THE UNIVERSITY OF
MELBOURNE

National Suicide Prevention Trial

Final Evaluation Report

December 2020

Dianne Currier, Kylie King, Sanne Oostermeijer, Teresa Hall, Adele Cox, Andrew Page, Jo-An Atkinson, Meredith Harris, Philip Burgess, Bridget Bassilios, Greg Carter, Annette Erlangsen, Jane Gunn, Kairi Kõlves, Karolina Krysinska, Andrea Phelps, Jo Robinson, Matthew Spittal, Jane Pirkis.

Acknowledgments

This report would not have been possible without the valuable contributions of many who generously shared their time, experience and knowledge. In particular, the evaluators would like to thank the Evaluation Steering Committee and the Aboriginal and Torres Strait Islander Sub-Committee for their advice; the 11 National Suicide Prevention Trial Primary Health Networks who have shown a high level of commitment to the evaluation, , provided valuable input into the development of data collection tools, provided data and facilitated our access to stakeholders; all the stakeholders who participated including service users, community representatives, Elders, service providers, and people with lived experience of suicide; Strategic Data Pty Ltd for building additional datasets, facilitating data collection and the online surveys; our Thirrili partners including Jacqueline McGowan-Jones (CEO), Catherine Elvins and the Thirrili consultants, Peter Stephenson, Jack and Lisa Bulman, Mandy Gadsdon and Anne Hanning who undertook the Aboriginal and Torres Strait Islander focused elements of the evaluation; and the Black Dog Institute for sharing information and including us in their workshops and events. Adam Skinner and Roman Scheurer contributed to the systems modelling work and analysis of the Primary Mental Health Care minimum dataset respectively. We also thank the professional staff at the Centre of Mental Health for supporting the administration of the evaluation and Robert Lukins and Campbell Aitken for editing this evaluation report.

We would like to acknowledge the Traditional Owners of the land were the University of Melbourne evaluation team is based, the Wurundjeri people of the Kulin nation, and pay respect to Elders past, present and emerging.

The evaluation of the National Suicide Prevention Trial was funded by the Australian Government Department of Health.

Table of contents

List of figures

List of tables

Abbreviations and acronyms

AAD	Alliance Against Depression
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ASIST	Applied Suicide Intervention Skills Training
ATAPS	Access to Allied Psychological Services
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CORES	Community Response to Eliminating Suicide
DoH	Department of Health
DVA	Department of Veterans Affairs
ED	Emergency Department
ERP	Estimated Resident Population
FIFO	Fly-In Fly-Out
GP	General Practitioner
HREC	Human Research Ethics Committee
IRR	Incidence Rate Ratio
IRSAD	Index of Relative Socio-economic Advantage and Disadvantage
K10	Kessler psychological distress scale
KAHPF	Kimberley Aboriginal Health Planning Forum
KAMS	Kimberley Aboriginal Medical Services
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender/Gender Diverse, Intersex and Queer
LHN	Local Health Network
LIFE	Living is For Everyone
MDS	Minimum Dataset
MHFA	Mental Health First Aid
MoU	Memorandum of Understanding
NATSISPS	National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

NGO	Non-Government Organisation
NSPT	National Suicide Prevention Trial
PHN	Primary Health Network
PMHC	Primary Mental Health Care
QPR	Question, Persuade, Refer
RR	Relative Risk
RSL	Returned & Services League
SD	Standard Deviation
SEIFA	Socio-Economic Indexes for Areas
SES	Socio-Economic Status
SEWB	Social and Emotional Wellbeing
SIDAS	Suicidal Ideation Attributes Scale
TAFE	Technical and Further Education
(the) Trial	National Suicide Prevention Trial
YAM	Youth Aware of Mental Health

EXECUTIVE SUMMARY

The National Suicide Prevention Trial

The National Suicide Prevention Trial was announced by the Australian Government in 2016. It was designed to gather evidence and further understanding of what strategies are most effective in preventing suicide at a local level and in at-risk populations.

More specifically, its objective was to provide evidence of how an evidence-based multi-component systems approach to suicide prevention might best be undertaken within the Australian context and to identify new learnings in relation to suicide prevention in at-risk population groups including people who have attempted suicide or are considered at risk of suicide, Aboriginal and Torres Strait Islander peoples, young adult and middle-aged men, young people, and ex-Australian Defence Force (ADF) members, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

Twelve Trial Sites were selected (Townsville, Central Queensland, Brisbane North, North Coast NSW, Western NSW, Northwest Melbourne, Tasmania, Country South Australia, Perth South, Mid-west Western Australia, the Kimberley, and Darwin), managed by 11 Primary Health Networks (PHNs). PHNs are key to the successful delivery of the Australian Government's approach to suicide prevention. Thirty-one PHNs were established in July 2015 following a review of their predecessors, Medicare Locals(1). The objective of PHNs is to 'increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time'(2). PHNs are responsible for the planning and commissioning of primary mental health care services, including suicide prevention activities, via what is known as the Primary Mental Health Care Activity.

Trial Sites undertook an extensive planning process and then commissioned a range of evidence-based, evidence-informed and innovative interventions guided by multi-component models including the Lifespan and Alliance Against Depression frameworks(3, 4). Sites focussing on suicide prevention for Aboriginal and Torres Strait Islander peoples drew on the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)(5) findings and principles. The Black Dog Institute was commissioned by the Department of Health to provide support to the PHNs in relation to planning, and the selection and implementation of evidence-based strategies.

Four Trial Sites commissioned aftercare services for people who had attempted suicide or were experiencing a suicidal crisis, and all Trial sites commissioned a range of community-based activities. The majority of those activities were either awareness raising and engagement activities or capacity building. These included providing training to community members, frontline workers and members of the health and allied health workforce on suicide prevention or offering mental health first aid training. Other activities involved providing information or activities for particular at-risk groups or individuals, cultural strengthening activities for Aboriginal and Torres Strait Islander peoples and communities, and the development of information resources and care pathways. All Trial Sites also undertook activities aimed at increasing integration and coordination among existing suicide prevention services and activity providers in the sector.

Evaluation of the National Suicide Prevention Trial

In late 2017, the University of Melbourne was commissioned to evaluate the National Suicide Prevention Trial. Guided by an Evaluation Framework developed by the Department of Health, the evaluation focussed on the key components of the Trial – planning, implementation, impacts and outcomes – in order to identify effective strategies for planning, adopting a systems approach, suicide prevention for focus populations, and to consider the implications of these findings for future suicide prevention activities.

The Evaluation Framework articulated five overarching questions as the focus of the evaluation:

1. What strategies were used by Sites to plan suicide prevention services/community-based activities and to ensure that these respond to local needs?
2. What are the key factors in the development of a systems approach to suicide prevention and what are the barriers to effective service integration?
3. How were PHN activities targeting people who have attempted suicide and those assessed as at risk of suicide enhanced, and were the enhanced services more effective in preventing suicide?
4. What strategies were found to be most effective in preventing suicide in each of the focus populations?
5. What are the implications for future Australian Government and national suicide prevention policy?

The evaluation did not assess the effectiveness of individual interventions or the performance of individual Trial Sites as it was focussed on identifying learnings across the Trial regarding effective strategies for planning and implementing a systems-based approach to suicide prevention, planning and implementing suicide prevention activity for target population groups, challenges encountered, and key outputs and outcomes across the Trial.

Evaluation design and approach

The evaluation used a mixed-methods design drawing on quantitative and qualitative data from a range of sources. It was recognised from the outset that due to the relatively rare incidence of suicide at a population level and the short duration of the Trial, that it was unlikely that the evaluation would have been able to detect any changes in the ultimate outcomes of suicide deaths and attempts. Therefore, the evaluation took a program logic approach which operationalised Trial activities and outcomes in terms of inputs, outputs, impacts and outcome objectives in a hierarchy embedded in a program logic matrix (Figure 1) (6). The hierarchical logic is based on the assumption, informed by the currently available evidence, that if the objectives at one step are achieved, then the objectives at the subsequent step should occur. The program logic functions as a guide, outlining a set of evidence-informed assumptions to be tested rather than as a definitive model.

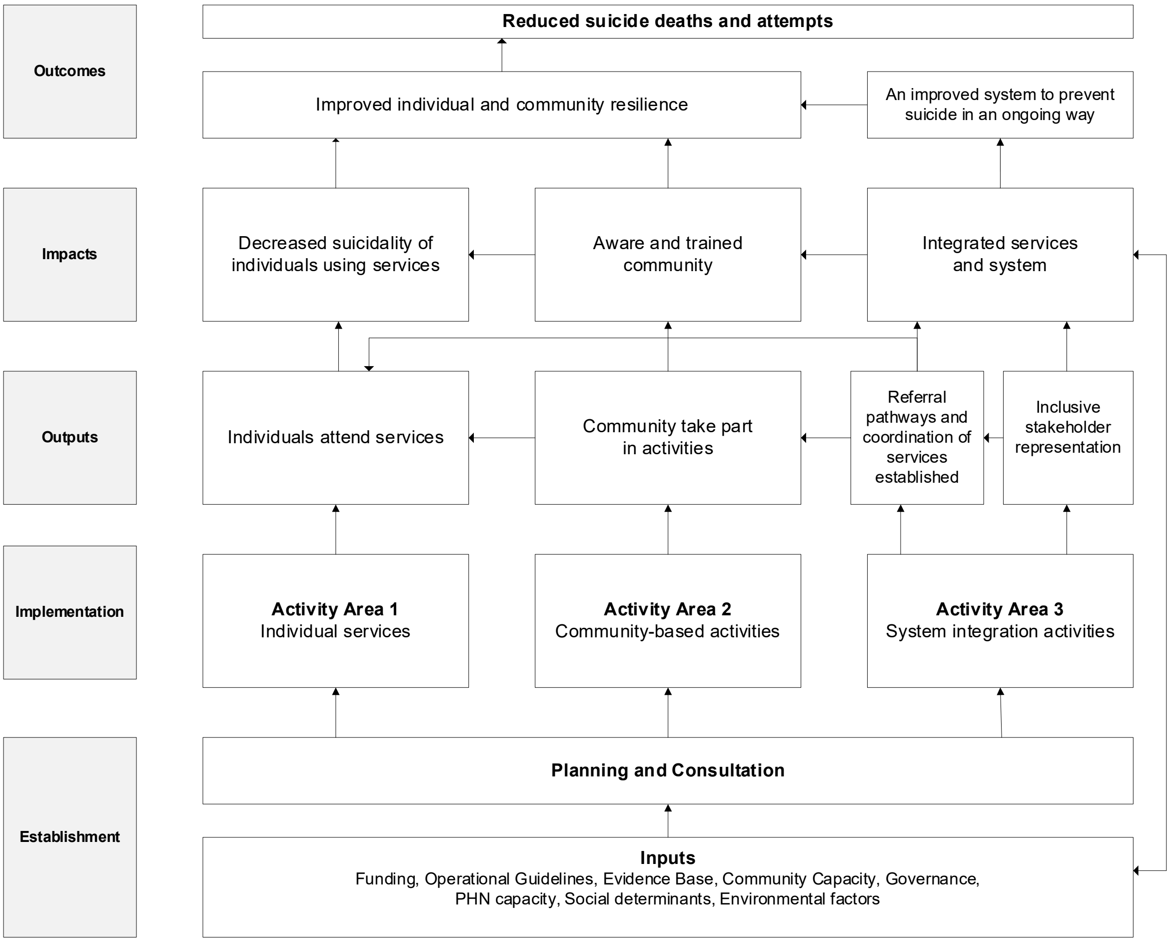


Figure 1 National Suicide Prevention Trial evaluation program logic

Evaluation Data

Data were collected and/or sourced from February 2018 until September 2020. Initial data collection efforts focused on implementation processes. Subsequent data collection efforts emphasised outputs and impacts of interventions. The following data were collected and analysed in the evaluation:

- *Review of key documents:* Documents were provided by Trial Sites in two rounds. In round one 309 documents were reviewed, and data extracted from 163 and in round two 428 documents were reviewed and data extracted from 315. Documents included PHN National Suicide Prevention Trial Site Activity Work Plans, and documents relating to mental health and suicide prevention needs assessments, Trial design and development, commissioning and implementation, provider performance reports and activity reports.
- *Stakeholder consultations:* In total 477 stakeholders participated in consultations. Of these, 382 were PHN staff, service providers, community members and other stakeholders who participated in focus groups or interviews. Eleven PHN staff completed a mid-trial survey, and 52 service providers completed a service provider survey (the latter two groups may or may not have also participated in the interviews and focus groups). Thirty-two aftercare service users completed a user experience survey.
- *Observational/participatory data:* Observational/participatory data was gathered by members of the evaluation team attending eight national forums convened by the Black Dog Institute to provide support to Trial Sites.
- *Aftercare service user data:* Data for 553 individuals who received services from Trial-funded aftercare services were obtained from the Primary Mental Health Care Minimum Dataset

(PMHC MDS) and an additional purpose designed Trial module. The PMHC MDS captures data for clients of PHN funded primary mental health services.

- *Community-based activities data:* Information on 1,105 activities, reaching 33,072 participants were entered in a database developed by the evaluation to capture descriptive data on the community-based suicide prevention activities and programs implemented across the Trial.
- *National epidemiological and service use datasets*: Population level epidemiological analyses and analyses of use of PHN funded mental health services was conducted using the PMHC MDS and Access to Allied Psychological Services datasets from 2010 to 2019; suicide deaths using national mortality data from 2010 to 2018 (the latest year available), and hospitalisations for self-harm from the National Hospital Morbidity Dataset from 2010 to 2019 (the latest year available).
- *Systems modelling and simulation*: Models were built for two demonstration Sites and simulation scenarios run to model the effects of suicide prevention interventions on the suicide death and attempt outcomes within complex service systems and in different socio-demographic contexts.

Aboriginal and Torres Strait Islander evaluation methods

A modified methodology was developed for Aboriginal and Torres Strait Islander peoples in line with the National Health and Medical Research Council's *Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities: Guidelines for Evaluators and Stakeholders*. Prior to data collection, initial engagement was undertaken at all seven Trial Sites focusing on Aboriginal and Torres Strait Islander suicide prevention. This led to modifications in the evaluation methodology including adding consultation questions; incorporating yarning as a consultation method; conducting consultations in locations preferred by participants; and consultations being conducted by consultants who identified as Aboriginal or Torres Strait Islander.

Evaluation Findings

There was considerable diversity across Trial Sites in terms of their general approach to conducting the Trial and the mix of activities implemented. This is consistent with the Trial's intention of adopting a localised approach to suicide prevention. Consequently, what was well received and effective at individual Sites was very much context dependent. This precludes universal recommendations about 'what works'. Instead, the evaluation findings focused on the diversity of approaches, facilitators and barriers, and outputs and impacts. In doing so, it identified factors that emerged as effective strategies and shared challenges across the Trial.

Evaluation question 1: What strategies were used by Sites to plan suicide prevention services/community-based activities and to ensure that these respond to local needs?

This evaluation question aligns with the evaluation program logic steps of establishment and implementation.

Effective strategies

PHNs made extensive efforts to plan suicide prevention services and activities that responded to local needs. Four key general planning strategies were identified.

The most important planning strategy was establishing broad and inclusive stakeholder involvement. Engaging a wide range of stakeholders from across the community and sector was necessary and required dedicated resources for coordinating stakeholder involvement. Achieving a balance in stakeholder representation between those with decision making authority and those working 'on the ground' was important to understand local conditions but also to drive change. Time was required to build and sometimes mend relationships between stakeholders and the stakeholder engagement process needs to be ongoing rather than a one-off exercise.

Conducting thorough needs analysis informed by both local data and stakeholder input was a core planning activity. Service mapping activities were also important and ideally include a consideration not only of service availability, but whether available services are actually used by those in need.

Establishing appropriate governance and leadership structures to drive trial planning was a key strategy. Implementing governance structures that balances community ownership, priorities and preferences with structured governance and coordination was an important facilitator of successful planning. PHNs played a crucial role in providing leadership and ability capacity to bring all stakeholders to the table, including government and community. Communicating effectively and transparent decision-making processes strengthened community and stakeholder engagement.

Building capacity by providing community stakeholders with foundational understanding of evidence-based and systems approaches facilitated full community participation in the Trial. Workforce capacity building in terms of recruiting and supporting a dedicated suicide prevention coordinator role was also crucial to maintaining engagement of stakeholders and momentum in the planning process.

In addition, planning strategies for Aboriginal and Torres Strait Islander focused Trial activities emphasised the importance of establishing genuine Aboriginal and Torres Strait Islander governance, including leadership and self-determination, as distinct from the structural governance established for the Trial. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) findings provided a key framework for planning activities for this population group.

Challenges

A range of challenges for planning suicide prevention services and activities were identified. For example, it was often difficult and time consuming to engage key stakeholders, stakeholder capacity to participate in planning activities was limited by lack of time and other commitments, and stakeholders sometimes had conflicting opinions on suicide prevention priorities.

Conducting a needs analysis was hindered by difficulty accessing the relevant local-level data (for example, data on rates of suicide and suicide attempts). The planning process involved negotiating tensions between community-driven and evidence-based approaches. High staff turnover and vacancies in the suicide prevention coordinator role delayed progress. Finally, the evidence-base was underdeveloped and where evidence was available, it was not always relevant to the particular focus population or the regional context.

Evaluation question 2: What are the key factors in the development of a systems-based approach to suicide prevention and what are the barriers to effective service integration?

This evaluation question also relates to the evaluation program logic establishment and implementation steps.

Effective strategies

Four key factors were found to effectively facilitate the development of a systems approach.

Using a systems-based suicide prevention framework such as Lifespan or the Alliance Against Depression to guide planning of a multi-component coordinated approach was helpful. It was important that any model chosen was flexible and could be adapted to local contexts and the needs of diverse populations.

Adopting a broader system-wide approach beyond health and mental health was also important. Broad and inclusive stakeholder involvement was the primary enabler of such an approach. The importance of seeking engagement from a wide range of government departments and levels of government was highlighted.

Community involvement was a key strategy and striking a balance between a community-driven approach and the need for more top-down initiatives to train professionals and drive system change was crucial to achieving meaningful community participation. The PHN-based Trial Coordinators were crucial for engaging community and building community capacity in evidence-based systems approaches.

Promoting coordination and integration at the service level and system level was critical. The PHNs were able to broker stakeholder engagement and coordination at the service level through their established networks and commissioning role. They were also able to coordinate with State suicide prevention initiatives, and system level activities through their involvement in intersectoral bodies and in regional planning.

Challenges

A range of challenges were encountered across the Trial with respect to developing a systems approach. In terms of adopting the Lifespan or Alliance Against Depression frameworks, the applicability of these to regional contexts and population sub-groups is yet to be established, and more guidance on operationalising and implementing such frameworks was needed. Moreover, many PHNs encountered some community resistance to engaging with a multi-component systems approach. Another challenge was that PHNs did not always have sufficient capacity or the level of influence needed to bring all the relevant stakeholders to the table to initiate and drive system-level change. As a consequence, stakeholders from key government agencies and departments were sometimes missing or less engaged. Finally, the time-limited nature of the Trial hindered the ability to develop and implement the long-term strategies necessary for system-level change. Moreover, the fixed time period for the Trial was a deterrent to Sites pursuing all elements of a multi-component approach, and made many reluctant to commission aftercare services for vulnerable individuals which would have to be de-funded at the end of the Trial.

Evaluation question 3: How were PHN activities targeting people who have attempted suicide and those assessed as at risk of suicide enhanced, and were the enhanced services more effective in preventing suicide?

As described above, given the difficulty in assessing the effect of interventions on suicide rates the evaluation followed a program logic approach whereby if the inputs, outputs and impacts of the Trial produce results consistent with the available evidence, then the ultimate outcome of preventing suicide is more likely to eventuate. The evaluation therefore reports on the enhanced services for people who have attempted suicide or have been assessed as at risk of suicide as a focus population. It notes the key impacts resulting from those service, as well as the main challenges encountered in establishing and delivering those services.

Enhanced activities

Four Trial Sites established aftercare services for people following a suicide attempt or who presented in suicidal crisis, with two Sites each implementing focus population specific services for

LGBTI people and Aboriginal and Torres Strait Islander peoples, and two Sites also implementing general population services. Services for focus populations were tailored through co-design with those stakeholders from those populations, including people with lived experience of suicide, and by commissioning LGBTI or Aboriginal and Torres Strait Islander specialist service providers to deliver them. Establishing broad referral pathways was also a key tailoring strategy to ensure services were available to those who needed them. These new services filled a service gap in terms of providing culturally safe services for the two focus populations and providing a service for the general population in regional areas where there previously had not been one. Services were promoted primarily through word-of-mouth and PHN and service provider networks for the focus population specific services, and through PHN networks and agreements with local hospitals for the general population services.

Key impacts

Services users reported reductions in their suicidal thoughts and feelings about suicide, and overall wellbeing. They also showed statistically significant reductions in suicidal ideation on the Suicide Ideation Attributes Scale, and in psychological distress on the K10 scale. Services users expressed high levels of satisfaction with the services, including the way in which the services gave credence to their cultural background and/or gender or sexual identity.

Impacts for the service sector include an increase in suicide literacy among service provider staff and the development of linkages and coordination between aftercare service providers and other support and service organisations and agencies which referred in to the service or to which the service referred clients.

Challenges

The main challenge observed around establishing services for people who have attempted or are at risk of suicide was the time-limited funding associated with the Trial. The majority of Sites that chose not to commission aftercare services cited this as the primary reason; they did not want to withdraw services at the end of the Trial. The time constraints around the Trial were also a challenge in terms of having sufficient time for the co-design process.

Other challenges related to difficulties in recruiting and retaining suitably qualified staff, particularly in regional and rural areas; the availability of organisations with the experience and capacity to deliver aftercare services; the lack of referral opportunities for clients exiting the services; and barriers in obtaining referrals from hospitals due to concerns over the non-clinical nature of the aftercare service model.

Evaluation question 4: What strategies were found to be most effective in preventing suicide in each of the focus populations?

As described above, difficulties in assessing the effect of Trial activities on suicide rates preclude the evaluation from determining the effectiveness of strategies in preventing suicide. However, the program logic approach described above does allow the evaluation to identify the main outputs of the Trial and impacts resulting from those outputs, with the assumption that if these achieve their expected results then some positive effect on suicide outcomes may be anticipated. Those outputs include they implementation of appropriately tailored suicide prevention activities and the engagement of participants in those activities. Impacts of suicide prevention strategies include increased knowledge, awareness, capacity in suicide prevention, and help seeking as well as impacts related to greater integration and coordination reflective of adopting a systems approach.

Identifying the key challenges faced in implementing suicide prevention strategies for focus populations is informative in terms of planning future approaches.

Aboriginal and Torres Strait Islander peoples

Trial outputs

Seven Sites identified Aboriginal and Torres Strait Islander peoples as a focus population, with two Sites doing so exclusively. As described above, two Aboriginal and Torres Strait Islander-specific aftercare services were established, and 314 activities were recorded in the community-based activities dataset. The main types of activities were suicide and mental health awareness raising (42%), cultural strengthening activities (26%), training to build capacity of community members and service providers (19%). A range of research and framework activities were also undertaken, including the development of a ‘no wrong door’ suicide and self-harm prevention protocol, cultural safety frameworks, and research on outcome measurement for Aboriginal and Torres Strait Islander peoples.

Tailoring activities for this focus population drew on a range of strategies, including adopting Social and Emotional Wellbeing and trauma-informed approaches, having Aboriginal and Torres Strait Islander leadership, embedding Culture in activities, taking a client, family- and community centered approach, developing and using an Aboriginal and Torres Strait Islander workforce to deliver programs, and finally working with mainstream organisations to embed cultural competency and cultural safety.

Key strategies to promote Trial activities and encourage participation involved using word-of-mouth, local community champions and ambassadors, and PHN and service provider networks. They also involved building relationships via face-to-face engagement with communities. Framing Trial activities in terms of wellbeing rather than suicide prevention was also adopted as a key strategy.

Key impacts

A range of impacts resulting from Trial activities were reported. Impacts related to knowledge and capacity included an increase in community knowledge and awareness around suicide and mental health, including how to identify and support people at risk; an increase in the capacity and confidence of community members to talk about suicide and aid someone in need with accessing support or services; and increased capacity in Aboriginal and Torres Strait Islander service providers to facilitate and deliver suicide prevention activities, and negotiate administrative processes around funding. Improvement in cultural competence was also observed among PHN staff and non-Aboriginal service providers.

A number of social and emotional wellbeing impacts were reported including increased connection to country and cultural identity; improved connection with families and community; increased confidence and empowerment among young people; increased help seeking and decreased thoughts of self-harm.

There was evidence of the establishment of linkages and coordination resulting from the Trial including the bringing together of organisations and stakeholders to share information and work collaboratively in a way that was not occurring prior to the Trial; the fostering or enhancement of partnerships between Aboriginal and Torres Strait Islander service providers and non-Aboriginal or government services providers; and the establishment of referral pathways and protocols such as the ‘no wrong door’ protocol.

Challenges

The overarching challenge for the Trial was that underlying structural and systemic conditions that are key drivers of suicide in Aboriginal and Torres Strait Islander communities are beyond the scope of a Trial to address.

Other challenges encountered included the lack of culturally competent mainstream services to deliver programs; lack of service capacity and integration in regional, rural and remote areas; difficulties in ensuring inclusive and genuine stakeholder engagement; community readiness; funding levels and control of funds; gaining community trust to participate in Trial activities, community concern about lack of communication and transparency from PHNs; and a lack of local-level data to inform Trial planning.

Men

Trial outputs

Six Trial Sites identified men as a focus population. There were no male-specific aftercare services established, and 189 activities were recorded in the community-based activities dataset as specifically targeting men. Sixty-five percent of those activities aimed to build capacity in the community and in workplaces to identify and support people at risk for suicide or experiencing distress via evidence-based or evidence-informed structured training programs. The MATES in Construction program, or a variant of it, was adopted at all six Sites. Other activities implemented included a range of awareness and engagement activities workshops and events, media campaigns and provision of information on resources. Two main approaches to tailoring activities for men were employed: providing male-specific workshops and training programs such as MATES and delivering suicide prevention activities in environments where men gather (for example, workplaces and sporting clubs). Men were considered a difficult to engage population and using word-of-mouth, engaging community champions, including men with lived experience of suicide, and involving partners and families were all strategies used to promote activities and encourage participation.

Key impacts

A number of impacts were observed that were consistent with the use of evidence-based or informed training programs. These included including increased knowledge and awareness about mental health and suicide, increased knowledge of how to help and confidence to help; and an increase in participants' willingness and intention to seek help for themselves. There were also reports that men had used skills gained in training to help others including connecting them with services.

Although there was no indication of increased help-seeking by men from PHN funded mental health services across the Trial in general, there were anecdotal reports of increases in men seeking help.

Challenges

Among the challenges encountered planning and implementing suicide prevention strategies for men was the fact that they are a broad and heterogenous population making targeting difficult. Engaging men in the planning process was a challenge, as was the lack of evidence on the effectiveness of interventions for this population group. There were administrative and logistical challenges involved in delivering activities in workplaces, and in general stigma was considered to be an ongoing challenge in terms of getting men to participate in Trial activities.

Young People

Trial outputs

Young people were a specific focus population for two Trial Sites, exclusively so for one of them, and five other Sites also offered some programs for young people. A total of 123 activities targeting suicide prevention in young people were recorded in the community-based activities database. The majority of activities (54%) involved awareness raising and engagement and included media and social media campaigns and community events. A further 30% of activities took the form of evidence-based capacity building training programs for young people or those who work with them. Other activities involved developing postvention response protocols and referral pathways, developing training resources for GPs for working with young people, providing small grants for youth focused events, and conducting youth camps. The main approach to tailoring activities for young people was to use training programs that were already purpose designed for young people, developing tailored media and social media content, and delivering activities in schools. Social media was an important avenue for promoting Trial activities for young people.

Key impacts

Increases among young people in awareness and knowledge about mental health and suicide, where to get help and how to help and confidence and intention to help were reported as a result of participation in training programs. While across the Trial in general there was no increase observed in use of PHN-funded mental health services by young people, there were anecdotal reports from Trial Sites of increased help-seeking by this group.

The two Trial Sites with a specific focus on young people established strong linkages with headspace, the key youth mental health organisation. They also achieved improvements in coordination with other local services and organisations, particularly those involved in the development and deployment of postvention protocols.

Challenges

The most common challenge encountered in delivering suicide prevention activities for young people was getting buy-in from schools. In some instances, prolonged negotiation was required and in others activities could not proceed at all. A range of reasons, including competing demands and risk aversion related to suicide and mental health content were observed.

Other challenges included difficulty in engaging young people in the planning and Trial governance, difficulty engaging GPs, and the lack of services for young people in regional areas.

Ex-ADF members

Trial outputs

A single site focused on ex-ADF members and expanded that focus to include their families. Overall, the Site developed an approach that focused on upstream psychosocial and situational factors that were considered to increase the vulnerability of ex-ADF members to suicide. Over half of the 29 activities recorded in the community-based activity dataset for that Site reflected that approach and were aimed at creating connection for socially isolated ex-ADF members, including a small grant program to fund community activities and events. Media and social media campaigns were an important element of outreach to this population and accounted for 21% of reported activities. Other activities included developing a peer worker model to support other ex-ADF members accessing mental health services, developing health pathways, supporting research related to traumatic brain injury, and supporting community advocacy groups. The main approaches to tailoring were adopting an overall focus on connection and wellbeing rather than on suicide prevention; recognise and work within ADF and ex-ADF culture, including acknowledging the role of rank and hierarchy; and including family members in order to reach the support networks of ex-ADF members. Activities were promoted through a broad communications campaign; capitalising on the high profile of the Steering Committee chair; and through ex-ADF and PHN networks.

Key impacts

The multi-platform Check Your Mates campaign achieved over a million engagements with the social media elements, predominantly among young men, with anecdotal reports of men following up and checking on their mates. The peer worker model was adopted by Open Arms (Department of Veterans Affairs mental health service provider) and is being scaled up nationally. There were anecdotal reports that participation in the small grant funded programs reduced the return to inpatient psychiatric care among participants, and 'saved lives'; and that there had been a reduction in stigma around mental health and suicide.

Strong local linkages and coordination were achieved through governance structures established for the Trial and the influential leadership of the main Steering Committee.

Challenges

Identifying and reaching ex-ADF members who are disconnected from and even distrustful of Department of Veterans Affairs and Australian Defence Force services and organisations was a significant challenge. The Trial Site had a relatively concentrated population, but achieving the balance between being responsive to local conditions and scalability and transferability may be a challenge in the future.

LGBTI people

Trial outputs

Two Sites, both in urban areas, elected to focus on LGBTI people. As describe above both Sites commissioned LGBTI-specific aftercare services as their early consultations identified that LGBTI people often do not feel safe presenting to mainstream services. In addition, 152 activities targeting LGBTI people were recorded in the community-based activities dataset including capacity building through evidence-based training programs on suicide prevention and/or mental health for LGBTI specialist services and organisations. Other activities included media and social media campaigns and awareness raising at community events; professional training for general practitioners and other health professionals in suicide prevention and in making general practice and other services culturally safe for LGBTI people; a mentoring program for young LGBTI people and for families of LGBTI people; research on peer support; and the development of health pathways. Co-design with LGBTI stakeholders, including people with lived experience of suicide, was the principal approach for tailoring Trial services and activities. Word-of-mouth, LGBTI service networks and PHN networks were the main avenues for promoting services.

Key impacts

Impacts related to aftercare services are described above.

Community members and staff from LGBTI-specialist service providers who participated in training programs reported increases in awareness of mental health and suicide and increased capacity to respond to suicidality within the community. There were also anecdotal reports of an increase in referrals to and uptake of support services generally, as well as an increase in the capacity of the suicide prevention workforce, including the peer workforce.

There was evidence of good integration and coordination of services between LGBTI-specialist providers, but linkages with mainstream services were less developed.

Challenges

Although the co-design process was ultimately successful, the process was lengthy and required building or rebuilding relationships and negotiating some tensions caused by a competitive funding environment. Other challenges include accommodating the diversity of the LGBTI population, the reliance on small volunteer organisations, and the lack of evidence on effective interventions and programs for LGBTI people.

Older adults

Trial outputs

A single site focused on older adults. There were no older adult-specific aftercare services and 12 activities targeting older adults were recorded in the community-based activities dataset, the majority of which focused on awareness and engagement (66%). These included community workshops and events that primarily targeted those who worked with older adults. Activities targeting older adults themselves were focused on social isolation and wellbeing, rather than suicide or mental health specifically. Other activities included some evidence-based suicide prevention and mental health first aid training, community grants for activities to reduce social isolation, establishing a suicide bereavement group, and creating a service directory. The main approach to tailoring activities was collaborating with organisations which work with older adults to address social isolation as an upstream risk factor.

Key impacts

There was limited information available on impacts, with a single report that showed that participation in an expert workshop increased knowledge about suicide, how to help someone at risk, and where to get help.

Some instances of enhanced linkages were noted, including between the PHN, mental health services and community organisations working with older adults.

Challenges

The main challenge was achieving substantive buy-in from key stakeholders in the aged care sector, as they do not regard suicide prevention as their core business. Competition between stakeholder organisations was also a challenge. Engaging directly with older adults was challenging because they are a broad and diverse population. Difficulties were also apparent in devising effective strategies to reach those who are not in contact with aged care support services.

Overall Trial outcomes – suicide and suicide attempts

Epidemiological analysis of national death data and national data on hospital admissions for self-harm was undertaken to investigate potential changes in rates of suicide deaths and suicide attempts associated with the Trial as a whole. Trial PHNs combined were compared with control PHNs where no other suicide prevention trials were occurring.

There were no differences between Trial PHNs and control PHNs in rates of suicide deaths or hospitalisations for self-harm over the period for which data were available (2010 to 2018 for suicide deaths, 2010 to 2019 for self-harm hospitalisations).

This finding does not mean that the Trial has not had an impact on reducing suicide or suicide attempts. Rather, it reflects the fact that outcomes of suicide prevention initiatives, particularly those aiming for change at a system-level, are difficult to measure and that any effects on rates of suicide and self-harm are unlikely to be detectable for some years.

Evaluation question 5: What are the implications for future Australian Government and national suicide prevention policy?

The evaluation of the National Suicide Prevention Trial has yielded a wealth of information on the planning, implementation and impacts of adopting evidence-based systems approaches to suicide prevention. Recommendations for consideration in future policy making and the key learnings supporting them are provided.

Recommendation 1: A whole-of-government approach with strong leadership should be developed as the foundation for system-wide suicide prevention.

- System-wide approaches that address the underlying social determinants of suicide as well as providing support to at-risk individuals and communities require a whole-of-government approach that includes coordination between State and Territory and Commonwealth governments.
- High-level leadership from the Commonwealth and State and Territory Governments plays an important role in bringing all the relevant stakeholders to the table and building commitment and long-term engagement.

Recommendation 2: A long-term strategy for resourcing is required to build capacity and confidence across the sector, support a responsive, continuous improvement approach to planning and implementation, and enable and embed system-wide changes.

- A longer-term strategy and resourcing model are necessary to provide confidence across the sector to invest in a full range of initiatives, establish and consolidate integration and coordination, build and retain an appropriately skilled workforce, and embed an evidence-based approach.
- Future policy should support a continuous improvement model where planning is an ongoing iterative process informed by evaluation in a virtuous cycle.
- Time-limited funding initiatives like Trials can initiate local coordination and lay the foundations for integration, but a longer-term strategic approach and ongoing resourcing are required to embed a systems approach.

Recommendation 3: A long-term view needs to be taken on assessing the success of suicide prevention initiatives and related decisions on continuing funding, due to the difficulties in measuring direct effects of multi-component interventions and the likely time-lag in seeing effects on rates of suicide and self-harm.

- To realise future gains, it is crucial to persevere with strategies for which there is some evidence, and systematically review, refine and adapt approaches as new evidence becomes available.
- To understand the longer-term impacts and outcomes of large-scale initiatives such as the National Suicide Prevention Trial, monitoring and analysis of outcome data should be continued over an extended period.

Recommendation 4: Suicide prevention strategies must originate from Aboriginal and Torres Strait Islander specific evidence and knowledge and genuine Aboriginal and Torres Strait Islander governance is fundamental.

- The renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and the Social and Emotional Wellbeing and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, provide the framework for preventing suicide in Aboriginal and Torres Strait Islander communities. Any suicide prevention initiatives targeting Aboriginal and Torres Strait Islander peoples should originate from within that framework rather than attempting to include or adapt these principles and elements after the fact.
- Aboriginal and Torres Strait Islander governance principles, including leadership and self-determination, should be the starting point for the planning, implementation and evaluation of all suicide prevention strategies for Aboriginal and Torres Strait Islander peoples and communities.
- Initiatives being led or funded through non-Aboriginal and Torres Strait Islander agencies must uphold and respect Aboriginal and Torres Strait Islander governance as separate from corporate governance.

Recommendation 5: A regional focus is necessary to ensure that initiatives meet local needs, are responsive to local contexts, and are sustainable. A regional-level coordinating entity would be best placed to coordinate and oversee regional level initiatives.

- Frameworks such as LifeSpan and the Alliance Against Depression are a useful guide for identifying domains of intervention and understanding multi-component approaches, however they cannot be used as blueprints. Regional approaches responsive to local needs are required. Resources and support are required to build capacity to identify local needs, work with the evidence-base, and develop tailored multi-component strategies to suit local conditions.
- There is a need for a regional level coordinating entity that is able to engage with government at all levels as well as with local communities. PHNs are well placed to undertake that role, however, dedicated resources are required to support them in such a role.

Recommendation 6: Continuing investment to develop the evidence base for suicide prevention is crucial.

- Continued investment to develop the evidence base both through directly sponsoring research initiatives to establish efficacy of interventions, particularly for higher-risk populations. Resourcing to develop evaluation capacity and embed evaluation as part of a continuous improvement approach within organisations who manage and deliver suicide prevention will also contribute to building the evidence base.
- As resources and capacity may not always be available to implement the full suite of interventions optimal for a systems approach at any given time, identifying the key ingredients and fostering and resourcing the implementation of those is desirable.
- Evaluation of services for people who have made a suicide attempt or are at risk of suicide should be ongoing, and findings should be shared to allow scaling up of service models, or components of service models which are effective.
- Continued research and evaluation to build the evidence-base on suicide prevention for Aboriginal and Torres Strait Islander people is required.

- The evidence on the effectiveness of interventions for specific at-risk populations is limited but developing and further research and evaluation are required.

Recommendation 7: Resources and mechanisms are required to build suicide prevention capacity across the system.

- Building the knowledge and skills of community stakeholders, PHNs and service providers in evidence-based and systems approaches to suicide prevention is the cornerstone of a system-wide coordinated, integrated approach.
- Developing the suicide prevention workforce, including a peer workforce, is a key area for action. Continuity of funding is crucial for building and retaining that workforce.
- Building the Aboriginal and Torres Strait Islander workforce and restoring capacity will be a key driver of suicide prevention across Aboriginal and Torres Strait Islander communities.
- System-wide cultural competence building is required for non-Aboriginal and Torres Strait Islander organisations, agencies and communities.

Recommendation 8: Tailored approaches are required when developing suicide prevention strategies for population groups with heightened risk of suicide, and time and resources to develop and evaluate these are necessary.

- The diversity within any focus population must be addressed in initiatives targeting particular at-risk populations.
- Co-design is an effective model for developing appropriate services, achieving engagement of focus population groups and integration and coordination across specialist and mainstream services.
- For aftercare services, culturally safe flexible service models with broad referral pathways that are not restricted to those who present at hospitals, are necessary to ensure services reach and are able to retain the greatest number of at-risk individuals.
- There is a role for whole-of-population initiatives in reaching people from at-risk population groups who do not necessarily identify with those groups.

Recommendation 9: People with lived experience of suicide have an invaluable contribution to make in the development and delivery of suicide prevention and their knowledge and expertise needs to be harnessed.

- Structured training programs for people with lived experience of suicide and from diverse focus populations is essential to ensure that they can participate safely and fully.
- Building capacity of organisations, PHNs and services providers to meaningfully involve people with lived experience in planning and delivering services is required.

Recommendation 10: Increased capacity to collect and provide timely accessible data is crucial to support planning, to ensure resources are directed according to need and so that outcomes of suicide prevention initiatives can be evaluated.

- Access to timely and appropriate data is crucial to support ongoing planning and evaluation. Continued development of data capture, analysis and access capacity is important.

Conclusion

The National Suicide Prevention Trial was a key Australian Government policy initiative to trial a regional approach to suicide prevention drawing the best available evidence and adopting a multi-component systems approach. To achieve this significant undertaking, the 11 PHNs involved in the

Trial successfully engaged a diverse range of stakeholders in their regions and planned and commissioned suicide prevention services and activities that targeted at-risk populations in their regions. The Trial has generated a wealth of new knowledge on effective strategies for planning regional suicide prevention activity, developing a coordinated systems approach to suicide prevention, issues facing at-risk populations in the community and how they might be addressed, the impacts of delivering a range of suicide prevention services and activities, and the challenges and barriers to be resolved. This knowledge represents a significant advance toward the ultimate outcome of reducing the toll of suicide in Australia. Realising that goal is a longer-term undertaking than can be accomplished in a single Trial, however the knowledge generated by the National Suicide Prevention Trial provides a foundation for the continuing development of the national, state, territory and regional-level initiatives needed to reduce the loss of life by suicide.

Part One: Evaluation overview

1 Background

1.1 Purpose and structure of this report

This report details the evaluation of the National Suicide Prevention Trial (NSPT, or the Trial) – a major initiative designed to build the evidence base on suicide prevention in Australia. This report is divided into two parts. Part One (Chapters 1 to 10) provides an overview of the Trial, the evaluation and the key findings, conclusions and considerations for policy. Chapter 1 describes the context of the Trial and its design. Chapter 2 outlines the design and methodology of the evaluation, including the range of data sources used. Chapters 3 to 9 provide a synthesis of the key findings on planning and implementation, Trial services and activities, and overall outcomes. Chapter 10 presents the evaluation's conclusions and considerations for policy. Part Two (Chapters 11 to 28) provides a detailed analysis and findings from each of the data sources included in the evaluation and describes the limitations of the evaluation.

1.2 Suicide prevention in Australia: the national policy context

Australia has grappled with the problem of suicide for more than 20 years and was one of the first countries to introduce a national suicide prevention strategy. The National Youth Suicide Prevention Strategy, with a focus on suicide among young people, was launched in 1995. In 1999, it was replaced by the National Suicide Prevention Strategy, which consolidated and built upon the achievements of its predecessor by emphasising suicide across the lifespan for a range of population groups. In 2006, the National Suicide Prevention Strategy adopted the Living is For Everyone (LIFE) Framework, which continues to provide an overarching evidence-based strategic policy framework for suicide prevention activities in all jurisdictions.

In 2015, the National Mental Health Commission's review of mental health programs and services included suicide prevention as one of its major foci(7). The Australian Government's response to the National Mental Health Commission's review, released later the same year, outlined reforms to mental health and suicide prevention funding and program delivery, including a renewed approach to suicide prevention(8). The approach involves combining strong national leadership with systematic regional efforts that recognise local differences, and strengthening the evidence base regarding what works in suicide prevention. It also has a focus on particular at-risk groups, notably Aboriginal and Torres Strait Islander peoples and people who have previously self-harmed or made a suicide attempt. The Fifth National Mental Health and Suicide Prevention Plan, endorsed by the Council of Australian Governments Health Council in 2017, reflects this approach of governments working together and integrating regional planning and service delivery, including suicide prevention services.

In recognition of the need for focused efforts in Aboriginal and Torres Strait Islander suicide prevention, the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS) was launched in 2013. The foundation of the strategy is Aboriginal and Torres Strait Islander peoples' holistic view of mental health, physical, cultural and spiritual health, and the strategy has an early intervention focus designed to build strong communities through community-focused and integrated approaches to suicide prevention. The Australian Government has asked Gayaa Dhuwi (Proud Spirit) Australia to renew the NATSISPS, and Gayaa Dhuwi is currently consulting stakeholders and community members.

In July 2019, the Prime Minister announced the appointment of the first National Suicide Prevention Advisor to work with relevant ministers to drive a whole-of-government approach to suicide prevention. In November 2019 the National Suicide Prevention Adviser provided initial advice and early findings, in which she noted the importance of a community-led, multi-component response and the need to develop an updated framework for suicide prevention to replace the LIFE framework(9).

Primary Health Networks (PHNs) are key to the successful delivery of the Australian Government's current approach to suicide prevention. Thirty-one PHNs were established in July 2015 following a review of their predecessors, Medicare Locals(1). The objective of PHNs is to "increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time"(2). PHNs are responsible for the planning and commissioning of primary mental health care services and community suicide prevention activity, via what is known as the Primary Mental Health Care Activity.

The National Suicide Prevention Trial is one of the Australian Government's major initiatives being delivered in this policy context. Other major multi-site, multi-year suicide prevention trials initiated in recent years also aim to build the evidence base, include the Victorian Place-based Suicide Prevention Trials (2017–22) and the LifeSpan NSW and ACT Trials (2017–21). Each of these initiatives is pursuing a multi-component, community-based systems approach to suicide prevention that is (in most cases) being delivered through PHNs. Harnessing the learnings of these Trials was noted as a key consideration for the National Suicide Prevention Adviser in the preparation of her reports to Government.

1.3 The National Suicide Prevention Trial

1.3.1 Background and objectives

The Australian Government funded the NSPT to gather evidence in relation to suicide prevention activities in local geographical areas of Australia, and to improve understanding of the strategies that are most effective in preventing suicide at a local level and in at-risk populations. More specifically, its objectives were to provide evidence of how a systems approach to suicide prevention might best be implemented in the Australian context and to identify new learnings in relation to suicide prevention in at-risk populations.

1.3.2 Timeline

Twelve Trial Sites were announced progressively between July 2016 and February 2017. The Trial was initially funded for three years and scheduled to conclude on 30 June 2019. In May 2018 the Trial was extended for 12 months until 30 June 2020 in recognition of the staggered commencement times and that the start-up and planning phase took considerably longer than expected, with the main roll-out of activities and services not commencing until late 2018 in many Sites. In February 2020, a further 12 months of funding was provided to Trial Sites to develop and implement transition plans. The evaluation of the NSPT was commissioned in November 2017, with the initial reporting date of December 2019 extended in line with the Trial extension to December 2020.

1.3.3 Design

The Trial was designed to allow Sites to be flexible in meeting local needs. The only requirements were that Trial Sites should select one or more focus population groups, that an evidence-based systems approach should be trialled, and that all Sites should participate in the evaluation.

1.3.4 Trial Sites

The NSPT comprises 12 Trial Sites managed by 11 PHNs. For some PHNs their Trial Site encompassed their entire catchment, but most (particularly the large regional PHNs) based their Trial Site in specific regions within their catchments. Table 1.1 lists the participating PHNs, Trial Sites and the regions they cover.

Table 1.1 PHN, Trial site region and focus population group

PHN	Trial Site/region	Focus population groups
Northern Territory	Darwin	Aboriginal and Torres Strait Islander people
Brisbane North	Brisbane North PHN region	Aboriginal and Torres Strait Islander people Men LGBTI people
North Queensland	Townsville	ex-Australian Defence Force members
Central Queensland, Wide Bay, Sunshine Coast	Gympie, Maryborough, North Burnett	Aboriginal and Torres Strait Islander people Men
Western New South Wales	Bourke, Brewarrina, Cobar, Lachlan, Walgett, Weddin LGAs	Aboriginal and Torres Strait Islander people Young people Men (miners, farmers)
North Coast New South Wales	Clarence Valley, Tweed/Byron, Lismore and Kempsey Bellingen, LGAs	Suicide attempters who have presented at the ED Local area-identified focus groups
North Western Melbourne	North Western Melbourne PHN region	LGBTI people
Tasmania	Launceston, Northwest Coast (Burnie, Central Coast, Devonport), Break O'Day LGA	Men Older adults
Country South Australia	Port Pirie, Whyalla, Port Augusta, Port Lincoln, Yorke Peninsula	Aboriginal and Torres Strait Islander people Men Youth
Perth South	Rockingham, Mandurah, Kwinana, Murray, Waroona	Youth
Country Western Australia	Kimberley (Broome, Bidvadanga, Dampier Peninsula including Beagle Bay, Lomboadinia/Diarindjin and One Arm Point, Derby, Fitzroy Crossing, Halls Creek including Warmun, Kununurra, Wyndham and the Kutjunka region including Balgo, Billiluna and Mulan)	Aboriginal and Torres Strait Islander people
Country Western Australia	Mid-West WA (Geraldton, Carnarvon, Meekatharra, Mullewa, Mt Magnet, Morawa)	Aboriginal and Torres Strait Islander people Men (fishers, miners, farmers)

1.3.5 Focus populations

Under the Trial, three sites were designated to focus on a specific single population: Aboriginal and Torres Strait Islander peoples for the Kimberley and Darwin, and ex-Australian Defence Force (ADF) members for Townsville. At the remaining Trial Sites the focus population was selected by the PHN based on factors including needs assessments, complementing current PHN suicide prevention activity, and characteristics of the population in the PHN catchment. Seven sites had a focus on Aboriginal and Torres Strait Islander peoples, six on men, two on young people, two on LGBTI people and one each on ex-ADF members and older adults. Some focused on specific sub-groups in their chosen focus population, for example, fishers, farmers and miners within men, LGBTI youth, and Aboriginal and Torres Strait Islander youth. Focus populations for each site are listed in Table 1.1.

1.3.6 Systems approaches to suicide prevention

Multi-component suites of coordinated interventions that target different elements of the system are described as systems-based or, more commonly, as systems approaches. Models of systems approaches include the LifeSpan and the Alliance Against Depression (AAD) frameworks, which promote approaches to suicide prevention that integrate a suite of universal, selective and indicated evidence-based interventions[1]. The LifeSpan framework, developed by the Black Dog Institute, comprises nine strategies:

- improving emergency and follow-up care for suicidal crisis
- using evidence-based treatment for suicidality
- equipping primary care to identify and support people in distress
- improving the competency and confidence of frontline workers to deal with suicidal crisis
- promoting help seeking, mental health and resilience in schools
- training the community to recognise and respond to suicidality
- engaging the community and providing opportunities to be part of the change
- encouraging safe and purposeful media reporting
- improving safety and reducing access to means of suicide(3).

The AAD framework was developed in Europe, and has a stronger focus on the recognition and support of people with depression via a four-pronged approach:

- primary care and mental health care education
- depression awareness campaigns for the general public
- initiatives for patients, high-risk groups and relatives
- education for community facilitators and stakeholders(4).

Both frameworks promote a system-wide coordinated approach to suicide prevention activity and services. Systems approaches are based on the theory that the cumulative effect of implementing a suite of interventions aimed at different elements of the system will produce a greater reduction in suicide and non-fatal suicidal behaviour than a scattering of standalone interventions targeting single elements.

Eight Trial Sites adopted (and adapted where necessary) the LifeSpan approach, and two Trial Sites adopted the AAD framework. The two Trial Sites that focused exclusively on Aboriginal and Torres Strait Islander peoples did not adopt either approach.

1.3.7 Aboriginal and Torres Strait Islander approaches to suicide prevention

The two Trial Sites that focussed exclusively on Aboriginal and Torres Strait Islander peoples adopted an approach guided by the principles set out in the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)(5). The ATSISPEP is not a systems framework, but rather a set of principles or success factors for suicide prevention that includes universal/community-wide approaches related to primordial and primary prevention, selectively focused initiatives for at-risk groups including school-aged children and young people, and clinical elements for at-risk individuals. It is grounded in a social and emotional wellbeing (SEWB) approach.

---

[1] LifeSpan and the Alliance Against Depression are also commonly referred to as ‘systems models’ however, to avoid confusions with the systems modelling and simulation component of the evaluation in this report they are referred to as ‘frameworks’.

The SEWB concept is central to Aboriginal and Torres Strait Islander responses to suicide prevention. It is broader than mental health approaches that come from an illness or clinical perspective and focus on individuals and their levels of functioning. The SEWB concept understands the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. A SEWB approach understands unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage as core contributors to problems such as suicidal behaviour(10). A SEWB approach to suicide prevention must include:

- having regard to the historical, political and cultural determinants that have harmed the mental health of Aboriginal and Torres Strait Islander peoples
- understanding that the concept of “self” used in the model is grounded within a perspective that views the self as inseparable from, and embedded within, family, kinship and community
- an emphasis on the importance of strengthening people’s connection to body, mind and emotions, family and kin, community, culture, country and spirit, spirituality and ancestors in order to support their mental health and overall wellbeing.

1.3.8 Phase 1: Planning and implementing evidence-based strategies

The initial phase of the NSPT involved assessing local needs and priorities and planning an appropriate set of interventions to meet them. This involved establishing a governance structure that included all key stakeholders and undertaking community consultations. In all cases but one the PHNs managed the Trial. The exception was in the Kimberley, where the PHN contracted a local Aboriginal Community Controlled Health Organisation (ACCHO) to manage the Trial.

The Department of Health (DoH) contracted the Black Dog Institute to provide support to the PHNs in relation to planning and the selection and implementation of evidence-based strategies.

1.3.9 Phase 2: Implementation

All Trial Sites implemented a range of suicide prevention activities aligned to their chosen systems frameworks. Sites were encouraged to use evidence-based programs where they were available, but because the evidence base for suicide prevention is still developing, a range of evidence-informed as well as innovative programs were also implemented. Trial Sites also undertook activity aimed at promoting integration and coordination among existing services and suicide prevention providers in the sector.

Only four of the 12 Trial Sites commissioned services for people following a suicide attempt or at risk for suicide. Although this is a strategy with a strong evidence base, PHNs generally elected not to commission new services due to concerns about sustainability and having to withdraw services at the conclusion of the Trial.

2 Evaluation design and methods

2.1 Design

An Evaluation Framework that was developed by the Australian Government guided the scope and parameters of the evaluation(11). The Department of Health commissioned the University of Melbourne to evaluate the National Suicide Prevention Trial. Thirrili Ltd partnered with the University to lead the evaluation of the Aboriginal and Torres Strait Islander component of the Trial.

The Evaluation Framework outlined five overarching questions:

6. What strategies were used by Sites to plan suicide prevention services/community-based activities and to ensure that these respond to local needs?
7. What are the key factors in the development of a systems-based approach to suicide prevention and what are the barriers to effective service integration?
8. How were PHN activities targeting people who have attempted suicide and those assessed as at risk of suicide enhanced, and were the enhanced services more effective in preventing suicide?
9. What strategies were found to be most effective in preventing suicide in each of the focus populations?
10. What are the implications for future Australian Government and national suicide prevention policy?

The Evaluation Framework determined that the evaluation should focus on both the implementation and the outcomes of the NSPT; that is, it should involve both formative and summative evaluation. A formative evaluation is designed to improve program performance by influencing decisions about the program, especially about how its elements, structures or processes could be improved(12, 13). A summative evaluation points to more definitive conclusions about the ultimate effectiveness of a program(12, 13).

The Trial design was structured around the implementation of “evidence-based” interventions on the assumption that their effectiveness is (at least partially) established, and because the purpose of the Trial was to implement a coordinated suite of such interventions under a systems approach in order to maximise reductions in suicidal thoughts and acts(14). Therefore, the evaluation design did not include assessing the efficacy of individual interventions delivered as part of the Trial, but focused on overall processes, outputs, impacts and outcomes of adopting a multi-component systems approach.

Given the relatively rare incidence of suicide at a population level and the short duration of the Trial, it is unlikely that the evaluation would have been able to detect any changes in the ultimate outcomes of suicide deaths and attempts. This is a well-known difficulty in suicide prevention research and evaluation(15), and one response has been to assess the intermediate impacts of interventions. Those impacts, along with the more distal outcomes, were operationalised as input, output, impact and outcome objectives in the evaluation’s program logic matrix (Figure 2.1)(6).

The program logic is hierarchical insofar as it is based on the principle that – given the current evidence – if the objectives in a prior step are implemented with reasonable fidelity, then the subsequent step should occur. For example, there is evidence that participants in suicide prevention gatekeeper training report increased knowledge and self-efficacy in identifying people at risk and providing information on sources for support, as well as expressing an increase in intention to take action(16). There is also evidence that people who have undertaken that training report an increase in actually taking action to support or aid someone who exhibits signs of risk for suicidal behaviour(16).

Those actions can include encouraging at-risk individuals to seek professional treatment, and there is evidence that treatment can reduce suicidal behaviours(17). Thus, it is possible to make inferences about the putative outcome pathways of suicide prevention activities, such as those mapped in a program logic. Such a program logic, based as it is on evidence, also permits inferences to be made about expected impacts and outcomes when it is not feasible to measure them. However, any program logic should be interpreted in the light of the many inconsistencies and gaps in the current evidence(18), and with the understanding that a program logic functions as a guide, setting out evidence-informed assumptions to be tested rather than a definitive model.

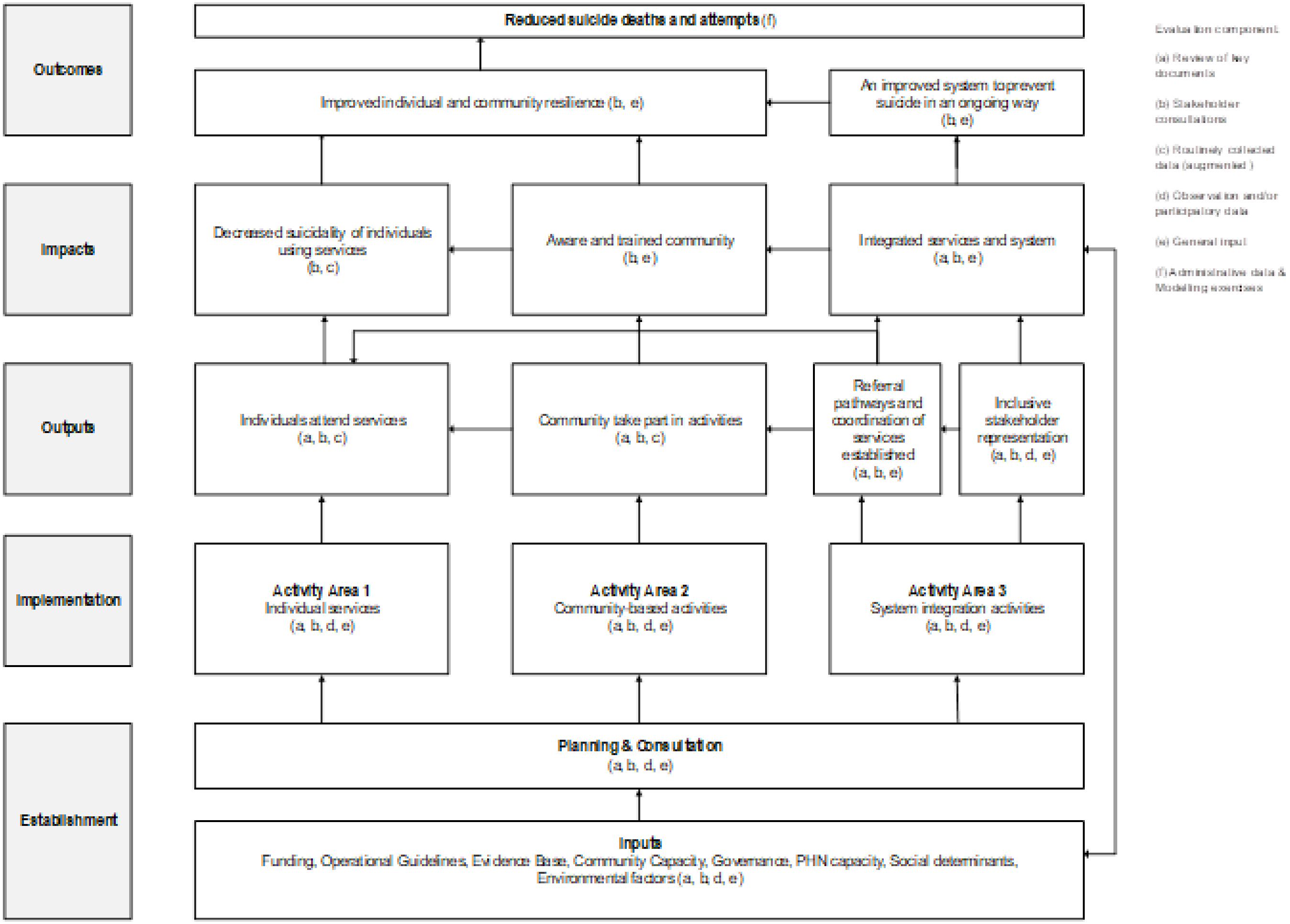


Figure 2.1 National Suicide Prevention Trial evaluation program logic

Figure 2.1 also indicates the data sources that may inform the evaluation of each of the objectives described in the program logic. Using multiple data sources allows for “triangulating” (13) in order to determine if data from different perspectives presents similar information. If there is agreement across data sources the conclusions that can be drawn are stronger, while disparity between sources indicates areas where further investigation is necessary.

2.2 Evaluation of Aboriginal and Torres Strait Islander-focused activities

More than half the Sites participating in the NSPT elected to focus on Aboriginal and Torres Strait Islander peoples and communities, reflecting the elevated levels of risk for suicide and self-harm in those populations. The evaluation of this component of the Trial is based on the National Health and Medical Research Council’s *Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities: Guidelines for Evaluators and Stakeholders*, and is guided by the key principles set out in that document: reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity(19).

In keeping with that approach, additional activities were undertaken before data collection commenced. Initial engagement was undertaken at all seven Trial Sites focusing on Aboriginal and Torres Strait Islander suicide prevention. The engagement was led by staff from Thirrili Ltd, and aimed at sharing information with communities about the evaluation and seeking input on evaluation methodology and Trial outcomes relevant and of interest to communities. Letters of support for the evaluation were obtained from appropriate local organisations. The Department of Health also convened an Aboriginal and Torres Strait Islander sub-committee of the NSPT Evaluation Steering Committee to provide advice and oversite of this component of the national evaluation.

Based on those activities some modifications were made to the evaluation methodology, including adding additional consultation questions to capture information identified as important in the initial engagement and by the sub-committee, adding yarning as a consultation method, conducting consultations in locations preferred by participants, and consultations being conducted by consultants who identified as Aboriginal or Torres Strait Islander. The sub-committee and Thirrili Ltd staff provided an Aboriginal and Torres Strait Islander lens on interpretation of information gathered by the evaluation.

