tr>
<td>beyondblue</td>
<td>Telephone</td>
</tr>
<tr>
<td>Council on the Ageing</td>
<td>Telephone</td>
</tr>
<tr>
<td>Mental Health Commission</td>
<td>Telephone</td>
</tr>
<tr>
<td>Mental Health Council of Australia</td>
<td>Written submission</td>
</tr>
<tr>
<td>National LGBTI Health Alliance</td>
<td>Telephone</td>
</tr>
<tr>
<td>Royal Australian and New Zealand College of Psychiatrists (RANZCP)</td>
<td>Written submission</td>
</tr>
<tr>
<td>SANE Australia</td>
<td>Telephone</td>
</tr>
<tr>
<td>Suicide Prevention Australia</td>
<td>Telephone</td>
</tr>
<tr>
<td><strong>Suicide prevention expert stakeholders</strong></td>
<td></td>
</tr>
<tr>
<td>Associate Professor Virginia Lewis</td>
<td>Telephone</td>
</tr>
<tr>
<td>Professor Jane Pirkis</td>
<td>Telephone</td>
</tr>
<tr>
<td>Professor Greg Carter</td>
<td>Telephone</td>
</tr>
<tr>
<td>Professor Diego De Leo</td>
<td>Telephone</td>
</tr>
<tr>
<td>Professor Graham Martin</td>
<td>Written submission</td>
</tr>
<tr>
<td>Professor Ian Webster</td>
<td>Written submission</td>
</tr>
<tr>
<td>Professor Helen Christensen</td>
<td>Telephone</td>
</tr>
<tr>
<td><strong>State/territory government suicide prevention representatives</strong></td>
<td></td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Telephone</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Desktop policy review</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Telephone</td>
</tr>
<tr>
<td>Queensland</td>
<td>Telephone</td>
</tr>
<tr>
<td>South Australia</td>
<td>Telephone</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Telephone</td>
</tr>
<tr>
<td>Victoria</td>
<td>Face-to-face</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

Consultations were also undertaken with representatives from the DoHA Central Office (CO) and State and Territory Offices (STO) responsible for administering NSPP-funded project activities (referred to as DoHA STO/CO representatives).
4 Methods

4.7 Desktop review of ATAPS Suicide Prevention service initiative and MindMatters initiative evaluations

To help inform the discussion of where the NSPP fits in the context of Australia’s overall approach to suicide prevention, AHA was asked to undertake a desktop review of published evaluation reports for the ATAPS Suicide Prevention service initiative and the MindMatters initiative. Note that the extent to which conclusions could be drawn regarding the appropriateness, effectiveness and efficiency of both programs was limited by the extent to which these areas were addressed within the original evaluation reports (see Sections 11.3 and 11.4).

4.7.1 ATAPS Suicide Prevention service initiative

Published evaluation reports (conducted by the Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne) were reviewed to consider the appropriateness, effectiveness and efficiency of the Program from the commencement of the demonstration pilots in 2008.

4.7.2 MindMatters

The assessment of the MindMatters initiative was based on evaluation reports published from 2006 to 2012, with reference to several journal articles published in the peer-reviewed literature and some supplemental information provided by Principals Australia Institute (which administers the MindMatters initiative). The reports available focused on awareness, reach and uptake of the program, and as such, it was not possible to address the questions relating to effectiveness or efficiency.

4.8 Minimum Data Set

A Minimum Data Set (MDS) was developed, consisting of a series of data items specifically designed to support the current and ongoing evaluation of NSPP and TATS-funded activities (Appendix C). Following Department and the advisory group feedback, consultations were held with project representatives at workshops in August 2012 at which all 49 projects were represented and the MDS was revised based on this feedback. Further additions were also made following implementation of the MDS. To support projects in the usage of the MDS, a Data Dictionary and User Guides were also developed by AHA.

The MDS comprises three main types of data:

- Program level information
- Individual activity data (which relates to episodes of service provided to or in relation to an individual)
- Group activity data.

Detail of the items collected for of these three data types is detailed in Appendix C.

All projects were required to submit program level data. They also submitted individual and/or group data depending on the type of activity they engaged in.

Data collection using the MDS began on 1 October 2012 and continued until the end of March 2013.
4 Methods

4.9 Data analysis protocols

The findings presented in this Report are based on analysis of the data sources described in Sections 4.1 to 4.7. The data analysis protocols are outlined below.

All project documentation/data provided by DoHA was systematically analysed across the key areas of enquiry listed in Section 2.2. Funding details were extracted and categorisation of information was verified by a minimum of two consultants. A range of descriptive statistics was generated from the quantitative data derived from the project survey and the MDS.

A thematic analysis of narrative data derived from the project documentation/data and the free text responses provided in the survey and MDS, and consultation transcripts was conducted to identify key themes and issues. The thematic analysis was conducted using grounded theory, a technique that uses a constant comparative method of coding and recoding. In each case, this process involved a minimum of two consultants.

4.10 Evaluability issues

The key evaluability issues that apply to this Report fall into two main groups:

- Internal data limitations
- Broader challenges in evaluating suicide prevention programs.

4.10.1 Internal data limitations

As outlined in Section 4.3, the pre-existing project documentation/data had a number of shortcomings. At the core of these is the fact that this pre-existing documentation/data was specifically designed to address DoHA’s standard reporting requirements and was not compiled with this Evaluation in mind.

Among the key shortcomings identified were:

- Inconsistency in data quality and availability across projects
- Data collection categories that were not aligned with other key external data sources
- Inadequate data collection for key variables that were critical to the Report and the overall Evaluation
- Missing or incomplete data
- Short timeframes for the Evaluation.

While the project survey addressed many of these gaps, a more refined analysis of specific activities based on target groups and setting was not possible prior to the implementation of the MDS. A number of MDS specific limitations also exist. These include:

- Missing data as a result of non-submission of monthly MDS data by the projects
- Inconsistencies in data quality as a result of data entry errors or omissions by projects
- The six-month time frame for MDS implementation meant that the full spectrum of activities was not captured for all projects (see Chapter 6 for further details).

4 Methods

4.10.2 Broader challenges in evaluating suicide prevention programs

Although internal data limitations have been outlined (Section 4.3), it is also important to acknowledge the significant challenges related to the evaluation of suicide prevention programs, which are well recognised in the sector. These include:

- The actual number of people who take their own lives 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.

- 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.

- Issues of attribution: suicide prevention programs do not operate in isolation. They are provided in an environment where other contextual factors are present. For example, the presence of other programs or improvements in economic or social circumstances can also have an effect on the suicide rate. It is therefore difficult to separate out these effects from the program itself.

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

- While the quality of Australian deaths information is high by world standards, the ABS acknowledge that ‘[t]here remain considerable challenges in improving the quality of suicide data, 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.’32 Some have argued that ABS figures underestimate the total figures.33

- The issue of evidence. Much has been written on suicide prevention generally, yet the issue of what constitutes evidence of success remains contested. This is because:
  - While randomised control trials or quasi-experiments are often considered the gold standard in terms of evidence, the conduct of such trials is often unfeasible/inappropriate in the suicide prevention context because of the complexity of causality described above and for ethical and/or funding reasons.
  - Reliance on peer-reviewed publications as an evidence source is itself problematic because of publication biases and the lag that exists between innovation, established practice, research and publication.
  - Established practice is often considered to afford the best opportunities to collect evidence and as a consequence, this can make it hard to achieve a balance between innovation and established practice in the published studies.
  - Reliance on peer-reviewed publications as the primary source of information may fail to acknowledge valuable local insights that smaller projects have to offer.3435

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32 DePoy & Gitlin, *Introduction to research.*
34 DoHA, *LIFE: Research and Evidence in Suicide Prevention.*
5 Profile of projects

5 PROFILE OF PROJECTS

This chapter provides a profile of all 49 specified NSPP/TATS funded projects across the life of the Evaluation. Projects characteristics examined include service approach, delivery mechanisms, target groups, LIFE Action Areas addressed and geographical reach.

A more detailed Snapshot of project activity, based on MDS data from October 2012 to March 2013, is provided in Chapter 6.

Assessment of the extent to which these 49 projects contribute to the appropriateness, effectiveness and efficiency of the NSPP is presented in subsequent chapters (7, 8, 9 and 10). For readability purposes, the term NSPP is used in this chapter to refer to both the NSPP and TATS funded projects included in this Evaluation.

5.1 Overview

A profile of each of the 49 projects is provided at Appendix A. The information presented in this chapter has been derived primarily from project representatives’ responses to the online survey (Section 4.4). The funding information identified for each project is based on data provided by the Department in June 2013.

One project was funded for both a local and a national component and is therefore treated as two projects for the purposes of some of the following analysis, yielding a total of 50 projects. Throughout each section of this chapter, the total number of projects analysed (49 or 50) is clearly indicated.

From July 2006 to June 2013, a total of $120.1 million was allocated to fund NSPP projects. The 49 projects included in this Project Profile received a total of $96.8 million funding over this seven-year period. Other NSPP-funded projects, not included in the Evaluation, received $23.3 million over this period.

The following Figure 5-1 shows the total NSPP funding for each year from July 2006 to June 2013. The figure identifies total funding allocated to the 49 projects each year, and total funding for other projects. Other projects (i.e., projects outside the scope of this Evaluation) are those that were not funded in 2010-11, because they ceased receiving funding before then or did not commence receiving funding until after 2010-11.
5 Profile of projects

Total NSPP funding increased from $15.8 million in 2006-07 to $21.3 million for 2012-13. The amount allocated to the 49 projects was $9.7 million for 2006-07; increasing to $18.0 million for 2011-12 and $16.1 million for 2012-13.

As shown, only 35 of the 49 projects received funding in 2006-07, ie, 14 did not commence until later years. By 2009-10, all but two of the 49 projects were operating.

Further information about the funding allocated to these 49 projects is provided in Section 5.11.

5.2 Project approaches

The NSPP-funded activities spanned the three major suicide prevention approaches: universal, selective and indicated. Universal approaches can be applied to a whole population or community; selective approaches can be applied to a sub-group known to be at increased risk while indicated measures target individuals who are at high risk.36

As shown in the following Table 5-1, selective approaches were the most common approach reported, with 72% of projects identifying this approach.

Table 5-1: Project approach (n=50)

<table>
<thead>
<tr>
<th>Approach</th>
<th>Projects</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>21</td>
<td>42%</td>
</tr>
<tr>
<td>Selective</td>
<td>36</td>
<td>72%</td>
</tr>
<tr>
<td>Indicated</td>
<td>19</td>
<td>38%</td>
</tr>
</tbody>
</table>

Many projects adopted multiple approaches, as illustrated in the following Figure 5-2.

---

5 Profile of projects

As shown above:

- Four (8%) of the 50 projects adopted all three approaches
- Eighteen (7+11), ie, 36% adopted two approaches
- Twenty-eight (4+10+14), ie, 56% adopted a single approach.

5.3 Service delivery mechanisms

Multiple service delivery mechanisms were used by most projects. Approximately 20 projects reported that they conducted some one-on-one activities with clients as one element of their services. This ranged from counselling (phone, face-to-face), case management and practical support, to the identification and referral of people at risk (without specific counselling intervention).

The scale of individual and/or group activities could not be quantified from the pre-existing data/documentation. Accordingly, an analysis of the number of one-on-one clients or the proportion of time one-on-one interventions constituted of all projects was not available. Activity-based information for the period October 2012 to March 2013 obtained from the MDS is presented in Chapter 6.

At the August 2012 consultation workshops, project representatives indicated that group activities often resulted in one-on-one interaction/follow-up with individual participants at a later date. This additional service delivery was seldom reported as part of the individual level activity submitted by projects as part of their standard DoHA reports. Furthermore, other initiatives that are outside the scope of this project profile, such as the ATAPS service initiative, are also involved in individual service provision. These combined factors suggest that the scale of one-on-one activities supported by NSPP funding may be understated and that the 20 projects cited above is an underestimation.

5.4 Target groups

All 18 major acknowledged at risk groups were represented as target groups across the NSPP-funded projects, as detailed in the following Table 5-2.
Table 5-2: Target group by approach

<table>
<thead>
<tr>
<th>Target group</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereaved</td>
<td>5</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Men</td>
<td>9</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Youth</td>
<td>7</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Indigenous</td>
<td>2</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Mental illness</td>
<td>2</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Previous attempt</td>
<td>2</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Self-harm</td>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Rural and remote</td>
<td>8</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>LGBTI</td>
<td>2</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>CALD</td>
<td>3</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Refugee</td>
<td>1</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Older people</td>
<td>1</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>AOD problem</td>
<td>1</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Whole community</td>
<td>11</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Workforce settings</td>
<td>10</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Redundancies</td>
<td>4</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Natural disasters</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

A small number of projects identified ‘other’ target groups in the survey, thus signifying that they target a group not specified in the list provided. However, in most cases the narrative description of these ‘other’ groups matched already selected target groups. Two newly identified target groups did emerge, namely:

- Domestic violence victims
- Families of specific at-risk groups.

Table 5-2 also summarises the range of approaches taken by projects to address the needs of these target groups. As previously identified, selective approaches were most commonly used.

5.5 LIFE Action Areas

Activities under the six LIFE Action Areas were explored from two perspectives. Project representatives were asked to:

- Identify which of the six LIFE Action Areas applied to their project
- Assess their progress toward achieving each of the individual LIFE Framework Action Area Outcomes.
5 Profile of projects

Sixteen (32%) of the 50 projects reported that they addressed all six LIFE Action Areas. As shown in Table 5-3, all LIFE Action Areas were well represented among the 50 projects.

Table 5-3: Project coverage of LIFE Action Areas

<table>
<thead>
<tr>
<th>LIFE Action Area</th>
<th>n = 50</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improving the evidence base and understanding of suicide prevention</td>
<td>29</td>
<td>58%</td>
</tr>
<tr>
<td>2. Building individual resilience and the capacity for self-help</td>
<td>41</td>
<td>82%</td>
</tr>
<tr>
<td>3. Improving community strength, resilience and capacity in suicide prevention</td>
<td>45</td>
<td>90%</td>
</tr>
<tr>
<td>4. Taking a coordinated approach to suicide prevention</td>
<td>35</td>
<td>70%</td>
</tr>
<tr>
<td>5. Providing targeted suicide prevention activities</td>
<td>39</td>
<td>78%</td>
</tr>
<tr>
<td>6. Implementing standards and quality in suicide prevention</td>
<td>26</td>
<td>52%</td>
</tr>
</tbody>
</table>

Four Action Areas were addressed by 70% or more of the projects, as follows:

1. Improving the evidence base and understanding of suicide prevention (58%)
2. Building individual resilience and the capacity for self-help (82%)
3. Improving community strength, resilience and capacity in suicide prevention (90%)
4. Taking a coordinated approach to suicide prevention (70%)
5. Providing targeted suicide prevention activities (78%)

Project representatives were also asked to assess their progress toward achieving each of the individual LIFE Framework Action Area Outcomes, thus facilitating a more refined assessment of achievements across each of the 19 outcome areas that make up the six LIFE Action Areas (see Section 3.3.1).

Assessment of progress was ranked using a five-point Likert style scale, with 1 indicating ‘not achieved’ and 5 indicating ‘fully achieved’. A ‘not applicable’ option was also provided.

The results of this assessment are summarised in the following Figure 5-3.

As shown in Figure 5-3 below, there was relatively little variation in average achievement score across the 19 LIFE Action Area Outcomes. The average outcome score per area ranged from 3.41 to 4.06, with the exception of one outlier. As a rating of five indicates fully achieved and a rating of one indicates not achieved, project representatives mostly self-reported their achievements at the top end of the scale.

One notable outlier was for outcome 5.2 (Systematic, long term, structural interventions), for which an average score of 3.06 was reported.
5 Profile of projects

Figure 5-3: Progress towards achieving LIFE Action Area Outcomes: average score per outcome

Note: The above wording for each Action Area Outcome is abbreviated – see Table 3-2 for a complete description.
5 Profile of projects

5.6 Geographical reach of projects

As shown in the following Table 5-4, locally oriented projects accounted for the largest proportion (56%) of projects, state-wide projects made up 14%, and projects with a national reach made up the remaining 30% of projects.

<table>
<thead>
<tr>
<th>Region</th>
<th>Projects</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>28</td>
<td>56%</td>
</tr>
<tr>
<td>State-wide</td>
<td>7</td>
<td>14%</td>
</tr>
<tr>
<td>National</td>
<td>15</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

Analysis of the geographical descriptions provided by project representatives indicated a more complex reach than Table 5-4 would suggest. For example:

- Four projects identified as local were found to operate in one or more other states. Their activities within these other states were, however, confined to small/local areas.
- One local project also had a national component.
- One local project contributed to international suicide prevention efforts.

The implications of this complex geographical reach within Australia are discussed in more detail in the subsequent chapters of this report.

The approach taken by projects differed according to geographical reach, as shown in Table 5-5.

<table>
<thead>
<tr>
<th>Region</th>
<th>Universal</th>
<th>Selective</th>
<th>Indicated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>8</td>
<td>23</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>State-wide</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>National</td>
<td>11</td>
<td>6</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>36</td>
<td>19</td>
<td>50</td>
</tr>
</tbody>
</table>

As indicated, locally oriented projects (28) mainly used selective (23) and indicated (15) approaches, with selective being the most commonly cited of the two approaches.

Projects with state-wide reach (7) tended to use selective approaches (7). As would be expected, the national projects (15) were largely characterised by universal approaches (11).

5.7 Strategies and activities

Project activities varied widely across the body of NSPP-funded projects. As indicated in Section 5.5 the majority of projects were multi-faceted and it was not uncommon for a single project to operate
5 Profile of projects

across a range of target groups and use a number of different interventions. The main activities applied by projects are described below.

5.7.1 Universal approaches

The key activities undertaken by projects engaged in universal approaches include:

- Public awareness campaigns designed to improve mental health literacy and encourage help-seeking (delivered via a range of channels including print, television, radio and online).
- Development of media guidelines and resources, and training for media personnel on appropriate reporting of suicide and mental illness.
- Advocacy and capacity-building approaches to strengthen the suicide prevention sector.
- Whole-of-school or whole-of-workplace activities such as resilience training or education for parents.
- Research and evaluation into suicide epidemiology and program effectiveness.

5.7.2 Selective approaches

The key activities undertaken by projects engaged in selective approaches include:

- Gatekeeper training for people who work (or live) with higher risk groups, to help these gatekeepers identify and respond to individuals at risk of suicide. This included support for health professionals working with people at risk of suicide, provision of educational resources (either print format or online) and face-to-face training.
- Training and support for personnel responding to suicide or suicide attempts (eg, police or ambulance officers).
- Postvention support for people and communities that have been bereaved by suicide. This included a range of activities such as support groups, counselling, assistance with funeral arrangements and ongoing follow-up.
- Community capacity-building or mental health promotion approaches aimed at reducing risk factors for suicide and improving resilience. This included activities to improve social connectedness (eg, community events, support groups, homework clubs), improve resilience (eg, education to improve mental health self-care), and culturally specific activities such as ‘back to country’ trips.
- Establishing peer support groups (this activity may be considered selective or indicated, depending on whether high-risk groups are involved, or if individuals identified as being at high risk of suicide are involved).

5.7.3 Indicated approaches

The key activities undertaken by projects engaged in indicated approaches include:

- Provision of clinical or counselling services (face-to-face, telephone-based or online).
- Activities to improve the care pathways and support for people at high risk of suicide moving through the health system. This included partnerships between organisations, strengthening discharge and referral protocols.
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- Practical assistance for people following suicide attempts upon discharge from hospital (such as support to manage activities of daily living, assistance to attend appointments, and referral to other services as required).

The formation and maintenance of partnerships or collaborative relationships to strengthen service delivery was an activity undertaken by almost all projects and has not been listed as a separate activity here. Collaboration by projects is examined in Section 5.10.

5.8 Stability or change over time

The extent of stability or change within projects was examined from three perspectives:

- Changes in aims/objectives
- Changes in activities
- Changes in scope.

5.8.1 Changes in aims/objectives

The majority of projects (77%) reported that their aims and objectives had remained unchanged over time (Table 5-6). Of the 11 projects that did report change, six were local, three were state-wide and two were national projects.

Table 5-6: Change in aims/objectives over time

<table>
<thead>
<tr>
<th>Have the aims or objectives changed over time?</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>37 (77%)</td>
</tr>
<tr>
<td>Yes</td>
<td>11 (23%)</td>
</tr>
<tr>
<td>Total</td>
<td>48 (100%)</td>
</tr>
</tbody>
</table>

Note: Information not available for two projects.

The main changes to aims/objectives cited were:

- Increase in scope of the project (ie, inclusion of new sites)
- Increasing public or community awareness of the services provided by the project
- More focussed targeting of particular high-risk groups.

In each case, the projects indicated that the change had occurred in response to identified need. Details of these changes are provided in the following sections.

5.8.2 Changes in activities

Less than half of all project representatives (45%) reported changes in their project strategies and activities over the life of the project.
5  Profile of projects

<table>
<thead>
<tr>
<th>Table 5-7: Change in activities/strategies over time</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have activities/strategies changed over time?</strong></td>
</tr>
<tr>
<td><strong>n (%)</strong></td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Note: Information not available for one project.

Of the 22 project representatives that did report changes in activities or strategies, feedback from staff and consumers emerged as the most frequently cited impetus for change. Learnings gleaned from project evaluations or reviews were also cited. The nature of the changes varied, but the majority were related to process refinements that aimed to improve efficiency or to better meet the needs of the target population.

Four projects referred to restrictive DoHA contractual obligations where short-term funding agreements reduced flexibility within projects or potentially created service delivery gaps.

5.8.3  Changes in scope

The majority of project representatives (81%) reported that their project had not grown in scope to national level (Table 5-8). Of the eight that did report such growth, the key mechanisms through which this growth was achieved was firstly by the project being recognised for the success of its activities and then being successful in securing additional funding to expand the scope of the project.

In one case, this expansion was from Australia to an international audience. Of the seven projects that grew to become national, four primarily used gatekeeper training approaches and three were community capacity-building projects. The project that expanded to an international audience was a research project.

<table>
<thead>
<tr>
<th>Table 5-8: Grown in scope from local to national</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Has your project grown in scope from a local project to a national project?</strong></td>
</tr>
<tr>
<td><strong>n (%)</strong></td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Notes:
1. One of the 'yes' projects changed from national to international.
2. Information not available for two projects.

5.9  Community acceptance

Overall, high levels of community acceptance were reported by the project representatives, with the majority (89%) rating it as either four or five on the Likert scale provided (Table 5-9). Five projects reported lower scores of two or three. These latter projects were either based in the healthcare sector or in local community settings. Of these, one of the healthcare sector projects reported low levels of
5 Profile of projects

acceptance within the professional community. Conversely, the other reported high levels of acceptance within the professional community but noted that the project was not designed to target the general community. Projects directed at the general community that scored poorly reported lack of community acceptance of suicide as a reality in the community or a reticence to address suicide as an issue because of ‘collective grief’ as the main reason for poor community acceptance.

Projects that were well accepted by the community tended to be those that serviced areas or communities where there was strong awareness of suicide as a problem, and in which the projects were perceived to be providing a necessary and valued service. Evidence for strong community acceptance cited by project representatives included high levels of uptake of resources or training, referrals to services from a range of sources, and feedback from service users on the appropriateness and value of the services. Several organisations attributed the level of community acceptance they received to the length of time they had been operating in the community.

Table 5-9: Level of community acceptance

<table>
<thead>
<tr>
<th>How would you rate the level of community acceptance of your project?</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (very low)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>2</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>3</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>4</td>
<td>12 (24%)</td>
</tr>
<tr>
<td>5 (very high)</td>
<td>32 (65%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49 (100%)</strong></td>
</tr>
</tbody>
</table>

Note: Information not available for one project.

5.10 Collaboration

Project representatives reported high levels of collaborative working with other organisations that conducted suicide prevention activities in their area/region, with 92% indicating that they engaged in such collaborations.

Table 5-10: Level of collaboration with other organisations

<table>
<thead>
<tr>
<th>Have you worked collaboratively with any organisations conducting suicide prevention activities in your area/region?</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Yes</td>
<td>45 (92%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49 (100%)</strong></td>
</tr>
</tbody>
</table>

Note: Information not available for one project.

Further details about the range and nature of these collaborations are provided below.
5 Profile of projects

5.10.1 Range of collaborating organisations

For those projects that worked collaboratively with other organisations, a diverse range of partner organisations were listed, including:

- Mental health and suicide prevention peak bodies (including consumer groups)
- Suicide prevention service providers (including crisis lines, counselling services, bereavement services)
- Police and emergency services
- Healthcare organisations (including hospitals, mental health services, community health services, Medicare Locals, Divisions of General Practice (now Medicare Locals) and Aboriginal Community Controlled Health Organisations)
- Courts, prisons and other law/justice agencies
- Research organisations
- Schools
- Corporate industries
- Welfare services and job network agencies
- Local, state and federal governments.

A number of organisations indicated that they collaborated with other NSPP-funded projects.

5.10.2 Nature of collaboration

For those projects who reported collaborating with other organisations, collaboration was undertaken for the following purposes:

- Joint provision of training or other activities
- Increase referral or access to appropriate services
- Resource sharing, communication and capacity building
- Participation on working groups or advisory panels
- Community awareness-raising about service availability or about suicide prevention more generally
- Data collection, evaluation or research.

5.11 Project funding and workforce resources

This section provides a profile of the resources and funding available to the 50 NSPP-funded projects. It provides detail on:

- NSPP funding
- Project workforce.
5 Profile of projects

5.11.1 NSPP funding

The following identifies the NSPP funding allocated to the 50 projects, in terms of:

- Year and funding round
- Project funding range
- Suicide prevention approach
- Geographic reach.

Funding by year and funding round

The following Table 5-11 identifies total NSPP funding for the 50 projects, by year and funding round, over the period 2006-07 to 2012-13.

<table>
<thead>
<tr>
<th>Funding</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>$9,693,265</td>
<td>$9,899,222</td>
<td>$12,728,465</td>
</tr>
<tr>
<td>Round</td>
<td>$32,320,952</td>
<td></td>
<td>$30,365,652</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As shown above, NSPP funding for the seven-year period totalled $96.8 million. Round 1 funding ($32.3 million) was broadly similar to funding for Round 2 ($30.3 million) and Round 3 ($34.1 million). Annual funding generally rose over the period identified, with funding of $9.7 million in 2006-07 and $16.1 million in 2012-13; however peak funding was in 2011-12 with funding of $18.0 million for these 50 projects.

Funding by project

Over the seven-year period identified, projects were allocated average funding of $1.94 million per project. Funding ranged from $143,231 for the project which received the least funding to $10,109,980 for the project which received the most. The following Figure 5-4 provides analysis of the range of project funding.
5 Profile of projects

Figure 5-4: Number of projects, by funding range, 2006-07 to 2012-13

The most common funding range was between $1 million and $2 million, with half (25) of all projects receiving this level of funding. Few projects received $3 million or more, i.e., only 12% (6 of 50), of which one project received funding of $10.1 million.

Funding by suicide prevention approach

As indicated previously, NSPP-funded activities spanned the three major suicide prevention approaches, namely:

- Universal
- Selective
- Indicated.

The following Table 5-12 presents an analysis of the number of projects which adopted each suicide prevention approach and the funding associated with these projects.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Projects</th>
<th>Funding</th>
<th>Funding per project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>$</td>
</tr>
<tr>
<td>Universal</td>
<td>21</td>
<td>42%</td>
<td>$43,989,059</td>
</tr>
<tr>
<td>Selective</td>
<td>36</td>
<td>72%</td>
<td>$65,169,601</td>
</tr>
<tr>
<td>Indicated</td>
<td>19</td>
<td>38%</td>
<td>$38,217,224</td>
</tr>
<tr>
<td>All projects/funding</td>
<td>50</td>
<td></td>
<td>$96,816,401</td>
</tr>
</tbody>
</table>

Note that the sum of number of projects and funding shown above for each approach is greater than the total NSPP projects (50) and funding ($96.8 million). This is because many projects adopted multiple approaches, and these projects have been included (i.e., repeated) in the figures shown for each approach.
5 Profile of projects

As indicated in Table 5-12, selective approaches were the most common approach, representing 72% (36) of projects and 67% ($65.2 million) of funding. Universal approaches accounted for 45% ($44.0 million) of funding while indicated approaches represented 38% ($38.2 million) of total funding.

For the universal approach, the share of funding (45%) was greater than the share of projects (42%), indicating higher than average funding for these projects ($2.1 million versus $1.9 million). Projects adopting the selective approach received average funding of $1.8 million, slightly below the overall average; while projects adopting the indicated approach received average funding of $2.0 million, slightly above the overall average.

Funding by geographic reach

The allocation of NSPP funding by the geographic reach of projects (national, state-wide or local) is identified in Table 5-13. The reach of each project was determined based on its response to the NSPP project survey.

Table 5-13: NSPP projects and funding by geographic reach, 2006-07 to 2012-13

<table>
<thead>
<tr>
<th>Reach</th>
<th>Projects</th>
<th>Funding</th>
<th>Funding per project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>$</td>
</tr>
<tr>
<td>National</td>
<td>15</td>
<td>30%</td>
<td>$37,091,816</td>
</tr>
<tr>
<td>State-wide</td>
<td>7</td>
<td>14%</td>
<td>$8,817,495</td>
</tr>
<tr>
<td>Local</td>
<td>28</td>
<td>56%</td>
<td>$50,907,090</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100%</td>
<td>$96,816,401</td>
</tr>
</tbody>
</table>

Locally oriented projects accounted for the largest proportion of projects (56%) and funding (53%). National projects represented the second largest group with 30% of projects and 38% of funding, while state-wide projects represented 14% of projects and received 9% of total funding.