2.3 Ethics and other approvals

Overall ethics approval for the evaluation was obtained from the University of Melbourne Human Research Ethics Committee (HREC 1851003 and HREC 1851745). Approval for the evaluation of Aboriginal and Torres Strait Islander components of the Trial was received from the WA Aboriginal Health Ethics Committee, the Kimberley Research Sub-Committee, the Menzies School of Health Research HREC, and the NSW Aboriginal Health and Medical Research Council. The evaluation was unable to obtain approval from the South Australian Aboriginal Health Research Ethics Committee, and so did not conduct any consultations with, or collect service use data from, Aboriginal and Torres Strait Islander peoples in that jurisdiction.

Approval for release of the National Hospital Morbidity Dataset was obtained from the Australian Institute of Health and Welfare (AIHW), the Western Australia Department of Health Human Research Ethics Committee, and Queensland Health. Approval for release of national mortality data was obtained from the Australian Bureau of Statistics (ABS), and the Department of Health obtained approval for release of the Primary Mental Health Care (PMHC) minimum dataset (MDS) on behalf of the evaluation.

2.4 Primary data sources

The evaluation drew information from the following data sources.

- *Review of key documents:* Collation and review of key documents, including included PHN NSPT Site Activity Work Plans, PHN six-monthly and 12-monthly performance reports, and documents relating to mental health and suicide prevention needs assessments, Trial design and development, commissioning and implementation, provider performance reports and activity reports.
- *Stakeholder consultations:* Stakeholder consultations were conducted with PHN staff, community representatives (including people with lived experience of suicide), service and activity providers, Trial aftercare service users, and other stakeholders.
- *Observational/participatory data:* Observational/participatory data was gathered by attending national forums convened by the Black Dog Institute to provide support to Trial Sites.
- *Aftercare service user data:* These data were captured in the Primary Mental Health Care minimum dataset (including the additional NSPT module).
- *Community-based activities data:* A database was developed to capture descriptive data on community-based activities implemented including awareness and engagement activities, capacity building, professional training, implementation of guidelines and standards, Aboriginal and Torres Strait Islander cultural strengthening activities, and information and services for at-risk individuals and groups.
- *National epidemiological and service use datasets*: Epidemiological data on suicide deaths and hospital admissions for self-harm were obtained from the from national mortality data , and the National Hospital Morbidity Dataset. Service use data for PHN funded mental health services was obtained from the Primary Mental Health Care minimum dataset..
- *Systems modelling and simulation*: Models were built for two demonstration Sites to simulate the effects of suicide prevention interventions on the highest-level outcomes of suicide deaths and attempts within complex service systems in different socio-demographic contexts.

Appendix 1 indicates data sources drawn on to address each of the primary evaluation questions.

2.5 Data collection

Data collection was broadly structured around two rounds. Round one focused on the planning and implementation phase (the formative evaluation) and round two on outputs and impacts (summative evaluation). Round one data collection took place, in the main, in 2018. Round two data collection was originally scheduled to occur in 2019, but the extension of the Trial for an additional 12 months saw round two being moved to 2020 and two additional mid-Trial consultation activities added (surveys for service providers and PHN Trial Coordinators). A single round of consultations covering planning, implementation, outputs and impacts was undertaken for the Aboriginal and Torres Strait Islander component of the evaluation.

2.6 Structure of this report

In Part 1, Chapters 1 and 2 provide background on the Trial and the evaluation. Chapters 3 to 8 provide a synthesis of the evaluation findings. They are structured around the key process and outcome evaluation questions set out in the Evaluation Framework, and present findings on planning in general, adopting a systems approach, and for focus populations. Chapter 9 presents findings from the analysis of suicide death and self-harm hospitalisation data and dynamic simulations modelling for the Trial overall. Chapter 10 presents conclusions drawn from the evaluation and considerations for policy.

Part 2 (Chapters 11 to 24) provides detailed findings from each data source included. Part 2 chapters are structured around the three evaluation domains of planning, adopting a systems approach, and services and activities for focus populations. Within each of those domains, findings are organised in response to key secondary questions provided in the Evaluation Framework for assessing the five primary evaluation questions (Appendix 2). Table 2.1 sets out the primary and secondary evaluation questions and corresponding Part 2 chapter sections.

Table 2.1 Report structure Part 2, chapters 11–24: Evaluation questions and chapter sections

Primary evaluation question	Secondary evaluation questions	Part 2: chapter sections
FORMATIVE EVALUATION		
Planning		
What strategies were used by sites to plan suicide prevention services/community-based activities and to ensure that these respond to local needs?	How did sites plan and develop suicide prevention strategies?	Planning – identifying local needs and service gaps Planning – stakeholder involvement
	What strategies facilitated local planning? What strategies were found to be effective in local planning?	Planning – facilitating factors
	What challenges were encountered?	Planning – challenges
Adopting a systems approach		
What are the key factors in the development of a systems-based approach to suicide prevention and what are the barriers to effective service integration?	What strategies were used to develop and sustain a systems approach to suicide prevention? What strategies facilitated development of a system approach?	Developing a systems approach – strategies
	What strategies were found to be effective in facilitating a systems approach?	Implementing a systems approach – impacts
	What challenges were encountered?	Developing and implementing a systems approach – challenges
SUMMATIVE EVALUATION		
Focus populations		
How were PHN activities targeting people who have attempted suicide and those assessed as at risk of suicide enhanced, and were the enhanced services more effective in preventing suicide? What strategies were found to be most effective in preventing suicide in each of the focus populations?	What strategies were used to enhance, target and deliver services and activities [for people who had made a suicide attempt or were at risk for suicide, focus populations, general population, focus populations]?	Focus population – strategies [outputs] - Service/activity description - Tailoring of services/activities - Service promotion and recruitment - Involvement of people with lived experience of suicide
	What strategies were found to be effective in preventing suicide deaths and suicidal behaviour [among Aftercare service users, general population, focus populations]?	Focus population – outputs and impacts - Participation - Appropriateness (met needs and expectations} - Increased awareness and knowledge

Primary evaluation question	Secondary evaluation questions	Part 2: chapter sections
		- Complementing existing services or filling a service gap - Integration and coordination of activities - Other impacts
	What challenges were encountered?	Focus population – challenges

3 Processes – Planning

This chapter presents a synthesis of the key findings from multiple data sources related to the Trial planning processes. Detailed information about planning can be found primarily in chapters 11-14, 16 and 17, with additional supporting information in chapters 15, 18 and 20.

3.1 Overall Trial planning

3.1.1 What strategies were used by Sites to plan suicide prevention services and activities and to ensure that these respond to local needs?

Overall Trial governance structures

The governance structure at each Site was the key mechanism for conducting the Trial. It drove the planning process and structured the decision-making. It also had a critical function in terms of engaging stakeholders, including influencing who was engaged and their level of commitment.

In the main, PHNs directed the management of the trial, but at four PHNs local organisations were contracted to run local Trial activity within the smaller regions they had selected to focus on in the Trial. In addition, one Trial Site contracted out carriage of the whole Site to an ACCHO, which took on the PHN's coordinating role as noted below.

While there were local variations at Sites in terms of the names of groups and committees and their exact parameters of activity, the five main governance structures of the 12 Sites can be broadly characterised as follows:

1) The PHN/ACCHO convened an overall strategic advisory and oversight committee. This group included broad stakeholder representation and set the overall direction and priorities.

   The PHN/ACCHO also established working groups or sub-committees comprising stakeholders with specific expertise, to study the evidence and make recommendations to the overall committee, or alternatively to make decisions about activities within the overall strategies set out by the strategic advisory and oversight committee. Four Sites predominantly had this structure.

2) The PHN convened implementation groups or steering committees of stakeholders from focus populations which then made all the decisions on strategies and priorities pertaining to that population. In parallel, the PHN convened an overall Trial committee which included broad representation and which made decisions about general population strategies and overall Trial coordination. Two Trial Sites adopted this approach.

3) The PHN co-designed activities with focus populations through a working group that was established and facilitated by the PHN, but with shared decision-making. One Site adopted this model.

4) The PHN established an overall Trial committee. In parallel, contracted organisations set up local working groups to implement local activities within the overall Trial committee's parameters. Those local working groups reported back to the PHN via representatives of the contracted organisations participating in the overall steering committee. One Site employed this structure.

5) The PHN did not establish a single overall Trial committee and devolved planning to regional committees with varying degrees of decision-making authority. Four Sites had this structure, with the following variations.

> At one Site regional steering committees were established in two regions within the catchment to provide guidance on planning and implementation to the PHN. Within those two regions, in several towns, contracted organisations set up local working groups which reported back to the relevant regional committee via the contracted organisation representative. The PHN determined the parameters of Trial activities in local areas and local working groups determined specific activities. The PHN made decisions on other Trial activities based on input from regional steering committees.
>
> At two Sites, contracted organisations established local working groups which reported back via the contracted organisation representative directly to the PHN. The PHN decided the overall strategies and selected some activities (regional and system-level). Local organisations and working groups made decisions about specific local activities within the PHN's parameters.
>
> At one Site, local working groups established by the PHN reported back to the PHN through PHN representation on the working group. The PHN decided the overall strategies and selected some activities (region-wide, system-level, individual). Local working groups made decisions about specific local activities within the PHN's parameters.

The governance structures sought to balance the input of stakeholders and achieve a mix of grassroots engagement and representation and involvement of people with decision-making authority in government agencies and larger non-government organisations (NGOs). The former was important to understand what was happening on the ground and to achieve community buy-in, the latter was important to make things to happen, and both were necessary to promote coordination.

Stakeholder involvement

Adopting a systems approach necessarily required the involvement of stakeholders from across the system in order to develop a coordinated and integrated approach, to build a shared commitment and will to take action, and to draw on the knowledge and perspectives of the full spectrum of stakeholders. Trial Sites made considerable effort to involve a wide range of stakeholders. The main types of stakeholders involved are presented in Table 3.1.

Government stakeholders involved were predominantly from departments or agencies related to health and mental health, or those relevant to their focus populations, for example, education, Veteran's Affairs and the Department of Prime Minister and Cabinet. Three Sites – two Aboriginal and Torres Strait Islander-focused, and one ex-ADF member-focused – had direct involvement from Commonwealth Ministers, with sustained involvement at the two Aboriginal and Torres Strait Islander-focused Sites. In regional areas, local councils were important stakeholders because they deliver many social services, while in two metropolitan Trial Sites there was no involvement of local councils who did not see suicide prevention as their remit.

The health and mental health service sector was the primary focus for recruiting stakeholders. All Sites made an effort to engage hospital stakeholders as well as the main state-funded mental health agencies and non-government mental health service providers. Alcohol and other drug agencies were also sometimes included, but not universally. In urban areas, Sites also focused on agencies and services working directly with their focus population groups, while in regional areas that level of service specialisation generally wasn't available, with the exception of Aboriginal and Torres Strait Islander services.

Table 1.1 Key stakeholders involved in Trial planning

Types of key stakeholder organisations
Government departments and agencies
• Australian Government Departments
• State and Territory Government Departments
• State Mental Health Commissions
• Local Councils
• Police
Health sector organisations and providers
• Professional bodies (e.g., Royal Australian and New Zealand College of Psychiatry, Royal Australian College of General Practice)
• Local health districts, hospital EDs
• Key service providers in the mental health and social services sectors (e.g., headspace, Anglicare)
• General practitioners
• Other service providers/health networks
• Ambulance service
Aboriginal and Torres Strait Islander organisations and communities
• Aboriginal Community Controlled Health Organisations/Services
• Aboriginal and Torres Strait Islander NGO service or activity providers
• Cultural and/or advocacy and support organisations
• National or regional peak bodies
• Elders
• Community members
• Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
• Existing Aboriginal Reference Groups
Non-government organisations and community organisations
• Non-government organisation delivering other mental health or social support services or activities (e.g., Relationships Australia)
• Non-government organisations related to focus population groups (for example, Men's Health Forum, LGBTI Health Alliance);
• Non-government organisations covering local towns/regions (e.g., Neighbourhood houses, regional development organisations)
• Local suicide prevention networks

As would be expected, the major suicide prevention NGOs were involved in most Trial Sites because they were either specialists in some element of evidence-based practice such as Mindframe (media guideline training), had a wide community-level presence such as Wesley Lifeforce through the suicide prevention networks it supports, or were key advocacy and training providers such as Roses in the Ocean (lived experience of suicide training providers). Community stakeholders also came from smaller local suicide prevention organisations, usually formed by a local community member or small group in response to loss in the family or community, or from local suicide prevention networks. Other NGOs were included because they undertook general community development work or delivered social support services and/or activities, for example, Neighbourhood Houses and Relationships Australia.

Advocacy organisations for focus populations involved in Trial Sites included those that had a specific health focus, such as the Men's Health Forum, or advocated in general for the focus population such as the Bisexual Alliance.

People with lived experience of suicide were involved in the planning at all Trial Sites primarily as members of Trial Committees[2]. In some cases, they were representing a lived experience of suicide organisation, such as Roses in the Ocean. In others, they were participating in the Trial Committee in another capacity but also had lived experience of suicide. The other way in which people with lived experience of suicide provided input was through participation in community consultations.

Identifying needs

Identifying local need was the first step for Trial Sites in the planning and development of local suicide prevention strategies. There were two elements of the needs analysis: identifying needs in terms of population groups or localities that had high levels of risk, or known risk factors; and identifying gaps in suicide prevention-related services and activities. Five main approaches were used across the Trial to ascertain needs and identify gaps.

1) *Obtaining Input from stakeholder members of Trial Committees*
   As described above, a broad range of stakeholders were recruited to Trial Committees, which gave them the opportunity to provide input on needs and services gaps from their organisations' perspectives. Many community organisations were included on Trial Committees, but other community consultation activities were conducted to collect information and input, including community surveys, forums, workshops, yarning circles for Aboriginal and Torres Strait Islander peoples, and targeted consultation with community leaders or groups.

2) *Undertaking consultations with other stakeholders and community*
   At six Sites the PHN commissioned an external organisation to undertake some or all of the community consultation. Organisations commissioned included ACCHOs, universities, community organisations, and external consulting companies.

3) *Obtaining data on suicide deaths and suicide attempts for local areas and for population groups within the Site*
   Primary Health Networks strived to access data on suicide deaths, suicide attempts and other known risk factors from state and national sources. Some Sites commissioned an external organisation to conduct a review of relevant data or a "suicide audit".

4) *Drawing on routine PHN needs assessment reports*
   Primary Health Networks conduct periodic needs analyses to inform service commissioning for their catchment areas as part of their core business activities. These include mental health and suicide prevention needs analysis, and generally report on incidence of suicide and suicide attempt by region, gender, age group and Aboriginal and Torres Strait Islander identity, as well as available mental health services.

5) *Undertaking or commissioning service mapping activities*
   Suicide prevention and mental health service mapping activities tended to be a Trial output rather than an input, but some PHNs commissioned external organisations to undertake service mapping to inform planning, while others drew on PHNs' service mapping activity done as part of routine needs analysis.

---

[2] Across the Trial, governance committee's scope, names, levels of decision-making responsibility, and so on varied considerably by Site. Mindful of those variations, for the purposes of this report we refer to these bodies generically as Trial Committees, except when needing to distinguish groups as at a single Site.

Other methods used to gain insight into local needs and gaps were using narrative and case study data, monitoring media reports, and drawing on anecdotal data.

Planning process

At the majority of Sites planning was ongoing across the duration of the Trial. This was generally not due to a decision to undertake a continuous improvement approach, but reflected operational factors including the repeated extension of the time-frame and funding of the Trial, adopting a staged approach to manage the scale of the undertaking, the result of delays and challenges that needed to be overcome, or a response to challenges encountered in initial implementation efforts.

As noted earlier, if a Trial Site focused on selected localities within the PHN catchment – as was the case for eight Trial Sites – the PHNs often subcontracted local organisations to conduct local needs assessment and consultation and planning, including forming working groups and overseeing implementation of activities for their locality.

Activity planning was structured around adopting a systems approach and a specific framework (LifeSpan or the AAD), drawing on the evidence base, and on using the ATSISPEP guidelines for Aboriginal and Torres Strait Islander-focused activities. The Department of Health contracted the Black Dog Institute to support the Trial Sites, including providing resources such as research reports and data, hosting forums, guidance on implementing the LifeSpan framework, and training for Trial staff. Most Trial Sites drew on the Black Dog Institute's support, although to a significantly lesser degree at Sites where the LifeSpan framework was not adopted (discussed below).

Trial Sites produced Annual Activity Workplans describing main activities, key partners, activities for focus populations, workforce, and so on. Plans changed considerably as the Trial progressed, because Sites refined their focus populations and the scope and type of activities in collaboration with the Trial Committees. Community Action Plans were produced for local regions within the PHN that had been selected as a focus locality or for focus populations in seven Trial Sites.

3.1.2 What strategies were found to be effective in facilitating local planning?

Several key facilitators of local planning were identified.

Stakeholder representation and engagement

Broad and inclusive stakeholder engagement in the Trial Committees was key to understanding needs and service gaps and actioning planned Trial activities and initiatives. It was also important in bringing stakeholders together from across the sector to overcome siloing, facilitating the mending of fractured relationships, and encouraging communication and sometimes even collaboration between organisations that often compete for funding.

No single governance model emerged as the "best", which, given the diversity of the Trial Sites in terms of geography, choice of focus populations, and organisational structures and culture of the PHNs, is as would be expected. However, characteristics of Trial Committees which facilitated strong stakeholder engagement with the Trial were that they were genuinely representative of community and local groups and included senior organisational staff, from both service providers and government agencies.

Leadership of Trial Committees from a respected external Chair and/or a more senior staff member from the PHN/ACCHO contributed to attracting and maintaining a high level of stakeholder engagement.

Governance models which devolved planning to local regional community organisations generally found it more challenging to maintain momentum and achieve a coordinated approach.

Time for planning

Building relationships between the PHN and stakeholders and between stakeholders took time but resulted in more inclusive and coordinated planning, greater commitment to the Trial from stakeholders, and was respectful of community readiness. Time was also required to build the knowledge and understanding of stakeholders about evidence-based approaches to suicide prevention.

Staffing

Establishing a dedicated Trial coordinator role was a critical success factor for accessing local knowledge, achieving buy-in across the community and service sector, and for the overall success of the Trial. In some instances, existing PHN staff moved into the role but in most cases, due to the specific requirements of the role, external recruitment was necessary.

The Trial coordinator role was complex, and key skills identified for that role included a background in community engagement, knowledge and passion about suicide prevention, project management skills, sector knowledge, relationship management skills, and existing connections with the community.

Other facilitating factors for Trial planning related to staffing were having continuity of Trial staff in order to sustain momentum and relationships. An important facilitator was high and sustained level of engagement of more senior PHN staff, such as mental health and suicide prevention portfolio managers or above, who had established networks across the sector, were involved in strategic planning and interagency activities at the PHN level, and had authority to make decisions.

Community leadership

Community leadership was operationalised in varying ways and to various degrees across the Trial Sites. Facilitators for effective community leadership included the PHN providing resources and support to stakeholders and community members to participate in the Trial planning in an informed and effective way, and the PHNs taking a collaborative approach to planning and being responsive to community input. The Trial coordinator role having an explicit community development focus or the employment of Trial coordinator with community development skills also enhanced community participation.

Other community-related factors

The presence of a community which was ready and keen to participate, with a high level of commitment to suicide prevention, facilitated relationship building around a common purpose, stakeholder willingness to commit time, and generally maintaining the momentum of the Trial. Pre-existing relationships between community organisations and agencies and the PHN and the presence of established community suicide prevention networks or groups also facilitated planning.

Black Dog Institute involvement

The Black Dog Institute provided support to Trial Sites in a range of ways that facilitated planning. Staff provided the PHNs with resources such as research and data to support Trial planning and gave commissioned community organisations resources and information to support them to adopt evidence-based approaches. They hosted hosting national forums and workshops for Trial Sites to allow sharing of knowledge and learnings between Sites and to provide updated or focus population-specific resources on suicide prevention strategies. They also delivered training for PHN Trial staff in suicide prevention.

3.1.3 Planning – what challenges were encountered?

As would be expected in rolling out a significant intervention such as the NSPT, substantial challenges and barriers were encountered in the planning process. These included challenges related to availability of data and the strength of the evidence base, stakeholder, PHN and community-related challenges, and operational challenges.

Data and evidence challenges

In terms of identifying needs, a consistently identified barrier was the lack of adequate data on suicide deaths and non-fatal suicide behaviour for focus populations and/or local areas within the Trial Site. Such data were considered important to understand the epidemiology of suicidal behaviour in Trial areas to inform planning. It was also widely considered that there were substantial gaps in the evidence base on the effectiveness of interventions for all of the focus populations and also for Australian regional, rural and remote settings.

Stakeholder engagement challenges

Primary Health Networks made extensive efforts to involve relevant stakeholders and be inclusive and generally achieved a high level of engagement. However, difficulty in obtaining and retaining engagement from some key stakeholder groups was noted. The most frequently identified difficult-to-engage stakeholder groups were hospitals, education departments and schools, general practitioners (GPs) and first responders. Many reasons were noted, including:

- Hospitals are large organisations and it is difficult to identify the right person to engage. Decision-makers at hospitals are more difficult to engage and may not necessarily have detailed knowledge about on-the-ground processes
- Education departments and schools are oversubscribed in terms of mental health and wellbeing programs aimed at young people, and schools can be risk averse with respect to suicide-related content in programs
- General practitioners are busy, have a business model that doesn’t readily accommodate participation in activities such as the Trial, and in many regional settings are a transitory workforce with no community ties
- First responders have little time to participate and in smaller communities are often called on to participate in every committee or initiative.

Identifying the “right” people from agencies and organisations was an challenge, specifically whether it was preferable to involve more senior decision-makers or staff who worked “on the ground”. The benefit of having decision-makers is that they can facilitate implementation of activities, for example, across a workforce, or initiate procedural changes. They also have more influence in terms of pursuing system level change. However, the advantage of involving people on the ground is that they are often more attuned to the day-to-day operational processes of organisations and the needs of their local communities.

Managing stakeholder involvement challenges

The diversity of the stakeholders brought with it differing levels of experience and knowledge that needed to be negotiated, and required finding a common language for clinical, community and government stakeholders. Competing priorities were encountered among stakeholders, as well in some cases pre-existing tensions or competitiveness between organisations around funding.

PHN staffing challenges

The most commonly-cited challenge for the PHNs was the recruitment and retention of suitably qualified staff. Recruitment issues related to the difficulty in finding people with the unique mix of skills and experience required for the role, particularly in regional areas. Insufficient support for PHN staff in terms of building capacity to use evidence and to evaluate was also noted. There was a high level of staff turnover during the planning phase of the Trial, and this resulted in considerable loss of knowledge, insight and relationships. Staff loss was attributed to a range of factors, including lack of role clarity, the complexity and difficulty of the role, and burnout.

PHN administrative challenges

The internal systems and processes of the PHNs, such as the procurement and contracting mechanisms, were felt to be cumbersome, inflexible, difficult for smaller community organisations to navigate, and favouring more established provider organisations.

Balancing PHN and community control

Several challenges related to the role of the PHNs in implementing the Trial were identified, primarily in community consultations, including that the PHN was too directive, that the Trial was not sufficiently community-owned or led, or that the PHN wasn't sufficiently responsive to the community's wishes. Conversely, some stakeholders felt that the PHN didn't provide sufficient guidance or direction.

The first two issues in part reflect the challenges involved in the Trial re-orienting suicide prevention activities toward an evidence-based systems approach, as well as instances in which the governance models at some Trial Sites were more PHN controlled. The third issue speaks to a more general resistance from smaller organisations already engaged in local suicide prevention activities to change what they were doing or concerns that their current activities would face competition from Trial-funded activities. Community stakeholders also raised perceptions of an overlap with existing suicide prevention activities, again generally in the context of unwillingness to change what was already going on. On the other hand, there was the view that community stakeholders did not receive enough direction and guidance from PHNs on understanding the systems approach or how to go about the planning process.

Community capacity and buy-in

Lack of community capacity was noted in terms of planning skills, overall knowledge about suicide prevention, ability, time and willingness to assimilate new knowledge, and time to contribute to planning activities. The latter was noted as a particular issue in regional areas, where the same stakeholders tended to be recruited for every initiative in their region.

In terms of achieving community buy-in, challenges related to community stakeholders pursuing diverse agendas and also having strong preferences for how suicide prevention should be "done" in their location. Lack of willingness to participate frequently involved some resistance to evidence-based approaches because they did not accord with people's personal views or experiences, and in general community experience was accorded priority over evidence-based approaches. It was also noted that there is a degree of reform fatigue, and particularly in smaller communities, "intervention fatigue", that makes it challenging to get buy-in.

Trial operational challenges

Operational challenges related to Trial design were cited, including the Trial timelines, particularly in the context of the extended time required to undertake proper community consultation, establish relationships, and build collaborations and shared understandings. Geographical factors were a challenge when a Trial Site encompassed multiple hospital district areas, or included regions or towns with very different needs and issues. Finally, the level of funding and PHN funding cycles were noted as problems.

4 Processes – Adopting a systems approach

The design of the Trial required Sites to adopt a systems approach that involved coordinated implementation of a suite of suicide prevention activities directed at different components of the system.

This chapter presents a synthesis of the key findings from multiple data sources related to the processes for adopting a systems approach. Detailed information about adopting a systems approach can be found primarily in chapters 11-14, 16, 17 and 20.

4.1 Developing a systems approach – strategies

Across Trial Sites, two streams of activity were pursued in efforts to develop a systems approach. Firstly, Trial Sites undertook to implement a range of activities according to the domains of their chosen framework (i.e., the LifeSpan “wheel”, the AAD “four pillars”, and/or the domains identified by the ATSISPEP framework). Secondly, Trial Sites undertook activities aimed at improving integration between services and coordination of community-based suicide prevention activities, as well as integration and coordination at a service and activity level and more generally across the system.

Systems frameworks

Trial Sites drew on systems frameworks to inform their planning and selection of particular suicide strategies to implement (LifeSpan: eight Trial Sites; AAD: two Trial Sites). Trial Sites used the ATSISPEP framework and success factors to guide approaches focused on Aboriginal and Torres Strait Islander peoples, and they also provided the overarching framework for Trial planning in one of the exclusively Aboriginal and Torres Strait Islander-focused Trial Sites.

Most Sites noted the necessity of adapting or modifying their chosen framework to suit local conditions in terms of the feasibility of certain domains of intervention given the local service infrastructure, to be appropriate for focus populations, and/or to include postvention initiatives.

The Trial Sites drew on the expertise and support of the Black Dog Institute, which developed the LifeSpan framework, to provide information and guidance on working with a systems approach and support in the design, implementation and evaluation of specific programs for focus populations.

Integration and coordination – service level

In terms of facilitating integration and coordination at a service or activity level, several Trial Sites which commissioned aftercare services for individuals took a co-design approach of services for focus population groups, which facilitated involvement of multiple agencies and key stakeholders. The establishment of referral pathways into Trial-funded services promoted coordination, and the aftercare service model, which is primarily focused on case management and linking clients with relevant agencies in the local area, is based on integration.

Other strategies for establishing a coordinated approach included commissioning activities to meet identified gaps, using the commissioning process to foster partnerships and integration between providers, implementing programs that complement, strengthen, or improve existing programs and services (including State-led initiatives), and developing referral or health pathways.

Integration and coordination – system level

Several strategies were adopted to improve integration and coordination more generally across the system.

Stakeholder engagement was a key element of Trial planning. This was not only to ensure knowledge from across the sector was available to inform planning, but to engage the entire sector in the planning process as a means of developing a more coordinated system-wide approach and facilitating implementation across the system, and that it was a whole-of-community systems approach, not just a service-driven systems approach. A dedicated and resourced coordinating role is necessary to establish, retain and manage stakeholder engagement, because stakeholders generally lack the capacity to dedicate time to build relationships and coordinate activities or necessarily view it as their organisation's core business.

Primary Health Network leadership was important for bringing together stakeholders from across the sector and facilitating relationships. PHNs are well placed to facilitate engagement of stakeholders and foster linkages and coordination due to their established relationships across the service sector, including with state-based agencies, as well as PHN Trial staff, who often had local connections and networks and knowledge of the community and stakeholders. PHNs have connections across the system via their participation in inter-agency and multi-jurisdictional committees and working groups and their involvement in regional planning activities. Moreover, PHNs are already engaged in networking and information-sharing activities.

Adopting a whole-of-community approach which recognised community knowledge and expertise and involved community members in key decision-making to encourage engagement and ownership was seen as a means to move beyond the health services system and facilitate a sustainable whole-of-community approach. However, community development and capacity building are necessary to support such an approach. All Trial Sites opted to provide programs and training to increase knowledge about suicide, build community capacity in suicide prevention and implement workforce development and training activities. In addition, at some Sites the role of the Trial Coordinator and other Trial staff included a greater community development focus.

4.2 Implementing a systems approach – outputs

Structural system-wide change is a long-term undertaking which cannot be achieved in the short lifetime of the Trial. However, some outputs from Trial Sites' attempts to adopt a systems approach can be observed that, following the program logic approach, begin to build a foundation for longer-term system change. Those outputs are related to adopting an overall systems approach and improved integration and coordination at service and system levels.

Implementing a multi-component systems approach

Most Trial Sites elected to implement only a subset of the strategies in their chosen framework. For example, with the LifeSpan frameworks, only four Sites elected to provide aftercare services for people who had made a suicide attempt or were experiencing a suicidal crisis, and only one Site undertook means restriction activity, while for the AAD, screening in general practice did not eventuate. However, overall, most Trial services and activities were focused on awareness raising and engagement, including media campaigns, and capacity building in community and service providers via structured suicide prevention and mental health training programs such as Advanced Suicide Intervention Skills Training or Mental Health First Aid.

In terms of re-orienting toward an evidence-based approach, where evidence-based interventions were available and deemed appropriate, there was good uptake of such programs, particularly for gatekeeper and general practice and other health and mental health professional capacity building.

Integration and coordination of services and activities

There were multiple instances of integration and improved coordination of services and suicide prevention activities being achieved over the course of the Trial. At a service level, these most often involved organisations delivering a Trial service or activity integrating it with non-Trial services or programs they also delivered, or organisations partnering to deliver a service or activity.

Other frequently mentioned integration and/or coordination outputs included the development of care or health pathways and referral pathways, the dissemination of service information to agencies and service providers, and the Trial providing a platform for agencies, services, NGOs and communities to connect and become aware of each other’s programs and services.

Integration and coordination across the system

Trial outputs related to efforts promote integration and coordination of suicide prevention efforts were generally related to building interagency relationships and greater community engagement. Data-sharing agreements were created with police and other State agencies. Relationships and strategic partnerships were built across PHN, health, mental health and social service providers and across levels of government.

Other examples of enhanced coordination across the sector include the PHNs widening the scope of their usual practice toward a whole-of-community approach, including undertaking a localised community development approach and commissioning a broader range of activities than services and health promotion programs. Among community stakeholders, there was a shift towards a better understanding and appreciation of an outcome-based approach focused on data and evidence-based activities among community partners.

4.3 Developing and implementing a systems approach – challenges

The main barriers identified in efforts to move towards a systems approach to suicide prevention related to capacity across the sector, implementation challenges, achieving community buy-in, unsatisfactory key stakeholder engagement, and structural factors.

Capacity

Capacity was identified as a barrier for both community and service providers, particularly the burden on individuals in terms of the time and effort required to acquire the necessary knowledge about systems approaches and the skills and confidence to deliver projects. Capacity was also identified as a barrier at PHNs, including the challenge of recruiting and retaining qualified PHN Trial staff, PHN staff lacking capacity in terms of workload and needing support to build their knowledge of a systems approach, and the capacity of PHN leaders to be involved.

Implementation

A range of implementation challenges were noted. These related to use of systems frameworks, including a lack of knowledge and guidance on how to operationalise the LifeSpan framework, as well as concerns that selective or partial implementation of the frameworks would prevent the achievement of results noted in the evidence.

There were capacity barriers at community organisations that had been commissioned to lead the local activities at several Trial Sites. Some organisations lacked sufficient understanding, skills, contact or influence with state and federal agencies, or willingness to drive a systems approach.

Finally, resource-related barriers were noted, including Sites having insufficient resources to implement a full multi-component systems approach, and concerns about sustainability given the current funding model.

Community buy-in

The main barrier identified in terms of achieving community buy-in was community resistance to adopting an evidence-based systems approach. Key points of community resistance were that that the frameworks were inappropriate for local conditions or the chosen focus population, and that in general systems approaches that emphasise evidence-based interventions are incompatible with a community-based suicide prevention approach, that they ignore local knowledge, and don't include activities communities are already doing or want to do.

Stakeholder engagement

Challenges relating to engaging stakeholders in general are discussed above in Chapter 3 section 3.1.3. With respect to adopting a systems approach to suicide prevention, the need to engage stakeholders in positions of influence across levels of government and portfolios is a challenge, particularly given the time-limited nature of the Trial and the time system reform takes. Local community organisations have no capacity to undertake that level of engagement, and PHNs varied in the extent to which they had pre-existing relationships they could leverage. Given that PHNs are a relatively new organisation, many were still establishing those networks.

Structural issues

The lack of service infrastructure and suitable providers to deliver suicide prevention interventions was a barrier in remote, rural and regional areas. Siloing and lack of communication, transparency and coordination across the health and social service sectors are also barriers. The competitive funding environment for non-government providers is a significant impediment to collaboration and coordination.

5 Outputs and impacts: Focus population – People who attempt or are at risk of suicide

This chapter presents a synthesis of the key findings from multiple data sources related to the Trial outputs and impacts for people who attempt or are at risk of suicide. Detailed information that informed this chapter can be found primarily in chapters 11-14, 16, 21, 22 and 25.

As described in chapter two, the difficulties in assessing the extent to which interventions are effective in preventing suicide are well documented. However, the evaluation has taken a hierarchical program logic approach to guide the assessment of the outputs and impacts of Trial services and activities. Hierarchical program logics are structured around the assumption, based on the best available evidence, that if the objectives at one step are achieved, then the objectives at the subsequent step should occur. Thus, if the outputs and impacts identified in the program logic are observed then potentially the longer-term outcomes of reductions in suicide and suicide attempts should eventuate.

Following the program logic, this chapter outlines findings and learnings regarding the achievement of objectives in the implementation, output and impact steps. Specifically, section 5.1 describes how the objective of establishment of aftercare services was met, including how they were developed, staffed, and promoted to meet the needs of at-risk individuals. Section 5.2 then describes the achievement of the primary output objective of people using the services, as well as outputs that support service use including if services are accessible and appropriately tailored to the needs of those they targeted. Section 5.2 also describes the impacts resulting from the achievement of output objectives – changes in suicidality and/or the wellbeing of service users. Additional impacts related to increasing coordination and service integration are also noted.

5.1 What strategies were used to enhance services for people who had attempted or were considered at risk of suicide?

5.1.1 Service description

Four Trial Sites commissioned aftercare services for individuals following a suicide attempt or who were at risk for suicide (i.e., presenting with suicidal ideation).

Two Sites commissioned services for the general population, and LGBTI-specific and Aboriginal and Torres Strait Islander-specific services were each commissioned at two Sites. Focus population specific services were commissioned because stakeholders considered that existing services and service models were not culturally safe for those populations.

All services adopted a broadly similar case management approach, providing intensive support, linking clients with other available services and support agencies, and in some cases providing some clinical and/or Aboriginal traditional healing therapies. The general approach across services was toward flexible service models focused on individual needs.

5.1.2 Tailoring

Each service was tailored to meet the needs of either the focus population or locality. Aboriginal and Torres Strait Islander and LGBTI-specific service models were co-designed with stakeholders including community members, advocates, community-specific service providers and people with lived experience of suicide. Customisations included adding Traditional Healers and narrative therapies to Aboriginal and Torres Strait Islander service models, and using peer workers for a LGBTI service. Moreover, Aboriginal and Torres Strait Islander or LGBTI organisations were contracted to deliver the services to ensure trust and cultural safety.

For general population services, modifications to standard services models included broadening referral pathways and adjusting intake procedures to make them more accessible. For example, general population services with narrow referral pathways will not capture people who rarely present to hospitals, such as Aboriginal and Torres Strait Islander peoples.

5.1.3 Service promotion and recruitment

Services were promoted to potential referring-in agencies and organisations primarily via PHN networks, stakeholder networks, and direct liaison between PHN staff or aftercare service provider staff and hospitals. To raise awareness about the services among potential clients, they were promoted via word of mouth, community networks and a Trial-sponsored community campaign.

Services accepted referrals from a wider range of sources than hospital and health/mental health service providers. These included:

- Police and ambulance services
- Community mental health services
- Service providers delivering other Trial activities
- Self-referrals and referrals from family and carers.

The Site delivering the Wayback aftercare service initially only accepted referrals from the hospital, as that service model specifies. However, referral sources were widened to make the service available to more at-risk individuals and because of difficulties in obtaining referrals from the local hospital.

5.1.4 Workforce

A range of qualifications and training were considered relevant for aftercare service workers, including clinical qualifications in psychology or social work, certificate-level mental health, peer mental health training, and trauma-informed care training. The exact qualification and skill profile depended on the service model. Services also provided additional training in suicide prevention and peer work.

Services users believed that it was important for service staff to be friendly and empathetic, have lived experience of suicide, and exhibit diversity.

5.1.5 People with lived experience of suicide

People with lived experience of suicide were involved in the co-design of focus population-specific services and employed as peer workers at one service.

5.2 What strategies were found to be effective in preventing suicidal behaviours and self-harm among people who had attempted or were at risk of suicide?

5.2.1 Outputs: service availability and accessibility

The establishment of new services in regions or to serve at-risk populations where a lack of service had been identified is an important output. That said, the majority of Trial Sites did not implement aftercare services, despite this being an intervention which has some of the strongest evidence for preventing future suicidal behaviour. The reason for not implementing aftercare services was primarily not wanting to implement a service and then have to discontinue it, particularly given the vulnerability of the target cohort. Another reason why aftercare services were not commissioned as part of the Trial was that a major expansion of the Wayback aftercare service, funded by the

Department of Health, was being rolled out, and PHNs intended to seek funding for a service through that initiative.

Notably, two of the Four Sites which implemented aftercare services were in metropolitan areas where other services were likely to be available after the Trial service was withdrawn. However, both those Sites implemented services for specific population groups which, according to the Sites, did not attend general population services because they were not culturally safe or appropriate.

Acceptance of referrals from a wide variety of sources at most services made them more accessible to those in need. Sixty per cent of service user survey respondents indicated they attended because they were referred, indicating that efforts to publicise the service and establish referral pathways were effective.

Services were also considered accessible because they did not require clients to bear any costs. Complete data on the overall number of clients attending aftercare services was not available, but PHN staff and service providers report high levels of attendance and good uptake at services, with most services running at capacity.

5.2.2 Outputs: service user characteristics and appropriateness of service

Information on service users was obtained from the PMHC MDS and the additional Trial-specific module, and a survey of aftercare service users.

Demographic data from the PMHC MDS suggest the services commissioned are reaching their target populations. The proportions of Aboriginal and Torres Strait Islander peoples and LGBTI-identifying people represented are substantially greater than the population fractions of those groups.

The service user survey indicates that almost half the respondents had used a service for the first time, specifically to manage suicidal thoughts or behaviours. This suggests the services are reaching people who had previously lacked an appropriate or accessible service or were experiencing their first episode of suicidality. Data confirms that aftercare services were reaching a high-risk population, with 53% of service users reporting a suicide attempt in their lifetime (including the attempt which preceded accessing the service). Moreover, psychiatric disorder diagnosis information available for 80% of clients in the PMHC MDS indicated that those using aftercare services had a high prevalence of psychiatric symptoms. Forty-seven per cent of service users for whom diagnostic information was available had a primary diagnosis of a mood or anxiety disorder, and an additional 30% had subsyndromal symptoms of a psychiatric disorder. Comorbidity was high with 79% of service users having more than one diagnosed disorder or subsyndromal symptoms of a disorder.

5.2.3 Impacts: improvement in service user suicidality and/or wellbeing

Consistent with the published evidence on the effectiveness of aftercare services, indications of improvement in suicidal thoughts and feelings, psychological distress and general wellbeing were observed, including:

- 75% of service users who completed the service user survey reported improved thoughts or feelings about suicide, 65% reported increased hopefulness about the future, and 72% reported improved overall wellbeing
- A statistically significant reduction in suicidal ideation (assessed using the Suicide Ideation Assessment Scale)

- A statistically significant reduction in psychological distress assessed using the Kessler psychological distress scale (K10)[3].

5.2.4 Impacts: integration and coordination of services

All aftercare services took a case management approach which involved establishing linkages with the services and agencies who referred into the service, and also linkages with services to which they referred clients. Two Sites established formal referral agreements with local hospitals.

Referral data from the PMHC MDS indicates that aftercare services were in contact with, accepting referrals from and making referrals to health and mental health services, as well as some social support agencies and organisations.

The main referral in services and agencies were public hospitals, general practices, private practices (psychologists), not-for-profit community support organisations, Aboriginal and Torres Strait Islander health organisations and public mental health services.

The main organisations to which referrals were made were public hospitals, general practices, not-for-profit community support organisations, and telephone helplines. A smaller number of referrals were made to public mental health services, psychologists, Centrelink, drug and alcohol services, emergency departments (EDs), Aboriginal and Torres Strait Islander health organisations, and family support services.

5.2.5 Impacts: other

Overwhelmingly, service users completing the survey expressed satisfaction with services. They cited reasonable wait times, good consideration of their cultural background and/or sexuality and gender, and gave overall high ratings of the services. Other impacts noted included an increase in suicide literacy among service provider organisation staff and the development of a peer workforce.

5.3 Aftercare services – challenges

As described above, the main barrier to establishment of aftercare services at the majority of Trial Sites was time-limited funding of the Trial. Those Trial Sites that did implement aftercare services noted a range of challenges.

Workforce barriers included difficulties in the recruitment and retention of a suitably skilled aftercare workforce in regional and rural areas and the scarce peer workforce available. Another challenge was poor availability of services, including suitably qualified organisations to deliver the aftercare service and client exit planning, particularly for focus population groups.

Issues related to referrals included overly narrow initial referral pathways limiting client uptake of the service, and the need to build knowledge and trust with potential referrers – in particular to gain the confidence of hospital-based clinical staff to refer to non-clinical services.

The extended time required to plan and develop focus-population specific services(e.g., PHNs had to build solid relationships before commencing design of Aboriginal and Torres Strait Islander-specific aftercare services) delayed implementation.

---

[3] The K10 is a self-report measure of psychological distress used to identify people who need further assessment for anxiety and depression.

Clients regarded the fixed time period of the service model as a limitation, with service users expressing the view that they would like support to continue beyond the standard three-month service time.

6 Outputs and impacts: Focus population – Aboriginal and Torres Strait Islander peoples

This chapter presents a synthesis of the key findings from multiple data sources related to the Trial outputs and impacts for Aboriginal and Torres Strait Islander peoples. Detailed information about this focus population can be found primarily in chapters 11, 17-19, and 23.

As described earlier, the evaluation is limited in the extent to which the outcome or preventing suicide can be directly assessed. However, following the program logic, this chapter describes findings and learnings regarding the achievement of objectives in the implementation, output and impact steps of the evaluation program logic that lay the foundation for achievement of that final key outcome. It must be recognised that the general Trial program logic does not fully capture the social and emotional wellbeing approach which is fundamental for Aboriginal and Torres Strait Islander suicide prevention. However, it does provide a general framework for assessing Trial achievements. In this chapter, section 6.1.1 describes how the objective of establishment of strategies for suicide prevention for Aboriginal and Torres Strait Islander peoples was achieved, including how they were tailored to meet their needs, and promoted to achieve engagement. Section 6.1.2 describes the achievement of the primary output objective of people participating in Trial activities as well as outputs that support community participation, that is, if the activities met identified needs and expectations. That section also describes the impacts observed from the achievement of the output objectives including changes in knowledge and awareness, community capacity, social and emotional wellbeing, cultural competency and safety and other reported impacts. Additional impacts of the implementation of Trial activities for focus populations related to increasing coordination and service integration are also noted.

Seven Trial Sites developed and implemented suicide prevention activities and services focused on Aboriginal and Torres Strait Islander peoples. There was wide variation in how each Site approached the Trial, including the types of activities planned and implemented. Sites also encountered different challenges during the process.

6.1 What strategies were established for the targeting and delivery of suicide prevention service and activities for Aboriginal and Torres Strait Islander peoples?

6.1.1 Activity description

The Trial Sites commissioned a wide array of activities and services focused on Aboriginal and Torres Strait Islander peoples, reflecting different localised and placed-based approaches. Two Aboriginal and Torres Strait Islander aftercare services were established and 314 separate activities recorded in the community-based activity dataset. A range of research, framework and protocol development activities also took place.

Pika Wiya, the aftercare service developed and trialled in Country South Australia, is provided as a case study in Box 6.1.

Box 6.1 Case study: Pika Wiya aftercare service in Country South Australia

The Pika Wiya aftercare service, Australia's first Aboriginal-specific aftercare service, was co-designed and trialled in Port Augusta as part of the NSPT. Pika Wiya means "no sickness" in Pitjantjatjara language, and is the name of the Aboriginal Health Service Corporation that delivered the Aboriginal aftercare service. Following consultations with the local Port Augusta community in 2017, an Aboriginal Working Group was established by the Country South Australia PHN with membership from the Port Augusta Aboriginal and Torres Strait Islander community, including people with lived experience of suicide, and representatives from the local health network (LHN) and ACCHO. The Aboriginal Working Group undertook an intensive eight-month process to co-design the Pika Wiya aftercare service to meet the need for a holistic, integrated and community-centred response that embedded traditional healing, SEWB and mental health support for Aboriginal and Torres Strait people and their families who had experienced suicidal crisis.

The project produced two sets of guidelines, one for use in the ED at Port Augusta Hospital and the second for the community mental health team. Each offers a comprehensive staged approach to maintaining contact through admission and after discharge, with a mix of psychosocial, clinical and healing approaches. A strong focus on family and community is a key element of the aftercare model. Nukunu health worker Kym Thomas explains this well: "*We are looking at a program that takes in language, takes in culture, takes in a person's environment… it's a holistic package that is suited to the individual and the families, not just one client or individual".*

Clients and families using the Pika Wiya aftercare service have made impressive gains. Key informants reported that there were no repeat admissions to the ED for clients using the service. From December 2018 to December 2019, approximately 120 people were supported, with 13–20 referrals per month coming from the ED and ACCHO – a good indication that the service is meeting the most acute needs. Greater collaboration between clinical and cultural workers across the spectrum of mental health services has also been seen during the project, which has important flow-on effects for strengthening cultural safety and reciprocity of mainstream services.

Of the 314 activities for Aboriginal and Torres Strait Islander peoples recorded in the community-based activities dataset, most (42%) focused on suicide and mental health-specific awareness-raising and engagement. These activities included media and social campaigns, workshops and community engagement, wellbeing and connection events, and activities that provided information on where to get help. The case study of Yarns Heal in Box 6.2 describes an innovative, co-designed, large-scale campaign developed and trialled in Brisbane North.

Box 6.2 Case study: Yarns Heal, large-scale campaign in Brisbane North

Yarns Heal, an innovative large-scale suicide prevention campaign for, by and with Aboriginal and Torres Strait Islander LGBTIQ+ Brotherboy & Sistergirl peoples, was co-designed and rolled out in Brisbane North as part of the NSPT. Yarns Heal aimed to improve the SEWB of the "rainbow mob" as well as the broader Aboriginal and Torres Strait Islander communities in Brisbane North through community awareness raising using strengths-based narratives of resilience, power and pride.

Yarns Heal was developed through a deep and comprehensive co-design process between the Brisbane North PHN, Indigilez Women's Leadership and Support Group, gar'ban'djee'lum network and a community working group comprised of Elders, community members and representatives from local Aboriginal and Torres Strait Islander organisations. This was the first time that members of the Aboriginal and Torres Strait Islander LGBTIQ+ Brotherboy & Sistergirl peoples had led decision-making about, planning and the implementation of suicide prevention activity for Aboriginal and Torres Strait Islander peoples, which sets an important precedent for future localised work both in and outside the suicide prevention area.

The co-design process combined intensive consultations with local communities and drew on the expertise of an Aboriginal and Torres Strait Islander creative agency, We Are 27 Creative, to cocreate the artwork for the campaign with the Yarns Heal Community working group through live drawing. This artwork visually captured the key campaign messages: strength within family and kinship, connection to a vibrant and diverse community, and healing. Cultural resilience was built and restored through this process.

The result of the co-design process was a large-scale suicide prevention and awareness-raising campaign using posters based on the co-designed artwork and messaging distributed widely using social media, billboards and the radio. The core campaign messaging for the feature artwork was "*Woven Together*". It provides context of the cultural protective factors that build a sense connection and a sense of belonging to a supportive mob and community in tougher times. Woven Together illuminates the message of a community together as a strength in suicide prevention initiatives and that talking together and walking together creates an awareness of supporting each other.

Other campaign messaging was drawn from campaign ambassadors – both grassroots and well-recognised – including gay Aboriginal writer, actor and comedian Steven Oliver, whose message was "*Yarns do heal. They make your spirit strong. You are a cultural connector*". The Yarns Heal Youth Ambassador, Tiahni, connected her message to young Aboriginal and Torres Strait Islander peoples: "*Yarns make us strong, deadly and proud*".

The success of the innovative Yarns Heal process and campaign has attracted international recognition, and it has been adopted by several PHNs across Australia. Yarns Heal also informed the development of a related LGBTIQ+ community awareness campaign at Brisbane North – Talking Heals – which illustrates the power of Aboriginal and Torres Strait Islander leadership in promoting wellbeing for the whole Australian community.

Aboriginal and Torres Strait Islander cultural strengthening activities constituted just over one quarter of implemented Trial activities (26%), including arts programs connecting young people with Elders, on country camps and activities, women's and men's groups (including a young fathers' group).

Capacity-building programs for community members and service providers accounted for 19% of activities, and included Aboriginal-specific training programs such as Suicide Story, You Me Which Way, Aboriginal Mental Health First Aid, Liyan Natural Helpers, Kimberley Empowerment Healing and Leadership Program, and generic training programs such as SafeTALK, Accidental Counselling and Applied Suicide Intervention Skills Training (ASIST), plus some Train-the-Trainer programs. Two Sites offered scholarships for Certificate IV programs to support workforce capacity building.

Some professional development training in suicide prevention was provided for health, mental health and allied health professionals, as well as for community members.

Programs and services for at-risk individuals were also implemented, including equine therapy, Traditional Healers, a crisis phone-line with immediate follow-up, and aftercare services.

Finally, the development of referral pathways, a "no wrong door" suicide prevention and self-harm protocol, cultural safety frameworks, a local cultural model for suicide prevention, and assessment tools were also undertaken as part of the Trial.

6.1.2 Tailoring activities

Aboriginal and Torres Strait Islander Trial Sites were not guided exclusively by the LifeSpan or AAD frameworks. This was because the primary focus on suicide and mental health of these evidence-based frameworks was seen to be incompatible with the holistic understanding of SEWB that is central to Aboriginal and Torres Strait Islander peoples' identity and wellbeing.

Eight strategies were employed to promote the cultural safety and relevance of the Trial activities for Aboriginal and Torres Strait Islander peoples. Some activities required tailoring, while other Trial activities were developed from a grassroots perspective to respond to Aboriginal and Torres Strait Islander community needs and preferences.

Aboriginal and Torres Strait Islander-led

A strong preference emerged for Trial activities that were co-designed and/or operated by the local community, rather than mainstream activities that were modified for Aboriginal and Torres Strait Islander peoples. The main approaches to embedding Aboriginal and Torres Strait Islander leadership were co-design of the service with Aboriginal and Torres Strait Islander people; contracting Aboriginal and Torres Strait Islander organisations to deliver the service to ensure trust and cultural safety; involving Elders; and implementing existing activities developed by and for Aboriginal communities.

Healing and trauma-informed approach

Most Trial Sites approached the Trial activities by adopting a healing and trauma-informed lens, through which they recognised and worked with the pain and trauma in the community and created safe spaces for people to share their stories and experiences. A focus on healing involved emphasising community strengths and assets; connecting to each other and with Elders; building community; sharing cultural knowledge and connecting to country and culture; Traditional Healers; trauma-informed care; and narrative therapies as part of the service model in one of the Aboriginal and Torres Strait Islander-specific aftercare service. This approach also involved Aboriginal and Torres Strait Islander Trial staff creating a safe space and looking out for each other and community members when planning and delivering Trial activities, particularly in traditionally white spaces such as meetings with the PHN.

Social and emotional wellbeing approach

All stakeholders underscored the importance of adopting a SEWB approach to the Trial activities. SEWB is an Aboriginal and Torres Strait Islander conceptualisation of identity and wellbeing, in which disruption or imbalance leads to distress and/or suicide. In this way, the Trial's suicide prevention efforts were focused on responding to multiple sources of identity and wellbeing, including incorporating or embedding cultural practices, connection to country and family, support for families, and providing opportunities to foster a sense of responsibility and agency. Most Trial activities focused on SEWB were conducted using local Aboriginal and Torres Strait Islander staff. SEWB Trial activities across Sites embedded cultural practices, recognised the need for connection to culture to start a healing process, such as yarning circles, camps on country, making art and smoking ceremonies. All SEWB activities took place in a non-clinical or service-oriented setting through use of yarning, conversations, and informal settings (e.g., barbecues) to foster connection within communities.

Connection to culture

Many Trial activities for Aboriginal and Torres Strait Islander peoples involved embedding cultural practices, including cultural healing, the inclusion of traditional and cultural knowledge systems and protocols, holding separate sessions for men and women, and using culturally safe venues. Approaches to promote connection to culture were embedded within the SEWB focus of many Trial activities.

Community engagement approach

All Trial Sites adopted a community engagement approach which included holding community workshops and consultations, liaising with local Elders, employing an Aboriginal and Torres Strait Islander consultant and/or using an Aboriginal and Torres Strait Islander reference group. Key to this approach was the recognition that relationship building took time; this enabled, for example, the identification and lowering of barriers to participation for community members by providing transport and resources.

Cultural competence and safety

Efforts to embed cultural competence in mainstream services and organisations was undertaken across Trial Sites. This included development of safety plans and procedures (e.g., cultural safety policies and safety plans for the Site's community consultations). Some Sites adopted a more informal, broader focus on cultural safety throughout their work. The National Indigenous Suicide Prevention Strategy was cited as assisting in this process.

Aboriginal and Torres Strait Islander workforce delivering programs

All Trial Sites employed local Aboriginal and Torres Strait Islander people to deliver their programs and activities. Some Trial Sites employed Aboriginal and Torres Strait Islander project staff from local organisations with local knowledge and connections. Others employed Aboriginal and Torres Strait Islander health and SEWB staff to work at the PHN. The Aboriginal and Torres Strait Islander workforce in the Trial was seen as an important aspect of delivering culturally appropriate and safe programs and activities, as well as building and restoring workforce capacity for local Aboriginal and Torres Strait Islander peoples.

Client, family and community-centred approach

Trial Sites recognised and accommodated a diversity of local needs and preferences by providing clients, families and communities with a choice of activities and facilitating circumstances in which they felt confident and able to exercise their agency. For example, they adapted the cultural activities undertaken on cultural camps depending on the groups' preferences. Most Trial activities across Sites incorporated families and communities, recognising the importance of relational approaches to Aboriginal and Torres Strait Islander wellbeing and suicide prevention.

6.1.3 Activity promotion and recruitment

A range of strategies were employed to raise awareness of Trial activities and encourage participation by Aboriginal and Torres Strait Islander peoples. The key strategies for promotion and recruitment were through local sector networks (including the PHN and local Suicide Prevention Networks), word of mouth (including through ambassadors and local champions), promotional materials (including advertisements, flyers and emails), social media (e.g., Facebook) and local news media (e.g., radio, TV and newspapers). The need to build rapport and trust with community members and participants was particularly emphasised. This was largely achieved through face-to-face engagement and non-clinical settings in which the community defined what a safe space for activities and programs looked like for them (e.g., yarning circles). Some Sites provided resources (e.g., transport, food and camping gear) to participants of Trial activities to facilitate their engagement. Many Sites framed Trial activities through the strengths-based lens of wellbeing and life promotion rather than suicide prevention. Having said this, it is worth noting that community members did not necessarily associate the activities with the Trial or with the PHN.

6.1.4 Involvement of people with lived experience of suicide

The involvement of Aboriginal and Torres Strait Islander people with lived experience of suicide in the Trial planning and implementation phases (e.g., on Trial working groups, through consultation and as participants in Trial activities) was highlighted across data sources. Many members of the community and service providers involved in the Trial disclosed having lived experience of suicide and/or mental ill-health. The involvement of Aboriginal and Torres Strait Islander people with lived experience was seen as both important and novel in the Trial because their perspectives and viewpoints are rarely sought.

6.2 What strategies were found to be effective in preventing suicide deaths and suicidal behaviour for Aboriginal and Torres Strait Islander peoples?

6.2.1 Outputs: participation

An estimated 9821 people participated in the Trial activities focused on Aboriginal and Torres Strait Islander peoples, according to the community-based activity database. Most participants took part in activities in the area of community education and support services (*n*=8840). Approximately 1300 people attended activities targeted at the workforce, most of whom came from community health organisations and related services, Aboriginal and Torres Strait Islander service providers and other organisations, and volunteer or community groups.

6.2.2 Outputs: appropriateness (met needs and expectations)

Most stakeholders and documents indicated that the Trial activities had filled a service gap or met a local need, as indicated by uptake of Trial activities and/or Trial services operating at capacity, including with waitlists; referrals being made into Trial activities; and participants, community members and service providers reporting they valued and were satisfied with the Trial activities. There was wide variation in the gaps Trial activities and services were considered to fill, including gaps related to youth-focused activities; in-school programs; community capacity building; peer support; LGBTI-specific programs; and programs specifically targeting suicide prevention, providing mental health support and involving men’s groups. In contrast, some stakeholders reported that the Trial activities had not met local needs and expectations, or that it was too early to tell.

6.2.3 Impacts: increased awareness and knowledge

Increased community knowledge and awareness of community members and service providers as a result of the Trial awareness-raising activities, training programs and workshops was reported. Specifically, there was reference to increased awareness about suicide and knowledge about how to identify and support people who might be at risk of suicide, including where to go for support. It was noted at one Site that that increased knowledge and awareness was more widespread among service providers than the community.

6.2.4 Impacts: improved capacity

A range of capacity-building impacts were reported across Trial Sites. Most Trial Sites reported an increased capacity and confidence of community members to talk about suicide, and willingness and confidence to help someone use referral and care pathways (e.g., as community helpers). Aboriginal service providers and organisations were reported to have increased or restored capacity, skills and knowledge to run, facilitate and/or deliver activities themselves and deal with administrative processes and requirements to secure program funding. The Trial was also said to have had an important cultural capacity impact by building the next generation of leaders.

6.2.5 Impacts: improved social and emotional wellbeing

Many Trial Sites described important improvements related to SEWB for Trial activity participants. Improved SEWB impacts reported across Sites included connection with country and cultural identity, healing and strengthened wellbeing, and improved communication and connection with families and community. Young Aboriginal and Torres Strait Islander participants in Trial activities reported higher levels of engagement, increased confidence, empowerment, taking on leadership roles, and strengthened cultural identity.

6.2.6 Impacts: enhanced cultural competence and safety

Multiple Trial Sites reported enhanced cultural competence of the PHN staff and other non-Aboriginal service providers resulting from the Trial. The Trial increased awareness of the need for PHNs to integrate cultural competence across all elements of their work and commissioned services. This included new understandings that a healing and place-based approach was necessary to prevent suicide in Aboriginal and Torres Strait Islander peoples; an appreciation of the role that the PHN can play as a facilitator; supporting capacity restoration and a neutral third party to hold funds; changes in commissioning practices to allow smaller and different types of organisations to be funded; and commissioning cultural activities, not just health and health promotion.

Several Trial Sites felt that the PHN had improved workforce cultural competence during the Trial. For example, some PHN staff illustrated cultural competence during the Trial process by recognising that the PHN did not have to (and should not have been) involved in all decision-making processes and discussions. The Trial was also said to build the capacity of non-Aboriginal service providers to work with Aboriginal and Torres Strait Islander peoples, including by employing Aboriginal workers and through cultural awareness training.

While gains were reported across Sites in terms of cultural competence and safety, it was noted that real, sustainable change requires a long-term commitment and action across multiple levels of the service systems and was thus beyond the scope of the Trial.

6.2.7 Impacts: linkages and coordination

There was a wide range of perspectives on and indicators of linkages and coordination reported across the Trial Sites. In part, this reflected the different approaches to the Trial across Aboriginal and Torres Strait Islander-focused Sites, as well as different knowledge and awareness of the Trial from the stakeholders consulted. For example, community stakeholders at some Sites were not involved in or aware of the broader Trial governance structures.

Most Trial Sites were reported to have increased linkages and coordination structures as a result of the Trial. For most Trial Sites, the Trial catalysed organisations to come together, share information and work collaboratively in a way that was not occurring previously. For example, an Aboriginal Cultural Security Framework was developed at one Site, and formal agreements were established between health and social support organisations to implement that Framework. The Trial was also reported to foster and enhance existing partnerships between Aboriginal and Torres Strait Islander service provider organisations and non-Aboriginal NGOs and government services to implement and/or deliver Trial services and programs, including local Aboriginal-controlled organisations and community groups, mainstream suicide prevention and/or mental health organisations, drug and alcohol services, and government departments and schools. Most Trial Sites also established referral pathways to support service coordination and integration (e.g., through implementation of a “no wrong door" approach, see Box 6.3 below), including between mainstream and Aboriginal community-controlled organisations, hospitals, corrections/courts, schools, housing and Centrelink.

Box 6.3 Case study: "No wrong door" – the Kimberley self-harm & suicidal behaviours protocol

The *Kimberley Protocol on Deliberate Self-Harm and Suicidal Behaviours* is the first co-designed protocol to clearly outline an accessible pathway for human service agencies to work collaboratively to better identify and support Aboriginal and Torres Strait Islander people at risk of deliberate self-harm of suicidal behaviours in the Kimberley. The vision of the protocol is for Kimberley community members to experience "no wrong door" to accessing integrated services that meet all their SEWB and mental health needs, rather than requiring separate services for each concern. The protocol provides a tool for human services organisations to implement culturally appropriate and safe screening and/or assessment processes coupled with effective follow-up, support and safety planning.

The Drug, Alcohol and Mental Health Subcommittee of the Kimberley Aboriginal Health Planning Forum (KAHPF) developed the protocol. In 2018, the KAHPF endorsed it for implementation across the region, led by Kimberley Aboriginal Medical Services (KAMS) as an initiative of the Kimberley Aboriginal Suicide Prevention Trial and supported by the WA Primary Health Alliance. True to the collaborative intent of the protocol, all KAPHF member organisations in the Kimberley are responsible for its implementation.

Capacity building of frontline staff is key to the successful translation of the protocol into practice. Interactive training commenced in 2020, with a focus on the purpose of the protocol, using practical tools to undertake risk assessments and screening, and how to collaboratively develop a safety plan. In addition, the training included planning for discharge and local referral processes, including a local service mapping activity, and the importance of effective, proactive follow-up services and supports. Frontline human service staff participated in the training to increase their skills and confidence in the use of the protocol, including SEWB workers, alcohol, drug, and mental health workers, health clinic staff (e.g., Aboriginal health workers, nurses and GPs), community-based program workers, family support workers, and youth workers. This training is being developed into webinars to ensure the continuous upskilling of human service workers, accessible on the KAMS and WA Country Health Service websites, and distributed to human service agencies across the region.

A key part of these training workshops was to ask workshop participants to identify recommendations for forging strategic collaborations and integration between their agencies. The protocol and its first stages of implementation represent a big step forward and together for meeting the needs of Aboriginal and Torres Strait Islander peoples in the Kimberley. The Protocol was modified into a community-facing resource, *the Kimberley Toolkit: LIYAN Natural Helper's Program for Deliberate Self-Harm and Suicidal Behaviours*. This resource informed the development of the LIYAN Natural Helpers Training program for Aboriginal community members. This training aims to build understanding of deliberate self-harm and suicidal behaviours and how to recognise them, provides steps to guide Natural Helpers to support someone they are worried about, and information on the services and supports available.

In some Trial Sites, some of the service providers consulted felt that the Site had achieved no or little service coordination and integration in the local area, with connections between local services, the PHN and community being limited to information sharing rather than partnerships. Some community stakeholders also reported that the Trial had not addressed the need for wrap-around, integrated service responses.

6.2.8 Impacts: other

A reduction in the stigma around mental illness and/or suicide in the community was noted at several Trial Sites. Other impacts mentioned included decreased thoughts of self-harm, increased help seeking for suicide.

6.3 Aboriginal and Torres Strait Islander peoples – what challenges were encountered?

The NSPT encountered nine main types of challenges to the planning and implementation of Trial activities focused on Aboriginal and Torres Strait Islander peoples.

Structural and systemic challenges

Structural and systemic factors including disempowerment, racism, colonisation and intergenerational trauma were key drivers of suicide and barriers to effective suicide prevention in the Trial communities. All Trial Sites acknowledged that the service response planned as part of the Trial could not undo generations of disconnection from culture and country. All Trial Sites emphasised the racism inherent in mainstream services and government systems that was difficult to change in the life of the Trial, and which hindered Trial activities that relied on mainstream services and government agencies.

Existing services and systems

A lack of culturally competent mainstream support services was a key barrier to implementation of the Trial activities in most Sites. A lack of service capacity, including inadequate services, long waiting times, inflexible service criteria and a lack of integrated, wrap-around care were also challenges for the Trial, particularly in rural and regional areas.

Stakeholder engagement challenges

Difficulties in engagement and management of relevant stakeholders were reported at most Trial Sites. These related to inclusive representation, negotiating competing priorities of stakeholders, managing expectations and giving local stakeholders a voice in the Trial planning process. Trial Sites also noted a need for healing in the community before moving on to planning and rolling out activities, as well as consultation fatigue for smaller communities. Establishing relationships with local stakeholders, including community members, was also hampered by the lack of cultural competency of some non-Aboriginal stakeholders.

Lack of funding and resources

Trial Sites reported that the scope of the Trial was beyond the resources available, noting that operational resources were insufficient, and that staffing levels were insufficient and resulted in a reliance on volunteers. Some Trial Sites also reported tension between PHNs and ACCHOs over the control of funds.

Workforce challenges

Workforce challenges were identified at most Trial Sites related to the Trial Coordinator position, delayed recruitment or turnover of Trial staff and at contracted organisations. The complex and multifaceted skill set required of the Trial Coordinator to drive the Trial activities (i.e., community engagement skills, SEWB skills, administrative and reporting skills) generally meant that Trial Coordinators were highly skilled in some areas and required upskilling in other competencies. Most Trial Sites prioritised local knowledge and connection to communities, which meant that their staff then required training in other areas such as administration and reporting or suicide prevention training. Providing support for staff was identified as crucial because the role is challenging and they are at risk of experiencing vicarious trauma.

Uptake and/or access challenges

Most Sites noted challenges with access to and/or uptake of Trial activities, such as an inability to meet the high demand for Trial services and receipt of inappropriate referrals (e.g., aftercare services receiving referrals of young people when their service models were designed for adults only). Some Trial Sites reported that community members were reluctant or unwilling to engage, because more time was required to build trust and for participants to be familiar and comfortable with the programs and activities being offered.

Communication challenges

Some Trial Sites reported that community members were not aware of the Trial and/or could not distinguish activities implemented as part of the Trial from general suicide prevention activity in their area. Some Trials reported difficulty in keeping community stakeholders informed about the Trial after the initial rounds of consultation. Service providers from most Trial Sites reported challenges with what they felt was the PHN’s lack of communication and transparency. All Trial Sites expressed a desire for their PHNs to involve them and communicate genuinely and openly.

Lack of data

A lack of data at the local level was cited as a key problem for Trial planning and ongoing monitoring and evaluation of the Trial activities. For example, existing data did not capture information on holistic elements of SEWB or real-time local data on suicides.

COVID-related challenges

All Sites discussed the negative effects of COVID-19 on the implementation of Trial activities. These included delays in the implementation and delivery of activities/programs, having to switch to online activities, losing momentum, a loss of engagement and community relationships, lack of access to technology, and impacts on people’s mental health. Many Trial Sites adopted innovative and responsive ways to deal with the impacts of COVID, such as switching to online meetings and activities, engaging people through social media, and setting up phone trees to check on community members.

7 Outputs and impacts: Other focus populations

This chapter presents a synthesis of the key findings from multiple data sources related to the Trial outputs and impacts for focus populations – men, young people, ex-ADF members and their families, LGBTI people and older adults. Detailed information about these focus populations can be found primarily in chapters 11, 12, 14, 16 and 23.

The evaluation questions structuring this chapter include the key outcome of preventing suicide among focus population groups. As described earlier, the evaluation in limited in the extent to which that outcome can be directly assessed. However, following the program logic, this chapter outlines findings regarding the achievement of objectives in the implementation, output and impact steps, that lay the foundation for achievement of that final key outcome. Specifically, sections 7.1.1 – 7.5.1 describe how the objective of establishing strategies for suicide prevention for each focus population was achieved, including how they were developed and promoted to meet the needs of focus population groups. Sections 7.1.2-7.5.2 describe, for each focus population, the achievement of the primary output objective of people participating in Trial activities including the extent to which those activities met the needs and expectations of focus populations. Those sections also describe the impacts observed from the achievement of the output objectives including changes in knowledge and awareness, help seeking and service use, and other reported impacts. Additional impacts of the implementation of Trial activities for focus populations with respect to increasing coordination and service integration are also noted.

7.1 Focus population – men

Six Trial Sites identified men as a focus population, in three cases also focusing on more specific cohorts including farmers, fishers, miners and older men.

7.1.1 What strategies were established for the targeting and delivery of suicide prevention service and activities for men?

Activities implemented

There were no male-specific aftercare services or other clinical services established as part of the Trial. One hundred and eighty-nine activities entered into the community-based activities database (21% of the total) were marked as targeting men. Table 7.1 details the types and proportions of activities targeting men.

Table 7.1 Types of activities for men

Activity type	%
Awareness raising and engagement	29.3
Capacity building	64.6
Professional development and training for GPs, health and mental health workforces	2.8
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	1.7
Implementation of guidelines, standards and other quality improvements	.06
Other	1.1

Capacity building was the most common activity targeting men. This included providing evidence-based training programs such as Question, Persuade, Refer (QPR) and ASIST, and programs for which evidence is still being developed, such as Tomorrow Man. The MATES in Construction program, and variations for mining and farming, were run at all six Sites. MATES offers General Awareness Training in workplaces, as well as a 'Connector' program in which individuals receive additional training to recognise workmates who may need help and connect them with support services. MATES programs have some evidence of effectiveness, and are currently undergoing further evaluation.

Awareness-raising and engagement activities were the next most frequently implemented activity, accounting for 28% of all activities. Male-specific workshops and events based on a range of awareness programs, such as Stop Male Suicide, I'm Not Afraid to Talk, and Save our Mates, many of which focus on stigma reduction, redefining masculinity, and help seeking, were delivered and have yet to be evaluated. Other activities included media campaigns featuring and aimed at men, community events with guest speakers, often with lived experience of suicide, and the distribution of information at public events such as farming field days.

Tailoring activities

There were two main approaches to tailoring suicide prevention activities for men. The first involved implementing training programs, workshops and campaigns created specifically for men, as described above. The second was delivering training or conducting awareness-raising activities in environments where men gather (e.g., male-dominated workplaces, sporting clubs).

Other, less-used tailoring strategies were adopting a whole-of-community approach and targeting partners, taking a general wellbeing non-health approach, and involving men with lived experience of suicide as peer educators or community champions.

Activity promotion and recruitment

Men were considered to be a difficult-to-engage population, so the approach described above of delivering programs in workplaces was the most commonly used recruitment strategy. Using community champions was also considered an effective strategy to promote suicide prevention activities, as was reaching men through their close support networks.

Involvement of people with lived experience of suicide

The involvement of men with lived experience of suicide was seen as an effective strategy for engaging men in suicide prevention activities. Several Sites supported more men with lived experience to take on that role by providing training (through Roses in the Ocean).

7.1.2 What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among men?

Outputs: participation

Consultations generally showed that there was a good uptake of activities targeting men, if not by men themselves, then by their partners. Table 7.2 indicates participation in activities targeted at men, noting that not all participants would have been men.

The workforce was the focus of 44% of activities for men. Fewer than 10% of workforce-focused activities were targeted at health workforces, first responders, or education, while 81% were described as "other workforces". This reflects the overall approach of delivering programs directly to men via male-dominated workplaces (e.g., steel mills, construction sites, local councils), rather than training the broader sector to be more responsive to men at risk.

Table 7.2 Men: Activity type and participant numbers

Activity type	Participants*
Awareness raising and engagement	2063

Activity type	Participants*
Capacity building	2310
Professional development and training for GPs, health and mental health workforces	71
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	58
Implementation of guidelines, standards and other quality improvements	13
Other	23
Total	4538

* Participant numbers for 11 activities are missing because they were not provided or were censored; they were estimated audience reach numbers for media and campaigns based on the population catchment area, so overestimated participation.

Outputs: appropriateness (met needs and expectations)

Men have consistently higher suicide rates than women in all age groups in national data, so in broad terms any suicide prevention strategies targeting this part of the population are addressing a need. As with general population activities (described below) , there was no systematic quantification of gaps in terms of activities and services for men beyond general service availability gaps identified in regional areas. Stakeholder consultations were the primary source of information needs for this population group. Stakeholders from PHNs and communities considered the activities delivered as part of the Trial met needs and that they had been well received.

Impacts: increased awareness and knowledge

Information on changes in awareness and knowledge was obtained from documents provided to the evaluation, including a small number of pre-post and post-only questionnaires, and reports of informal and anecdotal feedback in documents and from consultations with PHN Trial staff and service providers. Impacts reported by those sources included improvements in:

- General awareness about mental health and suicide
- Knowledge about suicide
- Knowledge about how to help/where to get help
- Confidence to help
- Intention to help
- Willingness to seek help for self.

Many of the training programs targeting men have some evidence base supporting their effectiveness in raising awareness, knowledge, and improving willingness and confidence to intervene to offer aid, which could be expected to be replicated.

Impacts: increased service use

There were anecdotal reports from one Site of increased numbers of men seeking help from GPs. Analysis of the PMHC MDS did not show any increased uptake of PHN-funded mental health services by men attributable to the Trial.

Impacts: Integration and coordination

A few small and local instances of improved coordination of suicide prevention activity focused on men was noted, although improvements overall coordination within Trial Sites will be relevant to men. New linkages related to suicide prevention activities focused on men were formed between offer PHNs and organisations providing activities as part of the Trial, primarily Mates in Construction.

Impacts: other

Reporting from Mates in Construction indicated that men who had been trained to be connectors had made referrals to services. Other impacts noted in anecdotal reports included that men had used skills learnt in training programs to help others or had sought help for themselves; there was less stigma and a greater openness to talking about suicide; lives were saved; participating as trainers in Trial funded-activities had been healing for men with lived experience of suicide; and there had been a general fostering of community connection.

7.1.3 Men: what challenges were encountered?

Several challenges related to planning suicide prevention activities for men, including difficulty in engaging men directly in Trial planning, the lack of evidence on effective interventions for men, and the scarcity of experts on men's mental health and suicide in regional areas. It was noted that men are not perceived as a minority population, so there was difficultly in engaging stakeholders to focus on this group. Moreover, it was a challenging to effectively target activities for such a broad and heterogenous group.

In terms of implementation, for programs delivered in places where men congregate, several barriers were noted around getting access to and buy-in from those Sites – industries and workplaces in particular. Administrative requirements and process have to be negotiated, and without a champion in a management role arranging time off for training, venues and encouraging participation, gaining access was difficult. It was also noted that stigma about mental health and suicide remains a major barrier to engaging male-dominated organisations.

Stigma was also considered to be a barrier to engaging men to participate in mental health or suicide prevention activities.

7.2 Focus Population – young people

Two Trial Sites specifically identified young people in the general population as a focus population, with one focusing entirely on young people. Five other Sites offered programs or activities for young people by including them in their chosen focus populations (Aboriginal and Torres Strait Islander peoples, LGBTI people).

7.2.1 What strategies were established for the targeting and delivery of suicide prevention service and activities for young people?

Activities implemented

Aftercare services established as part of Trial activities were not designed to cater to young people and the service models generally explicitly excluded them.

One hundred and twenty-three activities entered into the community-based activities database (17% of the total) were marked as targeting young people. Table 7.3 details the types and proportions of activities targeting young people. (Cultural strengthening activities for Aboriginal and Torres Strait Islander young people are described in Chapter 6.)

Table 7.3 Young people: Activity types

Activity type	%
Awareness raising and engagement	54.5
Capacity building	30.9
Professional development and training for GPs, health and mental health workforces	0

Activity type	%
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	8.9
Implementation of guidelines, standards and other quality improvements	0.8
Other	4.9

Overwhelmingly the main focus of activities recorded in the community-based activities database was *awareness raising and engagement,* aimed at both young people and those who work with them. Activities included media and social media campaigns and community awareness-raising events such as building RU OK benches in Schools.

Capacity building activities (including QPR) were delivered to people who work with young people, particularly teachers and other school staff, or young people themselves (primarily Youth Aware Mental Health, which was delivered in schools). Several other activities were focused on GPs, such as developing a training resource for GPs for working with young people, and establishing GP referral pathways for young people.

Other activities included providing small grants for community events, developing a postvention response, developing referral pathways and conducting youth camps.

Tailoring activities

The main approaches to developing and tailoring Trial activities focused on young people included selecting existing programs that were purposely designed for young people, developing media and social media content specifically for young people, delivering activities via school, and peer delivery of activities. They involved stakeholders from organisations that work with young people in activity planning, including headspace, and collaborations with youth services and organisations and local council youth programs. Another strategy for tailoring activities focused on young people was targeting people who support youth, including parents and teachers.

Activity promotion and recruitment

Few promotion and recruitment strategies were described. By far the most common approach was to try and deliver the activity where the audience is usually found, that is, schools or other places where youth congregate, and local council youth groups. Media, and particularly social media, were important vehicles for promoting Trial-related activities to young people.

Involvement of people with lived experience of suicide

Young people with lived experience of suicide were involved in planning at two Sites, which collaborated with headspace to ensure they were properly supported. Lived experience training for young people was also offered at two Sites.

7.2.2 What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among young people?

Outputs: participation

Table 7.4 indicates participation in activities focused on young people.

Table 7.4 Participation numbers in young people-focused activities

Activity type	Participants*
Awareness raising and engagement	3962

Activity type	Participants*
Capacity building	913
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	16
Implementation of guidelines, standards and other quality improvements	2
Other	802
Total	5695

* Participant numbers for two activities are censored because they were missing or were estimated audience reach numbers for media and campaigns based on the population catchment area, so overestimated participation.

Only 20 activities focused on young people were workforce related (16%). The main workforces targeted were community health organisations and related services, schools or other educational institution personnel, and volunteer or community groups providing services or support.

In consultations, one Site reported substantial uptake of QPR training by teachers in schools in the region, with over 500 trained. Service providers at three Sites reported good attendance and participation in activities they delivered.

Outputs: appropriateness (met needs and expectations)

Stakeholders considered that Trial activities for young people met an identified need, were useful, and complemented PHN activities and services already commissioned. They also noted gaps that were not addressed, specifically for LGBTI young people, and young people who are not engaged with services.

Impacts: increased awareness and knowledge

Changes in awareness and knowledge were noted in summaries of pre-post and post-only questionnaires and reports of informal and anecdotal feedback. Outcomes reported by those sources included improvements among young people in:

- General awareness about mental health and suicide
- Knowledge about suicide
- Knowledge about how to help/where to get help
- Confidence and intention to help.

A case–control evaluation at one Site found that young people felt more supported in schools where staff had undertaken QPR training than in schools with no QPR-trained staffed. School staff and other who had undertaken evidence-based programs such as QPR could be assumed to have gained skills and knowledge that have been demonstrated in the evidence.

Impacts: increased service use

There were anecdotal reports of increased help seeking by young people. Analysis of the PMHC MDS did not observe any increased uptake of PHN-funded mental health services by young people attributable to the Trial.

Impacts: integration and coordination

The two Trial Sites with an explicit focus on young people both established strong linkages with headspace as the key youth organisation. headspace was involved through membership of Trial Committees, co-locating a Trial youth project officer at headspace, commissioning headspace to deliver activities, and involving the headspace youth reference group in planning. headspace was also involved as a stakeholder at Sites without a declared youth focus, but which included activities for young people belonging to their other focus populations.

Other linkages pursued through Trial Committees included with youth services, NGOs, schools and state education departments. At one Site a local school network, made up of school principals, local youth service providers, clinical representatives from the local hospital, the local youth and family team and the PHN, was established and provided guidance to the Trial Site.

Some improved local coordination was observed, including the development of a coordinated postvention response protocol; the development of information on service availability and pathways for young people to access services; and connecting existing resources for young people within the system including GPs and headspace centres.

Impacts: other

There were anecdotal reports of a reduction in stigma in talking about suicide among young people and community members.

7.2.3 Young people: what challenges were encountered?

The most common challenge encountered was obtaining buy-in from schools and education departments, which hindered the implementation of suicide prevention activities. Accessing schools was difficult for several reasons, including schools being hesitant to participate due to being generally risk averse or concerned about managing duty of care issues, education department unwillingness in terms of teacher training initiatives, and the challenge of integrating suicide prevention with other mental health, health and general wellbeing initiatives targeted at young people via schools.

Other challenges included engaging meaningfully with young people in planning and governance; difficulty in engaging GPs; the lack of services in general for young people in regional areas, or lack of service capacity to meet demand; lack of parental engagement; and ensuring the safety of young people who were delivering programs or activities.

7.3 Focus population – ex-ADF members and their families

A single Site focused on suicide prevention for ex-ADF members and their families.

7.3.1 What strategies were established for the targeting and delivery of suicide prevention service and activities for ex-ADF members and their families?

Activities implemented

No aftercare services were commissioned, in keeping with an overall focus of the Site on “upstream factors”[4] and due to concerns about the sustainability of new services at the conclusion of the Trial.

As would be expected for a single Site, in the community-based activity database, fewer activities were noted as specifically targeting ex-ADF members and their families than for other focus populations. However, a range of general population activities were also undertaken at that Site which were not included in that count. Moreover, many of the activities implemented were recurring, such as weekly support sessions, but are recorded as a single activity in the database. Table 7.5 details the type of activity and proportion of activities directly targeting ex-ADF members and their families.

---

[4] Upstream factors refers to psychosocial and situational factors that may make an individual more vulnerable to mental illness and suicidal thoughts and acts.

Table 7.5 Ex-ADF members and their families: Types of activities

Activity type	%
Awareness raising and engagement	20.7
Capacity building	17.2
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	55.2
Implementation of guidelines, standards and other quality improvements	3.5
Other	3.5

Over half the activities were coded as information, services or other activities for high-risk groups of people, in that they focused on creating connections for socially isolated ex-ADF members considered to be at risk. Those activities were not overtly focused on suicide prevention or mental health. They included community grant-funded activities for ex-ADF members such as volunteering to help drought-affected farmers, exercise classes, forming a dragon boat team, and art workshops. A flagship development was a peer-worker program which was adopted by Open Arms, a Department of Veterans Affairs (DVA) agency which provides psychological counselling and support for ex-ADF members.

The range of *awareness raising and engagement* activities included media and social campaigns developed with the assistance of a professional communications agency, and community events.

Capacity-building activity consisted of the delivery of training programs, including the Community Based Response to Eliminating Suicide and Conversations for Life programs.

Implementation of guidelines activities involved training on the responsible reporting of suicide guidelines for the media.

Other activities undertaken included developing health pathways for ex-ADF members, supporting research related to Traumatic Brain Injury, and providing funding support to a community advocacy and support agency that assists ex-ADF members make DVA claims.

Tailoring activities

A range of strategies were employed, most of which were aimed at tailoring the overall approach of the Trial rather than individual activities. They included adopting an overall focus on connected and wellbeing rather than suicide prevention; recognising and working with rank and hierarchy within the ex-ADF community; developing an understanding of the ADF and ex-ADF culture, including their psychology and language; and broadening the scope of the Trial to include families in order to reach those who support ex-ADF members.

At the intervention level, selecting training programs that were more acceptable to ex-ADF members (i.e., those with Australian rather than United States content) was an instance of tailoring.

Activity promotion and recruitment

Recognising that higher-risk ex-ADF members were more likely to be disconnected from and possibly distrustful of mainstream DVA programs, promotion focused on establishing a distinct identity for the Trial and branding was developed to make clear the programs were not DVA. A communications company was engaged to develop the branding strategy.

Other promotion strategies used included capitalising on the high profile of the Steering Committee chair and using local networks, including the local suicide prevention network, ex-ADF networks and organisations, as well as the networks of the Steering Committee and Working Group members, to promote Trial activities.

Word of mouth and community champions were key strategies for engaging those who were distrustful of official DVA and ADF agencies and services. The Trial Site also undertook a sustained and professionally produced campaign of media activity, including local media and social media, to both promote Trial activities and raise awareness around the key wellbeing and connectedness messages.

Involvement of people with lived experience of suicide

Ex-ADF members with lived experience of suicide were involved throughout the Trial planning and in delivery of activities. It was considered that ex-ADF members with lived experience of suicide play an important role in reducing the stigma around help seeking and vulnerability that is inherently present in the defence forces. Training for people with lived experience of suicide to become advocates and share their stories safely was also provided as part of the Trial. What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among ex-ADF?

Outputs: participation

Seven hundred and seventy-one people participated in the community-based activities for ex-ADF members and their families, and stakeholders reported that activities were well attended. Table 7.6 gives a breakdown of participant numbers.

Table 7.6 Activities focused on ex-ADF members and their families: participation numbers

Activity type	Participants*
Awareness raising and engagement	160
Capacity building	181
Professional development and training	0
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	402
Implementation of guidelines, standards and other quality improvements	8
Other	20
Total	771

* the participant # is missing for one activity because it was a large media campaign.

The participation numbers in Table 7.6 exclude those for a multi-platform media campaign, Check Your Mates – a major Trial activity. The campaign was focused on getting community members to check on a friend at times of the year when socially isolated individuals may be at increased risk (e.g., Anzac Day, Christmas). Data show there were over a million engagements with the social media campaign, mostly among men in their early 20s and 30s, a group which would include many ex-ADF members.

Eleven activities were recorded as being workforce focused. These aimed at raising awareness or building capacity in workforces which had a high representation of ex-ADF members, such as first responders, or health and support service provider agencies which would have ex-ADF member clients.

Outputs: appropriateness (met needs and expectations)

Stakeholder considered that Trial activities focused on ex-ADF members complemented existing PHN activities, because ex-ADF members had not been identified as a population group in PHN service planning. It was also noted that the Trial represented the first instance of an empowerment approach being taken to address ex-ADF mental health and wellbeing. Stakeholders felt that there were gaps remaining around transition out of the services that required attention.

Impacts: increased awareness and knowledge

Information on changes in awareness and knowledge was obtained from documents provided to the evaluation, including feedback surveys from training programs and engagement activities, reports of informal and anecdotal feedback, and reports from consultations with PHN Trial staff and service providers. Outcomes reported included improvements in:

- General awareness about mental health and suicide
- Awareness and knowledge about suicide
- Awareness of available health, mental health and financial and employment services.

Impacts: integration and coordination

At this Site a high level of coordination was achieved through the establishment of a robust and inclusive governance structure and close collaboration with a general-population suicide prevention network. The Steering Committee brought cross-agency and cross-interest group organisations together and facilitated linkages between health and mental health sector and ex-serviceperson and veteran support services.

Key linkages formed were with the DVA; the OASIS, which is a new ex-ADF members wellbeing centre being launched in the region; the local hospital and local private psychiatric inpatient hospital; and the local suicide prevention network.

The local suicide prevention network was a key partner, with strong representation on the Trial Steering Committee and leading one of the Working Groups in a funded role. There was close coordination of events and activities between the Trial and the local suicide prevention network.

There were links with the ADF at a local level, through locally based senior personnel, but not at the departmental level. Established ex-ADF organisations, such as the Returned & Services League (RSL), were included in consultations but did not have a strong presence on the Trial Committees.

Impacts: other

There were anecdotal reports of a reduction in return to psychiatric inpatient care following participation in a wellbeing program; increased help seeking; men checking on mates; upscaling of the peer program nationally by Open Arms; that participating in Trial programs, especially in community grant programs, “saved lives”; and a reduction in stigma due to people having more open conversations about suicide.

Multiple stakeholders considered the community grants program to be a novel mechanism to empower ex-ADF individuals.

7.3.2 Ex-ADF members and their families: what challenges were encountered?

Several challenges were identified in the planning and implementation of suicide prevention activities for ex-ADF members and their families. Ex-ADF members and their families are a scattered population, and although some localities may have a more concentrated population and be amenable to place-based approaches, it can be hard to balance relevance to local conditions with scalability. The lack of data on suicide among ex-ADF members is a challenge for planning. The diversity of the ex-ADF population, including young men, First Nations peoples and LGBTI people, needs to be considered. In addition, reaching isolated ex-ADF members and engaging with those who mistrust civilian services but also DVA and ADF affiliate services is a challenge.

Other challenges include managing relationships in the context of competition between organisations in the ex-ADF sector, negotiating the culture clash between ADF background and civilians, and COVID-related obstacles to the delivery of Trial activities.

7.4 Focus population – LGBTI people

Two urban Sites elected to focus on LGBTI people, with one focusing exclusively on that group.

7.4.1 What strategies were established for the targeting and delivery of suicide prevention services for LGBTI people?

Activities implemented

Both Sites commissioned aftercare services, because they determined that this was a service gap insofar as LGBTI people often did not feel safe presenting to mainstream services.

One hundred and fifty-two activities entered into the community-based activities database (21%) were classified as focusing on LGBTI people. Table 7.7 details the types and proportions of activities targeting LGBTI activities.

Table 7.7 LGBTI people: Types of activities

Activity type	%
Awareness raising and engagement	26.3
Capacity building	40.1
Professional development and training for GPs, health and mental health workforces	14.5
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	11.8
Implementation of guidelines, standards and other quality improvements	2.0
Other	5.3

Awareness and engagement activities included media and social media campaigns, participation in Pride Day events and hosting community events.

Capacity building activities included SafeTALK, ASIST and Mental Health First Aid. Capacity building in suicide prevention was aimed at specialist LGBTI services.

Activities focused on *professional development and training* for general practice and health professionals included delivery of Advanced Suicide Prevention Training to GPs. Another focus professional development activities was making general practices and health services culturally safe for LGBTI people, and at one Site an affirmative practice module was developed and delivered.

Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide, aside from the aftercare services, included individual and family mentoring programs and social connection and support activities.

Other activities included research on peer support, establishing a community of practice and developing health pathways for LGBTI communities.

Tailoring activities

The overall co-design process was the mechanism for ensuring activities were tailored for the LGBTI community. It involved adopting a trauma-informed approach and considering the intersectional issues facing communities in the planning process.

At the activity level, tailoring activities included involving specialist LGBTI organisations in developing and delivering activities and adapting existing training programs such as SafeTALK to become LGBTI inclusive and affirmative. At one Site, a whole-of-population campaign was undertaken to reach people who don't necessarily align themselves with the LGBTI community.

Activity promotion and recruitment

Promotion and recruitment for the aftercare services are described in Chapter 5. The main avenues for promoting programs and activities were word-of-mouth and referral among commissioned providers. The delivery of activities by established and trusted specialist LGBTI organisations was key to getting people to participate and engage.

Involvement of people with lived experience

People with lived experience of suicide were involved in a range of ways, including through activity delivery as a peer workforce, in the planning and design of Trial activities, participating in lived experience training, and participating in tender evaluation panels. It was also noted that often stakeholders participating in some other capacity had lived experience of suicide, and that it was important to be cognisant of which "hat" they were wearing at a particular time.

7.4.2 What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among LGBTI people?

One Site has commissioned an evaluation of the Trial activities and services, but its results were not available to the national evaluation. Impacts identified for aftercare services are discussed in Chapter 5. This section describe the outputs and anticipated impacts from the other Trial activities focused on LGBTI people.

Outputs: participation

Consultations generally showed that there was a good uptake of activities for LGBTI people, including their being waitlists for aftercare services and other Trial programs, and requests for additional training. Table 7.8 provides participant numbers for LGBTI-focused activities by type.

A total of 1981 people participated in workforce-focused activities. Community health organisations and related services were the primary target workforce, reflecting the focus on building suicide prevention capacity in specialist LGBTI services and organisations.

Table 7.8 Community-based activities targeted at LGBTI people

Activity type	Participants*
Awareness raising and engagement	1068
Capacity building	887
Professional development and training	1063
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	498
Implementation of guidelines, standards and other quality improvements	99
Other	17
Total	3632*

* Participant numbers for 19 activities are missing because they were not provided or were censored due to being estimated audience reach numbers for media and campaigns based on the population catchment area, so overestimated participation.

Outputs: appropriateness (met needs and expectations)

Providing LGBTI-focused aftercare services met an identified need, because no such services existed previously in either PHN. Stakeholders agreed that LGBTI people often did not feel safe presenting to mainstream services. Trial services and activities complemented existing PHN services, because neither offered mental health or suicide prevention programs to this population specifically. They also complemented activity offered by specialist LGBTI services who did work related to alcohol and drugs or mental health, but not suicide prevention specifically.

Impacts: increased awareness and knowledge

Information on changes in awareness and knowledge was obtained from documents provided to the evaluation, including pre-post and post-only questionnaires, reports of informal and anecdotal feedback, and reports from consultations with PHN Trial staff and service providers. Outcomes reported included improvements in:

- General awareness about mental health and suicide
- Knowledge about suicide
- Knowledge about how to help/where to get help
- Capacity to respond to suicidality within the community.

There was no information available on improvements in cultural safety for LGBTI people at mainstream services.

Impacts: increased help seeking

Anecdotal information from consultations suggests increased service referrals and uptake of services. Data from the PMHC MDS was not suitable for investigating changes in mental health service use in this focus population.

Impacts: integration and coordination

At both Sites the Trial created new collaborations and coordination between organisations, some of which were formerly in competition and fragmented. It was recognised that this coordination was mainly between specialist LGBTI organisations, and there is still work to be done to achieve greater integration and coordination with mainstream services. Improved coordination of suicide prevention programs with other programs and services for LGBTI people occurred within commissioned provider organisations.

Impacts: other

Anecdotal reports identified an increase in the suicide prevention workforce capacity by building a peer workforce; empowering the community through taking a community-led approach to the Trial in general; and building the evidence base for LGBTI suicide prevention through research and evaluation.

7.4.3 LGBTI people: what challenges were encountered?

While ultimately a successful process, the co-design process was lengthy and required some difficult conversations to reduce pre-existing tensions or competitiveness and form solid relationships.

Other challenges were accommodating the diversity of the LGBTI population, including intersectional identities, and the limited capacity of small volunteer-run community organisations to participate. Historical competition for funding had resulted in distrust across the sector, and the dominance of large organisations meant relationships took time to build. One Site encountered resistance from schools to LGBTI-focused training programs. In common with other focus populations, the lack of evidence on the most effective and acceptable interventions was an obstacle for planning.

7.5 Focus population – older adults

A single Site elected to focus on older adults.

7.5.1 What strategies were established for the targeting and delivery of suicide prevention service and activities for Older Adults?

Activities implemented

There were no aftercare services or other clinical services for older adults established as part of the Trial. Other activities focused on older adults included PHN-level and local initiatives. In total, there were 12 activities recorded in the community-based activities database (1.1% of the total).

Most activities for older adults (66.7%) consisted of *awareness raising and engagement*, and included activities primarily aimed at those who work with older adults, although there were activities provided for older adults themselves. Activities included community champion-facilitated events and conversations with older people. These activities were about wellbeing and social isolation, rather than suicide or mental health explicitly.

A small number of *capacity building* activities were delivered, including Mental Health First Aid for Older people, and SafeTALK.

Other activities included creating a service directory, providing community grants for small outreach events aimed at reducing social isolation rather than directly addressing suicide prevention, and the development of a suicide response plan.

Tailoring activities

The main strategies for tailoring activities to suit older adults were delivery of training programs or workshops specific to suicide prevention in older adults; collaborating with organisations which work with older adults; and focusing on wellbeing and taking a social isolation perspective.

Activity promotion and recruitment

Promotion strategies included enlisting community champions, word of mouth and creating a poster campaign to raise awareness of activities. In order to reach socially isolated older adults in the general community population-wide campaigns were implemented.

Involvement of people with lived experience of suicide

Older adults with lived experience of suicide were involved as members of the Trial Committee and as community champions who delivered awareness activities and events.

7.5.2 What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among older adults?

Outputs: participation

Over 700 people participated in activities recorded in the community-based activity dataset, the overwhelming majority of whom attended awareness-raising and engagement events.

Outputs: appropriateness (met needs and expectations)

Little information was gathered regarding the appropriateness of Trial activities, but stakeholders mentioned in consultations that Trial information and awareness activities facilitated connections between older adults and services that did not exist prior to the Trial.

Impacts: increased awareness and knowledge

A single post-activity participant feedback report indicated benefits from participation in an expert workshop in terms of being more knowledgeable about suicide and its causes, how to help someone who may be at risk, and where to get help. Community stakeholders considered good progress had been made in raising awareness about the social isolation of older adults and the available support services, but not specifically about suicide, because that was not the aim of the majority of activities.

Impacts: integration and coordination

Stakeholders described the development of linkages between the PHN and mental health service providers, local councils and other community organisations working with older adults (e.g., the RSL). One staff member mentioned that the PHN had engaged with the Council of the Ageing but that this had not led to their substantive involvement in the Trial..

Linkages were made with existing older adult community groups to provide suicide prevention information, although not explicitly about suicide or mental health but instead framed around social isolation and wellbeing.

Impacts: other

Community members assumed that community connection and discussions about social isolation and wellbeing would reduce social stigma around mental health, but no evidence is available.

7.5.3 Older Adults: what challenges were encountered?

An overall challenge was the inability to achieve substantive buy-in from stakeholders, including local organisations contracted to implement Trial activities. Engaging the aged-care sector and building partnerships was difficult, because it does not see suicide prevention as its core business. Moreover, competition between service providers was a barrier to engaging stakeholders in the sector. The general lack of time of key health sector stakeholders, including GPs, hospital staff and aged care workers, to participate in the Trial was a challenge.

Barriers to direct engagement with older adults were noted, including that this is a broad and diverse population group, and the difficulty in reaching those who are not in contact with aged care support services or aged care.

There was resistance to specifically targeted suicide prevention due to stakeholder preferences for focusing on wellbeing and social isolation, and reaching older adults through their children or families was not explored as an option. COVID-19 was a significant challenge due to the vulnerability of this focus population.

Outputs and impacts: General population

Although the Trial was designed to focus on priority population groups, most Trial Sites also implemented activities for the general population. Sites with a single focus population often included some general population activities as a way of reaching members of their focus population who may not identify with that population or participate in focused activities. This chapter discusses Trial activities that were not described in the context of a particular focus population group. It presents a synthesis of the key findings from multiple data sources related to the Trial outputs and impacts for the general population. Detailed information about general population activities can be found primarily in chapters 11, 12, 14, 16, and 23.

Following the program logic, this chapter outlines findings and learnings regarding the achievement of objectives in the implementation, output and impact steps. Specifically, section 8.1 describes how the objective of implementation of community-based activities for the general population was met, including types of activities and how they were promoted. Section 8.2 then describes the key output of community participation as well as outputs that support community participation, that is if the activities met identified needs and expectations. Section 8.2 also describes the impacts resulting from the achievement of output objectives, including changes in awareness and knowledge, community capacity, mental health service use and other impacts. Additional impacts of the implementation of Trial activities for the general population with respect to increasing coordination and service integration are also noted.

7.6 What strategies were established for the targeting and delivery of suicide prevention service and activities for general population?

Activities implemented

Information on the types and numbers of activities was primarily collected via the community-based activity database into which Trial Sites entered descriptive data on non-aftercare service activities. Thirty-five per cent of activities entered into the community-based activities database (*n*=386) were marked as not specifically targeting one of the Trial focus populations.

Table 7.9 details the types and proportions of all general population activities.

Table 7.9 Types of activities for the general population

Activity type	%
Awareness raising and engagement	30.2
Capacity building	47.2
Professional development and training for GPs, health and mental health workforces	9.8
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	2.1
Implementation of guidelines, standards and other quality improvements	6.0
Other	4.7

Capacity building activities represented almost half of the activities implemented for the general population. They took the form of a range of training programs for communities, including programs for which there is evidence available such as ASIST, Mental Health First Aid, SafeTALK.

Awareness-raising and engagement activities accounted for 30% of general population activities. These included media and social media campaigns on suicide, mental health and/or general wellbeing, a wide variety of community events including exhibitions, family fun days, workshops and forums, and producing and distributing information and resources on available services.

Professional development and training for general practice and other health, mental health and allied health workers included the Screening Tool for Assessing Risk of Suicide Workshop for GPs and Advanced Suicide Prevention Training for health professionals.

Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide included a range of activities in addition to aftercare services described above. These included support services for individuals, supporting bereavement groups, drop-in and support groups, and developing a "warm line" to provide non-crisis support. Multiple Sites offered training to people with lived experience of suicide to become advocates and tell their stories safely.

Implementation of guidelines, standards and other quality improvements, in terms of general population activities, principally involved training for media professionals and others who engage with the media on responsible reporting of suicide guidelines.

Other activities included research, scholarships, developing postvention protocols, developing referral and health pathways, sponsoring conference attendance for PHN and/or contracted organisation workers, establishing and/or supporting local suicide prevention networks, and (at one Site) work to improve safety at a known local suicide hotspot.

Tailoring activities

By definition, general population activities are not tailored to specific populations, but they were tailored (particularly in regional areas) in a place-based manner, including through using local stories in information resources or media campaigns, engaging community champions, linking in with local events, and contracting local organisations to implement Trial activities.

Almost half of all activities were workforce related, either through the delivery of activities in workplaces, through focused training for particular professions, or the activities themselves being aimed at building a suicide prevention workforce.

Activity promotion and recruitment

Community activity and programs were promoted by a range of approaches, including local media, social media and websites; through local community organisations, businesses and networks, including suicide prevention networks; word of mouth; using community champions; and through PHN networks.

Involvement of people with lived experience of suicide

People with lived experience of suicide were involved in delivering some training programs, and shared their stories through materials such as calendars, books and media campaigns.

7.7 What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among the general population?

Outputs: participation

Trial Sites provided participation numbers for the activities recorded in the community-based activities database. Table 8.2 indicates participation in general population activities.

Table 7.10 Number of participants by Trial activity type

Activity type	Participants*
Awareness raising and engagement	5,074
Capacity building	3,647
Professional development and training for GPs, health and mental health workforces	618
Information, services or other activities for at-risk individuals, groups of people at higher risk of suicide, or people with lived experience of suicide	72
Implementation of guidelines, standards and other quality improvements	552
Other	251
Total	10,214

* Participant numbers for 11 activities are missing because they were not provided or were censored due to being estimated audience reach numbers for media and campaigns based on the population catchment area, so overestimated participation.

For activities focused on the workforce, the main target was community health organisations and related services, and volunteer or community groups providing services or support. Other workforces targeted included schools, Aboriginal and Torres Strait Islander service providers, PHN-commissioned services and emergency or crisis response services. A total of 5,173 participants were reported as attending the workforce-focused activities recorded in the database.

Outputs: appropriateness (met needs and expectations)

Community-based activities for the general population were implemented as part of the overall strategy for adopting a multi-component systems approach. There was no systematic assessment of the extent to which such activities were currently being delivered in the Trial Sites, but needs analysis activities (see Section 3.1.1), particularly community stakeholder consultations, identified a need for these types of activities. Indeed, at some Sites there were unmet community expectations about the extent of programs that were needed and which the Trial could provide.

Community stakeholders from six Sites considered that the shift towards delivery of a person and community-centred approach to suicide prevention was a key outcome of the general population Trial activities. Stakeholders saw this as promoting a broader focus on the community, rather than health or clinical responses to suicide, that included the voices of people with lived experience.

Impacts: increased awareness and knowledge

Information on changes in awareness and knowledge was obtained from documents provided to the evaluation including a limited number of pre-post and post-only questionnaires, and reports of informal and anecdotal feedback in documents and from PHN Trial staff. The results of participation in Trial activities reported in those data sources included improvements in:

- General awareness about mental health and suicide
- Knowledge about suicide
- Knowledge about how to help/where to get help
- Confidence to help
- Intention to help
- Willingness to seek help for self.

Moreover, many of the training programs implemented have some evidence base supporting their effectiveness in raising awareness, knowledge, and improving willingness and confidence to intervene to offer aid. The program logic approach assumes that those gains will be replicated in those who undertook those programs as part of the Trial.

Impacts: improved community capacity

Stakeholders considered that the overall approach of the Trial of providing the community with a grounding in evidence-based narratives and supporting data worked to increase their knowledge and confidence to undertake suicide prevention, empowered and engaged community to be part of the change, increased community pride, ownership, connectedness and resilience, and provided the community with an understanding of how systems work and how to work with them.

Impacts: increased mental health service use – primary mental health care minimum dataset

Analysis of the PMHC MDS revealed no increased uptake of PHN-funded mental health services in the general population related to the Trial.

Impacts: integration and coordination

Stakeholders identified a small number of instances in which some integration occurred and coordination improved. These included organisations jointly providing activities, partnerships formed between key stakeholders, and the establishment of ongoing local suicide prevention or mental health and wellbeing networks.

Impacts: other

Other impacts reported by stakeholders included feedback from GPs that there seemed to be less stigma and that more people were seeking help for mental health problems; improved knowledge and capacity for suicide prevention in the PHN network; and the adoption of new approaches to funding and commissioning services at PHNs that were more flexible and incorporated a broader range of programs.

7.8 General Population: what challenges were encountered?

Engaging general practice and getting GPs to attend training was a frequently mentioned challenge. This was due to the multitude of demands on GPs' time, the transient GP workforce in regional areas, the business model of general practice clinics, and the time commitment required for some of the GP suicide prevention training packages.

Other challenges included sustaining community involvement and engagement in local suicide prevention networks and activity over time, getting national training organisations to come to regional and rural locations to deliver training, working within the short Trial timelines, and the disruption to delivery of activities due to COVID-19.

8 Outcomes: Suicide and suicide attempts

The difficulty in directly assessing the outcome of Trial activities in terms of reduction in suicides and suicide attempts have been described above. Nonetheless the evaluation did endeavour to investigate those outcomes. Stakeholders at several Trial Sites provided anecdotal information of reductions in suicide attempts and lives saved. However, the main examination of the key outcomes of suicide deaths and suicide attempts was through an epidemiological analysis of two routinely collected datasets that investigated, at a population level, if any effects of the Trial could be detected for the two key outcomes: suicide deaths and hospitalisations following self-harm. In addition, dynamic simulation modelling exercises were conducted to model the potential for reducing suicide deaths and/or hospitalisations for self-harm by implementing multi-component approaches.

This chapter presents key results for the analysis of national mortality data and national data on self-harm hospitalisations. Detailed information the analysis methods and results can be found in Chapter 26.

8.1 Epidemiological analysis

8.1.1 Hospitalisations for self-harm

Self-harm hospital admission data for all jurisdictions for June 2010–June 2019 were obtained from the National Hospital Morbidity Database, administered by the AIHW. Monthly rates of hospital admissions over time within Trial PHNs were examined, and admission rates in Trial PHNs were compared with a control group of PHNs which were not taking part in other suicide prevention trials (e.g., the NSW LifeSpan Trial). Analyses were controlled for sex, age-group, socio-economic status, year and month.

Within the Trial regions only, comparison of data from the periods before and during the Trial found no evidence of a reduction in rates of hospital admissions for self-harm during the Trial period.

Comparison of Trial and non-Trial regions showed no difference in the rate of hospital admissions for self-harm during the Trial period, or in the rate of change in hospital admissions for self-harm between 2010 and 2019.

Where data were available for focus population groups – men and young people – analysis likewise showed no reductions in hospital admissions for self-harm.

8.1.2 Suicide deaths

Australian Bureau of Statistics cause of death data were obtained for January 2010–December 2018, the last month for which data were available. Monthly rates of suicide death over time within Trial PHNs were examined, and Trial PHNs were compared with a control group of PHNs which were not taking part in other suicide prevention trials. Analyses were controlled for sex, age-group, socio-economic status, year and month.

Within the Trial regions only, comparison of data from the periods before and during the Trial found no evidence of a reduction in the rate of suicide deaths during the Trial period.

Comparing Trial and non-Trial control regions revealed no difference in the rate of suicide deaths during the Trial period, or in the rate of change in suicide deaths between 2010 and 2018.

Where data were available for focus population groups – men and young people – analysis likewise showed no reductions in suicide deaths.

8.2 Systems modelling

Systems modelling demonstration scenarios from two Sites (Western NSW and Perth South), showed how implementing particular interventions and combinations of interventions can have different impacts on outcome measures, in part attributable to differences in service system infrastructure. These scenarios were for demonstration purposes only and did not reflect actual Trial activities or outcomes.

Models found that implementing GP training alone had little impact on mental health-related ED presentations, self-harm hospitalisations or suicide deaths. Combining GP training with mental health education programs reduced suicide deaths in the Perth South region, but unexpectedly significantly increased suicide deaths in the Western NSW region.

This unintended consequence arising from two evidence-based interventions applied in combination is explained, in the Western NSW region, by the additional mental health service demand generated beyond the availability of baseline service capacity, driving increases in the rate at which patients disengage from services as a result of increases in mean wait times and dissatisfaction with the quality of care they receive. Disengagement from the mental health system prolongs heightened psychological distress and increases the risk of suicidal behaviour.

In addition to differential impacts of interventions (both individually and in combination), the timing of impacts can also differ, and for both Sites will be well after the Trial and evaluation. For example, mental health education programs implemented in 2021 in the Perth South catchment would be unlikely to demonstrate impact until at least early 2027, whereas in the Western NSW catchment a positive impact is unlikely to be seen until late 2027 after a period of no impact. This has significance for the design of traditional evaluations, because potentially promising interventions may not show impacts during the traditional 2–3-year evaluation due to demand/capacity dynamics in local areas and other interventions being implemented in parallel, and hence may be inaccurately and dismissed as ineffective.

9 Conclusions and considerations for policy

The Evaluation framework provided guiding questions to consider in terms of evaluating the implications for policy of the Trial learnings in each the three domains of planning, adopting a systems approach and suicide prevention services and activities for focus populations. This chapter presents overall conclusions of the evaluation structured around those questions, namely: common issues across all Sites; essential factors; characteristics of a systems approach in the Australian context; and successful strategies that may be scaled up. Finally, it provides some overarching considerations for policy drawn from those conclusions.

9.1 Conclusions – Planning

9.1.1 Were there common issues across Sites?

Stakeholders

A universally identified issue was that stakeholder engagement and a consultative planning process takes time. Time is required to establish trust, build or rebuild relationships between community stakeholders and between the PHN and community, and to establish a shared understanding and common language across diverse stakeholders.

Sites experienced difficulties in engaging certain stakeholder groups, particularly GPs, and representatives from hospitals and state education departments. The main barrier for GPs was that they were time poor and had competing demands. There was no common barrier for hospitals and state education departments, but getting buy-in at senior levels was sometimes hard.

Representation from a broader range of government portfolios, such as employment and social services, was not widely or consistently included.

The capacity of community and NGO service provider stakeholders to participate was a common issue. Many stakeholders had little time due to work commitments, belonged to small unfunded community organisations, and had multiple competing demands, particularly in regional areas.

Identifying needs

The difficulty in accessing relevant local data on rates of suicide and suicide attempts to inform planning was a common issue. This was sometimes because data custodians could not release data specific enough to local areas and focus populations for confidentiality reasons (e.g., the small number of suicide deaths), or because relevant data were not systematically collected (e.g., suicide attempt data by ex-ADF status).

Planning process

Approaching planning as a one-off phase at the beginning of the Trial did not accommodate the scale or complexity of the Trial or the need to build capacity in PHNs and among stakeholders in evidence-based suicide prevention.

There was tension between community-driven approaches and evidence-based approaches. A key underlying factor in this tension was that the view that the evidence base was centred around a health or mental health response to suicide, whereas the community approach tended to be more holistic and emphasised/attempted to respond to the broader social drivers and protective factors.

The Trial Coordinator role is pivotal, and when this role became vacant, activity stalled. Lack of role clarity, complexity of the role, burnout and insecurity of tenure all contributed to staff turnover.

Across Trial Sites, both PHN staff and stakeholders identified the need for more information and support on operationalising a systems approach.

Evidence base

The lack of specific evidence for local contexts or focus population groups was a frequently identified issue. It was noted that the published evidence on effective interventions is largely drawn from metropolitan locations in Europe or North America, and rarely addresses population sub-groups. The applicability of that evidence to regional Australia and for Trial focus populations is unclear.

9.1.2 What factors are considered essential for effective planning?

Stakeholders

Broad and inclusive stakeholder engagement is essential for effective planning to ensure that planned strategies meet the needs of the community and to support the implementation and uptake of services and activities.

Getting the right stakeholders involved, in terms of their roles within the community or their organisations/agencies and their capacity to contribute, is also a key factor. The involvement of decision-makers in planning and ongoing governance is important in terms of assessing the feasibility of initiatives and progressing the implementation of planned activities.

Involvement of community stakeholders is crucial, and engaging with existing local suicide prevention networks and groups is an effective way to reach them. Providing support to build knowledge around evidence-based approaches and to coordinate involvement is necessary to facilitate substantive participation in Trial planning.

Stakeholder engagement needs to be an ongoing process and not a one-off exercise undertaken at the beginning of the Trial. It requires constant attention and reflection.

Taking time to engage meaningfully with the community and broker relationships with and between all stakeholders is an essential contributor to successful planning.

Needs analysis

A thorough needs analysis that draws information from multiple sources, including comprehensive consultation with community, is indispensable for planning. Mapping existing local and State suicide prevention activities and initiatives should be included in that analysis.

It is important that needs analysis not only covers service availability but also examines the extent to which those services reach those in need; for example, whether people don’t use available services because they are unaware of them or because they don’t feel safe using them.

Governance and leadership

An essential component for effective governance is a governance structure that balances community ownership and context, current events (such as drought, or loss of a community member by suicide), and community priorities and preferences with structured leadership and coordination.

Governance structures that enable stakeholders to overcome pre-existing tensions and conflicts are essential to build the foundation for inclusive stakeholder participation.

Leadership with the capacity to bring stakeholders to the table from all levels of government, the service sector and the community, including people in decision-making positions, is fundamental for effective planning and implementation.

Good communication and transparency around decision-making processes is key for maintaining stakeholder engagement.

Community capacity building

To support community participation and ownership of the Trial, it is important that PHNs adopt a community capacity-building role and provide stakeholders with a foundational understanding of evidence-based suicide prevention and systems approaches from which to proceed with the planning.

The resources of the Black Dog Institute and/or other established suicide prevention organisations are valuable supports for community capacity building.

Workforce capacity building

A dedicated suicide prevention coordinator role is essential. The position requires high-level project and stakeholder management skills and, particularly in regional areas, local knowledge is an asset. Continuity in the position is crucial.

9.2 Conclusions – Systems approaches

9.2.1 Were there common issues across Sites?

With respect to adopting either the LifeSpan or AAD framework, the most common issue was the relevance of the frameworks to the local context or focus population group due to the frameworks being derived from evidence produced in largely urban, general-population, non-Australian contexts.

A need for guidance on how to operationalise and implement such frameworks was noted.

Implementing the full suite of interventions from the chosen multi-component systems framework was not attempted at most Trial Sites due to concerns about resources, capacity and time constraints.

The time-limited funding period of the Trial proved a deterrent to most Trial Sites in terms of commissioning aftercare or other clinical services due to concerns about withdrawing services at the end of the Trial.

With multi-component systems frameworks, such as LifeSpan, there was a tendency among community and service providers to support the components that aligned with their current services or activities or priorities and be less supportive of the other components.

Common capacity issues hindering the adoption of a systems approach included knowledge about the evidence base, ability to bring all the relevant stakeholders to the table, and capacity to influence the system.

Across regional Trial Sites, workforce availability and capacity and service availability and capacity were barriers to implementing many of the recommended interventions. This was exacerbated by remoteness.

9.2.2 What factors are considered essential for effective service integration and coordination of suicide prevention activities?

Bringing stakeholders from across the sector into the planning process and maintaining and supporting their engagement over the longer term is fundamental for coordination of suicide prevention activities.

Ongoing coordination, in the form of an identifiable, ongoing coordinator role, as well as an effective governance structure to maintain stakeholder engagement and oversight, is essential.

Achieving buy-in from state and territory government departments and agencies, particularly health and education departments, is key for integrating services and coordinating suicide prevention activities.

In addition, working in collaboration with state-driven suicide prevention initiatives is important for achieving coordination.

Local hospitals and health districts are key stakeholders for suicide prevention, and establishing effective collaborations is an essential component of creating more integrated services.

9.2.3 What are the elements that define a systems approach within an Australian context?

No single systems-based framework is likely to be able to accommodate the diversity of Australian communities and contexts. A localised approach that can address the specific needs, context, availability of services and other resources for a given region, and also considers the needs of diverse population groups within the region, is required.

A systems approach would preferably adopt a more expansive definition of the system to include a whole-of-government approach to address upstream social determinants of suicide, rather than a predominantly health and mental health focus.

A systems approach needs to achieve a balance between a community-driven approach and elements that require more top-down service capacity building and action at the structural level.

Some mechanism or agency is required to provide coordination and broker the engagement of stakeholders across the sector, including community-based organisations and all levels of government. Coordination between the state, territory and Commonwealth governments is essential to develop and sustain a systems approach.

9.3 Conclusions – People who attempt or are at risk of suicide

9.3.1 Were there significant differences in approaches across Sites in terms of services offered and links with other local services?

Most Trial Sites did not implement services for individuals, such as aftercare services, citing the lack of continuity of funding as the key barrier to establishing such services.

The four Trial Sites that did implement services for individuals opted for aftercare for people who had made a suicide attempt or had been assessed as at risk for suicide. All services adopted a client-centred case management approach focused on linking clients with appropriate support services. However, service models needed to be customised to be appropriate for different population groups and account for the local context including the availability of support services.

General population aftercare services were not felt to meet the needs of LGBTI people or Aboriginal and Torres Strait Islander peoples. A need was identified to develop safe, appropriate service models for both population groups and developing services through co-design processes with LBGTI and Aboriginal and Torres Strait Islander-specific service providers.

9.3.2 What factors are considered essential in providing effective follow-up services and ongoing support for people who attempted or are at risk for suicide?

Continuity of funding is essential to support the development and embedding of aftercare services where a need for such a service has been established.

Hospitals are a key stakeholder and establishing formal referral agreements, while time consuming, can overcome issues around staff changes, trust and understanding of non-clinical models of care.

Broad referral pathways to reach a greater number of at-risk individuals are important. Service models that are limited to referrals from hospitals following presentation for a suicide attempt will miss many at-risk individuals who do not present to hospitals because they do not feel culturally safe, or because they don’t need medical intervention but are nevertheless at high risk.

The involvement of people with lived experience of suicide in the design of the services, particularly those for LGBTI and Aboriginal and Torres Strait Islander-specific services, is key to developing effective services.

Building cultural competence in mainstream services is essential, because clients from specialist services need to be referred out at the end of the aftercare service program.

Accessing or developing a skilled workforce, including peer workers, is crucial for delivery of an effective aftercare service.

9.3.3 What strategies have had a significantly positive impact and might be adopted in other regions?

All Trial aftercare services were well received and well attended, and the availability of a service at no cost to the client was a significant positive impact.

The focus population-specific services are innovative and responded to a pronounced need for culturally safe services. They were well received and would be relevant to other regions.

9.4 Conclusions – Aboriginal and Torres Strait Islander Peoples

9.4.1 Were there common issues across Sites?

Working within the timelines set out for the Trial was experienced as a significant challenge across all Sites which were undertaking Aboriginal and Torres Strait Islander-focused activities. Short timelines were felt to impede genuine community engagement.

Community readiness was an issue because many communities had experienced recent loss, and were overburdened by health and wellbeing initiatives and/or research and consultation.

Establishing governance structures that promoted genuine Aboriginal and Torres Strait Islander governance was an issue at some Sites.

In addition, aligning the expectations and design of the Trial with the priorities and needs of Aboriginal and Torres Strait Islander communities and stakeholders was a challenge.

The inherent design of the Trial as a time and place-limited initiative could not address structural and systemic challenges such as disempowerment, racism, colonisation and intergenerational trauma, nor the social determinants of health, all of which are underlying casual factors for suicide in Aboriginal and Torres Strait Islander communities.

9.4.2 What factors are considered essential in providing effective suicide prevention services for Aboriginal and Torres Strait Islander peoples?

Suicide prevention services and activities need to be developed in the context of the structural and systemic challenges and social determinants underlying suicide in Aboriginal and Torres Strait Islander communities.

Governance models and ways of working and engaging with Aboriginal and Torres Strait Islander communities that align with local Aboriginal and Torres Strait Islander governance are critical. Across the Trial, the most coordinated and coherent overall approach was achieved when a single ACCHO had carriage of the Trial and had a governance structure with strong leadership which brought all the stakeholders together to resolve problems.

Governance structures in which the PHN role was focused on facilitating stakeholder engagement, supporting Aboriginal and Torres Strait Islander leadership and decision-making, and undertaking administrative processes around procurement were effective in identifying and implementing activities that communities wanted and engaged with.

Comprehensive and inclusive planning processes, including the use of and access to suicide data to support needs analysis and strong engagement of a diverse range of stakeholders from multiple sectors and segments of the community, are vital.

Localised qualitative needs analysis based on broad consultation and local knowledge is required to inform understanding of needs and gaps, including if available services are actually used, and if not, why not.

Aboriginal and Torres Strait Islander-led design of activities and services or genuine co-design ensure they are culturally safe, engender trust which supports their uptake, and build capacity in the organisations participating in the design and service delivery.

The considerable diversity of Aboriginal and Torres Strait Islander communities requires suicide prevention strategies and approaches to planning and implementing programs that are localised and adaptive.

Adopting a community development approach to strengthen and restore local Aboriginal and Torres Strait Islander governance by focusing on and starting from existing community strengths and assets is important.

Building and restoring the capacity of the Aboriginal and Torres Strait Islander workforce to deliver suicide prevention programs, either as staff from local organisations or from within the PHN, is necessary to deliver culturally appropriate and safe programs and activities.

Improving cultural competency in non-Aboriginal organisations and agencies is essential to ensure cultural safety for Aboriginal and Torres Strait Islander peoples, which in turn increases the use of services.

Timing of suicide prevention initiatives has to be guided by community readiness and “work at the speed of trust”. Communities may need time to heal, have more pressing priorities, or be experiencing consultation or intervention fatigue.

9.4.3 What strategies have had a significantly positive impact and might be adopted in other regions?

The demonstrated commitment from the federal Minister for Indigenous Affairs and state and territory members of government at the two Trial Sites exclusively focused on suicide prevention for Aboriginal and Torres Strait Islanders had a significantly positive impact. Establishing some mechanism for continuing and extending that visible Commonwealth and state government commitment to ongoing suicide prevention efforts across the country would be valuable.

Operationalising the ATSISPEP framework to guide planning a multi-component, multi-level suicide prevention approach was an effective strategy for developing a coordinated and coherent suite of interventions.

Primary Health Networks facilitating a safe environment for Aboriginal and Torres Strait Islander stakeholders to meet, work through any community and/or organisation issues, and then coordinate the planning and decision-making on Trial activities was a successful approach. Key to such an approach was the PHN taking time, listening and building and facilitating relationships between the themselves and other stakeholders.

Strategies that empowered young people to participate and Trial Sites valuing and actioning their contributions had positive impacts for the young people involved and for the Trial planning and implementation.