State-wide projects had the lowest average funding ($1.3 million), considerably lower than the average funding for all projects ($1.9 million). National projects had the highest average funding ($2.5 million), significantly higher than the average for all projects, while local projects received average funding ($1.8 million) broadly in line with the average overall.

5.11.2 Project workforce

Project representatives were asked in the survey to identify the number of full time equivalent (FTE) staff and volunteers that worked with their project during each funding period. This information was used to identify the number of staff/volunteers that worked with each project over its duration to date, ie, the typical number of staff/volunteers that worked with the project at a given point in time. This information is summarised in the following Table 5-14.
5 Profile of projects

Table 5-14: NSPP projects staff and volunteers

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Total FTE workforce across all projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>176.9</td>
</tr>
<tr>
<td>Volunteers</td>
<td>221.7</td>
</tr>
<tr>
<td>Total</td>
<td>398.6</td>
</tr>
</tbody>
</table>

Note: Information is for 48 projects as two did not respond to this question.

As identified in Table 5-14, across all 48 projects that responded, there were a total of 176.9 FTE staff and 221.7 FTE volunteers, representing a total NSPP workforce of 398.6 FTE personnel. It should be noted, however, that the majority of volunteers work in a small number of projects, with more than half of all FTE volunteers (116.7) associated with a single project.

As identified in Table 5-15, across all 48 projects that responded, there were a total of 176.9 FTE staff and 221.7 FTE volunteers, representing a total NSPP workforce of 398.6 FTE personnel. It should be noted, however, that the majority of volunteers work in a small number of projects, with more than half of all FTE volunteers (116.7) associated with a single project.

The following Table 5-15 identifies the average number project staff by geographic reach.

Table 5-15: NSPP project staff, by project geographic reach

<table>
<thead>
<tr>
<th>Reach</th>
<th>FTE Staff</th>
<th>Average project funding (2006-07 to 2012-13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSPP-funded</td>
<td>Non-NSPP-funded</td>
</tr>
<tr>
<td>National</td>
<td>2.8</td>
<td>0.6</td>
</tr>
<tr>
<td>State-wide</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Local</td>
<td>2.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>2.6</td>
<td>1.1</td>
</tr>
</tbody>
</table>

As identified in Table 5-15, state-wide projects had notably more staff (5.7 FTE) than both national (3.4 FTE) and local (3.3 FTE) projects. Our investigation indicates that in part this may be due to some state-wide projects receiving additional non-NSPP funds, which allowed them to employ non-NSPP-funded staff. State-wide projects employed an average of 2.4 non-NSPP-funded staff, compared with local (1.1 FTE) and national (0.6 FTE) projects. By virtue of the type of work undertaken by national level projects, fewer staff may be required. This was found to be the case for national projects engaged in media work, web-based services and conference organisation, for example.

It would also appear that the average number of NSPP-funded staff employed was broadly similar across national (2.8 FTE), state-wide (2.3 FTE) and local (2.5 FTE) projects. This was despite state-wide projects receiving significantly less NSPP funding ($1.3 million) on average, than local ($1.8 million) and national ($2.5 million) projects.
5 Profile of projects

5.12 Summary profile

Overall, NSPP-funded activities can be summarised as follows.

Suicide prevention approach:
- Spanned all three major suicide prevention approaches
- Often used multiple approaches within projects
- Most commonly used selective approaches or combinations of selective and indicated approaches.

Life Framework Action Areas:
- Spanned all six LIFE Framework Action Areas
- Addressed multiple LIFE Framework Action Areas within individual projects.

Target groups:
- Included all major acknowledged ‘at risk’ target groups
- Were multi-faceted and it was not uncommon for a single project to operate across a range of target groups and use a number of different interventions.

Aims, objectives, strategies and scope
- Had aims and objectives that had remained unchanged over time during the review period
- Had remained largely unchanged in terms of project strategies and activities over the life of the project
- Had not grown in scope from local to national.

Community acceptance and collaborative work in area/region:
- Received high levels of community acceptance
- Involved very high levels of collaborative work with other organisations conducting suicide prevention activities in their area/region that were not NSPP-funded.

Funding:
- Over the seven-year period to June 2013, projects were allocated average funding of $1.93 million per project. Funding ranged from $143,231 for the project which received the least funding, to $10,109,980 for the project which received the most.
- Locally oriented projects accounted for the largest proportion of projects (56%) and funding (53%).
- On average each project had 8.3 full time equivalent (FTE) workforce at a given point in time, comprising 3.7 FTE paid staff and 4.6 FTE volunteers
- The average number of NSPP-funded staff employed was broadly similar across national (2.8 FTE), state-wide (2.3 FTE) and local (2.5 FTE) projects.
6 Snapshot of project activity: Oct 2012 to Mar 2013

SNAPSHOT OF PROJECT ACTIVITY: OCTOBER 2012 TO MARCH 2013

The data presented in this chapter provides a snapshot of project activities based upon data collected via the MDS for the six month period October 2012 to March 2013. By providing an analysis of the activities undertaken during the snapshot period, it builds on the overview of NSPP-funded activities presented in Chapter 5.

It is important to note that prior to the implementation of the MDS, existing project data was only able to be used to generate a broad overview of project activities. While areas of activity could be established, information regarding the scale of this activity was not available. Likewise, analysis of activities was not able to be undertaken, including relation to dimensions such as participant demographics, target groups, and referral pathways, for example. The MDS data therefore facilitates the first in-depth review of NSPP-funded activity.

Sections 6.1 and 6.2 examine the scope and quality of the MDS data. The subsequent sections provide analysis of the data at program level, individual or group level, and by target group.

6.1 Scope of MDS data

A total of 47 of the 49 projects included in Chapter 5 were required to collect data using the MDS during the snapshot period. Two projects, Healing Through the Map and Post-discharge Care from Hospital Emergency Departments, were not funded beyond June 2012 and were therefore exempt from MDS data collection.

StandBy ACT submitted data each month as part of the Standby Response Service project MDS data. Accordingly, analysis in this section is based upon MDS data collection for 46 projects.

As outlined in Chapter 4, the MDS comprises three components (see Appendix C for further details):

- **Program level data.** Program level data reports on the LIFE Action area(s) addressed, type(s) of suicide prevention activities (universal, selective, indicated), promotion of activities, activity settings, time estimates in relation to travel, administration, etc, and good news/barriers and challenges encountered during the reporting period.

- **Individual level data.** Individual level data relates to episodes of service provided to or in relation to an individual during the reporting period.

- **Group level data.** This includes a broad spectrum of activities such as workshops, meetings, homework groups, community events and research/development. These group activities can vary in scale from small local events to national level projects, and can be once-off or ongoing.

All projects were required to submit program level data. Individual level data and/or group level data were also required to be submitted by projects that delivered individual or group-based services. A summary of these data requirements across the 46 projects is provided in Table 6-1.
Table 6-1: Overview of MDS data submission requirements by project

<table>
<thead>
<tr>
<th>Program</th>
<th>Individual</th>
<th>Group</th>
<th>Projects</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
<td>18</td>
<td>39%</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>✓</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>25</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>46</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The status of data submission and the type of data provided by each project is shown in Table 6-2.

Table 6-2: Data submission status, per NSPP project

<table>
<thead>
<tr>
<th>Project name</th>
<th>Complete submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Program level data</td>
</tr>
<tr>
<td>Active Life Enhancing Intervention (ALIVE) Program</td>
<td>✓</td>
</tr>
<tr>
<td>Active Response Bereavement Outreach Program (ARBOR)</td>
<td>✓</td>
</tr>
<tr>
<td>Apprentices Project ACT</td>
<td>✓</td>
</tr>
<tr>
<td>Apprentices Project NT</td>
<td>✓</td>
</tr>
<tr>
<td>Basic Needs Project</td>
<td>✓</td>
</tr>
<tr>
<td>Building Bridges</td>
<td>✓</td>
</tr>
<tr>
<td>Burdekin SP and MH Support</td>
<td>✓</td>
</tr>
<tr>
<td>Community Broadcasting SP Project</td>
<td>✓</td>
</tr>
<tr>
<td>Community Capacity Building and Training Project</td>
<td>✓</td>
</tr>
<tr>
<td>Community Connections</td>
<td>✓</td>
</tr>
<tr>
<td>Community Connections Toowoomba</td>
<td>✓</td>
</tr>
<tr>
<td>Comprehensive Suicide Prevention Service</td>
<td>✓</td>
</tr>
<tr>
<td>Deadly Alive¹</td>
<td>✓</td>
</tr>
<tr>
<td>Expanded Horizons</td>
<td>✓</td>
</tr>
<tr>
<td>Farm Link</td>
<td>✓</td>
</tr>
<tr>
<td>HOPE – SRA</td>
<td>✓</td>
</tr>
<tr>
<td>Hope for Life</td>
<td>✓</td>
</tr>
<tr>
<td>Incolink</td>
<td>✓</td>
</tr>
<tr>
<td>Koori Kids Wellbeing Program</td>
<td>✓</td>
</tr>
<tr>
<td>LIFE Communications</td>
<td>✓</td>
</tr>
<tr>
<td>LifeForce</td>
<td>✓</td>
</tr>
<tr>
<td>Living Beyond Suicide</td>
<td>✓</td>
</tr>
</tbody>
</table>
## 6 Snapshot of project activity: Oct 2012 to Mar 2013

<table>
<thead>
<tr>
<th>Project name</th>
<th>Complete submissions</th>
<th>Program level data</th>
<th>Individual level data</th>
<th>Group level data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men’s Health Information and Resource Centre (MHIRC) ‘The Shed’</strong></td>
<td></td>
<td>-1 month</td>
<td>-1 month</td>
<td>-1 month</td>
</tr>
<tr>
<td><strong>Mental Illness and Bereavement Project</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>MindFrame Education and Training Projects</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>MindOUT!</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>National Centre of Excellence in Suicide Prevention</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>National Suicide Call Back Service</strong></td>
<td>✓</td>
<td>✓</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>NEXUS</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Peer Support</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Phoenix Centre SP Project</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>R U OK? Day</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>RAW – Rural Alive and Well Program</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>ReachOut! Pro Website</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Real engagement and linking for Men in industry (RealMii)</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Response to Youth Suicide in Greater Geelong</strong></td>
<td>-1 month</td>
<td>NA</td>
<td>-1 month</td>
<td></td>
</tr>
<tr>
<td><strong>SANE Media Centre and Stigmawatch</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>SPA Strategic Partnership</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>StandBy Brisbane</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>StandBy Response Service</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Suicide Story Train the Trainer</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Support After Suicide</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainable Personal Development for Aboriginal Men</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>WHO START Project</strong></td>
<td>✓</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>Workplace Training and Education</strong></td>
<td>✓</td>
<td>NA</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Yiriman Project</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

NA = Not Applicable (signifies that data of this type was not required).

* Data submitted too late and in wrong format to be included in this Report.

** The Yiriman project did not submit data for 3 out of 5 months, as the project did not operate during December to February for various reasons. In the Kimberley, law time runs during this time and weather conditions halt their on-country work. Yiriman is a small organisation with a full time staff of two, who work away from their families for 10 months of the year.

As indicated in Table 6-2, the majority of projects submitted all required data within the timeframes required for inclusion in this Report, with only a small number submitting data behind schedule.
6 Snapshot of project activity: Oct 2012 to Mar 2013

Key findings

- Funded organisations were generally compliant with MDS submission requests. Despite working in sometimes difficult environments with limited capacity for administration, responses to requests for data were outstanding and allowed an excellent picture of the NSPP-funded program activity to be developed.

Analysis of the program, individual and group level data submitted by projects is presented in the following sections.

6.2 Data quality

There are a number of data quality considerations associated with the data set out in this chapter, as follows:

- As outlined in Table 6-2, not all projects submitted data within sufficient time for it to be included in this Report.

- Not all MDS data items were fully completed by all projects. For this reason, the total number of responses reported for specific data items may not match the total number of projects that submitted program, individual or group data.

- Inconsistencies in data reporting across projects were evident. For example, some projects used narrative such as ‘many’ or ‘1 person plus three schools’ to describe group size or reach rather than numbers as instructed in the MDS Data Dictionary. For this reason, group size data does not fully reflect the true scale of group activities.

- The six month snapshot period includes months where some projects were not operating for seasonal/cultural reasons or where peak activity periods were missed. Examples include the Western Australia-based Yiriman project which did not undertake activities over the December to February period; and organisations with key date-specific activities such as R U OK? which conducts a national day of action on the second Thursday of September each year.

Collectively, these data quality issues mean that the scale of project activity presented in the following sections is understated.

6.3 Program level data

6.3.1 Overview of program level data submitted

A full six months of data was received from 43 out of 46 projects (94%), providing a total of 270 program data submissions for the period October 2012 to March 2013. The distribution of these submissions by month is shown in Table 6-3. The majority of projects submitted program level data for each of the six months from October 2012 to March 2013.
Table 6-3: Program level data submission by month

<table>
<thead>
<tr>
<th>Collection period</th>
<th>No. submitted</th>
<th>% total projects (n=46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2012</td>
<td>46</td>
<td>100%</td>
</tr>
<tr>
<td>November 2012</td>
<td>45</td>
<td>98%</td>
</tr>
<tr>
<td>December 2012</td>
<td>45</td>
<td>98%</td>
</tr>
<tr>
<td>January 2013</td>
<td>45</td>
<td>98%</td>
</tr>
<tr>
<td>February 2013</td>
<td>46</td>
<td>100%</td>
</tr>
<tr>
<td>March 2013</td>
<td>43</td>
<td>93%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>270</strong></td>
<td></td>
</tr>
</tbody>
</table>

6.3.2 Time estimates for program activities

Program level data included estimates of the proportion of time spent by each project in relation to nine key activities, as follows:

- Travel
- Event planning
- Administration
- Event/activity promotion
- Service provision
- Research and development
- Information development and provision
- Supervision
- Other.

The following Table 6-4 provides a summary of information provided by projects regarding time spent in relation to the above activities. For each activity, the table identifies, the minimum, maximum and mean percentage of time reported.
Table 6-4: Proportion of time allocation by program activity (%)

<table>
<thead>
<tr>
<th>Program activity</th>
<th>Minimum %</th>
<th>Maximum %</th>
<th>Mean %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel</td>
<td>0</td>
<td>60</td>
<td>11.2</td>
</tr>
<tr>
<td>Event planning</td>
<td>0</td>
<td>75</td>
<td>13.7</td>
</tr>
<tr>
<td>Administration</td>
<td>0</td>
<td>100</td>
<td>15.4</td>
</tr>
<tr>
<td>Event/activity promotion</td>
<td>0</td>
<td>65</td>
<td>8.7</td>
</tr>
<tr>
<td>Service provision</td>
<td>0</td>
<td>87</td>
<td>28.1</td>
</tr>
<tr>
<td>Research and development</td>
<td>0</td>
<td>87</td>
<td>11.6</td>
</tr>
<tr>
<td>Information development and provision</td>
<td>0</td>
<td>80</td>
<td>6.9</td>
</tr>
<tr>
<td>Supervision</td>
<td>0</td>
<td>30</td>
<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>40</td>
<td>2.6</td>
</tr>
</tbody>
</table>

The minimum and maximum percentage range for each activity indicates that projects differed substantially in terms of the time spent in relation to each activity. Overall, service provision was, on average, the activity upon which projects spent most time (mean = 28.1%). However, it should be noted that some organisations were not involved in direct service provision, defined in the *MDS Data Dictionary* as time spent actually delivering services to individual or groups. Projects that allocated a greater proportion of their time to activities such as research and development or administration have low percentages allocated to service provision.

The time allocated to each activity is shown using 5% intervals in *Table 6-5*. The table identifies, for example, that 28 of the 270 program data submissions (over the six month period) report that travel time represented zero (0) percent of their time.
## 6 Snapshot of project activity: Oct 2012 to Mar 2013

Table 6-5: Time allocation by program activity, all program data submissions

<table>
<thead>
<tr>
<th>Time allocation (%)</th>
<th>Travel</th>
<th>Event planning</th>
<th>Administration</th>
<th>Event/activity promotion</th>
<th>Service provision</th>
<th>Research</th>
<th>Information provision</th>
<th>Supervision</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>0%</td>
<td>28</td>
<td>29</td>
<td>11</td>
<td>32</td>
<td>65</td>
<td>82</td>
<td>164</td>
<td>215</td>
<td>205</td>
</tr>
<tr>
<td>1-5%</td>
<td>82</td>
<td>60</td>
<td>43</td>
<td>112</td>
<td>10</td>
<td>90</td>
<td>45</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>6-10%</td>
<td>70</td>
<td>70</td>
<td>75</td>
<td>75</td>
<td>20</td>
<td>39</td>
<td>21</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>11-15%</td>
<td>39</td>
<td>32</td>
<td>47</td>
<td>19</td>
<td>15</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>16-20%</td>
<td>22</td>
<td>23</td>
<td>46</td>
<td>17</td>
<td>14</td>
<td>15</td>
<td>10</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>21-25%</td>
<td>5</td>
<td>23</td>
<td>16</td>
<td>5</td>
<td>12</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>26-30%</td>
<td>12</td>
<td>14</td>
<td>9</td>
<td>4</td>
<td>20</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>31-35%</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>-</td>
<td>16</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>36-40%</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>31</td>
<td>5</td>
<td>9</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>41-45%</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>46-50%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>51-55%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>56-60%</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>23</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>61-65%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>66-70%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>71-75%</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>76-80%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>81-85%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>86-90%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>91-95%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>96-100%</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
</tr>
</tbody>
</table>

**Key findings**

- Program data indicates that NSPP-funded projects spent more time on service provision activities than any other activity. Wide variations existed in the way projects spent their time, reflecting the diversity of the project activities undertaken and the settings in which the activities take place.
6.4 Individual level contact or activity data

This section provides an analysis of individual contacts or activities, under the following headings:

- Number of individual activities
- Mode of delivery
- Session type
- Duration of contact
- Activity mechanism
- Age groups
- Sex
- Aboriginal and Torres Strait Islander status
- Ethnicity
- Refugee status
- Target group
- Referral pathways
- Geographical distribution of activities.

6.4.1 Number of individual contacts or activities

In the six month period October 2012 to March 2013, a total of 16,222 individual contacts or activities were recorded. A contact or activity is defined as an episode of service that may be delivered in one or more sessions over a period of time. Contacts or activities can be delivered face-to-face, by telephone or online. This varies from one project to the next based upon their scope and function.

The number of contacts or activities in each month of the six-month MDS period was broadly consistent, with reduced activities recorded in December 2012 period as identified in Table 6-6.

<table>
<thead>
<tr>
<th>Collection period</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2012</td>
<td>3,014</td>
<td>18.6</td>
</tr>
<tr>
<td>November 2012</td>
<td>2,762</td>
<td>17.0</td>
</tr>
<tr>
<td>December 2012</td>
<td>2,281</td>
<td>14.1</td>
</tr>
<tr>
<td>January 2013</td>
<td>2,719</td>
<td>16.8</td>
</tr>
<tr>
<td>February 2013</td>
<td>2,618</td>
<td>16.1</td>
</tr>
<tr>
<td>March 2013</td>
<td>2,828</td>
<td>17.4</td>
</tr>
<tr>
<td>Total</td>
<td>16,222</td>
<td>100.0</td>
</tr>
</tbody>
</table>
6 Snapshot of project activity: Oct 2012 to Mar 2013

6.4.2 Mode of delivery

Table 6-7 identifies the mode of delivery (ie, face-to-face, telephone or online) for individual contacts or activities. Telephone sessions represented the primary mode of service delivery (59.2%), with face-to-face and online sessions representing 38.7% and 2.1% respectively.

Lower levels of contact or activity were recorded in December 2012 across all modes of delivery. This was most pronounced in relation to face-to-face contacts or activities. The reduction in telephone-based contacts or activities was less pronounced, possibly reflecting the greater accessibility of these services during the holiday period.

Table 6-7: Number of individual activities by mode of session

<table>
<thead>
<tr>
<th>Mode of session</th>
<th>Collection period</th>
<th>Share of total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oct 12</td>
<td>Nov 12</td>
</tr>
<tr>
<td>Face-to-face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>1,337</td>
<td>1,204</td>
</tr>
<tr>
<td>%</td>
<td>21.4</td>
<td>19.2</td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>1,621</td>
<td>1,492</td>
</tr>
<tr>
<td>%</td>
<td>16.9</td>
<td>15.6</td>
</tr>
<tr>
<td>Online</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>52</td>
<td>60</td>
</tr>
<tr>
<td>%</td>
<td>14.9</td>
<td>17.2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>3,010</td>
<td>2,756</td>
</tr>
<tr>
<td>%</td>
<td>18.6</td>
<td>17.0</td>
</tr>
</tbody>
</table>

Note: Information not available for 44 (0.3%) of 16,222 individual responses.

Key findings

- In the six month period from October 2012 to March 2013, a total of 16,222 individual activities were reported.
- The most frequently reported mode of delivery for individual activities was telephone.

6.4.3 Session type

The majority of individual contacts or activities (94.5%) involved direct client contact (Table 6-8). Non-direct contacts or activities (such as case planning and engagement with community leaders) and supportive services activities accounted for the remainder (5.5%).

Table 6-8: Number of individual activities by session type

<table>
<thead>
<tr>
<th>Session type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct client contact</td>
<td>15,049</td>
<td>94.5</td>
</tr>
<tr>
<td>Non-direct client case planning with professionals</td>
<td>379</td>
<td>2.4</td>
</tr>
<tr>
<td>Non-direct case planning/management with families, careers and/or significant others</td>
<td>95</td>
<td>0.6</td>
</tr>
<tr>
<td>Non-direct engagement with community leaders</td>
<td>7</td>
<td>&lt;0.1</td>
</tr>
</tbody>
</table>
### 6.4.4 Duration of contact or activity

The duration of each contact or activity ranged from 0-15 minutes to 7 days or longer, however approximately half (51%) of all contacts or activities were less than 15 minutes duration (Table 6-9). Overall, 85.6% of contacts or activities were of less than one hour in duration.

Further exploration of MDS data has identified that almost half (42.1%) of all contacts or activities of less than one hour duration were attributable to the National Suicide Call Back Service, a service that provides up to six 50-minute telephone call-back counselling sessions for up to six months.

#### Table 6-9: Duration of contact or activities

<table>
<thead>
<tr>
<th>Duration of contact</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–15 mins</td>
<td>8,141</td>
<td>51.0</td>
</tr>
<tr>
<td>15–30 mins</td>
<td>2,560</td>
<td>16.0</td>
</tr>
<tr>
<td>30–45 mins</td>
<td>1,319</td>
<td>8.3</td>
</tr>
<tr>
<td>45 mins–1 hr</td>
<td>1,647</td>
<td>10.3</td>
</tr>
<tr>
<td>1 hr–1 hr 15 mins</td>
<td>936</td>
<td>5.9</td>
</tr>
<tr>
<td>1 hr 15 mins–1 hr 30 mins</td>
<td>363</td>
<td>2.3</td>
</tr>
<tr>
<td>1 hr 30 mins–1 hr 45 mins</td>
<td>79</td>
<td>0.5</td>
</tr>
<tr>
<td>1 hr 45 mins–2 hrs</td>
<td>272</td>
<td>1.7</td>
</tr>
<tr>
<td>2–4 hrs</td>
<td>355</td>
<td>2.2</td>
</tr>
<tr>
<td>4–8 hrs</td>
<td>166</td>
<td>1.0</td>
</tr>
<tr>
<td>1 day</td>
<td>29</td>
<td>0.2</td>
</tr>
<tr>
<td>2 days</td>
<td>47</td>
<td>0.3</td>
</tr>
<tr>
<td>5 days</td>
<td>44</td>
<td>0.3</td>
</tr>
<tr>
<td>7 days or longer</td>
<td>6</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15,964</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Note: Information was not available for 258 (1.6%) of the 16,222 individual responses.
Key findings

- Individual contacts or activities ranged widely in duration from 15 minutes to 7 days; however most contacts or activities (85.6%) had a duration of less than one hour.

6.4.5 Activity mechanism

Activity mechanism refers to the context in which care was provided to an individual. A list of these mechanisms is provided in Table 6-10. In the majority of cases (89.9%) care was provided directly to the individual client rather than by working with family, peer groups, workplace, educational or community groups.

Table 6-10: Activity mechanism of individual activities

<table>
<thead>
<tr>
<th>Activity mechanism</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>14,181</td>
<td>89.9</td>
</tr>
<tr>
<td>Family</td>
<td>582</td>
<td>3.7</td>
</tr>
<tr>
<td>Peer group</td>
<td>176</td>
<td>1.1</td>
</tr>
<tr>
<td>Workplace</td>
<td>285</td>
<td>1.8</td>
</tr>
<tr>
<td>School</td>
<td>130</td>
<td>0.8</td>
</tr>
<tr>
<td>Tertiary education setting</td>
<td>16</td>
<td>0.1</td>
</tr>
<tr>
<td>Community</td>
<td>171</td>
<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>235</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15,776</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: Information not available for 446 (2.7%) of 16,222 individual responses.

Key findings

- The majority of individual contacts or activities were undertaken directly with the individual client rather than via other avenues such as through family or friends.

6.4.6 Age groups

Age group data was not provided for 7,410 (45.7%) of individual contacts or activities (Table 6-11). The National Suicide Call Back Service did not provide age information for any individual contacts, and accounted for 3,941 (53.2%) of the 7,410 activities for which age was not reported.

In those cases where age group was recorded, a spread across age groups was evident. Children (0-14 years) accounted for 7.5% (660 out of 8,812) of individual contacts or activities. Youth and emerging adults (15-24 years accounted for 24.5% (2,158 out of 8,812) of individual contacts or activities.37,38 The age cohorts 25-29, 45-49 and 50-54 accounted for the greatest proportion of the

---

37 Emerging adulthood is defined as the period from late teens through the twenties, with a focus on ages 18-25 years. JJ Arnett, ‘Emerging Adulthood – A theory of development from the late teens through the twenties’, American Psychologist, vol 55, no 5, 2000, pp.469-480.
remaining contacts or activities. A marked decline was evident in the number of contacts or activities in age groups over 55.

### Table 6-11: Age groups of individual contacts or activities

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>5-9</td>
<td>159</td>
<td>1.0</td>
</tr>
<tr>
<td>10-14</td>
<td>500</td>
<td>3.1</td>
</tr>
<tr>
<td>15-19</td>
<td>1,193</td>
<td>7.4</td>
</tr>
<tr>
<td>20-24</td>
<td>965</td>
<td>5.9</td>
</tr>
<tr>
<td>25-29</td>
<td>765</td>
<td>4.7</td>
</tr>
<tr>
<td>30-34</td>
<td>708</td>
<td>4.4</td>
</tr>
<tr>
<td>35-39</td>
<td>640</td>
<td>3.9</td>
</tr>
<tr>
<td>40-44</td>
<td>714</td>
<td>4.4</td>
</tr>
<tr>
<td>45-49</td>
<td>874</td>
<td>5.4</td>
</tr>
<tr>
<td>50-54</td>
<td>818</td>
<td>5.0</td>
</tr>
<tr>
<td>55-59</td>
<td>414</td>
<td>2.6</td>
</tr>
<tr>
<td>60-64</td>
<td>377</td>
<td>2.3</td>
</tr>
<tr>
<td>65-69</td>
<td>220</td>
<td>1.4</td>
</tr>
<tr>
<td>70-74</td>
<td>198</td>
<td>1.2</td>
</tr>
<tr>
<td>75 or older</td>
<td>266</td>
<td>1.6</td>
</tr>
<tr>
<td>Unknown</td>
<td>7,410</td>
<td>45.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16,222</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Key findings

- The age of individuals to whom services were delivered broadly reflects the Australian population age distribution. The notable exception was children aged between 0 and 14 years who, as would be expected, received proportionally fewer services than their share of the Australian population.

### 6.4.7 Sex

For a small proportion of individual contacts or activities (7.2%), sex was not stated or inadequately described. For those participants for whom information regarding sex was provided (n=15,056), over half (58.1%) were female, with males representing 41.9% (Table 6-12). This signifies an imbalance in the sex composition of the individual contact or activity participants.

---

When sex distribution is explored by age group, the under-representation of males is further illustrated (Table 6-13). Few exceptions exist where the proportion of males exceeds that of females. Males exceeded females in the age cohorts for children (5-14 years) and over 75 year age groups, where the proportion of males is up to twice that of females. For many other age cohorts, females outnumbered males by a 2:1 ratio.

Several reasons may account for the difference in participation by gender, including:

- The greater help-seeking behaviour of females over males
- The fact that more men than women suicide, hence women present for postvention support more often than men.

Given that over three-quarters (76.0%) of people who died by suicide in 2011 were male, this finding is of importance in reviewing the appropriateness of activities provided to this age group of men and the willingness of this cohort to seek help.\(^{39}\)

It is noted however, that in the absence of data on those who are not using the services and the reasons why, the extent to which these gender differences can be apportioned to these or other factors/barriers is unknown.

The following Table 6-13 provides further detail of sex distribution, broken down by age cohort.

---

### Table 6-12: Sex of individual contact or activity participants

<table>
<thead>
<tr>
<th>Sex</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6,312</td>
<td>38.9</td>
</tr>
<tr>
<td>Female</td>
<td>8,744</td>
<td>53.9</td>
</tr>
<tr>
<td>Not stated/inadequately described</td>
<td>1,166</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,222</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

---

### Table 6-13: Age and sex distribution of individual contacts or activities

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Not stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>n</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>100.0</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>5-9</td>
<td>n</td>
<td>110</td>
<td>49</td>
<td>159</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>69.2</td>
<td>30.8</td>
<td>100.0</td>
</tr>
<tr>
<td>10-14</td>
<td>n</td>
<td>287</td>
<td>158</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>57.5</td>
<td>31.7</td>
<td>10.8</td>
</tr>
<tr>
<td>15-19</td>
<td>n</td>
<td>368</td>
<td>610</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>30.9</td>
<td>51.2</td>
<td>18.0</td>
</tr>
<tr>
<td>20-24</td>
<td>n</td>
<td>364</td>
<td>561</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>38.5</td>
<td>59.3</td>
<td>2.2</td>
</tr>
</tbody>
</table>

\(^{39}\) ABS, *Causes of Death, Australia, 2011.*
### Age

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>Male</th>
<th>Female</th>
<th>Not stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-29</td>
<td></td>
<td>349</td>
<td>412</td>
<td>4</td>
<td>765</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>45.6</td>
<td>53.9</td>
<td>0.5</td>
<td>100.0</td>
</tr>
<tr>
<td>30-34</td>
<td></td>
<td>241</td>
<td>465</td>
<td>2</td>
<td>708</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>34.0</td>
<td>65.7</td>
<td>0.3</td>
<td>100.0</td>
</tr>
<tr>
<td>35-39</td>
<td></td>
<td>216</td>
<td>423</td>
<td>1</td>
<td>640</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>33.8</td>
<td>66.1</td>
<td>0.2</td>
<td>100.0</td>
</tr>
<tr>
<td>40-44</td>
<td></td>
<td>198</td>
<td>516</td>
<td>-</td>
<td>714</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>27.7</td>
<td>72.3</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>45-49</td>
<td></td>
<td>217</td>
<td>654</td>
<td>2</td>
<td>873</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>24.9</td>
<td>74.9</td>
<td>0.2</td>
<td>100.0</td>
</tr>
<tr>
<td>50-54</td>
<td></td>
<td>278</td>
<td>538</td>
<td>2</td>
<td>818</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>34.0</td>
<td>65.8</td>
<td>0.2</td>
<td>100.0</td>
</tr>
<tr>
<td>55-59</td>
<td></td>
<td>176</td>
<td>238</td>
<td>-</td>
<td>414</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>42.5</td>
<td>57.5</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>60-64</td>
<td></td>
<td>139</td>
<td>237</td>
<td>1</td>
<td>377</td>
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<td>%</td>
<td>36.9</td>
<td>62.9</td>
<td>0.3</td>
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<tr>
<td>65-69</td>
<td></td>
<td>108</td>
<td>112</td>
<td>-</td>
<td>220</td>
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<tr>
<td></td>
<td>%</td>
<td>49.1</td>
<td>50.9</td>
<td>-</td>
<td>100.0</td>
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<tr>
<td>70-74</td>
<td></td>
<td>93</td>
<td>105</td>
<td>-</td>
<td>198</td>
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<tr>
<td>75 or older</td>
<td></td>
<td>190</td>
<td>74</td>
<td>2</td>
<td>266</td>
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<tr>
<td></td>
<td>%</td>
<td>71.4</td>
<td>27.8</td>
<td>0.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Unknown</td>
<td>n</td>
<td>2,698</td>
<td>2,937</td>
<td>835</td>
<td>6,470</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>41.7</td>
<td>45.4</td>
<td>12.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>n</td>
<td>6,032</td>
<td>8,090</td>
<td>1,138</td>
<td>15,260</td>
</tr>
</tbody>
</table>

*Information not available for 962 (5.9%) of 16,222 individual responses.

#### Key findings

- Fewer males than females participated in suicide prevention individual activities.

### 6.4.8 Aboriginal and Torres Strait Islander status

Aboriginal and Torres Strait Islander status was not reported for more than half (53.0%) of all individual contacts or activities (Table 6-14). Almost two-thirds (65%) of these unknown contacts or activities were attributable to the National Suicide Call Back Service.
6 Snapshot of project activity: Oct 2012 to Mar 2013

A total of 2,379 individual contacts or activities were recorded for people of Aboriginal and/or Torres Strait Islander descent. The majority of these (2,255 out of 2,379, 94.8%) were of Aboriginal, but not Torres Strait Islander origin.

Table 6-14: Aboriginal and Torres Strait Islander status of individual contacts or activities

<table>
<thead>
<tr>
<th>Aboriginal and Torres Strait Islander status</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal but not Torres Strait Islander origin</td>
<td>2,255</td>
<td>13.9</td>
</tr>
<tr>
<td>Torres Strait Islander but not Aboriginal origin</td>
<td>74</td>
<td>0.5</td>
</tr>
<tr>
<td>Both Aboriginal and Torres Strait Islander origin</td>
<td>50</td>
<td>0.3</td>
</tr>
<tr>
<td>Neither Aboriginal nor Torres Strait Islander origin</td>
<td>5,249</td>
<td>32.4</td>
</tr>
<tr>
<td>Not stated/inadequately described</td>
<td>8,594</td>
<td>53.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,222</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Key findings

- Data collected from NSPP projects suggests that Aboriginal and Torres Strait Islander peoples are receiving a high number of suicide prevention services (14.7% of total contacts or activities compared to an estimated 2.5% of the population). This suggests that the NSPP-funded projects are successfully targeting this group who have a significantly higher rate of suicide than the non-Indigenous population.

6.4.9 Ethnicity

Ethnicity details were self-reported by either the individual client or project staff and were captured using a free text data entry field. In nearly half (49.1%) of individual contacts or activities, no information was provided in this field (Table 6-15). Where details were provided, Australian represented the largest single ethnicity category reported. Although not mutually exclusive, Australian and Aboriginal and Torres Strait Islander were listed as two distinct categories in the self-reported responses and are presented accordingly in Table 6-15.

Table 6-15: Ethnicity of individual activities

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian</td>
<td>5,472</td>
<td>33.7</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander</td>
<td>1,127</td>
<td>6.9</td>
</tr>
<tr>
<td>CALD</td>
<td>1,305</td>
<td>8.0</td>
</tr>
<tr>
<td>Other</td>
<td>357</td>
<td>2.2</td>
</tr>
<tr>
<td>Not stated</td>
<td>7,961</td>
<td>49.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,222</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

---

40 ABS, Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006.
Over 60 ethnicities were reported in the CALD category. These are listed in the following Table 6-16. The 'other' category generally comprised people of English-speaking background. These included British, Canadian, English, Irish, Scottish and New Zealander.

Table 6-16: Ethnicity (CALD)

<table>
<thead>
<tr>
<th></th>
<th>Afghanistan</th>
<th>Arabic</th>
<th>Argentinian</th>
<th>Asian</th>
<th>Asian descent</th>
<th>Bangladeshi</th>
<th>Bhutanese</th>
<th>Bosnia</th>
<th>Brazil</th>
<th>Bulgarian</th>
<th>Burma (Republic of the Union of Myanmar)</th>
<th>Burundi</th>
<th>Cantonese</th>
<th>Chilean</th>
<th>China</th>
<th>Colombian</th>
<th>Congo, Democratic Republic of</th>
<th>Cote d'Ivoire</th>
<th>Croatian</th>
<th>Danish</th>
<th>Dutch</th>
<th>Egypt</th>
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<tr>
<td>El Salvador</td>
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</tbody>
</table>

Note: This is as reported in the MDS. It is noted to be a mix of countries and ethnicities.

Key findings

- The NSPP-funded projects have reported that over 60 different ethnic groups have been involved in individual suicide prevention activities.
- Notwithstanding the large number of different ethnic groups involved in individual activities, CALD clients appear to be under-represented, with only 8.0% of the total number of activities assigned to CALD clients.

6.4.10 Refugee status

Refugee status details were either not stated or unknown for 8,329 (51.4%) of individual contacts or activities. For the contacts or activities for which refugee status was reported (n=7,893), 7.8% were activities delivered to refugees, with 92.2% delivered to non-refugees.
Table 6-17: Refugee status of individual activities

<table>
<thead>
<tr>
<th>Status</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee</td>
<td>614</td>
<td>3.8</td>
</tr>
<tr>
<td>Not a refugee</td>
<td>7,279</td>
<td>44.9</td>
</tr>
<tr>
<td>Unknown</td>
<td>8,329</td>
<td>51.4</td>
</tr>
<tr>
<td>Total</td>
<td>16,222</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Key findings
- Refugees living in the community are accessing NSPP-funded services. Given the relatively small cohort of refugees living in the community and their high suicide risk, it is noteworthy that 3.8% of individual activities reached this target group.

6.4.11 Target group

This section identifies the group or groups which were targeted by each NSPP project for suicide prevention activities. Projects were able to assign multiple target group codes to a single contact or activity; hence the values presented in Table 6-18 exceed 16,222, the total number of individual activities.

Overall, the most frequently reported target group was whole-of-community (36.5%). Men (23.6%), people bereaved by suicide (17.8%), Indigenous populations (16.5%) and people living with a mental illness (16.3%) were the four other target groups most frequently cited. The inclusion of men as one of the top five target groups is surprising given that, as earlier reported (Section 0), only 41.9% of individual contacts or activities involved men. This suggests incongruence between the projects’ perceived focus on men as a target group and actual service uptake by men.
Table 6-18: Target group composition of individual contacts or activities

<table>
<thead>
<tr>
<th>Target group</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>People bereaved by suicide</td>
<td>2,889</td>
<td>17.8</td>
</tr>
<tr>
<td>Men</td>
<td>3,826</td>
<td>23.6</td>
</tr>
<tr>
<td>Children</td>
<td>418</td>
<td>2.6</td>
</tr>
<tr>
<td>Youth</td>
<td>1,257</td>
<td>7.7</td>
</tr>
<tr>
<td>Indigenous populations</td>
<td>2,674</td>
<td>16.5</td>
</tr>
<tr>
<td>People living with a mental illness</td>
<td>2,649</td>
<td>16.3</td>
</tr>
<tr>
<td>People who have previously attempted suicide</td>
<td>966</td>
<td>6.0</td>
</tr>
<tr>
<td>People who have self-harmed</td>
<td>1,245</td>
<td>7.7</td>
</tr>
<tr>
<td>Rural and remote communities</td>
<td>1,767</td>
<td>10.9</td>
</tr>
<tr>
<td>LGBTI populations</td>
<td>325</td>
<td>2.0</td>
</tr>
<tr>
<td>CALD communities</td>
<td>139</td>
<td>0.9</td>
</tr>
<tr>
<td>Refugee communities</td>
<td>375</td>
<td>2.3</td>
</tr>
<tr>
<td>Older people</td>
<td>393</td>
<td>2.4</td>
</tr>
<tr>
<td>People living with an alcohol or other drug problem</td>
<td>273</td>
<td>1.7</td>
</tr>
<tr>
<td>Whole-of-community</td>
<td>5,920</td>
<td>36.5</td>
</tr>
<tr>
<td>Workforce</td>
<td>766</td>
<td>4.7</td>
</tr>
<tr>
<td>People affected by workforce redundancies</td>
<td>64</td>
<td>0.4</td>
</tr>
<tr>
<td>People affected by natural disasters</td>
<td>33</td>
<td>0.2</td>
</tr>
<tr>
<td>People at risk (no previous attempts of suicide or self-harm)</td>
<td>226</td>
<td>1.4</td>
</tr>
<tr>
<td>Those engaged with the justice system</td>
<td>27</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>808</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Note: Multiple target groups could be selected.

Key findings

- The NSPP-funded projects are providing individual activities to a wide range of people from specific target groups.
- The provision of individual contacts or activities to LGBTI and CALD community members is relatively fewer than other high-risk groups. It would be expected that activity should at a minimum reflect the proportion of those groups in the general population.
6 Snapshot of project activity: Oct 2012 to Mar 2013

6.4.12 Referral pathways

Multiple referral sources and destinations could be listed in relation to each individual activity; hence the totals presented in the following tables exceed 16,222, the total number of individual activities reported.

A broad range of referral sources were noted (Table 6-19). Although nearly a third of referral sources (29.4%) were unknown, self-referrals were the most frequently listed referral source (30.9%). This finding reflects strong help-seeking behaviour. Health providers (including emergency departments, inpatient units, community and primary care) were listed as the referral source for 5.6% of individual activities. Referrals from mental health providers (including inpatient units, community care and Aboriginal mental health services) were listed for a further 3.4%.

Table 6-19: Individual activity by referral source

<table>
<thead>
<tr>
<th>Referral source</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-referral</td>
<td>5,018</td>
<td>30.9</td>
</tr>
<tr>
<td>Health provider – emergency department</td>
<td>489</td>
<td>3.0</td>
</tr>
<tr>
<td>Health provider – inpatient</td>
<td>76</td>
<td>0.5</td>
</tr>
<tr>
<td>Health provider – community care</td>
<td>127</td>
<td>0.8</td>
</tr>
<tr>
<td>Health provider – primary care</td>
<td>209</td>
<td>1.3</td>
</tr>
<tr>
<td>Mental health provider – inpatient unit</td>
<td>111</td>
<td>0.7</td>
</tr>
<tr>
<td>Mental health provider – community care</td>
<td>423</td>
<td>2.6</td>
</tr>
<tr>
<td>Mental health provider – Aboriginal mental health services</td>
<td>12</td>
<td>0.1</td>
</tr>
<tr>
<td>Community and social service (government)</td>
<td>156</td>
<td>1.0</td>
</tr>
<tr>
<td>Community and social service (non-government organisation)</td>
<td>501</td>
<td>3.1</td>
</tr>
<tr>
<td>Education sector</td>
<td>439</td>
<td>2.7</td>
</tr>
<tr>
<td>Juvenile justice</td>
<td>70</td>
<td>0.4</td>
</tr>
<tr>
<td>Housing provider</td>
<td>8</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Employer</td>
<td>233</td>
<td>1.4</td>
</tr>
<tr>
<td>Police</td>
<td>501</td>
<td>3.1</td>
</tr>
<tr>
<td>Coroner</td>
<td>396</td>
<td>2.4</td>
</tr>
<tr>
<td>Internal referral</td>
<td>358</td>
<td>2.2</td>
</tr>
<tr>
<td>Migration/settlement service</td>
<td>32</td>
<td>0.2</td>
</tr>
<tr>
<td>Community event or activity</td>
<td>145</td>
<td>0.9</td>
</tr>
<tr>
<td>Other</td>
<td>1,245</td>
<td>7.7</td>
</tr>
<tr>
<td>Unknown</td>
<td>4,775</td>
<td>29.4</td>
</tr>
</tbody>
</table>

Referral destinations are shown in Table 6-20. Overall, on-referral of persons engaged in individual activities was not the norm. Referrals were unnecessary for 32.1% of individual activities. No further action or referrals were required for a further 1.2% of individual activities. Collectively, health providers, mental health providers and community social services were listed as referral destinations for 6.2%, 8.6% and 12.6% of individual activities respectively.
Table 6-20: Referral destination for individual activities

<table>
<thead>
<tr>
<th>Referral destination</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral not necessary</td>
<td>5,210</td>
<td>32.1</td>
</tr>
<tr>
<td>Health provider – emergency department</td>
<td>161</td>
<td>1.0</td>
</tr>
<tr>
<td>Health provider – community care</td>
<td>587</td>
<td>3.6</td>
</tr>
<tr>
<td>Health provider – primary care</td>
<td>252</td>
<td>1.6</td>
</tr>
<tr>
<td>Mental health provider – inpatient unit</td>
<td>215</td>
<td>1.3</td>
</tr>
<tr>
<td>Mental health provider – community care</td>
<td>1,113</td>
<td>6.9</td>
</tr>
<tr>
<td>Mental health provider – Aboriginal mental health services</td>
<td>57</td>
<td>0.4</td>
</tr>
<tr>
<td>Community and social service (government)</td>
<td>1,543</td>
<td>9.5</td>
</tr>
<tr>
<td>Community and social service (non-government organisation)</td>
<td>502</td>
<td>3.1</td>
</tr>
<tr>
<td>Education sector</td>
<td>214</td>
<td>1.3</td>
</tr>
<tr>
<td>Juvenile justice</td>
<td>10</td>
<td>0.1</td>
</tr>
<tr>
<td>Housing provider</td>
<td>221</td>
<td>1.4</td>
</tr>
<tr>
<td>Employer</td>
<td>9</td>
<td>0.1</td>
</tr>
<tr>
<td>Police</td>
<td>268</td>
<td>1.7</td>
</tr>
<tr>
<td>Coroner</td>
<td>4</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Internal referral</td>
<td>975</td>
<td>6.0</td>
</tr>
<tr>
<td>Migration/settlement service</td>
<td>8</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Self-management</td>
<td>238</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>516</td>
<td>3.2</td>
</tr>
<tr>
<td>No further action required</td>
<td>195</td>
<td>1.2</td>
</tr>
<tr>
<td>Not applicable</td>
<td>1,299</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Key findings

- The NSPP-funded projects are receiving referrals from a number of different sources, indicating intersectoral collaboration.
- There was a high rate of self-referrals, which reflects strong help-seeking behaviour among those using NSPP-funded services.
- Referrals are also frequently made from NSPP-funded projects. This indicates a multi-disciplinary approach which is an important aspect of embedding suicide prevention activity in the broader community. Notably, significant numbers of referrals were made to health and mental health services.
6 Snapshot of project activity: Oct 2012 to Mar 2013

6.4.13 Geographical distribution of contacts or activities

Analysis of the geographical distribution of individual contacts or activities by state is restricted by the substantial number of activities (19.6%) for which state details are unknown (Table 6-21). These unknown cases are largely attributable to one organisation, the National Suicide Call Back Service. This telephone-based service did not have state details for 2,999 (51.7%) of their 5,803 individual activities, which in turn represents 94.3% of all unknown state designations for the period.

<table>
<thead>
<tr>
<th>State or territory</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>4,021</td>
<td>24.8</td>
</tr>
<tr>
<td>Victoria</td>
<td>2,174</td>
<td>13.4</td>
</tr>
<tr>
<td>Queensland</td>
<td>3,016</td>
<td>18.6</td>
</tr>
<tr>
<td>South Australia</td>
<td>538</td>
<td>3.3</td>
</tr>
<tr>
<td>Western Australia</td>
<td>2,172</td>
<td>13.4</td>
</tr>
<tr>
<td>Tasmania</td>
<td>520</td>
<td>3.2</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>299</td>
<td>1.8</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>303</td>
<td>1.9</td>
</tr>
<tr>
<td>Unknown</td>
<td>3,179</td>
<td>19.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,222</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The highest proportion of individual activities is found in New South Wales followed by Queensland, Victoria and Western Australia. These four states correspond to the four states with the highest populations in Australia.41

6.5 Group level activities

Group level activities are examined in this section under the following headings:

- Number of group activities
- Activity type
- Mode of delivery for group activities
- Number of people engaged
- Duration of group activity/event
- Sector
- Settings
- Age groups
- Sex
- Aboriginal and Torres Strait Islander status


- Ethnicity
- Target groups
- Effect of group activities
- Geographical distribution of activities.

6.5.1 Number of group activities

In the six month period (October 2012 to March 2013), a total of 2,425 group activities were recorded.

While the number of group activities recorded per month ranged from 230 to 546 (Table 6-22), more than 444 group activities occurred each month, with the exception of the December and January periods.

Table 6-22: Group activities by month

<table>
<thead>
<tr>
<th>Collection period</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2012</td>
<td>450</td>
<td>18.6</td>
</tr>
<tr>
<td>November 2012</td>
<td>444</td>
<td>18.3</td>
</tr>
<tr>
<td>December 2012</td>
<td>230</td>
<td>9.5</td>
</tr>
<tr>
<td>January 2013</td>
<td>286</td>
<td>11.8</td>
</tr>
<tr>
<td>February 2013</td>
<td>469</td>
<td>19.3</td>
</tr>
<tr>
<td>March 2013</td>
<td>546</td>
<td>22.5</td>
</tr>
<tr>
<td>Total</td>
<td>2,425</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Key findings

- Over the six month period from October 2012 to March 2013, a total of 2,425 group activities were reported.
6.5.2 Activity type

Group activities included a range of activity types (Table 6-23). The five activity types that accounted for the greatest number of group activities were:

- Direct service delivery (22.4%)
- Service promotion (15.1%)
- Community engagement and/or community development (13.9%)
- Training (11.9%)
- Information development and/or provision (10.6%).

Table 6-23: Group activity by activity type

<table>
<thead>
<tr>
<th>Activity type</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct service delivery</td>
<td>533</td>
<td>22.4</td>
</tr>
<tr>
<td>Service integration</td>
<td>176</td>
<td>7.4</td>
</tr>
<tr>
<td>Service promotion</td>
<td>360</td>
<td>15.1</td>
</tr>
<tr>
<td>Community engagement and/or community development</td>
<td>331</td>
<td>13.9</td>
</tr>
<tr>
<td>Evaluation</td>
<td>47</td>
<td>2.0</td>
</tr>
<tr>
<td>Research</td>
<td>58</td>
<td>2.4</td>
</tr>
<tr>
<td>Training</td>
<td>284</td>
<td>11.9</td>
</tr>
<tr>
<td>Sector development</td>
<td>195</td>
<td>8.2</td>
</tr>
<tr>
<td>Information development and/or provision</td>
<td>253</td>
<td>10.6</td>
</tr>
<tr>
<td>Community awareness</td>
<td>143</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,380</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Note: Information was not available for 45 (1.9%) of the 2,425 group activities.
6 Snapshot of project activity: Oct 2012 to Mar 2013

6.5.3 Mode of delivery for group activities

The range of modes through which group activities were delivered is identified in Table 6-24. Meetings (37.3%), presentations (12.9%) and workshops (11.5%) were the most frequently reported modes of delivery.

Table 6-24: Group activity by mode of delivery

<table>
<thead>
<tr>
<th>Activity mode</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshops</td>
<td>268</td>
<td>11.5</td>
</tr>
<tr>
<td>Meetings</td>
<td>869</td>
<td>37.3</td>
</tr>
<tr>
<td>Presentations</td>
<td>301</td>
<td>12.9</td>
</tr>
<tr>
<td>Training</td>
<td>183</td>
<td>7.9</td>
</tr>
<tr>
<td>Consultation events</td>
<td>176</td>
<td>7.6</td>
</tr>
<tr>
<td>Community events</td>
<td>206</td>
<td>8.8</td>
</tr>
<tr>
<td>Clinical/counselling</td>
<td>43</td>
<td>1.8</td>
</tr>
<tr>
<td>Desk-based work</td>
<td>128</td>
<td>5.5</td>
</tr>
<tr>
<td>Other</td>
<td>154</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,328</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Note: Information was not available for 97 (4.0%) of the 2,425 group activities.

6.5.4 Number of people engaged

The number of people reportedly engaged in group activities varied considerably (Table 6-25). More than one-third (36.2%) of groups engaged one to five persons. Cumulatively, 71.8% of group activities engaged 15 people or less. Group sizes included in the ‘over 100’ category ranged from 102 to 6.2 million.

This diversity in group size reflects that group activities ranged from small, community-based opportunities for people to come together to large scale national events such as RUOK day. This range of activities included the universal, selective and indicated approaches that are recommended in the LIFE Framework.

Table 6-25: Group activity by number of people engaged

<table>
<thead>
<tr>
<th>People</th>
<th>Activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>785</td>
<td>36.2</td>
</tr>
<tr>
<td>6-10</td>
<td>420</td>
<td>19.3</td>
</tr>
<tr>
<td>11-15</td>
<td>353</td>
<td>16.3</td>
</tr>
<tr>
<td>16-20</td>
<td>186</td>
<td>8.6</td>
</tr>
<tr>
<td>21-50</td>
<td>239</td>
<td>11.0</td>
</tr>
<tr>
<td>51-100</td>
<td>77</td>
<td>3.5</td>
</tr>
<tr>
<td>Over 100</td>
<td>111</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,171</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Note: Information was not available for 254 (10.5%) of the 2,425 group activities.
The number of people engaged needs to be interpreted with caution. In some cases, the figures reported represent precise numbers of group attendees. In other cases, the potential reach of the group activity is reported. These figures should therefore be taken as indicative only.

Cross-tabulation of group size by group purpose provides further insight into the possible reach of group activities (Table 6-26). In several cases, group size may mask the true potential reach of the activity. This is particularly true in the case of groups where the main purpose was training, community awareness or sector development. While the majority (74.2%) of training was delivered to groups of 20 or less, the reach of such training exceeds the number of people trained. Likewise, groups of over 100 whose primary purpose was community awareness (20.6%) or sector development (7.4%) may have a larger than reported reach.

Table 6-26: Group purpose by group size (number of people)

<table>
<thead>
<tr>
<th>Group purpose</th>
<th>1–5</th>
<th>6–10</th>
<th>11–15</th>
<th>16–20</th>
<th>21–50</th>
<th>51–100</th>
<th>&gt;100</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service delivery</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>30.7</td>
<td>24.8</td>
<td>18.8</td>
<td>12.4</td>
<td>7.8</td>
<td>2.2</td>
<td>3.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Service integration</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>43.4</td>
<td>18.5</td>
<td>31.2</td>
<td>3.5</td>
<td>2.9</td>
<td>-</td>
<td>0.6</td>
<td>173</td>
</tr>
<tr>
<td>Service promotion</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>32.1</td>
<td>18.5</td>
<td>16.8</td>
<td>8.5</td>
<td>15.6</td>
<td>3.5</td>
<td>5.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Community engagement and/or community development</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>20.0</td>
<td>22.1</td>
<td>18.6</td>
<td>11.0</td>
<td>17.9</td>
<td>7.2</td>
<td>3.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Evaluation</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>88.6</td>
<td>-</td>
<td>5.7</td>
<td>-</td>
<td>-</td>
<td>2.9</td>
<td>2.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Research</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>77.6</td>
<td>5.2</td>
<td>1.7</td>
<td>1.7</td>
<td>12.1</td>
<td>1.7</td>
<td>-</td>
<td>100.0</td>
</tr>
<tr>
<td>Training</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>13.7</td>
<td>26.2</td>
<td>22.1</td>
<td>12.2</td>
<td>15.5</td>
<td>4.4</td>
<td>5.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Sector development</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>64.2</td>
<td>11.1</td>
<td>4.7</td>
<td>3.7</td>
<td>7.4</td>
<td>1.6</td>
<td>7.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Information development and/or provision</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>68.2</td>
<td>9.7</td>
<td>4.5</td>
<td>2.6</td>
<td>5.8</td>
<td>1.9</td>
<td>7.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Community awareness</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>34.9</td>
<td>13.5</td>
<td>5.6</td>
<td>6.3</td>
<td>8.7</td>
<td>10.3</td>
<td>20.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>36.5</td>
<td>19.2</td>
<td>16.2</td>
<td>8.5</td>
<td>10.9</td>
<td>3.6</td>
<td>5.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: Information was not available for 289 (11.9%) of the 2425 group activities.
6 Snapshot of project activity: Oct 2012 to Mar 2013

6.5.5 Duration of group activity/event

The duration of group activities reported ranged from 0-15 minutes to 7 days or longer, the majority of activities (52.5%) were of less than two hours duration (Table 6-27). Durations of two to four hours were the next most frequently reported (17.4%). Groups of 45 minutes to one hour and four to eight hours accounted for 10.5% and 10.3% of group activities respectively. Groups of one day duration represented 12.8% of activities.

Table 6-27: Group activity by duration of contact or activity

<table>
<thead>
<tr>
<th>Duration of contact or activity</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–15 mins</td>
<td>138</td>
<td>6.3</td>
</tr>
<tr>
<td>15–30 mins</td>
<td>196</td>
<td>9.0</td>
</tr>
<tr>
<td>30–45 mins</td>
<td>104</td>
<td>4.8</td>
</tr>
<tr>
<td>45 mins–1 hr</td>
<td>229</td>
<td>10.5</td>
</tr>
<tr>
<td>1 hr–1 hr 15 mins</td>
<td>188</td>
<td>8.6</td>
</tr>
<tr>
<td>1 hr 15 mins–1 hr 30 mins</td>
<td>106</td>
<td>4.9</td>
</tr>
<tr>
<td>1 hr 30 mins–1 hr 45 mins</td>
<td>31</td>
<td>1.4</td>
</tr>
<tr>
<td>1 hr 45 mins–2 hrs</td>
<td>149</td>
<td>6.9</td>
</tr>
<tr>
<td>2–4 hrs</td>
<td>379</td>
<td>17.4</td>
</tr>
<tr>
<td>4–8 hrs</td>
<td>223</td>
<td>10.3</td>
</tr>
<tr>
<td>1 day</td>
<td>278</td>
<td>12.8</td>
</tr>
<tr>
<td>2 days</td>
<td>81</td>
<td>3.7</td>
</tr>
<tr>
<td>3 days</td>
<td>18</td>
<td>0.8</td>
</tr>
<tr>
<td>4 days</td>
<td>3</td>
<td>0.1</td>
</tr>
<tr>
<td>5 days</td>
<td>4</td>
<td>0.2</td>
</tr>
<tr>
<td>6 days</td>
<td>1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>7 days or longer</td>
<td>46</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>2,174</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: Information was not available for 251 (10.4%) of the 2,425 group activities.
6.5.6 Sector

Group activities/events were undertaken in a variety of different sector contexts (Table 6-28). The sectors in which most group activity/events occurred were mental health (23.3%), community and social services (17.7%) and construction and mining (13.4%).