Resources dedicated to strengthening the Aboriginal and Torres Strait Islander workforce, including employment and capacity building and restoration of local community members to undertake suicide prevention-related work, had a positive impact for individual workers, their community and the organisations employing them.

Co-design of services and activities had a positive impact in terms of building working collaborations and relationships and developing services and activities that were safe, appropriate and responsive to community needs.

9.5 Conclusions – Other focus populations

9.5.1 Were there common issues across Sites?

Men

A common problem was identifying key stakeholders, including relevant community stakeholders. Men are not a minority group in the community, and thus there are few male-focused organisations, programs and agencies.

The diversity of men as a population group made it difficult to identify needs and target strategies. A more targeted approach was required, and Sites focusing on men commonly narrowed their focus to particular cohorts of men, usually workforce groups.

There is limited evidence about male-specific interventions, and there are few existing male-focused programs or other interventions to implement. Trial Sites tended to commission generic interventions but deliver them in environments where they would reach men.

Young people

The most common issue identified was difficulty in accessing the education sector to participate in Trial planning and to secure permission to deliver Trial activities in schools. Even having an education representative on the Trial Committees did not necessarily facilitate access to local schools.

Young people themselves were less engaged in Trial planning than members of other focus population groups. Advocates for young people or representatives of organisations providing services or support for young people were more commonly involved than young people themselves.

Ex-ADF members and their families

Only one Trial Site focused on ex-ADF members and their families, and therefore no cross-Site conclusions are possible. However, key issues identified at that Site are likely relevant to developing a systems approach to suicide prevention for ex-ADF members and their families.

Negotiating cultural differences between stakeholders with an ADF background and civilians was a challenge in the initial planning process.

Lack of data, in that ex-ADF status is rarely recorded in datasets, is an impediment to planning.

Difficulty in engaging ex-ADF members who are disconnected from and distrustful of DVA services and mainstream ex-ADF organisations, as well as engaging younger ex-ADF members, were issues in terms of delivery of initiatives.

LGBTI people

Key LGBTI organisations have had a lot of influence in the sector historically, and creating a space for other input was seen as important.

Evidence on the effectiveness of interventions in LGBTI populations was largely absent, and Sites considered that existing frameworks required modification.

Relationships needed to be rebuilt across a historically fragmented, fractious and competitive LGBTI service sector.

Service capacity is limited in terms of availability of specialist LGBTI services, particularly in regional areas.

Older adults

Only one Site focused on older adults. Getting traction with the Council on Ageing was difficult, and engaging agencies and organisations who work with older people likewise. Reaching isolated older adults was also an issue.

9.5.2 What factors are considered essential in providing effective suicide prevention services or activities for focus populations?

Men

Men were difficult to engage in Trial activities; delivering programs in the workplace was an effective strategy to reach them. Involving partners and families was also an effective strategy.

Young people

Supporting and empowering young people, including those with lived experience of suicide, to become involved in suicide prevention planning and delivery of programs is essential.

The involvement of key stakeholders, such as headspace and schools, is key for planning and delivery of suicide prevention services and activities.

Ex-ADF members

It is important that people with lived experience of both ADF service and suicide are involved in developing suicide prevention strategies and delivering suicide prevention activities and services for this population. Respected leadership, including access to and influence with decision-makers in the DVA, is a key factor.

Ex-ADF members who are disconnected from or distrustful of DVA services are potentially a high-risk group. Developing a distinct non-DVA identity in order to reach this group is an important strategy.

Including families, the broader community, and workforces with high numbers of ex-ADF members as first responders in suicide prevention initiatives targeting ex-ADF members enables programs to reach as many ex-ADF members as possible.

LGBTI people

Providing capacity building and training to ensure non-LGBTI services are safe for LGBTI people to attend is essential for delivering suicide prevention services and activities to LGBTI people.

Recognition of the diversity of LGBTI people and intersectional identities when developing services and activities is important to ensure inclusion and relevance.

Building coordination and collaboration across the LGBTI service sector can improve care pathways for LGBTI people seeking help.

Older adults

There was insufficient information available to draw conclusions about essential factors of successful strategies for this focus population.

9.5.3 What strategies have had a significant positive impact and might be adopted in other regions?

Men

Working with MATES in Construction had a positive impact, and the MATES model is readily transportable.

Using community champions and men with lived experience of suicide to reduce stigma received positive feedback.

Young people

Building the capacity of young people to participate in and lead suicide prevention planning and activities through paid roles located at PHNs and/or headspace facilitated greater engagement of young people in suicide prevention.

Developing and implementing inter-agency cross-sectoral postvention response protocols embedded a coordinated response.

Delivering evidence-based suicide prevention gatekeeper training to those who work with young people – particularly in schools – had a positive impact on students’ feelings of safety.

Ex-ADF members and their families

A successful peer support model for ex-ADF members experiencing mental health problems has been adopted by Open Arms (the DVA mental health service provider) in the local area and is being scaled up.

The development of veterans health pathways will help ex-ADF members to navigate the complex service system and facilitate access to services for those who need them.

An upstream focus on connection via participation in community volunteer and other activities and seasonal media and social media campaigns encouraging connection received positive feedback, with the latter being adopted in other regions.

LGBTI people

The co-design process forged collaborations and encouraged information sharing and partnerships in what was previously a fractured service provider sector.

Harnessing the strong desire in the LGBTI community to take action in the area of suicide prevention provided momentum and drove the planning and co-design processes.

The central presence of LGBTI people with lived experience of suicide in the planning but also delivery of services and activities, including building a peer workforce, had a significant positive impact.

The Trial's emphasis on building LGBTI cultural competency in mainstream organisations, including among general practice and other health and mental health service delivery settings, was well received.

9.6 Considerations for policy

The evaluation of the National Suicide Prevention Trial has yielded a wealth of information on the planning, implementation and the impacts of adopting evidence-based systems approaches to suicide prevention. Recommendations for consideration in future policy making, and key learnings supporting them, are provided below.

9.6.1 Taking a whole-of-government approach

Recommendation 1: A whole-of-government approach with strong leadership should be developed as the foundation for system-wide suicide prevention.

- System-wide approaches that address the underlying social determinants of suicide as well as providing support to at-risk individuals and communities require a whole-of-government approach that includes coordination between State and Territory and Commonwealth governments. This is consistent with the Productivity Commission's Draft Report on Mental Health (2019)[20], the Prime Minister's National Suicide Prevention Adviser's Initial Advice and Early Findings (2019)[3] and the approach being adopted for the new Closing the Gap 2020 target to reduce suicide.
- The imprimatur of high-level leadership from Commonwealth and State Governments, plays an important role in bringing all the relevant stakeholders to the table and building commitment and long-term engagement.

9.6.2 Developing a long-term strategy

Recommendation 2: A long-term strategy and approach to resourcing are required to build capacity and confidence across the sector, support a responsive continuous improvement approach to planning and implementation, and enable and embed system-wide changes.

- A longer-term strategy and resourcing model are necessary to provide confidence across the sector to invest in a full range of initiatives, establish and consolidate integration and coordination, build and retain an appropriately skilled workforce and embed an evidence-based approach.
- A time-limited approach with a linear plan-implement structure does not accommodate the developmental and foundational work which is required to move toward an evidence-based systems approach to suicide prevention. Future policy should support a continuous improvement model where planning is an ongoing iterative process informed by evaluation in a virtuous cycle.
- Time-limited funding initiatives such as Trials can initiate local coordination and lay the foundations for integration, but a longer-term strategic approach and resourcing are required to embed a systems approach.

Recommendation 3: A long-term view needs to be taken on assessing the success of suicide prevention initiatives and related decisions on continuing funding, due to the difficulties in measuring direct effects of multi-component interventions and the likely time-lag to see effects on rates of suicide and self-harm.

- To realise future gains it is crucial to persevere with strategies for which there is some evidence, and systematically review, refine and adapt approaches as new evidence becomes available.
- To understand the longer-term impacts and outcomes of large-scale initiatives such as the National Suicide Prevention Trial, monitoring and analysis of outcome data should be continued over an extended period.

9.6.3 Aboriginal and Torres Strait Islander governance

Recommendation 4: Suicide prevention strategies must originate from Aboriginal and Torres Strait Islander specific evidence and knowledge and genuine Aboriginal and Torres Strait Islander governance is fundamental.

- The renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and the Social and Emotional Wellbeing and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, provide the framework for preventing suicide in Aboriginal and Torres Strait Islander communities. Any suicide prevention initiatives including Aboriginal and Torres Strait Islander peoples should originate from within that framework rather than attempting to include or adapt these principles and elements after the fact.
- Aboriginal and Torres Strait Islander governance principles, including leadership and self-determination, should be the starting point for the planning, implementation and evaluation of all suicide prevention strategies for Aboriginal and Torres Strait Islander peoples and communities.
- Initiatives being led or funded through non-Aboriginal and Torres Strait Islander agencies must include deeper consideration of structures and mechanisms to uphold and respect

Aboriginal and Torres Strait Islander governance as separate from corporate governance and indivisible from Aboriginal and Torres Strait Islander social and emotional wellbeing.

9.6.4 Adopting a regional approach

Recommendation 5: A regional focus is necessary to ensure that initiatives meet local needs, are responsive to local contexts and are sustainable. A region-based entity would be best placed to coordinate and oversee regional level initiatives.

- Frameworks such as LifeSpan and the Alliance Against Depression are a useful guide for identifying domains of intervention and understanding multi-component approaches, however they cannot be used as blueprints. Regional approaches responsive to local contexts and conditions, and to the needs of different population groups within communities, are required. Resources and support are required to build capacity to identify local needs, work with the evidence-base, and develop tailored multi-component strategies to suit local conditions.
- There is a need for a coordinating entity at a regional level. That entity needs to be able to engage with government at all levels as well as with community. PHNs are potentially well placed to undertake that role, however, dedicated resources are required to support them in such a role. Moreover, the ability of an organisation to engage stakeholders and drive a more coordinated approach is enhanced when they have control or influence over dispersing funding.
- An important driver of regional suicide prevention activities was having a dedicated local suicide prevention coordinator role to support community engagement and maintain momentum. Key skills for such a role include a background in community engagement; knowledge and passion about suicide prevention; sector knowledge; relationship management skills; and existing connections with the community.

9.6.5 Building the evidence base

Recommendation 6: Continuing investment to develop the evidence base for suicide prevention is crucial.

- Continued investment is required to develop the evidence base both through directly sponsoring research initiatives to establish the effectiveness of interventions, particularly for higher-risk populations.
- Resourcing to develop evaluation capacity and embed evaluation as part of a continuous improvement approach within organisations who manage and deliver suicide prevention will also contribute to building the evidence base.
- Research that includes strong community and/or service partnerships, including a co-design approach, may increase alignment of community-driven and evidence-based approaches.
- As resources and capacity may not always be available to implement the full suite of interventions optimal for a systems approach at any given time, identifying the key ingredients and fostering and resourcing the implementation of those is desirable. This requires building the evidence base not just at the intervention level, but at the system level to determine what are the key components that deliver the best results in a given community context. Systems modelling can make an important contribution in this area.
- Evaluation of services for people who have made a suicide attempt or are at risk for suicide should be ongoing, and findings shared to allow scaling up of service models, or components of service models which are effective.

- Continued research and evaluation to build the evidence-base on suicide prevention for Aboriginal and Torres Strait Islander peoples is required. Aboriginal land Torres Strait Islander led research and evaluation should be supported to lead that work.
- The evidence on the efficacy and effectiveness of interventions for specific at-risk populations is limited but developing and further research and evaluation are required.

9.6.6 Building capacity across the system

Recommendation 7: Resources and mechanisms are required to build suicide prevention capacity across the system. National, jurisdiction-based or regional resources may be an appropriate mechanism.

- Building the knowledge and skills of community stakeholders, PHNs and service providers in evidence-based and systems approaches to suicide prevention is the cornerstone of a system-wide coordinated, integrated approach.
- Building a suicide prevention workforce, including a peer workforce, is a key area for action, particularly in regional areas and for Aboriginal and Torres Strait islander communities. Continuity of funding is crucial for building and retaining that workforce.
- To support a community-driven approach, mechanisms for building community and service provider knowledge and confidence to engage with evidence-based approaches to suicide prevention are required.
- Building the Aboriginal and Torres Strait Islander workforce and restoring capacity will be a key driver of suicide prevention across Aboriginal and Torres Strait Islander communities.
- System-wide cultural competence building is required for non-Aboriginal and Torres Strait Islander organisations, agencies and communities.

9.6.7 Initiatives for at-risk population groups

Recommendation 8: Tailored approaches are required when developing suicide prevention strategies for population groups with higher risk for suicide, and time and resources to develop and evaluate these are necessary.

- The diversity within any focus population must be addressed in initiatives targeting particular at-risk populations. The availability of more fine-grained data is an essential tool for this.
- Co-design is an effective model for developing appropriate services, achieving engagement of focus population groups and integration and coordination across specialist and mainstream services.
- For aftercare services, culturally-safe flexible service models with broad referral pathways that are not restricted to those who present at hospitals, are necessary to ensure services reach and are able to retain the greatest number of at-risk individuals.
  There is a role for whole-of-population initiatives in reaching people from at-risk population groups who do not necessarily identify with those groups.

9.6.8 The role of people with lived experience of suicide

Recommendation 9: People with lived experience of suicide have an invaluable contribution to make in the development and delivery of suicide prevention and their knowledge and expertise needs to be harnessed.

- Support for people with lived experience of suicide, such as through structured training programs, is essential to ensure that they can participate safely and fully.

- Building capacity of organisations, PHNs and services providers to meaningfully involve people with lived experience in the planning and delivery of services and initiatives is required.

9.6.9 Data

Recommendation 10: Increased capacity to collect and provide timely accessible data, including at a regional level, is crucial to support planning, to ensure resources are directed according to need and so that outcomes of suicide prevention initiatives can be evaluated.

Recommendation 11: Opportunities to optimise currently collected data such as the Primary Mental Health Care minimum dataset to capture data relevant to suicide prevention should be explored.

- Access to timely and appropriate data is crucial to support ongoing planning and evaluation. Current initiatives such as the AIHW's suicide and self-harm monitoring project will in part address this, however continued development of data capture, analysis and access capacity is important.

Part Two: Evaluation details

10 Document review

10.1 Summary of approach

Documents were collected from Trial Sites, the Department of Health and from PHN websites. Two formal rounds of document collection took place over the course of the Trial, the first in the last quarter of 2018 and the second at the end of the Trial in June/July 2020. Additional documents were incorporated as they became available. At each timepoint a list of document types was provided to PHNs with a request to provide all such documents they held, as well as any additional documents they felt were relevant. Publicly available documents were sourced from PHN websites at both timepoints. The Department of Health provided copies of routine reports submitted to them by Trial Sites for January 2017–June 2020 as they became available.

10.2 Sample information

There was considerable variation in the number and type of documents Sites provided to the evaluation. In the first round of document collection an average of 31 documents per Site were reviewed (range 18–38), and data extracted from an average of 16 documents. In the second round, an average of 43 documents per Site (range 13–97) were reviewed and data extracted from an average of 33 documents.

Appendix 3 provides a detailed description of the documents included in the review. Briefly, they included PHN National Suicide Prevention Trial Site Activity Work Plans, PHN six-monthly and 12-monthly performance reports, PHN PMHC Activity Work Plans, and other documents relating to mental health and suicide prevention needs assessments, Trial design and development, commissioning and implementation, provider performance reports and activity reports.

10.3 Data analysis

All documents sourced were recorded in an inventory in broad categories of type of document for each Site. A data extraction template was developed based on the evaluation questions that the document review was expected to answer. Evaluation staff conducted an initial scan of document titles and contents, and excluded those that were not relevant (e.g., copies of media campaign materials and contact lists). They then reviewed remaining documents and input relevant data into the template. The most common responses identified for each evaluation question and the number of Sites for which the theme was present in documents is noted. Because of the variability in type and number of documents provided, the absence of a theme from Trial Sites does not necessarily mean it was not relevant; it may have not been provided.

10.4 Planning

10.4.1 Planning – identifying local needs and service gaps

Trial Sites used a variety of approaches to ascertain information on local needs and service gaps. Sites used between two and six sources of information. The main data sources used were consultations with stakeholders conducted by the PHN and routine PHN needs assessment reports. Data on suicide deaths and attempts was also commonly accessed. Table 10.1 outlines the main data sources used by Trial Sites identified in documents.

Table 10.1 Document review: Data sources for identifying local needs and service gaps

Data source	Sites (n)
PHN-run consultation with stakeholders	11
Routine PHN needs assessment reports	10

Data source	Sites (n)
Data on suicide deaths and attempts	8
Community consultation by contracted organisation	6
Consultations by ACCHO contracted to run entire Trial	1
PHN service and workforce mapping reports	5
Contracted organisation service and workforce mapping reports	4
Existing regional or state suicide prevention reports	2
A Black Dog Institute “suicide audit”	1

Consultations were conducted with a broad range of stakeholders, including service providers, government departments and agencies, NGOs and community groups, and local suicide prevention networks. All 12 Trial Sites conducted in-person consultations, and three Trial Sites also collected stakeholder input via surveys.

At six Sites, community consultation on local suicide prevention needs was not directly conducted by the PHN. Instead, at one Site an ACCHO was contracted to run the entire Trial, including community consultations, and at others the PHN contracted community organisations (2 Sites), a university (1 Site), consultants (1 Site) or an ACCHO (1 Site) to conduct consultations.

Data on suicide deaths and suicide attempts were sourced either from data custodians specifically for the Trial or drawn from other PHN needs analyses activities.

10.4.2 Planning – stakeholder involvement

Key partners were identified in Trial Annual Activity Workplans and their roles identified. Stakeholder engagement commenced early in the Trial, and stakeholders were involved in planning activities which continued in some form across the duration of the Trial at most Sites. A broad range of stakeholders and service providers was involved through a variety of mechanisms in the development of suicide prevention strategies at each Site.

Stakeholders were drawn from government departments and agencies, both Federal and State, health sectors providers, NGOs and community organisations. The Federal Minister for Indigenous Affairs (previously the Federal Minister for Indigenous Health) chaired a governance committee at the two exclusively Aboriginal and Torres Strait Islander Sites. People with lived experience of suicide were also included in Trial planning activities at all 12 Sites.

Table 10.2 indicates the main types key stakeholders identified in documents as involved in the planning process.

Table 10.2 Document review: Key stakeholders involved in Trial planning

Key stakeholder organisations represented	Sites (n)
Government departments and agencies	
• Federal Government Departments: (for example, Health, Defence, Veterans Affairs, Prime Minister and Cabinet)	5
• State health departments	3
• State mental health commissions	2
• State education departments	3
• Other state government departments and agencies	5
• Local councils	6
• Police	5
• Schools	1
Health sector organisations and providers	
• Local hospital districts, hospital EDs	7
• Ambulance service	2
• General practitioners	4
• Royal Australian and New Zealand College of Psychiatry	1
• Royal Australian College of General Practice	1
• Key service providers in sector (headspace, Anglicare, etc.)	9
• Other providers/health networks	11
Aboriginal and Torres Strait Islander organisations and community	
• Aboriginal Community Controlled Health Organisations/Services	7
• Aboriginal NGO service or activity providers	3
• Cultural and/or advocacy and support organisations	4
• National or regional peak bodies	3
• Elders	5
• Community members	5
• Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention	2
Non-government organisations and community organisations – (non-Indigenous)	
• Non-government organisations related to particular types of suicide prevention or mental health service/activities (e.g.Roses in the Ocean, Wesley Lifeforce, Mindframe)	5
• Non-government organisations related to focus population groups (for example, Men's Health Forum)	3
• Non-government organisations covering local towns/regions	3
• Advocacy organisations related to focus population groups	2
• Local suicide prevention networks	2
Other stakeholders	
• Local universities	4
• People with lived experience of suicide	12

State government

The main mechanism for involving state governments in Trial planning was via representation on Trial Committees (10 Sites). State government stakeholder membership on Trial Committees included representatives from local hospital districts, police, ambulance, justice departments, education departments, health departments and other state-based agencies.

Other mechanisms through which states were involved in Trial planning included PHN Trial staff sitting on state-wide committees related to suicide prevention specifically or mental health more broadly (3 Sites), through inclusion in consultations, entering into partnership agreements, State agencies providing data for the Trial, and at one Trial Site through the co-design and implementation of a Trial activity.

Local councils

Local councils were involved in Trial planning mainly through participation on Trial Committees (7 Sites). Other mechanisms of local council involvement included participating in stakeholder consultations (4 Sites) and being contracted to undertake local planning and delivery of Trial activities in a specific area (1 Site).

Aboriginal and Torres Strait Islander organisations, services and communities

In the seven Sites which had a focus on Aboriginal and Torres Strait Islander suicide prevention, documents noted the involvement of a range of Aboriginal community-controlled organisations. Aboriginal community-controlled health organisations (6 Sites) participated as members of a Trial Committee, and/or were commissioned to undertake consultations (3 Sites). Other organisations included in Trial planning included:

- National or regional peak bodies such as the National Aboriginal Community Controlled Health Organisation, and the Aboriginal Medical Services Association Northern Territory
- Cultural or advocacy support organisations, such as KALAC, Empowered Communities, 2Spirits and IndigiLez
- NGO service providers, such as RM Williams Bush Learning
- Elders and community members, including young people
- The Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention was involved at two Sites and the Institute for Urban Indigenous Health at 1 Site.

People with lived experience of suicide

People with lived experience of suicide were involved in the planning at all Trial Sites, primarily as members of Trial Committees (11 Sites). Some were representing an organisation for people with lived experience of suicide, such as Roses in the Ocean. Others were participating in the Trial Committee in another capacity but also had lived experience of suicide. People with lived experience of suicide were also included in community consultations at six Trial Sites.

Community stakeholders

In their Annual Activity Workplans, all Trial Sites described a broad range of community stakeholders involved in the Trial planning, noting that they were either members of a Trial Committee or consulted as part of the planning process. The majority of community stakeholders mentioned were affiliated with NGOs, advocacy groups representing focus populations, or established local suicide prevention networks or groups.

10.4.3 Planning – Trial governance structures

This section describes the structures employed by Trial Sites to oversee the planning and implementation of Trial activities. The governance structures for the Trial Sites were described in the Annual Work Plans, committee terms of reference and other documents.

Note: Four Sites contracted regional organisations to run the local Trial activity within the Site and one Site contracted out management of the whole Site to an Aboriginal Community-controlled Health Organisation. In the latter case, the organisation took on the PHN coordinating role, so they are included below in the descriptions as a de facto PHN.

Overall Trial governance structures

While there were local variations at Sites in terms of the names of groups and committees and their exact parameters of activity, the main governance structures described in documents were as follows.

- PHNs convened an overall strategic advisory, decision-making and oversight that included broad stakeholder representation (including, where possible, stakeholders in decision-making positions in their organisations) and set the overall direction and priorities.

  PHNs also convened working groups or sub-committees with specific expertise to research the evidence and make recommendations to the overall committee, or alternatively make decisions about activities within the overall strategies set out by the steering committee. Four Sites had this structure.

- PHNs convened an overall steering committee which included broad representation and made decisions about general population strategies and overall coordination. In parallel, implementation groups of stakeholders from focus populations were established which made all the decisions on strategies and priorities pertaining to that population for the Trial. Three Trial Sites adopted this approach.

- PHNs established an overall steering committee as described above. In parallel, contracted organisations set up local working groups to implement local activities within the parameters set out by the overall steering committees. Those local working groups reported back to PHNs via representatives from the contracted organisations participating in the overall steering committee. One Site had this structure.

- PHNs did not establish a single overall steering committee (4 Sites). At those four Sites:
  - Regional steering committees to provide guidance on planning and implementation to PHNs were established in two regions. Contracted organisations set up local working groups which reported back to the relevant regional committee via the contracted organisation representative (1 Site)
  - Contracted organisations set up local working groups which reported back via the contracted organisation representative directly to the PHN (2 Sites)
  - PHN established a local working group which reported back to the PHN through PHN membership (1 Site).

Aboriginal and Torres Strait Islander governance

In the seven Sites with a focus on Aboriginal and Torres Strait Islander peoples suicide prevention, the governance structure and degree of Aboriginal and Torres Strait Islander leadership of the Trial varied across Sites. The main mechanisms were:

- Aboriginal and Torres Strait Islander-led overall Trial committees and working groups supporting those committees (2 Sites)
- Aboriginal and Torres Strait Islander-led implementation groups with decision-making responsibility (2 Sites)
- Aboriginal and Torres Strait Islander organisation representatives sit on overall Trial Committees (1 Site), regional Trial committees (1 Site) or local working groups where there is no overall Trial Committee (1 Site). Note that at two of these Sites local ACCHOs were commissioned to manage the Trial in sub-regions and had a degree of leadership of planning, but not carriage of the entire Trial within those regions.

10.4.4 Planning – facilitating factors

The main facilitating factor for planning described in documents was the involvement of key stakeholders in identifying needs, planning strategies and coordinating implementation. Table 10.3 describes the main mechanisms through which stakeholders were involved in the Trial planning, including membership of Trial Committees and participation in consultations.

Table 10.3 Document review: Mechanisms for stakeholder involvement in planning

Mechanisms	Sites (n)
Membership of Trial Committees	12
Participation in consultations	11
Member of a community organisation or ACCHO commissioned to lead all or some components of the Trial	6
Local suicide prevention networks or staff collaborating with PHN	3

Documents also described various levels of stakeholder involvement in planning and decision-making across Trial Sites.

At 10 Trial Sites, the PHN initially determined which systems framework approach to adopt, while at the two Trial Sites focused exclusively on Aboriginal and Torres Strait Islander suicide prevention, Aboriginal and Torres Strait Islander-led Trial Committees decided on the overall approach.

For the remainder of the Trial planning, the extent of stakeholder involvement and control over service and activity planning varied between Trial Sites, as well as sometimes within Trial Sites for different types of activities and focus populations.

For the 10 Sites which were not exclusively Aboriginal and Torres Strait Islander-focused, there were varying degrees of stakeholder involvement in planning and decision-making.

A higher level of stakeholder involvement occurred at Trial Sites that opted to co-design strategies with focus population groups and activities, either for the whole Trial Site or for particular elements of Trial activities (3 Sites). Other Trial Sites ensured a high-level of stakeholder involvement by having the majority, if not all, strategies and activities planned by contracted community organisations, with PHN guidance and support (2 Sites). In three Trial Sites, the PHN made unilateral decisions about the inclusion of individual services, but had a high degree of joint planning for the rest of the Trial activities. A lesser degree of joint planning occurred when the PHN and Trial Committees or contracted community organisations each made some decisions on strategies and activities, or when the PHN planned the overall strategies, and local community organisations or working groups identified specific activities within those strategies (2 Sites). The lowest level of stakeholder involvement in planning and decision-making occurred if the PHN decided the overall strategies, took advice on the specific activities from Trial Committees, but retained decision-making control over which activities to implement (2 Sites).

In some cases more than one approach was involved. For example, some PHNs made unilateral decisions around activities involving existing inter-agency or regional activity in which the PHN was already involved, but jointly plan other all other strategies. In other cases, there was a greater degree of stakeholder involvement in planning for a particular focus population than in planning for general population strategies.

Aboriginal and Torres Strait Islander leadership

Documents contained information on the extent of Aboriginal and Torres Strait Islander leadership of the Trial planning process at the seven Sites with this focus population group:

- At one Site, an Aboriginal and Torres Strait Islander organisation was contracted to manage the entire Trial and established Aboriginal and Torres Strait Islander-led Trial Committees to undertake the planning
- At three Sites, Aboriginal and Torres Strait Islander-led Trial Committees were established by PHNs which led planning and decision-making
- At two Sites, local ACCHOs or Aboriginal Medical Services were contracted to lead consultations and develop activity plans in their local regions within the Site, within PHN guidelines
- At one Site, Aboriginal and Torres Strait Islander stakeholders were involved in planning through membership of a general Trial Committee or informal consultation.

10.4.5 Planning – challenges

There was limited information on planning challenges in documents. Documents from nine Trial Sites provided some information on challenges encountered in the planning process. Challenges could be categorised as related to stakeholders, community readiness, or capacity and other issues. Table 10.4 outlines the main planning challenges mentioned in documents.

Table 10.4 Document review: Challenges encountered in planning

Challenges	Sites (n)
Stakeholder-related challenges	
• Length of time needed to consult with stakeholders	5
• Length of time to establish collaborations, build relationships and find common ground to develop plans	3
Community readiness and capacity	
• Community resistance to new initiatives and/or lack of buy-in	2
• Community and sector capacity in terms of skill, knowledge and time	2
• Community members unwilling to commit to a three-year project	1
• Recent bereavement and loss in the community	1
• Change/reform fatigue in the sector	1
• Competing priorities of stakeholders	1
Other	
• Lack of data/evidence for focus population groups or regional areas	2
• Slow pace of change in state systems	1

10.5 Systems approach

10.5.1 Developing a systems approach – strategies

A range of strategies for developing a systems-based approach were identified in documents and are described in Table 10.5.

Table 10.5 Document review: strategies used to develop a systems approach

Strategies	Sites (n)
Engaging with stakeholders across the sector	12
Adopting the LifeSpan or AAD systems framework	10
Developing referral pathways or health pathways	5
Signing of MOUs or formal agreements with state government departments, agencies and/or service provider organisations	4
Integration of suicide prevention activities within and between Trial commissioned providers	2
Integration of suicide prevention across PHN mental health services/activities	1
Partnerships and collaborations established to deliver Trial activities	1
Liaising with government agencies and other service providers in the sector to avoid duplication and establish linkages	1

All 12 Trial Sites focused on engaging with key stakeholders across the community, government and service sectors. Stakeholder involvement is described in Section 11.4.2.

Most Trial Sites elected to implement to some degree either the LifeSpan (8 Sites) or the AAD frameworks (2 Sites), which provided a framework for coordinating Trial activities. The two Sites focused exclusively on Aboriginal and Torres Strait Islander suicide prevention did not adopt the LifeSpan or Alliance frameworks. One used the ATSISPEP framework, and the other drew on ATSISPEP but also developed their own framework: Strengthening our Spirits.

10.5.2 Implementing a systems approach – impacts

Documents identified instances in which improved coordination of services and suicide prevention activities was achieved:

- PHN involvement in regional suicide planning, state government suicide prevention planning or activities, cross-sectoral or inter-agency committees (4 Sites)
- PHN coordinating activity with state mental health and health agencies or key service provider agencies (3 Sites)
- Care/health pathways developed (or under development) or dissemination of service information to agencies and providers (8 Sites)
- Involvement in Trial governance committees facilitating connection between service providers, agencies, NGOs – breaking down silos (9 Sites)
- Implementation of a “no wrong door” approach (2 Sites)
- Development and distribution of a region-wide protocol for self-harm and suicide and an implementation guide (1 Site)
- Development of an Aboriginal Cultural Security Framework and formal agreements with health and social support organisations to implement the Framework (1 Site)
- Data sharing agreements with agencies (ambulance, police) (4 Sites).

10.5.3 Developing and implementing a systems approach – challenges

Documents did not directly address challenges relating to implementing a systems approach, but documents from nine Trial Sites identified challenges involved in implementing the suite of planned activities and services indicative of system-related issues. These included:

- Recruitment of suitably qualified staff at provider organisations and turnover of staff at providers (2 Sites)
- Providers and community organisations need significant time for developing the knowledge, skills and confidence to deliver projects (2 Sites)
- Lack of services in general and lack of culturally safe services (for Indigenous and LGBTI) in particular, both to deliver Trial-funded services and to refer out to from Trial-funded services or meet increased demand generated by awareness raising (4 Sites)
- Poor awareness of other services and their activities (1 Site)
- Other lead agencies in the sector focusing on similar priorities but not collaborating with the PHN (1 Site)
- Funding insecurity (1 Site).

10.6 Aftercare services for people who attempt or are at risk of suicide

10.6.1 Aftercare services – approach

Four Trial Sites commissioned services for individuals who had made a suicide attempt or were experiencing suicidal ideation. In all cases, services filled a gap because they were established in regions or developed for population groups which were not covered by existing aftercare services.

Service description

All commissioned services were primarily aimed at supporting clients through case management and linking them with appropriate support and services in their community. Some services also included a clinical component, such as sessions with a psychologist. Three Sites developed service models for their chosen focus populations (Aboriginal and Torres Strait Islander peoples, LGBTI people) using a co-design process. One Site implemented the Beyond Blue Way Back model as a general population service, and one Site implemented a service model already operating in other regions of the PHN. Table 10.6 describes service types and the number of Trial Sites commissioning each type of service.

Table 10.6 Document review: Types of aftercare services established

Type of service	Sites (n)
Aboriginal and Torres Strait Islander specific	2
LGBTI specific	2
General population	2

Tailoring services

The main approaches to tailoring the services mentioned in documents were:

- Co-design of the service with Aboriginal and Torres Strait Islander peoples or LGBTI people (2 Sites)
- Contracting Aboriginal and Torres Strait Islander or LGBTI organisations to deliver the service to ensure trust and cultural safety (2 Sites)
- Including Traditional Healers, trauma-informed care, and narrative therapies as part of the service model in Aboriginal and Torres Strait Islander-specific services (1 Site)

- Broadening referral pathways and adjusting intake procedures in general population services to make them more accessible (1 Site).

Linkages and referrals

Documents indicate that one Site had a narrow referral pathway into their general population service limited to the local hospital, while the other three Sites had broader referral pathways into the service, including accepting referrals from hospitals, GPs, other health and social services, psychologists in private practice, police and magistrates courts, family, carers and self-referral. Two Sites had formal referral agreements in place.

Service promotion and recruitment

Primary Health Networks promoted the services via their established network of providers (2 Sites), regular communication with the relevant hospital staff if hospitals were the primary source of referrals (1 Site), and through the stakeholders involved in Trial Committees (4 Sites).

Involvement of people with lived experience of suicide

Documents indicated that people with lived experience of suicide were involved via participating in the co-design process, or as staff members, including as part of a peer-delivered service model at one LGBTI service.

10.6.2 Aftercare services – outputs and impacts

Documents had no information on impact of aftercare services on rates of suicide death or suicide attempts, and very limited information on the impact of services for clients. However, those provided indicated:

- Improvement in severity of suicidal thinking as captured on the Suicidal Ideation Attributes Scale (SIDAS) scale (1 Site)
- Improvement in level of distress as assessed on the K10 scale (2 Sites)
- Anecdotal feedback of positive outcomes from service (3 Sites)
- Anecdotal feedback of no repeat admissions to ED for service users (1 Site)
- Anecdotal reports of no new deaths by suicide in the local community (1 Site).

Other outcomes noted in documents include high levels of demand for the service, including waiting lists at some services; benefits for family and friends due to the holistic approach taken at one Aboriginal and Torres Strait Islander specific service; and close collaborative links being established between the Aboriginal and Torres Strait Islander service and the state mental health service, with an exchange of knowledge.

10.6.3 Aftercare services – challenges

Several challenges were identified in documents relating to the implementation of aftercare services, including:

- Availability of suitably qualified organisations to deliver the service (1 Site)
- Recruiting suitably qualified staff, and staff turnover at service providers (2 Sites)
- Getting referrals from hospitals (2 Sites), with documents from one Site noting this was due to the concerns about the non-clinical nature of the service
- Managing complex cases (2 Sites)
- Exit planning, due to long waitlists for LGBTI-specialist services to refer out to (1 Site)

- Receiving referrals outside the remit of the service, due to the service being known in the community as a culturally safe service for Aboriginal and Torres Strait Islander peoples (1 Site).

10.7 General population suicide prevention activities

10.7.1 General population activities – approach

Although all Sites identified focus population groups, most also implemented activities for the general population. Even Sites with a single focus population included general population activities as a way of reaching members of their focus population who may not identify with that population or participate in focused activities. (This section excludes the two exclusively Aboriginal and Torres Strait Islander Sites, which are discussed in Section 11.8.)

Activity description

The community-based dataset (Chapter 12) captures a more comprehensive account of activities delivered. Documents generally only indicated the range and types of activities conducted. The main activities for the general population described in documents were as follows.

Awareness raising and engagement activities. All 10 Sites also undertook awareness and engagement activities, including hosting or participating in community events, media and social media campaigns, and producing and distributing resources. At two Sites, small grant programs were implemented for community groups to run awareness and engagement activities. Not all awareness and engagement activities were focused directly on suicide prevention; some were directed more broadly at wellbeing, social connection or mental health generally.

Training to build capacity in communities, service providers, organisations, communities or other groups to identify and/or support with people at risk or affected by suicide. All 10 Sites undertook activity in this area. A variety of evidence-based trainings were conducted, including QPR, SafeTALK, ASIST, Mental Health First Aid and Mindframe media training. A range of other training packages were implemented for which the evidence base is still being built, for example, Wesley LifeForce Training, Community Response to Eliminating Suicide (CORES). Training for people with lived experience of suicide to become advocates was mentioned in documents from five Sites, and Train the Trainer programs were mentioned in documents from four Sites.

Professional development and training. Seven Sites provided professional development or training for GPs or other mental health or health professionals, including Advanced Training in Suicide Prevention, affirmative practice training, and workshops on working with older adults.

Other activities. Other activities mentioned in documents include research, scholarships, developing postvention protocols, referral pathways and care pathways, warm lines, and sponsoring conference attendance for PHN and/or contracted host organisation workers.

Tailoring activities

General population activities by definition did not target specific groups within the population, but rather reflected a place-based approach to suicide prevention. Documents from six Sites, all regionally based, mentioned activities undertaken to tailor general population activities to the local community. These included using local stories in information resources or media campaigns, engaging community champions, linking in with local events, and contracting local host organisations to implement Trial activities.

Linkages and coordination

Documents contained little information about linkages between Trial activities and the wider sector. Documents from four Sites mentioned coordinating activities with local suicide prevention networks, and two Sites noted that formal MOUs had been signed: one with first responders for postvention response, and a second with a local TAFE to deliver peer education project.

Activity promotion and recruitment strategies

The main strategies mentioned in documents for promoting Trial activities were via local media (6 Sites), social media and/or websites (5 Sites), and through local community organisations, business and networks (4 Sites).

10.7.2 General population activities – outputs and impacts

Five Sites provided documents which described activity impacts. Pre-post-activity surveys (4 Sites), post-activity surveys (4 Sites), and reports of informal or anecdotal feedback (4 Sites) all indicated that the activity had been beneficial.

Improvements were noted in general awareness (2 Sites), knowledge about suicide in general (3 Sites), knowledge about how to help and/or where to get help (2 Sites), confidence to help someone (3 Sites), intention to help someone (3 Sites), and willingness to seek help for self (1 Site).

10.7.3 General population activities – challenges

The main challenges encountered in implementing general population activities mentioned in documents were:

- Location related, including getting trainers to regional areas to deliver programs and getting the media interested in regional stories (2 Sites)
- Staffing related, including difficulties in recruiting and retaining staff (3 Sites)
- Participation related, including getting GPs to attend training and sustaining community engagement in local suicide prevention networks and activity over time (4 Sites)
- COVID-19 reducing ability to continue offering activities (1 Site).

10.8 Focus populations – Aboriginal and Torres Strait Islander peoples

10.8.1 Activities for Aboriginal and Torres Strait Islander peoples – approach

Activity description

At the time of the document review, two Sites with a focus on Aboriginal and Torres Strait Islander peoples had yet to roll out many of their planned activities, due to a protracted planning process and the disruption caused by the COVID-19 pandemic.

Two of the seven Trial Sites focusing on this population group commissioned individual services specifically aimed at Aboriginal and Torres Strait Islander peoples (discussed in Section 11.6.1).

Other activities mentioned in documents were:

- Awareness and engagement activities, including community events and workshops (6 Sites), creating and/or providing resources and information (2 Sites), and media and social media campaigns (4 Sites)

- Training to build capacity in the community (5 Sites), including Aboriginal and Torres Strait Islander-specific training programs such as Suicide Story, You Me Which Way, Aboriginal Mental Health First Aid, Liyan Natural helpers, Kimberley Empowerment Healing and Leadership Program, and generic training programs such as SafeTALK, Accidental Counselling and ASIST. Train the Trainer programs were also noted in documents from three Sites. Training to build capacity in the workforce was also delivered, including scholarships to support Certificate IV studies (2 Sites)
- Activities to strengthen connection to community and culture (5 Sites) including on-country camps and activities, men's and women's groups, young fathers' group, arts and music activities
- Cultural competency training for GPs and the health workforce (2 Sites), developing a postvention response protocol or service (3 Sites), an empowered young leaders campaign (1 Site), establishing and/or supporting an Aboriginal and Torres Strait Islander suicide prevention network (2 Sites), Traditional Healing (2 Sites) and equine therapy (1 Site).

Documents indicated that most Sites also provided some activities targeted at groups within the population, including young people (4 Sites), men (5 Sites), women (5 Sites) and service provider staff (5 Sites).

Tailoring activities

Documents described strategies used to ensure activities were culturally appropriate, including:

- Programs being delivered by Aboriginal and Torres Strait Islander service providers, trainers or facilitators (5 Sites)
- The involvement of Elders (2 Sites)
- Delivering programs specifically designed for Aboriginal and Torres Strait Islander peoples (5 Sites)
- Developing or providing a cultural safety framework for service providers (2 Sites)
- Co-design of activities with Aboriginal and Torres Strait Islander peoples (2 Sites)
- Holding separate sessions for men and women, using culturally-appropriate venues (2 Sites).

Activity promotion and recruitment strategies

Strategies mentioned in documents for promoting Trial services and activities and engaging community to participate included:

- Word of mouth (3 Sites)
- Merchandise, flyers and posters (5 Sites)
- Social media (4 Sites) and local media (2 Sites)
- PHN networks (2 Sites)
- Service provider networks (1 Site).

10.8.2 Activities for Aboriginal and Torres Strait Islander peoples – outputs and impacts

Information on impacts related to aftercare services is provided in Section 11.6.2. There was little information on the effectiveness of other suicide prevention activities. Documents from six Sites include anecdotal reports on the outcomes of Trial Activities. These included improvements in:

- Awareness and knowledge about suicide (2 Sites)
- Intention, willingness and confidence to help someone (2 Sites)

- Confidence to talk to others about suicide (1 Site).

Other impacts noted were greater connection to community and culture (1 Site), healing and strengthened wellbeing (3 Sites), and decreased thoughts of self-harm (1 Site). Documents from four Sites noted general positive feedback about programs had been received.

10.8.3 Activities for Aboriginal and Torres Strait Islander peoples – challenges

The main challenges noted in documents relating to implementing suicide prevention activities focussed on Aboriginal and Torres Strait Islander peoples were:

- Staffing issues including recruiting and retaining Trial staff and having adequate resources for staffing (4 Sites), staff recruitment and turnover at contracted organisations (2 Site)
- Poor attendance at events (2 Sites)
- PHN administrative delays in contracting (1 Site)
- Some organisations unwilling to collaborate (1 Site)
- Community readiness due to other priorities (2 Sites)
- COVID-19 (2 Sites).

10.9 Focus populations – men

Six Trial Sites elected to focus on suicide prevention activities for men.

10.9.1 Activities for men – approach

Planning of suicide prevention activities targeted at men was incorporated into the overall Trial planning process. No Trial Site established a specific Trial Committee to focus on men.

Activity description

None of the six Trial Sites focusing on this population group elected to commission individual services specifically aimed at men.

Activities focused on men mentioned in documents were:

- Awareness and engagement activities, including hosting or attending community events (4 Sites) and media campaigns (2 Sites)
- Training to build capacity, including evidence-based training programs QPR (2 Sites), SafeTALK (3 Sites), Applied Suicide Intervention Skills (1 Site) and other training programs for which the evidence base is yet to be established (4 Sites) including I'm Not Afraid To Talk, Save our Mates, Tomorrow Man, Check Mate. Four Sites had implemented some activity connected with the Mates in Construction – Mates General Awareness Training and/or Connector Training. At two Sites the Mates in Farming model was implemented; the two other Sites offered the standard Mates programs, through sporting clubs at one Site and in industry settings at the other.

Tailoring activities

Documents mentioned two main strategies for tailoring Trial activities for men:

- Offering training or running awareness-raising events in male-dominated environments, for example, workplaces, rotary clubs, and sporting clubs (4 Sites)
- Implementing male-specific training programs, workshops and campaigns (6 Sites).

Activity promotion and recruitment strategies

Documents mention several avenues through which potential participants were reached. These include promoting activities through:

- Word of mouth (2 Sites)
- Sporting clubs, pubs and bars (3 Sites)
- Local media (2 Sites)
- Social media and/or websites (2 Sites)
- Male-dominated workplaces (4 Sites).

10.9.2 Activities for men – outputs and impacts

There was little information in documents on the effectiveness of suicide prevention activities. Only three Sites provided documents reporting on activity impacts, including pre-post-activity surveys (2 Sites), a three-month follow-up survey (1 Site), and anecdotal feedback (1 Site). All reports indicated that the activity had been beneficial.

Improvements were noted in general awareness (1 Site), knowledge about suicide in general (3 Sites), knowledge about how to help and/or where to get help (2 Sites), and intention to help someone (1 Site). Other impacts mentioned in documents included 38 referrals to services by peoples who had undertaken Mates in Construction connector training, and participants in the Mates in Construction training reporting that they had used their skills or had sought help themselves.

10.9.3 Activities for men – challenges

The main challenges noted in documents relating to implementing suicide prevention activities focused on men were:

- Achieving buy-in from industries/workplaces/sporting clubs (2 Sites)
- Onerous administrative requirements and processes for delivering activities in workplaces (2 Sites)
- Managing expectations about the scope of training that could be provided within the time and funding constraints of the Trial (1 Site)
- COVID-19 (1 Site).

10.10 Focus population – young people

Two Sites identified young people as a focus population, although several Sites also included some youth-focused activities, including activities for young people within other focus population groups (i.e., young men, young LGBTI people).

10.10.1 Activities for young people – approach

Activity description

No youth-specific individual services were commissioned. Other activities included those targeting young people and those targeting people who worked with young people.

The main activities mentioned in documents were:

- Awareness raising and engagement, including media and social media awareness campaigns directed at youth (3 Sites) and community awareness-raising events (2 Sites)

- Capacity building for young people, including evidence-based programs Youth Aware Mental Health training in schools (4 Sites), providing bursaries and support for young people to study for Certificate qualification in community service (1 Site), and upskilling young people to participate in Youth Reference Groups (1 Site)
- Capacity building for those who work with young people, including evidence-based training programs such as Youth Mental Health First Aid (1 Site), QPR (1 Site) and ASIST (1 Site) for teachers and other school staff
- Professional development and training for GPs and other mental health and health professionals, including developing a GP training resource and offering Youth Mental Health First Aid
- Other activities, including developing and distributing resources for families to support self-harming youth, small grants, and a school support program.

Tailoring activities

The main mechanism for tailoring programs for young people noted in documents was the involvement of organisations representing or working with young people, such as headspace, education departments, and community organisations, in the Trial planning process through membership of Trial Committees.

Documents note minimal involvement of young people themselves in the planning process. The main mechanisms through which young people had input into Trial planning were consultation via a youth survey, the PHN employing youth project officers, and membership of a Youth Reference Group which was consulted as part of the planning.

Linkages and coordination

headspace was a key stakeholder at both Sites, and close linkages were established through representation on Trial governance committees, the use of the Headspace Youth Reference Group to inform planning, and locating Trial youth project workers at headspace. headspace was also commissioned to deliver activities.

Activity promotion and recruitment strategies

Documents indicated that Trial activities aimed at youth were promoted through media and social media and hosting events in locations where youth gather such as schools, sporting clubs and local skate parks.

10.10.2 Activities for young people – outputs and impacts

Documents provided little information on effective strategies for young people. Post-training surveys from one Site indicated improved awareness and confidence to help.

10.10.3 Activities for young people – challenges

Several challenges were mentioned in documents, including:

- Engaging GPs (1 Site)
- Engaging schools and getting access to students to deliver training (2 Sites)
- Reaching and engaging young people in Trial planning, as well as Trial activities (2 Site)
- COVID-19. (1 Site)

10.11 Focus population – ex-ADF members and their families

10.11.1 Activities for ex-ADF members and their families – approach

A single Trial Site focused on ex-ADF members and their families. The Site developed and implemented a strategy based on promoting social connection as key to wellbeing, rather than emphasising suicide prevention directly.

Activity description

No aftercare services were commissioned for ex-ADF members as part of the Trial, but there was a strong emphasis on developing general practice and mental health pathways for ex-ADF members. There was also strong involvement from stakeholders representing organisations that provide clinical and support services for ex-ADF members, such as Open Arms (an agency of the DVA).

Other activities included:

- Awareness campaigns involving media, social media and community events, including the Check Your Mates campaign
- Training programs, including Mindframe and programs for which the evidence base is yet to be fully established, such as CORES
- A small grants program to fund social and wellbeing activities for ex-ADF members and their families
- The development of a peer support model rolled out through Open Arms, and the development of Veterans health pathways.

Tailoring activities

There was no specific information in documents on how activities were tailored for ex-ADF members and their families.

Linkages and coordination

The local suicide prevention network was a key partner, with strong representation on the Trial Governance committee and close coordination of events and activities. There was also linkage with the DVA, through the Open Arms agency involvement in the Trial Governance Committee and adoption of the peer support model developed by the Trial. Linkages with the ADF were primarily through the connections of members on the Governance Committee with personnel at the local Army Facility.

Activity promotion and recruitment strategies

Activities were promoted through local media, social media, ex-ADF networks and organisations, the local suicide prevention network and through the networks of members of the governance committees.

10.11.2 Activities for ex-ADF members and their families – outputs and impacts

Documents provided included post-event participant feedback reports and anecdotal reports, all of which reported improvements in awareness and knowledge about suicide and its causes.

10.11.3 Activities for ex-ADF members and their families – challenges

Documents noted that the planned delivery of Youth Aware Mental Health training in schools could not proceed, because approval from local schools could not be obtained.

10.12 Focus population – LGBTI people

10.12.1 Activities for LGBTI people – approach

Two Trial Sites focused on LGBTI people.

Activity description

Both Trial Sites commissioned an LGBTI-specific aftercare service, and contracted service providers that delivered other LGBTI-focused services to develop and deliver them. Other suicide prevention activities implemented for this focus population included:

- Awareness raising through social media campaigns and attendance at community events
- Evidence-based training, such as QPR and SafeTALK, including Train the Trainer programs
- Training for general practice and other health, mental health and frontline workers, involving either affirmative practice training developed by the Site or the Screening Tool for Assessing Risk of Suicide Training
- Other programs such as a family and individual mentoring program, peer support events, and research.

Tailoring activities

At both Sites, LGBTI stakeholders were involved in the planning and development of suicide prevention strategies via Trial Committees which co-designed suicide prevention strategies with the PHNs. Those Trial Committees included representation from community-based LGBTI services, allied health practitioners focused on LGBTI communities, peak bodies such as the LGBTI Health Alliance and AIDS councils, advocacy groups, and people with lived experience of suicide.

Other ways in which Trial activities were tailored to be appropriate for LGBTI people included adapting existing training programs to be LGBTI inclusive, the delivery of generic suicide prevention training to specialist LGBTI agencies and services, and contracting services with LGBTI focus to deliver suicide prevention activities.

Linkages and coordination

Documents indicate that at both Sites aftercare services coordinated with a range of other agencies and services for referrals into the service, linking clients with other support services and referrals out of the service.

Activity promotion and recruitment strategies

Documents indicate that aftercare services were promoted through LGBTI organisations and networks, including those services and organisations that were involved in the Trial either as members of governance committees or commissioned providers of Trial activities.

10.12.2 Activities for LGBTI people – outputs and impacts

Documents from both Sites note that the LGBTI-specific aftercare services filled a gap, insofar as LGBTI people often did not feel safe presenting to mainstream services.

An evaluation of LGBTI-focused services and activities is underway at one Site, with results not yet available at the time of writing. Documents provided little information on impacts of activities and services for LGBTI people, with only one anecdotal report that participants benefited from using the aftercare service.

10.12.3 Activities for LGBTI people – challenges

Challenges mentioned in documents include:

- The extended length of time required for co-design resulted in a delay in rolling-out services
- Resistance from schools to LGBTI-focused training programs
- Recruitment and retention of suitably qualified staff for the aftercare service
- Difficulties obtaining referral to aftercare services from hospitals
- Exit planning for the aftercare service due to long waitlists for LGBTI services
- COVID-19.

10.13 Focus population – older adults

One Site identified older adults as a focus population. At that Site, local organisations were contracted to implement Trial programs in each of three regional areas within the PHN catchment.

10.13.1 Activities for older adults – approach

Activity description

No aftercare services were commissioned for older adults. Activities mentioned in documents were:

- Awareness raising, including community awareness-raising events and service navigation information sessions
- Capacity building with Mental health First Training for people who work with older adults
- Information sessions for GPs.

Tailoring activities

Documents mention liaising with peak bodies such as the Council on Ageing, and delivering programs to people who work with older adults as approaches to developing activities for older adults.

Activity promotion and recruitment strategies

There was no information in documents on how activities were promoted to older adults or to those who work with older adults.

10.13.2 Activities for older adults – outputs and impacts

A single post-activity participant feedback report indicated benefits from participation in terms of being more knowledgeable about suicide and its causes, how to help someone who may be at risk and where to get help.

10.13.3 Activities for older adults – challenges

There was no information on challenges in the documents.

11 Consultations with PHNs (interviews)

11.1 Summary of approach

Consultations were undertaken with PHN representatives via two rounds of interviews (group or individual) conducted in May–December 2018 and March–July 2020, and via a brief mid-Trial survey in mid-2019. This chapter describes the interviews and Chapter 13 describes the survey.

The two Sites that were exclusively focused on Aboriginal and Torres Strait Islander populations were not included in the Round 1 and 2 PHN consultations. As described in Chapter 2, a modified methodology was used for the evaluation of the Aboriginal and Torres Strait Islander component of the Trial. Findings from PHN consultations regarding Trial activities focused on Aboriginal and Torres Strait Islander people are reported in Chapter 17.

Trial coordinators were asked to identify PHN staff who had had some involvement with the planning and/or implementation phase of the Trial and invite them to participate in consultations. Interviews were conducted in person wherever possible, and by phone or via online videoconference (Zoom, Skype, Microsoft Teams) when this was not possible due to distance or timing or COVID-19 travel restrictions. The questions for the group and individual interviews were the same, and were based on the Evaluation Framework(10).

Round 1 questions focused on planning and implementation, including activities undertaken to identify local needs, stakeholder involvement, barriers; the development and implementation of a systems approach, including barriers; and planning, activities and challenges for focus population groups. Round 2 questions focussed on implementation, integration and coordination of services and activities; overall Trial impacts and outcomes; sustainability; and focus population activities and challenges. A list of Round 1 and Round 2 interview questions is provided in Appendix 4. Not all questions were asked at every interview; a subset relevant to each PHN staff member's role and the focus of their Site's activities was used.

Interviews were conducted by two evaluators, with one acting as scribe, and were also audio-recorded (with participants' permission). Group interviews lasted 1–2 hours, and individual interviews 30 minutes to one hour. Each participant received a plain language statement providing information about the evaluation and the interview, and all participants provided informed verbal or written consent to take part.

11.2 Sample information

Sixty-two PHN staff from 10 Trial Sites participated in consultations across two rounds. In Round 1, 46 PHN staff took part in consultations, with an average of five participants per Site (range 2–9). Thirty-nine PHN staff participated via group interviews (36 in-person, 3 via videoconference), five participated in individual in-person interviews, and two via individual phone interviews. One PHN staff member participated in two group interviews.

In Round 2, 36 PHN staff took part in consultations, with an average of four participants per Site (range 2–7). Twenty participants took part via online group interviews, 15 via online individual interviews, two via individual phone interviews, and one via an individual in-person interview. Two PHN staff participated in consultations for two Trial Sites which their PHN included. Twenty participants had also taken part in Round 1 consultations.

Table 11.1 details the roles of PHN staff who participated in interviews.

Table 11.1 PHN consultations: participant roles

PHN roles	Round 1 participants (n)	Round 2 participants (n)
NSPT coordinators, project workers	13	11
Portfolio manager: mental health, suicide prevention, AOD portfolio/program managers	7	4
Portfolio manager: other portfolio	8	4
PHN-wide suicide prevention managers	2	3
Commissioning, procurement officers	3	2
Communications/community outreach staff	3	-
CEO/executives	2	6
Research, evaluation, QA staff	3	4
Other	4	3

11.3 Data Analysis

Notes from the group and individual interviews were uploaded to NVivo V.12 for analysis. Thematic analysis of the interviews was then undertaken, considering all responses from all focus population groups, using the notes taken by the researcher, supplemented by the audio-recordings when needed. Initially, the two evaluators read all the interview notes and used the interview schedule to deductively identify key themes and develop a coding framework that captured the full range of comments. A modified framework analysis was conducted to order the themes into an overarching framework to make sense of the emerging themes(21). The two evaluators then independently coded two of the interviews and determined their level of agreement. The themes were further refined to address areas of disagreement, and consensus was obtained regarding the coded focus group. One of the evaluators then coded the remaining content, consulting with another evaluator when needed. The framework, and associated coding, was then finalised.

11.4 Planning

11.4.1 Planning – identifying local needs and service gaps

Trial Sites were asked to describe what activities they undertook to understand local needs and identify service gaps. The most commonly described strategies were consultation (10 Sites) and using data (9 Sites). Table 12.2 outlines the main strategies used by Trial Sites, and Appendix 5 details themes and provides related quotes.

A variety of consultation methods were used, including forums, meetings, surveys, individual contact from PHN Trial staff, and engagement with existing community networks. Many Sites used multiple, complementary methods of community consultation. Most community consultation activities were undertaken by PHN staff, but four Trial Sites also contracted external agencies, such as universities and consultants, to undertake some or all of the consultations.

Six Trial Sites incorporated information from consultations undertaken by the PHN as part of routine planning activities, such as routine needs assessments and service mapping activities. One Trial Site used findings from a previous PHN regional suicide planning symposium to inform the Trial planning.

Table 11.2 PHN consultations: Strategies used to identify local needs and service gaps

Strategies	Sites (n)
Trial-specific consultation	10
Consultation data from routine PHN needs analysis or service mapping activities	6
Data	
• Drew on data already routinely collected by the PHN	5
• Contracted and organisation to source relevant data	4
• Trial staff sought from data custodians (ABS, AIHW, LHNs)	3
• Anecdotal data from local service providers/agencies/ networks	4
PHN regional planning symposium findings	1
Existing interagency relationships	1
Employed local Trial Coordinators to identify local needs	1
Monitored media to identify trends in suicide	1
Ongoing evaluation of Trial activities to identify emerging needs	1

The number of community members and the extent of their involvement varied. For instance, at one PHN over 3000 community members and organisations contributed to the routine PHN Needs Analysis report that was used to inform Trial planning, whereas another PHN relied on a group of around 30 key community representatives throughout the Trial planning and implementation process.

Nine Trial Sites sourced data specifically to inform planning. Four Trial Sites contracted other organisations, such as the Australian Institute for Suicide Research and Prevention, universities and the Black Dog Institute, to source suicide-specific data.

11.4.2 Planning – stakeholder involvement

At all 10 Trial Sites the primary mechanism through which community stakeholders were involved in the planning process was participation in Trial Committees established to inform and guide the Trial. Six Trial Sites reported that they drew on pre-existing community groups to assist with planning for the Trial. These community groups typically comprised service providers and other key community representatives with an interest in suicide prevention. Staff from two Trial Sites described how these community groups incorporated the Trial into their remit, and the other four Trial Sites used community groups as the starting point for developing Trial-specific committees.

Primary Health Network staff described the involvement of a wide range of stakeholders in planning, including representatives from community-based service providers, federal and state governments, local hospital networks, local government, community organisations (including advocacy groups and local suicide prevention networks or groups), GPs and mental health professionals, first responders, Aboriginal and Torres Strait Islander organisations, and people with lived experience of suicide.

State government

Staff at two PHNs reported that the state government was not involved in the Trial; the other eight PHNs reported a range of state government involvement. Stakeholders at most of these eight PHNs reported that state government representatives attended Trial Committee meetings. Stakeholders at four PHNs reported a close working relationship with state government that was underpinned by formal agreements or supported by a state suicide prevention strategy. Other PHNs experienced frustration in their efforts to engage with their state government.

Staff at six PHNs reported that representatives of local hospital networks were involved in the Trial.

Local Government

Local government was involved in the Trial to varying degrees. Staff at two urban PHNs reported that the local government was not involved in the Trial. Other PHNs had involvement of local government in planning forums and ongoing representation in Trial groups. Some local governments were actively involved and had already been working in suicide prevention, while for other PHNs work was required to get local governments' buy-in to the Trial. Involvement of local government in the Trial was somewhat linked to the location of the Trial, with more involvement in rural areas.

Local Health Networks/ Hospitals

Seven Trial Sites described collaborations with LHNs and/or hospitals. These involved including LHN stakeholders in initial consultations and then ongoing involvement on Trial Committees, participation in care pathway mapping activities, and in sharing funding for a suicide prevention coordinator role at one Trial Site. In most cases Trial Sites reported a positive and effective relationship between the PHN and local hospitals.

General practice

Primary Health Network Staff reported a range of avenues through which they engaged with GPs, including GP representation in consultations conducted to establish local needs, GP representation on Trial Committees, involving GPs in health pathway development work, in developing specialist training or information resources for focus population groups, and offering suicide prevention training to GPs.

People with lived experience of suicide

Staff at nine Trial Sites reported involvement of people with lived experience of suicide in the planning for the Trial. In five PHNs, Roses in the Ocean facilitated involvement of people with lived experience of suicide through training of representatives. People with lived experience of suicide were members of various PHN Trial Committees involved in the planning and governance of the Trial.

11.4.3 Planning – facilitating factors

Stakeholders from all 10 Trial Sites identified strategies to respond to challenges and factors that facilitated local planning. They identified facilitators related to the PHNs' planning process and role, as well as community-related facilitating factors. PHN-related and community-related facilitating factors identified are listed in Table 11.3.