Table 6-28: Group activity by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>106</td>
<td>4.4</td>
</tr>
<tr>
<td>Mental health</td>
<td>558</td>
<td>23.3</td>
</tr>
<tr>
<td>Community and/or social services</td>
<td>425</td>
<td>17.7</td>
</tr>
<tr>
<td>Education</td>
<td>176</td>
<td>7.3</td>
</tr>
<tr>
<td>Police</td>
<td>9</td>
<td>0.4</td>
</tr>
<tr>
<td>Justice</td>
<td>12</td>
<td>0.5</td>
</tr>
<tr>
<td>Transport</td>
<td>4</td>
<td>0.2</td>
</tr>
<tr>
<td>Finance</td>
<td>1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Media</td>
<td>133</td>
<td>5.6</td>
</tr>
<tr>
<td>Construction/mining</td>
<td>320</td>
<td>13.4</td>
</tr>
<tr>
<td>Consumer/people with lived experience</td>
<td>107</td>
<td>4.5</td>
</tr>
<tr>
<td>Carer</td>
<td>5</td>
<td>0.2</td>
</tr>
<tr>
<td>Advocate</td>
<td>14</td>
<td>0.6</td>
</tr>
<tr>
<td>Research/academic</td>
<td>33</td>
<td>1.4</td>
</tr>
<tr>
<td>Public service (not otherwise captured above)</td>
<td>35</td>
<td>1.5</td>
</tr>
<tr>
<td>Volunteers</td>
<td>39</td>
<td>1.6</td>
</tr>
<tr>
<td>General public</td>
<td>151</td>
<td>6.3</td>
</tr>
<tr>
<td>Other</td>
<td>159</td>
<td>6.6</td>
</tr>
<tr>
<td>Not applicable</td>
<td>109</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,396</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Note: Information was not available for 29 (1.2%) of the 2,425 group activities.
6 Snapshot of project activity: Oct 2012 to Mar 2013

6.5.7 Settings

The settings in which group activities occurred are listed in Table 6-29. The two most frequently cited settings for group activities were workplace (28.1%) and community-based (26.4%).

Table 6-29: Group activity by setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based</td>
<td>625</td>
<td>26.4</td>
</tr>
<tr>
<td>Health service</td>
<td>59</td>
<td>2.5</td>
</tr>
<tr>
<td>Mental health service</td>
<td>239</td>
<td>10.1</td>
</tr>
<tr>
<td>Primary care setting</td>
<td>18</td>
<td>0.8</td>
</tr>
<tr>
<td>School</td>
<td>172</td>
<td>7.3</td>
</tr>
<tr>
<td>Tertiary institution</td>
<td>113</td>
<td>4.8</td>
</tr>
<tr>
<td>Vocational services</td>
<td>69</td>
<td>2.9</td>
</tr>
<tr>
<td>Workplace</td>
<td>666</td>
<td>28.1</td>
</tr>
<tr>
<td>Other law enforcement</td>
<td>15</td>
<td>0.6</td>
</tr>
<tr>
<td>None of the above</td>
<td>391</td>
<td>16.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,367</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: Information was not available for 58 (2.4%) of the 2,425 group activities.

Key findings
- Most group activities take place in community-based or workplace settings.

6.5.8 Age groups

The average age of participants involved in group activities is identified in Table 6-30. Just over one-fifth of groups (21.5%) were reported as being across all age groups and 19.8% were unknown. Among those groups that reported specific average age cohorts, the 35-44 age groups accounted for the greatest proportion of group activities. Few recorded groups featured the youngest and oldest age cohorts in their average age profile. Activities comprising children (0-14 years) and youth/emerging adults (15-24 years) accounted for 4.4% and 10.2% of activities respectively. Groups involving people from each of the three oldest age cohorts collectively accounted for 1.7% of group activities represented.

---

6 Snapshot of project activity: Oct 2012 to Mar 2013

Table 6-30: Average age groups of group activity participants

<table>
<thead>
<tr>
<th>Age group</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>5-9</td>
<td>1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>10-14</td>
<td>107</td>
<td>4.4</td>
</tr>
<tr>
<td>15-19</td>
<td>180</td>
<td>7.4</td>
</tr>
<tr>
<td>20-24</td>
<td>68</td>
<td>2.8</td>
</tr>
<tr>
<td>25-29</td>
<td>91</td>
<td>3.8</td>
</tr>
<tr>
<td>30-34</td>
<td>123</td>
<td>5.1</td>
</tr>
<tr>
<td>35-39</td>
<td>246</td>
<td>10.1</td>
</tr>
<tr>
<td>40-44</td>
<td>256</td>
<td>10.6</td>
</tr>
<tr>
<td>45-49</td>
<td>175</td>
<td>7.2</td>
</tr>
<tr>
<td>50-54</td>
<td>109</td>
<td>4.5</td>
</tr>
<tr>
<td>55-59</td>
<td>39</td>
<td>1.6</td>
</tr>
<tr>
<td>60-64</td>
<td>13</td>
<td>0.5</td>
</tr>
<tr>
<td>65-69</td>
<td>12</td>
<td>0.5</td>
</tr>
<tr>
<td>75 years or older</td>
<td>17</td>
<td>0.7</td>
</tr>
<tr>
<td>Across all age groups</td>
<td>509</td>
<td>21.0</td>
</tr>
<tr>
<td>Age unknown</td>
<td>479</td>
<td>19.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,425</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Key findings**
- Only very small numbers of children and older people are represented in group activities.

6.5.9 Sex

Only 179 (7.4%) group activities were exclusively male and 400 (16.5%) were exclusively female. A further 407 (16.8%) were either not stated or inadequately described. The remainder comprised a mix of males and females, ranging from one percent to 99% in each case.

6.5.10 Aboriginal and Torres Strait Islander status

The Aboriginal and Torres Strait Islander status for group activities is recorded on the basis of majority composition of the group, i.e., if a majority of the group participants are of Aboriginal and/or Torres Strait Islander background, the group is recorded accordingly. As identified in Table 6-31, 19.4% of group activities were recorded as being comprised of groups where the majority of participants were of Aboriginal and Torres Strait Islander origin. However, for the remaining 51.8% of group activities, the Aboriginal and Torres Strait Islander status of participants was either not stated or inadequately described.
6 Snapshot of project activity: Oct 2012 to Mar 2013

Table 6-31: Group activity by Aboriginal and Torres Strait Islander status

<table>
<thead>
<tr>
<th>Aboriginal and Torres Strait Islander status</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal but not Torres Strait Islander origin</td>
<td>261</td>
<td>10.8</td>
</tr>
<tr>
<td>Torres Strait Islander but not Aboriginal origin</td>
<td>1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Both Aboriginal and Torres Strait Islander origin</td>
<td>209</td>
<td>8.6</td>
</tr>
<tr>
<td>Neither Aboriginal nor Torres Strait Islander origin</td>
<td>699</td>
<td>28.8</td>
</tr>
<tr>
<td>Not stated/inadequately described</td>
<td>1,255</td>
<td>51.8</td>
</tr>
<tr>
<td>Total</td>
<td>2,425</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Key findings**

- Aboriginal and Torres Strait Islander peoples are over-represented in group activity data (19.4% of group activities compared to an estimated 2.5% of the population). This may signify that the NSPP-funded projects are successfully targeting this group, who have a significantly higher rate of suicide than the non-Aboriginal population.

6.5.11 Ethnicity

Projects were asked to provide information on the predominant ethnicity of group activity participants. A free text box was provided for doing so. The information provided was mixed in terms of quality, with many responses listing more than one ethnicity.

Overall, the predominant ethnicity of group participants was those who identified as being Australian (60.2%). A mismatch occurred between the number of groups where Aboriginal and Torres Strait Islander was listed as the predominant ethnicity in the group and the proportion of groups reported in Section 6.5.10 as having the majority of its members comprised of people from Aboriginal and Torres Islander backgrounds. For more than a quarter of group activities (25.6%), ethnicity was not stated.

Table 6-32: Group activity by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian</td>
<td>1,459</td>
<td>60.2</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander</td>
<td>60</td>
<td>2.5</td>
</tr>
<tr>
<td>Both Aboriginal and non-Indigenous</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td>CALD</td>
<td>179</td>
<td>7.4</td>
</tr>
<tr>
<td>Other</td>
<td>104</td>
<td>4.3</td>
</tr>
<tr>
<td>Not stated</td>
<td>621</td>
<td>25.6</td>
</tr>
<tr>
<td>Total</td>
<td>2,425</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Those groups listed as having predominantly CALD group members included more than 37 ethnic groups as shown in the following Table 6-33.

---

Table 6-33: Ethnicity (CALD)

<table>
<thead>
<tr>
<th>Afghani (Hazara)</th>
<th>Ethiopia</th>
<th>Oromo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Iran</td>
<td>Pacific Islanders</td>
</tr>
<tr>
<td>Asia Pacific</td>
<td>Guinea</td>
<td>Pakistan</td>
</tr>
<tr>
<td>Australian/Greek</td>
<td>India</td>
<td>Persian</td>
</tr>
<tr>
<td>Australian/Sudanese</td>
<td>Iraq</td>
<td>Philippine</td>
</tr>
<tr>
<td>Bhutan/Nepali</td>
<td>Karen</td>
<td>Russian</td>
</tr>
<tr>
<td>Brazil</td>
<td>Korea</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>Burma (Republic of the Union of Myanmar)</td>
<td>Kurdish</td>
<td>Somalia</td>
</tr>
<tr>
<td>Burundi</td>
<td>Kuwait</td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>China</td>
<td>Liberia</td>
<td>St. Barthelemy</td>
</tr>
<tr>
<td>Congo (Republic of)</td>
<td>Malaysian</td>
<td>Sudanese</td>
</tr>
<tr>
<td>Eritrea</td>
<td>Maori</td>
<td>Thailand</td>
</tr>
<tr>
<td></td>
<td>Mozambique</td>
<td>Zimbabwe</td>
</tr>
</tbody>
</table>

Note: This is as reported in the MDS. It is noted to be a mix of countries and ethnicities.

The 'other' category generally comprised people of English-speaking background. These included British, Canadian, English, Irish, Scottish and New Zealander.

Key findings

- Although a wide range of ethnic groups were represented in group activity data, the number of people from CALD communities is relatively low.

6.5.12 Target groups

Group activities were evident for all target groups (Table 6-34). In rank order, the greatest proportion of group activities was directed to the following target groups:

- Workforce (40.2%)
- Whole of community (22.9%)
- Men (19.5%)
- Rural and remote communities (19.5%)
- People bereaved by suicide (17.3%).

The groups which ranked lowest in terms of proportion of group activities were:

- People affected by natural disasters (0.5%)
- People affected by workforce redundancies (1.1%)
- Those engaged with the justice system (1.1%)
- LGBTI populations (3.8%)
- People at risk (no previous attempts of suicide or self-harm) (4.6%).
It should be noted that two of these target groups (those engaged with the justice system and people at risk) were additions to the list of target group options provided to projects based on feedback from project representatives. Consequently, data was not collected in relation to these target groups for the full snapshot period and this may explain the low percentages recorded.

**Table 6-34: Group activity by target groups**

<table>
<thead>
<tr>
<th>Target group</th>
<th>No. of activities*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>People bereaved by suicide</td>
<td>420</td>
<td>17.3</td>
</tr>
<tr>
<td>Men</td>
<td>472</td>
<td>19.5</td>
</tr>
<tr>
<td>Children</td>
<td>191</td>
<td>7.9</td>
</tr>
<tr>
<td>Youth</td>
<td>375</td>
<td>15.5</td>
</tr>
<tr>
<td>Indigenous populations</td>
<td>370</td>
<td>15.3</td>
</tr>
<tr>
<td>People living with a mental illness</td>
<td>346</td>
<td>14.3</td>
</tr>
<tr>
<td>People who have previously attempted suicide</td>
<td>172</td>
<td>7.1</td>
</tr>
<tr>
<td>People who have self-harmed</td>
<td>130</td>
<td>5.4</td>
</tr>
<tr>
<td>Rural and remote communities</td>
<td>472</td>
<td>19.5</td>
</tr>
<tr>
<td>LGBTI populations</td>
<td>92</td>
<td>3.8</td>
</tr>
<tr>
<td>CALD communities</td>
<td>157</td>
<td>6.5</td>
</tr>
<tr>
<td>Refugee communities</td>
<td>140</td>
<td>5.8</td>
</tr>
<tr>
<td>Older people</td>
<td>121</td>
<td>5.0</td>
</tr>
<tr>
<td>People living with an alcohol or other drug problem</td>
<td>136</td>
<td>5.6</td>
</tr>
<tr>
<td>Whole of community</td>
<td>555</td>
<td>22.9</td>
</tr>
<tr>
<td>Workforce</td>
<td>976</td>
<td>40.2</td>
</tr>
<tr>
<td>People affected by workforce redundancies</td>
<td>26</td>
<td>1.1</td>
</tr>
<tr>
<td>People affected by natural disasters</td>
<td>12</td>
<td>0.5</td>
</tr>
<tr>
<td>People at risk (no previous attempts of suicide or self-harm)</td>
<td>111</td>
<td>4.6</td>
</tr>
<tr>
<td>Those engaged with the justice system</td>
<td>27</td>
<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>477</td>
<td>19.7</td>
</tr>
</tbody>
</table>

Note: Multiple target groups could be nominated.

**Key findings**

- It appears that LGBTI people and people engaged with the justice system are ‘at risk’ populations that are underrepresented in the group activities funded by the NSPP.

**6.5.13 Effect of group activities**

Group activities primarily resulted in sector engagement, with almost half of all groups (46.9%) being listed as having this as the main effect of their activities (*Table 6-35*). Group activity resulted in a direct
referral for individual services in 18.5% of activities, or led to requests for specific resources/information (13.4%). Less than 10% of group activities resulted in requests for specific additional activities.

Table 6-35: Effect of group activity

<table>
<thead>
<tr>
<th>Effect of activity</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual referral to services (help-seeking)</td>
<td>412</td>
<td>18.5</td>
</tr>
<tr>
<td>Request for specific activities</td>
<td>174</td>
<td>7.8</td>
</tr>
<tr>
<td>Sector engagement</td>
<td>1,047</td>
<td>46.9</td>
</tr>
<tr>
<td>Request for specific resources/information</td>
<td>299</td>
<td>13.4</td>
</tr>
<tr>
<td>Other</td>
<td>300</td>
<td>13.4</td>
</tr>
<tr>
<td>Total</td>
<td>2,232</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: Information was not available for 193 (8.0%) of the 2,425 group activities.

Key findings

- The main effect of group activities was sector engagement.
- Over one third of group activities lead to requests for specific resources/information, activities or referral of individuals to services. This level of further engagement appears to be an important by-product of group activities.

6.5.14 Geographical distribution of activities

The geographical distribution of group activities is shown in Table 6-36. Most activities were state/territory specific in their focus, with only 9.5% reported as being related to the whole of Australia. At state/territory level, more than one-quarter (27.8%) of all group activities occurred in New South Wales. Victoria (16.9%), Western Australia (13.5%) and Queensland (12.5%) were the next states in terms of highest group activity numbers reported.

Table 6-36: Group activity by state/territory

<table>
<thead>
<tr>
<th>State/territory</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>651</td>
<td>27.8</td>
</tr>
<tr>
<td>Victoria</td>
<td>395</td>
<td>16.9</td>
</tr>
<tr>
<td>Queensland</td>
<td>293</td>
<td>12.5</td>
</tr>
<tr>
<td>South Australia</td>
<td>65</td>
<td>2.7</td>
</tr>
<tr>
<td>Western Australia</td>
<td>316</td>
<td>13.5</td>
</tr>
<tr>
<td>Tasmania</td>
<td>152</td>
<td>6.5</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>220</td>
<td>9.4</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>28</td>
<td>1.2</td>
</tr>
<tr>
<td>Other territories</td>
<td>1</td>
<td>&lt;0.1</td>
</tr>
</tbody>
</table>
6 Snapshot of project activity: Oct 2012 to Mar 2013

<table>
<thead>
<tr>
<th>State/territory</th>
<th>No. of activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole of Australia</td>
<td>222</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Total group activities</strong></td>
<td><strong>2,343</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Note: Information was not available for 82 (3.4%) of the 2,425 group activities reported.

6.6 Target group analysis

Activities related to specific target groups are analysed in this section from two perspectives:

- The number of individual and group activities by target group is compared, to establish the main modes of service delivery for each target group.
- State/territory level comparisons are made regarding individual and group activities, to identify any geographical differences in modes of service delivery.

6.6.1 Comparison of individual and group level activities by target groups

The number of individual and group activities by target group is shown in Table 6-37. In each case, the number of activities is presented in rank order to indicate the level of individual and group activity directed to each target group. This in turn, provides an indication of the preferred mode of service delivery relative to each target group.

<table>
<thead>
<tr>
<th>Target group</th>
<th>Individual activities</th>
<th>Group activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>People bereaved by suicide</td>
<td>2,889</td>
<td>17.8</td>
</tr>
<tr>
<td>Men</td>
<td>3,826</td>
<td>23.6</td>
</tr>
<tr>
<td>Children</td>
<td>418</td>
<td>2.6</td>
</tr>
<tr>
<td>Youth</td>
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</tr>
<tr>
<td>Indigenous populations</td>
<td>2,674</td>
<td>16.5</td>
</tr>
<tr>
<td>People living with a mental illness</td>
<td>2,649</td>
<td>16.3</td>
</tr>
<tr>
<td>People who have previously attempted suicide</td>
<td>966</td>
<td>6.0</td>
</tr>
<tr>
<td>People who have self-harmed</td>
<td>1,245</td>
<td>7.7</td>
</tr>
<tr>
<td>Rural and remote communities</td>
<td>1,767</td>
<td>10.9</td>
</tr>
<tr>
<td>LGBTI populations</td>
<td>325</td>
<td>2.0</td>
</tr>
<tr>
<td>CALD communities</td>
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<td>0.9</td>
</tr>
<tr>
<td>Refugee communities</td>
<td>375</td>
<td>2.3</td>
</tr>
<tr>
<td>Older people</td>
<td>393</td>
<td>2.4</td>
</tr>
<tr>
<td>People living with an alcohol or other drug problem</td>
<td>273</td>
<td>1.7</td>
</tr>
<tr>
<td>Whole of community</td>
<td>5,920</td>
<td>36.5</td>
</tr>
<tr>
<td>Workforce</td>
<td>766</td>
<td>4.7</td>
</tr>
</tbody>
</table>
6 Snapshot of project activity: Oct 2012 to Mar 2013

<table>
<thead>
<tr>
<th>Target group</th>
<th>Individual activities</th>
<th>Group activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>People affected by workforce redundancies</td>
<td>64</td>
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</tr>
<tr>
<td>People affected by natural disasters</td>
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</tr>
<tr>
<td>People at risk (no previous attempts)</td>
<td>226</td>
<td>1.4</td>
</tr>
<tr>
<td>Those engaged with the justice system</td>
<td>27</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>808</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Overall, individual and group activities are implemented in roughly equal measure by each target group. In terms of number of activities, most of the target groups ranked in top ten individual activities (whole of community, men, people bereaved by suicide, Indigenous populations, people living with a mental illness, rural and remote communities, youth, people who have self-harmed, people who have previously attempted suicide, other) are also ranked in the top ten group activities. Likewise, many of the target groups that were represented in the lowest ranks in terms of volume of individual activities also occupied similar ranks in the group activity rank table.

Where marked differences in rank order occur, this signified a preference for one form of activity over another. For example, workforce was ranked eleventh for individual activities and first for group activities, thus indicating that group level activities were more common than individual activities for this target group.

6.6.2 State/territory level comparisons of individual and group level activities

Table 6-38 shows the spread of individual level activity for each target group by state/territory. One of the striking features of this table is the number of states/territories in which no or limited NSPP-funded individual level activities were reported for specific groups. Examples include the absence of individual activities for Indigenous populations in Victoria, Tasmania and the Australian Capital Territory, and the low levels of activity for people bereaved by suicide in Northern Territory. Among the most surprising gaps is the absence of individual activities for:

- LGBTI in almost all states, with 99.7% of activities for this cohort reported in Queensland.
- CALD groups in all states and territories except New South Wales, Queensland and Tasmania.
- People affected by natural disasters in all states and territories except Tasmania, particularly given the recent flood disasters in Queensland.

Furthermore, the NSPP-funded activities are not proportionality distributed by population size. For example, 83.0% of all individual activity related to children is provided in New South Wales and 46.7% of all individual activity related to people bereaved by suicide is provided in Victoria. Furthermore, only 0.3% of all individual activities related to Indigenous populations are provided in Northern Territory.

Table 6-38: Individual activities – target group by state/territory

<table>
<thead>
<tr>
<th>Target group</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>People bereaved by suicide</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,853</td>
</tr>
<tr>
<td>%</td>
<td>2.7</td>
<td>46.7</td>
<td>14.7</td>
<td>4.6</td>
<td>16.3</td>
<td>4.0</td>
<td>0.1</td>
<td>8.9</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>393</td>
<td>97</td>
<td>159</td>
<td>250</td>
<td>152</td>
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<td>488</td>
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</table>
## 6 Snapshot of project activity: Oct 2012 to Mar 2013

<table>
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<tr>
<th>Target group</th>
<th>%</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
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<td></td>
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<tr>
<td>n</td>
<td></td>
<td>347</td>
<td>12</td>
<td>-</td>
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<td>20</td>
<td>30</td>
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<tr>
<td>%</td>
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<td>-</td>
<td>0.2</td>
<td>1.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Youth</strong></td>
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<td>75</td>
<td>882</td>
<td>13</td>
<td>128</td>
<td>14</td>
<td>7</td>
<td>-</td>
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<td>75</td>
<td>882</td>
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<td>128</td>
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<td>6.4</td>
<td>75.8</td>
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<td>11.0</td>
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<td>-</td>
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<td>-</td>
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<td>26</td>
<td>287</td>
<td>-</td>
<td>9</td>
<td>-</td>
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<tr>
<td>n</td>
<td></td>
<td>1,996</td>
<td>-</td>
<td>351</td>
<td>26</td>
<td>287</td>
<td>-</td>
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<td>2,674</td>
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</tr>
<tr>
<td>%</td>
<td></td>
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<td>-</td>
<td>13.1</td>
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<td>10.7</td>
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<td>-</td>
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<td>100.0</td>
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<td>679</td>
<td>77</td>
<td>42</td>
<td>165</td>
<td>14</td>
<td>28</td>
<td>352</td>
<td>2,647</td>
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<tr>
<td>n</td>
<td></td>
<td>1,013</td>
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<td>679</td>
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<td>165</td>
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<td>28</td>
<td>352</td>
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<tr>
<td>%</td>
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<tr>
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<td>963</td>
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<td>963</td>
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<tr>
<td>%</td>
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<td>-</td>
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<td>-</td>
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<td>-</td>
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<td>456</td>
<td>22</td>
<td>402</td>
<td>310</td>
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<td>-</td>
<td>28</td>
<td>1,672</td>
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<td>456</td>
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<td>310</td>
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<td>1,672</td>
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<tr>
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<td>27.3</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
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<td></td>
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<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>100.0</td>
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<td>-</td>
<td>110</td>
<td>-</td>
<td>7</td>
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<td>-</td>
<td>-</td>
<td>139</td>
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<td>110</td>
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<td>7</td>
<td>-</td>
<td>-</td>
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<td>139</td>
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<tr>
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<td>-</td>
<td>79.1</td>
<td>-</td>
<td>5.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100.0</td>
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</tr>
<tr>
<td><strong>Refugee communities</strong></td>
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<td>345</td>
<td>-</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>375</td>
</tr>
<tr>
<td>n</td>
<td></td>
<td></td>
<td></td>
<td>345</td>
<td>-</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>14</td>
<td>375</td>
</tr>
<tr>
<td>%</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>62</td>
<td>1</td>
<td>-</td>
<td>392</td>
<td></td>
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<tr>
<td>n</td>
<td></td>
<td>45</td>
<td>-</td>
<td>260</td>
<td>3</td>
<td>21</td>
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<td>392</td>
<td></td>
</tr>
<tr>
<td>%</td>
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<td>11.5</td>
<td>-</td>
<td>66.3</td>
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<td>5.4</td>
<td>15.8</td>
<td>0.3</td>
<td>-</td>
<td>100.0</td>
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<tr>
<td><strong>People living with an alcohol or other drug problem</strong></td>
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<td>57</td>
<td>7</td>
<td>18</td>
<td>50</td>
<td>3</td>
<td>-</td>
<td>16</td>
<td>272</td>
</tr>
<tr>
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<td>114</td>
<td>7</td>
<td>57</td>
<td>7</td>
<td>18</td>
<td>50</td>
<td>3</td>
<td>-</td>
<td>16</td>
<td>272</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td>41.9</td>
<td>2.6</td>
<td>21.0</td>
<td>2.6</td>
<td>6.6</td>
<td>18.4</td>
<td>1.1</td>
<td>-</td>
<td>5.9</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Whole of community</strong></td>
<td></td>
<td>594</td>
<td>524</td>
<td>955</td>
<td>355</td>
<td>305</td>
<td>63</td>
<td>97</td>
<td>28</td>
<td>2,954</td>
<td>5,875</td>
</tr>
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<td></td>
<td>594</td>
<td>524</td>
<td>955</td>
<td>355</td>
<td>305</td>
<td>63</td>
<td>97</td>
<td>28</td>
<td>2,954</td>
<td>5,875</td>
</tr>
</tbody>
</table>
6  Snapshot of project activity: Oct 2012 to Mar 2013

The spread of group level activities by target group and state/territory is shown in Table 6-38. When the group level data is compared with the individual activity data by state, it is evident that many of the gaps in NSPP-funded individual level activities are met by group level activities.

Table 6-38: Group activities – target group by state/territory

<table>
<thead>
<tr>
<th>Target group</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
<th>Other territories</th>
<th>Whole of Australia</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>People bereaved by suicide</td>
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<td>103</td>
<td>20</td>
<td>27</td>
<td>123</td>
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<td>3</td>
<td>-</td>
<td>22</td>
<td>3</td>
<td>419</td>
</tr>
<tr>
<td>% 20.8</td>
<td>24.6</td>
<td>4.8</td>
<td>6.4</td>
<td>29.4</td>
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<td>0.7</td>
<td>-</td>
<td>5.3</td>
<td>0.7</td>
<td>100.0</td>
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</tr>
<tr>
<td>Men</td>
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<td>-</td>
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<td>14</td>
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<td>461</td>
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<td>2.8</td>
<td>7.4</td>
<td>32.1</td>
<td>-</td>
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<td>3.0</td>
<td>0.4</td>
<td>100.0</td>
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<td>Children</td>
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<td>10</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>-</td>
<td>10</td>
<td>3</td>
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</tr>
</tbody>
</table>

Note: Multiple responses permitted.

The spread of group level activities by target group and state/territory is shown in Table 6-38. When the group level data is compared with the individual activity data by state, it is evident that many of the gaps in NSPP-funded individual level activities are met by group level activities.
### 6 Snapshot of project activity: Oct 2012 to Mar 2013

<table>
<thead>
<tr>
<th>Target group</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
<th>Other territories</th>
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<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>50</td>
<td>102</td>
<td>111</td>
<td>14</td>
<td>13</td>
<td>39</td>
<td>4</td>
<td>-</td>
<td>18</td>
<td>3</td>
<td></td>
<td>370</td>
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6 Snapshot of project activity: Oct 2012 to Mar 2013

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Note: Multiple responses permitted

Despite the broad coverage identified for group and individual activities, a number of gaps are evident including:

- No NSPP-funded group or individual level activities were reported for any of the following target groups in the following states/territories:
  - People who have self-harmed (ACT)
6 Snapshot of project activity: Oct 2012 to Mar 2013

- Rural and remote communities (ACT)
- 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, NT, ACT)
- People at risk (no previous attempts of suicide or self-harm) (ACT, NT)
- People engaged with the justice system (Qld, NT, ACT).

- No NSPP-funded group level activities were reported for any of the following target groups in the following states/territories (ie, only individual level activities reported):
  - Men (ACT)
  - People who have previously attempted suicide (ACT)
  - Older people (WA)
  - People affected by workforce redundancies (SA, WA)
  - People at risk (no previous attempts of suicide or self-harm) (WA)
  - People engaged with the justice system (WA).

- No NSPP-funded individual level contacts or activities were reported for any of the following target groups in the following states/territories (ie, only group level activities reported):
  - Children (NT)
  - Youth (ACT)
  - Indigenous populations (Tas, ACT)
  - LGBTI population (ACT)
  - CALD communities (Vic)
  - Refugee communities (NSW, Vic)
  - Older people (Vic)
  - People affected by workforce redundancies (Vic, Qld)
  - People affected by natural disasters (NSW, Vic, Qld)
  - People engaged with the justice system (Vic).

It is important to note that each state/territory government also funds a range of projects and activities related to mental health that may be similar to some of the NSPP-funded projects, and the fact that some of these groups are not targeted by NSPP-funded projects does not mean there is no activity in that area.
6.7 Summary of key findings

Funded organisations were generally compliant with MDS submission requests. Despite working in sometimes difficult environments with limited capacity for administration, responses to requests for data were outstanding and allowed an excellent picture of the NSPP-funded program activity to be developed.

Program data indicates that NSPP-funded projects spent more time on service provision activities than any other activity. Wide variations existed in the way projects spent their time, reflecting the diversity of the project activities undertaken and the settings in which the activities take place.

Individual activities

- In the six month period from October 2012 to March 2013, a total of 16,222 individual activities were reported.
- The most frequently reported mode of delivery for individual activities was telephone.
- The majority of individual activities (94.5%) involved direct client contact.
- Individual contacts or activities ranged widely in duration; however most contacts or activities (85.6%) had a duration of less than one hour.
- The majority of individual contacts or activities were undertaken directly with the individual client rather than via other avenues such as through family or friends.
- The age of individuals to whom services were delivered broadly reflects the Australian population age distribution. The notable exception was children aged between 0-14 years who, as would be expected, received proportionally fewer services than their share of the Australian population.
- Fewer males than females participated in suicide prevention individual activities.
- Data collected from NSPP projects suggests that Aboriginal and Torres Strait Islander peoples are receiving a high number of suicide prevention specific services (14.7% of total contacts or activities compared to an estimated 2.5% of the population).44 This suggests that the NSPP-funded projects are successfully targeting this group, who have a significantly higher rate of suicide than the non-Indigenous population.
- The NSPP-funded projects have reported that over 60 different ethnic groups have been involved in individual suicide prevention activities.
- Notwithstanding the large number of different ethnic groups involved in individual activities, CALD clients appear to be under-represented, with only 8.0% of the total number of activities assigned to CALD clients.
- Refugees living in the community are accessing NSPP-funded services. Given the relatively small cohort of refugees living in the community and their high suicide risk, it is noteworthy that 3.8% of individual activities were identified as having reached this target group.
- The NSPP-funded projects are providing individual activities to a wide range of people from specific target groups.