Table 11.3 PHN consultations: Facilitating factors and effective strategies for planning

Facilitators	Sites (n)
PHN-related facilitators	
• Skilled Trial staff	6
• Providing support and resources	3
• Working with existing organisations	2
• Time spent building relationships	2
• Maintaining engagement through information sharing	1
Community-related facilitators	
• Motivated community	7
• Pre-existing relationships with the PHN	4
• Established community networks	2
• Having the "right" people involved	3
Support from Black Dog Institute	8

Staff at six Trial Sites described individual PHN staff members who had brought skills to the role that had facilitated the Trial planning. Key skills identified were a background in community engagement, knowledge and passion about suicide prevention, good relationship skills, and existing connections with the community. These were seen as critical to the success of the Trial because the Trial was "outside how the PHN usually does things".

The most commonly reported community-related facilitating factor was a community that was motivated and "keen" to take part in the Trial, and community representatives who were passionate and eager to help.

Trial Sites use Black Dog Institute support in a range of ways. PHN Staff at four Trial Sites reported that they had used the Black Dog Institute to provide resources such as research and data to support the Trial. In three Trial Sites the Black Dog Institute had assisted selection of focus population groups. Other support provided by the Black Dog Institute included hosting national forums and workshops for Trial Sites, training for Trial staff, and regular monthly contact and support. The majority of the PHN staff were positive about the role of the Black Dog Institute in the Trial, describing its staff as supportive, responsive and helpful.

11.4.4 Planning – challenges

Primary Health Network staff at all 10 Trial Sites identified challenges encountered in the planning and implementation process. The key themes were stakeholder-related challenges, operational challenges, PHN-related challenges and data-related challenges. Table 12.4 details the main challenges encountered.

Stakeholder-related challenges

Challenges related to working with community stakeholders were raised by stakeholders at all PHNs. The most commonly-reported challenge, raised by PHN staff at seven Trial Sites, was that effective stakeholder involvement in the Trial took much longer to coordinate than was anticipated. Trust needed to be built between community stakeholders that had not previously worked together, and to overcome pre-existing tensions. PHNs also often needed to work to develop their relationships with community stakeholders.

Table 11.4 PHN consultations: Challenges encountered in planning

Challenges	Sites (n)
Stakeholder-related challenges	
• Length of time required to engage community	7

Challenges	Sites (n)
• Getting the "right" people on board	6
PHN-related challenges	
• Staff recruitment and retention	6
• PHN's relationship with the community	6
• Internal PHN systems and processes	3
Operational challenges	
• Short duration of the Trial	8
• Geography of Trial Site	6
• Funding	4
Data-related challenges	
• Lack of access to quality data	7
• Lack of real-time data on success of Trial activities	3

"Getting the right people on board" and getting those people to then work effectively together was also a common challenge, cited by PHN staff at six Trial Sites. Challenges to effective community stakeholder participation included practical constraints of meeting logistics, the capacity of the community stakeholders to be involved, the level of community buy-in to the issue, and other competing community needs and priorities.

PHN-related challenges

Primary Health Network staff at eight Trial Sites spoke about challenges related to the PHN that had affected the Trial negatively.

While staffing was also identified as a facilitating factor, PHN staff from six Trial Sites described problems with staffing of the Trial – primarily in finding skilled people to undertake the roles and high turnover of staff.

Staff at six Trial Sites identified the PHN's relationship with the community as an issue that hampered the Trial. Stakeholders from two PHNs reported that a negative perception of the PHN, or lack of knowledge of the PHN, in the community was an issue. PHN staff at three Trial Sites identified negotiating the level of PHN versus community ownership of Trial with the community as a challenge and noted that they had needed to step back and let the community own and drive the Trial.

Primary Health Network staff at three Trial Sites reported that internal contracting and procurement processes hindered the Trial by delaying implementation.

Operational challenges

Primary Health Network staff at eight Trial Sites raised the length of the Trial as a problem. As mentioned previously, involving community stakeholders in planning took longer than anticipated, and pressure was felt to achieve Trial goals within the original three-year timeframe.

Staff at six Trial Sites described challenges related to the geography of their Site. The distances required to travel to undertake work and meet people in person was a significant factor in rural Sites. Difficulties related to working across boundaries of hospital areas and across cities with different needs were also raised.

Funding challenges included restrictions imposed by government budget cycles, the siloing of funding from different levels of government, delays in receiving funding, and a need for more funding.

Data-related related challenges

Primary Health Network staff at seven Trial Sites reported that difficulty in accessing good-quality data was a challenge for planning. Trial Sites were keen to access data related to suicide attempts and deaths, especially regarding their focus population groups, but they reported that data was not available, delayed or was inaccurate. Lack of data reduced Trial Sites' ability to effectively plan Trial activities. Three Trial Sites also said that they lacked real-time information about which suicide prevention activities were successful, which they could have used to assess if they were on the right track.

11.5 Systems approach

11.5.1 Developing a systems approach – strategies

Primary Health Network staff described strategies that had they had found effective in promoting a more coordinated and integrated approach to suicide prevention within their Trial Site regions. All 10 Sites included in consultations identified working with a systems framework and the involvement of stakeholders from across the system in the Trial planning and/or governance structures as effective strategies. A range of other strategies also considered effective are detailed in Table 11.5.

Table 11.5 PHN consultations: Strategies effective for facilitating a systems approach

Strategies	Sites (n)
Involving key stakeholders from across the sector	10
Adopting or adapting a systems framework	10
Existing PHN governance and processes	4
Linking with key local groups/organisations	3
Community development approach	2
Identifying system-level needs or gaps	2
PHN flexibility in commissioning	2
The Trial coordinator role	4
Other	4
Development of referral or health pathways	4
Using commissioning to support integration and coordination	4

Staff from all 10 Trial Sites described stakeholder involvement as key to developing a systems approach in terms of fostering engagement and cooperation across the wider sector. Stakeholder engagement is discussed in detail in Section 12.4.2 above.

All 10 Trial Sites included in consultations had elected to work with a systems-based framework, eight with LifeSpan and two with the AAD. However, most determined that it was not feasible to implement all the strategies included in the frameworks and identified a subset of interventions and activities to implement. In particular, only four Sites opted to implement services for individuals such as aftercare services or other clinical services. The reasons given were concerns about sustainability and potential harm in withdrawing a services at the end of the Trial. PHN staff from six Sites felt having a framework was a useful tool, because it gave an overall structure to the Trial program of work, helped identified areas to focus on, and aided in communication with stakeholders and working group members to promote a shared understanding of the objectives and approaches.

Staff at seven PHNs spoke about the way in which they had adapted their chosen framework to be appropriate for their local context (e.g., regional communities with limited services) or to suit their focus populations. One PHN staff member spoke about how they had talked with their GPs and learned that the way they assessed for depression was different than described in their framework.

At another PHN, a staff member reported that they had added an element to the framework regarding “social-connectedness, belonging, culture”. Staff from PHNs who were using the AAD framework explained that they had chosen the framework for its focus on depression and working with general practice rather than suicide, which felt like a “good fit” for the PHN.

Primary Health Network staff from four Trial Sites noted that the usual business of the PHN – including existing PHN governance structures, PHN participation in inter-agency and multi-jurisdictional committees and working groups, their established relationships across the sector including with State based agencies, and their role in regional planning activities – aided in working towards adopting a systems approach.

Four Sites mentioned the importance of a coordinator role to facilitate and maintain engagement between service providers and organisations. It was noted that the engagement and coordination between organisations requires time and resources which organisations themselves don’t have capacity to provide, and so without a resourced dedicated role the level of engagement, the cooperation and integration that has resulted from the Trial will not be sustainable.

Staff from four Sites used the commissioning process to foster integration of suicide prevention-specific activity with other PHN-funded activity. One Trial Site described how they commissioned a provider for a Trial-funded service which provides other related services as a way of building integration between services; another described including suicide prevention knowledge/experience as a requirement when commissioning non-suicide-specific mental health services.

Primary Health Network staff at two Sites mentioned a community development approach as an effective facilitator. They considered that it increased community buy-in, promoted community ownership and control, focused on social connectedness, general community wellbeing, sustainability, and bringing community and the mental health/health system together.

Staff from three Trial Sites noted that linking in with key local groups or agencies facilitated coordination across the sector, though not necessarily covering all elements. Two Sites highlighted the role of local Suicide Prevention Networks and one local government. All three Sites were in regional areas.

Staff from two PHNs noted that flexibility was required in PHN funding guidelines to be able to fund the broader range of community-based activities that are included in the systems frameworks, because these fall outside the traditional commissioning remit of PHN. As part of the Trial, the PHNs had been able to have that flexibility.

Primary Health Network staff at two Sites mentioned identifying needs and gaps as a way in which they engaged with addressing system-wide change. Both mentioned a focus on system-level needs, rather than service-level needs, in terms of identifying pressure points within the system as well as silos, and attempted to address these in planning.

Other strategies mentioned by single Sites only as facilitating a more coordinated approach to suicide prevention were:

- Including a requirement for integration of services in contracts with commissioned providers
- Implementing suicide awareness programs across all the PHN’s commissioned services, not just the Trial services, which strengthened awareness and cooperation around care pathways in the region
- Signing a formal MoU with the State Health Service
- The coordinator dealing directly with other services and organisations to promote referrals.

11.5.2 Implementing a systems approach – impacts

Integration of Trial activities and services with existing activities and/or services

Primary Health Network staff from nine Trial Sites commented on the integration of Trial service and/or activities with existing services. Staff from five Trial Sites felt that there had been integration of Trial activities and services with existing services and agencies, with the qualification that integration was still a work in progress. Staff from two Sites noted that there had been only a small degree of integration, while staff from two Trial Sites considered there had been little or no integration. Neither of the latter two Sites had implemented individual services.

Among Sites which did report some degree of integration, PHN staff mentioned a range of avenues through which that integration had been achieved. There was no dominant approach taken across Sites, with the most frequently mentioned outcome being increasing the availability of information on existing services and/or health pathways (4 Sites). Other impacts are noted in Table 11.6.

Table 11.6 PHN consultations: Impacts related to service and activity integration

Impacts	Sites (n)
Integration within and between commissioned providers	2
Partnerships and collaborations in delivery	2
Development of referral pathways	2
Development of health pathways, service information provision	4
Integration via participation in PHN governance bodies	1

The organisations commissioned to provide Trial services and/or activities played a role in working towards integration in several respects. For example, commissioned service providers integrated the Trial-commissioned service or activity with the other activities they offered and by using their existing networks and connections to other services to integrate Trial activities/services. Where a commissioned organisation was a lead service provider in their particular locale or for a particular population group, it had more opportunity for achieving integration via those avenues.

Partnerships and collaborations between commissioned organisations were also noted as an avenue for service integration, including the development of referral pathways. Referral pathways between commissioned services and state agencies also increased service integration. Non-Trial PHN governance bodies have cross-sectoral representation and provided a forum to pursue linkages between Trial services/activities and other services.

Achieving a more integrated and coordinated approach to suicide prevention across the system

Staff from 7 PHNs identified impacts related to overall integration and coordination across the system. Key impacts identified were building relationships, the transfer of knowledge and breaking down silos. Table 11.7 outlines main impacts.

Table 11.7 PHN consultations: Outcomes related to system-wide integration and coordination

Impacts	Sites (n)
Building of relationships and partnerships	7
Transfer of knowledge	5
Connected services and agencies: breaking down silos	4
Co-hosted events, aligning with other activities	2
Widened PHN scope of activities	2
Other outcomes	2

The most commonly-mentioned impact of the Trial in terms of endeavouring to establish a systems approach was the building of partnerships and relationships between organisations. This included between PHNs and NGOs , between PHN and state health and mental health agencies, and between PHN and federal agencies (7 Sites).

Another impact in terms of promoting greater coordination and integration, mentioned by PHN staff from five PHNs, was the mobilisation of the knowledge gained in the Trial. This took the form of the take-up Trial programs by organisations not involved in the Trial (1 Site), organisations integrating a Trial program across all their activities (1 Site), and the sharing of learnings and models from the Trial with other organisations, PHNs and state government (2 Sites). Staff from three PHNs described how their PHN was working with state government to provide input into suicide prevention at the strategic policy level based on their increased knowledge from the Trial.

Staff from four PHNs noted as a key impact that the Trial enabled organisations and services to connect and gain awareness about each other and the services and activities they offered. This included both commissioned organisations and those that were not commissioned but were involved in the planning phase of the Trial.

Primary Health Network staff from two Sites noted that co-hosting events and collaborating on delivering training increased integration with community-based suicide prevention organisation grassroots activities and state government initiatives.

Staff from two PHNs identified the widening the PHN scope as an impact of efforts to take a systems approach. This included taking a more active localised community development approach, commissioning a range of activities wider than services and health promotion, and also being more flexible about contracting requirements and guidelines.

Other impacts resulting from adopting a more coordinated approach mentioned by a single Site were:

- Building of capacity across non-specialist services as a way to break down silos between specialist and mainstream services
- Commissioning of programs to fill gaps and provide a full suite of prevention, aftercare and postvention programs
- Involvement of a large number of diverse organisations, agencies and business across regional communities (60 organisations).

11.5.3 Developing and implementing a systems approach – challenges

Primary Health Network staff identified a range of challenges encountered in the process of developing and implementing a systems approach. Table 11.8 outlines the main challenges mentioned.

Table 11.8 PHN consultations: Challenges in establishing a systems approach

Challenges	Sites (n)
Implementing a systems framework	
• Resistance from community to systems frameworks	6
• Lack of information and support on implementation of LifeSpan	3
• Negotiating the level of modification required to the selected framework to meet local needs/preferences	4
Coordination and integration challenges	
• Conflict/competition between providers or community organisations	6

Challenges	Sites (n)
• Limited influence across the system	5
• Other barriers to integration	3
Stakeholder-related challenges	
• General stakeholder engagement (described in 4.4.2)	10
• State government	4
• Local councils	3
• General practitioners, hospitals	3
• Education departments, schools	4
• Service providers	3
• Other key stakeholders	2
Capacity and logistic issues	4
Other challenges	2

Systems framework-related challenges

Staff at six Trial Sites described encountering resistance from the community about their chosen systems framework. PHN staff noted that there were concerns from the community that the framework would not be appropriate for them, and that community representatives had communicated that “we already know what we’re doing”.

Primary Health Network staff at three Trial Sites commented that they lacked information and support about how to operationalise and implement the LifeSpan framework, and that they required assistance in translating the research into action. PHN staff from four Trial Sites felt that the Black Dog Institute was not always able to adapt the LifeSpan framework to local conditions and need, and two noted that the Black Dog Institute was insufficiently resourced to provide the level of support they required. Three Trial Sites mentioned the dual roles of the Black Dog Institute, noting that it was also a provider of several recommended training packages.

Stakeholder-related challenges

In terms of key stakeholder challenges, three Trial Sites noted difficulties in engaging with state government, with one suggesting that, having already developed a State Suicide Prevention Plan, there was some strategic planning fatigue. Two Sites commented that incompatibility with the operating procedures or structures of State agencies hampered the implementation and coordination of services or activities, and one Site mentioned that the time-limited nature of Trial activities was an impediment to getting state government buy-in.

Three Trial Sites also noted difficulties getting local government involved, indicating that they had different priorities, may not have established networks in the health sector, and lacked capacity in terms of time and knowledge of the area. One Trial Site noted that it was a challenge to engage GPs in development work, both due to lack of capacity and unwillingness to step outside their traditional role. Two Trial Sites reported that gaining access to schools to implement programs is time-consuming and not always possible.

Staff from three Sites noted challenges related to achieving engagement from organisations that provide services/activities. These were related to providers being unwilling to engage if they were not receiving funding from the project or to participate in any activity that was outside the scope of their usual business.

Coordination and integration challenges

Primary Health Network staff from six Trial Sites noted that service providers and organisations were often in competition with each other for funding. In some cases there were pre-existing conflicts between community organisations, meaning that considerable time and effort were required to repair and build relationships in order to establish a coordinated approach.

Staff from five Sites identified the limited degree of influence of PHNs (3 Sites), local organisations commissioned to implement the Trial (1 Site), and the membership of the Trial Committee (1 Site) as a challenge for implementing a systems approach.

Staff from three PHNs mentioned barriers to achieving integration across the system. PHN staff from two Sites thought that integration and coordination had not been prioritised, and that at their Sites the focus on community-level activities rather than on service delivery did not lend itself to a more integrated approach. One other Site, which did include a service delivery element, noted that while there was more integration it was at the service level, not the system level.

Operational and logistical challenges

Staff from four PHNs raised challenges related to operational and capacity issues, all of which were in regional or rural locations. Challenges included staff turnover in regional areas, diversity of local government's engagement across large regional PHN catchments, a lack of service capacity to deliver new services in regional areas, and the Trial Site catchment sitting across regional boundaries.

Other

Other challenges identified were the difficulty in migrating learnings from specialist services for target populations into mainstream services (1 Site), and the lack of data on focus populations to provide evidence of need (1 Site).

11.6 Aftercare services for people who attempt or are at risk of suicide

11.6.1 Aftercare services – approach

Service description

Four Trial Sites implemented non-clinical follow-up aftercare for individuals who had made a suicide attempt or were experiencing suicidal ideation. Across the four Sites there were three general population services (2 Sites), two Aboriginal and Torres Strait Islander-specific services (2 Sites) and two LGBTI-specific services (2 Sites). All services were commissioned to address a lack of services either in a specified region or for a specified population group. PHN staff from the two Sites that commissioned general population services noted that the new service enhanced prior PHN suicide prevention activity in terms of complementing existing commissioned services and increasing the focus on aftercare.

Tailoring services

Staff from three Sites described ways in which the services were targeted either to regional context or focus population. The three strategies mentioned included co-design of the service model with stakeholders from focus populations (2 Sites); adapting Beyond Blue's Wayback service model, particularly the referral and intake pathways, to suit regional settings (1 Site); and delivery of the service by focus-population provider organisations (1 Site).

Service promotion and recruitment

Services at all four Sites received referrals from GPs or local hospitals, with two Sites having formalised referral agreements with hospitals in place. One Site implemented the Wayback service, which has a restricted referral pathway from hospital only, while the other three Sites accepted referrals from a wider range of sources including police, ambulance, community mental health services, other service providers delivering Trial activities, as well as self-referrals and referrals from family and carers.

Linkages

The service model at all six aftercare services is a case-management approach which involves linking service users with appropriate services and supports in the community. PHN staff at three Sites noted that linkages with other services included connecting clients with other services offered by the commissioned provider or with organisations that were part of their networks. At the PHN level, linkages were facilitated through the PHN Trial Committees (2 Sites).

Involvement of people with lived experience of suicide

People with lived experience of suicide were involved in a range of capacities, including assessing the need for the service (1 Site), design of the service model (3 Sites), and delivery of the service (1 Site).

11.6.2 Aftercare services – outputs and impacts

Staff did not have specific information on whether suicidal behaviour and self-harm had been prevented among aftercare service users. Outputs and impacts for service users are described in Chapters 21 and 22. PHN staff did, however, describe other outputs resulting from the implementation of the aftercare services relating to meeting needs and fostering a coordinated approach.

Complementing existing services or filling a service gap

Primary Health Network staff from all four Trial Sites that commissioned aftercare services were strongly of the opinion that the services had successfully filled a gap, either in their region or for a population group that had no targeted culturally safe services prior to the Trial.

Meeting needs and expectations

In terms of meeting community needs, PHN staff from three Sites indicated that the services had had good uptake, with two Sites reporting that services were at capacity. PHN staff indicated they had received feedback that clients were happy with the service (2 Sites), and that the service was valued by other service provider organisations (2 Sites).

Staff from two Sites believed that the services were meeting their workplan targets, while at one Site the provider had experienced difficulties for some time in obtaining referrals, which initially restricted their ability to meet their targets.

Coordination with other services

At all four Sites offering aftercare services, coordination between the aftercare service and other services was achieved primarily through the establishment of referral pathways. Other effective coordination strategies mentioned included involving the state health department, state mental health and LHN representation on the Trial Committee (1 Site), and integration of the services with the other services delivered by the provider (1 Site).

11.6.3 Aftercare services – challenges

Primary Health Network Staff identified several challenges relating to implementation of services, as well as the strategies used to address them. Table 11.9 lists the main challenges experienced.

Staff at three Sites indicated that establishing the initial referral pathways and building knowledge and trust with potential referrers about the service were early challenges. Strategies to address that challenge included the service provider staff having face-to-face meetings with potential referrers, providing feedback on the service outcomes to referrers to demonstrate the value of the service, and including information about the service in community campaigns.

Table 11.9 PHN consultations: Aftercare service implementation challenges

Challenges	n
Referrals	3
State and local hospital system issues	2
Provider operational issues	2
Sector capacity	2
Other	1

Staff at two Sites referred to challenges related to state agencies, including the local hospital systems. At one Site, the challenges included incompatibility in assessment and case risk classification between the state-mandated model and the aftercare service model, which affected who was referred to the service. The challenge was addressed through negotiations between the provider and state agencies over referral pathways. The other Site experienced challenges around the reluctance of LHDs to refer into the service, because it was a non-clinical service and they were not confident referring vulnerable clients to it. The challenge was addressed in part through adjusting the model of care to include a more clinical focus, with a clinician as team leader as well as implementing a bi-lateral agreement with the LHD.

At two Sites there were challenges relating to service delivery capacity, with providers not having sufficient staff to deliver the type or volume of services required. These issues were addressed by restructuring contracts.

At the two regional Sites implementing aftercare services, issues around sector capacity were raised – specifically, the limitations of the mental health infrastructure (1 Site) and limited availability of a peer workforce (1 Site).

Two further challenges mentioned by one Site were the need to build an understanding of the service with peak organisations so they would promote the service, and the need to build understanding with potential clients so they would trust the service and make use of it.

11.7 General population suicide prevention activities

Most Trial Sites implemented whole-of-population, whole-of-community activities in addition to more targeted activities for focus populations.

11.7.1 General population activities – approach

Activity description

Specific information on the types of activities implemented as part of the Trial were not sought in consultation with PHN staff, because this information was more comprehensively captured in the community-based activities dataset (reported in Chapter 13). While all Sites specified focus population groups, they all also commissioned activities directed at the general population. This was particularly the case in regional Sites. Examples of general population activities include:

- Media campaigns that may have been focused on issues relevant to the target population but had a general population reach

- Community-wide initiatives such as workshops, suicide prevention training courses, and community events
- Developing general health pathways
- Establishing or supporting local suicide prevention networks
- Capacity-building such as Train the Trainer training, offering scholarships to support Certificate IV training
- Supporting people with lived experience of suicide to participate and become advocates.

Tailoring activities

General population activities, by definition, are not tailored for a particular focus group. However, PHN staff from six Sites indicated that they commissioned broader community-focused or whole-of-population activities to reach members of their focus population who may not identify or align themselves with that population or be isolated (3 Sites), or because in smaller regional settings there is community resistance to only offering services or activities to particular segments of the population (3 Sites).

Linkages and coordination

Approaches to coordinating and integrating are as described in section 12.5.2.

Activity promotion and recruitment strategies

Media campaigns (2 Sites) and getting the word out through stakeholder networks (1 Site) were the two strategies for whole-of-population activities specifically mentioned.

Involvement of people with lived experience of suicide

Staff from six Trial Sites described the involvement of people with lived experience of suicide in their general population activities. At all six Sites, people with lived experience of suicide had been involved through their participation in the planning phase via membership of Trial Committees, and at four Sites through involvement in delivering programs, the commissioning process or participation in media campaigns. Five Trial Sites funded Roses in the Ocean training for people with lived experience of suicide as part of their whole-of-community suicide prevention activities.

11.7.2 General population activities – outputs and impacts

Primary Health Network staff did not have information on the effectiveness of general population activities with respect to the Trial outcomes of preventing suicide or self-harm. However, they described outputs and impacts resulting from the implementation of activities related to meeting needs, fostering a more coordinated approach and increasing awareness and knowledge.

Complementing or filling a gap

Staff from all 10 PHNs expressed the view that overall, the Trial activities addressed a gap or need. PHN staff at two Sites noted that a lack of data and time to systematically assess needs in some cases meant that Trial activities may not have been optimally directed toward greatest need.

Coordination of activities

Primary Health Network staff from seven Sites provided examples of areas in which greater coordination and/or integration of population-wide suicide prevention activities had been achieved:

- Organisations jointly providing activities (3 Sites)
- Partnerships formed between key stakeholders (2 Sites)

- The establishment of ongoing local suicide prevention or mental health and wellbeing networks (2 Sites).

Met needs and expectations

In terms of meeting needs, PHN staff from four Sites indicated that the activities had been well received and had had good uptake among both community members (4 Sites) and GPs (2 Sites). PHN staff indicated they had received feedback that activity participants were satisfied with the Trial activities (3 Sites), but dissatisfaction with Trial activities was noted at two Sites. GPs were dissatisfied with the selected training package in one instance, and in another due to unmet community expectations about the scope of activities the Trial should deliver.

Staff from five Sites believed that the Trial activities implemented at their Site were consistent with their workplan targets, and had wholly or partially achieved their workplan objectives. However, PHN staff noted that the initial workplans were often developed in a rushed manner, in the absence of data and prior to a full community consultation process, and so did not accurately reflect community priorities and capabilities. As such, workplans evolved over the course of the Trial, with later workplans much more accurately reflecting feasible objectives and targets.

Increased awareness and knowledge

Primary Health Network staff from eight Trial Sites commented that the Trial activities had increased knowledge about suicide and/or responsiveness to the needs of people at risk for suicide. They offered a range of examples, including raising community awareness, reduction of stigma and increased knowledge. In most instances the source of the information was from informal feedback, anecdotal reports or observations, with only three instances citing campaign evaluation, survey or participation numbers. Table 11.10 details the impacts identified.

Table 11.10 PHN consultations: Awareness and knowledge impacts

Impacts	Sites (n)
Increased community awareness	7
Increased knowledge	7
Reduced stigma	5
Increased confidence to provide help	3

Greater community awareness around suicide, suicide prevention, depression and/or mental wellbeing was a key outcome mentioned by PHN staff at seven Sites. PHN staff at one Site cited a consultant’s report on impact of a media campaign, and another Site noted that it had reached over 100,000 people over the life of the Trial through media campaigns and other Trial activities.

In terms of increasing knowledge, PHN staff referred to the uptake of structured suicide prevention training programs (QPR, SafeTALK, ASIST etc.) among frontline staff, GPs, service providers (5 Sites) and the broader community (5 Sites), while two Sites also mentioned Train the Trainer programs.

Primary Health Network staff from five Trial Sites reported that as a result of the Trial activities that there had been a reduction of stigma and that people were more willing to have a conversation about suicide or mental health. One Site reported that they received feedback from local GPs that there seemed to be less stigma and they had been seeing an increase in people seeking help for mental health problems.

Finally, three Sites noted that participants in training indicated they would feel more confident to provide help to someone at risk for suicide or experiencing mental health problems.

Other impacts

Staff mentioned a range of other impacts. Several PHN-related outcomes were noted, including the building of knowledge and expertise in suicide prevention in the PHN network (1 Site), new skills in using media for initiatives (1 Site), and new approaches to funding and commissioning services at PHN (2 Sites).

Community impacts mentioned included providing the community with a grounding in evidence-based narratives; increasing their knowledge about and confidence to act on suicide prevention; empowering and engaging community to be part of the change; increased community pride, ownership, connectedness and resilience; and the community gaining understanding of how systems work and how to work with them.

Other impacts noted were the successful participation in work to restrict access to a known site where multiple suicides had occurred (1 Site), suicide prevention workforce capacity building (1 Site), and the transfer of Trial learnings/programs to other areas of an organisation's work or other regions within the PHN (1 Site). Staff from one Site reported that police and postvention data showed there had been a reduction in suicides in the Trial Site's region.

11.7.3 General population activities – challenges

Primary Health Network staff identified the main challenges to the overall success of general population activities as being related to engaging general practice (4 Sites), engaging the community (4 Sites), and Trial design (4 Sites).

Staff from four Sites noted they had been less successful than they'd hoped in engaging GPs, noting the multitude of demands on GPs' time, the transient GP workforce in regional areas, the business model of general practice clinics, and the time requirements of some of the suicide prevention training packages for GPs as underlying factors. Approaches to overcoming these problems included developing alternative training packages, offering training out of hours, and running events with high-profile GP "champions". However, overall PHN staff felt there was a need for substantial further work to fully engage general practice.

Staff identified community-related challenges including resistance to evidence-based approaches, existing community suicide prevention networks or lived experience of suicide organisations not knowing the impact or safety of their (pre-Trial) activities, dominant organisations wanting to impose their own agendas, and lack of reporting transparency in local implementation organisations. The main approach to managing community-related issues involved Trial Coordinators engaging in extensive interaction with community organisations and members to build knowledge and relationships.

Trial design challenges related to timelines, sustainability and the applicability of systems frameworks.

11.8 Focus population – Aboriginal and Torres Strait Islander peoples

Separate consultations were held with PHN staff from the Trial Sites focusing on Aboriginal and Torres Strait Islander suicide prevention. These are reported in Chapter 17.

11.9 Focus population – men

Six Sites identified men as a focus population group, in some instances focusing on particular cohorts such as farmers, fishers, miners or older men.

11.9.1 Activities for men – approach

Activity description

Comprehensive information on activities implemented for men is collected in the community-based activities dataset and is reported in Chapter 13. However, PHN staff from the six Sites described in general terms the range of activities that had been implemented. Activities were primarily focused on awareness raising around mental health and suicide and providing information on where to seek help. They included media and social media campaigns, community events with lived experience of suicide/community champion speakers, and providing information at regional events such as farming field days. Structured male-focused training programs such as the Mates in Construction General Awareness Training and/or Connector Training were implemented three Sites.

Tailoring activities

There were two main approaches. The first involved delivering generic programs and materials/information in environments where men congregate, such as workplaces, men's sheds, pubs and sporting clubs (3 Sites). The second was to partner with male-focused organisations (e.g., Mates in Construction, Mates 4 Mates, Stop Male Suicide) to deliver male-specific programs and workshops (5 Sites). One Site also engaged with women to get them to take the message home to their male family members.

Activity promotion and recruitment strategies

Primary Health Network Staff noted that men can be difficult to engage. They described a range of avenues through which they accessed male community members, including sporting clubs, employers or workplaces, local councils, service clubs and farming field days (3 Sites). The involvement of men with lived experience of suicide in delivering activities and the presence of active community champions was mentioned as an effective strategy to encourage men to participate (2 Sites).

Involvement of people with lived experience of suicide

Staff from three Sites described a range of ways in which men with lived experience of suicide were involved in Trial activities. They included delivery of community awareness activities and appearing in media campaigns (2 Sites), becoming trained trainers in Mental Health First Aid (MHFA)(1 Site), and contributing via Trial Committees (2 Sites).

11.9.2 Activities for men – outputs and impacts

Staff did not have information on the effectiveness of Trial activities with respect to the Trial outcomes of preventing suicide deaths or suicidal behaviour among men. However, they described outputs and impacts resulting from the implementation of activities related to meeting needs, fostering a more coordinated approach and increasing awareness and knowledge.

Complementing or filling a gap

Primary Health Network staff from four Sites stated that the focus on men was based on needs being identified for this target population. Needs were ascertained through consultations with community and other stakeholders (4 Sites) and by using data (3 Sites). However, PHN staff from one

Site commented that other population groups with higher incidence of suicide death in parts of their catchment were not being reached.

Coordination of activities

Staff from two Sites commented on coordination; at one Site, staff commented that there had been some service improvement in service integration for men but there was still work to be done. PHN staff at the other Site noted that the Trial Coordinator was engaging with established local networks for men, and through that had increased collaboration between organisations.

Met needs and expectations

Staff from three Sites reported they had good uptake of activities targeting men. However, one Site reported modest participation in training programs from men, and that their partners were attending instead.

Two Sites reported that they had received informal positive feedback from participants in community awareness and training activities, and one Site reported positive feedback from other stakeholders.

Increased awareness and knowledge

Primary Health Network Staff from three Sites believed that the Trial activities had improved awareness of the issue of male suicide.

Other impacts

Staff from one Site relayed anecdotal reports of more men seeking help from GPs in the region following the roll-out of Trial awareness-raising and mental health training activities.

11.9.3 Activities for men – challenges

Primary Health Network staff from four Trial Sites identified challenges that reduced the success of Trial activities for men:

- Difficulty in engaging men directly in the Trial planning (2 Sites)
- Scarcity of experts on men’s mental health and suicide in regional areas (1 Site)
- Difficulty getting traction because men were not perceived as a minority population or a high-risk group (1 Site)
- Difficulty in engaging fly-in fly-out (FIFO) workers (1 Site)
- Difficulty in reaching the right person within workplaces and large companies to support and progress the implementation of activities (1 Site)
- COVID-19-related restrictions had halted or severely impeded the implementation of activities (1 Site).

11.10 Focus population – young people

One Trial Site was exclusively focused on young people, and PHN staff from five other Sites also provided information on Trial activities involving young people.

11.10.1 Activities for young people – approach

Activity description

Primary Health Network staff mentioned a range of mental health or suicide prevention activities aimed at young people:

- Awareness raising through social media and other media, community events and workshops
- Capacity building such as Youth Aware Mental Health for young people and QPR training for adults working with young people in schools and other settings
- Activities directed at elements of the system that engage with young people, including developing a resource for GPs, capacity building for the workforce, and developing a postvention response.

Tailoring activities

Strategies mentioned for tailoring activities for young people included selecting youth-specific training programs (1 Site), working with youth services and organisations including headspace and local council youth programs (3 Sites), and tailoring media and workshop content to young people (1 Site).

Linkages

Staff from three Sites described ways in which linkages were made between Trial activities and other agencies and organisations. These included the involvement of Schools in program planning and delivery (3 Sites), working with local councils (3 Sites) and with youth services and youth-focused organisations (3 Sites). PHN staff from one Site described how they worked with local councils who do youth work and service providers to make each other aware of the services operating in the region and to develop relationships between those organisations (1 Site).

Activity promotion and recruitment strategies

The main strategies for engaging young people to participate in Trial activities were delivering programs in schools or other places where youth congregate (3 Sites), using social media to reach young people (3 Sites), and working with local councils who run youth programs (2 Sites).

Involvement of people with lived experience of suicide

Primary Health Network staff from two Sites commented specifically on the involvement of young people with lived experience of mental health or suicide in the Trial. That involvement had occurred as part of the planning, and staff at both Sites indicated that they had done so in conjunction with headspace to ensure a supportive and safe environment for young people with lived experience.

11.10.2 Activities for young people – outputs and impacts

Staff described outputs and impacts resulting from the implementation of activities related to meeting needs, fostering a more coordinated approach and increasing awareness and knowledge.

Complementing or filling a gap

Staff from three Sites indicated that Trial activities aimed at young people met an identified need, with staff from two Sites stating that Trial activities complemented other activities and services that the PHNs commissioned in their region.

Coordination of activities

Primary Health Network staff at three Sites described strategies that had been effective for increasing coordination. These included the Trial coordinator helping services and community organisations to work collaboratively (1 Site), the development of information on service availability in the area and on the links and pathways to access services (1 Site), and tapping into the shared commitment of the community to reduce suicidal behaviour in young people in the region (1 Site).

Met needs and expectations

One Site reported substantial uptake of QPR by teachers in schools in the region, with over 500 trained. At another Site, PHN staff remarked that while youth were chosen as a target population primarily in response to high community recognition of a series of deaths among young people, according to the data, middle-aged men were the population group with highest suicide death rates.

Increased awareness and knowledge

Three Sites provided indicators that Trial activities had increased awareness and capacity in youth and adults who work with youth. Pre-post data showed increased suicide literacy and help seeking (1 Site); in surveys, more young people reported that they felt supported in schools with staff training in QPR than in schools with no QPR training (1 Site); and reviews of media campaigns reported increased community awareness of suicide prevention (2 Sites).

Other impacts

Primary Health Network staff also mentioned increased help seeking by the audience of a social media campaign, assessed by click-throughs to relevant Sites (2 Sites), and increased demand for services following awareness activities, although this was based on anecdotal reports from a local provider (1 Site).

11.10.3 Activities for young people – challenges

Staff at four Sites (from two states) noted challenges in implementing programs in schools, citing reasons including saturation of schools with other mental health and wellbeing programs, political resistance to LGBTI-related programs, and lack of engagement from the education department. Other challenges they identified were engaging GPs and awareness activities generating demand for services that could not be met.

11.11 Focus population – ex-ADF members and their families

11.11.1 Activities for ex-ADF members and their families – approach

A single Site focused on ex-ADF members and their families.

Activity description

The Site that focused on ex-ADF members and their families did not commission individual services, but focused their activities on upstream risk factors which they characterised as the loss of connection, purpose and comradery – the shared life – on exiting the defence forces. They developed an overarching strategy organised into six “campaigns” (evidence-based programs, clinical support, innovative programs, enduring connections, data and evidence, and community response), most of which mapped to LifeSpan strategies. The activities included in the various campaigns were GP training, developing ex-ADF members’ health pathways, community grants for activities to foster social connection and/or purpose, mental health and suicide prevention training, awareness-raising activities, and media campaigns.

Tailoring activities

Primary Health Network staff described the decision to focus on connectedness and wellbeing rather than mental health or suicide prevention explicitly as the first and most significant tailoring strategy. Other tailoring activities mentioned included expanding the cohort to families to reach those who live with and support ex-ADF members, and adapting programs to ensure cultural safety for ex-ADF members. PHN staff reported that one currently available training product (QPR) was not well received because it was not an Australian product, and therefore they decided to adapt an Australian program (CORES) to use instead.

Linkages and coordination

Staff indicated that linkages had been established with key stakeholders in the sector. Open Arms (the DVA) adopted the peer worker model that was developed as part of the Trial, initially in the Trial region, but is scaling it up nationally. OASIS, the new ex-ADF members' wellbeing centre, is opening in Townsville, has strong linkages with the Trial Site, and will take over some activities at the conclusion of the Trial. There have also been collaborations with Defence Forces locally, however these have not been at a system level, but local linkages based on the personal relationships of stakeholders.

Activity promotion and recruitment strategies

A range of strategies were implemented to promote Trial activities and boost participation by ex-ADF members, including:

- Using branding that made it clear the programs were not DVA programs
- Developing a distinctive brand and multi-pronged communication strategy that would resonate with ex-ADF members
- Focussing on connection and wellbeing rather than mental health and suicide, because the latter were thought likely to deter participation
- Embedding awareness raising in a range of engaging community activities
- Opening events to the broader community so they can learn how to support ex-ADF members who might not engage with Trial activity.

Involvement of people with lived experience of suicide

People with lived experience of mental illness and suicide (including ex-ADF members) had multiple roles, including delivering Trial-funded activities, involvement in the design and planning of the Trial activities through membership of Trial Committees, and participating in lived experience training.

11.11.2 Activities for ex-ADF members and their families – outputs and impacts

Primary Health Network staff described outputs and impacts resulting from the implementation of activities related to meeting needs, fostering a more coordinated approach and increasing awareness and knowledge.

Complementing or filling a service gap

Staff felt that the Trial activities had complemented existing PHN activities in the Trial region, insofar as ex-ADF members had not previously been identified as a target group in service planning and delivery at PHN level, despite constituting a high proportion of the population. They also said that Trial activities were filling a gap by developing care pathways specifically for ex-ADF members.

Coordination of activities

Staff identified the sustained engagement of a large range of stakeholders from key organisations in the sector and region in the Trial Steering Committee as evidence of effective coordination. They noted that those stakeholders were in leadership and decision-making positions within their organisations. Through establishing a strong collaboration with the local Suicide Prevention Network, the Trial resulted in coordination of suicide prevention activities aimed at the general population and those focused on ex-ADF members and their families.

Met needs and expectations

Primary Health Network staff reported strong engagement with social media – over a million engagements, mostly of men in their 20s and 30s, a group which would include ex-ADF members.

Support for Trial activities from a range of other stakeholders was noted by PHN Staff, including from stakeholders sitting on the Steering Committee, and positive feedback from local and national groups who adopted the Check your Mates campaign developed for the Trial.

Increased awareness and knowledge

Staff provided anecdotal reports of increased awareness among both community and service providers of the issues of mental wellbeing and suicide among of ex-ADF members and their families. They also noted that they believed the ex-ADF community was more aware of what services were available to them, and that anecdotally they were aware that ex-ADF members were responding to the messaging in campaigns such as Check Your Mates and reaching out to their peers. Training was considered to have improved GPs' understanding of the particular issues and barriers ex-ADF members may face when accessing services.

Other impacts

Staff mentioned other indicators of effectiveness of activities, including a reduction of return to inpatient psychiatric care following participation in a wellbeing program, men checking on mates, and the adoption of or scaling up of Trial initiatives to broader populations or regions. PHN staff reported direct feedback from participants that participating in Trial activities, especially the community grant programs, had "saved their lives".

11.11.3 Activities for ex-ADF members and their families – challenges

Challenges mentioned included that at the commencement of the Trial the PHN was still a relatively new organisation, and initially lacked capacity for such a large undertaking. PHN staff noted that there was a culture clash between those with an ADF background and civilians in the initial planning stages, but that governance structures, regular and clear communication and a shared commitment to the aims of the Trial overcame the issue. Reaching isolated ex-ADF members was identified as a problem, and strategies to overcome it included funding community grants for engagement programs as well as distancing Trial activities from the DVA. Resistance to imported training programs was addressed by adopting and adapting local programs. It was also noted that the small grant program involved working with small community organisations who were not always equipped to meet the PHN's administrative requirements, the solution to which was simplifying funding application and reporting processes and providing support to organisations to meet those requirements. An ongoing challenge is the complexity of navigating the system for ex-ADF members, but the continuing work on developing care pathways will resolve that.

The PHN was unable to get approval to implement school-based mental wellbeing training and had to abandon the program.

11.12 Focus population – LGBTI people

11.12.1 Activities for LGBTI people – approach

Two Sites focused on suicide prevention activities for LGBTI people.

Activity description

Both Sites commissioned LGBTI-specific aftercare services and a range of community-based activities. One Site also commissioned research on informal mental health and suicide prevention-related support provided by peers and LGBTI community leaders. Activities included awareness campaigns that offered information on services, affirmative practice training for emergency services and first responders, individual and family mentoring programs, social connection and support activities, establishing a community of practice for services involved in the Trial, and developing health pathways for LGBTI communities.

One Site had a significant capacity-building focus. Capacity building was targeted at two cohorts: people and organisations who had not worked with the LGBTI community, and people and organisations who had worked with the LGBTI community but not in suicide prevention. Capacity was built in the former cohort through an affirmative practice program, and in the latter with suicide prevention training programs such as SafeTALK and ASIST.

Tailoring activities

Activities and services were tailored in a range of ways to be appropriate for the LGBTI population. They included undertaking extensive community consultation that took a cultural approach; co-design of activities and services with LGBTI services, community members and people with lived experience; and by commissioning specialist LGBTI providers and organisations to deliver activities and services. One Site also noted that it developed a whole-of-population campaign to capture micro-communities who may not necessarily align themselves with the LGBTI community.

Linkages and coordination

Primary Health Network staff observed that, as a result of the Trial, linkages had occurred between the specialist services commissioned to provide Trial activities as well as linkages within those organisations between the Trial activities and other services they deliver. Other examples were the aftercare services linking with GPs and Hospitals through referrals, and aftercare service clients linking with other LGBTI-safe services.

Activity promotion and recruitment strategies

For the aftercare services, having broad referral pathways including self-referral, promoting the service to other specialist LGBTI services, and promoting the services on the PHN Health Pathways page were all used to engage clients. Additionally, word of mouth was one of the most important avenues for promoting the service due to historical distrust of services in the LGBTI community.

For other Trial activities, word-of-mouth and cross-referral among commissioned providers were the main avenues for engaging participants. Overall, PHN staff considered that the delivery of services and activities by specialist LGBTI organisations built the trust needed to encourage participation.

Involvement of people with lived experience of suicide

Primary Health Network staff noted that people with lived experience of suicide had been involved in a range of ways, including through activity delivery as a peer workforce, in the planning and design of Trial activities, participating in lived experience training, and participating in tender evaluation panels. It was also noted that many stakeholders participating in some other capacity had lived experience of suicide, and that it was important to be cognisant of which “hat” they were wearing at a particular time.

11.12.2 Activities for LGBTI people – outputs and impacts

Information on the outcomes for aftercare service users is presented in Chapters 11 and 12. PHN staff described outputs and impacts resulting from the implementation of activities related to meeting needs, fostering a more coordinated approach and increasing awareness and knowledge.

Complementing or filling a service gap

The PHNs did not deliver specific mental or suicide prevention programs to the LGBTI community at either Site. The Trial activities also complemented work done in LGBTI specialist services (e.g., alcohol and other drug-related activities).

At both Sites the co-design process resulted in the LGBTI community identifying and prioritising gaps which the Trial then set out to fill. PHN staff from both Sites believed that the services and activities met an identified need. Although mainstream aftercare services existed, these were not perceived as culturally safe for LGBTI people. One of the Sites reported that they had substantial unmet demand for the service.

Coordination of activities

Primary Health Network staff nominated several effective strategies for coordinating services and activities. These included the establishment of referral pathways and the forming of new partnerships and linkages between organisations which compete for funding.

Staff from both Sites acknowledged that most of the coordination and integration is between and within specialist LGBTI services, and that achieving greater coordination and integration with mainstream services requires further work.

Met needs and expectations

Staff from both Trial Sites indicated that there had been very good uptake of the Trial activities and high numbers of participants in Connector training. They both also noted that the aftercare services were at full capacity, with wait lists, and at one Site there were waitlists for other Trial activities.

Primary Health Network staff reported receiving positive feedback about Trial activities from participants and from other service providers and stakeholders, including requests for additional training.

Increased awareness and knowledge

Primary Health Network staff noted several impacts of the Trial in terms of increased knowledge about and responsiveness to the needs of the LGBTI community. Impacts included increased provider knowledge in non- specialist LGBTI services via participation in affirmative practice training, in specialist LGBTI services via general suicide prevention training, increased community knowledge, and the reduction of stigma as a result of awareness campaigns. The commissioning of new aftercare services designed specifically to respond to the needs of LGBTI people experiencing a suicidal crisis was seen by PHN staff as a successful outcome.

Other impacts

Other Trial impacts identified included the improvement of relationships and collaborative working partnerships and linkages in the previously competitive and fragmented sector; the development of an effective governance structure built around community implementation teams to oversee the Trial; and the building of the evidence base in LGBTI suicide prevention through local evaluations and research projects.

11.12.3 Activities for LGBTI people – challenges

Primary Health Network staff identified challenges such as community resistance to LGBTI work, including political barriers resulting from advocacy from conservative lobby groups. PHN staff at one Site reported encountering considerable resistance to an attempt to implement LGBTI-focused programs in schools, related to the Safe Schools controversy in the media, but also due to the influence of conservative community organisations. To counter this challenge, they changed focus to training staff who work with students rather than students themselves, and have continued to engage with the education department to remove barriers.

Sector-specific challenges related to the size and funding structures of specialist services, and historical competition for funding leading to distrust across the sector and dominance by the big players. These challenges were overcome through the establishment of governance structures and a co-design process which built relationships, trust and collaborations.

Further challenges mentioned included the length of time required for an authentic co-design process, staff changes at PHNs and commissioned services, and PHNs having to find new ways to work in terms of contracting and commissioning.

11.13 Focus population – older adults

Two Sites undertook some activities focused on older Australians.

11.13.1 Activities for older adults – approach

No aftercare services specifically targeting older adults were commissioned. The main activities were awareness raising, training and lectures by an expert in the field of mental health in older people for professionals, service providers and community members.

Primary Health Network staff from one Site indicated that they used population-wide activities to attempt to reach older people in the general community. At another Site, PHN staff mentioned adapting some of their training programs to ensure older people were better engaged. People with lived experience of suicide were involved in the delivery of an awareness activity.

11.13.2 Activities for older adults – outputs and impacts

Primary Health Network staff had very little information on effective strategies for suicide prevention among older Australians. One staff member mentioned that the PHN had engaged with the Council of the Ageing but that it had not led to their substantive involvement in the Trial, and another commented that the expert workshops had been well received but had not reached a lot of people.

11.13.3 Activities for older adults – challenges

Staff at one Site indicated that there had been a general lack of traction in terms of implementing suicide prevention activities for older adults. In part this was attributed to the fact that the community organisations which the PHN had contracted to deliver the Trial in their local regions were not motivated to focus on older adults and preferred to focus on the population as a whole. Moreover, those community organisations did not have the same purchase in the aged care sector as the PHN, thus the PHN needed to take more of a lead in progressing the Trial for this focus population. PHN staff at that Site also noted that it had been a challenge to find inroads into the aged care sector and build partnerships.

12 Consultations with PHNs (mid-Trial survey)

12.1 Summary of approach

The extension of the Trial by 12 months allowed the opportunity for additional data collection from PHN staff via the mid-Trial survey, undertaken in mid-2019. The mid-Trial survey was designed to obtain an update on the planning and implementation of the Trial. At the time of the first round of PHN consultations in 2018, many Trial Sites were only in the early stages of the planning process.

In May 2019 an invitation, along with a link to the survey and a plain language statement, was emailed to 16 PHN staff at the 10 eligible Trial Sites. The two Indigenous-only Sites were excluded because the survey was not included in the original protocols approved by the respective Aboriginal Ethics Committees. Invitations were sent to the Trial coordinators and to other PHN staff who the evaluators knew to have significant involvement in the planning, implementation and/or oversight of the Trial (generally one or two staff per Site). Invitees could nominate additional staff members they thought were relevant, and as a result, two additional invitations were sent.

The survey was programmed in REDCap, a secure online data management and online survey platform. Questions focused on factors relating to the role of the Trial coordinator in planning and implementation in terms of challenges and as a facilitator, and also briefly asked about facilitators and barriers to adopting a systems approach. The survey questionnaire is shown in Appendix 6. The survey was anonymous, and the respondents' PHNs were not identified.

12.2 Sample information

Eleven PHN staff completed the survey. The survey was anonymous so there is no information on which Trial Site participants were from.

12.3 Data analysis

Responses to the online mid-Trial survey were imported into NVivo V.12 for analysis. Thematic analysis of survey responses, considering all responses together was undertaken. The survey questions were used to deductively identify key themes and develop a coding framework that captured the full range of comments. A modified framework analysis was conducted to order the themes into an overarching framework to make sense of the emerging themes(21). One of the evaluators independently coded the responses, consulting with the other researcher as needed; the second researcher then reviewed the coding and consensus was achieved between the two evaluators. Themes and quotes are provided in Appendix 7.

12.4 Planning

12.4.1 Planning – facilitating factors

The mid-Trial survey survey gathered information on the role of the PHN Trial coordinators as key facilitators of the planning and implementation process. Many skills and knowledge domains were mentioned, the most frequent being project management skills (9 respondents) and stakeholder management skills (7 respondents). Table 12.1 shows the main Trial coordinator facilitating factors identified in the survey.

Table 12.1 PHN mid-Trial survey: Trial coordinator facilitating factors

Facilitators	Respondents (n)
Project management skills	9
Stakeholder management skills	7
Suicide prevention experience/knowledge	4

Facilitators	Respondents (n)
Sector knowledge	3

Nine respondents commented on the value of good project management skills and experience. They specifically mentioned strategic thinking, knowledge of project management best practices and principles, organisation skills, attention to detail, project planning, reporting, and evaluation.

Seven respondents highlighted stakeholder management skills as important to the Trial coordinator role. They mentioned networking and relationship building, interpersonal and communication skills, and influence and negotiation skills.

Four respondents commented on the importance of suicide prevention experience or knowledge, including experience in conducting community suicide prevention programs.

Three respondents mentioned sector knowledge, describing it as sound knowledge of the community that the Trial covers and the context of the Trial within suicide prevention and mental health.

12.4.2 Planning – challenges

Ten respondents identified challenges related to PHN staff.

Seven respondents mentioned difficulties with staff turnover and recruitment that had slowed the roll of the Trial and led to loss of insight and knowledge. This was identified as a more significant issue in remote communities.

Four respondents commented on the challenging nature of the coordinator role, stating that it involved high workloads and a unique set of skills. Working with communities was thought to lead to burn-out due its time-consuming nature and the degree to which it taxed networking and relationship skills.

12.5 Systems approach

The mid-Trial survey asked about facilitators of, and challenges encountered in, the process of trying to implement a systems approach.

12.5.1 Developing a systems approach – strategies

Integrating and coordinating services and activities

A range of facilitators were identified, each by a single respondent, that promoted the integration and coordination of services and activities. They included encouraging partners to collaborate, sharing resources, applying a whole-of-community systems (vs service-driven) approach, engaging the community and sector to be part of the change, developing referral pathways, improving collaboration, and promoting programs to increase knowledge and confidence across community, primary and acute care settings.

Involvement of key stakeholders

The involvement of key stakeholders was seen as a facilitator of developing a systems approach. Respondents identified several factors that promoted the involvement of key stakeholders, including the PHN having well-developed relationships with key stakeholders across jurisdictions (1 respondent), the PHN having strong relationships with services and agencies across the sector (2 respondents), the capacity and knowledge of Trial staff (and particularly their connections to and knowledge of the community and key stakeholders, 5 respondents), engaging in networking and information sharing (2 respondents), and funding local coordinator positions for local areas within the Trial Site (1 respondent).

12.5.2 Developing and implementing a systems approach – challenges

Respondents identified a range of challenges affecting the implementation of a systems approach: working with stakeholders, timelines, working with a systems framework, the PHN's role and capacity, Trial administration, and other unique challenges. Table 12.2 outlines the major challenges.

Table 12.2 PHN mid-Trial survey: Challenges encountered in developing a systems approach

Challenges	Respondents (n)
Time required to develop	5
Systems frameworks	4
PHN's role and capacity	4
Accountability	1
Data collection	1
Engaging lived experience in a meaningful way	1
Inadequate funding/resourcing	1

Five respondents reported that it took much longer than anticipated to engage the community, develop plans, understand and operationalise a systems approach, and commission providers, and that the initial time allocated to the Trial for this establishment phase was unrealistic.

Four respondents commented about difficulties in applying a systems framework. Respondents reported that it had been challenging to implement all parts of the framework, and others expressed concerns that the frameworks did not attend to other factors such as social determinants of suicide.

Four respondents remarked on the challenge of getting PHN staff and the community to understand and accept the PHN's role in the Trial, and also that PHN staff often had insufficient capacity in terms of workloads and knowledge to undertake suicide prevention work.

13 Consultations with community

13.1 Summary of approach

Two rounds of consultations were undertaken with community stakeholders. The first round involved in-person consultations (May–December 2018). The second round of consultations was undertaken via online videoconferencing, phone and in-person interviews (March–June 2020). Round 2 consultations were conducted in person at one Site only, then moved to online videoconference or phone to comply with COVID-19 physical distancing restrictions. The two Sites that were exclusively focused on Aboriginal and Torres Strait Islander populations were not included in the consultations. As described in Chapter 2, a modified methodology was used for the evaluation of the Aboriginal and Torres Strait Islander component of the Trial.

Trial coordinators at each Site identified relevant community stakeholders and invited them to participate in an individual or group interview. Interviews were semi-structured, using an interview guide with open-ended questions based on the Evaluation Framework(10). Round 1 consultation topics covered the establishment process, including how community representatives were involved, their satisfaction with the process, facilitators and challenges in the establishment process, and views on stakeholder inclusion. For Round 2, the consultations concentrated on the community stakeholders' involvement in the Trial and Trial impacts and outcomes (see Appendix 8 for the Round 1 and 2 interview guides).

Interviews were conducted by two evaluators, with one acting as scribe, and were audio-recorded with the participants' permission. Group interviews lasted 1–2 hours and individual interviews between 30 minutes and one hour. Each community stakeholder received a plain language statement providing information about the evaluation and the interview, and all participants provided informed verbal or written consent to take part.

13.2 Sample information

Participants were community stakeholders who were involved in the establishment, planning and/or implementation of the Trial. Table 13.1 provides details of participant numbers and modes of participation for community stakeholder consultations. In total, 127 community stakeholders across 10 Trial Sites participated in Round 1 consultations. Ten individuals from Round 1 participated in two consultations. Thirteen participants from Round 1 responded to the consultation topics in survey form. For Round 2, 124 community stakeholders from 10 Trial Sites (average per Site 24.5 consultations, range 10–46) participated in 81 interviews. Sixty-one community stakeholders participated in an individual interview and 63 individuals participated in one of the 21 group interviews. Thirty-nine community stakeholders in Round 2 had also taken part in Round 1 consultations.

Across both rounds of consultations, most community stakeholders came from the local and state government health sectors, NGO service providers, local suicide prevention networks and community organisations. In total, 19 community members with a lived experience of suicide contributed to the consultations. Note that some community stakeholders in Round 1 belonged to organisations that went on to deliver services or suicide prevention activities. At the time of the consultations, they participated in the Trial as sector representatives involved in planning rather than as commissioned providers. Table 13.2 displays the community stakeholder roles.

Table 13.1 Community stakeholder consultations: Mode of participation

Interview format	Round 1 Participants (n)	Round 2 Participants (n)	Total participants (n)
Individual interview: in-person	26	5	31
Individual interview: phone	32	8	40
Individual interview: phone + survey	5	0	5
Individual interview: videoconference	0	48	48
Group interview: in-person	41	13	54
Group interview: in-person + survey	3	0	3
Group interview: in-person + individual interview	2	0	2
Group interview: phone	0	2	2
Group interview: videoconference	5	48	53
Survey only	13	0	13
Total	127	124	251*

* includes thirty-nine individuals who participated in both Rounds of consultation.

Table 13.2 Community stakeholder consultations: Community stakeholder roles

Roles	Round 1 Participants (n)	Round 2 Participants (n)	Total participants (n)
Advocacy organisations	1	0	1
ACCHOs, Aboriginal and Torres Strait Islander groups	3	0	3
Community organisations focused on mental health/suicide prevention	8	16	24
Councils	9	3	12
Defence force, ex-ADF agencies, veterans	7	10	17
Educators	2	3	5
General practitioners, psychiatrists, psychologists	5	5	10
headspace	6	3	9
Lived experience of suicide community members	10	9	19
Local hospital networks, state government health departments or agencies	12	8	20
Local evaluators and consultants	5	1	6
Mental health, alcohol service provider/agency	8	4	12
Neighbourhood centres	8	3	11
Non-government organisation service providers	17	18	35
Other government agencies	4	3	7
Police	3	4	7
Local suicide prevention network/action group members	9	16	25
Community stakeholder and service provider	1	6	7
Other	2	12	14
Missing	8	0	8
Total	127	124	252

13.3 Data analysis

Notes from the individual and group interviews were imported into NVivo V.12 for analysis. A modified six-stage framework analysis(21) was conducted by considering all responses together and for all focus population groups using the evaluators' interview notes, supplemented by the audio recordings when needed. Two evaluators read and re-read the notes from a subset of 10 interviews, then used the interview schedule to deductively identify key themes and develop a preliminary coding framework that captured the full range of comments. They applied this framework to the subset of interviews, identifying emergent themes. The two evaluators met to discuss and refine the preliminary framework to address areas of disagreement, and consensus was reached on how to code information pertaining to focus population groups and whole-of-population approaches. One evaluator then coded the remaining content, consulting with the other evaluators when needed. The framework and associated coding was finalised and used to interpret the data to answer the Evaluation Framework(10) questions. Themes and sample quotes are shown in Appendix 9.

13.4 Planning

13.4.1 Planning – identifying local needs and service gaps

Community stakeholders described the ways in which they were involved in the planning and development of Trial activities. Committee membership was the main mode of involvement, being mentioned in 82% of consultations covering all 10 Trial Sites. Community stakeholders became involved in Trial Committees through a variety of avenues. Some were involved via targeted recruitment based on being a representative of a community organisation, government department department/agency, service, local suicide prevention network or action group. Some community stakeholders became involved in the Trial through their pre-existing involvement with the PHN, that is, as a lived experience of suicide representative or a member of other PHN committees, Others took part through being employed, either pre-Trial or in a Trial-funded role, at an organisation commissioned to undertake local planning/needs analysis/community consultation to develop community action plans and/or implement the Trial. Other avenues of involvement mentioned included attending an initial community-wide consultation and then being recruited, being recruited as a lived experience of suicide representative, belonging to pre-existing group or network that took on the role of a Trial Committee, or volunteering in response to a call-out to community.

Non-committee-based community involvement in planning occurred via community outreach, in which PHNs undertook targeted consultation with key community stakeholders, agencies and organisations; consultation activities such as open community meetings, forums and surveys; and ad-hoc interaction between Trial staff and community members.

13.4.2 Planning – stakeholder involvement

The nature and scope of the Trial Committee’s involvement in planning and development of Trial activities varied across Trial Sites. Community stakeholders described three broad approaches. In one approach the initial planning and scope of Trial activities was largely predetermined then passed to the Trial Committee to progress the implementation. The scope may have been determined via community consultation, or the PHN, or by a different body in the Trial governance structure, such as an Advisory Group. That initial planning generally involved selecting the focus population and regions within a Site, selection of a specific systems approach to adopt, and deciding the general type of activities. This approach was reported by community stakeholders from three Sites. A second approach reported by stakeholders from five Sites involved the Trial Committee deciding on activities within broad parameters of the systems framework, and for the focus population group that the PHN had selected. In some cases, this occurred through the development of a community action plan, or in other instances via being involved in the overarching whole-Trial plan facilitated by the PHN. A third approach reported by stakeholders from two Sites was that the Trial Committee engaged in a co-design process with the PHN.

13.4.3 Planning – facilitating factors

Community stakeholders from all 10 Trial Sites identified strategies to respond to challenges and factors that had facilitated local planning. These included factors related to stakeholder engagement, community enablers and PHN enablers (see Table 13.3).

Table 13.3 Community stakeholder consultations: Facilitating factors for planning

Facilitators	Sites (n)
Stakeholder engagement	10
Community-related facilitators	
• High level of commitment to suicide prevention	8
• Trial community-owned and led	3
PHN-related facilitators	
• Taking a collaborative approach	6
• Bringing together community stakeholders	6
• Taking community input on board	3
• Communication	6
• PHN staff/team	6

Community stakeholders from all 10 Trial Sites reported that stakeholder inclusion was strong and commented that the PHNs had done a good job in engaging them in the Trial planning process. They believed that for the most part all relevant stakeholders were included and, while they did note missing stakeholders (described in Sections 16.4.4 below), they explained that generally the PHNs had attempted to include them but they were unable or unwilling to participate.

Six Trial Sites noted that a strength of the Trial was that the PHN was taking a collaborative approach, including leveraging local resources by funding existing programs or organisations, working with state suicide prevention activities and/or personnel, taking care not to duplicate activities, and working with existing suicide prevention networks.

Community stakeholders at six Trial Sites asserted that the Trial was bringing together stakeholders who did not usually collaborate and who may sometimes even be competitors, including from across community organisations, government agencies and service providers.

Community stakeholders from seven Trial Sites commended the PHN for listening to local knowledge and welcoming input from the community.

Good communication with the PHN Trial coordinators and openness from the PHN were noted as strengths of the PHN management of the Trial by community stakeholders from six of Trial Sites.

Finally, six Trial Sites' comments mentioned the committed, enthusiastic, capable, well organised PHN staff/teams.

13.4.4 Planning – challenges

Stakeholders from all 10 Trial Sites identified challenges to the planning process. The main themes were stakeholder engagement challenges, community-related factors, PHN-related factors, and other challenges (see Table 13.4).

Table 13.4 Community stakeholder consultations: Challenges encountered in planning

Challenges	Sites (n)
Stakeholder-related challenges	
• Missing stakeholders	8
• Getting stakeholders to work together	9
• Stakeholders wearing 'multiple hats'	3
• Operational challenges	7
• Other	9
Community-related challenges	
• Competing priorities or preferences	8
• Lack of community capacity	9

Challenges	Sites (n)
PHN-related challenges	
• PHN not directive enough	9
• Overlap with existing activities	9
• PHN not responsive to community	8
• Communication	6
• Funding mechanisms	4
• Staff issues	5
• PHN 'taking over'	3
Other Challenges	
• Data	2
• Trial timeframes	8

Stakeholder-related challenges

Community representatives from eight Trial Sites noted missing stakeholders. The stakeholders mentioned were Site specific; there was no one group of stakeholders consistently noted across Sites. However, hospital, first responder and education stakeholders were most frequently mentioned.

Community stakeholders recognised the efforts made by PHNs to be inclusive and identified multiple challenges to the involvement of stakeholders, including:

- Capacity issues, such as difficulty in balancing competing work and community activity demands
- Logistic barriers related to the travel distances within regional Sites, timing of meetings and Trial timelines for identifying and recruiting stakeholders
- Relationship barriers, such as the need for strong relationships to be established within communities, particularly for Aboriginal community involvement, personality clashes on Trial committees, and discord on Trial committees leading to people dropping out
- Risk-related barriers, for example, the appropriateness of having young people involved when it might put them at risk if exposed to the subject matter
- Recruitment issues, such as the PHNs not reaching out to groups, community members being unsure or unaware that there is a place for them at the table, invited stakeholders not attending, and organisations being unaware that the Trial was happening.

Getting stakeholders to work together. Community stakeholders noted that the diversity of stakeholders involved meant that Trial Committee members had different levels of exposure, experience, and knowledge of suicide and suicide prevention. Consequently, managing the process to ensure all viewpoints were considered, while giving due weight to experience, was a challenge in terms of stakeholder management reported by community stakeholders from nine Sites.

There was recognition that community stakeholders often had competing demands and priorities and that managing diverse agendas and getting stakeholders to focus on the Trial could be hard.

It was also noted that the diversity of stakeholders – clinicians, community advocates, lived experience of suicide representatives, government agencies and others – made it difficult to find a common language.

Multiple hats. Another challenge identified by community stakeholders from three Sites is that they often wear multiple hats. For example, many people involved in the Trial had lived experience of suicide, as well as being an organisation representative, and it was not always clear in their participation in Trial Committees which hat they wore. Another example was that individuals may be invited onto a Trial Committee to represent their community, but also be employees of services intending to tender to provide Trial services. It was noted that in small regional communities, or in certain focus populations within communities, this is largely unavoidable.

Operational challenges. Several operational challenges were identified in terms of effective running of Trial Committees by stakeholders from seven Sites. The issue of finding the optimal size for the Trial Committee was raised; in many cases it was difficult to ensure that the group was sufficiently agile to facilitate consensus while representing a diversity of views. In terms of moving the planning and implementation process along, good facilitation, consistency of attendance and regular meetings were identified as vital to avoid repeating work when members didn't attend or when new people joined. Membership change and the loss of knowledge over time was also identified as a challenge.

Other stakeholder challenges. A few comments from community stakeholders from nine Sites related to who would be the most appropriate representative from organisations or agencies, with differing views. One community stakeholder noted the difficulty in identifying the right people, for example, chief executive officers and decision-makers versus people who know what is happening on the ground. Another observed that when agencies or government departments do participate, they generally don't send a representative from the executive level (i.e., a decision-maker).

Community-related challenges

Stakeholders from all 10 Trial Sites discussed community factors that presented challenges in the Trial planning process. In the main, those comments concerned competing interests or priorities, lack of community capacity, and overlap with existing activities.

Competing priorities or preferences. Broadly, the comments in this theme concerned the challenge of implementing a systems, evidence-based approach in the context of communities having other priorities or preferences. Community stakeholders from eight Trial Sites reported this challenge.

Comments indicated a tension between using evidence or using experience as the basis for planning Trial activities, and in general community experience was accorded priority over an evidence-based approach. Some community stakeholders noted that community experience and/or opinion did not match the information from the data, and some community stakeholders explicitly stated that they were not using evidence but their own experience as the basis for planning. Views were expressed that community service providers or community suicide prevention organisations already know what to do so do not need to consult the evidence base.

Community stakeholders also identified a range of challenges involved in the adoption and implementation of a systems approach. These are discussed below in Section 6.5.4 in relation to challenges encountered in developing a systems approach.

Lack of community capacity. This was identified as a challenge to the planning and implementation of the Trial on multiple fronts by stakeholders from nine Sites. The first was burden on community representatives and organisations in terms of time commitments required, balancing work, and involvement in other non-Trial community activities. Capacity was also raised as an issue in terms of lack of understanding of the systems approach being taken by the PHNs, resulting sometimes in decisions about activities not being informed by understanding of the logistics of implementation.

Lack of interest in the community and an unwillingness to get involved were identified as challenges. In some instances, this was attributed to "trial fatigue", because communities had seen various programs come and go over the years. A related challenge was that of keeping people, organisations and agencies interested and engaged over time.

PHN-related challenges

PHN not directive enough. Community stakeholders involved in Trial planning at nine Trial Sites commented that they had insufficient direction or information from their PHN. An area in which more information would have been useful was the bigger picture of the Trial, including its purpose, context, funding and process of dispersing funds, roles and responsibilities. It was felt that having more of this type of information would have led to more informed decision-making and avoided revisiting decisions made hastily with incomplete information.

Community stakeholders also mentioned insufficient guidance and training of project leaders (both host organisation staff and stakeholders) on Trial Committees, and that more direction and support around the systems framework was needed.

PHN not responsive to community. Community stakeholders from eight Trial Sites commented that the PHN was not sufficiently responsive to the community on several fronts. Multiple stakeholders expressed the view that only local people know what works in their area, that the PHN and systems approaches are not local and therefore the PHN doesn't understand local conditions, local communities, local organisations and community approaches.

Others commented that the PHN arrived with a pre-determined framework/activities/program so there was little room for community voices, and that the PHN imposed their framework on the community. Related to this were comments that PHN staff retained the decision-making role, regardless of their level of understanding (in the community's view), and that PHN control of the funding was a mechanism for imposing their will.

Overlap with existing services/activities. Community stakeholders at nine Trial Sites expressed concerns that Trial activities would overlap with services or programs already going on. There did not seems to be any perception among those stakeholders that any service mapping or systematic identification of gaps had occurred. Comments indicated that there was a lot of suicide prevention activity going on already and that overlap was either already evident or probable.

Stakeholders expressed the view that a better approach for the Trial would be to negotiate relationships with existing agencies/organisations offering services and programs, and that in some cases the Trial just came in and started up without seeming to consider existing services and programs, or just subsumed existing activities.

Communication. Challenges related to communication included that community stakeholders didn't know what was going on or that there was a lack of feedback from community consultation or the outcomes of commissioned consultations, and insufficient information on the implementation and status of the Trial (6 Sites).

Funding mechanisms. The PHN funding mechanisms were described as onerous and slow to disperse funds, the commissioning process as complex, and the time for tender processes as compressed (4 Sites).

PHN staff. Several challenges related to PHN staffing, including that staff were often under-resourced and spread too thin, that they were not necessarily always the best fit for the job, and that staff turnover delayed progress considerably (5 Sites).

PHNs "taking over". Community stakeholders at three Sites raised the issue of the PHN "taking over", that is, the perception that the PHN had come in and taken over an existing community-led group or initiative (although in all cases the groups or organisations had agreed to become part of the Trial). Dissatisfaction with a change in direction was expressed in one case, and with the Trial "branding" of the activity obscuring the original organisation in the other two cases.

Other challenges

Data. Community stakeholders from two Sites commented on the lack of data, the need for data to assess Trial impacts and outcomes, and that community "knowledge" is often not backed up by data.

Trial timeframes. There were concerns from stakeholders from eight Sites that the Trial period is not long enough to be able to see change. In addition, that rushing to meet Trial timeframes makes it difficult to do things properly and to a high standard (e.g., build relationships and get buy-in, bring stakeholders up to speed with evidence and a systems approach, consult, and develop action plans). It was commented that Trial timelines are driven by internal and government requirements, not by the actual time it takes to perform the necessary community engagement.

13.5 Systems approach

13.5.1 Developing a systems approach – strategies

13.5.1.1 Strategies to facilitate adoption of a systems approach

Community stakeholders highlighted a range of strategies undertaken by PHNs which they considered facilitated efforts to adopt a systems approach (see Table 13.5).

Table 13.5 Community stakeholder consultations: Strategies for facilitating a systems approach

Facilitating factors of a systems approach	Sites (n)
Involving key stakeholders in Trial planning	9
Using an evidence-based framework (i.e., LifeSpan/AAD framework)	6
Drawing on the evidence-base	4
Community engagement approach	8
• Community as experts	7
• Localised and holistic	7
• Community ownership and buy-in	5
• Time to build relationships and trust	4
• Direct participation in Trial	3
• Involvement of people with lived experience	2
PHN-related facilitators	
• Communication strategy	6
• PHN flexibility	6
• Capacity building of community and service providers	5
• Interagency policies and agreements	5
• Identifying needs and gaps	5
• Funding	4
• Place based approach	4
• Monitoring and evaluation	4
• Succession planning	3

The involvement of key stakeholders in the Trial planning process was the most mentioned strategy. Community representatives from nine Trial Sites indicated they considered that the PHN had included all the key stakeholders, and the 10th Trial Site noted that the PHN had tried but encountered difficulties due to local factors. Key stakeholders included police, ambulance, local hospital networks and EDs, education departments and schools, target group advocacy organisations, Aboriginal organisations, community members and elders, local government, mental health agencies (state, local), local suicide prevention network members, headspace, people with lived experience of suicide, state suicide prevention coordinators and ex-ADF organisations. Key stakeholders were involved in ongoing coordination of Trial activities through membership of Trial Committees. Section 6.4.2 describes the mechanisms through which stakeholders were involved in Trial planning.

Stakeholders from six Sites identified working with either the LifeSpan or AAD framework as a useful strategy, most often using it as a starting point for assessing where gaps existed in current suicide prevention activities, as well as adapting or modifying it to suit local conditions. Community stakeholders at four Trial Sites mentioned using evidence to inform decision-making about programs and activities to implement.

Community engagement approach

Adoption of a community engagement approach to the Trial implementation was cited as a key facilitating factor at eight Trial Sites. Stakeholders from seven Sites explained that such an approach positioned the community as experts in their own setting and involved the PHN recognising, valuing and drawing upon multiple segments of the community. A community engagement approach was contrasted with a health or clinical approach, in that it was localised and holistic (7 Sites) and involved people with a lived experience of suicide (2 Sites). For stakeholders from five Sites, the involvement of community members in key decisions promoted community ownership and buy-in for suicide prevention activities. The opportunity for direct participation in the Trial through the grant programs was also seen to promote community buy-in in Trial activities (3 Sites). Stakeholders from four Sites emphasised the importance of having adequate time to build relationships and trust with community members.

PHN-related facilitators

Communications strategy: Stakeholders from six Sites identified a clear communication strategy as facilitating a systems approach to suicide prevention. Stakeholders from five Sites said it was helpful for the PHN to maintain open and transparent communication with community members and service providers about Trial activities, including strategies and activities that were not working. Community stakeholders from three Sites described mechanisms for sharing information, including Trial representatives sitting on high-level committees, using existing community networks, stakeholder engagement gatherings, social media and radio promotions.

PHN flexibility: Stakeholders from six Sites underscored that it was critical for PHNs to adopt a flexible mindset to adapt the scope of the Trial activities to local needs to facilitate a systems approach.

Capacity building: Stakeholders from five Sites said that capacity building of community members and service providers in suicide prevention (e.g., knowledge of frameworks, how to respond people in crisis) built their trust and confidence and kept people engaged in the Trial. Stakeholders from two Sites also noted that Trial staff had professional development opportunities through Trial activities, which were important in rural and regional Sites.

Interagency policies and agreements: Interagency policies and agreements were identified as strategies for facilitating a systems approach by stakeholders from five Sites. Examples included integration of Trial activities into local mental health, wellness or alcohol management plans; agreements between the PHN and state mental health organisations to align forward plans; shared investment in suicide prevention activities; and formal partnership agreements for practice, referral pathways and data sharing.

*Identify needs and gaps: S*takeholders from five Sites saw strategies to identify needs and gaps in the Trial Sites as facilitating a systems approach to suicide prevention, including the mapping of key stakeholders in the region, staff competencies and service delivery challenges.

Evidence-based framework: The use of an evidence-based framework such as the LifeSpan framework was seen to be useful for structuring a systems approach to suicide prevention, particularly in areas with some existing community suicide prevention activities and/or networks (4 Sites). Multiple stakeholders emphasised the importance of the framework being used in conjunction with community engagement.

Funding: Stakeholders from four Sites identified funding as a key facilitator of the systems approach. Funding allowed for activities and organisations to be coordinated in a systematic way (2 Sites) or existing activities running on a volunteer basis to be funded (1 Site).

Place-based approach: Stakeholders from three Sites saw adoption of a place-based approach, including the colocation of services and the creation of a physical space for people in crisis, as facilitating systems activities.

*Monitoring and evaluation: S*takeholders from three Sites recognised iterative planning, monitoring and evaluation, and data-driven decisions as important for implementing a systems approach.

Succession planning: Community stakeholders from three Sites commented that succession planning, and a focus on the sustainability of Trial activities from the outset, helped to foster ownership for Trial activities from the organisations and stakeholders involved.

13.5.1.2 Developing a systems approach – strategies to facilitate coordination

Community stakeholders across Trial Sites described four broad strategies for facilitating engagement and cooperation as a means to develop a more coordinated approach to suicide prevention. Details are provided in Table 13.6.

Table 13.6 Community stakeholder consultations: Factors facilitating engagement and cooperation

Facilitating factors	Sites (n)
Bringing organisations together	9
• From different sectors and levels of operation	8
• Clarified organisational role in suicide prevention	5
• Overcame historical siloing and interorganisational competition	5
• Opportunity for face-to-face meetings and networking	4
PHN coordinator role	8
• Leadership and responsiveness	8
• Well connected to local community	5
• Engaged stakeholders through committees and networks	4
Enabling environment	8
• Leveraging existing networks	8
• Direct contracting of local organisations	4
• Community readiness	4
• Mobilised around recent loss	2
Involvement in planning, consultation, Trial Committees	7

Bringing organisations together. Bringing organisations together was the most common way in which engagement and cooperation was facilitated, discussed by community stakeholders from nine Sites. For community stakeholders from eight Sites, this involved bringing organisations from different sectors and levels of operation together. The Trial served as a platform for organisations to come together on equal footing, focused attention on suicide prevention, and clarified the role that each organisation played in suicide prevention in their locality (5 Sites). Stakeholders from five Sites commented that the Trial had brought together organisations and representatives that had historically not worked together because of siloing and competition. Stakeholders from four Sites observed that the face-to-face meetings, forums and networking facilitated collaboration.

PHN coordinator role. Community stakeholders from eight Sites identified the PHN coordinator role as key to promoting engagement and cooperation in the Trial. With respect to that role, stakeholders from eight Sites identified leadership, openness and responsiveness as key capabilities enabling the suicide prevention coordinator to be the go-to person and able to drive targeted action.

Stakeholders from five Sites indicated that the coordinator being well connected to the community, providing a local presence, seen and known by community was important for engagement.

The Trial coordinator also had a key role in promoting stakeholder engagement through coordinating the Trial committees, participating in non-Trial committees and working groups, and liaising with community organisations and service providers (4 Sites).

Enabling environment. The broader enabling environment surrounding the Trial was described as facilitating engagement and cooperation (8 Sites). Community stakeholders spoke about how the Trial had promoted engagement through leveraging existing local, regional, state and interstate suicide prevention networks, action groups, alliances, partnerships, support groups, community groups, identity groups (e.g., Indigenous groups) and industry groups (e.g., farmers' groups) to support Trial activities. Stakeholders discussed how having the same organisations and representatives sitting on local, state and federal committees facilitated information sharing and a consistency of approach to suicide prevention.

Stakeholders from four Sites spoke about the direct contracting of local NGOs, community organisations and networks to run Trial activities as another way to foster stakeholder engagement. Community stakeholders commented that it was more effective to build on existing networks, ideas and programs than to start afresh in areas where there was significant historical distrust of public institutions, such as regions with large Aboriginal and Torres Strait Islander populations.

Stakeholders from four Sites described a high level of community readiness, openness and willingness as a key component of this broader enabling environment to facilitate engagement and cooperation. Some stakeholders explained that the Trial had satiated a thirst for activity and funding in suicide prevention that had existed for many years.

Stakeholders from two Sites stated that recent deaths by suicide had forged community commitment and resolve to working together.

Involvement in planning, consultation, Trial Committees. Stakeholders from seven Sites highlighted that the involvement of community and service provider stakeholders in planning, consultation and Trial committees was a key mechanism for facilitating engagement and cooperation. In this regard, they mentioned Trial committees, subcommittees and lived experience committees formed to develop plans and oversee implementation of the Trial activities. Some stakeholders emphasised the importance of strategic planning and clearly specifying goals, responsibilities and timeframes for action. Community consultation and stakeholder engagement gatherings were also identified, for example, the use of focus groups to receive input and engage community members from groups with historical mistrust and trauma, including Aboriginal and Torres Strait Islander peoples (4 Sites).

13.5.2 Implementing a systems approach – impacts

13.5.2.1 Integration of Trial services and activities with existing services and activities

Community stakeholders were asked about the extent to which Trial activities had integrated with related health and community support services. Views varied between and within Sites regarding the degree of integration that had been achieved. Stakeholders from nine Sites considered that Trial activities had been integrated, stakeholders from nine Sites thought that Trial activities had only been partially integrated, and stakeholders from four Sites indicated no or limited integration.

A range of indicators of integration were mentioned by community stakeholders, most commonly partnerships and collaborations around the delivery of Trial services. Table 13.7 below provides details of the outcomes related to integration of Trial activities with existing services.

Table 13.7 Community stakeholder consultations: Outcomes related to service and activity integration

Outcomes	Sites (n)
Partnerships and collaborations in delivery	9
• Between federal and state health services and the PHN	3
• Between NGO service providers	3
• Between non-health organisations and agencies	3
• With existing suicide prevention networks	1
Referral pathways	5

Outcomes	Sites (n)
- Trial activities and mental health, health, social and community services	3
- Between mental health, health, social and community services	1
Provision of service information	5
PHN governance bodies	1

Partnerships and collaborations in delivery. The most frequently cited systems impact identified by community stakeholders (9 Sites) was partnerships and collaborations in delivery. Stakeholders specified partnerships and collaboration between federal and state health services and the PHN (3 Sites); between NGO service providers (e.g., community mental health and drug and alcohol services) (3 Sites); between non-health organisations and agencies (e.g., police and educators) (3 Sites); and connections with existing suicide prevention networks and Trials (1 Site).

Referral pathways. Community stakeholders from five Sites discussed referral pathways as a key impact of the Trial in their area. Stakeholders specified referral pathways between suicide prevention Trial activities and mental health services, as well as broader health, social and community services (3 Sites) and the integration of these providers with each other (1 Site). Stakeholders from one Site highlighted that the links between the Trial activities and hospitals were not strong.

Provision of service information. Community stakeholders from four Sites reported that the Trial had resulted in the development of information sharing across organisations (through the Trial committee). Stakeholders from one Site said that existing interagency groups were employed to share information between organisations.

PHN Governance bodies. Stakeholders from one Site described a partnership between the local health alliance, hospital and health services and the PHN that had strengthened as a result of Trial activity.

13.5.2.2 Achieving a more integrated and coordinated approach to suicide prevention across the system

Community stakeholders identified four main areas in which they felt the Trial had supported a more coordinated approach to suicide prevention (Table 13.8).

Building relationships and partnerships. Community stakeholders from all 10 Sites discussed the Trial's achievement in building relationships and strategic partnerships. Strategic partnerships mentioned included those between and across the PHN, health, mental health and social service providers, and across levels of government (i.e., local, state, federal). Those partnerships facilitated joint strategic planning to avoid duplication, supporting and expanding on existing work, shared investment and data sharing. Stakeholders from three Sites underscored the involvement of people with a lived experience of suicide in these partnerships. Stakeholders also reported the development of partnerships to support collaboration outside of the Trial, for example, between state and federal service providers (3 Sites).

Table 13.8 Community stakeholder consultations: Impacts related to system-wide integration and coordination

Impacts	Sites (n)
Building relationships and partnerships	10
- Strategic partnerships between PHN, service providers and government	10
- Involvement of people with lived experience of suicide	3
- Collaborations supporting work outside the Trial	3

Impacts	Sites (n)
Connections between services and agencies	9
Information sharing	8
Co-hosting events, aligning with other activities	4

Notably, stakeholders from four Sites identified some limitations and drawbacks to the partnerships or relationships established. Stakeholders noted that these partnerships did not always translate into implementation or ownership of Trial activities (1 Site) and were held at the strategic level but not community level (1 Site). Some stakeholders felt that the focus on building new partnerships for the Trial came at the detriment of building on or enhancing existing relationships (1 Site), or that attendance at the Trial committee reduced attendance and commitment to existing community-based suicide prevention networks (1 Site).

Connections between services and agencies. Community stakeholders from nine Sites reported that the Trial had increased connections between services and agencies. Stakeholders stated that the Trial committee had connected service providers for the first time or in new ways, and unified their efforts under the common banner of the Trial (9 Sites). Community stakeholders reported that the Trial had bridged the gaps between health, mental health and suicide prevention service providers and non-health services (1 Site) or hospitals and GPs (1 Site). Stakeholders from one Site highlighted the establishment of new processes and systems for these connections resulting from Trial activities.

Information sharing. Community stakeholders from seven Sites reported that the Trial committees gave organisations and representatives the opportunity to hear about the service offerings of other providers and any updates from these services. Stakeholders from two Sites felt that there was good knowledge of available supports at the local level but not the higher levels of service organisations.

Co-hosting of events. Community stakeholders from four Sites described the co-hosting of events as a key output of the Trial in terms of coordination. The Trial's suicide prevention activities were mainstream community events, including roadshows, stalls, forums and awareness days or weeks.

13.5.3 Developing and implementing a systems approach – challenges

Stakeholders from all 10 Trial Sites identified key challenges to the development and implementation of systems approaches. The themes identified were engaging relevant stakeholders and sectors, community resistance, workforce, existing services and systems, communication and measuring impact. Table 13.9 provides details of these challenges.

Table 13.9. Community stakeholder consultations: Challenges to implementing a systems approach

Challenges to a systems approach	Sites (n)
Engaging relevant stakeholders and sectors	10
Difficult-to-engage stakeholders	
• GPs and hospitals	7
• Education departments and schools	3
• Social sector stakeholders	3
• Police and law enforcement	2
• Local government	1
• Media	1
Engagement challenges	
• Different priorities and agendas	6
• Outside of remit	6
• Historical lack of trust	5
• Competing demands	4
• Inter-organisational competition	2

Challenges to a systems approach	Sites (n)
• Stigma of suicide	2
• Logistical challenges	1
Community resistance to systems frameworks	7
• Inappropriate for local conditions or focus populations	4
• Incompatibility with community-based suicide prevention approach	3
• Validity of framework questioned	3
• Ignores local knowledge and current suicide prevention activity	2
• Burden on community to understand	2
Trial scope and duration	9
• Lack of understanding of Trial scope	7
• Not community led	7
• Too short	7
• Trial scope limited and wasted opportunity	6
Workforce	9
• PHN staff lacking competency	7
• Capacity of community and service provider workforce	6
• PHN staff turnover	5
Existing services and systems	8
• Lack of support services	8
• Lack of existing referral pathways	3
Communication and information sharing	8
• No communication with stakeholders outside Trial committees	6
• No communication with stakeholders on Trial committees	4
• Lack of data sharing	4
• Lack of communication about other Trial Sites	1
Measuring impact	6
• Challenge to measure impact on suicide	5
• Lack of uptake of evaluation	1
External factors	10
• COVID-19	10
• Natural disasters	5
Other	
• Lack of guidance on implementation	3
• Achieving adequate fidelity in implementation	3

Engaging relevant stakeholders and sectors

Challenges with engaging stakeholders with the Trial in general are described in section 6.4.3. With respect to developing a systems approach, stakeholders from all 10 Trial Sites identified engaging key stakeholders from across the sector and jurisdictions as a key challenge.

Difficult to engage stakeholders

Stakeholders from seven Sites reported challenges with engaging key health sector stakeholders, notably GPs and hospitals. Community stakeholders noted that it was challenging to engage GPs in the Trial despite the involvement of the PHN, which was seen to be responsible for facilitating GP engagement. Other community stakeholders discussed challenges with engaging education sector stakeholders (i.e., schools, 3 Sites), social sector representatives (3 Sites), police and law enforcement (2 Sites), local government (1 Site) and the media (1 Site).

Engagement challenges

A wide range of factors were identified as contributing to difficulties in engaging key stakeholders.

Different priorities and agendas: Diverse priorities and agendas of stakeholder groups was the most frequent barrier to engaging relevant stakeholders and sectors (6 Sites)

Outside of remit: Stakeholders from three Sites explained that some key stakeholders in suicide prevention often did not view suicide prevention as their remit, prioritise prevention activities focused on upstream determinants of suicide, or prioritise prevention activities at the service delivery level

Historical lack of trust: Stakeholders from five Sites reported issues with engaging or re-engaging community stakeholders when there was a historical lack of trust with public institutions, or when the Trial planning stage did not go smoothly or changed direction

Competing demands: Key stakeholders were reported to struggle to be involved in the Trial and other non-Trial suicide prevention and mental health activities in their regions (4 Sites)

Inter-organisational competition: Stakeholders from two Sites indicated that competition between stakeholders and conflicts of interest presented a barrier to their engagement (2 Sites)

Stigma of suicide: The stigma of suicide was suggested as an explanation for the reluctance for GPs to be involved (1 Site) and for community members to attend events (1 Site)

Issue saturation: Stakeholders from two Sites reported that it was difficult to capture the attention of relevant stakeholders because of the plethora of suicide prevention activities that had already happened in those Sites

Logistical challenges: Small community-based organisations without infrastructure struggled to fulfill contractual agreements, policies and procedures required by the PHN, for example, indemnity insurance (1 Site).

Community resistance to systems frameworks

Several points of resistance to systems approaches to suicide prevention were observed in community stakeholder comments:

- Stakeholders from three Trial Sites felt that it was not compatible with a community-based approach to suicide prevention, because it was a more clinical or technical approach
- Stakeholders from four Trial Sites remarked that systems frameworks aren’t necessarily suitable for local conditions, such as regional areas with sparse services, or for some focus populations (particularly LGBTI and Aboriginal and Torres Strait Islander populations)
- Stakeholders from two Trial Sites raised concerns about the suitability of the systems approach, including that adopting such an approach disregarded their local knowledge, lived experience, local priorities and work done to date
- Other comments regarding the systems approach were that it placed a time and cognitive burden on community to “get up to speed” with the chosen framework (2 Sites)
- Some stakeholders questioned the validity of the systems frameworks (three Sites).

Trial scope and duration

Issues related to the scope and duration of the Trial were discussed as key challenges to implementation of a systems approach by stakeholders from nine Sites.

Lack of understanding of Trial scope: Community members and service providers were said to lack a clear understanding of the scope of Trial (7 Sites).

Not community led: Stakeholders from seven Sites felt that the Trial scope (i.e., target populations and locality) was determined by the federal government or PHN and not the community, and that there was a lack of flexibility from the PHN.

Too short: Stakeholders from most Sites felt that the time frame for the Trial was too short for meaningful change and considered the funding to be too “short term” (7 Sites). These same stakeholders explained that insufficient time was allocated to build relationships and momentum, and that the allocated time frame reduced trust, particularly in regional and rural areas.

Trial scope limited and wasted opportunity: Stakeholders from two Sites felt that the perceived short duration of the Trial impaired the activities planned and delivered by limiting the Trial to what was achievable in the timeframe rather than what was needed to make meaningful change. Relatedly, community stakeholders from four Sites thought that more could have been achieved in the given timeframe, that the implemented activities represented a wasted opportunity, and that there was still gap for hard-to-reach populations or regions.

Workforce challenges

Community stakeholders from nine Sites mentioned workforce challenges.

PHN lacking competency: Community stakeholders from seven Sites reported a lack of key workforce skills and competencies among PHN staff, including the need for high-level leadership, program management, stakeholder engagement, strategic thinking, information technology and mental health/counselling.

Capacity of community and service provider workforce: Stakeholders from six Sites discussed challenges to the capacity of the community and service provider workforce, including inadequate availability, staff turnover, burnout, and the expectation that people do work on top of existing jobs. For community members with a lived experience of suicide, this often meant contributing to the Trial activities for free as volunteers.

PHN staff turnover: Stakeholders from five Sites identified barriers to recruitment and retention of key PHN staff due to the demands of the role and short-term contracts, particularly in rural areas. This turnover was perceived to reduce the communities’ trust and buy-in to Trial activities and the PHN staff’s engagement with the broader service system.

Existing services and systems

Community stakeholders from eight Sites spoke about the lack of capacity in the existing mental health and other support services for detecting and responding to suicidal crises, particularly in regional and rural areas.

Stakeholders from three Sites discussed a lack of existing referral pathways and partnerships between state and NGOs and the siloing of health and social sectors as barriers to the implementation of a systems approach to suicide prevention.

Communication and information sharing

Stakeholders from eight Sites said that communication and information sharing represented a key barrier to implementing a systems approach to suicide prevention:

No communication with stakeholders outside Trial committees: Community stakeholders reported that there had been a lack of communication about Trial activities to stakeholders outside of the

Trial committees (6 Sites), including an ineffective communication strategy for reaching the community (3 Sites).

No communication with stakeholders on Trial committees: Stakeholders from four Sites reported a lack of communication with stakeholders on the Trial committee about decision-making processes and expectations and feedback on Trial activities.

Lack of data sharing: Stakeholders from four Sites highlighted that a lack of sharing of relevant information (for example, local suicide data) between the PHN and key organisations and community members impeded a systems approach (4 Sites).

Lack of communication about other Trial Sites: Stakeholders from one Site felt that communication about what other Trial Sites had tried and achieved could have helped them to implement their own systems approaches, but this information was not supplied.

Measuring impact

Community stakeholders from six Sites said that there were challenges in measuring the impact of Trial activities. Stakeholders from five Sites said that it was difficult to measure the impact of prevention activities on completed or attempted suicide (5 Sites) and to attribute change to the Trial because of previous or concurrent suicide prevention activities (1 Site). One stakeholder said service providers and participants had not embraced the results of evaluations of events.

External factors

External factors were a key barrier to implementation of Trial activities. COVID-19 was reported to stop planned Trial activities at all 10 Sites, as well as increase the risk of poor mental health and suicide (6 Sites). Stakeholders from two Sites emphasised that COVID-19 exacerbated existing stakeholder engagement challenges. Natural disasters (i.e., bushfires, drought and flood) were also reported to challenge implementation of the Trial activities (5 Sites).

Other challenges

There was concern expressed about several aspects of implementation of the frameworks, including the lack of information and guidance on implementation and a concern that communities lacked capacity to undertake a high-fidelity implementation (3 Sites), and that a partial implementation may not be enough to achieve the promised results (3 Sites).

13.6 General population suicide prevention activities

Community stakeholders from eight Trial Sites discussed whole-of-population and whole-of-community Trial activities.

13.6.1 General population activities – approach

Activity description

Training and awareness raising. These were the most common activities discussed by stakeholders from eight Sites, with activities mentioned including:

- Standardised training to support the detection and response to suicide risk (e.g., ASSIST, Safe Talk, QPR) delivered to community members (7 Sites)
- Standardised training to support the detection and response to suicide risk delivered to service providers or organisations (6 Sites)
- Media training for safe reporting of suicide (2 Sites)
- Workforce training for community service providers (1 Site)

- Activities to raise community awareness about available support services through posters, flyers, stickers, resource sheets and local information kits (6 Sites)
- Awareness-raising events including community forums, walks and family days (4 Sites)
- Media campaigns on television or radio (2 Sites).

Support services for individuals. Community stakeholders from four Sites discussed individual services provided for the general population. Services described included full or partial funding of bereavement support groups (4 Sites), adapting the SafeSpace initiative to institute a warm line in which callers were provided with information on coping skills, digital mental health interventions and support with service navigation (1 Site), and establishment of an aftercare service as part of the Trial (1 Site).

Community grants. Community stakeholders from four Sites stated that community grants were employed to fund small community-led projects for the general population, and reached unique and diverse communities.

Mapping of existing services and referral pathways. Stakeholders from two Sites highlighted this activity, which included the creation of a mental health directory for service providers (1 Site).

Means restriction. Community stakeholders from one Site discussed means restriction through changing the design of a local suicide hotspot.

Linkages and coordination

Strategies for coordinating the Trial activities included the Trial committee (5 Sites), collaboration with suicide prevention networks and other community groups (4 Sites), and joint funding of PHN and police staff (1 Site). Stakeholders from two regional Sites identified the local Trial coordinator as a key force for coordinating activities.

Activity promotion and recruitment strategies

Community stakeholders identified a range of strategies for promoting Trial activities and attracting participants, including:

- Promoting Trial activities and stories through the Trial newsletter, partner websites, radio and television (4 Sites)
- Using social media to promote training and events (4 Sites)
- Word of mouth, including through community champions employed to promote Trial activities and recruit participants (4 Sites)
- Using local forums and events to promote Trial activities in regional areas (3 Sites)
- Using PHN contacts as another source of recruitment (2 Sites).

Involvement of people with lived experience of suicide

Community stakeholders from eight Sites discussed this strategy. Stakeholders identified a range of ways in which people with lived experience of suicide were involved, including:

- Participation in Trial advisory committees (7 Sites)
- As trainers delivering Trial-funded training programs (e.g., through Roses in the Ocean and Mates in Construction, 5 Sites)
- As advisors to service providers (1 Site)
- Sharing their voice and stories through Trial materials (e.g., a calendar) (1 Site).

Stakeholders from two Sites described how the involvement of people with lived experience of suicide introduced innovative approaches and served to expand the focus of the Trial from service delivery to a community engagement approach.

13.6.2 General population activities – outputs and impacts

Community stakeholders did not have information about the outcome of the Trial on rates of suicide deaths or suicide attempts. However, community stakeholders provided their perspectives on a range of impacts that might be attributed to the Trial, including whether the general population activities had complemented or filled a gap in existing suicide prevention activities, if Trial activities met community needs and expectations, if knowledge and awareness had improved (Table 13.10).

Table 13.10 Community stakeholder consultations: Impacts of general population Trial activities

Impacts of general population Trial activities	Sites (n)
Complementing or filling a service gap	
• Complemented or filled a gap	6
• Partially complemented or filled gap	1
Met needs and expectations	
• Met needs and expectations	4
• Partially met	4
• Not sure or too early to tell	6
Increased knowledge and awareness	
• Detection and response to suicide	7
• Available supports and services	7
Increased openness and confidence to discuss suicide	6
Reduced stigma of suicide	3
Increased service usage and help seeking	5
Reduced suicide attempts and deaths (anecdotal)	4
Improved wellbeing	
• For participants	3
• For people with lived experience of suicide	1
Cultural shift	6

Complementing or filling a gap

Community stakeholders from six Sites said that the Trial activities was complementing or filling a service gap, while stakeholders from one Site said this gap had only been partially filled.

Coordination of activities

Community stakeholders from five Sites described links between the Trial activities and a range of services and organisations, including health and mental health services, community services and organisations, local councils, police, ambulance, fire, schools, commercial businesses and sporting clubs. Stakeholders from one Site also described the establishment of health-service-to-health-service linkages as a result of the Trial.

Met needs and expectations

Community stakeholders from four Sites felt that the Trial activities had met needs and expectations, but stakeholders from another four Sites reported that this was only partially the case. Stakeholders from six Sites said they were not sure, or it was too early to tell.

Increased awareness and knowledge

Community stakeholders from seven Sites reported that the Trial activities had increased knowledge of how to detect and respond to suicide for community and service providers, as well as the available supports in their locality.

Other impacts

Stakeholders described increased openness and confidence to talk about suicide among community members (6 Sites), in part explained as a reduction in stigma about suicide (3 Sites). The Trial was also thought to increase service usage and help seeking (5 Sites) and anecdotally to reduce the number of suicide attempts and deaths (4 Sites). Community stakeholders said that the Trial activities had improved mental health and wellbeing for participants of programs (3 Sites), as well as for people with lived experience involved in the Trial as peers (1 Site).

Community stakeholders from six Sites identified a cultural shift towards delivery of a person and community-centred approach to suicide prevention as a key outcome of the general population Trial activities. Stakeholders saw this as achieving a broader focus on the community, rather than health or clinical responses to suicide, that embedded the voices of people with lived experience of suicide in planning, delivery and evaluation.

13.6.3 General population activities – challenges

Community stakeholders identified many of the same challenges related to implementation of general population Trial activities as were described in relation to the implementation of a systems approach in Section 14.5.3 above.

Stakeholders from two regional Trial Sites mentioned geography as a unique barrier to the implementation of Trial activities for the general population. These stakeholders said that the large geographical areas these Sites covered made it difficult to mobilise communities, conduct training and distribute Trial resources equitably.

13.7 Focus population – men

13.7.1 Activities for men – approach

Activity description

Stakeholders from four Sites described general events targeted at men that included suicide messaging (e.g., roadshows). Other activities targeted at men included community grants (3 Sites), training by Mates in Construction (2 Sites), service mapping (2 Sites) and a television campaign (1 Site).

Tailoring activities

In order to tailor suicide prevention activities for men, community stakeholders from four Sites emphasised the importance of adopting a community-centric, non-health approach. Stakeholders from three Sites considered the involvement of men with lived experience as peer educators or community champions as consistent with such an approach. Stakeholders from three Sites said that strategies to engage and support men indirectly, through connecting their wives, partners and friends with Trial activities, were also necessary to tailor suicide prevention activities for men.

Linkages and coordination

Community stakeholders reported that activities for men involved establishing linkages between the PHN and NGO service providers (3 Sites), male-dominated businesses or civil society (e.g., agricultural shows, football clubs) (2 Sites), aftercare services (2 Sites) and GPs (1 Site). Community stakeholders from one Site felt that there were insufficient links between Trial activities targeting men and other health or social services.

Activity promotion and recruitment strategies

Community stakeholders from two Sites reported that word of mouth through community champions was used to promote the Trial and recruit men to Trial activities. Stakeholders from two Sites also highlighted the use of flyers or other printed materials for this purpose, and stakeholders from another two Sites reported that social media was employed to recruit men. However, some community stakeholders felt that social media was not the best way to reach men, and instead it was preferable to reach men through their close support networks. Community stakeholders also reported that men were recruited into the Trial activities through suicide prevention networks and support groups (2 Sites), roadshows and other organisations (e.g., Rotary, 2 Sites), the Trial website (1 Site) and the email list of service providers (1 Site).

Involvement of people with lived experience of suicide

There was a strong emphasis on the involvement of people with lived experience of suicide in male suicide prevention activities. Training conducted by peers or people with lived experience was described by stakeholders from five Sites, three of whom specifically mentioned Roses in the Ocean. Community stakeholders from three Sites reported training of local men with lived experience to use their stories for advocacy and to support others. Stakeholders from one Site mentioned that men with lived experience were involved on the Trial advisory committee.

13.7.2 Activities for men – outputs and impacts

Community stakeholders discussed impacts of Trial activities for men, including whether the male focus population activities had complemented or filled a service gap and met community needs and expectations. They also identified other outcomes, such as increased knowledge and awareness. These findings are summarised in Table 13.11 below.

Complementing or filling a gap

Stakeholders from three Sites felt that Trial activities were complementing existing services or filling a service gap. It was felt that the Trial increased the frequency of discussion of suicide prevention and information about available services, particularly for men who were normally hard to reach (2 Sites) and mobilised lived experience to shape programming (1 Site). Conversely, other stakeholders said that Trial activities had only partially complemented or filled a gap (2 Sites) or not at all (1 Site), citing that some activities did not focus directly on the target group (1 Site).

Table 13.11 Community stakeholder consultations: Impacts of activities focused on men

Impacts of male-focused Trial activities	Sites (n)
Complementing or filling a gap	
• Complemented or filled a gap	3
• Partially complemented or filled gap	2
• Not at all	1
Met needs and expectations	
• Met needs and expectations	5
• Partially met	1
Increased knowledge and awareness	
• Detection and response to suicide	5
• Available supports and services	2
Increased openness and confidence to discuss suicide	4

Impacts of male-focused Trial activities	Sites (n)
Reduced stigma of suicide	4
Reduced suicide attempts and deaths (anecdotal)	1
Improved wellbeing	
• For participants	2
• For people with lived experience of suicide	2
Sense of community connection, belonging and hope	3

Coordination of activities

Community stakeholders from three Sites reported that regular inter-agency and community suicide prevention groups were effective for coordinating male-targeted suicide prevention activities. Stakeholders from one Site also highlighted the role of existing suicide prevention networks for coordinating activities. Stakeholders from one Site said that coordination was achieved through community ownership of Trial activities.

Meeting needs and expectations

Stakeholders from five Sites felt that the Trial activities had met community needs and expectations. One stakeholder argued that Trial funds would have been better used for service delivery than awareness raising, given the dearth of available services in their regional locality.

Increased awareness and knowledge

Community stakeholders said that the male-focused population Trial activities increased knowledge about suicide and how to respond and confidence to respond (5 Sites), including coping skills and management strategies (2 Sites). Stakeholders from two Sites also stated that the Trial had increased knowledge of available supports and services.

Other impacts

Community stakeholders from four Sites reported that the Trial activities had increased community openness to talk about suicide and reduced stigma. Stakeholders from one Site believed that the Trial activities had “saved lives”. Stakeholders from two Sites reported improved mental health and non-clinical recovery for people involved, including people with lived experience sharing their own experiences as trainers. Community stakeholders from three Sites said that the male-specific Trial activities had fostered a sense of community connection, belonging and hope.

13.7.3 Activities for men – challenges

Community stakeholders reported some of the same challenges for implementing male focus population suicide prevention activities as those noted for whole-of-population and systems approaches, including engaging relevant stakeholders and sectors, external factors, communication and workforce challenges. Stakeholders reported differences in the way these challenges operated for male-specific activities, as well as unique challenges for the male focus population (Table 13.12).

Table 13.12 Community stakeholder consultations: Challenges implementing activities for men

Implementation challenges	Sites (n)
Engaging relevant stakeholders and sectors	4
• High-level organisational stakeholders	3
• Stigma of suicide	1
Engaging men	4
• Stigma of suicide and mental health	2
• Social media	1
• Seasons	1
Diversity of male focus population	2

Implementation challenges	Sites (n)
External factors (i.e., COVID-19)	2
Communication and information sharing	2
Workforce	1

Stakeholders reported barriers to engaging relevant organisations in Trial activities (4 Sites), specifically difficulties with engaging high-level organisational stakeholders (3 Sites). Community stakeholders explained that it was better not to mention mental health or suicide when engaging male-dominated organisations, due to stigma (1 Site), or when suicide prevention was not their core business (1 Site).

Stakeholders from four Sites highlighted unique barriers to engaging men in Trial activities. Specifically, these stakeholders felt that men would not engage if mental health or suicide prevention was mentioned in any branding due to stigma (2 Sites); men did not access social media so did not find out about Trial activities (1 Site); and male farmers would not attend activities during high season (1 Site). Relatedly, stakeholders from two Sites stated that the broad and heterogenous target group made it difficult to target activities to effectively engage with all men.

COVID-19 restrictions were also reported to hinder Trial activities in two Sites. Stakeholders from two Sites cited a lack of communication between Trial organisers, existing networks and community members. Workforce limitations for staff from key organisations who were contributing to Trial activities on top of their normal work was also seen to challenge implementation of male focus population activities (1 Site).

13.8 Focus population – Young People

13.8.1 Activities for young people – approach

Activity description

Awareness-raising and training was the youth-specific activity community stakeholders mentioned most frequently. Community stakeholders from four Sites reported that information sessions and training programs hosted at the school (Youth Aware of Mental Health – YAM, R u ok benches, Chew with the Crew community group) had been implemented as part of the Trial. Youth camps (2 Sites) and the establishment of GP referral pathways (1 Site) were also reported.

Tailoring activities

In order to tailor suicide prevention activities for youth, stakeholders spoke about the importance of an external organisation providing supports in schools (4 Sites) and giving young people the choice to participate rather than requiring participation (1 Site). Stakeholders also mentioned that youth-to-youth peer support, capacity building of adults and teachers to talk openly about suicide and mental health, and focusing on youth and their families were important activities (4 Sites).

Linkages and coordination

Stakeholders reported that steering committees (3 Sites), a youth reference group (1 Site), school networks (1 Site) and a place-based approach (1 Site) were effective strategies for coordinating the Trial activities for young people.

Activity promotion and recruitment strategies

Community stakeholders reported that young people were recruited into Trial activities through an opt-out program run through schools (1 Site), social media (1 Site) and a program launch to schools in lay language (1 Site).

Involvement of people with lived experience of suicide

Community stakeholders said that young people with a lived experience of suicide were involved in the development of Trial activities, for example, consultation (1 Site), community grants (3 Sites), through a Youth reference group (1 Site) and lived experience training (2 Sites). For the community grants, the entry point for participation was sometimes an individual's youth identity, and their lived experience of suicide was subsequently disclosed after they were engaged in the activity.

13.8.2 Activities for young people – outputs and impacts

Community stakeholders discussed impacts of Trial activities for young people, including whether the activities had complemented or filled a service gap and met community needs and expectations. They also identified other impacts such as increased knowledge and awareness (Table 13.13).

Complementing or filling a gap

Community stakeholders reported that youth-specific Trial activities had filled a gap by bringing together schools and other organisations that had not historically worked productively together (2 Sites), provided training for independent schools in youth mental health (1 Site), and produced specific programming to engage youth (1 Site). Stakeholders from two Sites said that there were still gaps in their communities for LGBTIQ youth and youth not engaged with services.

Table 13.13. Community stakeholder consultations: Impacts of youth-focused Trial activities

Effective strategies for youth-specific Trial activities	Sites (n)
Complementing or filling a gap	
• Complemented or filled a gap	3
• Partially complemented or filled gap	2
Met needs and expectations	
• Met needs and expectations	2
Increased knowledge and awareness	
• Detection and response to suicide	3
• Available supports and services	2
Increased openness and confidence to discuss suicide	5
Increased service usage and help seeking	1
Improved wellbeing for participants	1
Improved other health behaviours for participants	1

Coordination of activities

Linkages related to youth-focused activities were reported between the PHN and mental health service providers (for example, headspace), youth services, NGOs and schools (2 Sites) and the education department (1 Site).

Met needs and expectations

Community stakeholders said they considered the Trial activities to be useful (2 Sites) and that school staff could see the benefit of the school-based activities (1 Site).

Increased awareness and knowledge

Youth-specific Trial activities were reported to have increased knowledge of suicide and how to respond (3 Sites) and knowledge of available supports (2 Sites).

Other outcomes

Youth-specific Trial activities were also reported to have improved openness to talking about suicide by young people and the community (5 Sites), increased help seeking (1 Site), improved mental health due to alleviated worries about friends and family members (1 Site), and improved other health behaviours (e.g., stopped drug use) (1 Site).

13.8.3 Activities for young people – challenges

Community stakeholders reported that the youth-specific suicide prevention activities were challenged by many of the same barriers as for the general population approaches, including engagement of key stakeholders, external factors and a lack of existing services.

Challenges specific to delivering youth-focused activities included:

- Engagement of schools and state education departments due to an already crowded curriculum (5 Sites)
- Difficulty of meaningfully engaging young people in Trial activities and the steering group (1 Site)
- Difficulty engaging with GPs (1 Site)
- Lack of mental health support services for young people, particularly in rural and regional areas, including long waiting lists (3 Sites)
- Parental engagement (2 Sites)
- Safety concerns for youth involved in program delivery as staff members (2 Sites).

13.9 Focus population – Ex-ADF members and their families

13.9.1 Activities for ex-ADF members and their families – approach

Activity description

Trial activities for ex-ADF individuals and their families were mentioned by community stakeholders from one Trial Site, the most frequently mentioned being awareness raising and training. All community stakeholders interviewed highlighted the large-scale ex-ADF suicide prevention media campaign Check Your Mates. Some stakeholders also discussed Check Your Mates-affiliated events (e.g., BBQ). Other awareness-raising and training initiatives mentioned were first responder training (e.g., of police and ambulance staff) and general community suicide prevention training (e.g., CORES).

Community stakeholders spoke about the community grants program, which was used to fund a range of “innovative, non-clinical programs”, including “social prescribing” to free physical health group fitness classes, field trips, family weekends away, and an outreach support program for drought-affected farmers (Farmer Assist). Multiple stakeholders considered the community grants program to be a novel mechanism for empowering ex-ADF individuals.

A peer worker initiative developed as part of the Trial but then adopted by Open Arms (the DVA service agency) was described by several community stakeholders. Peer workers were trained ex-ADF members with a lived experience of suicide who provided case management to their peers. The

Trial also provided funding support to Mates4Mates, a community organisation that provides counselling and advocacy for ex-ADF individuals making a claim through the DVA.

Other ex-ADF-specific activities discussed by community stakeholders included the development of health pathways for veterans and support for ex-ADF members with traumatic brain injury. Stakeholders also highlighted the planning activities to establish the Oasis, an integrated hub model of care for ex-ADF members in the latter stages of the Trial. Multiple community stakeholders nominated the Oasis as the succession plan for the Trial activities.

Tailoring activities

In order to tailor suicide prevention activities for ex-ADF individuals and their families, community stakeholders emphasised the importance of ex-ADF specific messaging that focused on empowerment, mateship, connection and purpose rather than suicide prevention. Community stakeholders explained that it was critical to underscore the self-sufficiency and independence of ex-servicepeople by teaching them self-care-skills and strategies, to avoid them being construed as passive recipients of services. They said that recognising and working with rank and hierarchy within the ex-ADF community were key to tailoring suicide prevention activities for ex-ADF individuals and their families, and that it was crucial to include families in suicide prevention activities.

Some community stakeholders explained that having the health sector (i.e., the PHN) as the leading player in the ex-ADF suicide prevention Trial activities helped to (re)build trust for ex-ADF members who distrusted the defence force and affiliated organisations. That said, other stakeholders attributed the success of many of the activities delivered as part of the Trial to the delivery of activities by ex-ADF individuals rather than civilians.

Linkages and coordination

Community stakeholders identified the strategic campaign approach to the ex-ADF Trial activities as critical to the Site's successful coordination of suicide prevention activities. Stakeholders explained that the Trial was approached as an overarching campaign, "Operation Compass", with each Trial activity treated as a separate strategic element. Multiple stakeholders reported that this approach meant that a succession plan was developed from the outset of the Trial, which promoted delegated organisations' ownership of each campaign element. Community stakeholders also identified the Trial Steering Committee as a key coordination strategy.

Promotion and recruitment strategies

Community stakeholders reported the Trial activities were promoted through an extensive professional media campaign, including social media and radio. Stakeholders felt that promotion of Trial activities through word of mouth, including through community champions, was the most effective way of engaging ex-ADF individuals and their families. Stakeholders also stated that the Trial was promoted through existing suicide prevention networks, ex-service person organisations and through presentations at the transitions seminars for personnel who were preparing to leave the defence force.

Involvement of people with lived experience of suicide

There was a strong emphasis on the involvement of ex-ADF individuals with lived experience of suicide in the Trial, notably in planning the Trial activities through the steering committee and consultation. People with lived experience were also involved in providing Trial activities as peer workers and running activities funded by the community grants program.

13.9.2 Activities for ex-ADF and their families – outputs and impacts

Community stakeholders discussed the impacts of Trial activities for ex-ADF members and their families, including if activities had complemented or filled a service gap, met community needs and expectations, as well as identifying other outcomes such as increased knowledge and awareness. These findings are summarised in Table 13.14.

Table 13.14 Community stakeholder consultations: Impacts of activities for ex-ADF members and their families

Impacts
Complementing or filling a gap
• Complemented or filled a gap
• Partially complemented or filled gap
Met needs and expectations
• Met needs and expectations
• Exceeded needs and expectations
• Partially met
• Not aware
• Too early to tell
Increased knowledge and awareness
• Detection and response to suicide
• Available supports and services
Increased openness and confidence to discuss suicide
Reduced stigma of suicide
Increased service usage and help seeking
Reduced suicide attempts and deaths (anecdotal)
Improved outcomes for participants
• Sense of connection
• Mental health and wellbeing
• Physical health outcomes
• Employment
Cultural shift

Complementing or filling a gap

Multiple community stakeholders stated that the ex-ADF-specific Trial activities had filled a gap in the existing support services for ex-ADF individuals. Stakeholders explained that the Trial activities were the first time that an explicit empowerment focus had been adopted for this population. The Trial was also the first time that peer support workers had been trialled for ex-ADF individuals. Other stakeholders noted that there was a still a need to develop a clear referral pathway in the health system for ex-ADF individuals and their families, including links to drug and alcohol support services. Stakeholders also highlighted the need to bolster the support provided to ex-ADF individuals and their families as they transition from the defence forces.

Coordination of activities

Community stakeholders reported that the Trial activities for ex-ADF members and their families had brought agencies and interest groups together. Specifically, the Trial had made linkages with health and mental health sector stakeholders (i.e., PHNs, public and private mental health services) and ex-serviceperson organisations and veteran support services (e.g., Open Arms). Stakeholders also identified linkages between the Trial activities, the local suicide prevention network and the DVA.

Met needs and expectations

Most community stakeholders felt that the Trial had met the needs and expectations of ex-ADF community members. Some stakeholders reported that the Trial had exceeded their expectations. Other stakeholders said that the remaining gaps (discussed above) meant that community needs were only partially met. Community stakeholders also said that some ex-ADF community members were not aware of the Trial so might not feel that their needs were met. Finally, other stakeholders said it was too early to tell if community needs and expectations had been met during the Trial.

Increased awareness and knowledge

Community stakeholders stated that the Trial activities had increased the knowledge and awareness of suicide within the ex-ADF community. Specifically, stakeholders reported that the ex-ADF community possessed new knowledge about how to respond to personal crises and support others. Community stakeholders also reported more awareness in the ex-ADF community about the available supports and services within the health, social and community sectors (i.e., mental health services, financial and employment services).

Other impacts

Community stakeholders said that ex-ADF individuals who attended the Trial activities were more open and confident to discuss suicide, which they also saw as indicating a reduction in suicide stigma. Some community stakeholders said that the Trial had increased help seeking and use of support services for ex-ADF individuals at risk of suicide, and in some cases had “saved lives”.

Community stakeholders reported that participants of Trial activities had improved mental health and wellbeing outcomes by giving them a sense of empowerment. Participants of Trial activities were also said to have improved health and social outcomes (e.g., cardiovascular health and employment). Finally, stakeholders pointed to a cultural shift for ex-ADF community members towards being more open, community focused and trusting of services.

13.9.3 Activities for ex-ADF and their families – challenges

Community stakeholders identified a range of challenges encountered in implementing Trial activities for ex-ADF and their families:

- Engaging relevant stakeholders and sectors in implementing the Trial activities for ex-ADF and their families (the most frequently mentioned challenge)
- Difficulties in engaging ex-ADF individuals due to their mistrust of mainstream (civilian) services, and mistrust of services affiliated with the defence force
- Interorganisational competition between organisations within the ex-serviceperson sector
- The diversity of the ex-ADF focus population made it difficult for the Trial to engage effectively with young ex-servicepeople or sub-populations (e.g., First Nations ex-ADF individuals, families)
- External factors, notably COVID-19 and the Townsville floods, hampered the implementation of Trial activities
- Confusion among the broader ex-ADF community about the scope of the Trial, specifically as to why it was focusing on prevention when they perceived a need for more clinical supports
- Workforce challenges. Stakeholders reported that despite the prevention focus, the Trial staff were regularly triaging crisis situations.

13.10 Focus population – LGBTI

13.10.1 Activities for LGBTI people – approach

Activity description

Community stakeholders discussed the provision of peer activities, for example, peer counselling (2 Sites) and training in affirmative practice to make mainstream services accessible to people who identify as LGBTI (2 Sites), including the adaptation of existing training materials to be LGBTI-inclusive through use of peer trainers (1 Site). Other activities reported by community stakeholders were awareness raising about available mental health supports for trans and gender diverse young people (1 Site).

Tailoring activities

In order to tailor suicide prevention activities for LGBTI people, stakeholders spoke about the importance of recognising and overcoming barriers to access to mainstream services and negative community attitudes for people who identify as LGBTI (2 Sites). They advocated tackling the intersectional issues facing communities (1 Site), adopting a trauma-informed approach (1 Site), and providing non-clinical support services (1 Site).

Linkages and coordination

Community stakeholders felt that the following strategies were effective for coordinating LGBTI-specific Trial activities: LGBTI-specific Trial committees (2 Sites), LGBTI representation on the general-population Trial Committee (1 Site) and bringing together LGBTI organisations with other focus population organisations and groups (1 Site).

Involvement of people with lived experience of suicide

Community stakeholders reported that people who identified as LGBTI with a lived experience of suicide were involved in the Trial activities as peer support workers (2 Sites), on the Trial advisory committee (1 Site) and as co-design partners (2 Sites).

13.10.2 Activities for LGBTI people – outputs and impacts

Community stakeholders provided a small amount of information about the impacts of Trial activities for LGBTI people.

Complementing or filling a gap

Community stakeholders from one Site stated that the Trial activities had filled a gap by meeting the needs for support and service navigation for of LGBTI-identifying people, in the context that mainstream services are not inclusive (1 Site). One stakeholder stated that the intentional focus of the Trial activities on non-health service responses meant that a gap remained in terms of educating mainstream health services, including EDs, in affirmative practice (1 Site).

Coordination of activities

The establishment of strong linkages between organisations as a result of membership of the Trial Committee were mentioned by stakeholders from one Site.

Met needs and expectations

Stakeholders from both LGBTI Sites considered the Trial activities met needs and expectations by engaging with peers with lived experience for the first time (1 Site) and employment of a range of LGBTI-inclusive activities (1 Site).

13.10.3 Activities for LGBTI people – challenges

Community stakeholders highlighted the unique challenges presented by the socio-political context for LGBTI-specific Trial activities (namely, conservative attitudes towards gender and sexuality), and the perception from the LGBTI community that mainstream support service staff are not inclusive (2 Sites). Community stakeholders from one Site discussed the challenge in accommodating the diversity of intersectional identities that exist within the LGBTI population.

A stakeholder from one Site felt that there were insufficient links between the Trial activities and medical or health sector organisations, which precluded effective suicide prevention within the LGBTI population. Stakeholders from another Site discussed the dearth of trans-affirming health services available in the community. Stakeholders from a third Site mentioned COVID-19 as a barrier to implementation of Trial activities. Finally, stakeholders from a fourth Site said that a lack of data on the rate and risk factors for suicide among LGBTI Australians precluded data-informed planning and programming.

13.11 Focus population – Older Adults

13.11.1 Activities for older adults – approach

Activity description

Community stakeholders from one Site discussed Trial activities for older adults, including awareness-raising and training activities. Community champions were local people trained in mental health first aid who facilitated events and conversations with older adults about wellbeing and social isolation, connecting them to friendship groups and sporting clubs. Stakeholders also highlighted a community grants program that funded small events and activities, including an outreach van, a summit, delivery of Easter bunnies and a cupcake stall. Other activities mentioned by stakeholders included awareness raising about existing support services, a service directory and a suicide bereavement group.

Tailoring activities

Community stakeholders stated that a community development approach was adopted to tailor the Trial activities for older adults. Stakeholders explained that because many older adults refrain from help seeking, Trial activities focused on the promotion of wellbeing and a sense of purpose and combating social isolation, instead of focusing explicitly on suicide prevention, which was felt to be stigmatising for older adults. Due to difficulties in engaging older adults, community stakeholders said that the Trial worked with organisations working with older adults rather than directly with the target group.

Linkages and coordination

Community stakeholders highlighted the use of an existing mental health action group for Trial governance as an effective strategy for coordinating Trial activities for older people. Other community stakeholders said that using existing engagement forums to add suicide prevention information and frame suicide prevention activities in everyday non-clinical language (i.e., social isolation and wellbeing)was also effective for this purpose.

Promotion and recruitment strategies

Community stakeholders reported that older adults were recruited to Trial activities through community champions, word of mouth and a poster campaign.

Involvement of people with lived experience of suicide

Community stakeholders stated that older adults with a lived experience of suicide were involved in the Trial as members of the Trial Committee and as community champions who organised, promoted and facilitated activities and events.

13.11.2 Activities for older adults – outputs and impacts

Community stakeholders provided a small amount of information on the impacts of Trial activities for older adults.

Complementing or filling a gap

Community stakeholders felt that the Trial had facilitated connections between older adults and services that did not exist prior to the Trial, including the development of a suicide response plan in one sub-Trial Site. Stakeholders explained that the Trial did not institute a service for older adults due to concern that this service would not receive ongoing funding after the completion of the Trial.

Coordination of activities

Community stakeholders described the development of linkages between the PHN and mental health service providers, local councils and other community organisations working with older adults (e.g., the RSL).