44 ABS, Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006.
6 Snapshot of project activity: Oct 2012 to Mar 2013

- The provision of individual contacts or activities to LGBTI and CALD community members is relatively fewer than other high-risk groups. It would be expected that activity should at a minimum reflect the proportion of those people in the general population.
- The NSPP-funded projects are receiving referrals from a number of different sources, indicating intersectoral collaboration.
- There was a high rate of self-referrals, which reflects strong help-seeking behaviour among those using NSPP-funded services.
- Referrals are also frequently made from the NSPP-funded projects to other services and programs. This indicates a multi-disciplinary approach which is an important aspect of embedding suicide prevention activity in the broader community. Notably, significant numbers of referrals were made to health and mental health services.

Group activities

- Over the six month period from October 2012 to March 2013, a total of 2,425 group activities were reported.
- Most group activities take place in community-based or workplace settings.
- Only very small numbers of children and older people are represented in group activities.
- Aboriginal and Torres Strait Islander peoples are over-represented in group activity data (19.5% of cohort compared to an estimated 2.5% of the population). This may signify that the NSPP-funded projects are successfully targeting this group who have a significantly higher rate of suicide than the non-Indigenous population.
- Although a wide range of ethnic groups were represented in group activity data, the number of people from CALD communities is relatively low.
- It appears that LGBTI and people engaged with the justice system are ‘at risk’ populations that are underrepresented in the group activities funded by the NSPP.
- The main reported effect of group activities was sector engagement
- Over one third of group activities lead to requests for specific resources/information, activities or referral of individuals to services. This level of further engagement appears to be an important by-product of group activities.

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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

<table>
<thead>
<tr>
<th>Summary of current evidence/best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evidence suggests that multilevel interventions are the strategy of choice for suicide prevention.4748</td>
</tr>
</tbody>
</table>

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:
Section 7: Findings: Appropriateness

Figure 7.2: National and state/territory projects by target group

- **National**
  - 4 Bereaved, 1 CALD, 1 Refugee, 1 Older people
  - 2 Men, 1 Rural & remote, 1 LGBTI
  - 0 AOD problem, 0 Natural disasters

- **Western Australia**
  - 3 Bereaved, 0 Men, 0 Children, 0 Youth
  - 2 Older people, 0 AOD problem
  - 0 Mental illness, 0 Self-harm, 0 Rural & remote
  - 2 People at risk, 0 LGBTI

- **South Australia**
  - 1 Bereaved, 0 Men
  - 0 Children, 0 Youth, 0 Indigenous
  - 0 Mental illness, 0 Previous attempt
  - 0 Self-harm, 0 Rural & remote

- **Queensland**
  - 5 Bereaved, 2 CALD, 1 Refugees
  - 1 Children, 1 Aboriginal and Torres Strait Islanders
  - 0 AOD problem, 0 Mental illness
  - 2 People at risk, 0 LGBTI

- **New South Wales**
  - 2 Bereaved, 0 Men
  - 1 Children, 1 Rural & remote
  - 0 AOD problem, 0 Mental illness
  - 1 LGBTI

- **Australian Capital Territory**
  - 1 Bereaved, 0 Men
  - 0 Children, 0 Youth, 0 Indigenous
  - 1 Mental illness

- **Tasmania**
  - 2 Bereaved, 1 Self-harm, 1 AOD problem
  - 1 Rural & remote, 2 People at risk

**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 NSPSS Survey.
Figures for the target groups “People at risk (no previous attempt)” and “Those engaged with the justice system” are based on MGS data collected after the NSPSS 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>
<td></td>
<td></td>
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<tr>
<td>Men</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Children</td>
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<tr>
<td>Youth</td>
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<tr>
<td>Indigenous</td>
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<tr>
<td>Mental illness</td>
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<tr>
<td>Previous attempt</td>
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<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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<tr>
<td>AOD problem</td>
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<tr>
<td>Whole community</td>
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<td></td>
<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>
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<tr>
<td>Justice system*</td>
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</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 through 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>$1.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>22,785,500</td>
<td>$96,816,401</td>
<td>$4.25</td>
<td>10.6</td>
</tr>
</tbody>
</table>


II Source: DoHA Project Data.


IV Source: ABS Summary 3303.0 Causes of Death, Australia, 2011.
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.

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 practice(^{54})</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A number of at-risk sub-groups have been identified.</td>
<td>These include but are not limited to:</td>
</tr>
<tr>
<td>- people with physical illness</td>
<td>- lesbian, gay, bisexual and transgender and intersex (LGBTI) populations</td>
</tr>
<tr>
<td>- people with a history of suicide related behaviour or self-harm</td>
<td>- Culturally and Linguistically Diverse (CALD) populations</td>
</tr>
<tr>
<td>- people with mental illness</td>
<td>- older adults</td>
</tr>
<tr>
<td>- Indigenous populations</td>
<td></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*.  

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7 Findings: Appropriateness

<table>
<thead>
<tr>
<th>Summary of current evidence/best practice&lt;sup&gt;54&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ men</td>
</tr>
<tr>
<td>▪ people with substance misuse problems</td>
</tr>
<tr>
<td>▪ rural and remote populations</td>
</tr>
<tr>
<td>▪ youth</td>
</tr>
<tr>
<td>▪ people who have been bereaved by suicide</td>
</tr>
<tr>
<td>▪ people engaged with the justice system</td>
</tr>
<tr>
<td>▪ people who are divorced, widowed, separated or single</td>
</tr>
<tr>
<td>▪ people who are unemployed or with low socioeconomic status</td>
</tr>
<tr>
<td>▪ people who are socially isolated or who lack social support</td>
</tr>
</tbody>
</table>

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.<sup>55</sup>

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.

7 Findings: Appropriateness

- Lack of access to culturally appropriate services.
- Loss of cultural identity and cultural disintegration.\textsuperscript{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\textsuperscript{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\textsuperscript{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.\textsuperscript{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.


\textsuperscript{58} K Koloves, 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.

Summary of current evidence/best practice

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<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>62</td>
<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>63</td>
<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.

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><strong>Summary of current evidence/best practice</strong></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>
</tr>
</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 Beautrais et al, ‘Effective Strategies for Suicide Prevention in New Zealand’.
66 Mann et al, ‘Suicide Prevention Strategies’.
67 Nordenstorf, ‘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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69 Beautrais et al, ‘Effective Strategies for Suicide Prevention in New Zealand’.
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’.
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.\(^{73}\) 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.

\(^{73}\) 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.
8 Findings: Effectiveness – Outcomes and achievements

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. 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.

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’.
8 Findings: Effectiveness – Outcomes and achievements

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’.  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).

This, in essence, involves measuring motivation in an empirical way. This can be problematic, especially, for example, where death or injury from motor accidents 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.

8 Findings: Effectiveness – Outcomes and achievements

- 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. Some have argued that ABS figures underestimate the total figures.

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.

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 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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80 Williams et al, 'Accuracy of Official Suicide Mortality Data in Queensland'.
8 Findings: Effectiveness – Outcomes and achievements

Table 8-1: External evaluation profile of projects

- 29 of 47 projects (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
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’. 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.

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**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.

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**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.*
8 Findings: Effectiveness – Outcomes and achievements

- 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.
8  Findings: Effectiveness – Outcomes and achievements

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 the community as a whole was better equipped to respond to risk of suicide.
8 Findings: Effectiveness – Outcomes and achievements

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.
8 Findings: Effectiveness – Outcomes and achievements

**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 (e.g., 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 (e.g., LGBTI, Aboriginal cultural appropriateness), and for some groups in particular, cultural norms around stoicism and independence (e.g., 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.
8 Findings: Effectiveness – Outcomes and achievements

**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.
8 Findings: Effectiveness – Outcomes and achievements

LIFE Action Area 4: Taking a coordinated approach to suicide prevention

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.
Findings: Effectiveness – Outcomes and achievements

LIFE Action Area 5: Providing targeted suicide prevention activities

**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 (e.g., 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 (e.g., 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 Section 8.2 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...
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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.
Findings: Effectiveness – Outcomes and achievements

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.

<table>
<thead>
<tr>
<th>Key findings</th>
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<tr>
<td>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.</td>
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<td>Many project representatives expressed a desire for greater support to evaluate their activities.</td>
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8.6 Unintended outcomes

To understand what works in what situations, it is important to review both the intended and unintended outcomes of interventions. 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/recipient 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.
8 Findings: Effectiveness – Outcomes and achievements

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. 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.

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 (e.g., 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 (e.g., 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
Findings: Effectiveness – Outcomes and achievements

- 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.
9 Findings: Effectiveness – Enablers and barriers

9 FINDINGS: EFFECTIVENESS – ENABLERS AND BARRIERS

This chapter identifies key enablers and barriers to the effectiveness of NSPP-funded projects. The information presented is based on projects' reported experiences in terms of their capacity to meet need and potential opportunities to improve effectiveness. Suggestions for improvement are presented in Section 9.3. The information presented is drawn from the project survey, thematic analysis of project data and documentation (including progress reports), and information submitted for the MDS.

9.1 Enablers

Four key enablers that positively impacted on project effectiveness were identified:

- Community engagement
- Strong relationships
- Existing networks
- Productive project teams.

9.1.1 Community engagement

Engaging a wide range of community members in projects was an important way to ensure suicide prevention messages were disseminated as widely as possible. Examples of this engagement included:

- Continued attempts to improve attendance at events. Inviting parents and community members to dance events and graduation ceremonies or encouraging them to assist with the running of a sports team improved community involvement and pride in the outcomes achieved
- Use of innovative approaches such as art classes, art exhibitions or cultural performances which helped projects reach a wider audience
- In Aboriginal and Torres Strait Islander communities, encouraging elders to engage in the development of suicide prevention messages and materials promoted community ownership of the messages and meant that the information was much more likely to be relevant and accepted as culturally appropriate. This in turn increased the likelihood of its success and effectiveness
- Working in class environments was important for some projects
- Media activities, which were an aspect of several projects, reach a wide audience and assist with educating media workers about how to deal with suicide sensitively, appropriately and in ways that reduce the risks of further harm related to reporting (eg, stimulating ‘copy-cat’ type behaviours).

9.1.2 Strong relationships

Relationships emerged as the key enabler which facilitated the successful implementation of NSPP-funded projects. Relationships were particularly important in terms of facilitating greater community engagement.

Relationships in this context, however, were multifaceted and included both external (with other organisations) and internal (between staff/volunteers) components. External relationships not only included the community in which the project was set, but also other service providers in the area, and stakeholders such as police or ambulance services. The presence of positive relationships among workers in a healthy, productive team environment was cited as a key internal enabler. One project
9 Findings: Effectiveness – Enablers and barriers

reported that ‘the workers seemed pleased that [NSPP-funded project’s] presence in and around the building and construction industry was continuous, consistent and a resource which they could draw on for support as required’.

Additionally, relationships that were built and maintained led to other contacts and the potential for expansion of program work.

9.1.3 Existing networks

Using existing networks and building on previous work helped projects to get established. Extensive networking and relationship building was particularly important in the early stages of a project and required ongoing attention in order to help the project grow and embed in the community. In some smaller communities, local responsiveness and a close-knit community meant that workers tended to know one another and were able to establish networks and understand the issues leading to difficulties in the community.

9.1.4 Productive project teams

Maintaining a well-functioning, productive team with paid full- or part-time staff, casual staff and/or volunteers was a challenge but vitally important in delivering high quality services. Achieving team cohesiveness through regular training, mentoring and social interaction with the team, as well as through long-term investment in staff wellbeing via supervision and wellbeing assessment processes, was identified as important but difficult to achieve, particularly for projects in isolated areas. Suicide prevention work can be stressful and challenging and staff wellbeing required continued attention.

Recruiting the right personnel was also found to be very challenging, but when recruitment strategies worked well and people remained in roles for an extended period of time, performance was reported as superior.

Key findings

- Strong relationships within the community, between service providers, and with other stakeholders such as police or ambulance services, as well as positive relationships among workers in a productive team, were key enablers for projects.

9.2 Barriers and challenges

Barriers and challenges can negatively impact on effectiveness. This section identifies the key barriers and challenges that emerged from the project survey, thematic analysis of project data and documentation (including progress reports), and information submitted as part of the MDS.

9.2.1 Funding

Funding limitations were recognised as a barrier for a number of projects, and the shortage of resources this produced was cited as a reason for difficulties delivering the number, range, intensity or geographic coverage of services needed. Several projects reported a desire to expand their services to other areas or other settings (such as schools or workplaces) but could not do so because of funding limitations.
9 Findings: Effectiveness – Enablers and barriers

The short-term nature of funding was also reported to limit the potential for ongoing program development, as well as leading to recruitment difficulties. In some cases, reduction in funding amounts between funding periods placed a strain on the ability to deliver services as planned. In addition, some projects were reluctant or not able to promote their services because they were concerned that a lack of future funding would mean that services could not be delivered.

In some projects, there were concerns related to the small size of the project (in terms of amount of funding and/or number of staff) and the ability to cover absences and continue service delivery and service development. In some cases, the small size of the project limited the ability to cover leave, ensure information technology was up to date and operational or ensure that optimal care of workers (related to supervision, etc) could be undertaken.

**Key findings**

- Some projects reported that funding limitations and uncertainties:
  - Made it difficult to deliver the number range, intensity or geographical coverage of services needed
  - Restricted expansion and/or development of project activities
  - Restricted their ability to ensure optimal employee supervision and staff recruitment.

9.2.2 Staffing

Recruitment and retention of adequately trained and skilled staff was a common issue for projects. This was in addition to the expected typical staffing challenges, such as resignations and illness. Specific issues included:

- The specialist skills required for some suicide-prevention roles. Attracting and retaining ‘work-ready’ staff was a problem, especially for projects requiring staff from particular cultural backgrounds (eg, Aboriginal and Torres Strait Islander people) or who understood the particular needs of the target group (eg, working with older men)
- Difficulties recruiting staff to rural and remote locations
- Remuneration levels required to attract and retain staff were prohibitive to program sustainability in some areas
- Long gaps in service delivery whilst recruitment was being undertaken led to loss of confidence in the services and a continual need to rebuild trust with new staff members
- The short-term nature of NSPP funding led to difficulties recruiting staff to short-term roles because of a perceived lack of job security
- The often stressful and demanding nature of suicide prevention work (particularly in some community settings) was suggested as a reason for higher levels of staff turnover and position vacancies.
9 Findings: Effectiveness – Enablers and barriers

Key findings

- Staff recruitment and retention difficulties, which were seen to be largely a function of the short-term NSPP funding, were commonly cited as a barrier to effective program implementation.

9.2.3 Administration

Barriers and challenges in the administration of projects took several forms. Issues associated with organisational culture, and the skill levels of staff, managers and decision-makers, were cited as difficulties by some projects. The burden of continually applying for funding to deliver services and the pressure of delivering on short-term financial contracts were noted challenges that, in some cases, stifled change, flexibility and capacity.

9.2.4 Weak relationships

- While strong partnerships and relationships were seen as key to project success, challenges to developing partnerships and relationships were also a barrier to success. Difficulties included:
  - Relationship building was inevitably time-consuming, and the time required was sometimes underestimated, especially in the project start-up phase
  - Engaging external stakeholders in the project (eg, local schools, health services or other service providers) was challenging due to competing demands on their time and, in some cases, differing perspectives on the importance of suicide prevention
  - Lack of clarity around roles and referrals between service providers (eg, linking hospital patients with GPs) and, in some cases, perceived ‘territorial behaviour’ among partnering organisations. For example, some mental health clinicians were reluctant to accept approaches to suicide prevention that used peer support models if they did not see these approaches as a legitimate model of care
  - Administrative and bureaucratic issues and ‘unsupportive policies’ within organisations were also identified as problems for some projects.

Key findings

- The key relationship barriers identified were:
  - Time required for relationship building
  - Difficulties engaging external stakeholders
  - Lack of clarity around roles and referrals between service providers.

9.2.5 Target group

Engaging target groups in suicide prevention activities was challenging for a number of projects. Examples of difficulties included:

- People not turning up to planned workshops or events, in some cases necessitating cancellation of events due to low participant numbers
- Concerns about the confidentiality of divulged problems or difficult circumstances
9 Findings: Effectiveness – Enablers and barriers

- For some target groups, a reluctance to discuss emotions or to talk about the issue of suicide because of the fear of stigmatisation.
- Similarly, some target groups were reluctant to engage with health professionals. This was noted particularly for projects targeting older men. Social stigma related to mental illness and suicide was reported as a barrier to help-seeking and engagement by some projects. Projects employed a number of strategies to reach their target groups in a way that was non-threatening.
- For participants of workforce development projects, suicide prevention training necessitated time away from their day-to-day jobs. Time release was often resisted by management.
- Projects that operated in school settings often reported conflicting priorities and demands on the curriculum.

### Key findings

- Projects experienced difficulties in engaging with target groups due to:
  - Poor attendance at events
  - Social stigma relating to suicide which resulted in a reluctance to talk about suicide or seek help
  - Competing priorities within settings such as schools and workplaces.

#### 9.2.6 Specific challenges for projects focusing on Aboriginal and Torres Strait Islander populations

The complex social and cultural issues faced by Aboriginal and Torres Strait Islander communities created challenges for projects addressing this target group. Key issues included:

- Time required to build trust in Aboriginal and Torres Strait Islander communities, including building positive relationships with elders
- Importance of ensuring that resources developed or training provided is culturally appropriate and pitched at an accessible literacy level
- Permission was required to access some Aboriginal and Torres Strait Islander communities and this process was time-consuming
- Recruitment and retention of Aboriginal and Torres Strait Islander staff was difficult
- One project reported that events were often cancelled because of funerals or other sorry business (due to suicide or other reasons), underscoring the magnitude of the health and social problems faced by some Aboriginal and Torres Strait Islander communities
- Difficulties collecting data due to reluctance or inability to fill out forms or reluctance to be formally followed up.

### Key findings

- A range of additional challenges exist for projects targeting Aboriginal and Torres Strait Islander populations, which can increase the time and resources required to establish initiatives.
9 Findings: Effectiveness – Enablers and barriers

9.2.7 Data collection

There are several areas where data collection and availability was reported to create barriers to the work of projects. Difficulty obtaining data on suicide rates and at-risk groups made it difficult for some projects to understand the specific needs of their target groups and also made it difficult to assess the effectiveness of their interventions. A lack of time and money to collect reliable, consistent data also impacted on the ability of project staff to conduct evaluation activities. The nature of some NSPP-funded activities (such as work with some Aboriginal communities or work through the media) meant it could be difficult to collect reliable statistics on the number of people assisted or reached by the activities.

9.2.8 Technology, literacy and language

In some cases, lack of computer access and low levels of literacy were reported to influence the usefulness of interventions. In one instance, materials (e.g., pamphlets, DVDs, etc.) were pitched inappropriately for the audience, hampering the ability to engage the target group. Voice Over Internet Protocol (VOIP) has been a significant issue for one project, with ‘line drop outs’ making service delivery disjointed. Embedded computer software systems have hampered some projects collecting the MDS data as modifications to existing systems were necessary (taking considerable time and costing considerable amounts of money).

9.2.9 Rurality and distance

Rurality and distance created a number of challenges. The geographic spread of some projects meant that staff needed to travel large distances, and also created logistical problems with coordinating programs from a distance. Attracting staff to rural and remote parts of Australia is generally difficult, and attracting workers with specific skills in mental health and/or suicide prevention may be more difficult still. Furthermore, living in rural or remote areas is a risk factor for suicide in its own right (for a number of reasons that include the potential for social isolation and limited access to services), which created additional challenges in terms of engaging this target group.

9.2.10 Other factors

Several projects reported that external factors beyond their control created obstacles. These included natural disasters (floods, cyclones) and limited employment opportunities for people who had undergone training.

9.3 Improving effectiveness

The information presented about improving project-level effectiveness was derived from three sources:

- Thematic analysis of project data/documentation
- Survey responses
- Comments from project staff made during the workshops.

The following three sub-sections identify:

- Project design issues
- Data and evaluation issues
- Other suggestions for improvement.
9 Findings: Effectiveness – Enablers and barriers

9.3.1 Project design issues

Some projects acknowledged weaknesses in project design that were considered to have influenced project effectiveness. These included:

- Duplication between service providers
- Inappropriateness of resources or training programs, eg, culturally inappropriate, inappropriate to literacy level
- Poor governance, eg, dissolving stakeholder reference groups, out-dated policies and procedures
- Misjudged demand for services
- Registration forms not able to be used
- Sub-optimal communication with stakeholders leading to a lack of clarity around project purpose/activities.

9.3.2 Data and evaluation issues

A number of projects reported sub-optimal data collection and evaluation processes that limited their ability to measure effectiveness. These included:

- Inadequate baseline data collection
- Limited evaluation data collection, eg, clinical outcomes
- Difficulties recruiting clients for interview (eg, to enable exploration of qualitative barriers and enablers related to pathways to care)
- Inconsistent record keeping, making it difficult to track clients and measure progress
- Insufficient documentation of referral pathways/destinations
- Difficulties administering measurement tools (eg, pre-post workshop surveys) or collecting data on some service users. For some older men, for example, the need to document personal details was described as a barrier to service usage. Similarly, completing follow-up assessments of young people from refugee backgrounds was difficult.
- Inadequate documentation of suicide related behaviours or deliberate self-harm for people presenting to emergency departments.

9.3.3 Other suggested improvements

Of the 49 NSPP-funded projects examined, 35 provided comments in response to questions about suggestions to improve program/project effectiveness. The most common suggested areas for improvement were in relation to:

- Funding
- Collaboration and coordination
- Project support.

Funding

Almost half of the projects (16 of 35) that commented on potential ways to improve effectiveness cited funding as an issue. Ten of these 16 respondents reported that expansion of their project was not
9 Findings: Effectiveness – Enablers and barriers

possible because of funding uncertainty or lack of funds for expansion. A number of respondents recommended longer funded periods.

Collaboration and coordination

Almost one-third of respondents (11 of 35) suggested that improved collaboration with other suicide prevention projects would increase effectiveness by developing a better understanding of the work of other NSPP-funded projects and encouraging closer links with national initiatives and promotional campaigns.

More than one-quarter of projects (10 of 35) suggested that enhancing communication between NSPP-funded organisations would improve program effectiveness. Suggested methods of improving communication included presentations, conferences, workshops and other networking opportunities, as well as a telephone information service.

It was also suggested that the links between researchers and practitioners could be strengthened.

Project support

Several projects requested assistance with program development and evaluation to both increase effectiveness and enable demonstration of effectiveness. One project expressed a desire for evaluation support in order to ensure that project activities are ‘doing no harm’.

Key findings

- Projects reported that:
  - Some project-specific design issues impacted effectiveness
  - Sub-optimal data collection and evaluation limited projects’ ability to measure effectiveness
- Other suggestions by project staff for improving project effectiveness were:
  - Increasing funding amounts and periods
  - Improving collaboration with, and coordination between, funded organisations
  - Providing support for organisations to improve capabilities in project development and evaluation.
9.4 Summary of key findings

- Relationships within the community, between service providers, and with other stakeholders such as police or ambulance services, as well as positive relationships among workers in a productive team, were key enablers for projects.

- Some projects reported that funding limitations and uncertainties:
  - Made it difficult to deliver the number, range, intensity or geographical coverage of services needed
  - Restricted expansion and/or development of project activities
  - Restricted their ability to ensure optimal employee supervision and staff recruitment.

- Staff recruitment and retention difficulties, which were seen to be largely a function of the short-term NSPP funding, were commonly cited as a barrier to effective program implementation.

- The key relationship barriers identified were:
  - Time required for relationship building
  - Difficulties engaging external stakeholders
  - Lack of clarity around roles and referrals between service providers.

- Projects experienced difficulties in engaging with target groups due to:
  - Poor attendance at events
  - Social stigma relating to suicide which resulted in a reluctance to talk about suicide or seek help
  - Competing priorities within settings such as schools and workplaces.

- A range of additional challenges exist for projects targeting Aboriginal and Torres Strait Islander populations, which can increase the time and resources required to establish initiatives.

- Projects reported that:
  - Some project-specific design issues had impacted effectiveness
  - Sub-optimal data collection and evaluation limited their ability to measure effectiveness.
  - Other suggestions by project staff for improving project effectiveness were:
    - Larger funding amounts and longer funding periods
    - Improving collaboration with, and coordination between, projects
    - Providing support for organisations to improve capabilities in project development and evaluation.
10 Findings: Efficiency

10 FINDINGS: EFFICIENCY

In the preceding chapters, evaluation findings are presented in relation to appropriateness (Chapter 7) and effectiveness (Chapters 8 and 9). This chapter examines the extent to which the NSPP and funded activities have been delivered efficiently and represent value for money to the Australian Government.86

10.1 Measuring efficiency in the suicide prevention context

Measuring efficiency in the suicide prevention context faces two key challenges:

- Lack of outcome data
- Difficulties assessing the cost of suicide and consequent economic benefit of prevention.

Considerable information is available regarding the inputs and outputs of NSPP-funded projects. As identified in Chapter 6, 16,222 individual and 2,425 group activities were delivered by the 47 projects that provided MDS data over the six months to March 2013.

However, as detailed in Chapter 8, outcome measurement using validated tools has been rare among NSPP-funded projects. Only three of the 47 projects conducted evaluations that measured outcomes using validated tools (see Section 8.3). Challenges associated with outcome measurement are identified in Chapter 8, and Chapter 12 identifies ways to improve outcome measurement in future.

A further key challenge is that there is limited information available about the financial cost of suicide in Australia (see Appendix E), making it difficult to determine the economic benefit of prevention. Indeed, the report on the Senate Inquiry into Suicide, The Hidden Toll87, sought to address this deficit by recommending that the Australian Government commission a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia.

Given these limitations, the efficiency of NSPP-funded projects was examined from the following perspectives:

- Apparent cost efficiency of projects, calculated by relating costs to outputs (ie, hours of service delivered) to enable analysis and comparison of average cost-per–hour of service delivery (Section 10.2)
- Sustainability of projects (Section 10.3)
- Potential efficiency improvements, based on consultations with projects and the Department (Sections 10.4 and 10.5).

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86 "Efficiency is the extent to which an evaluand produces outputs and outcomes without wastage of time, effort, money, space, or other resources. Efficiency alone is insufficient to determine merit or worth – an evaluand could be highly efficient but produce outcomes of insufficient value (eg, too small an effect), or it could still be excessively costly even though it used as few resources as possible (ie, it exceeded budgetary or time constraints, even in its most efficient form).” J Davidson, ‘Efficiency’, in S Mathieson (ed), The Encyclopaedia of Evaluation, Sage Publications, London, 2007, p123.

10 Findings: Efficiency

Key finding

- A detailed independent economic assessment of the cost of suicide and attempted suicide in Australia is needed to help inform future investment decisions.

10.2 Cost efficiency of projects

In this section, the apparent cost efficiency of NSPP-funded activities is analysed based on projects’ costs and their outputs, ie, the services and support that projects deliver.

Specifically, this section provides a cost analysis of NSPP-funded projects for the six month period from October 2012 to March 2013. Using MDS data, project costs have been allocated to activities in order to calculate the average cost per activity per hour for each project.

Key assumptions and caveats are as follows:

- Annual funding has been pro-rated to identify expenditure for the six month MDS snapshot period
- It has been assumed that expenditure equates to funding, ie, NSPP funding is fully expended by the projects
- For each project, costs have been allocated to activities based on the relative proportion of hours reported for each activity in their MDS data
- The MDS data included in this analysis is presented in terms of 46 NSPP-funded projects, as one organisation submitted combined data for two projects (see Section 6-1).

10.2.1 Expenditure by program activity

The MDS program level data identifies nine program activities. For the purposes of cost analysis, these nine activities were classified as either outputs (activities which represent project outputs) or inputs (administration and other activities which are not outputs but rather support the delivery of outputs) as follows:

Outputs:

- Service provision
- Research and development
- Information development and provision.

Inputs:

- Travel
- Event/activity planning
- Administration
- Event/activity promotion
- Supervision
- Other.

Costs were allocated to each of these nine activities based on the relative proportion of hours reported in the MDS for each activity, as summarised in the following Table 10-1.
10 Findings: Efficiency

Table 10-1: Expenditure by program activity, October 2012 to March 2013

<table>
<thead>
<tr>
<th>Activities</th>
<th>Expenditure</th>
<th>Allocation of all expenditure to outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ million</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>$ million</td>
<td>%</td>
</tr>
<tr>
<td>Outputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service provision</td>
<td>$2.4</td>
<td>29%</td>
</tr>
<tr>
<td>Research and development</td>
<td>$0.8</td>
<td>10%</td>
</tr>
<tr>
<td>Information provision</td>
<td>$0.5</td>
<td>6%</td>
</tr>
<tr>
<td>Subtotal – outputs</td>
<td>$3.7</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>$8.1</td>
<td>100%</td>
</tr>
<tr>
<td>Inputs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td>$1.1</td>
<td>13%</td>
</tr>
<tr>
<td>Planning</td>
<td>$1.1</td>
<td>14%</td>
</tr>
<tr>
<td>Administration</td>
<td>$1.2</td>
<td>15%</td>
</tr>
<tr>
<td>Promotion</td>
<td>$0.7</td>
<td>9%</td>
</tr>
<tr>
<td>Supervision</td>
<td>$0.2</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>$0.2</td>
<td>2%</td>
</tr>
<tr>
<td>Subtotal – inputs</td>
<td>$4.5</td>
<td>55%</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>$8.1</td>
<td>100%</td>
</tr>
</tbody>
</table>

Expenditure over the six month period totalled $8.1 million. This represents half (50%) of the total NSPP funding for the year 2012-13 (see Figure 5-1). Direct expenditure on output activities totalled $3.7 million (45%), and $4.5 million (55%) was expended on administrative and other input activities. Expenditure on input activities was then allocated to output activities based on the relative proportion of hours for each output activity. The results (shown in the final two columns of Table 10-1) identify that the total expenditure of $8.1 million was utilised as follows:

- Service provision $5.3m (65%)
- Research and development $1.8m (23%)
- Information provision $1.0m (12%)

This is illustrated in the following Figure 10-1.
As illustrated above (Figure 10-1), if expenditure associated with input activities is allocated to the three output areas, the total expenditure associated with service provision represents nearly two-thirds (65%) of all expenditure, with R&D and information provision representing 23% and 12% of expenditure respectively.