Met needs and expectations

Community stakeholders said that they thought the Trial had made good progress in raising awareness about the social isolation of and the support services available for older adults, but may not have been sufficiently targeted to suicide prevention. Other stakeholders reported that the Trial had connected with older women more effectively than with older men.

Increased awareness and knowledge

Community stakeholders reported that the Trial activities had increased knowledge in the community about available services, and increased service providers' knowledge about and responsiveness to the needs of older adults.

Other impacts

Community stakeholders reported that the Trial had prompted community members to start conversations about social isolation and wellbeing and to look after each other, which reduced the social stigma of poor mental health, especially among older men. Stakeholders also felt that activities had fostered and maintained connections between community members and older adults. Stakeholders from one Trial district stated that there had been fewer suicides among older adults during the Trial than expected in such a period of time.

13.11.3 Activities for older adults – challenges

Community stakeholders reported that the suicide prevention activities targeted at older adults were challenged by many of the same barriers as for the general population approaches, including engagement of key stakeholders, a lack of existing services and external factors.

Community stakeholders identified unique workforce challenges for Trial activities focused on older adults, due to the small number of key stakeholders with specific knowledge and skills for working with that group. Stakeholders also mentioned barriers to engaging relevant sectors due to competition between service providers, a lack of common language across stakeholder groups (e.g., refusal to target activities at suicide prevention) and a lack of time from key health sector stakeholders (i.e., GPs, hospital staff and aged care workers). Stakeholders also said that the dearth of support services in regional areas for the general population affected the available support for older adults.

Community stakeholders discussed barriers to direct engagement of older adults in Trial activities due to the diversity of this focus population. Stakeholders mentioned specific barriers to engaging older adults who could not be contacted through aged-care service providers (i.e., who were not living in an aged care facility or in contact with support services). Technology literacy was also mentioned as a barrier for older adults to access Trial activities and service information. Finally, stakeholders said that COVID-19 had disproportionately affected planned Trial activities for older adults because of their heightened vulnerability (e.g., to health complications, fears of leaving their homes), inability to switch many activities to online forums, and the busyness of GPs.

14 Consultation with service providers (survey)

14.1 Summary of approach

A brief online survey of staff from organisations commissioned by PHNs to provide services or activities as part of the NSPT was undertaken in November 2019.

Primary Health Network Trial coordinators forwarded an email invitation to participate in an online survey to relevant staff members at organisations they had contracted to provide services or activities as part of the Trial. The email contained a link to the online survey, and indicated that staff receiving the invitation should feel free to forward it to others in their organisation who might be more appropriate respondents or might like to participate. The initial invitations were sent in early November 2019, and a general reminder sent two weeks later. The survey was anonymous, and no information was collected about participants' or service provider organisations' identities.

The survey contained open-ended questions focused on the types of services or programs funded by the PHN that had been delivered or were still being delivered, provider involvement in the Trial planning processes, tailoring activities for focus populations, challenges and successes experienced in delivering Trial-funded services or activities, and any impacts and outcomes of Trial services and activities observed. The questionnaire is available in Appendix 10.

The two Sites focused exclusively on suicide prevention for Aboriginal and Torres Strait Islander peoples were not included in the survey, because it was a late inclusion in the evaluation protocol and had not been approved by Aboriginal and Torres Strait Islander Research Ethics Committees.

14.2 Sample information

Completed questionnaires were received from 52 respondents from service provider organisations at nine Trial Sites and one national organisation that provided services to multiple Trial Sites. Three respondents were from organisations providing aftercare services (2 Sites), and the remaining 49 respondents were from organisations providing other suicide prevention activities. Table 14.1 describes the types of activities being provided by respondent's organisations.

Table 14.1 Service Provider survey: Types of activities and services being delivered

Types of activities or services	Respondents (n)	Sites (n)
Community events including workshops, training and community courses	28	8
Workforce development and training	17	8
Aftercare services	3	2
Other activities for individuals (e.g., psychosocial support or life coaching)	4	4
Activities focused on referral pathways and/or service navigation	7	4
Media campaigns and advertisement	4	3
Postvention support services	3	2
Funding a new co-located position	1	1

14.3 Data analysis

Survey responses were imported into NVivo V.12 for analysis. A coding framework was developed based on the evaluation questions, the survey questions and initial impressions from a preliminary thematic analysis of 10% of all responses by two evaluators independently. The survey questions were used to deductively identify key themes and develop a coding framework that captured the full range of comments. A modified framework analysis was conducted to order the themes into an overarching framework to make sense of the emerging themes(21). The two evaluators achieved consensus on the final framework, then one evaluator independently coded all the responses, consulting with the other as needed. Appendix 11 provides themes and sample quotes from service provider consultation.

14.4 Planning

14.4.1 Planning – Identifying local needs and service gaps

No data was collected on this topic.

14.4.2 Planning – stakeholder involvement

Thirty respondents from nine Trial Sites indicated that they had had some involvement in the planning process for the Trial. Two respondents from two Trial Sites reported being unsure about whether their organisation was involved in the planning process. Table 14.2 details ways in which respondents were involved in Trial planning.

Table 14.2 Service provider survey: Service provider involvement in Trial planning

Method of involvement	Respondents (n)	Sites (n)
Participated in community consultation or engagement	15	7
Member of Trial Committee	8	6
Local working groups	4	3
Stakeholder partnerships	3	3
Co-designing process	2	2
Local suicide prevention network, or action group	2	2
Program development by people with lived experience of suicide	1	1

The main mechanisms through which respondents were involved were participation in broader community consultations or general planning meetings and workshops that were held as part of broader PHN consultation and engagement activities, or via their involvement in local suicide prevention networks, committees, advisory or action groups.

14.4.3 Planning – facilitating factors

Eight respondents from five Trial Sites provided information on strategies used to facilitate planning. Effective facilitating factors included focusing on the development of local action plans and proposals, using existing links between providers and community, consulting community and using data. Table 14.3 details facilitating strategies.

Table 14.3 Service provider survey: Facilitators of planning

Facilitating strategies	Respondents (n)	Sites (n)
Capitalising on existing networks	2	2
Developing a local strategic plan of action	2	2
Targeted community consultations	2	2
Developing local project proposals	2	2
Data collection, review and sharing	1	1

14.4.4 Planning – challenges

Nine respondents identified multiple challenges encountered in the planning of Trial services or programs (Table 14.4). The most frequently mentioned challenges were the capacity and time available for the planning activities, engaging in genuine community consultations, and the funding available for planning activities.

Table 14.4 Service provider survey: Challenges encountered in Trial planning

Challenges	Respondents (n)	Sites (n)
Limited planning capacity and time	4	3
Engaging in genuine consultations and/or co-design with community	3	3

Challenges	Respondents (n)	Sites (n)
Limited funding	3	3
Maintaining stakeholder engagement	2	2
Engaging with people with lived experience of suicide	2	2
Integrating with key stakeholder strategies and activities	2	2
Working with a prescribed service model	1	1
Lack of PHN transparency and support	1	1
Insufficient input into planning process	1	1

14.5 System-based approach

14.5.1 Developing a systems approach – strategies

Beyond contributing to the Trial planning, service providers had little input into the Trial in terms of pursuing a systems approach, because they were contracted to deliver specific services or activities. Therefore, the service provider consultations focused on linkages between organisations and other strategies for establishing a more coordinated suicide prevention ecosystem in their local region.

Fifty respondents from nine Trial Sites and the national organisation described ways their organisation or the activities delivered strengthened the sector, engaged across the community and sector, and promoted coordination (Table 14.5). Other strategies mentioned were increasing coordination and integration through co-located positions and adopting holistic or partnership service models.

Table 14.5 Service provider survey: Strategies used to develop a systems approach

Activities	Respondents (n)	Sites (n)
Service/activity level strengthening		
• Tailoring to local context and/or focus population group	29	9
• Establishing new services	7	4
• Developing cultural awareness and responsivity	4	4
Building capacity in the sector		
• Workforce development and training	16	8
• Building community capacity	16	7
• Engaging lived experience of suicide or peer workers	8	5
• Building community awareness and engagement	8	5
Other activities to increase coordination	5	3

14.5.2 Implementing a systems approach – impacts

Twelve respondents (5 Sites) commented on local arrangements or strategies for integrating services and activities. This mostly involved the establishment or strengthening of referral pathways for consumers and collaboration between organisations delivering complementary services/activities. Table 14.6 provides further details on strategies for integrating services.

Table 14.6 Service provider survey: Strategies for integrating services/activities

Strategy	Respondents (n)	Sites (n)
Established or strengthened referral pathways	6	4
Formed a local collaboration to deliver complementary services	4	2
Provided service navigation support	2	1
Funded a co-located position	1	1
Participated in inter-agency training	1	1

Strategy	Respondents (n)	Sites (n)
Leveraged funding with other services	1	1

14.5.3 Developing and implementing a systems approach – Challenges

Forty-six respondents from nine Trial Sites and one national organisation identified challenges encountered in implementing and delivering Trial-funded services or programs (Table 14.7). The most frequently mentioned challenges were the uncertainty or inability to continue activities and services after the Trial; the limited amount of funding available hindering the establishment and delivery of services or programs; challenges related to community awareness, knowledge and uptake of activities or services; high staff turnover at PHNs and/or service providers; and the restricted timelines for the planning and delivery of services and programs.

Table 14.7 Service provider survey: Challenges encountered in implementation

Challenges	Respondents (n)	Sites (n)
Uncertainty or inability to continue activities and services	12	5
Insufficient funding available	8	6
Community awareness and/or engagement	8	4
High staff turnover	7	5
Restricted timelines in planning and delivery	6	5
Poor service integration	5	5
Locality/specificity versus scalability	4	3
Lack of support from stakeholders	4	3
Large geographical area and/or remoteness	4	2
Finding staff with the appropriate skill set	3	2
Accessing required tools and resources	3	3
Role and requirements of the PHN	3	2
Lack of cultural competence or responsivity	2	2
Meeting diverse needs of the community	3	1
Sustaining LifeSpan framework fidelity	2	1

14.6 Aftercare services for people who attempt or are at risk of suicide

14.6.1 Approach

Service description

The service provider survey yielded little data on aftercare services. Three respondents from two organisations (2 Sites) delivered follow-up aftercare services for people who attempt or are at risk for suicide. One respondent indicated that their organisation had worked with the PHN to co-design the follow-up aftercare service for their focus population group (the LGBTI community).

14.6.2 Aftercare services – output and impacts

Benefits noted by respondents from organisations providing aftercare services included:

- Increased access to support and services in the region (2 respondents, 1 Site)
- Improvements in consumers' wellbeing and the fact they remained alive throughout their engagement with the service (1 respondent, 1 Site)
- An increase in suicide literacy among organisations staff (1 respondent, 1 Site).

14.6.3 Aftercare services – challenges

The main challenges mentioned were high staff turnover in either partner organisations or in the ED, resulting in the need for ongoing contact and education (2 respondents, 2 Sites). Accessing services for clients in regional areas was also noted as a challenge (1 respondent, 1 Site), as well as concerns about transition arrangements at the end of the Trial and the impact on clients when services are withdrawn (2 respondents, 2 Sites).

14.7 General population suicide prevention activities

14.7.1 Approach

Activity description

Seven respondents from six Trial Sites commented on other suicide prevention activities for the general population. Table 14.8 lists the whole-of-population or whole-of-community activities that were respondents' organisations undertook.

Table 14.8 Service provider survey: Strategies used to target the general population

Strategies	Respondents (n)	Sites (n)
Building community capacity (e.g., MHFA, local working suicide prevention groups, lived experience of suicide workshops)	4	4
Localised and place-based approaches	3	3
Providing outreach services	2	2
Workforce suicide prevention training (e.g., ASIST)	2	2
Building the capacity of people with lived experience of suicide	1	1

14.7.2 General population activities – outputs and impacts

Nine respondents from four Trial Sites reported benefits of the Trial activities:

- Boosting local suicide prevention activities (2 respondents, 2 Sites)
- Increased local coordination of suicide prevention activities (1 respondent, 1 Site)
- Building local community and PHN relationships (2 respondents, 2 Sites)
- Positive impact on participants' wellbeing (5 respondents, 4 Sites)
- An increased local workforce (1 respondent, 1 Site).

Two respondents reported it was still too early to comment on any successes.

14.7.3 General population activities – challenges

Eight respondents from six Trial Sites and one national respondent commented on the challenges encountered in delivering suicide prevention activities for the general population. Challenges mentioned were:

- Poor uptake and/or engagement with activities (4 respondents, 2 Sites and national providers)
- Turnover of Trial Coordinator staff (2 respondents, 2 Sites)
- Lack of resources to provide programs (1 respondent, 1 Site)
- Inability to meet high demand (1 respondent, 1 Site).

14.8 Focus population – men

14.8.1 Activities for men

Activity description

Six respondents from three Trial Sites described activities their organisations were delivering for men. Activities included building community awareness and engagement, gatekeeper and community training, and men's support groups or coaching.

Tailoring activities

Seven respondents from four Trial Sites noted strategies used to adapt services or programs to make them more appropriate or appealing to men. Strategies mentioned were:

- Delivering programs that were already specific to men (4 respondents, 2 Sites)
- Adapting program content to be appropriate for men (2 respondents, 2 Sites)
- Delivering program in predominantly male workplaces (1 respondent, 1 Site)
- Engaging men in implementation and delivery processes (1 respondent, 1 Site).

14.8.2 Activities for men – outputs and impacts

Nine service providers from four Trial Sites identified the following benefits of the Trial activities focusing on men:

- Improved community awareness, engagement and capacity (6 respondents, 4 Sites)
- Greater knowledge, skills and wellbeing of participants (6 respondents, 2 Sites)
- Increased capacity in the local workforce (1 respondent, 1 Site)
- Increased reach for suicide prevention activities (1 respondent, 1 Site)
- Increased local stakeholder collaborations (1 respondent, 1 Site)
- Improved community relationships and community support (2 respondents, 1 Site).

14.8.3 Activities for men – challenges

Twenty-one respondents from eight Trial Sites provided information on challenges encountered in providing activities for men. Challenges mentioned included:

- Accessing/attracting participants (5 respondents, 3 Sites)
- PHN processes (3 respondents, 3 Sites)
- Funding (3 respondents, 3 Sites)
- Distances in Trial Site regions (2 respondents, 2 Sites)
- Community engagement/ readiness (2 respondents, 2 Sites)
- Time-related challenges (2 respondents, 2 Sites)
- Sustainability (2 respondents, 2 Sites)
- Accessing resources (1 respondent, 1 Site)
- Staff turnover (1 respondent, 1 Site).

14.9 Focus population – young people

14.9.1 Activities for young people

Activity description

The services and programs providers were delivering to address the needs of youth included the co-design of a mental health and wellbeing mobile app (1 respondent, 1 Site), a TAFE work placement collaboration (1 respondent, 1 Site), community engagement and awareness raising about youth suicide prevention (1 respondent, 1 Site), and workforce training and development targeting educators (e.g., ASIST, 2 respondents, 1 Site).

Tailoring activities

Five respondents from three Trial Sites noted information strategies used to develop or adapt Trial services and activities to address suicide prevention in young people. These were:

- Delivering activities directly to young people via school-based programs, (2 respondents, 2 Sites)
- Engaging young people in the delivery of suicide prevention activities (1 respondent, 1 Site)
- Workforce training and development to build capacity in youth suicide prevention (1 respondent, 1 Site)
- Building community capacity in youth suicide prevention (1 respondent, 1 Site).

14.9.2 Activities for young people – outputs and impacts

Six service providers from three Trial Sites reported benefits they had observed from Trial activities focused on young people. They included:

- Increased community awareness, engagement and capacity (4 respondents, 3 Sites)
- Good attendance and participation in activities (4 respondents, 3 Sites)
- More services and/or reach (2 respondents, 2 Sites)
- Improved knowledge, skills and wellbeing of participants (2 respondents, 2 Sites)
- An increased local workforce (1 respondent, 1 Site)
- Increased local stakeholder collaboration (1 respondent, 1 Site)
- Greater availability of community support (1 respondent, 1 Site).

Additionally, one respondent reported that the Trial had resulted in successful development of tailored activities for young people, achieved through the establishment of a local school network made up of school principals, local youth service providers, and clinical representatives from the LHD, the local youth and family team and the PHN that provided guidance.

14.9.3 Activities for young people – challenges

Five respondents from three Trial Sites delivering activities for youth mentioned challenges, including:

- Limited uptake of activities or services (2 respondents, 1 Site)
- Delivering programs across large geographical areas or in remote locations (1 respondent, 1 Site)
- Balancing locality/specificity and scalability of the program (1 respondent, 1 Site)
- Uncertainty or inability to continue activities and services at the end of the Trial (1 respondent, 1 Site).

14.10 Focus population – ex-ADF members and their families

14.10.1 Activities for ex-ADF members and their families

Activity description

Five respondents from a single Trial Site commented on activities for ex-ADF members and their families. The types of activities respondents' organisations were delivering to ex-ADF members and their families included field trips providing an immersion experience, providing local employment opportunities, and community training.

Tailoring activities

Five respondents from a single Trial Site commented on the strategies that were used to develop Trial services and activities to meet the needs of ex-ADF members and their families. They were:

- Building community capacity in ex-ADF suicide prevention (2 respondents)

- The involvement of people with lived experience (of the ADF, and suicide) in service design (1 respondent)
- A joint partnership service model (1 respondent)
- Engaging the ADF community in the development and delivery process (1 respondent)
- Developing an ex-ADF specific program (1 respondent).

14.10.2 Activities for ex-ADF members and their families – outputs and impacts

Five respondents from one Trial Site reported benefits of the Trial activities for ex-ADF members and their families that they had observed:

- Increased community awareness, engagement and capacity (three respondents)
- Increased knowledge and confidence of participants (two respondents)
- Improved community relationships (one respondent)
- Good attendance and participation in activities/services (two respondents).

One respondent noted that while many of the services available in the region operate on a FIFO basis, the Trial contributed to the continuation of a local and ongoing activity.

14.10.3 Activities for ex-ADF members and their families – challenges

Challenges noted by four respondents were:

- Uncertainty about continuing or inability to continue activities and services (2 respondents)
- Insufficient funding (1 respondent)
- Lack of support from stakeholders (1 respondent)
- Difficulty accessing required tools and resources (1 respondent)
- Balancing locality/specificity versus scalability of the program (1 respondent)
- Limited activity or service uptake (1 respondent).

14.11 Focus population – LGBTI people

14.11.1 Activities for LGBTI people

Activity description

Five respondents from three Trial Sites commented on activities for LGBTI people. The types of activities being provided by respondents' organisations included providing holistic services, training mainstream service providers in LGBTI-affirmative practices, and media campaigns.

Tailoring activities

Five respondents from three Trial Sites provided information on strategies used to develop Trial services and activities to meet the needs of LGTBI people. They were:

- Offering specialist LGBTI services/activities or delivery of generic activities services by a specialist LGBTI organisation (3 respondents, 2 Sites)
- Engaging LGBTI people in service or activity planning and delivery 1 respondent, 1 Site).

14.11.2 Activities for LGBTI people – outputs and impacts

Five service providers from three Trial Sites noted several benefits of the Trial activities for LGTBI people or communities:

- The improved awareness of, engagement with and capacity in LGBTI suicide prevention of the general community (3 respondents, 2 Sites)

- Positive impacts on the knowledge, skills and wellbeing of activity participants (4 respondents, 2 Sites)
- Availability of appropriate and LGTBI-affirmative services (2 respondents, 2 Sites)
- An increased local workforce (1 respondent, 1 Site)
- Increased service referrals and access (2 respondents, 1 Site)
- Including consumer input and feedback on Trial activities (1 respondent, 1 Site)
- Successful collaboration with key LGTBI partners (1 respondent, 1 Site).

One respondent also commented that the Trial had highlighted the amount of unfunded suicide activities their organisation was already undertaking.

14.11.3 Activities for LGBTI people – challenges

A range of challenges were noted by respondents delivering LGBTI-focused programs, including:

- Insufficient community awareness and/or engagement (1 respondent, 1 Site)
- Integrating with key stakeholder strategies and activities (2 respondents, 1 Site)
- Restricted timelines in planning and delivery (2 respondents, 2 Sites)
- Insufficient funding (2 respondents, 1 Site)
- High staff workloads and turnover (2 respondents, 1 Site)
- A prolonged change-management process (1 respondent, 1 Site)
- PHN administrative processes and requirements (2 respondents, 2 Sites)
- Lack of cultural competence or responsivity in the sector (1 respondent, 1 Site)
- Lack of lived experience of suicide consultation (1 respondent, 1 Site).

15 Consultations with service providers (interviews)

15.1 Summary of approach

Two rounds of consultations were undertaken with representatives from organisations commissioned by PHNs to provide services or activities for the Trial. The first round was conducted via an online survey in mid-2019 (findings are reported in Chapter 15). The second round took place between March and June 2020 via in-person and online or phone interviews. This chapter reports on results of those interviews. The two Trial Sites which focused solely on activities or services for Indigenous people and/or communities were not included in this round of consultations. A separate round of consultations was undertaken with service providers from Sites with a focus on Aboriginal and Torres Strait Islander suicide prevention (see Chapter 19).

Trial coordinators from the remaining 10 Sites were asked to identify service provider organisations who were commissioned to provide services or activities as part of the Trial and invite relevant staff members to participate in an individual or group interview. Interviews were conducted via online videoconference (Skype, Teams or Zoom) or phone due to COVID-19 travel restrictions. The questions for the group and individual interviews were the same and were based on the Evaluation Framework(10). Interview questions focused on the impacts and outcomes of Trial activities and services and how these were achieved. The interview questions are provided in Appendix 12.

Interviews were conducted by two evaluators, with one acting as scribe, and audio-recorded with the participant's permission. Group interviews lasted between 30 minutes and one hour, and individual interviews 20–45 minutes. Each participant received a plain language statement providing information about the evaluation and the interview, and all participants provided informed verbal or written consent to take part.

15.2 Sample information

Thirty-six staff members from 19 service provider organisations in seven Trial Sites took part in consultations. Table 15.1 describes participants' service provider organisation type, roles and the number of Sites.

Table 15.1 Service provider interviews: Staff roles by service type and Site

Service type and staff role	Participants (n)	Sites (n)
Aftercare service providers		
• CEO or deputy CEO	1	1
• Program/service manager	6	3
• Project officer	3	3
• Staff member	8	4
Subtotal	18	4
Staff of other activities or programs		
• CEO or deputy CEO	3	2
• Program founder	1	1
• Program/service manager	8	5
• Project officer	3	2
• Staff member	4	2
Subtotal	19*	6
Total	36	7

* one participant was both an aftercare service provider and a provider of other activities.

Thirteen participants took part via online group interviews, 22 via online individual interviews and one via individual phone interview. The participants represented a total of 19 provider organisations, with six organisations providing aftercare services and 13 organisations providing other Trial activities, and one organisation providing both aftercare services and other activities.

The aftercare services included services focused on LGBTI people (including youth) and the general population. Other suicide prevention activities provided by the participants included capacity-building activities, such as suicide awareness training in communities, schools and male-dominated workplaces (7 providers, 4 Sites). Several service providers were involved in various activities and others provided activities across two Sites. Table 15.2 gives an overview of the types of services and activities that the participants delivered.

Table 15.2 Service provider interviews: Types of services and activities provided

Services and activities provided by participants	Providers	Sites (n)
Aftercare services		
• LGBTI specific	4	2
• General population	2	2
Other suicide prevention activities		
• Media campaigns	2	1
• Awareness raising activities (e.g., workshops)	3	3
• Community capacity building (e.g., ASIST, YAM)	7	4
• Workforce training and education	3	3
• Peer-based support programs	2	2
• Research and program development	4	2
• Parent and carer support programs	1	1

15.3 Data Analysis

Notes from the group and individual interviews were uploaded to NVivo V.12 for analysis. Thematic analysis of the interviews was then undertaken considering all responses together and for all focus population groups using the notes taken by the evaluator in the interviews, supplemented by the audio-recordings when needed. Initially, the two evaluators read all the interview notes and used the interview schedule to deductively identify key themes and develop a coding framework that captured the full range of comments. A modified framework analysis was conducted to order the themes into an overarching framework to make sense of the emerging themes(21). The two evaluators then independently coded two of the interviews and determined the level of agreement on coding the data. The themes were further refined to address areas of disagreement and consensus was obtained regarding the coded interviews. One of the evaluators then coded the remaining content, consulting with another evaluator when needed. The framework and associated coding was then finalised. Themes and sample quotes are provided in Appendix 13.

Results are reported by service, not respondent, because there was substantial variation in the number of respondents by provider organisation (mean 1.9, range 1–4). In total there were six aftercare services across the four Sites and 14 service providers of other Trial activities across seven Sites.

15.4 Planning

No data were collected on this topic.

15.5 System-based approach

15.5.1 Developing a systems approach – strategies

Beyond contributing to the Trial planning, service providers had little input into the Trial in terms of developing a systems approach, because they were contracted to deliver specific services or activities. Therefore, the service provider consultations focused on strategies they felt had been effective in achieving linkages between services and/or a more coordinated approach to suicide prevention in general in their local region.

15.5.2 Implementing a systems approach – impacts

Staff from aftercare service providers from all four Trial Sites discussed approaches to coordinating and integrating services with existing local aftercare service providers. Table 15.3 details the strategies service provider staff considered effective for coordinating services and care. Staff from one provider noted they were still in the early stages of developing linkages with other services.

Table 15.3 Service provider staff interviews: Effective strategies for coordinating aftercare services

Effective strategies	Providers (n)	Sites (n)
Advocacy and information sharing about the service and/or focus population group	2	2
Pre-existing linkages with other services	2	2
PHN bringing service providers together	2	1
Providing warm referrals between services	1	1
Collaboration agreements	1	1

Staff from organisations providing other activities from six Trial Sites commented on linkages with other service providers or other relevant organisations, including suicide prevention networks and community groups. Table 15.4 describes the key strategies mentioned.

Table 15.4 Service provider staff interviews: effective strategies for coordinating other suicide prevention activity

Effective strategies	Providers (n)	Sites (n)
Collaboration and/or partnerships with relevant stakeholders	10	5
Providing referrals pathways	3	3
Avoiding duplication and/or ensuring complementing activities	4	3

Staff from over half the provider organisations included mentioned they had collaborated or partnered with a local organisation, either to organise specific activities or to facilitate a more collaborative approach generally (10 providers, 5 Sites). Staff from three provider organisations (3 Sites) noted they were linked directly to other service providers and provided a referral pathway into those services. Other provider staff commented that they had made efforts to avoid duplication and/or ensure they delivered complementary activities, for example, by sharing calendars or doing scoping exercises of suicide prevention activities (4 providers, 3 Sites).

15.5.3 Developing and implementing a systems approach – challenges

Staff from aftercare service providers at four Trial Sites mentioned several challenges that were related to integration and coordination with other services. Table 15.5 outlines the challenges mentioned.

Table 15.5 Service provider staff interviews: Aftercare services challenges

Challenges	Providers (n)	Sites (n)
Misaligned of values and/or service approaches between providers	2	1
Lack of cultural competence of other providers	1	1
Lack of collaboration with hospital and emergency services	1	1
Short timeframe of the service	1	1
Integrating the clinical and non-clinical service components	1	1

Staff from two service providers (1 Site) mentioned a misalignment of values and/or an incongruence in service approaches between services as challenging when having to collaborate and coordinate between services. One staff member also mentioned that the lack of cultural competence was a barrier for service collaboration. These challenges appeared to be largely managed by minimising the collaboration with such providers.

Staff from one service provider commented that they had missed an opportunity by not investing early in establishing collaborations with hospitals and EDs. They perceived that this resulted in their service having poor reach in terms of people with high needs and more of a focus on people at moderate risk.

One provider felt that the short timeframes of the service model (3 months) were challenging with respect to linking consumers with other services such as the NDIS and drug and alcohol services, which tended to have long waiting times and/or lists. They had not been able to link with other services quickly enough.

Staff from another service provider noted that their main challenge was integrating the clinical and non-clinical service components of the service model, both within their organisation and externally, due to resistance from mental health professionals. This challenge was addressed by improving communication and building relationships.

Additionally, staff from organisations providing other Trial activities at two Sites reported challenges related to coordination and integration of activities with other local existing service providers. These included a lack of (central) coordination of local suicide prevention activities (1 provider, 1 Site), and their perception that the local priority populations of the Site had been chosen based on community consultations, rather than data on suicide rates available (1 provider, 1 Site).

15.6 Aftercare services for people who attempt or are at risk of suicide

15.6.1 Aftercare services – approach

Service description

Four Trial Sites implemented non-clinical follow-up aftercare for individuals who had made a suicide attempt or were experiencing suicidal ideation. The staff consulted included personnel from two organisations providing general population services (2 Sites) and four organisations which provided LGBTI-specific services during the Trial (2 Sites), one of which focused on LGBTI youth.

Staff from aftercare service providers mentioned various intake and/or initial assessment processes across the different Sites and service types:

- Initial assessment by a clinician (3 providers, 2 Sites)
- Initial assessment by a clinician and/or a case-manager (2 providers, 1 Site)
- An initial informal meeting by a peer worker and triaging by the project officer (1 provider, 1 Site).

Staff from one service provider mentioned that having a third party, that is, not the peer worker, doing the initial intake was beneficial for building rapport with consumers as a peer worker.

Staff from three service providers (3 Sites) noted that their process requires they make contact within one or two days after receiving the initial referral.

Workforce requirements

Table 15.6 details the qualifications required or preferred for clinical and non-clinical staff involved in aftercare services, as well as additional short courses that were provided to staff to deliver aftercare services.

Table 15.6 Service provider staff interviews: Workforce capabilities

Workforce qualifications and training
Clinical qualifications
• (Clinical) psychology
• Accredited mental health social work
• Mental health occupational therapy
Non-clinical qualifications or training
• Social work, psychology or occupational therapy
• Certificate IV mental health
• Peer mental health training or experience
Short training courses provided
• Suicide or mental health training courses
• Peer worker or lived experience of suicide training

Staff from four aftercare service providers (3 Sites) reported that staff received additional training courses, such as suicide first-aid training (i.e., ASIST), Mental Health First Aid, Roses in the Ocean training and peer worker training. Staff from two providers (2 Sites) mentioned that their non-clinical staff also received professional supervision.

One LGBTI-specific aftercare service provider mentioned other relevant workforce experience and training, which included experience in relational vulnerabilities, sex positivity and trans-affirmative practices, cultural safety and LGBTI suicide first-aid training.

Staff from one service provider emphasised the importance of a peer workforce for the LGBTI community.

Tailoring services

Staff from aftercare service providers identified several strategies used to tailor their services either to their regional context or their focus population. Strategies included:

- Adjusting elements of the service model, such allowing for more flexibility in the intake and/or service to suit individual needs (3 providers, 2 Sites)
- Developing the service model, informed by consultations with focus population groups (2 providers, 2 Sites)
- Responding to client feedback (2 providers, 1 Site)
- Working with key local stakeholders (1 provider, 1 Site).

It was noted that LGBTI clients are marginalised by their mental health as well as their LGBTI status, and therefore intersectionality is an important consideration in designing and delivering services for this focus population group.

Staff from three service providers delivering LGBTI-specific services reported that few adjustments were required to tailor their service for the focus population group, because they had pre-existing expertise as an organisation.

Linkages and referrals

Aftercare service providers reported on the referral sources of their services, which are described in Table 15.7.

Table 15.7 Service provider staff interviews: Aftercare service referral sources

Referral sources	Providers (n)	Sites (n)
Community organisations	5	4
Other service providers	4	3
GPs	3	3
Hospitals and/or EDs	3	3
Self-referral	3	3
Others	3	3
Internal referrals	2	1

One service provider noted that they only accepted referrals from the hospital under the regulations of the Trial. Other sources of referrals included the police, university counsellors, teachers and community groups.

Service promotion and recruitment

The main avenue for promoting Trial-funded aftercare services was local sector networks. Other methods identified are detailed in Table 16.8.

Staff from two service providers (2 Sites) indicated that active and ongoing service promotion by staff was needed to receive adequate referrals from local services. Specifically, one Site received very few referrals from hospitals and EDs. Staff from another provider indicated they had established very good referral pathways with the ED, with their staff attending community mental health interagency meetings and handovers.

Table 15.8 Service provider staff interviews: Aftercare service promotion strategies

Promotion strategies	Providers (+n)	Sites (n)
Through local sector networks	5	4
Websites and/or social media	2	2
Word of mouth	3	1
Promotion via email	1	1
Community campaigns	1	1
Promotion at community events	1	1

Staff from one LGBTI-specific provider mentioned that the LGBTI community is very tight and their organisation draws on their established community ties to promote the services. Staff from another LGBTI-specific provider mentioned they had actively involved the community in the production and promotion of their community campaign to promote the service.

Involvement of people with lived experience of suicide

Staff from aftercare service providers at all four Trial Sites reported that people with lived experience of suicide had been or were involved in their service to some degree (Table 15.9).

Table 15.9 Service provider staff interviews: Involvement of people with lived experience of suicide

Involvement	Providers (n)	Sites (n)
Participating in the planning and implementation	4	3
Recruiting a lived experience of suicide workforce	4	3
Providing consumer feedback	3	3
Acting as peer companions	1	1

Staff from four LGBTI service providers from two Sites noted the strong peer component of their organisations, with numerous members of their workforce having lived experience of suicide and identifying as members of the LGBTI community.

15.6.2 Aftercare services – outputs and impacts

Met needs and expectations

Staff from four service providers (3 Sites) reported, based on anecdotal feedback, that both clients and local stakeholders were positive about their service and considered it a useful additional service in their region. Several benefits of the aftercare services for both the consumers and service providers were reported (Table 15.10).

The positive impacts on client wellbeing mentioned by service provider staff included keeping consumers alive and increased social connections and support. Several service provider staff commented on the fact that services were more accessible for consumers, including free and safe services for people who would otherwise not receive support, services that don't require a referral from a GP, and peer-based support. The ability to be flexible within the service model was noted as important in order to provide a consumer-focused service that fit people's individual needs.

Table 15.10 Service provider staff interviews: Benefits of aftercare services

Benefits	Providers (n)	Sites (n)
Client benefits		
• Positive impacts on wellbeing	4	2
• More accessible services	3	2
• Flexible service models	2	2
Service benefits		
• Increased resources available	1	1

Service provider staff specifically mentioned the benefit of more accessible and safer services available to LGBTI consumers.

Coordination with other services

Two aftercare service providers reported increased collaboration across the sector as a result of the Trial (2 respondents, 1 Site). Furthermore, five service providers from the four Trial Sites indicated that clear referral pathways were developed with other community organisation and service providers, and indicated they (mostly) received appropriate referrals.

15.6.3 Aftercare services – challenges

Service provider staff identified various challenges related to the establishment and delivery of the aftercare services (Table 15.11).

Table 15.11 Service provider staff interviews: Aftercare services challenges

Challenges	Providers (n)	Sites (n)
Stakeholder engagement and buy-in		
• Hospitals or emergency services	4	3
• Mental health professionals	3	3
• General practitioners	2	2
Coronavirus-related challenges	5	3
Finding suitable staff and/or staff retention	3	3
Access barriers for consumers	3	3
Other workforce related challenges	3	3

Challenges	Providers (n)	Sites (n)
Internal processes and logistics (e.g., referral pathways and client management software)	3	2
Short timelines of the Trial	2	1
Lack of local services for referral	1	1
Lack of clinical support for staff	1	1
Administration and paperwork burden	1	1

Staff from most services identified challenges related to engagement with hospitals and emergency services. Staff from one service provider explained that the major challenge in engaging with hospitals was concerns from clinical staff at the hospital around risk management and handing over to a psychosocial service. Staff from another service provider described how their initial difficulties in engaging the local hospital were ameliorated by establishing a new coordinating role – jointly funded by the PHN and the Local Health Districts – to oversee the referrals, as well as employing a clinical team leader. Similarly, staff from a third provider mentioned that their staff regularly spent time at the local hospital to liaise and coordinate referrals.

Staff from several providers commented on service gaps due to access barriers for clients (3 providers, 3 Sites), such as limited access in regional areas and inaccessible referral pathways. In regional areas, most referrals come from clinical services, which was mentioned as an access barrier for LGBTI people in regional areas by staff from one provider. It was noted that LGBTI young people who had not disclosed their gender identify to family and/or were unable to travel independently could have poor access to LGBTI-specific aftercare services.

Staff from one service provider found that because most of their referrals come from the hospital, they were missing population groups who rarely present at hospitals, such as Aboriginal and Torres Strait Islander people and people dealing with situational crises (e.g., relational breakdown or job loss). Staff from another service provider found they mostly received referrals for inner-city consumers, and they had yet to determine how to reach consumers in regional areas of the PHN catchment. Staff from one service provider mentioned that they had adjusted or broadened their referral process to break down some of these barriers, for example, opening up their referral pathway to Aboriginal Health Services. For LGBTI-specific aftercare services, the importance of safe, sex-positive and trans-affirmative referral pathways was highlighted; many consumers are worried about being mis-gendered when presenting at mainstream services.

Workforce-related challenges were a common challenge mentioned by service provider staff. Finding suitable staff and/or staff retention was very difficult (3 providers, 3 Sites). Other workforce-related challenges mentioned included staff turnover at partner organisations, internal staff turnover eroding stakeholder relationships, and peer workers often being unpaid staff with other commitments. Finding suitable staff with the right experience, frameworks and boundaries was noted as particularly challenging for LGBTI-specific services.

Finally, staff from several providers commented on COVID-19 restrictions disrupting referral pathways, stakeholder engagement, service demand and the ability to have face-to-face meetings (5 providers, 3 Sites). Staff from one provider noted they had to do more service promotion and that they hold consumers in their service longer as a result. Another provider noted that they had moved to online services.

15.7 Other suicide prevention activities

15.7.1 Other suicide prevention activities – approach

Activity description

Most service provider organisations represented in the consultations were involved in activities focused on LGBTI people and/or communities (6 providers, 2 Sites). Other focus populations included men, youth and older people, and one provider was focused on the general population, as detailed in Table 15.12.

Table 15.12 Service provider staff interviews: Focus populations

Focus populations	Providers (n)	Sites (n)
LGBTI*	6	2
Males**	4	6
Youth	4	4
Older people	1	1
General population	1	1

*including one LGBTI youth-specific and one LGBTI Aboriginal and Torres Strait Islander provider involved in broader LGBTI activities. **two providers worked across multiple Sites.

Most activities were focused on community education and capacity-building activities (9 providers, 6 Sites), which included school programs, lived experience of suicide workshops and community suicide awareness and prevention training (see Table 15.2).

Some service providers described specific approaches of activities for their focus populations:

- For men, awareness-raising and capacity-building activities specifically involved workplace training in male-dominated industries such as construction, mining and smelters
- For youth, including LGBTI youth, activities were targeted at schools, with one provider targeting students as well as teachers and administration staff
- For LGBTI-focused activities, community education and capacity-building activities involved adapting an existing training program to be LGBTI inclusive, and affirmative practice training of mainstream organisations
- For older people, one service provider indicated they involved other service providers which were already involved with this population.

Tailoring activities

Service provider staff reported various ways in which activities were adopted to fit local needs or focus populations. Most mentioned they consulted with key stakeholders in their region (7 providers, 4 Sites) or with their focus populations (7 providers, 3 Sites). The strategies are described in Table 15.13.

Table 15.13 Service provider staff interviews: Tailoring strategies

Tailoring strategies	Providers (n)	Sites (n)
Consultations with key local stakeholders	7	4
Consultations with representatives from focus populations groups	7	3
Adjusting elements of the activity to be relevant or safe	6	5
Consultations with potential participants	4	3
Activities delivered by organisations with existing expertise	3	3

Tailoring activities for men involved adjusting the activity to suit the particular (male-dominated) work setting in which the activity was delivered (e.g., construction), adjusting the language, and having peers deliver the activities.

Activities for LGBTI people or communities were all delivered by specialist LGBTI organisations with existing expertise.

A staff member from one provider pointed out they were "not a big fan of targeting" because they saw great value in engaging people surrounding the focus populations, such as family members.

Activity promotion and recruitment strategies

Activities were promoted through provider organisation's local PHN and/or sector networks, including other service providers, suicide prevention networks and community organisations (8 providers, 5 Sites). Other common promotion strategies are detailed in Table 15.14.

Table 15.14 Service provider staff interviews: Promotion strategies for suicide prevention activities

Promotion strategies	Providers (n)	Sites (n)
PHN and/or local sector networks	8	5
Websites and/or social media	5	4
Word of mouth	4	4
Promotional materials (e.g., flyers)	4	4
Public event(s)	3	3
Directly approaching focus population group or organisation	2	3
Following up with previous participants	1	1

Service provider staff mentioned a range of strategies they employed to facilitate participation in the activities they delivered. The most commonly mentioned strategy was taking activities to the audience, such as schools, sporting clubs or via roadshows (4 providers, 3 Sites). Staff from two providers (2 Sites) mentioned that their organisational reputation had facilitated participation in their activities.

Involvement of people with lived experience of suicide

People with lived experience of suicide were involved in the development and delivery of suicide prevention activities in several ways across Trial Sites (Table 15.15).

Table 15.15 Service provider staff interviews: Involvement of people with lived experience in suicide prevention activities

Involvement	Providers (n)	Sites (n)
A lived experience workforce delivered the activity	7	5
Consulted during planning	6	4
Formal role via advisory groups or MoUs	4	2
Lived experience of suicide speakers	1	1

Most service providers involved people with lived experience of suicide in the delivery of Trial-funded activities (7 providers, 5 Sites). Another common avenue of involvement was through consultations during the planning stages (6 providers, 4 Sites). Four providers from two Sites mentioned a more formal and structural role of people with lived experience of suicide through advisory groups and/or MoUs with lived experience organisations. One provider noted they invited lived experience of suicide speakers to their activities. Lastly, one provider reported they did not purposefully engage with people with lived experience of suicide, although some of their staff identified as such.

15.7.2 Other suicide prevention activities – outputs and impacts

Coordination of activities

Staff from several providers reported improved relationships and collaboration between services and organisations as a result of the Trial activities (5 providers, 3 Sites).

Met needs and expectations

Staff from six providers (4 Sites) mentioned they had received positive feedback from participants, either anecdotally or from post-training surveys.

Increased awareness and knowledge

Staff from 10 providers at six Sites reported increased awareness of mental health or suicidality, and greater capacity to respond to suicidality or suicide ideation within the community.

Other impacts

Other benefits mentioned were:

- Enabling providers to provide support or activities for participants, including for people who would otherwise not engage or attend (5 providers, 4 Sites)
- Improvements in participants' wellbeing, such as increased confidence and sense of connection (3 providers, 2 Sites)
- Empowerment of the LGBTI community by allowing the process to be community led (2 providers, 2 Sites)
- Highlighting specific barriers or needs and thereby increasing understanding of the needs of their focus population group (2 providers, 2 Sites).

15.7.3 Other suicide prevention activities – challenges

A range of challenges related to the delivery of suicide prevention activities were identified (Table 15.16).

Table 15.16 Service provider staff interviews: Suicide prevention activity challenges

Challenges	Providers (n)	Sites (n)
COVID-related delays or disruptions	9	5
Limited resources	4	4
Lack of community buy-in	3	3
Workforce-related challenges	3	3
Short Trial timelines and delays	3	2
Mental health and/or suicide stigma in the community	2	3
Key stakeholder engagement and buy-in		
• Schools	2	2
• Stakeholders generally	2	2
• Local governments	1	1
Unmet demand or need	2	2
Parental consent (youth-specific services)	2	2
Lack of activity uptake	2	2
Geographical distance (activities off-site)	2	2
Lack of services for referral	2	2
Lack of data/evidence	1	1
Local tensions between stakeholders	1	1
PHN reporting requirements	1	1
Scope and scale of project too big	1	1
No clear funding directions	1	1

The most common challenge reported was COVID-related delays and disruptions to the delivery of activities (9 providers, 5 Sites). Staff from two providers (2 Sites) reported they had moved to online activities as a result.

Other common challenges included inadequate resources to run the activities (4 providers, 4 Sites), and a lack of buy-in from specific groups such as parents, carers and minority groups, as well as the broader community (3 providers, 3 Sites).

Workforce-related challenges noted by staff from three providers (3 Sites) concerned finding appropriate staff for the positions, for example, male staff or staff with a particular gender identity. Another workforce challenge was managing the boundaries and risks of their staff members having conversations with participants without being properly trained to do so.

Staff from two providers (2 Sites) that were delivering youth-specific activities in schools reported it had been very hard to engage with their local schools. This was mainly due to schools being hesitant to engage with suicide prevention activities, the school culture not being ready for it, or concerns around community and parents or carer perceptions. Another challenge for activities involving young people in schools was duty of care issues, but these were managed by building a trusting relationship between the teachers and activity staff members. Staff from one provider mentioned that they had trouble engaging with their department of education for their teacher training activities.

16 Aboriginal and Torres Strait Islander consultations – PHN

16.1 Summary of approach

Seven Trial Sites focused on suicide prevention for Aboriginal and Torres Strait Islander peoples, five as one of several focus populations and two exclusively. At one of the exclusively Aboriginal and Torres Strait Islander Sites, carriage of the Trial was contracted to a local ACCHO. At one Site with multiple focus populations, a local ACCHO was commissioned to undertake planning and implementation activities for the Aboriginal and Torres Strait Islander component of the Trial. These organisations played a significant role in Trial establishment and implementation, so they were included in the PHN consultations.

Primary Health Network staff from all seven Sites had participated in consultations in May–December 2018 and March–July 2020, during which they had provided some information about Trial activities for Aboriginal and Torres Strait Islander peoples. An Aboriginal and Torres Strait Islander-focused round of consultations was then held with PHN and ACCHO staff between July and September 2020. PHN staff at one Site had also participated in a pilot consultation in March 2019. This chapter reports on finding from the Aboriginal and Torres Strait Islander-focused consultations and draws in relevant information from the general PHN consultations.

Individual or group semi-structured interviews were conducted in person by a locally-based Thirrili consultant wherever possible, or by phone or via online videoconference (Zoom, Skype, Teams) when this was not possible due to constraints of distance, timing or COVID-19 travel restrictions. Interview topics for the group and individual interviews were the same and were based on the Evaluation Framework(10).

Interview questions covered planning and implementation activities, including identifying local needs, stakeholder involvement, governance, developing the overall approach, challenges encountered in planning and implementation, and Trial impacts and outcomes. A copy of the interview guide is provided in Appendix 14.

Interviews were conducted by either Thirrili staff members or consultants or University of Melbourne evaluation team members, or both. Interviews were conducted by two evaluators, with one acting as scribe. Where possible, one of the evaluators was Aboriginal and/or Torres Strait Islander. Group interviews lasted 1–2 hours and individual interviews 30 minutes to one hour, and were recorded if the participant agreed. Each participant received a plain language statement providing information about the evaluation and the interview, and all participants provided informed verbal or written consent to take part.

16.2 Sample information

Nine PHN Staff and six ACCHO staff participated in the consultations, eight in person and seven via video conference. Table 16.1 describes the roles of participants.

Table 16.1 Aboriginal and Torres Strait Islander PHN/ACCHO consultations: Participant organisations and roles

Participant organisations and roles	Participants (n)
PHN – NSPT coordinators, project workers	2
PHN – Portfolio manager – mental health, suicide prevention, alcohol and other drugs	4
PHN – SEWB worker, Aboriginal health worker	2
PHN Other – Commissioning lead	1
ACCHO – Executive	2
ACCHO – NSPT coordinators, project workers	3
ACCHO – Portfolio manager	1

16.3 Data analysis

Notes from the individual and group interviews were imported into NVivo V.12 for analysis. A modified framework analysis(21) was conducted by considering all responses together and for all focus population groups using evaluator's notes on the interviews, supplemented by the audio-recordings when needed. Two evaluators read and re-read the notes from a subset of interviews, then used the interview schedule to deductively identify key themes and develop a preliminary coding framework that captured the full range of comments. They applied this preliminary coding framework to the subset of interviews, identifying emergent themes. The evaluators then met to discuss and refine the preliminary framework to address areas of disagreement, and reached consensus on how to code information pertaining to focus population groups and whole-of-population approaches. One evaluator then coded the remaining content, consulting with the other evaluators when needed. The framework and associated coding was then finalised and used to interpret the data to respond to the evaluation questions. Themes and sample quotes are available in Appendix 15.

16.4 Planning

16.4.1 Planning – identifying local needs and service gaps

Staff from PHNs and ACCHOs were asked to describe the activities they undertook to understand local needs and identify service gaps. PHN/ACCHO staff indicated that there was little local data on suicide and self-harm, and that the predominant method for identifying needs was through consultations. Beyond availability, there were limitations around using data to inform planning, because it does not capture contextual information or offer a holistic picture of SEWB.

Consultations were reported by PHN staff from all seven Sites. Consultations occurred with a wide range of stakeholders, including Elders, community members (including young people) and service providers from both Aboriginal and Torres Strait Islander-specific and non-Aboriginal and Torres Strait Islander-specific services, government-funded services and NGOs, representatives from government departments and agencies, universities, the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, Aboriginal and Torres Strait Islander peak bodies and community organisations. More details on stakeholder involvement in the Trial are provided below in section 16.4.3.

With respect to local needs, consultations sought information on:

- The activities being undertaken, and by whom, in the local region/community, including suicide prevention and mental health services and activity, but also broader health and wellbeing services and activities
- What stakeholders considered to be the current needs and priorities in their region/community.

Consultations were also opportunities to engage with the community and share information about the Trial, gain insight into the local context, and gauge the level of community readiness to embark on the Trial. This was an important consideration in planning the type and timing of Trial activities, including planning activities.

Consultations were most often led by Aboriginal and Torres Strait Islander staff at the PHN or ACCHO. They were either specifically recruited for their local knowledge and community connections, or by existing PHN/ACCHO SEWB or Aboriginal and Torres Strait Islander health workers (5 Sites). At two Sites, non-Aboriginal and Torres Strait Islander PHN staff facilitated the consultations, which were led by Aboriginal and Torres Strait Islander stakeholders involved in Trial Committees. At one Site, consultations were conducted by Aboriginal and Torres Strait Islander staff at non-Aboriginal and Torres Strait Islander organisations were contracted to run the Trial in specific localities.

Consultations took place in a variety of formats, including:

- Trial Committees and working groups (discussed below)
- Informal engagement in communities, including yarning circles
- Direct liaising/engagement with Elders and key community members and organisations
- Workshops
- Forums.

Service gaps and needs were considered, not just in terms of whether services were available, but whether available services met the needs of community members, including young people, were known, trusted and used by community members, and were culturally safe and appropriate. All Sites included some consideration of service gaps and use in their planning consultation process, and two Sites undertook more sustained analysis involving:

- A client mapping process, in which those affected by suicide were asked to identify local needs and gaps in services based on their experiences (1 Site)
- Workshops and forums with community, including young people and service providers, to identify how the existing service system currently supported Aboriginal and Torres Strait Islander peoples and to identify gaps and opportunities to improve (7 Sites)
- A “mapping and gapping” analysis of community services (1 Site).

16.4.2 Planning – process

Primary Health Network/ACCHO staff described a range of ways in which the planning process was structured, including the extent of Aboriginal and Torres Strait Islander input and leadership. The main processes were:

- Community-based Aboriginal and Torres Strait Islander-led working groups or project workers leading consultations and making recommendations to Aboriginal and Torres Strait Islander-led Trial Committees (1 Site)
- PHN-based Aboriginal and Torres Strait Islander-led Trial Committees making recommendations, based on their own experience and information from consultations conducted by PHN staff/Trial workers or an organisation commissioned by a PHN (3 Sites)
- PHN contracting a local Aboriginal and Torres Strait Islander organisation (2 Sites), or in some localities, a non-Aboriginal and Torres Strait Islander organisation (1 Site), to consult the community and develop action plan/recommendations

- Community-based working groups which included some Aboriginal and Torres Strait Islander representation making recommendations to PHNs, and PHNs also undertaking consultations (1 Site).

Action plans

As a tool for operationalising the overall approach, aligning activities with evidence and establishing shared agreement on the scope of the Trial activities, actions plans were developed. Again, Trial Sites took varying approaches:

- Action plans (following LifeSpan) were created for local regions with the Site, but no Aboriginal and Torres Strait Islander community-specific action plans were created (1 Site)
- Local community working groups, with support from Aboriginal and Torres Strait Islander Trial project workers, developed community activity plans (aligned with ATSISPEP), including program logics for each activity (1 Site)
- Local Aboriginal and Torres Strait Islander organisations commissioned to implement the Trial produced local activity plans using a community development model, within PHN determined activity types and levels (2 Sites)
- The two urban Sites did not use community action plans.

16.4.3 Planning – stakeholder involvement

Primary Health Network/ACCHO staff described a range of stakeholders who had been involved in the Trial planning in some capacity. Across all seven Trial Sites focused on Aboriginal and Torres Strait Islander peoples, stakeholders were involved in Trial planning were via participating in the identification of needs, priorities, community readiness and service gaps through consultations, workshops or forums as described above, or joining Trial Committees which undertook and/or oversaw planning and implementation of the Trial.

Stakeholders included, Elders, ACCHOs (both commissioned and not commissioned to deliver Trial activities), local and regional Aboriginal community-controlled organisations, non-Aboriginal and Torres Strait Islander service providers and NGOs, state and federal government departments and agencies, local government, community members, existing Aboriginal Reference Groups, local suicide prevention networks, the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, community members, and people with lived experience of suicide.

16.4.4 Planning – Trial governance and decision-making

Sites established a governance structure to oversee the planning and implementation of the Trial. PHN/ACCHO staff described various approaches to governance, including the extent to which they were Aboriginal and Torres Strait Islander-led/controlled.

Trial governance arrangements took three main forms:

- A PHN contracted an ACCHO to manage the entire Trial, and established an Aboriginal and Torres Strait Islander-led governance structure (1 Site)
- A PHN convened an Aboriginal and Torres Strait Islander committee(s) to direct the Trial (3 Sites)
- A PHN included Aboriginal and Torres Strait Islander stakeholders on their general Trial committees (3 Sites).

Within the governance structure, the degree of Aboriginal and Torres Strait Islander-led decision-making ranged from predominantly Aboriginal and Torres Strait Islander-led, to providing advice to PHN but having no say in decision-making. The three main decision-making processes were:

- The Aboriginal and Torres Strait Islander-led Trial Committees make decisions – the PHN implements them (4 Sites)
- The PHN general committee makes decisions based on input from Aboriginal and Torres Strait Islander representatives and consultations (2 Sites), and/or based on ad hoc community engagement and consultation (1 Site)
- The PHN approves some or all of a community action plan from a contracted local organisation (Aboriginal and Torres Strait Islander or non-Aboriginal and Torres Strait Islander) (2 Sites).

At most Sites some initial decisions were made at the PHN level in terms of the broad scope of the Trial (e.g., whether to commission an aftercare service), but the rest of Trial planning decisions were made by Aboriginal and Torres Strait Islander-led committees. Also, at most Sites, PHNs undertook service system-level activity, or research, or quality improvement activities which did not emerge from the community-based planning process.

16.5 Planning – facilitating factors

Primary Health Network/ACCHO staff described factors and strategies that they considered had facilitated (or would facilitate) local planning and managing challenges associated with the Trial planning process (described below). These included approaches to managing the planning process, staff-related factors, factors related to the PHN's role and function, strategies for community engagement, and general strategies.

Strategies to facilitate the *planning process* included:

- Establishing a safe and respectful working environment with good governance, leadership and clear communication to allow for any tensions or disagreements within and between communities to be accommodated and worked through (4 Sites)
- Acknowledging and remunerating Elders, volunteers and others who contributed their time and knowledge (2 Sites)
- Establishing, governance and decision-making processes that support a community-led approach (4 sites).

Workforce-related factors highlighted by PHN/ACCHO staff as facilitating planning included:

- Employing Aboriginal and Torres Strait Islander project staff with local knowledge and connections (3 Sites)
- Involving Aboriginal and Torres Strait Islander health and SEWB staff employed at the PHN (3 Sites)
- Drawing on additional expertise as needed (Centre for Best Practice, research and/or evaluation specialists, community development experts and facilitators)(4 Sites)
- Building the cultural competency of PHN staff (2 Sites).

Primary Health Network/ACCHO staff mentioned strategies they had found effective in *maintaining community buy-in and engagement* with the Trial, including:

- Making stakeholders official members and giving them a role (i.e., creating ownership)(1 Site)
- Having the Minister co-chair Trial Working Groups at the two dedicated Aboriginal and Torres Strait Islander Sites (2 Sites)
- Working with known and trusted Aboriginal and Torres Strait Islander organisations (5 Sites)
- Asking for feedback and incorporating it (1 Site)

- Holding regular meetings to maintain momentum and a sense of progress (1 Site)
- Regular open communication (e.g., newsletters, updates)(3 Sites).

Several factors related to *the role of the PHN* in the Trial were identified as effective facilitators for planning. These included the PHN:

- Bringing together organisations which do not normally engage with each other, and providing neutral space for conversations (4 Sites)
- Being able to adopt a neutral position – creating space for smaller organisations to have a seat at the table (3 Sites)
- Facilitating discussions but not making decisions (3 Sites)
- Pursuing coordination and integration across community, state and federal layers (2 Sites).

Primary Health Network/ACCHO staff also mentioned *administrative and commissioning strategies* used to support smaller community organisations to participate in delivering Trial initiatives:

- Commissioning small organisations working directly with the community (3 Sites)
- Commissioning Aboriginal and Torres Strait Islander community-controlled organisations (6 Sites)
- Auspicing non-incorporated groups and/or organisations (1 Site)
- Changing rules to allow broader range of organisations to be commissioned (4 Sites)
- Changing compliance requirements to make initiatives more accessible to small organisations (4 Sites).

Finally, ge*neral strategies* were mentioned, including:

- Taking a place-based approach (3 Sites)
- Taking the necessary time. This was mentioned frequently; it was emphasised that considerable time was needed to have authentic consultation, build relationships and trust, and to engage in a genuine co-design process (6 Sites)
- Prioritising face-to-face conversations (7 Sites).

16.6 Planning – challenges

Primary Health Network/ACCHO staff mentioned challenges encountered in the planning process which provide insight into factors which need to be considered in initiating suicide prevention activities, including the planning phases. Table 16.2 outlines the key challenges related to community and organisational readiness, staffing, funding and resources, other community factors and Trial design features.

Table 16.2 Aboriginal and Torres Strait Islander PHN/ACCHO consultations: Planning challenges

Issue	Specific challenge	Sites (n)
Community readiness	• Need for healing in community before moving on to planning and rolling out activities • Consultation fatigue	7
Organisational readiness	• Commissioned ACCHOs dealing with internal organisation issues • Commissioned organisations need time to build capacity/gear up to deliver services or programs	5
Staffing	• Complexity of the project coordinator role; no one person will have all skills – need community engagement skills, SEWB skills, administrative and reporting skills • Lack of suitably qualified staff • Staff turnover due to burden of the roles	3
Funding/resources	• The scope of the task was beyond the resources available • Insufficient operational resources • Staffing levels were insufficient • Reliance on volunteers • Tension between PHNs and ACHHOs over control of funds	5
Other community factors	• Cultural diversity • Tensions between different groups within a community • Only those who are supportive participate in the consultation • Managing expectations	7
Trial design factors	• Timeframes	3

Community readiness

Primary Health Network/ACCHO staff from seven Sites pointed out that planning suicide prevention activities needs to be cognisant and accommodating of community readiness, to listen to what communities want and are ready for, and not impose project timelines and expectations on them. They also pointed to the need to be aware of what else is going on in the community in terms of state and other federal government initiatives and manage the burden on community.

Organisational readiness

Staff from five Sites indicated that organisational readiness needs to be taken into account, and that time and – if appropriate – capacity building or other support should be provided to organisations to improve their readiness to participate.

Staffing

The need to build and restore capacity in Aboriginal and Torres Strait Islander Trial staff was identified as a challenge by Primary Health Network/ACCHO staff from three Sites. This was because the complexity of the role generally meant that people would be highly skilled in some areas and need upskilling in others. Local knowledge and connection to local communities was identified as a key strength in staff, and prioritising this and then providing training in other skills (e.g., administration and reporting or suicide prevention training) was the approach taken at some Sites. Providing support for staff was identified as crucial, because the role is challenging and staff are at risk of experiencing vicarious trauma.

Resourcing and funding

Primary Health Network/ACCHO staff from five Sites noted that initiatives need to be properly resourced in terms of access to operational resources such as equipment, and transport in big geographical regions, to support the proper levels and type of staffing (i.e., need for male and female workers), and to recompense people for their time and not rely on volunteers. At two Sites, the control of funds by the PHN rather than an ACCHO was noted as a point of tension.

Other community-related challenges

Primary Health Network/ACCHO staff from seven Sites noted the vast diversity across Aboriginal and Torres Strait Islander communities, that planning needs to account for cultural diversity within and between them and that adopting a place-based approach is an important strategy for doing so.

Staff from two Sites described how they worked to create an inclusive environment with good governance and strong leadership that allows for tensions or disagreements within and between communities to acknowledged and worked through.

It was acknowledged that more effort needed to be made to reach out to community members who were "outside the tent", and that clear and frequent communication was the best way to manage expectations about the scope of the Trial.

Trial design

The main challenge mentioned by Primary Health Network/ACCHO staff from seven Sites was the limited timeframe of the Trial, with general consensus expressed that it did not allow the time required to build relationships and trust, to undertake genuine co-design, or be sensitive to community readiness.

16.7 Systems approach

16.7.1 Developing a systems approach – strategies

Systems frameworks

Primary Health Network/ACCHO staff across all Sites generally agreed that there were limitations in the LifeSpan and AAD frameworks with respect to suicide prevention among Aboriginal and Torres Strait Islander communities. The supporting evidence in those frameworks is drawn from non-Aboriginal and Torres Strait Islander, generally urban populations, and their focus on suicide and/or mental health does not reflect Aboriginal and Torres Strait Islander understandings of wellbeing or consider cultural knowledge and traditional healing. Moreover, they do not take into account the historical trauma and institutionalised racism associated with colonialism that still affects the lives and wellbeing of Aboriginal and Torres Strait Islander peoples.