Key findings
- Service provision (65%) and information provision (23%), account for 88% of expenditure.

10.2.2 Project efficiency

This section provides an analysis of project efficiency by calculating and analysing the cost per hour of service provision by NSPP-funded projects. The cost per hour was calculated for each of the 39 projects that submitted data identifying time spent undertaking individual or group service provision activities.

The remaining projects did not submit individual or group activity data as they solely undertook R&D and/or information provision activities, and/or worked with other organisations to build capacity rather than delivering direct services. Based on the information available, it is not possible or meaningful to identify the cost per hour of outputs for R&D or information provision.

The cost per hour of service provision was calculated for each project by dividing the estimated expenditure associated with service provision (see Table 10-1) by the total hours of service provision as identified in the individual and group MDS data combined.

The following Figure 10-2 illustrates the cost per hour and total hours of service provision for the six-month period to March 2013 for each of the 39 projects analysed.
10 Findings: Efficiency

Figure 10-2: Cost per hour of service provision, October 2012 to March 2013

<table>
<thead>
<tr>
<th>Cost per hour</th>
<th>Minimum</th>
<th>Lower quartile</th>
<th>Median</th>
<th>Mean</th>
<th>Upper quartile</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$11</td>
<td>$137</td>
<td>$344</td>
<td>$350</td>
<td>$444</td>
<td>$1,144</td>
</tr>
</tbody>
</table>

As identified above, the cost of service provision ranged from $11 to $1,144 per hour (median $344; mean $350 per hour). For most projects (75%), cost was below $444 per hour (upper quartile).

Of the 39 projects, 36 (92%) had a cost per hour of between $50 and $700, with three outliers outside this range (two above and one below this range). These three outliers are discussed below. Possible reasons to explain these outliers are identified, based upon review of available data and consultation with the projects:

- **$1,114 per hour** – This project had one of the highest reported percentages of time spent in relation to travel (23.5%) and administration (18.3%), which contributed to the high cost per hour. Consultation with this project indicated that it spends a significant amount of time developing resources and supporting other organisations in relation to suicide prevention rather than directly delivering services itself.

- **$992 per hour** – Similar to the previous project, this project reported a particularly high percentage of time spent in relation to travel (19.2%) and administration (28.8%). It is possible that low levels of recorded activity also elevated the cost per hour for this project.

- **$11 per hour** – This project delivered a significant amount of service provision (3,228 hours) during the period and nearly all of this was direct client support (group) using volunteers. The high use of volunteers resulted in this notably low cost per hour.

In relation to Figure 10-2, it is worth noting that the exponential trend line indicates an inverse relationship between the number of hours of service provision and the cost per hour, ie, the more hours of service delivered, the lower the cost per hour.
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10.2.3 Cost drivers

Further analysis was undertaken in relation to the cost per hour of service provision, to identify key drivers of cost. This analysis explored whether cost per hour appeared to be linked to:

- Project size, measured by project funding
- Primary type of service delivered (individual or group)
- Use of volunteers
- Proportion of time spent on travel
- Proportion of time spent undertaking administration
- Proportion of time spent undertaking event/activity planning
- Project reach, ie, national, state-wide or local.

To explore the above, projects were divided into categories for each variable as follows:

<table>
<thead>
<tr>
<th>Potential cost driver</th>
<th>Category</th>
<th>Projects included in cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project size</td>
<td>Small</td>
<td>Project funding for 2012-13 is below the median for all projects</td>
</tr>
<tr>
<td></td>
<td>Large</td>
<td>Project funding for 2012-13 is above the median for all projects</td>
</tr>
<tr>
<td>Individual/group</td>
<td>Individual</td>
<td>Projects for which the majority of service delivery time was individual</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>Projects for which the majority of service delivery time was group</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Yes</td>
<td>Projects that indicated they use volunteers</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Projects that indicated they do not use volunteers</td>
</tr>
<tr>
<td>Travel</td>
<td>High</td>
<td>Projects which reported the proportion of time spent on travel was above the median for all projects</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Projects which reported the proportion of time spent on travel was below the median for all projects</td>
</tr>
<tr>
<td>Administration</td>
<td>High</td>
<td>Projects which reported the proportion of time spent on administration was above the median for all projects</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Projects which reported the proportion of time spent on administration was below the median for all projects</td>
</tr>
<tr>
<td>Event/activity planning</td>
<td>High</td>
<td>Projects which reported the proportion of time spent on event/activity planning was above the median for all projects</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Projects which reported the proportion of time spent on event/activity planning was below the median for all projects</td>
</tr>
<tr>
<td>Reach</td>
<td>National</td>
<td>Projects with national reach</td>
</tr>
<tr>
<td></td>
<td>State-wide</td>
<td>Projects with state-wide reach</td>
</tr>
<tr>
<td></td>
<td>Local</td>
<td>Projects with local reach</td>
</tr>
</tbody>
</table>

Note: The categories for all cost drivers except volunteers include the 39 projects for which the cost per hour was calculated. The categories related to volunteers include only 34 projects as information regarding volunteer numbers was not available for five projects.
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The following Figure 10-3 identifies the average cost per hour for each of the above categories.

**Figure 10-3: Average cost per hour of service provision, by category, October 2012 to March 2013**

As indicated above, the difference in average cost per hour is relatively small for two categories:

- **Individual/group:** Individual ($363), Group ($332) – difference of $31 per hour
- **Reach:** State-wide ($400), National ($345), Local ($339) – difference of between $6 and $55 per hour.

This suggests that the type of service delivered (Individual or Group) and the project reach (national, state-wide, local) have only a minor bearing on the cost per hour of service.

Conversely, the difference in the average cost per hour is relatively large for the following categories:

- **Project size:** Large ($308), Small ($394) – difference of $86 per hour
- **Volunteers:** Yes ($307), No ($360) – difference of $53 per hour
- **Travel:** Low ($277), High ($418) – difference of $141 per hour
- **Administration:** Low ($310), High ($387) – difference of $77 per hour
- **Event/activity planning:** Low ($285), High ($411) – difference of $126 per hour.

This suggests that each of the above factors potentially has a significant impact on the cost per hour of service delivery.

Of particular note is the result for travel, which indicates that projects which spend a large amount of time undertaking travel ($418, High) have an average cost per hour some 51% higher than projects
10 Findings: Efficiency

which spend less time undertaking travel ($277, Low). This suggests that travel time is potentially a key driver of costs.

It is important to note when interpreting the above analysis that the differing costs per hour may reflect a range of factors, including:

- Varying accuracy and completeness of projects’ MDS reporting
- Differences in the nature of the services delivered by projects
- Relative efficiency of each NSPP project.

Key findings

- The cost per hour of service provision varies across projects.
- Projects that provide relatively more hours of service tend to have a lower cost per hour. This may demonstrate greater efficiency of these projects, or other factors such as data accuracy or the different types of services delivered.
- Projects that spend relatively more time on travel and event/activity planning, tend to have a higher overall cost per hour of service, ie, travel and event/activity planning appear to be key drivers of cost.

10.3 Sustainability of projects

This section examines the potential for projects to be able to continue operating in future, in the absence of NSPP funding. Analysis is provided of:

- Non-NSPP funding
- Volunteer support
- In-kind support
- Projects’ self-assessment of sustainability
- Overall assessment of sustainability.

10.3.1 Non-NSPP funding

Projects were asked to indicate in the survey whether they received any funding in addition to that provided under the NSPP and, if so, to identify the funding sources as follows:

- Australian Government
- State/territory government
- Private business or corporate funds
- Research
- Non-government organisation
- Philanthropic
- Donations
- Other.
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Table 10-3 provides a breakdown of the number of additional funding sources reported by the NSPP-funded projects.

Table 10-3: Number of additional sources of funding for NSPP projects

<table>
<thead>
<tr>
<th>No. of additional sources of funding</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>28</td>
<td>56%</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>16%</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

As indicated in Table 10-3, 44% of projects received funds other than NSPP funding and 56% did not receive any other funds. The most commonly reported sources of additional funds were:

- Private – five projects
- Philanthropic – four projects
- Donations – four projects.

Only two projects received additional funding from a state/territory government.

However, other survey information indicates that where non-NSPP funds were received, this typically represented a very small proportion of total project funding/income. This is consistent with the fact that private, philanthropic and donations were the most commonly reported additional funding sources.

10.3.2 Volunteer support

The following Table 10-4 summarises the share (%) of projects' full time equivalent (FTE) workforce which was made up of volunteers. As identified, nearly two thirds of projects (65%; 31 of 48 respondents) did not have any volunteers, ie, all staff were paid employees. Of the 35% of projects which received some level of volunteer support:

- Six projects (13%) – volunteer workforce represented between 1% and 25% of total FTE
- Two projects (4%) – volunteer workforce represented between 26% and 50% of total FTE
- Four projects (8%) – volunteer workforce represented between 51% and 75% of total FTE
- Five projects (10%) – volunteer workforce represented between 76% and 100% of total FTE.
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Table 10-4: Share of project FTE workforce represented by volunteers

<table>
<thead>
<tr>
<th>Volunteer share of workforce</th>
<th>Projects (no.)</th>
<th>Projects (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>31</td>
<td>65%</td>
</tr>
<tr>
<td>1%–25%</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>26%–50%</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>51%–75%</td>
<td>4</td>
<td>8%</td>
</tr>
<tr>
<td>76%–100%</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: N=48, as data was not available for two projects.

10.3.3 In-kind support

As identified in the following Table 10-6, NSPP-funded projects benefited from a range of in-kind support.

Table 10-5: Projects that received in-kind support, by type of support

<table>
<thead>
<tr>
<th>In-kind support</th>
<th>Projects (no.)</th>
<th>Projects (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>17</td>
<td>34%</td>
</tr>
<tr>
<td>External</td>
<td>15</td>
<td>30%</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>17</td>
<td>34%</td>
</tr>
<tr>
<td>Staff</td>
<td>14</td>
<td>28%</td>
</tr>
<tr>
<td>Management</td>
<td>18</td>
<td>36%</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>38%</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: N=48, as data was not available for two projects.

As shown above, the prevalence of in-kind support was similar across all six types of support, ranging from 28% (staff support) to 38% (other) of projects receiving in-kind support.

10.3.4 Projects’ self-assessment of sustainability

The survey asked project representatives to indicate the sustainability of their project in the absence of NSPP funding, on a scale from 1 (not sustainable) to 5 (very sustainable).
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<table>
<thead>
<tr>
<th>Sustainability</th>
<th>Rating</th>
<th>Projects (No.)</th>
<th>Projects (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not sustainable</td>
<td>1</td>
<td>37</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>10</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>Very sustainable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>50</td>
<td>100%</td>
</tr>
</tbody>
</table>

As indicated in the above Table 10-6, all 50 projects rated their sustainability without NSPP funding at 1, 2 or 3, indicating that no projects were likely to be sustainable to any significant degree without NSPP funding. Nearly three-quarters of projects (74%) reported a rating of 1, indicating their belief that there was no likelihood that they would be sustainable. Only three projects rated themselves as 3 in terms of sustainability, indicating marginal sustainability.

This suggests that the majority of projects would not be sustainable in the absence of NSPP funding. This viewpoint was supported in consultations with Department STO and CO representatives.

10.3.5 Overall assessment of sustainability

The analysis set out in this section indicates that few, if any, projects believe they would be able to continue in the absence of NSPP funding. This assessment is based upon the information presented, indicating that:

- 56% of projects had no alternative sources of income
- 44% of projects received other income; however, this represented a very small proportion of their total income
- 56% of projects were reliant on in-kind support
- 65% of projects did not have the assistance of any volunteers, i.e., all workers were paid staff
- 94% of projects rated themselves as 1 (not sustainable) or 2, in terms of sustainability.

No projects rated themselves as 5 (very sustainable) or 4, in terms of sustainability, while only three projects rated themselves as 3, indicating marginal sustainability.
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Key findings
- More than half (56%) of projects received no additional funds other than NSPP funding.
- Where non-NSPP funds were received, they were typically from private, philanthropic sources and donations and represented a very small proportion of total project funding/income.
- Only two projects received additional funding from a state/territory government.
- 65% of projects did not have the assistance of any volunteers, i.e., all workers were paid staff.
- The vast majority of projects did not believe that their project would be sustainable without continued NSPP funding.

10.4 Program administration

Three aspects of project administration were examined in the project survey:
- Level of communication by DoHA with projects
- Responsiveness of DoHA in communicating with projects
- Potential improvements.

10.4.1 Level of communication by DoHA with projects

The majority of projects reported high levels of satisfaction with the level of communication they received from the DoHA office that administers their project (Table 10-7). Thirty-two projects (66%) rated their level of satisfaction with DoHA communication as 5, i.e., very satisfied (15 projects), or 4 (17 projects).

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Rating</th>
<th>Projects (No.)</th>
<th>Projects (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>5</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>12</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>17</td>
<td>35%</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>5</td>
<td>15</td>
<td>31%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>49</td>
<td>100%</td>
</tr>
</tbody>
</table>

10.4.2 Responsiveness of DoHA communication with projects

The majority of projects (30 of 49, 62%) rated their satisfaction with DoHA’s responsiveness in terms of communication as either 5, i.e., very satisfied (17 projects), or 4 (13 projects), as shown in Table 10-8.
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Table 10-8: Level of satisfaction with DoHA responsiveness

<table>
<thead>
<tr>
<th>Satisfaction</th>
<th>Rating</th>
<th>Projects (No.)</th>
<th>Projects (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>15</td>
<td>31%</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>13</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>17</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48</strong></td>
<td></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

10.4.3 Potential improvements

Twenty-two projects offered suggestions for improving DoHA’s administration of projects. These suggestions fell into three main categories:

- Contract notification delays
- Engagement and communication with projects
- Reporting processes.

Contract delays

Several respondents were concerned about delays in notifying project representatives when contracts had been awarded. They reported this made it difficult to plan for subsequent funding periods and, in particular, to secure staff. Others called for longer lead times to develop tender responses and, as noted in Section 9.2.1, longer funding periods were also requested. One respondent suggested that an online portal would assist with contract management.

Engagement and communication with projects

A number of respondents believed that DoHA contract managers sometimes do not have a good understanding of what the projects do, and called for better engagement with the projects. Suggestions to improve engagement included:

- Visits to project sites by contract managers so that they can see achievements ‘on the ground’
- A single point of contact for contract management and communication of issues
- Improved handover between DoHA staff at times of staff turnover, so that historical knowledge of projects is not lost
- Regular formal meetings with DoHA to provide project updates.

Other respondents asked that DoHA place more emphasis on facilitating and enhancing communication between funded organisations.

Reporting processes

Views and concerns expressed by projects in relation to reporting processes included:

- Need to streamline data collection to make it less onerous and repetitive
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- Current reporting system does not enable all relevant information to be captured
- Concern about occasions when reports have been lost by DoHA, resulting in requests for projects to re-submit.

**Key findings**

- Projects reported high levels of satisfaction with regards to the level of communication and responsiveness of the DoHA office responsible for the administration of their project.
- Suggestions for improving DoHA administration of projects included:
  - Improved contract management, eg, speedier notification of contact awards and greater engagement of DoHA contract managers with projects
  - More streamlined reporting that is less repetitive and more inclusive of project activities
  - Greater care in data management so that resubmission of data is not required.

10.5 DoHA administrators' perspectives of NSPP program efficiency

Staff from the DoHA State/Territory Offices (STOs) and Central Office (CO), who are responsible for administering the NSPP-funded projects, were asked to comment on the efficiency of the program in terms of program administration and the consistency of NSPP administration model with the DoHA National Alignment process (DNA).

10.5.1 Program administration

For most STO and CO staff, NSPP-funded projects comprised a relatively small component of the total number of contracts that they were responsible for overall. Consequently, they reported that the administration of the NSPP projects was not particularly problematic in terms of their total workload. However, they identified a number of barriers to efficient administration:

- Resource constraints made it difficult for DoHA staff to have the level of engagement with projects that they felt would be ideal. For the most part, their interaction with the project staff focused on contract management issues and they did not have capacity to provide much practical support or advice to project staff
- Teleconferences were the main source of communication between projects and DoHA staff. While a number of STO staff reported making annual visits to meet with project staff, CO staff reported that they did not have the budget to do this, which made it difficult to develop an in-depth understanding of the projects. STO and CO staff reported that some project staff were more proactive than others in providing updates to DoHA or seeking advice
- Relatively high levels of staff turnover within the STOs resulted in a loss of corporate knowledge that was frustrating for project representatives who were required to repeat information about their projects to new STO staff
- Some of the smaller projects had difficulty getting their reports in on time. Generally however, projects submitted their deliverables on time and without difficulty, by virtue of the fact that they had been funded for a sufficiently long period of time such that any issues with the process had been resolved
10 Findings: Efficiency

- In some cases, smaller NGOs were not able to produce reports to the standard required by DoHA. As one interviewee noted, ‘the public sector and private sector communicate differently’.

Suggestions from STOs and CO for improving the efficiency of project administration included:

- Providing guidelines for project administration that cover practical information such as what to do with under-spends, what to do if projects do not submit their reports on time, etc. It was indicated that such guidelines exist for other funding programs
- Provide more resources to the STOs and CO to enable more ‘hands-on’ support for projects and facilitate site visits
- Consider changing the reporting templates to ensure they are consistent with the Australian Accounting Standards as specified by the Australian Accounting Standards Board (note that further detail of the nature of the discrepancies was not provided)
- Reduce the number of funded projects to reduce the administrative burden
- The planned change to an online grants management system (see Section 10.5.2) was expected to improve efficiency.

One respondent commented that it was inefficient to have NSPP-funded projects administered through eight different offices (seven STOs plus CO), and that administration would be streamlined if all projects were administered from one office. Another commented that CO would be better able to focus on setting suicide prevention policy direction if they did not also have to administer project funding.

10.5.2 Consistency of NSPP administration model with the DoHA National Alignment process

The term ‘DoHA National Alignment’ (DNA) encompasses a range of changes within the Health and Ageing portfolio that are intended to transform the Department into a contemporary, best-practice organisation that is ‘both capable and flexible’. The two key projects within the DNA include the Database Alignment Project (which aims to improve efficiencies within data collection, storage and analysis processes) and the IT Governance Project (which will implement a formal approach to the governance of all IT work across the Department, thereby reducing duplication and better supporting the future needs of the Department).88

Another key change occurring through the DNA program is the consolidation of 159 programs into 18 flexible funds. This change is intended, over time, to reduce red tape and provide increased flexibility to respond to emerging issues and deliver better value for money with quality- and evidence-based funding.89 As part of the NSPP evaluation, STO and CO staff were asked to comment on the alignment of the existing NSPP administration with the DNA process.

The DNA process was generally viewed as a promising development that would lead to improved administrative efficiency. However, many interviewees at STO level felt that it was a difficult transition phase that was increasing the administrative burden. One interviewee reported that team resourcing had been reduced prematurely, in anticipation of the efficiencies that the DNA would deliver. Another reported that the SAP financial management changes had created more work for the team (but did not provide details).

Several respondents reported that the shift to a flexible funding model had not affected the NSPP administration yet as there had been no new funding rounds in recent years. Indeed, STO staff

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88 Suicide prevention sector staff, personal communication via email, 26 February 2013.
10 Findings: Efficiency
generally felt that they had minimal involvement in funding processes or decision-making for the NSPP, so a move to flexible funding was not likely to impact on them. However, they spoke positively about changing to an online grants management system, which is expected to occur in the near future. They anticipated that this would result in less paper-work and improved efficiency. Most respondents felt that they received an adequate level of support from CO to navigate the DNA changes.

Key findings
- A potential improvement identified by STO and CO staff was that they undertake site visits to funded organisations in order to better understand the work of these projects. This was seen as particularly valuable given the relatively high turnover of STO staff and consequent absence of corporate knowledge.
- STO and CO staff believed that the DoHA National Alignment (DNA) changes will lead to more efficient administration of the NSPP projects; however, these benefits have not yet been realised.

10.6 Summary of key findings

Economic Analysis
- A detailed independent economic assessment of the cost of suicide and attempted suicide in Australia is needed to help inform future investment decisions.

Project Expenditure
- Service provision (65%) and information provision (23%), account for 88% of project expenditure.
- The cost per hour of service provision varies across projects.
- Projects that provide relatively more hours of service tend to have a lower cost per hour. This may demonstrate greater efficiency by these projects, or other factors such as data accuracy or the different types of services delivered.
- Projects that spend relatively more time on travel and event/activity planning tend to have a higher overall cost per hour of service, ie, travel and event/activity planning appear to be key drivers of cost.

Sustainability
- More than half (56%) of projects received no additional funds other than NSPP funding.
- Where non-NSPP funds were received, they were typically from private, philanthropic sources and donations and represented a very small proportion of total project funding/income.
- Only two projects received additional funding from a state/territory government.
- 65% of projects did not have the assistance of any volunteers, ie, all workers were paid staff.
- The vast majority of projects did not believe that their project would be sustainable.
10 Findings: Efficiency

without continued NSPP funding.

Administration

- Projects reported high levels of satisfaction with regards to the level of communication and responsiveness of the DoHA office responsible for the administration of their project.

- Suggestions for improving DoHA administration of projects included:
  - Improved contract management, eg, speedier notification of contact awards and greater engagement of DoHA contract managers with projects.
  - More streamlined reporting that is less repetitive and more inclusive of project activities.
  - Greater security in data storage so that resubmission of data is not required.

- A potential improvement identified by STO and CO staff was that they undertake site visits to funded organisations in order to better understand the work of these projects. This was seen as particularly valuable given the relatively high turnover of STO staff and consequent absence of corporate knowledge.

- STO and CO staff believed that the DoHA National Alignment (DNA) changes will lead to more efficient administration of the NSPP projects; however, these benefits have not yet been realised.
11 Positioning the NSPP in Australia’s suicide prevention efforts

11 POSITIONING THE NSPP IN AUSTRALIA’S SUICIDE PREVENTION EFFORTS

This chapter contextualises the NSPP within the broader suicide prevention sector in Australia.

11.1 Introduction

The NSPP is one component of the Australian effort to combat suicide. Other activities include those undertaken by state/territory and local governments, non-NSPP-funded Non-government organisations (NGOs) and research bodies, as well as programs delivered through schools, workplaces and other settings. In addition, there is an array of activities that may impact on suicide rates even though suicide prevention is not the primary focus and they are not labelled as such. This includes services delivered through the health sector (in particular, the mental health sector) and a broad range of services that address risk factors for suicide – including, but not limited to, housing, employment, education and social inclusion.

11.2 The spectrum of suicide prevention activities in Australia

Through consultations with STO and CO staff, jurisdictional representatives, peak body representatives and other suicide prevention experts, a picture has emerged of the range of initiatives underway that impact on suicide prevention. This has been supplemented with further information gleaned from a desktop review of the policy literature. The section below gives some indication of the breadth of initiatives underway at the national level, noting that this is not a complete list.

11.2.1 National initiatives

The following Table 11-1 covers some of the key national initiatives.

<table>
<thead>
<tr>
<th>Table 11-1: Selected key national initiatives</th>
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<tbody>
<tr>
<td>• NSPP and TATS-funded projects</td>
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<td>• MindMatters and KidsMatter</td>
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<td>• Aboriginal and Torres Strait Islander Suicide Prevention activity</td>
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<tr>
<td>• Development of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy</td>
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<tr>
<td>• Renewal of the National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing (in development)</td>
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<tr>
<td>• Research bodies and related funding, including the Black Dog Institute, the Australian Institute for Suicide Research and Prevention, the Hunter Institute for Mental Health and beyondblue’s research program</td>
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<tr>
<td>• Acute, sub-acute and community mental health services</td>
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<tr>
<td>• ATAPS, the Better Access initiative, and other programs offered through Medicare Locals</td>
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<tr>
<td>• Initiatives under the National Drug Strategy</td>
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<tr>
<td>• Aged care programs</td>
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<tr>
<td>• Initiatives under A Stronger, Fairer Australia – Australia’s social inclusion policy, including a range of strategies that address unemployment, homelessness, disability and other key forms of disadvantage, all of which are risk factors for suicide</td>
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- Initiatives run by headspace – Australia’s National Youth Mental Health Foundation – including headspace centres, headspace school support and headspace online counselling
- beyondblue services
- Helplines, including Lifeline, Kids Helpline and MensLine Australia
- Initiatives that support GPs (and other primary care health professionals), including GP Psych Support, Primary Mental Health Care, the Royal Australian College of General Practitioners (RACGP) mental health page and Suicide Questions, Answers and Resources (SQUARE)
- Online counselling and self-help services, such as the MoodGYM program established by the Centre for Mental Health Research at Australian National University
- Programs delivered through the Department of Veterans Affairs, such as Operation Life
- Indigenous initiatives and mental health programs delivered through Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), such as Personal Helpers and Mentors Services (PHaMS).

11.2.2 State and territory initiatives

It is not feasible within this evaluation to conduct a mapping exercise of all suicide prevention activities occurring at state/territory level. This is a challenging task which has been taken on by researchers in some jurisdictions; however, a key methodological issue with such mapping studies relates to the definition of what constitutes suicide prevention activity.

While every state and territory used the LIFE Framework in the development of their individual suicide prevention strategies, part of the complexity of mapping suicide prevention activities lies in the way that each Australian jurisdiction operationalises their own suicide prevention strategy. Most jurisdictions use capacity-building approaches involving the development of community networks or community reference groups to tailor suicide prevention responses to local needs (including in those areas that experience high rates, or ‘spikes’, in suicide). This approach aims to foster a sense of ownership over, and responsibility for, suicide prevention in all parts of society, including businesses, schools, sporting and other community groups. As such, the intention is that the prevention of suicide and self-harming behaviour becomes embedded within the community, and in the process many of the activities undertaken are no longer considered under the banner of ‘suicide prevention’ but, rather, are activities that aim to improve community connectedness, harmony and wellbeing.

Similarly, jurisdictional governments are moving towards a more integrated approach to suicide prevention, whereby the responsibility for suicide prevention stretches across all portfolios and is driven through all areas of government activity. For these reasons, it is extremely difficult to accurately depict the depth of activity that impacts on suicide prevention at state/territory level.

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Positioning the NSPP in Australia’s suicide prevention efforts

11.3  ATAPS Suicide Prevention service initiative

11.3.1  Background to ATAPS

The Access to Allied Psychological Services (ATAPS) service initiative was established in 2003 as part of the Better Outcomes in Mental Health Care (BOiMHC) program. The initiative provides consumers with access to evidence-based psychological services delivered by allied health professionals, and is administered through Medicare Locals. In 2006, the Australian Government introduced the Better Access initiative to psychiatrists, psychologists and GPs through the Medicare Benefits Schedule (MBS), a similar program which facilitates access to mental health care from similar providers, but which is funded through MBS item numbers. Following the introduction of the Better Access initiative, the ATAPS service initiative shifted its focus to provide services to hard-to-reach groups and at-risk populations.

Since 2008, additional funding has been provided to the ATAPS service initiative to deliver ‘Tier 2’ sub-programs which address the needs of at-risk groups, or use specific modes of service delivery. The Tier 2 special purpose funding addresses the needs of the following at-risk groups: women with perinatal depression, people at risk of suicide and self-harm, people experiencing or at high risk of homelessness, people impacted by extreme climatic events (eg, bushfires, floods, cyclones), people in remote locations including Indigenous communities, and children with mental disorders. The Tier 2 Suicide Prevention service initiative is the focus of this discussion.

The ATAPS Suicide Prevention service initiative was initially delivered through pilot demonstration projects implemented by 19 Divisions of General Practice from 2008 to 2011. The pilots were delivered by trained ATAPS professionals (psychologists, appropriately trained nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers), and aimed to provide an intensive, prioritised service for people at risk of suicide (eg, those who had recently made a suicide attempt, had recently self-harmed, or were having severe suicidal thoughts) who may or may not have a mental disorder.91

The services initially delivered through the pilots were expanded nationally under the TATS package and continue to be partly funded by the NSPP. The services include focused psychological services, case management, proactive follow-up, and liaison with local accident and emergency services and state mental health services. The services continue to be delivered by health professionals who have completed additional mandatory training.92 Health professionals are required to make contact with the referred consumer within 24 hours of referral and provide the first session of care within 72 hours. Therapeutic support can occur over a period of two months, with an unlimited number of sessions during that time.

As part of the roll out of the ATAPS Suicide Prevention service initiative nationally, a telephone support service was also rolled out. This service was initially an after-hours service; however, from July 2012, it was expanded to a 24 hours per day, seven days per week ATAPS Suicide Support Line. This project is partially funded by the NSPP.

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11.3.2 ATAPS evaluations

The Centre for Health Policy, Programs and Economics (CHPPE) at the University of Melbourne has been evaluating the general ATAPS program and its sub-components since their inception. The most recent evaluation data on the ATAPS Suicide Prevention service initiative is contained in the *Nineteenth Interim Evaluation Report of the Evaluating the Access to Allied Psychological Services (ATAPS) program*.93 This report drew on data from a purpose-designed Minimum Data Set (MDS) to address the following evaluation questions:

- What is the level of uptake of ATAPS by consumers?
- What is the level of participation in ATAPS by professionals?
- What are the socio-demographic and clinical profiles of consumers of ATAPS?
- What is the nature of the treatment received by ATAPS consumers?
- Is ATAPS achieving positive outcomes for consumers?

11.3.3 Summary of ATAPS Suicide Prevention service initiative evaluation findings

The *Nineteenth Interim Evaluation Report* provides combined data from the pilots and the national expansion of the ATAPS Suicide Prevention service initiative to December 2011. Key findings are outlined below.

Level of uptake by consumers

To December 2011, there had been 3,877 referrals to the ATAPS Suicide Prevention service initiative. Of these, 3,443 resulted in treatment sessions and the average number of sessions per referral was 5.9. The high proportion of referrals that translated into sessions is notable, and suggests that the program is addressing consumer need. The number of referrals peaked in the first quarter of 2011 and the number of sessions peaked in the second quarter of 2011. Two possible reasons for the subsequent decline have been suggested. First, following the national expansion of the ATAPS Suicide Prevention service initiative in 2010, the initial influx may have slowed as the consumers in need were attended to. The second possible reason is that the transition of Divisions of General Practice to Medicare Locals may have temporarily affected referral numbers due to changes in data entry processes.

Level of participation by professionals

Whilst psychiatrists, community mental health workers and emergency department staff, as well as GPs, are able to make referrals to the ATAPS Suicide Prevention service initiative, GPs are the primary referral source (87.5% of all referrals). Emergency departments were the second highest source of referrals (4.9% of all referrals).

Socio-demographic and clinical profiles of consumers

The following summary describes the socio-demographic and clinical profile of consumers accessing the ATAPS Suicide Prevention service initiative. Due to missing data, this should be considered indicative only:

- The majority of consumers were female (59.8%, compared with 35.7% men)
- The mean age was 33.9 years

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- Over half (55.7%) had low incomes
- Almost 40% (39.9%) had a history of previous psychiatric service use (compared with 29.7% who did not have a history of previous psychiatric service use)
- 2.4% identified as Aboriginal and 0.4% identified as Torres Strait Islander
- The vast majority spoke English at home (81%).

The most frequent diagnosis was depression (56.3%) followed by uncategorised (33.7%) and anxiety disorders (26.4%). Less common diagnoses were alcohol and drug use disorders (5.7%) and psychotic disorders (3.0%).

Nature of the treatment received by consumers

Most consumers taking part in the ATAPS Suicide Prevention service initiative had sessions of 46 to 60 minutes duration. The vast majority of sessions were face-to-face; however, a small percentage (6.3%) were conducted by telephone. A range of interventions were used, with four elements of cognitive-behavioural therapy (namely cognitive, behavioural, relaxation and skills training components) predominating. Other reported interventions included diagnostic assessment, psycho-education and interpersonal therapy.

Outcomes for consumers

Pre- and post-treatment outcome data was available for 424 (12%) consumers taking part in the ATAPS Suicide Prevention service initiative (this was based on a pre-requisite that a minimum of 50 consumers were required to have pre-and post-treatment scores on a given outcome measure in order for their data to be included in the analysis). The measures used were the Depression Anxiety and Stress Scales (DASS), the Kessler 10 (K-10) and the Modified Scale for Suicidal Ideation (MSSI). Across all these measures, the mean difference between pre-treatment and post-treatment scores was statistically significant and indicative of clinical improvement.

11.3.4 Implications of the ATAPS Suicide Prevention service initiative evaluation findings

The discussion below considers the published evaluation findings relating to the appropriateness, effectiveness and efficiency of the ATAPS Suicide Prevention service initiative and reflects the views of AHA.

Appropriateness

Based on review of the published evaluation reports, it is clear that the ATAPS Suicide Prevention service initiative is meeting a consumer need. Consumer uptake is high, and the majority of referrals to the program have translated into sessions. Importantly, the services reached people who may not otherwise have had access to psychological care, given that more than half of the consumers were on low incomes.

The program is also supported by the evidence for best practice in suicide prevention. A number of studies have shown that a significant number of people who die by suicide seek help from primary care providers – particularly GPs – in the period leading up to their death. There is evidence from systematic reviews demonstrating that equipping physicians to recognise and treat depression is an effective approach (see Section 11.4.4).94 The ATAPS approach follows this rationale, but provides treatment by allied health professionals with expertise and time rather than by GPs. It stands to reason that strong

94 Mann et al, ‘Suicide Prevention Strategies’.
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Outcomes may be produced if GPs and other health professionals with specialised health care skills work together in the delivery of care.

Importantly, the ATAPS Suicide Prevention service initiative appears to be filling a gap that has been identified in our evaluation of NSPP-funded projects (2007-13) in relation to improving the capacity of GPs and other health professionals to recognise and treat depression. While the ATAPS Suicide Prevention service initiative did not provide training for GPs, it has provided an enabling structure within which people at risk of suicide may be more readily referred for treatment.

Effectiveness

The ATAPS Suicide Prevention service initiative has produced positive consumer outcomes. Across all the outcome measures for which an adequate sample was provided, the mean difference was statistically significant and indicative of clinical improvement. That said, the extent to which the improvements have been sustained following completion of the intervention is not known.

Efficiency

It has not been possible to establish the extent to which the ATAPS Suicide Prevention service initiative represents value for money. No economic analysis has been undertaken to date because the national expansion of the program is still in its infancy and there is limited data on outcomes at this stage.

Key findings

- The ATAPS Suicide Prevention service initiative is an appropriate and effective suicide prevention intervention. It is not possible to establish the efficiency of the program because the national expansion of the program is still in its infancy and there is limited data on outcomes at this stage.

11.4 MindMatters

11.4.1 Background to MindMatters

MindMatters was the national mental health initiative for secondary schools funded by DoHA and implemented by Principals Australia Institute (PAI). The MindMatters initiative delivered to December 2013 was a resource and professional development initiative which supported Australian secondary schools in promoting and protecting the mental health, resilience and social and emotional wellbeing of students. It involved professional workshops for classroom teachers, whole school planning workshops for leaders and school teams, other workshops and a range of resources. MindMatters aimed to:

- Embed promotion, prevention and early intervention activities for mental health and wellbeing in Australian secondary schools
- Enhance the development of school environments where young people feel safe, valued, engaged and purposeful
- Help young people develop the social and emotional skills required to meet life’s challenges

95 Officer from DoHA Mental Health Services Branch, personal communication, 23 April 2013.
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- Help school communities create a climate of positive mental health and wellbeing
- Develop strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing
- Enable schools to better collaborate with families and the health sector.96

The MindMatters initiative is currently being redeveloped and a new program will be available in 2014.

11.4.2 The MindMatters evaluations

The following discussion focuses on the MindMatters initiative from 2006 to 2013. It is informed primarily by two documents: the MindMatters Evaluation Report September 201097 and The Impact of MindMatters by State98, which is based on data collected through the Principals School Leadership Survey in 2011. Whilst a more comprehensive suite of evaluation reports (including case studies of individual schools) was completed between 2000 and 2005, they have not been reviewed here as they are outside the timeframe for the current NSPP evaluation.

11.4.3 The MindMatters evaluation findings

The following section outlines the key MindMatters evaluation findings based on the available reports.

The MindMatters Evaluation Report September 2010

The MindMatters Evaluation Report September 2010 assessed awareness and uptake of the MindMatters initiative, based on the administration of a brief questionnaire for school staff. The evaluators reported difficulties with engaging schools to complete the questionnaire: in total, 1,200 schools across Australia were contacted, with 166 participating in the survey. This low response rate has implications for the representativeness of the sample.

The key evaluation findings were:
  - Of those responding:
    - 98% of secondary schools were aware of the MindMatters initiative
    - 66% of secondary schools were using at least some aspects of the MindMatters initiative, with government schools more likely to use MindMatters than non-government schools
    - 77% of schools had used at least some aspect of MindMatters in the past three years
  - In 68% of those schools using MindMatters, the program was the responsibility of an implementation team (suggesting a higher level of engagement with the program)
  - 65% of schools had used MindMatters as a curriculum resource
  - 38% of schools reported using MindMatters as their key organising resource for mental health promotion
  - 51% of schools reported using programs other than MindMatters for mental health promotion. In most cases, these schools were using the other program in addition to MindMatters. A wide range of programs were reported in the survey, but the only one listed in the evaluation report was beyondblue

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- 64% of schools reported that staff members had attended recent MindMatters professional development sessions.

The authors noted that the findings from this evaluation were largely consistent with those from the previous (2006) evaluation.

**Impact of MindMatters by State**

A 2011 survey of school principals by PAI assessed levels of satisfaction with MindMatters.99 Note that no information was provided regarding the sample size or response rate for this survey and, as such, the results should be interpreted with caution. The survey found that of the school leaders nationally:

- 79% were satisfied or very satisfied with MindMatters providing strategies for classroom teachers in supporting mental health and wellbeing for students
- 71% were satisfied or very satisfied with MindMatters contributing to providing knowledge, understanding and strategies specifically for high support needs students
- 73% were satisfied or very satisfied with MindMatters building their own personal understanding of mental health and wellbeing
- 79% were satisfied or very satisfied with MindMatters increasing knowledge and understanding of mental health and wellbeing of staff attending professional learning
- 78% were satisfied or very satisfied with MindMatters providing professional development ideas used in their schools
- 71% were satisfied or very satisfied with MindMatters assisting in dealing with staff issues in relation to their mental health and wellbeing
- 80% were satisfied or very satisfied with MindMatters with the overall benefits it provided for staff, students and the school community.

**11.4.4 Implications of the MindMatters initiative evaluation findings**

The following considers the MindMatters initiative evaluation findings in terms of appropriateness, effectiveness and efficiency.

**Appropriateness**

The widespread uptake of the MindMatters initiative by schools and the high levels of satisfaction of school leaders suggest that MindMatters was considered appropriate by its target audience. The delivery of mental health prevention, promotion and early intervention to secondary schools through the MindMatters initiative was based on the Health Promoting Schools Framework, and the WHO Comprehensive School Mental Health Model, and on sound evidence concerning the capacity of schools to enhance protective factors.100

The curriculum materials focused on issues such as resilience, loss and grief, bullying and harassment, understanding of mental illness and reduction of stigma. Notably, the issue of suicide was not dealt with directly in the program. This is a prudent approach given that there is currently a lack of evidence that

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school-based programs that focus on raising awareness about suicide are beneficial and not harmful.\textsuperscript{101} There is also some evidence that MindMatters can be successfully adapted and implemented in schools with high numbers of students from Aboriginal and Torres Strait Islander backgrounds, as it provides sufficient flexibility to enable schools to take ownership of the program.\textsuperscript{102}

**Effectiveness**

Based on the evaluation reports available, it is not possible to comment on the extent to which the MindMatters initiative has influenced help-seeking behaviour or measures of mental health (or suicide rates) within the student population during the period 2006-13. However, the level of uptake of the initiative suggests that MindMatters may have assisted schools in creating an environment that is supportive of mental health. It should also be noted that as a population health intervention (as compared with mental health clinical interventions), a program such as MindMatters has the capacity to achieve large collective benefits, although the benefits to the individual may be small and difficult to measure.\textsuperscript{103}

**Efficiency**

Based on the evaluation reports available to inform this report, it is not possible to comment on the extent to which the MindMatters initiative has been delivered efficiently, or if it represents value for money.

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<th>Key findings</th>
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<tr>
<td>MindMatters was a national mental health promotion initiative for secondary schools that addressed some of the risk and protective factors for suicide. It had high levels of uptake and acceptance across Australian schools and appears to be an appropriate intervention. The evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of MindMatters.</td>
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### 11.5 Integration and synergies between the NSPP and other suicide prevention activities

Through consultations with stakeholders, a rich range of perspectives were offered on the extent to which the NSPP is integrated or works synergistically with other suicide prevention efforts. The key themes that emerged from these interviews are described below.

#### 11.5.1 Understanding of the NSPP

The stakeholders consulted held a variety of views about what the NSPP was, and, consequently, these differing interpretations influenced their views of how the NSPP is integrated with other activities. A number of stakeholders did not understand the difference between the NSPS and the NSPP, and the two terms were often used synonymously. While some people referred to the NSPP as the program of funding for suicide prevention activities, others considered it to be the overarching strategy for suicide prevention.

\textsuperscript{101} Beautrais et al, ‘Effective Strategies for Suicide Prevention in New Zealand’.

\textsuperscript{102} Closing the Gap Clearinghouse, Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, Resource Sheet 19, Australian Institute of Health and Welfare and Australian Institute of Family Studies, Canberra, 2013.

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prevention in Australia, and still others considered that the NSPP was encapsulated within the LIFE Framework. One suicide prevention expert was not certain whether ‘the NSPS is operationalised within the LIFE Framework, or is it the other way round?’ The relationship between the NSPP and the TATS package was also not well understood.

This confusion made it difficult to unpack stakeholders’ views about the contribution of the NSPP to overall suicide prevention efforts in Australia and the way that it integrates with other programs. For example, one respondent remarked that a key success of the NSPP has been in shining a light on the need for better data and monitoring in suicide prevention. However, it is possible that in making this comment the respondent was referring to the LIFE Framework or the broader NSPS, rather than the NSPP specifically.

Those who were aware of the body of NSPP-funded projects were generally uncertain about the rationale for funding the existing mix of projects (this included representatives from the DoHA STOs). Some suggested that while the projects did reflect the LIFE Framework, the LIFE Framework was so broad that any and all suicide prevention activities could conceivably be considered to align with the framework.

Other stakeholders felt that Australia’s approach to suicide prevention was too narrowly focused on mental illness and this criticism was levelled at both the NSPP and the LIFE Framework. Arguably, this view points to a limited understanding of the NSPP and the LIFE Framework, because the LIFE Framework and the NSPP funding guidelines do in fact include a strong focus on the ‘upstream’ risk factors for suicide and the role of universal interventions (see Section 3.3.1). At the same time, this view also suggests that when considering Australian Government strategy around suicide prevention, people do not easily differentiate between the NSPS, the NSPP, the LIFE Framework and other Australian Government mental health initiatives such as the Report Card and the Roadmap.

Key findings
- People working in the suicide prevention sector held mixed and sometimes confused views of what the NSPP is. Many did not see the NSPP as a distinct component of the Australian Government’s activity around suicide prevention, and several confused the NSPP with the NSPS or the LIFE Framework.

11.5.2 Integration between the NSPP and other suicide prevention efforts

Discussions with DoHA STO representatives showed that there were variations in their level of understanding of NSPP-funded projects underway in their jurisdiction. This variability may be a function of the staff turnover and the diversity of programs included in the STO portfolios.

Communication and leadership were consistently reported as areas in which improvements could be made to enhance integration. These are described below.

Communication

STO representatives listed intra- and inter-departmental communication as an area for possible improvement. Examples cited included:
- Jurisdictions would benefit from more information about developments at federal level regarding departmental restructures, strategy development and funding announcements. This would assist
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Jurisdictions to plan their activities, have input into decisions about where funds may be needed and avoid duplication of services or competition for funding between NGOs. The national expansion of two NSPP-funded projects under the TATS package was identified as an example where such information was not made available.

- Some jurisdictions found it difficult to adjust their service provision models to align with Australian Government projects.
- STO representatives reported having good working relationships with jurisdictional staff responsible for developing and implementing state/territory level suicide prevention strategies; however, jurisdictional staff tended to approach DoHA CO directly with questions or concerns, thereby excluding STO staff.

Leadership

While the jurisdictional representatives were consistently of the view that communication regarding the NSPP could be improved, they also suggested that the Australian Government should take a stronger leadership role in shaping the direction of suicide prevention in Australia. This view was echoed by the peak body representatives and other experts interviewed. They suggested that the leadership role of the Australian Government could be strengthened in the following areas:

- Providing a more detailed vision for suicide prevention in Australia. While the LIFE Framework was seen in general as a useful document, it was considered by some to lack specificity regarding priorities and concrete actions.
- Better promotion of the evidence for what works, and promotion of a stronger commitment to evidence-based practice.
- Playing a stronger role in the collection, management and dissemination of data.
- Playing a coordinating role between national and jurisdictional suicide prevention efforts to ensure that gaps in the delivery of services are taken into account in a more systematic manner (this included a stronger role in coordinating ‘rapid responses’ to suicide ‘clusters’ in particular areas).
- Strengthening the terms of reference of ASPAC to enable the Council to take a more strategic role.
- Setting targets for the reduction in suicide rates and related outcomes.
- Supporting improved sector coordination mechanisms to promote a shared vision of suicide prevention in Australia.

Key findings

- Communication and leadership between DoHA, the jurisdictions and the sector was seen as an area for improvement, to ensure the NSPP is integrated with other suicide prevention activities in Australia.

11.6 Gaps and opportunities in national suicide prevention efforts

Stakeholders provided a range of responses in relation to perceived gaps in suicide prevention activities. These included a stronger focus on emerging or under-recognised target groups, including:
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- Youth (particularly Aboriginal and Torres Strait Islander youth)
- People recently released from prison
- Men who have been involved with Family Court matters
- People who have recently separated or divorced
- Refugees
- Elderly people
- People who have previously attempted suicide or self-harmed (to better understand and respond to their needs beyond the immediate crisis period).

Stakeholders also stressed that while Australia's approach to suicide prevention needs an overarching structure, it must also be flexible enough to respond to societal changes. Examples included addressing the role of the social media in influencing suicide and self-harm risk, the needs of the veteran community and the impact of socio-demographic changes on the distribution of risk across society. Examples of the latter include reportedly higher rates of suicide amongst 'fly-in fly-out' workers, and amongst men in the rock lobster fishing industry in Western Australia as a result of job losses.

Although the Australian Government has taken a leadership role in suicide prevention through the Living is For Everyone (LIFE) website, many stakeholders called for greater Australian Government leadership and coordination across the spectrum of suicide prevention activities as outlined in Section 11.5.

In response to questions about where the Australian Government should focus its suicide prevention funding, two distinct opinions were voiced. A number of experts argued that it was appropriate to fund a broad range of suicide prevention initiatives covering a range of target groups, settings, intervention points and activities. The rationale for this was that since the aetiology of suicide is complex and multifactorial, the response should reflect this. The alternate view was that the government should concentrate its efforts on a narrower range of interventions that have been proven to be effective, and to roll these out consistently. Several stakeholders commented that the NSPP should look to 'scale up' effective initiatives. Within both camps there was unanimous agreement that research and evaluation needs a stronger commitment and better resourcing – a view reflected in the recommendations and conclusions made within the previous evaluations of the NSPS/NSPP (see Section 3.11) and the Senate Inquiry into Suicide (as outlined in Section 3.4).

11.7 Consistency with the Australian Government Mental Health Reform agenda

As outlined in Section 3.6, the Mental Health Reform package, released in 2011, signalled the then-incumbent Labor Government’s commitment to ongoing mental health reform.104 The reform package aimed to:

- Improve access not only to mental health services, but also to social support, housing, education and employment services for people with a mental illness
- View mental illness not just as a health issue, but also take steps to improve economic and social participation by people with mental illness
- Take a whole-of-life approach to the prevention and treatment of mental illness.

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104 This refers to the government at the time that the evaluation commenced. In September 2013 a change of government occurred.
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As described in Section 3.6, initiatives under the Mental Health Reform package that are particularly relevant to the NSPP are the formation of the Roadmap for Mental Health Reform (the Roadmap), the National Mental Health Commission and delivery of its first Report Card, the TATS package, and the expansion of the ATAPS Suicide Prevention service initiative.  

The NSPP was considered by stakeholders to be broadly aligned with the Mental Health Reform agenda. However a number of stakeholders expressed the view that the cause of suicide prevention has suffered due to too narrow a focus on mental health and mental illness (the one exception to this was a submission by the Royal Australian and New Zealand College of Psychiatrists (RANZCP)). This was considered in part to be a consequence of the responsibility for suicide prevention being ‘pigeon holed’ within the mental health units of governments. While the link between mental illness and suicide was acknowledged (including the increased risk of mental ill-health amongst those bereaved by suicide), there was general agreement that suicide prevention needs to broaden its focus beyond the biomedical paradigm to a broader ‘social determinants’ approach. There was strong agreement that suicide prevention should be leveraged out of all human service programs and receive attention and commitment from all areas of government. A number of respondents commented on the need for a ‘joined up’ approach to suicide prevention.

By extension, articulating the Australian Government’s direction regarding suicide prevention in documents whose primary focus is on mental health and treatment of mental illness may potentially be seen to represent a similar narrowing of perspective in relation to suicide prevention. This is despite the fact that, under closer scrutiny, the Mental Health Reform agenda (as articulated through the Report Card and the Roadmap in particular) clearly addresses the issue of mental illness from a social determinants approach and advocates collective, multi-sectoral action to improve outcomes.

Key findings

- While the NSPP is broadly aligned with the National Mental Health Reform agenda, some stakeholders believed that suicide prevention is too strongly linked to a mental health agenda, at the expense of a broader ‘social determinants’ approach.

11.8 Potential consequences of not continuing the NSPP

At the local level, cessation of the projects would be likely to be strongly felt by those who used the services (for example, those using counselling or support services). Several stakeholders felt that a key strength of the NSPP was the opportunity it provided to trial innovative responses for emerging risk groups and did not want this opportunity to be lost. Notable exceptions are those projects with a strong capacity building focus that developed community links and networks. For these projects, the NSPP funding was used as ‘seed funding’ with the expectation that, once established, the networks would be sustainable.

From a national perspective, it is difficult to comment on the potential consequences of not continuing the NSPP funding. The stakeholders interviewed were unanimously of the view that the Australian Government needs to retain a strong commitment and vision in relation to suicide prevention (including funding for suicide prevention activities). However, they did not see that the NSPP in its current form was integral to this vision. Those interviewed also reiterated the view that, given the multiplicity of

105 Note: The Coalition Government, elected in 2013, has given a commitment to review existing mental health programs.
activities and initiatives that exist within the suicide prevention space (see Section 11.2) and the lack of outcome data for the individual programs, it is unlikely that the cessation of the NSPP in its current form would lead to a measurable increase in rates of suicide or self-harm.

11.9 Summary of key findings

- The ATAPS Suicide Prevention service initiative is an appropriate and effective suicide prevention intervention. It is not possible to establish the efficiency of the program because the national expansion of the program is still in its infancy and there is limited data on outcomes at this stage.

- MindMatters was a national mental health promotion initiative for secondary schools that addressed some of the risk and protective factors for suicide. It had high levels of uptake and acceptance across Australian schools and appears to be an appropriate intervention. The evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of MindMatters.

- People working in the suicide prevention sector held mixed and sometimes confused views of what the NSPP is. Many did not see the NSPP as a distinct component of the Australian Government’s activity around suicide prevention, and several confused the NSPP with the NSPS or the LIFE Framework.

- Communication and leadership between DoHA, the jurisdictions and the sector was seen as an area for improvement, to ensure the NSPP is integrated with other suicide prevention activities in Australia.

- Some stakeholders believe that suicide prevention is currently too strongly linked to a mental health agenda at the expense of a broader ‘social determinants’ approach.
12 Improving outcome measurement

12 IMPROVING OUTCOME MEASUREMENT

This chapter examines ways to improve outcome measurement of NSPP-funded projects and identifies opportunities for program enhancements to achieve these improvements. These enhancements draw on the knowledge of project activities gained through engagement with projects and the insights gained from stakeholder consultations throughout this evaluation. They are also informed by the current literature on suicide prevention and evaluation (see Appendix E).

12.1 Conceptualising outcome measurement

As outlined in Chapter 8, outcome measurement for suicide prevention is complex and multifaceted. In part this reflects the range of factors that need to be considered in measuring outcomes, as illustrated by the following definition:

Outcomes are 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.\(^\text{106}\)

In the context of evaluating effectiveness, outcome measurement plays a central role in addressing the following core questions posited in Section 8:

| Question 1: Did interventions or programs deliver what they said they would? |
| Question 2: What were the outcomes of these programs? |

Figure 12-1 provides a causal mechanism model to explain how NSPP-funded activities are intended to lead to a reduction in completed suicides and demonstrates how these two questions fit into the evaluation continuum. Question 1 is primarily addressed by measuring inputs and outputs while Question 2 is addressed by measuring outcomes (proximal and distal). Note: This causal mechanism model is based on the conceptual framework that underpins the overarching program logic developed as part of the evaluation framework (see Appendix F).

\(^{106}\) S Mathison, ‘Outcomes’.
In the above causal mechanism model (Figure 12-1), Question 1 focuses on program/project inputs and outputs and thus falls primarily into the domain of process evaluation. Question 2 specifically relates to outcome measurement. To date, evaluations of NSPP-funded projects have largely addressed Question 1. For most projects, therefore, outcome measurement represents a further and unfamiliar step in the evaluation continuum.

In the context of NSPP-funded projects, it is also worth noting that issues related to outcome measurement at project level are overlaid by the broader questions of what works and what is likely to work according to the evidence base. As outlined in Section 7.2, the evidence base for effective suicide prevention activities that answer these broad questions is small and growing. This is coupled with the fact that:

- Suicide prevention is a dynamic, constantly changing field that generates new questions that need to be addressed
- There is often a time lag between innovation and evidence, which contributes to significant gaps within the evidence base. The impact of social media on suicide is one such example.

Therefore, while NSPP-funded projects currently engage in a diverse range of activities that, overall, are consistent with current best practice as indicated by the literature review and the LIFE Framework (see Chapters 5 and 6), the evidence base on which these best practices have been developed is incomplete. Consequently, outcome measurement is not only an issue for individual projects but also for the broader suicide prevention research community.

Outcome measurement at project level has the potential to:

- Contribute to the evidence base by highlighting innovative initiatives that show promise and thus warrant further investigation by the research community

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12 Improving outcome measurement

- Provide better understanding of the chain of effects related to short- and medium-term outcomes achieved by projects
- Provide a translational research environment where outcome measurement tools and evidence-based findings can be explored in specific settings and contexts in Australia. This could include involvement in case-control studies, quasi-experimental evaluation designs and randomised control trials being undertaken by the research community
- Provide ongoing quality control in service provision
- Identify initiatives that could potentially be expanded in terms of reach.

To achieve this potential and bridge the evidence–practice gaps, further collaboration and partnership between projects and the research community is required.

12.2 Where to start

While outcome measurement using validated tools is a new venture for most projects, outcome measurement of suicide prevention activities has been a focus of international and Australian efforts for some time.

Internationally this includes the WHO’s *Towards Evidence-based Suicide Prevention Programmes*,108 and, in Australia, *Outcomes and indicators, measurement tools and databases for the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*.109 Mitchell and Lewis’ *A Manual to Guide the Development of Local Evaluation Plans* was specifically designed to assist in the evaluation of the LIFE Framework.110 Each of these publications provide a list of potential indicators and possible outcome measurement tools and thus serves as a useful starting point for addressing outcome measurement in the NSPP going forward. The LIFE website includes a list of program evaluation resources that could also assist with this process.111

It is important to acknowledge the need for the inclusion and/or development of culturally appropriate outcome measurement tools, particularly for projects that work with CALD and Aboriginal and Torres Strait Islander populations.

12.3 What, how and when to measure outcomes

The causal inference model presented in *Figure 12-1* identifies four domains (types) of project outputs:

- Provision and consolidation of suicide prevention information resources and research
- Direct individual client services to high-risk groups
- Community focused services/activities for people at risk of suicide

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- **Training** in recognising and responding to risk for front line workers, families and community members, and workforce development.

Separate causal inference models have been developed for each of these four domains, and are presented as follows:

- Information resources, research and information provision (*Figure 12-2*)
- Individual client services (*Figure 12-3*)
- Community focused services (*Figure 12-4*)
- Training (*Figure 12-5*).

In each case, examples of possible data sources are provided. A full taxonomy of possible tools and questions has not been developed for each output domain as this is beyond the scope of this evaluation.

Output domains rather than LIFE Action Areas are used as the basis of these causal inference models because, from a project perspective, these output domains are more applied and less conceptual. As a result, projects can more easily identify with the output domains that relate to the modes of activities they provide.

Consistent with best practice advocated by the realist evaluation approach, a range of timeframes and tools/data are suggested in the following four models (*Figure 12-2* to *Figure 12-5*). These include a mix of quantitative and qualitative measures that are designed to unpack *‘the long sequences of steps before the outcome’*\(^{112}\) while at the same time ensuring the validity and reliability of the data collected.\(^{113}\) The qualitative component is essential to understanding lived experiences and the context-specific elements that serve as mediating factors in achieving outcomes.

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\(^{112}\) Pawson & Tilley, *Realistic Evaluation*.

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Figure 12-2: Causal mechanism model: Information resources, research and information provision

Causal Mechanism Model: Information resources, research and information provision

Monitoring
Q1: Did interventions or program deliver what they said they would?

Evaluation
Q2: What were the outcomes of these programs?

Inputs
- Project logistics: Funding, Staff, Supportive mechanisms

Outputs
- Research papers and presentations
- Information resources
- Policy/strategy development

Proximal Outcomes
- Improved access to information
- Improved understanding of what works in practice
- Increased community understanding of suicide

Distal Outcomes
- Increased evidence based practice
- Improved capacity to respond at tipping points and points of imminent risk
- Reduced incidence of completed suicide

Examples of possible data sources
- Funding Agreements
- Progress Reports
- MDS
- Number of publications
- Number of presentations
- Number of information resources developed
- Citation indexes
- Number of people attending presentations
- Number of information resources distributed
- Key informant interviews
- Survey of information resource users
- ABS Data
- State-based suicide registers (where they exist)
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Figure 12-3: Causal mechanism model: Individual client services

Causal Mechanism Model: Individual Client Services

Process Evaluation
Q1: Did interventions or program deliver what they said they would?

Inputs
- Project logistics:
  - Funding
  - Staff
  - Supportive mechanisms

Outputs
- Strong referral pathways and coordinated care
- Provision of appropriate range of direct support and care services
- Engagement of high risk groups
- Targeted suicide prevention activities in high risk groups

Outcomes Evaluation
Q2: What were the outcomes of these programs?

Proximal Outcomes
- Increased help seeking
- Decreased suicidal ideation
- Improved QoL/SEWB

Distal Outcomes
- Increased social connection and participation
- Improved capacity to respond at tipping points and points of imminent risk
- Improved individual resilience and wellbeing
- Reduced incidence of suicidal behaviour (self harm/suicide attempts)
- Reduced incidence of completed suicide

Examples of possible data sources

Funding Agreements
- Progress Reports
- MDS

Client Records
- Number of clients
- Demographics compared to target
- Client satisfaction surveys
- MDS

Pre- and Post-K10
Pre- and post-QoL
Pre- and post-SEWB
Exit interviews

Client follow up 12 months after intervention (online pop-up survey, phone)

Focus groups
Network analysis
Surveys
Interviews

ABS Data
State-based suicide registers (where they exist)

Key: QoL = Quality of Life; SEWB = Social and Emotional Wellbeing
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Figure 12-4: Causal mechanism model: Community focused activities

Causal Mechanism Model: Community* Focused Activities

Inputs
- Project logistics:
  - Funding
  - Staff
  - Supportive mechanisms

Outputs
- Community events/activities

Monitoring
Q1: Did interventions or program deliver what they said they would?

Evaluation
Q2: What were the outcomes of these programs?

Proximal Outcomes
- Increased community awareness of what is needed to prevent suicide
- Increased understanding of whole of community risk and protective factors and how best to build resilience of communities and individuals

Distal Outcomes
- Improved community strength and resilience
- An environment that encourages and supports individual help-seeking
- Reduced incidence of suicidal behaviour (self harm/suicide attempts)
- Reduced incidence of completed suicide

Examples of possible data sources

Funding Agreements
Progress Reports
MDS
Event records
- Number of attendees
- Demographics compared to target
Satisfaction surveys
MDS
Community survey (pre and post)
Interviews with key informants/stakeholders
Community survey (pre and post), e.g.
Community Readiness Questions Interview
Interviews with key informants/stakeholders
ABS Data
State-based suicide registers (where they exist)

*Community refers to: either the general community (whole of Australia) or a more specific geographic community; or a community of shared interest or culture (Lewis and Mitchell, 2003)
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Figure 12-5: Causal mechanism model: training

Causal Mechanism Model: Training

Inputs
- Project logistics:
  - Funding
  - Staff
  - Supportive mechanisms

Outputs
- Provision and consolidation of suicide prevention resources and information
- Provision of evidence based training
- People complete training

Proximal Outcomes
- Changes in understanding
- Changes in confidence

Distal Outcomes
- Application of knowledge
- Staff role post training
- Performance change
- Increased recognition of signs/symptoms
- Increased help seeking
- Increased resilience
- Increased awareness
- Reduced incidence of suicidal behaviour (self harm/suicide attempts)
- Reduced incidence of completed suicide

Process Evaluation
Q1: Did interventions or program deliver what they said they would?

Outcome Evaluation
Q2: What were the outcomes of these programs?

Examples of possible data sources

Funding Agreements
Progress Reports
MDS

Training content/curriculum
Trainee Records
- Number of trainees
- Demographics compared to target
Trainee satisfaction surveys
MDS

Pre- and post-training knowledge
Pre- and post-training confidence

Survey of trainees 12 months after training
Survey of beneficiaries of original trainees (e.g. Teachers, students, workmates etc.)

ABS Data
State-based suicide registers (where they exist)
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12.4 Barriers to outcome measurement in the NSPP

Outcome measurement presents a significant change and challenge for many projects and for the Department, as it represents a new and expanded mode of reporting. It is important, therefore, to highlight the key issues that may arise so that change can be appropriately managed. These issues were identified through consultation with the projects and the Department throughout this evaluation.

As indicated in each of the causal mechanism models (Figure 12.2 to Figure 12.5), outcome measurement in the NSPP context presupposes data collection at two levels:

- Project level
- National level.

The challenges related to outcome measurement at each level are examined below.

12.4.1 Project level

One of the key lessons learned from administering the MDS is that there is a general willingness among NSPP-funded projects to participate in data collection. This is evidenced by the fact that all 47 eligible projects submitted data during the snapshot period (October 2012 to March 2013). All required data was provided by 44 of the 47 projects (94%), and partial data by the remaining three projects. Furthermore, positive feedback was provided either in writing or verbally from many of the projects. Examples of written feedback include:

- Overall, the portal is brilliant. It makes entering the data quick and simple.
- The reports are really useful for us. We’ll be able to use them for our business purposes here.
- What you have designed is very comprehensive.

Discussions with project representatives at the workshops held in August 2012 also indicated a willingness to collect outcome data.

Despite this general willingness, a number of barriers were evident that could have implications for the introduction of outcome measurement at project level:

- Engagement with projects highlighted that the majority are focussed on the business of service delivery
- For some, outcome measurement is perceived as research and therefore outside their core business of service delivery
- Many lack training in outcome measurement, ie, selection, identification, administration and analysis of appropriate tools.
- Project effects have generally been reported using narrative accounts or invalidated tools in the past
- Projects were generally unaware of the range of outcome measurement tools currently available. They also indicated that a repository of NSPP-appropriate outcome measurement tools and guidance in the use of these tools would be welcomed
- Where resistance occurs, it is likely to be on the grounds of inadequate time and limited staff availability. In some cases this may be justified, particularly among those projects with large volumes of clients and few staff
- For some projects, outcome measurement may be impractical, eg, those operating crisis lines where they do not have the capacity to follow-up
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- Loss to follow-up is likely to be raised as an issue by projects for establishing long-term outcomes
- Non-compliance may be an issue. As noted above, not all projects completed the MDS. This is also likely to be the case with outcome measurement.

Addressing these issues with projects will be essential to securing project buy-in.

Additional considerations for the Department include:

- Cessation of funding will mean that project staff will be unable to follow up with service users in later years to establish the long-term outcomes of project activities. Funding duration at project level may need to be reviewed or alternative follow-up arrangement considered
- Assessing NSPP-funding applicants to determine their capacity to undertake the required level of service delivery and data collection (including outcome measurement)
- Investment in capacity building at project level to ensure compliance with service delivery and data collection and outcome measurement requirements. This could involve expanding the role of existing NSPP-funded projects. For example, under its funding agreement, the National Centre of Excellence in Suicide Prevention is tasked, with ‘conducting educational workshops on a range of topics agreed by the Department to provide NSPP projects with additional support, for example, evaluation and data collection practices’
- Facilitating collaborations and partnerships between projects and the research sector to bridge the evidence–practice gap. Again, this could involve expanding the role of existing NSPP-funded projects. For example, in its funding agreement, the Suicide Prevention Australia (SPA) Strategic Partnership is tasked with ‘building and consolidating alliances with researchers and centres of excellence’
- Introduction of accountability measures for non-compliant projects
- Outcome evaluation at state/territory and national levels is a matter for public health specialists.

12.4.2 National level

While the introduction of outcome measurement at project level will do much to address the lack of information on project-specific outcomes, it is important to note that no matter how well outcome measurement is undertaken at project level, it is not possible to establish a direct correlation between individual project-level activities and reductions in the suicide rate nationally. It is for this reason that ‘governments look at suicide rates as the main outcome measure to determine the efficacy of their policies’ in the absence of other more proximal measures being available.\textsuperscript{114}

Much has been written on the problematic nature of suicide data in Australia (see Section 4.10.2). If changes in national suicide statistics are to serve as a surrogate measure of long-term project outcomes, reliable national suicide statistics are as crucial to outcome measurement in the NSPP.

Consultations with key stakeholders in the preparation of this report highlighted the need to include suicide attempts, not just completed suicides, as key indicators of change. This would require consideration of implementing a suicide attempt register and the follow-up of people who used services as a result of attempted suicide or self-harm, to establish what happens in the 12 months after contact with the service or emergency department.

Data linkages are crucial if an analysis at this level is to be achieved.

\textsuperscript{114} Williams et al, ‘Accuracy of Official Suicide Mortality Data in Queensland’, p819.
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12.5 Summary of possible improvements

Based on the preceding analysis of outcome measurement in the NSPP, key areas of possible program improvement are summarised below.

At project level:

- A taxonomy of practical, evidence-based outcome measures that could be used by NSPP-funded projects needs to be created. Once established, this taxonomy needs to be updated as new tools and measures become available and the evidence base evolves.

- A repository of NSPP-appropriate outcome measurement tools and guidance in the use of these tools would be useful. Projects were generally unaware of the range of outcome measurement tools currently available and indicated that such a repository of tools would be welcome.

- An advisory group needs to be established to provide direction on the best measures to be used by individual projects.

- Capacity building is needed at project level in terms of instrument selection, administration, analysis and reporting of outcome measures. Opportunities should be provided for information sharing among projects regarding best practice strategies to implement outcome measures. This could take the form of a best practice register.

- While validated tools are important, a mix of qualitative and quantitative outcome measures is essential to understanding lived experiences and the context-specific elements that serve as mediating factors in achieving outcomes.

- Project engagement and consultation is essential throughout this change process to ensure project buy-in.

- Oversight is needed to determine the extent to which measures have been appropriately implemented.

- Projects that apply for NSPP-funding should be assessed in terms of their capacity to conduct and report on outcome measures.

- Collaborations and partnerships between projects and the research sector need to be further developed to bridge the evidence–practice gap.

- Accountability measures need to be introduced for non-compliant projects.

- Outcome evaluation at state/territory and national levels is a matter for public health specialists.

At a national level:

- Outcome measurement needs to include suicide attempts, not just completed suicides.

- Data linkages are essential to facilitate outcome measurement.

- Ongoing improvements are needed in suicide death data.
13 Summary of findings, suggested program improvements and conclusions

13 SUMMARY OF FINDINGS, SUGGESTED PROGRAM IMPROVEMENTS AND CONCLUSIONS

This chapter summarises NSPP achievements and the key Evaluation findings including suggested improvements.

To contextualise the achievements and findings, the chapter begins with an overview of the Evaluation objectives, the methods used to address these objectives, and the caveats and limitations that apply to the interpretation of findings presented in this Final Report.

13.1 Evaluation overview

This Evaluation analysed NSPP-funded project activities from 2006 to 2013 and had two broad objectives:

- Evaluate existing activity under the NSPP and new activities funded under the 2010 TATS package, in order to determine appropriateness, effectiveness and efficiency of these activities within the broader policy context
- Inform the evidence base for future policy direction and implementation of suicide prevention activity and create and put in place a comprehensive evaluation framework for ongoing use.

A mixed methods approach was used in the conduct of this Evaluation, using both quantitative and qualitative data sources. The historical component of project activities was assessed by means of a desktop review of existing documentation and data for each of the in-scope NSPP-funded projects. This included funding agreements, progress reports, final reports, internal evaluations and external evaluation reports. Gaps identified in the data provided were addressed via a survey of NSPP-funded organisations.

A Minimum Data Set (MDS) was developed and implemented, consisting of a series of data items specifically designed to support the current and ongoing evaluation of NSPP- and TATS-funded activities. Data collection using the MDS began on 1 October 2012 and continued until the end of March 2013. All 47 projects funded during the period provided MDS data, albeit incomplete data in a few cases.

Consultations were held with a range of key stakeholders and two literature reviews were undertaken to support the evaluation activities. Published evaluation reports of the Access to Allied Psychological Services Suicide Prevention Program (ATAPS Suicide Prevention service initiative) and MindMatters were also considered.

Throughout this Evaluation, an advisory group provided critical feedback regarding the direction of the evaluation and its findings.

A number of limitations and caveats apply to the findings that follow. These include internal data limitations such as incomplete data and the relatively short timeframe of the Evaluation, and external factors such as the significant challenges related to the evaluation of suicide prevention programs, which are well recognised in the sector. These external challenges include the fact that suicide is a statistically rare event, attribution is difficult and there are many issues related to the quality and timeliness of suicide data.
13 Summary of findings, suggested program improvements and conclusions

13.2 Appropriateness

Overall, the NSPP-funded projects conformed to the best practice recommendations of the LIFE Framework, providing 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 of suicide. Importantly, this mix not only occurs at state/territory level but also within individual projects.

The project activities 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, other non-NSPP-funded initiatives (that are not part of this Evaluation) may be filling these gaps.

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

A mix of universal, selective and indicated approaches was evident in project activities. A number of NSPP-funded projects used universal approaches to address media reporting of suicide and mental illness, and 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 the knowledge and awareness of medical practitioners, there were a number of other initiatives that supported 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.

Importantly, none of the NSPP-funded projects reported using activities or approaches that were identified in the peer-reviewed literature as potentially harmful. Survey responses from funded organisations 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.

NSPP project funding per capita varied considerably between jurisdictions. However, 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. Jurisdictions with the greatest need (ie, highest age-standardised suicide rates) were therefore recipients of the highest funding per capita.
13 Summary of findings, suggested program improvements and conclusions

13.3 Effectiveness

13.3.1 Outcomes and achievements

Assessing the effectiveness of NSPP activities was hampered by a general absence of quantifiable outcome measurement by the projects. Routine progress reports submitted by funded organisations were largely based on quantitative output and financial data, with narrative self-reports used to describe the effects of activities. Outcome measurement involving validated tools has been rare among NSPP-funded activities. Even in cases where independent external evaluations had been undertaken, most reported on the achievement of project objectives rather than on short-, medium- or long-term outcomes. This issue is not unique to the NSPP and has been a challenge for suicide prevention activities throughout Australia and internationally.

The dearth of validated and standardised tools limited the extent of comparison that could be made between NSPP-funded projects engaged in similar activities.

Based on self-reported assessments, most projects, including those in their infancy, reported having achieved their objectives. A wide range of project achievements were cited as a result of a diverse range of activities. The MDS data identified that 16,222 individual client contacts/activities and 2,428 group activities occurred over the six months to March 2013.

The LIFE Framework lists a number of LIFE Action Areas that describe the intended effect of the NSPS. Achievements related to these LIFE Action Areas were assessed using documentation, reports and survey responses from the funded organisations. Based on this data, self-reported achievements were demonstrated across the full range of LIFE Action Areas, particularly in relation to:

- Improving understanding of imminent risk and how best to intervene, particularly through gatekeeper training and community awareness approaches
- Improving access to support for people at risk of suicide and, in some cases, improving the knowledge, attitudes and help-seeking behaviours of those at high risk
- Improving community strength through capacity-building approaches, particularly for some well-defined target populations
- Providing information about suicide prevention
- Improving the profile of risk and protective factors at the individual level.

Positive unintended outcomes of the projects included positive reciprocity and expansion of project reach or goals. A negative unintended outcome was that some individuals felt that accessing services led them to be stigmatised in the community.

Although significant achievements have been identified, it should be noted that it is not possible to determine the extent to which the NSPP-funded activities have impacted on rates of suicide.

The DoHA staff who administer the NSPP-funded projects spoke positively about the achievements of the projects; however they also expressed concern that the existing reporting mechanisms (progress reports, final reports) did not adequately capture information about project outcomes and impacts. Furthermore, it was noted that data generated through the NSPP has not been made available in the public domain or to funded projects.

The documentation, reports and survey responses submitted by funded organisations indicate several areas with scope for improvement. These areas include:
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- Limited opportunities exist for funded organisations to share strategies and best practice
- There was little evidence that regionally-integrated approaches were operating
- The ability to achieve long-term, structural change was beyond the scope of many projects. Many projects reported that this partly due to the short-term nature of NSPP funding
- Many project representatives expressed a desire for greater support to evaluate their activities
- There was limited access to information and data about suicide prevention activities.

13.3.2 Effectiveness: Enablers and barriers

Project representatives identified a number of enablers that contributed to the success of projects. These included:

- Strong, effective relationships between service providers and a range of other community stakeholders
- Strong relationships within project teams
- Recruiting the right staff and providing them with adequate support.

Key barriers to project effectiveness included:

- Funding limitations (amount and duration)
- Difficulties recruiting and retaining staff
- Sub-optimal partnerships and relationships (and the amount of time invested in these)
- Difficulties reaching and engaging the project’s target populations, including a number of specific challenges for Aboriginal and Torres Strait Islander populations and rural and remote populations
- Difficulties collecting data.

In addition, projects reported that a number of project-specific design issues, and sub-optimal data collection and evaluation had limited their ability to measure effectiveness.

Project representatives made a number of suggestions for improving effectiveness, including:

- Increasing funding amounts and periods
- Improving collaboration with, and coordination between, funded organisations
- Providing support for organisations to improve capabilities in project development and evaluation.

13.4 Efficiency

Measuring efficiency in the suicide prevention context faces two key challenges:

- Lack of outcome data
- Difficulties assessing the cost of suicide and consequent economic benefit of prevention.

Considerable information is available regarding the inputs and outputs of NSPP-funded projects. As identified in Chapter 6, 16,222 individual and 2,425 group activities were delivered by the 47 projects that provided MDS data over the six months to March 2013.
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However, as detailed in Chapter 8, outcome measurement using validated tools has been rare among NSPP-funded projects. Only three of the 47 projects conducted evaluations that measured outcomes using validated tools (see Section 8.3). Challenges associated with outcome measurement are identified in Chapter 8, and Chapter 12 identifies ways to improve outcome measurement in future.

A further key challenge is that there is limited information available about the financial cost of suicide in Australia (see Appendix E), making it difficult to determine the economic benefit of prevention. Indeed, the report on the Senate Inquiry into Suicide, The Hidden Toll\textsuperscript{115}, sought to address this deficit by recommending that the Australian Government commission a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia.

Efficiency was therefore examined from the following perspectives:

- Apparent cost efficiency of projects calculated by relating costs to outputs (ie, hours of service delivered), to enable analysis and comparison of average cost–per-hour of service delivery
- Sustainability of projects
- Potential efficiency improvements, based on consultations with project representatives and the Department.

This analysis found that:

- The cost per hour of service provision varied across projects
- Projects that provided relatively more hours of direct service provision (to individuals or groups) tended to have a lower cost per hour and hence appear to be more efficiently delivering services
- Projects that spend relatively more time on travel and event/activity planning appear to have higher costs, ie, travel and event/activity planning appear to be key driver of costs.

In relation to sustainability, more than half of the projects indicated that they receive no funding other than the NSPP. Where projects did receive funding from other sources, the amounts received were relatively small. The vast majority of project representatives did not believe that their project would be sustainable without continued NSPP funding. Project representatives reported high levels of satisfaction with regards to the level of communication and responsiveness of the DoHA officers responsible for the administration of their project. Suggestions for improving DoHA administration of projects included:

- Improved contract management, eg, speedier notification of contract awards and greater engagement of DoHA contract managers with projects
- More streamlined reporting that is less repetitive and more inclusive of project activities
- Greater care in data management so that resubmission of data is not required.

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13.5 Positioning the NSPP in Australia’s suicide prevention efforts

The NSPP represents one component within a complex range of suicide prevention activities in Australia. While it is outside the scope of this evaluation to map these in detail, a desktop review of two initiatives was undertaken, namely the ATAPS Suicide Prevention service initiative and the MindMatters initiative. ATAPS provides consumers with access to evidence-based psychological services delivered by allied health professionals, and is administered by Medicare Locals. MindMatters was a national mental health promotion initiative for secondary schools that addressed some of the risk and protective factors for suicide. A review of previous evaluation reports for these two initiatives found that:

- The ATAPS Suicide Prevention service initiative is an appropriate and effective suicide prevention intervention. The efficiency of the program has not been established due to a lack of data.
- MindMatters had high levels of uptake and acceptance across Australian schools and appears to be an appropriate intervention. The evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of the program.

Through interviews, stakeholders expressed a range of views regarding the positioning of the NSPP in Australia’s suicide prevention efforts. The following findings emerged:

- People working in the suicide prevention sector held mixed and sometimes confused views of what the NSPP is. Many did not see the NSPP as a distinct component of the Australian Government’s activity around suicide prevention, and several confused the NSPP with the NSPS or the LIFE Framework.
- Communication and direction from the Australian Government were seen as key factors that limited the extent to which the NSPP was integrated with other suicide prevention activities in Australia.
- Some stakeholders argued that, currently, suicide prevention is too strongly linked to a mental health agenda, at the expense of a broader social determinants approach.
- Stakeholders felt that most of the NSPP-funded projects would not be able to continue in the absence of specific NSPP funding, and that the impact of this would be felt by service users at the local level.
- Stakeholders stressed the importance of a strong and continuing Australian Government commitment to suicide prevention.
- The concept of setting a national suicide reduction target was raised by several stakeholders. Details of what this target should be or how it should be set were not specified.
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13.6 Opportunities for program improvement

Based on the findings of this Evaluation, including consultation with stakeholders, the following opportunities for program improvement are presented for consideration, under the headings of effectiveness, efficiency and appropriateness.

<table>
<thead>
<tr>
<th>Effectiveness</th>
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<tbody>
<tr>
<td><strong>1. Positioning suicide prevention</strong></td>
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<tr>
<td>Suicide prevention should be promoted as a whole-of-government and whole-of-community endeavour that stretches beyond the domain of mental health/illness.</td>
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<td><strong>2. Evaluation</strong></td>
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<tr>
<td>All Australian Government-funded suicide prevention activities should be rigorously evaluated, and adequate support, access to expertise and resourcing to do this should be provided. Where possible, the findings from these evaluations should be made available in the public domain.</td>
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<td><strong>3. Improving outcome measurement</strong></td>
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<td>A range of factors at project and national level need to be considered to improve outcome measurement and thus facilitate a greater range and depth of evaluation of NSPP activities. Project-level considerations include: capacity building; oversight and information sharing regarding the use of appropriate qualitative and quantitative tools and measures; and expanding collaborations/partnerships between projects and the research sector to bridge the evidence–practice gap. Outcome evaluation at the macro level (state/territory/national) is a matter for public health specialists, not individual projects.</td>
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<td>At a national level, the key considerations are data-related and involve inclusion of suicide attempts (not just completed suicides) as outcome measures, improved data linkages and ongoing improvement of suicide death data.</td>
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<th>Efficiency</th>
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<td><strong>4. Economic Analysis</strong></td>
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<tr>
<td>A detailed independent economic assessment of the cost of suicide and attempted suicide in Australia is needed in order to determine the economic benefit of prevention and to help inform future investment decisions.</td>
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<td><strong>5. Administration</strong></td>
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<tr>
<td>Consideration should be given to administering NSPP funding through a single office in order to improve efficiencies and reduce duplication and fragmentation of suicide prevention efforts.</td>
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<td><strong>6. Funding</strong></td>
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<td>Funding surety would assist projects with recruitment, expansion and sustainability. An open and transparent tendering process would ensure that innovative approaches to suicide prevention are supported alongside established programs.</td>
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<th>Appropriateness</th>
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<td>7. <em>Strengthening DoHA’s role</em></td>
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<td>Opportunities for strengthening the Australian Government’s role in leading and coordinating suicide prevention activities across Australia should be explored. This includes considering:</td>
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<td>▪ Better coordination between federal and jurisdictional suicide prevention activities</td>
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<tr>
<td>▪ Mechanisms for improving communication and information-sharing between all stakeholders in the suicide prevention sector</td>
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<tr>
<td>▪ A stronger role for the Australian Government in setting and disseminating the policy agenda (through appropriate consultation)</td>
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<tr>
<td>▪ Improving coordination, facilitation and funding of strategic, translational research that addresses the key evidence gaps in suicide prevention. Opportunities include:</td>
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<td>‒ Exploring the most appropriate strategies for those who are at immediate risk</td>
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<tr>
<td>‒ Improving understandings of community risk and protective factors</td>
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<tr>
<td>‒ Determining the most effective ways to build community and individual resilience</td>
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<td>‒ Exploring opportunities for measuring outcomes.</td>
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8. *Areas for continued work*

Continued work aimed at improving public awareness about mental health issues, encouraging help-seeking behaviours and reducing stigma is important. Community development in this area provides impetus for social change and challenging social norms.

13.7 Conclusions

The overall objective of the Evaluation was to inform the evidence base for future policy direction and implementation of suicide prevention activity, and to put in place a comprehensive evaluation framework for ongoing use. This Final Report provides an analysis of the appropriateness, effectiveness and efficiency of NSPP-funded projects from 2006 to 2013.

The initial retrospective evaluation of the projects encountered many data limitations. These were addressed by obtaining more comprehensive data about project activities from the MDS (*Appendix C*) and through in-depth consultations with stakeholders. Direct engagement with funded organisations has been one of the strengths of the current evaluation and differentiates it from prior evaluations where such engagement was not possible.

As a result, this evaluation represents the most extensive evaluation of NSPP-funded activities to date, and provides government with a solid foundation upon which to base future program-related decisions. Data derived from the MDS has been particularly valuable in this regard. Prior to the implementation of the MDS, existing project data could only be used to generate a broad overview of project activities. While areas of activity could be established, the scale of this activity was unknown. Likewise, a refined analysis of activities could not be undertaken including participant demographics, target groups, and referral pathways, for example.

This Final Report is based on MDS data for only a six month period (October 2012 to March 2013); however, it provides an essential baseline for future measures. The Department’s decision to extend
MDS data collection for a further 12 months to May 2014 means that comparable data on NSPP-funded activities will ultimately be available for a 20-month period.

Despite these achievements and advances, information gaps still remain. This is particularly true in relation to outcome measurement. While the MDS has contributed greatly to the process evaluation of the NSPP, outcome measurement represents the next major frontier for NSPP evaluations. Without outcome measurement, the question of ‘what works for whom in what circumstances, in what respects, and how’ will remain unanswered. So, too, will questions of economic efficiency.

Consequently, at this time it is not possible to assess whether alternative configurations of suicide prevention activities funded under the NSPP would be beneficial. This Evaluation found that the current community-based approach appears to be responsive to local need. However, the absence of outcome measurement has impeded comparison of this approach with potential alternative future strategies, such as:

- Smaller number of larger programs
- Different mix of larger and smaller programs
- Delivering services and influencing behaviour through online mediums, including social media.

Implementation of outcome measurement needs to be a facilitated process. Capacity building at project level in terms of the selection, administration and analysis of appropriate outcome measures and tools is essential. First, a body of work needs to be undertaken in consultation with projects to compile a taxonomy of appropriate tools and, where needed, develop additional tools (quantitative and qualitative).

Such a task is beyond the remit of individual funded organisations. Although this would represent an additional cost to government, the returns in terms of national consistency in measurement and comparability across projects would be great. Importantly, it would provide more robust information on which to base decisions about which projects should be continued, expanded upon, refined or eliminated. Incorporation of appropriate outcome measurement would also enable learnings from the NSPP to inform the international evidence base.

Nonetheless, despite these information gaps at project level, this Evaluation provides important insights for decision makers. Recent evidence of what works is summarised and consolidated in the literature reviews, while the extent of community support for NSPP projects serves as a strong indicator of the perceived appropriateness of suicide prevention activities at local level.

Going forward, organisations funded to undertake suicide prevention activities, the government funding these activities and, ultimately, those at risk of suicide can benefit from the opportunities for program improvement identified in this report.

### 13.7.1 Scene setting going forward

The social and environmental factors related to suicide are complex and dynamic. As a result, outcome measurement will need to evolve as new risk and protective factors are identified and new programs and initiatives are implemented in response. One key emerging area is the impacts of social media and the internet on suicide and self-harm risk. These impacts may be negative (eg, through exposure to methods of self-harm or suicide) or positive (as a medium for service provision for some groups).

The recent developments and investments in e-mental health highlight the importance of these different service delivery modalities in providing treatment and support to people with mental health disorders.
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The utility of these modalities in the suicide prevention arena needs further investigation, including consideration of the age appropriateness of social media and the internet as modes of service delivery.

Policy and funding changes also add to the dynamic landscape of suicide prevention in Australia. The introduction of Australia's first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is one such example. Released in May 2013 and supported by funding of $17.8 million over four years (2013-14 to 2016-17), this new strategy prioritises local, community-led activities developed in close consultation with Aboriginal and Torres Strait Islander communities.

The strategy will provide opportunities to overcome many of the challenges related to the cultural appropriateness of services as well as the tools and approaches used for monitoring and evaluation purposes. With this development comes the question of whether projects that target Aboriginal and Torres Strait Islander populations are now more appropriately the domain of the new strategy rather than the NSPP.

There has been increased attention given to the local coordination of primary care. These coordination mechanisms offer the potential to further refine and integrate suicide prevention activities. This could include increased opportunities for collaborative engagement such as training for gatekeepers, including GPs and other health professionals.

Another important consideration is the NSPP’s positioning relative to other activities being undertaken with at-risk groups targeted by the NSPP. This includes non-NSPP-funded suicide prevention organisations and wider mental health activities such as headspace and beyondblue. Possibilities for synergies between the NSPP and other players need to be considered.

Australia’s long history of migration has resulted in it being the second most multicultural nation in the world. This poses particular challenges for suicide prevention activity given the cultural and linguistic diversity of this immigrant population. These challenges are further compounded by the complex needs of refugee and humanitarian immigration streams.

These examples highlight the need to regularly review the range of projects that remain under the NSPP as policy and funding changes occur.

13.8 Concluding observations

Throughout the course of conducting this Evaluation, it has been gratifying for the evaluation team to see not only the passion with which people working in the suicide prevention projects go about their business, but also their genuine willingness to engage in data collection and evaluation activities, now and in the future. They, too, acknowledge that suicide prevention is an area characterised by a high level of complexity and a lack of conclusive guidance about the most effective strategies. Working with people at an extremely difficult time in their life is stressful and often very sad. In very challenging situations, this group of people work with passion and dedication and a high degree of willingness to do the best work they can.