Rather than adopt either Lifespan or the AAD as a guiding framework, most Sites aligned their Trial planning with the ATSISPEP success factors, regarding them as the best available evidence of what works in Aboriginal and Torres Strait suicide prevention. Most Sites described their approach to working with the ATSISPEP framework as using it as either a guide or a reference document (5 Sites), while one Site aimed to implement activities in all areas of the framework.

One Site developed its own local framework through extensive community consultations. That framework, Strengthening our Spirits, is structured around concepts and symbols that are meaningful to the Aboriginal and Torres Strait Islander community in the region, which are then linked to the types of activities and approaches most appropriate to address suicide and self-harm in the region.

Overall approach

As noted above, PHN/ACCHO staff felt that a limitation of the LifeSpan and AAD frameworks was that their primary focus was on suicide and mental health, which was not compatible with a holistic SEWB approach. PHN/ACCHO staff from all Sites described how they reoriented the broader approach to suicide prevention that informed the Trial at their Sites, including focusing on:

- Cultural healing
- Community development
- A SEWB approach
- Connecting to culture
- Including traditional and cultural knowledge systems and protocols
- A SEWB approach to addressing spiritual needs and intergenerational trauma.

Strategies to promote coordination and service integration

While not adopting a particular systems framework, PHN/ACCHO staff recognised the need for greater coordination in the provision of services and suicide prevention activities and described a range of strategies used to try and improve or initiate coordination (Table 16.3).

Table 16.3 Aboriginal and Torres Strait Islander PHN/ACCHO consultations: Strategies to promote coordination

Broad strategy	Detail	Sites (n)
Engagement of stakeholders	• Involvement of/connection with sector-wide bodies, peak bodies from across the sector • Involvement of decision-makers from agencies, organisations, government departments • Stakeholders from across system involved in planning and Trial governance, and/or via regular meetings	7
Service-level coordination/integration approaches	• "No wrong door" model – services all link up and refer to each other to provide wrap-around services for clients and families • Coordination at a service level (i.e., aftercare service taking referrals from and referring to other service providers) • Linking existing and Trial funded activities	2
Communication and information sharing	• Involvement on Trial committees • Referral pathways, service directories • Awareness raising across the Trial about Trial activities	1
Other strategies	• Aligning with the LifeSpan framework • Whole-of-population approaches to upskill mainstream services • Shared commitment	3

16.7.2 Implementing a systems approach – impacts

Consultation with PHN/ACCHO staff identified a few impacts of efforts to coordinate the approach to suicide prevention in their regions. The main impacts mentioned were:

- The governance and planning process created relationships and partnerships, rebuilt fractured relationships and got people talking to each other (2 Sites)

- There were improvements in information sharing (2 Sites)
- Cross-promotion of Trial activities and services across PHN-funded Trial and non-Trial services (2 Sites)
- Improved linkages and/or coordination between services and organisations delivering Trial-funded activities (5 Sites).

16.7.3 Developing and implementing a systems approach – challenges

Primary Health Network/ACCHO staff noted that while Sites had made a start in terms of improving coordination and integration, this was a long-term endeavour. Moreover, it was observed that the underlying causes of suicide for Aboriginal and Torres Strait Islander peoples were complex and require system reform, which was out of the scope of Trial. The main challenges noted were:

- While willing, providers lacked capacity to pursue linkages and coordination, because they were focused on their core service delivery activities (1 Site)
- Systemic issues around service and availability, particularly in remote and rural communities (4 Sites)
- Cultural safety is a barrier for the integration of Aboriginal and Torres Strait Islander peoples services and mainstream services (2 Sites)
- The degree to which PHNs/ACCHOs can influence different elements of the system (1 Site).

16.8 Suicide prevention activities and services

16.8.1 Activities and services

Activity description

A more comprehensive description of the number and types of activities implemented drawn from the community-based activities dataset is given in Chapter 23.

Primary Health Network/ACCHO staff described the general types of activities and services they had commissioned as part of the Trial, including:

- Suicide and mental health-specific awareness-raising activities such as media and social campaigns, workshops and community events, including providing information on where to get help
- Community engagement, wellbeing and connection events and activities
- Cultural activities, such as arts programs connecting young people with Elders, on country camps and activities, women's and men's groups (including a young fathers group)
- Capacity building – including scholarships, supporting conference attendance, other suicide prevention, mental health, SEWB training, including Train the Trainer programs
- Structured training in suicide prevention, such as Mental Health First Aid, for community members and service providers
- Programs and services for at-risk individuals, including equine therapy, Traditional Healers, a crisis phone-line with immediate follow-up, aftercare services
- Developing referral pathways, a "no wrong door" program, cultural safety frameworks, and undertaking development of assessment tools.

Tailoring activities

Primary Health Network/ACCHO staff described multiple ways in which cultural safety was addressed in the services and activities rolled out as part of the Trial:

- Type and design of services and activities
    - Aboriginal and Torres Strait Islander-led design of new services or activities (2 Sites)
    - Implementing existing activities developed by and for Aboriginal and Torres Strait Islander communities (1 Site)
    - Only rolling out activities communities want (3 Sites)
- Delivery of services and activities
    - Using an Aboriginal and Torres Strait Islander workforce (including trainers, 4 Sites)
    - Commissioning Aboriginal and Torres Strait Islander providers, non-Aboriginal and Torres Strait Islander organisations who had worked in communities already, partnerships between Aboriginal and Torres Strait Islander/non-Aboriginal and Torres Strait Islander organisations (4 Sites)
- Cultural governance (2 Sites)
    - Engaging cultural leaders
    - Respecting, following cultural protocols
- Contracting requirements including adherence to a cultural safety framework (2 Sites).

Meeting needs and expectations

To the extent that activities rolled out as part of the Trial were decided upon following a needs analysis, they met identified needs. PHN/ACCHO staff reported that other indicators that the Trial services were meeting a need were that services were at capacity, including some having waitlists, and that stakeholders were referring into Trial services, indicating that they considered the service met a need.

Activity promotion and recruitment strategies

Primary Health Network/ACCHO staff described a range of strategies to raise awareness of Trial activities and encourage participation:

- Ambassadors, champions (1 Site)
- Trial workers’ connections to local community (3 Sites)
- Framing activities not as “suicide” but positively – for example, as “life promotion” (1 Site)
- Campaigns: fliers, posters, traditional media (2 Sites)
- Social media, websites (2 Sites)
- Word-of-mouth (2 Sites)
- PHN networks, outlets (2 Sites)
- Service provider’s networks, contacts (2 Sites)
- Community ownership achieves buy-in (2 Sites).

It was noted that in smaller communities people were more aware of the Trial activities going on, while in urban Sites there were pockets of awareness. At both types of Sites, it was observed that people did not necessarily associate the activities with the Trial or with the PHN.

16.8.2 Activities and services – impacts

A range of impacts related to Trial outputs were described, including greater SEWB, capacity building, knowledge and awareness, cultural safety, and activities complementing existing activities.

Social and emotional wellbeing

Social and emotional wellbeing impacts were identified by Primary Health Network/ACCHO staff from four Sites. These included increased connection with country and culture, improved communication and connection with families and community. For young people participating, impacts included high levels of engagement, increased confidence, empowerment, taking on leadership roles, and strengthened cultural identity.

Capacity building

Primary Health Network/ACCHO staff reported many impacts of capacity building, including:

- For community: increased capacity and confidence to talk about suicide and use referral and care pathways, including among young people (4 Sites)
- For Aboriginal and Torres Strait Islander service providers and organisations (4 Sites)
    - Training for Aboriginal and Torres Strait Islander peoples to run, facilitate and deliver activities themselves
    - More capacity to deal with administrative processes and requirements, to get funding
    - Greater skills and knowledge of Aboriginal and Torres Strait Islander workers
- For non-Aboriginal and Torres Strait Islander service providers (1 Site)
    - Employment of Aboriginal and Torres Strait Islander workers at provider organisations.

Knowledge and awareness

Primary Health Network/ACCHO staff from five Sites felt that community knowledge and awareness had increased as a result of the awareness-raising activities and training programs and workshops. These impacts included increased awareness about suicide, increased knowledge about how to identify and support people who are not doing well, and increased knowledge about where people can go for support if they are experiencing distress.

At one Site, it was noted that increased knowledge and awareness was more widespread among service providers than the community.

Cultural safety

One Site noted increased awareness at the PHN of the need to integrate cultural safety across all elements of their work and commissioned services. At another Site, the PHN reported that non-Aboriginal and Torres Strait Islander services were adopting cultural awareness training. Another Site had developed a Cultural Safety Framework to be provided to all service providers in the region to help them ensure their services are safe for Aboriginal and Torres Strait Islander peoples, and included cultural competency training as an activity in the Trial. However, PHN/ACCHO staff from all Sites noted that this was long-term work that had to occur at a system level – across schools, mainstream services and community groups– and thus was beyond the scope of the Trial.

Complementing or filling a gap

Trial services and activities were purposefully planned to avoid duplicating existing programs, and thus by design complemented existing activities. PHN/ACCHO staff from one Site noted Trial funding was used to increase the scale of suicide prevention work already being undertaken by local Aboriginal and Torres Strait Islander organisations to accommodate more participants, or to expand the regional reach of the program.

Cultural and organisational shifts at PHNs

Other impacts relating to cultural and organisational shifts at PHNs included:

- New understandings that healing has to be part of the process, and that a place-based approach is necessary (2 Sites)
- Changes in commissioning practices to allow smaller and different types of organisations to be funded and commissioning cultural activities not just health and health promotion (1 Site)
- An increase in cultural awareness, inclusion and acknowledging the importance of Aboriginal and Torres Strait Islander ownership, and that a PHN can play a role as a facilitator, capacity builder and a neutral third-party to hold funds (2 Sites).

Other impacts mentioned were that the process of developing Trial plans and activities had brought organisations together, and in some cases mended relationships between them (2 Sites).

16.8.3 Activities and services – challenges

A few challenges relating to delivering Trial activities were noted, including:

- The complexity of the work for a single client in aftercare services is not accounted for in key performance indicators such as client numbers
- The use of the term “suicide” at the community level is problematic and can be a barrier for engaging community (4 Sites)
- Competition between service providers or protecting their patches (3 Sites)
- The availability of Aboriginal and Torres Strait Islander trainers to deliver training programs such as Aboriginal Mental Health First Aid (1 Site).

17 Aboriginal and Torres Strait Islander consultations – Community

17.1 Summary of approach

Community consultations were conducted at four Trial Sites providing activities focused on Aboriginal and Torres Strait Islander peoples. Community members were not consulted at the three other Trial Sites providing activities for Aboriginal and Torres Strait Islander peoples due to logistical challenges (i.e., ethical approval was not received, COVID-related restrictions on travel, and timelines for consultations). Consultation topics for community members are shown in Appendix 16.

17.2 Sample information

Twenty-six community stakeholders from four Sites took part in one of the 13 individual or five group Aboriginal and Torres Strait Islander community consultations. One stakeholder answered questions for both community stakeholders and service providers.

Community stakeholders held a range of roles within their communities (Table 17.1). Most stakeholders were connected to an Aboriginal and Torres Strait Islander community organisation or network. Five stakeholders took part in the Trial evaluation in their capacity as a community member, with four stakeholders identifying as community Elders.

Table 17.1 Aboriginal and Torres Strait Islander community stakeholder consultations: Stakeholder roles

Roles	Participants (n)
Aboriginal and Torres Strait Islander community organisation, networks	8
Community member	5
Community Elder	4
Aboriginal Medical Service, Community Controlled Health Service	2
Local hospital networks, state government health departments or agencies	1
Other Government agencies	1
Consultant	1
Youth service provider	1
Missing	3
Total	26

17.3 Data analysis

Notes from the individual and group interviews were imported into NVivo V.12 for analysis. A modified framework analysis(21) was conducted by considering all responses together and for all focus population groups using the evaluator's notes, supplemented by audio recordings when needed. Two evaluators read and re-read the notes from a subset of interviews. They then used the interview schedule to deductively identify key themes and develop a preliminary coding framework that captured the full range of comments, and applied this preliminary coding framework to the subset of interviews, identifying emergent themes. The evaluators then met to discuss and refine the preliminary framework to resolve disagreements, and reached consensus on how to code information pertaining to focus population groups and whole-of-population approaches. One evaluator then coded the remaining content, consulting with the other evaluators when needed. The framework and associated coding was then finalised and used to interpret the data to answer the Evaluation Framework(10) questions. Themes and sample quotes are provided in Appendix 17.

17.4 Planning

17.4.1 Planning – community stakeholder-identified priorities for Aboriginal and Torres Strait Islander suicide prevention

Community stakeholders across all four Sites discussed approaches to suicide prevention for Aboriginal and Torres Strait Islander people and identified nine key priorities for planning, developing, implementing and evaluating systems approaches (Table 17.2). Section 18.4.3 elaborates on the extent that community stakeholders felt that these approaches had been successfully implemented by the Trial Sites.

Table 17.2 Aboriginal and Torres Strait Islander community stakeholder consultations: Priorities for a systems approach suicide prevention

Priorities	Sites (n)
Aboriginal and Torres Strait Islander-led	4
Healing and trauma-informed approaches	4
Cultural competence and safety	4
Community engagement approach	3
SEWB approach	3
Client and family-centred	3
Wrap-around holistic care	2
Sustainable	2

Aboriginal and Torres Strait Islander-led

Community stakeholders from all four Sites underscored the need for suicide prevention activities for Aboriginal and Torres Strait Islander peoples to be led and owned by their communities. Community stakeholders stated that the community needed to be given responsibility across all stages of an initiative, from planning to implementation and evaluation. Stakeholders emphasised the central role of Elders in this process, and explained that such an approach was a means of empowerment and transfer of knowledge. Some community stakeholders explained that the process of having Aboriginal and Torres Strait Islander-led suicide prevention activities served to embed Aboriginal and Torres Strait Islander knowledge and created tools to hold the government accountable for future action in this area.

A focus on healing and trauma-informed approaches

Community stakeholders from all four Sites explained that suicide for Aboriginal and Torres Strait Islander people was best approached from a healing perspective. Stakeholders said that it was important for Indigenous and non-Indigenous peoples working in this area to recognise and work with the pain and trauma in the community, and to foster the ability to sit with pain before beginning any sharing. For several community stakeholders, healing was seen to stem from the restoration of family and connection to culture.

Cultural competence and safety

Stakeholders from all four Sites highlighted embedding cultural competence in mainstream services and organisations as critical for a systems approach to Aboriginal and Torres Strait Islander suicide prevention. An example given was ensuring that intake and assessment processes at the local hospital and health services were done in a way to promote cultural safety of Aboriginal and Torres Strait Islander peoples. Stakeholder also saw supporting and developing cultural competence and safety for Aboriginal and Torres Strait Islander workers in suicide prevention initiatives as important.

Community engagement approach

Community stakeholders explained that a community engagement approach involved spending time with people, and that suicide prevention work did not occur on a 9-to-5 schedule; they advanced the notion that a "cup of coffee and a biscuit can change someone's life". Community stakeholders said this approach was facilitated by having a local staff member who held the trust and respect of the community. As part of a community engagement approach, stakeholders said it was necessary to tap into multiple segments of a community. Such an approach also involved identifying and lowering barriers to participation in formal Trial meetings and activities, such as transport and resources.

Social and emotional wellbeing approach

Community stakeholders from three Sites underscored the importance of adopting a SEWB approach to the Trial activities in their area. For these stakeholders, SEWB was about a Aboriginal and Torres Strait Islander conceptualisation of identity and wellbeing in which distress and suicide is caused by disruption or imbalance. In this way, community stakeholders said that Trial suicide prevention efforts were focused on responding to multiple sources of identity and wellbeing, including incorporating or embedding cultural practices, connection to country and family, support for families, and fostering a sense of responsibility and agency. Some stakeholders placed SEWB in contrast to a Western clinical approach.

Client-and family-centred approaches

Community stakeholders from three Trial Sites noted that it was important to recognise and accommodate a diversity of client and family needs and preferences. Such a client-centred approach involved providing clients and their families with a choice of activities and facilitating circumstances in which they felt confident and able to exercise their agency.

Wrap-around holistic care

Community stakeholders from two Sites cited the need for wrap-around and holistic services and approaches that addressed the complex intersectoral drivers of suicide (e.g., poor mental and physical health, financial stress, insecure housing, involvement with the justice system).

Sustainable

Community stakeholders from two Sites specifically called for long-term and sustainable suicide prevention initiatives in their area, citing their own and the communities' saturation with FIFO services.

17.4.2 Planning – facilitating factors

Community stakeholders identified a range of factors that they considered had facilitated the planning stage of the Trial (Table 17.3).

Table 17.3 Aboriginal and Torres Strait Islander community stakeholder consultations: Factors that facilitated planning

Facilitating factors	Sites (n)
Community buy-in and readiness	3
Enough time and flexibility to achieve due process	3
A common goal	1
Community champions	1
Responsiveness to feedback	1

Community buy-in and readiness

Community stakeholders from three Trial Sites said that the broader enabling environment and setting of community readiness had helped to facilitate the community buy-in and planning of the Trial activities. These community stakeholders explained that the Trial had satiated a thirst for activity and funding in Aboriginal and Torres Strait Islander suicide prevention that had existed for many years in their regions. Community stakeholders stated that some heavily invested community members were involved in the Trial planning. Community stakeholders also explained that the involvement of Elders in the Trial planning was both promoted by, and promoted, a grassroots approach to the Trial, which also facilitated community buy-in.

Enough time and flexibility to achieve due process

Community stakeholders from three Sites said that the allocation of enough time for planning the Trial in their locations fostered an inclusive approach to the planning process. For these stakeholders, the PHN's adoption of a flexible mindset was critical for creating a safe space for genuine sharing and recognising the diversity within the Aboriginal and Torres Strait Islander communities. Part of this flexibility also involved the removal of barriers to community participation, including by providing transport.

A common goal

Stakeholders from one Site said that the Trial was facilitated by its focused attention and promotion of suicide as a priority, which allowed it to add value to programs and previous approaches.

Community champions

Stakeholders from one Site identified the involvement of community champions to mobilise and tap into community voices through their connections as a key factor facilitating planning.

Responsiveness to feedback

Community stakeholders from one Site felt that the Trial planning was facilitated by responsive PHN staff who had listened to community perspectives, took feedback into account and adjusted the PHN planning processes accordingly.

17.4.3 Planning – outcomes: meeting community priorities

Community members reported on the extent to which they felt the priorities for suicide prevention they had identified (Section 17.4.1) had been met at their Sites.

Aboriginal and Torres Strait Islander-led

Community stakeholders across Trial Sites discussed the extent to which the Trial had been Aboriginal and Torres Strait Islander led, in reference to the level of community participation and grassroots orientation of the Trial.

There were mixed perspectives on the level of community participation in Trial planning. That is, community stakeholders from the same Sites reported different and sometimes conflicting accounts and views of the extent that the Trial was Aboriginal and Torres Strait Islander led. Thirteen community stakeholders from three Sites expressed satisfaction with the level of community participation in planning the Trial. These community stakeholders, many of whom were involved directly themselves, felt that the Trial had been grassroots and that the PHNs had listened to and valued the communities' input. One stakeholder stated that every voice that was included in the consultations was listened to, and that the intentional focus on cultural safety during the process mean that community members felt safe and secure to speak up. Another stakeholder emphasised the importance of involving Aboriginal and Torres Strait Islander families with lived experience in this process.

In contrast, 14 community stakeholders from four Sites felt that there had been a low level of participation by community members, or that the participation of community members in planning Trial activities could have been improved. These stakeholders explained that there had been insufficient representation from the community and that while the Trial in their areas had tried to be grassroots, “grassroots people” were not involved in making key decisions about the Trial. Stakeholders also stated that community involvement in Trial planning had been tokenistic, such that decisions and structures were already executed by the PHN and there was limited scope for community participation and ownership.

Community stakeholders from three Sites reported that their perspectives and inputs were not valued or taken on in the planning stage. Elders reported having their ideas rejected or dismissed because they were deemed to be outside the Trial’s scope. Some community stakeholders felt that the PHN staff only listened to agreeable voices, the perspectives of young Aboriginal and Torres Strait Islander people were not taken on board, and there was a lack of recognition of the diversity within Aboriginal and Torres Strait Islander communities.

A focus on healing and trauma-informed approaches

Multiple community stakeholders from four Sites described how the Trial Sites had successfully embedded a focus on healing by creating a safe space. These stakeholders also reported that they looked out for each other when planning and delivering Trial activities, particularly in traditionally white spaces like meetings with the PHN. Community stakeholders said that the Trial had successfully focused on healing by emphasising community strengths and assets and celebrating the “good and peaceful things” that were happening in their communities.

Cultural competence and safety

Stakeholders from two Sites reported that PHN staff had illustrated cultural competence and understanding during the Trial process by recognising that the PHN did not have to (and should not have been) involved in all decision-making processes and discussions. One stakeholder felt that the Trial Sites had not always adequately supported Aboriginal and Torres Strait Islander staff who may have been experienced from a cultural perspective but lacked clinical or suicide prevention competencies.

Community engagement approach

There were mixed perspectives on the extent to which a community engagement approach had been achieved across Trial Sites. That is, community stakeholders from the same Sites reported different and sometimes conflicting accounts and views of this indicator.

Community stakeholders from three Sites highlighted the success of a relational, community engagement approach to planning and implementing Trial activities in their area. However, other stakeholders felt the Trial had not always successfully tapped into multiple segments of their communities or lowered barriers to participation. Community stakeholders from all four Sites asserted that an ineffective or inappropriate approach to planning and consultation had been undertaken at their Trial Site. These stakeholders claimed that the timeframe for planning was too short. Others said the format was inappropriate, in that Trial planning meetings were overly formal, and the community did not feel comfortable to ask questions.

Social and emotional wellbeing approach

Community stakeholders from three Sites explained that the Trial had enacted a SEWB approach through use of non-clinical or service-oriented methods and settings to conduct suicide prevention activities such as yarning circles, conversations, and informal settings (for example, BBQs) to foster connection within communities.

Client-centred approach

Community stakeholders from three Trial Sites explained that the Trial had been beneficial in its focus on recognising and accommodating a diversity of client needs and preferences.

Wrap-around holistic care

Community stakeholders who identified the need for wrap-around and holistic services and approaches that addressed the complex intersectoral drivers of suicide did not feel this had been achieved by the Trial at their two Sites.

Sustainable

At one Site, the focus on sustainability from the outset of the Trial helped to craft the Trial's approach in their location. However, sustainability was also cited as a barrier to the Trial being able to address broader, systemic drivers of suicide.

17.4.4 Planning – challenges

Community stakeholders identified five main factors that challenged the planning stage of the Trial (Table 17.4).

Table 17.4 Aboriginal and Torres Strait Islander community stakeholder consultations: Challenges to Trial planning

Challenges to Trial planning	Sites (n)
Engagement and management of relevant stakeholders	4
Trial scope	3
Communication challenges	3
Red tape	2
Lack of culturally appropriate planning tools and resources	1

Engagement and management of relevant stakeholders

Community stakeholders from all four Sites reported that the planning stage of the Trial had faced difficulties in obtaining, retaining and managing the engagement of some key stakeholders. Community stakeholders reported that it was difficult to engage a diverse range of representatives, to negotiate and manage the different agendas, priorities and perspectives of community members and to ensure that everyone had an equal seat at the table.

Trial scope

Community stakeholders from three Sites saw the parameters and scope of the Trial as limiting the Trial planning such that activities did not address the root causes of suicide. Multiple stakeholders said that it was unclear to community members why particular Sites were chosen for the Trial and not others, and that there was a mismatch between the priorities of the government and community. For one stakeholder, the LifeSpan framework did not align with the need to foster connection with Aboriginal and Torres Strait Islander peoples before offering services.

Communication challenges

Community stakeholders from three Sites felt that it was difficult to inform most community members about the Trial, and as such many were unaware of the Trial. Other community stakeholders reported that they were not kept informed about the Trial planning after they were engaged in the initial rounds of consultation.

Red tape

Community stakeholders from two Sites claimed that the processes and regulations of the PHNs were obstacles to effective and meaningful community participation in the Trial planning. These stakeholders explained that the PHN's key performance indicators did not marry with the intent of the Trial Sites' co-designed and community-led approach.

Lack of culturally appropriate planning tools and resources

A lack of culturally appropriate planning tools and resources to guide the planning process was also identified as a challenge to planning the Trial activities.

17.5 Suicide prevention activities and services

17.5.1 Activities and services

Community stakeholders discussed two main types of Trial activities of which they were aware: activities for Aboriginal and Torres Strait Islander men, and training and awareness-raising activities. Community stakeholders from two Sites described Trial activities targeted at men, including men's cultural camps and groups, that focused on connection and cultural strengthening activities and served as a vehicle for local men to learn about supports and services available in their area.

Community stakeholders from four Sites also described an array of training and awareness-raising activities implemented as part of the Trial. Community awareness-raising events mentioned included a festival, gatherings, games, play groups with young kids, and art. Stakeholders also said that suicide prevention training had been conducted in evidence-based training programs, for example, ASIST and Aboriginal and Torres Strait Islander Mental Health First Aid.

Activity promotion and recruitment strategies

Community stakeholders identified a range of promotion and recruitment strategies employed by the Trial Sites. These are displayed in Table 17.5 below.

Table 17.5 Aboriginal and Torres Strait Islander community stakeholder consultations: Promotion and recruitment strategies

Strategies	Sites (n)
Word of mouth	2
Promotional materials	2
Local networks	2
Social media	2
Radio, TV and newspaper	2
Provision of food	1
Other	1

Activity promotion and recruitment strategies included:

- Word-of-mouth to promote participation in activities by Trial-commissioned service staff and local networks helped to build trust, including through door knocking
- Promotional materials to garner interest in the activities, for example, t-shirts, flyers and beer coasters
- Promotion through local networks and connections with other organisations

- Use of social media, such as public posts on Facebook, as well as private Facebook groups to facilitate participation in Trial activities, especially during COVID-19 restrictions
- Provision of food to promote participation in activities
- Radio, TV and newspaper advertisements to promote Trial activities
- Removal of known barriers to participation, for example, provision of transport and resources to activity participants.

Involvement of people with lived experience of suicide

Community stakeholders at all four Sites highlighted the involvement of Aboriginal and Torres Strait Islander people with lived experience of suicide in the Trial planning and implementation phases (i.e., on Trial working groups, through consultation and as participants in Trial activities). Community stakeholders said the involvement of Aboriginal and Torres Strait Islander people with lived experience of suicide was important because they were not usually asked for their viewpoints. One stakeholder described how people with lived experience who initially engaged in Trial activities as participants had the opportunity to become part of the delivery team.

17.5.2 Activities and services – impacts

Coordination of activities

Community stakeholders from three Sites reported increased coordination of services as a result of the Trial in their area. These community stakeholders said that the Trial had created a space for organisations to work collaboratively in a way that was not occurring previously. Community stakeholders from three Sites explained that organisations were brought together through the initial yarning sessions, which carried over to the Trial implementation. Community stakeholders from two Sites said that there had been referrals made between organisations during the Trial. Stakeholders from one Site said that the Trial had catalysed information sharing between organisations about the available services in the area.

Met needs and expectations

Community stakeholders all four Sites felt that the Trial activities were valued by stakeholders, with stakeholders from three Trial Sites stating that there had been good uptake of Trial activities. On the other hand, stakeholders from three Sites said that the Trial had not met local needs and expectations, with stakeholders from two Trial Sites reporting that there had been no uptake of Trial activities. Community stakeholders from one Site said that they were not sure, or it was too early to tell, if the Trial activities had met local needs and expectations.

Increased awareness and knowledge

Community stakeholders from all four Sites reported increased awareness and knowledge of community members and service providers. Community stakeholders stated that the Trial activities had increased community knowledge and awareness about how to support people going through crisis, where to get help for themselves or others, and where they could go for support after there had been a suicide. Community stakeholders also reported that the Trial activities had increased the knowledge and awareness of service providers about how to support people in suicidal crisis.

Other impacts

Community stakeholders identified other impacts resulting from the Trial activities :

- Improved wellbeing of activity participants (2 Sites)

- Greater capacity of community members to feel confident and capable to help people who are feeling suicidal (2 Sites)
- Increased help seeking for suicide and broader social determinants (e.g., substance use, 1 Site)
- Cultural outcomes (e.g., building the next generation of elders through the Trial process, 1 Site)
- Reduced stigma of mental health and suicide (1 Site).

There were, however, also community stakeholders at all four Sites who commented that they were not aware of any change in knowledge, capacity, type of service provision and cultural safety of local services resulting from the Trial in their area.

17.5.3 Activities and services – facilitating factors

Community stakeholders identified several factors, detailed in Table 17.6, that facilitated the implementation of the Trial activities.

Table 17.6 Aboriginal and Torres Strait Islander community stakeholder consultations: Factors facilitating implementation of Trial activities

Factors	Sites (n)
Community readiness and buy-in	3
Locally run	2
Trial coordinator	2
Time and resources	1

Community readiness and buy-in

Similar to the planning stage of the Trial, community stakeholders from three Sites explained that the enabling environment for the Trial activities brought on by community readiness and buy-in facilitated the implementation of the Trial. Stakeholders cited the dedication and commitment of local Trial-commissioned staff as key to driving the Trial implementation.

Locally run

The importance of the Trial activities being provided by local people and organisations was highlighted by stakeholders from two Sites.

Trial coordinator

Community stakeholders from two Sites underscored the importance of a positive and supportive relationship between the community and the Trial coordinator as a key facilitator of the implementation of Trial activities.

Time and resources

Community stakeholders from one Site noted that having enough time to spend with community members, often outside of business hours, was an important factor facilitating the Trial activities. Community stakeholders also explained that the Trial resources had allowed for their communities to fund existing programs.

17.5.4 Activities and services – challenges

Community stakeholders identified several factors that challenged the implementation of the Trial activities (Table 17.7).

Table 17.7 Aboriginal and Torres Strait Islander community stakeholder consultations: Factors hindering implementation of Trial activities

Challenges	Sites (n)
Structural challenges and the ecology of suicide	4
Engagement and management of relevant stakeholders	4
Existing services and systems	4
Communication challenges	3
Workforce challenges	3
COVID-related	2
Contextual challenges	2
Trial scope	1
Resource challenges	1

Structural challenges and the ecology of suicide

Community stakeholders from all four Trial Sites pointed to the structural challenges faced by Aboriginal and Torres Strait Islander peoples as a key obstacle to the implementation of the systems-based approach to suicide prevention intended by the Trial. Multiple community stakeholders explained that the broader ecology of disempowerment, systemic racism, colonisation and intergenerational trauma was both a key driver of suicide and a barrier to effective suicide prevention in their communities. Community stakeholders explained that the service response planned as part of the Trial could not undo generations of disconnection from culture and country. Stakeholders also highlighted the racism inherent in mainstream services and government systems that was difficult to change over the course of the Trial, and which consequently hindered Trial activities that relied on mainstream services and governments.

Engagement and management of relevant stakeholders

Community stakeholders from all four Sites reported that the implementation of Trial activities was challenged by the engagement of relevant stakeholders due to logistical challenges (e.g., transport, timing of meetings). Community stakeholders also described the challenges of managing and accommodating the diversity of priorities within communities and organisations in Trial activities.

Existing services and systems

Community stakeholders from all four Trial Sites said that the lack of culturally competent mainstream support services was a key barrier to implementation of the Trial activities. Community stakeholders also cited a lack of service capacity, including insufficient services available, long waiting times, inflexible service criteria and a lack of integrated, wrap-around care.

Communication challenges

Community stakeholders from three Sites said that the community was largely unaware of the Trial activities. Stakeholders also said that they and other community members could not distinguish activities implemented as part of the Trial from general suicide prevention activity in their area.

Workforce challenges

Community stakeholders from three Trial Sites identified workforce challenges, including the delayed recruitment or turnover of Trial staff. One stakeholder felt that the requirement for Trial staff to hold formal qualifications meant that Aboriginal and Torres Strait Islander knowledge was undervalued in the Trial staffing mix.

COVID-related challenges

Community stakeholders from two Sites said that the COVID-19 pandemic had harmed the Trials' engagement with the community and the wellbeing of Trial staff.

Contextual challenges

Community stakeholders from two Sites reported that community losses (i.e., deaths by suicide) during Trial implementation presented a difficulty to the implementation of the Trial activities.

Trial scope

Stakeholders from one Site felt that the Trial activities had operated in isolation from other suicide prevention activities. These stakeholders also reported that the duration of the Trial was too short.

Resource challenges

Community stakeholders from one Site reported resource challenges, including organisations having insufficient resources and funding to run activities.

18 Aboriginal and Torres Strait Islander consultations – Service providers

18.1 Summary of approach

Staff members from service provider organisations from six of the seven Sites with a focus on Aboriginal and Torres Strait Islander peoples participated in consultations from July to September 2020, providing information about local services, activities and programs for Aboriginal and Torres Strait Islander peoples. Consultations with service providers from one Trial Site could not be conducted, because approval from the Aboriginal and Torres Strait Islander Research Ethics Committee in that jurisdiction could not be obtained.

Individual or group semi-structured interviews were conducted in person by a locally-based Thirrili consultant wherever possible, or by phone or via online videoconference (Zoom, Skype MS Teams) when this was not possible due to constraints of distance, timing or COVID-19 travel restrictions. Interview topics for the group and individual interviews were the same and were based on the Evaluation Framework(10).

Interview questions focused on the impacts and outcomes of Trial activities and services, and how these were achieved. The interview questions are provided in Appendix 18. Interviews were conducted by either Thirrili staff members or consultants. Interviews were conducted by two evaluators, with one acting as scribe. Where possible, one of the evaluators was Aboriginal or Torres Strait Islander. Group interviews lasted 30 minutes to two hours, and individual interviews between 15 minutes and one hour, and were recorded if the participant agreed. Each participant received a plain language statement providing information about the evaluation and the interview, and all participants provided informed verbal or written consent to take part.

18.2 Sample information

Fifty-four staff members of 30 service provider organisations across six Trial Sites (5–17 participants per Site) participated in the consultations. Most were staff of organisations commissioned to provide services or activities for the Trial. They included 10 staff members from three organisations who delivered local mental health programs, but which were not providing services as part of the Trial. Staff occupied various roles in a variety of service provider organisations, as described in Table 18.1.

Table 18.2 gives an overview of the types of services and activities that were delivered by the participants' organisations, which mainly included awareness-raising activities and cultural healing programs. Several staff mentioned their service also provided referrals to other services for participants in their activities and/or local community members (8 providers, 3 Sites).

Table 18.1 Aboriginal and Torres Strait Islander service provider interviews: Staff roles by service type and Site

	Participants (n)	Sites (n)
Aboriginal community-controlled health organisation		
• CEO/founder	3	2
• Executive director	1	1
• Manager	6	2
• Project coordinator	3	2
• Staff member	3	2
• Community Elder	2	1
Aboriginal medical service		
• Project officer	1	1

	Participants (n)	Sites (n)
• Team leader	1	1
• Staff member	1	1
Community/service provider organisation (mainstream)		
• CEO	1	1
• Community Elder	1	1
• Manager	3	1
• Project coordinator	2	1
• Staff member	2	2
• Other	8	3
Youth service provider (mainstream)		
• Manager	2	1
Country health service		
• Various staff members (unknown roles)	4	1
National suicide prevention training organisation		
• CEO	1	1
• Manager	1	1
• Staff member	1	1
Research institute/university		
• Project coordinator	1	1
• Researchers	4	3
General practice		
• Staff member	1	1
Government organisation		
• School principal	1	1
Total	54	6

Table 18.2 Aboriginal and Torres Strait Islander service provider interviews: Types of services and activities provided by participants

Types of services and activities provided by participants	Provider organisations	Sites (n)
Awareness-raising activities (such as campaigns or workshops)	12	5
Cultural healing programs	12	4
Capacity building (such as Mental Health First Aid)	9	5
Individual and family support services (such as SEWB support)	6	5
Non-Trial service provider (Mental Health program, local suicide prevention networks)	3	4
Other (equine therapy, case management, aftercare service)	3	3

18.3 Data analysis

Notes from the individual and group interviews were imported into NVivo V.12 for analysis. A modified framework analysis(21) was conducted by considering all responses together and for all focus population groups using the evaluators' notes from the interviews, supplemented by the audio recordings. Two evaluators read and re-read the notes from a subset of interviews, then used the interview schedule to deductively identify key themes and develop a preliminary coding framework that captured the full range of comments. The evaluators then applied this preliminary coding framework to the subset of interviews, identifying emergent themes. The two evaluators met to discuss and refine the preliminary framework to resolve areas of disagreement, and reached consensus on how to code information pertaining to focus population groups and whole-of-population approaches. One evaluator then coded the remaining content, consulting with the other evaluators when needed. The framework, and associated coding, was finalised and used to interpret the data to respond to the evaluation questions. Themes and sample quotes are provided in Appendix 19.

18.4 Planning

Several service providers were involved in the planning component of the Trial as community and sector representatives and provided their perspectives on the planning process.

18.4.1 Planning – stakeholder involvement

Staff from four providers from three Trial Sites commented on the level of community involvement in the planning of Trial services, which varied across Sites. Staff from two other providers from two Sites briefly noted that their local community, including people with lived experience of suicide, had been involved in the planning process through consultations. Staff from one provider described the successful use in the planning stage of a co-design model led by an Aboriginal and Torres Strait Islander organisation, which involved extensive community consultations. Staff at another provider from the same Site, however, asserted that they were not involved in any co-design process. Rather, they independently organised consultations with community and local community Elders before applying for funding and negotiated the types of activities with the PHN.

18.4.2 Planning – facilitating factors

Staff from two providers from two Trial Sites commented on factors that facilitated planning of services for Aboriginal and Torres Strait Islander peoples. One staff member noted the importance of building relationships between community-led organisations and other mainstream services in order for community-led organisation to lead the way in culturally safe and appropriate services. They pointed out that community members were invested in the suicide prevention Trial, knowing that they were able to collectively make decisions about their local community. The other staff member mentioned Aboriginal and Torres Strait Islander people who were involved in the planning processes of the Trial were appropriately remunerated for their time, recognising and valuing their input and work.

18.4.3 Planning – challenges

One staff member pointed out they were not involved in a true co-design process for the planning of services for Aboriginal and Torres Strait Islander peoples in their local area. They felt that there had been a lot of uncertainty and a lack of transparency from the PHN about the funding available, which required extra effort and resources to be put into secure funding for their services.

18.5 Systems approach

18.5.1 Developing a systems approach – strategies

Service provider staff described the key factors which facilitated the implementation of Trial-funded services and activities, including bringing stakeholders together (11 providers, 5 Sites), achieving community buy-in (10 providers, 5 sites) and opting for locally run and grassroots programs (7 providers, 4 Sites).

Bringing stakeholders together

Staff members highlighted how they had worked with local organisations and/or community to coordinate the approach to suicide prevention in their region (11 providers, 5 Trial Sites). This was done in various ways, ranging from “keeping an eye on each other” to having regular interagency meetings.

Community buy-in

Staff members also described how community buy-in had facilitated the implementation of their activities and programs (10 providers, 5 Sites). It was clear from consultations that many providers had taken the time and effort to build community relationships and trust. Engaging genuinely with the community, enabling community decision-making and having community-led responses all contributed to community support and buy-in.

Locally run and grassroots programs

Staff members stressed the importance and positive impact of community and locally run programs (7 providers, 4 Sites). As mentioned above, this fostered community buy-in, local ownership and ensured culturally appropriate responses.

18.5.2 Implementing a systems approach – impacts

There were mixed perspectives among service providers on the extent to which The Trial had achieved a more coordinated or integrated approach to suicide prevention. That is, service providers from the same Sites reported different and sometimes conflicting accounts and views of this issue.

Staff from five providers from four Sites considered that there had been no or limited service coordination and integration in their local area, with local services generally still being siloed. Staff from three providers from three Sites indicated there was minimal service coordination in their local region, and they had to rely solely on the sharing of information between local organisations, community and/or the PHN.

Staff from other service providers were able to describe how, at a service level, greater coordination of suicide prevention activities and increased integration of services had been achieved through partnerships (5 providers, 5 Sites), offering complementary services (6 providers, 4 Sites) and establishing referral pathways (11 providers, 3 Sites).

Partnering with other providers

Staff mentioned various partnerships they had established to facilitate implementation and/or delivery of services and programs (5 providers, 5 Sites). Partner organisations included local Aboriginal community-controlled organisations and community groups, mainstream suicide prevention and/or mental health organisations, drug and alcohol services, government departments and schools. Staff from one provider indicated their program had up to 50 service agreements and partnerships with local organisations, providing a strong program interface.

Establishing referral pathways

A key element in service coordination and integration is the ability to provide “warm” and culturally safe referral pathways and preventing clients from “bouncing [a]round the system”. Staff members commented on the existing referral pathways (6 providers, 4 Sites), and described receiving referrals from various organisations including mainstream and Aboriginal-controlled organisations, hospitals, corrections/courts, schools, housing agencies and Centrelink.

Complementary services

Staff described how their program/activity filled a pre-existing service gap or how their service was complementary to existing services and programs (11 providers, 3 Sites). The areas in which service providers said the Trial had filled a gap or complemented existing services varied widely. They included youth-focused activities, in-school programs, community capacity-building activities, peer support, LGBTI-specific programs, specifically targeting suicide prevention, providing mental health support and organising men’s groups.

18.5.3 Developing and implementing a systems approach – challenges

Service providers generally had minimal involvement in developing and implementing a systems approach across the sector. However, they did play a role in coordinating and integrating with local services, and identified several challenges to achieving a more coordinated approach.

Staff members from nine providers from five Sites described difficulties they had experienced in engaging relevant stakeholders, including schools, police, first responders, hospitals and community health services. Several providers commented that disagreements and politics between local stakeholders can be challenging when trying to implement suicide prevention activities and establish collaboration.

Staff from two providers from two Sites felt that there was a need to broaden the scope of the Trial beyond suicide prevention, creating more opportunities to engage with other programs, such as crisis support and mental health programs.

18.6 Suicide prevention activities and services

18.6.1 Activities and services

Activity description

The service provider organisations participating in the consultations were involved in a range of suicide prevention activities and programs commissioned as part of the Trial.

Most provider organisations were involved in community awareness-raising activities (12 providers, 5 Sites), such as campaigns, producing resources, information sessions, community events and activities. Many of the programs provided were focused on cultural healing and connecting participants to culture (12 providers, 4 Sites), including camps and excursion on country, cultural healing retreats, and yarning circles.

One provider organisation ran an aftercare service for Aboriginal and Torres Strait Islander young people, and was also involved in providing other Trial activities.

Workforce requirements

Staff members from all Sites represented in the consultations reported that their organisation employed local Aboriginal and Torres Strait Islander people to deliver programs and activities (24 providers, 6 Sites). They highlighted that this is an important aspect of delivering culturally appropriate programs and activities. However, they also noted that many of the programs and activities rely on volunteer workers from the community.

Some staff members from a few organisations reported that they either employed a small number of Aboriginal and Torres Strait Islander staff members (6 providers, 5 Sites) or none (1 provider), with one provider noting it was hard to find staff with the appropriate qualifications.

Tailoring activities

Service providers mentioned various strategies for tailoring services and activities and/or ensuring they were culturally appropriate, as described in Table 18.3.

Staff from most providers (20 providers, 6 Sites) highlighted the need for and success of activities and services that were co-designed and/or operated by the local community, rather than tailored for Aboriginal and Torres Strait Islander peoples. One provider noted the importance of recognising the diversity within Aboriginal and Torres Strait Islander communities. This was further emphasised by several providers describing the need for and success of utilising and mobilising local voices, local knowledge and local solutions. This involved service design being led by the local community, involving local Elders and training, and employing local people.

Table 18.3 Aboriginal and Torres Strait Islander service provider interviews: Strategies used to tailor services and/or ensuring culturally appropriate services

Strategies	Providers	Sites (n)
Developed and/or operated by local Aboriginal and Torres Strait Islander community	20	6
Healing, trauma-informed and strength-based approaches	13	6
Community involvement	16	5
SEWB approach	7	3
Non-clinical approaches	4	4
Tailored to needs and interests	5	3
Safety plans and procedures in place	5	4
Embedding cultural practices	4	3
Focusing on cultural safety more broadly	4	3
Applying the National Indigenous Suicide Prevention Strategy	1	1

Many staff described their suicide prevention activities as culturally healing while taking a trauma-informed and/or strength-based approach (13 providers, 6 Sites). Participants described how the healing power lay in connection: connecting to each other and with Elders, building community, sharing cultural knowledge and connecting to country and culture.

Staff also pointed out that they had involved and engaged with the local community as a way of ensuring cultural appropriateness of programs and tailoring to local needs (16 providers, 5 Sites). Community engagement varied across Sites, including holding community workshops and consultations, liaising with local Elders, employing an Aboriginal and Torres Strait Islander consultant and/or using a reference group. One provider commented that programs will only be effective in the place where it was designed, highlighting the importance of locally tailored and/or developed programs.

Seven providers from three Sites noted that they took a SEWB approach to their activities and programs, ensuring a culturally safe and appropriate response. Most providers described using local and Aboriginal and Torres Strait Islander staff for these programs. Furthermore, staff noted they had embedded cultural practices into their activities and programs (4 providers, 3 Sites), recognising again the need for connection to culture to start a healing process, such as yarning circles, camps on country, making art and smoking ceremonies. Others highlighted the role of non-clinical approaches in promoting a cultural response and early intervention, and providing a non-threatening and safe space for Aboriginal and Torres Strait Islander people at risk of suicide (4 providers, 4 Sites). It was also pointed out that programs need to be flexible to fit the local community and the individual needs and interests of participants (5 providers, 3 Sites).

Several staff mentioned they had safety plans and procedures in place, such as a cultural safety policy and safety plans for each community consultation (5 providers, 4 Sites). Others mentioned a focus on cultural safety throughout their work (4 providers, 3 Sites). Staff from one provider mentioned they tailored their activities through the National Indigenous Suicide Prevention Strategy.

Activity promotion and recruitment strategies

Staff reported that the main way of promoting their services was through word of mouth and local sector networks, including the local suicide prevention network and the PHN. Various other methods were identified, and are detailed in Table 18.4.

Table 18.4 Aboriginal and Torres Strait Islander service provider interviews: Promotion and recruitment strategies

Promotion and recruitment strategies	Providers	Sites (n)
Through local sector networks (including PHN)	20	6
Word of mouth	18	6
Social media	15	4
Promotional materials (including advertisements, flyers and emails)	13	5
Building rapport and trust with community/participants	12	4
Providing resources/incentives (including transport, food & camping gear)	9	4
Face-to-face engagement	7	4
Non-clinical approach and settings (e.g., yarning circles)	5	3
Promotion or information events	4	3
Radio, TV and newspapers	4	4
Place-based approaches	3	3
Others (e.g., football ambassadors, podcast, live billboards)	5	4

An overarching theme across several strategies is the importance of building trusting and genuine relationships with community. Staff described how word of mouth was a very effective way of getting people to engage and participate (18 providers, 6 Sites), especially when coming from trusted local community members. Many staff members noted building rapport and trust with the community and individuals over time had been effective (12 providers, 4 Sites). Others felt face-to-face engagement and being present in community to be essential (8 providers, 4 Sites).

Staff highlighted that using a non-clinical approach and settings had been an effective way of getting people to participate in their activities and programs (5 providers, 3 Sites). This includes place-based approaches, in which the providers let the community define what a safe space for activities and programs looked like for them (3 providers, 3 Sites).

Some staff members described how they provided resources and incentives to facilitate and encourage participation in their activities and programs, such as transport and camping gear (9 providers, 4 Sites). Many mentioned providing food as a useful way to engage community members (8 providers, 4 Sites).

Staff also spoke about conventional ways of promoting their activities and programs using social media (15 providers, 4 Sites), promotional materials (13 providers, 5 Sites), organising information or promotional events (4 providers, 3 Sites) and using local radio, TV and newspapers (4 providers, 3 Sites).

Involvement of people with lived experience of suicide

Staff members from six providers (4 Sites) mentioned they had involved people and communities with lived experience of suicide in delivering their programs. One staff member highlighted the importance of people being able to talk with, and relate to, staff who have lived experience of suicide. It is worth noting that many members of the community and those involved in the Trial have lived experience of suicide and/or mental ill-health.

18.6.2 Activities and services – outputs and impacts

Increased collaboration and connection

Staff from three providers (3 Sites) indicated that they had experienced increased connections and local collaboration with other organisations across sectors and/or the community throughout the Trial. One provider explained that the community had really come together and shown love and support for one another.

Met needs and expectations

Service provider staff described various ways in which the suicide prevention activities and programs were valued by stakeholders and had met local needs and expectations, including that:

- They felt programs/activities are very much needed in their local region (2 providers, 2 Sites)
- The activities and programs had increased availability and access to culturally appropriate activities and programs for community (7 providers, 3 Sites)
- Trial activities were at full capacity or had good uptake (3 providers, 3 Sites)
- Local stakeholders, including participants, community members and other providers, had expressed they valued the suicide prevention programs and activities that were provided (5 providers, 2 Sites).

Increased awareness and knowledge

Staff members from over half the organisations interviewed mentioned increased awareness and knowledge about suicide prevention and/or mental health in the community as a result of the local Trial activities (16 providers, 5 Sites). They noted that community members were more able and comfortable to talk about suicide and mental health, as well as knowing how and where to get help and access to services that are culturally safe.

Improved social and emotional wellbeing

Increased SEWB of participants and their family involved in suicide prevention activities and programs was reported by staff from 15 providers (5 Sites). Staff members also described improvements in the wellbeing, confidence, self-awareness, family relationships and cultural connectedness of the community members who participated in their activities, with some reporting that Trial activities had saved lives.

Cultural awareness and safety

Staff described increased cultural awareness and safety for people and organisations (e.g., schools) that participated in their activities and programs (7 providers, 5 Sites). Activities connected people with their community and culture, sometimes for the first time in their lives, elevating their SEWB significantly. Furthermore, providers noted their activities and programs had created more culturally safe spaces for the community to be understood and supported.

Community empowerment

Staff from three providers (2 Sites) noted that the Trial had built community leadership and empowerment, facilitating localised solutions and governance of suicide prevention work. One provider commented that such work and opportunities contributed to self-determination of Aboriginal and Torres Strait Islander communities and placed “black voices at the table to provide black solutions”.

Increased capacity

Staff members from four providers (4 Sites)reported greater capacity of community members to respond to people with mental ill health and/or suicidal ideation. Some staff members said they had upskilled people by providing training, such as Mental Health First Aid or ASIST, while others had seen people applying skills learned during the Trial more generally.

Reduced stigma

A reduction in the stigma around mental illness and/or suicide in the community was noted by staff members from four providers (3 Sites). One staff member commented that it had been important to find the appropriate language for their participants, because the word “suicide” may still be taboo. Another provider said they were able to break down the stigma by sharing their own lived experience of mental ill health.

18.6.3 Activities and services – challenges

Many challenges related to the delivery of suicide prevention activities were identified (Table 18.5).

Table 18.5 Aboriginal and Torres Strait Islander service provider interviews: Suicide prevention activities challenges

Implementation challenges	Providers	Sites (n)
COVID-related challenges	20	5
Lack of/inconsistent funding	12	5
Uptake and/or access	11	4
Community engagement	11	5
Workforce	9	4
Managing relationships with the PHN	6	5
Lack of data	7	4
Lack of resources	5	5
Structural and systemic challenges	6	5
Lack of expertise and knowledge	2	2
Lack of transfer of cultural knowledge	2	2
Lack of community training and other services	2	2
Protocols and Trial requirements	2	1
Seasonal challenges (e.g., wet season)	2	1
Geographical/rural location	1	1

COVID-related challenges

Most staff members reported various impacts of COVID-19 and the restrictions that were or had been in place (20 providers, 5 Sites). These included delays in the implementation and delivery of activities/programs, having to switch to online activities, losing momentum, a loss of engagement and community relationships, lack of access to technology, and reduced mental health. Many staff members described innovative and responsive ways to deal with the impacts of COVID-19, such as switching to online meetings and activities, engaging people through social media, and setting up phone trees to check on community members.

Lack of/inconsistent funding

Many staff members (12 providers, 5 Sites) mentioned that the lack of funding or the inconsistency of funding formed a major barrier to the implementation and delivery of services and programs. This resulted in providers being under-resourced and under-staffed, constantly chasing additional funding, and being unable to provide certainty and consistency for community members and/or participants. Staff from many providers clearly articulated that they needed adequate and long-term funding to provide and continue their services and programs.

Uptake and/or access

Staff noted several challenges resulting in a lack of access to and/or uptake of Trial activities (11 providers, 5 Sites). This included an inability to meet the high demand and receipt of inappropriate referrals (e.g., from Youth Justice). Provider staff also mentioned instances of community members being reluctant or unwilling to engage, explaining that it requires time and the building of trust for community members and participants to become familiar and comfortable with the programs and activities being offered.

Workforce

Staff from nine providers (4 Sites) commented on workforce challenges, which included staff shortages, finding appropriate staff, staff retention and a need for more staff training. Several providers mentioned they run mostly on volunteer staff, which was viewed as insufficient and unsustainable. Many of these challenges are related to a lack of and/or inconsistent funding.

Community engagement

Several staff from 11 providers (5 Sites) commented that engaging with the local community takes time. Establishing these relationships is dependent on the cultural competency of mainstream and non-Aboriginal and Torres Strait Islander stakeholders involved. Furthermore, it can be challenging to balance the different views and input of different communities and factions that exist locally.

Managing relationships with the PHN

Staff from six providers (5 Sites) felt that there was a lack of communication and transparency from the PHN. Some said the PHN did not actively involve them, and others reported a lack of leadership, management and support from the PHN. One staff member said they were mindful of keeping their cultural integrity when sharing information and knowledge with the PHN. Staff from all providers expressed a need for the PHNs to involve and communicate with them genuinely and openly.

Lack of data

Provider staff commented on the lack of data and the challenges in data collection, both for measuring SEWB and real-time reductions in suicide (7 providers, 4 Sites). Some noted they relied mostly on qualitative data. Two staff members commented that there is a lack of evidence for the effectiveness of Aboriginal and Torres Strait Islander suicide prevention programs.

Lack of resources

Staff from five providers (5 Sites) reported a lack of resources, stating that they needed more and better resources to be able to deliver their activities and programs adequately, including infrastructure, administrative support, computers and camping gear.

Structural and systemic challenges

Service provider staff members noted that the community as a whole and their individual participants face many structural and systemic challenges that need to be addressed when delivering activities and programs targeting mental health and suicide prevention (6 providers, 5 Sites). These include the ongoing impacts of colonisation, racism, discrimination, intergenerational trauma, lack of housing, and relational and physical ill health. One commented on the negative impact that the lack of cultural awareness of mainstream services had on the community, such as misunderstanding cultural self-harm as suicidal tendencies.

Other challenges

Staff from one or two providers mentioned other challenges, including:

- A lack of expertise and knowledge of non-Aboriginal and Torres Strait Islander Trial leads on Aboriginal and Torres Strait Islander suicide prevention (2 providers, 2 Sites). For example, providers reported that they were constantly being contacted by Trial staff for instructions and feedback on whether a Trial staff member was doing the right thing

- Identifying the appropriate community members to participate in the transfer of cultural knowledge in their community to implement and deliver cultural healing programs and activities (2 providers, 2 Sites)
- Insufficient capacity training available for the community (1 provider, 1 Site)
- The lack of other services available for the community (1 provider, 1 Site)
- Trial protocols and requirements pushed the timelines and boundaries for ensuring a localised and community-based approach (2 providers, 1 Site)
- Difficulties in attracting services to rural and remote locations (1 provider, 1 Site)
- Access issues during the wet season hindered the delivery of activities and/or programs (2 providers, 1 Site).

19 Consultations with other stakeholders

19.1 Summary of approach

In-depth individual interviews were conducted with five Black Dog Institute staff who had been involved with providing support for the implementation of the Trial. Interviews were conducted between February 2019 and July 2020 via telephone or online by two evaluators, with one acting as scribe. Interviews were audio recorded with participants' permission. The role of the Black Dog Institute afforded them a unique overview of the Trial planning and implementation, therefore their observations and perspectives were sought on the full range of topics covered by the evaluation. Interviews were semi-structured using an interview schedule based on the Evaluation Framework(10). The interview topics are provided in Appendix 20; they focus on the challenges and facilitators of planning and implementing the Trial, including adopting a systems approach. Interviews lasted one hour on average.

19.2 Data analysis

Notes from the interviews were imported into NVivo V.12 for analysis. Interview notes were analysed using deductive thematic analysis. One researcher read and re-read the interview notes and developed a preliminary coding framework based on the interview schedule. Two evaluators then met to discuss the preliminary coding framework in reference to one interview. One evaluator then coded all interviews, consulting with another when needed. Themes and samples quotes are provided in Appendix 21.

19.3 Planning

19.3.1 Planning – identifying local needs and service gaps

Black Dog Institute participants described several strategies used to plan the Trial at each Trial Site and across the whole Trial. Involvement and consultation with multiple stakeholder groups was the most commonly mentioned strategy for planning, and is discussed below. Some Trial Sites also undertook research to identify needs and service gaps in their catchments, either through internal mechanisms or by hiring external consultants. This method was used to identify barriers to service access and use by focus populations, including Aboriginal and Torres Strait Islander and LGBTI people. Other Sites subcontracted community organisations to independently design and plan their Trial program.

19.3.2 Planning – stakeholder involvement

Black Dog Institute participants confirmed that a range of intersectoral stakeholders were involved in planning and implementing the Trial across Sites, including local community networks, lived experience of suicide networks, the health sector, the education sector and police and law enforcement. Stakeholder involvement and consultation was achieved through governance structures including advisory groups, implementation groups and local working groups.

19.3.3 Planning – facilitating factors

Black Dog Institute participants emphasised the importance of Trial Committees in coordinating Trial activities and ensuring that these activities were tailored to the local context. They explained that the most successful Trial Committees were those that were genuinely representative of community and local groups, included the membership of senior organisational staff, and dedicated adequate time to building relationships between stakeholders before moving onto implementation of Trial activities. Black Dog Institute participants underscored the need for strong leadership within these Trial Committees to manage the expectations and priorities of stakeholders.

19.3.4 Planning – challenges

Black Dog Institute participants described a range of challenges encountered during the planning phase of the Trial.

Three Black Dog Institute participants noted governance challenges. Two participants thought that there could have been greater oversight of the Trial by the Department of Health and/or the PHNs. For example, Black Dog Institute participants reported having to provide additional support to staff at local organisations sub-contracted to deliver Trial activities to enhance their capacity to use evidence and evaluation methods, including the use of program logic. Tensions also arose due to differences in the expectations and priorities of stakeholder groups. For example, some communities had a clear view about the activities they wanted to conduct but these did not necessarily align with the systems framework.

Black Dog Institute participants also noted differing levels of engagement with people with a lived experience of suicide in planning the Trial, and that some Sites had struggled to understand and see the benefit of their involvement. While some Trial Sites leveraged existing networks to facilitate the involvement of people with lived experience of suicide, involvement was minimal when these networks did not exist in the local community prior to the Trial. One participant described the complexity of lived experience of suicide representation, particularly in Trial Sites with multiple focus populations or groups with diverse needs (e.g., Aboriginal and Torres Strait Islander peoples, people with a lived experience of suicide, LGBTI people).

A further challenge for Trial Sites described by Black Dog Institute participants was in the incorporation of evidence-based strategies and a systems approach into the planning process. Black Dog Institute participants discussed the difficulties they had in advocating for the use of evidence-based programs when there was a dearth of evidence for focus populations or regions. For example, one participant noted issues with the applicability of universal programs for focus populations such as LGBTI people, or for use in regional areas that did not have the same service infrastructure as the location in which the evidence was generated. Black Dog Institute participants also explained that the evolving evidence for suicide prevention meant that interventions with a stronger evidence base were often less acceptable or feasible in practice than interventions that appeared more relevant to particular contexts but did not currently have a strong evidence base.

Black Dog Institute participants identified logistical challenges to the planning of the Trial, particularly in regional Sites. Geographical distance prevented some stakeholders from regularly attending advisory groups, which reduced buy-in and local ownership of the Trial activities. Relatedly, Trial Sites responsible for servicing large geographical areas and diverse populations struggled to plan activities that were appropriate for their whole catchment. Geographical factors also complicated the planning and implementation of some aspects of the systems approach (e.g., means restrictions) that required working with infrastructure and supply pathways (e.g., railway corridors, pharmaceutical dispensing) across state and federal jurisdictions. Time was also mentioned as a key logistical challenge for all Trial Sites. Despite the extension of the Trial, Black Dog Institute participants noted that some Trial Sites felt pressure to launch immediately into planning and implementation, which meant that key governance structures were not agreed upon or the local context properly understood.

Staffing was a key challenge to effective planning. Black Dog Institute participants described the difficulties in recruiting staff with relevant experience to rural and regional areas where staff required extensive stakeholder engagement and management skills as well as knowledge of the existing service networks, sometimes across large geographical areas. One Black Dog Institute participant deemed the local coordinator role to be “too junior” to achieve buy-in from the community and negotiate the community priorities with the use of evidence-based frameworks. Across Trial Sites, staff turnover led to a loss of knowledge and relationships with the community and other stakeholder groups.

19.4 Systems approach

19.4.1 Developing a systems approach – strategies

Black Dog Institute participants viewed their organisation’s advisory role as a key strategy for achieving a systems approach. In that role, The Black Dog Institute conducted workshops and webinars and provided individualised advice to Trial Sites in the use of evidence-based frameworks, including the LifeSpan framework. Such frameworks were seen to provide a shared framework and set of principles to guide Trial Sites as they developed and implemented their approaches. Black Dog Institute participants also reported providing support at the planning phase of the Trial to ensure that each Site plan was broadly aligned with a systems approach while still being tailored to the local context. Part of this role was to support Trial Sites to design, implement and evaluate specific programs for their focus populations to grow the evidence base when it was lacking.

Black Dog Institute participants described strategies used at Trial Sites to develop a systems approach, including engagement of key stakeholders and establishing robust governance structures. Key stakeholders were involved in the ongoing coordination of activities through the governance structures at the Trial Sites. Clear governance structures and strong leadership were identified by all Black Dog Institute participants as key to implementing a systems approach to suicide prevention across Trial Sites. Given the need to bring intersectoral stakeholders together to achieve a systems approach, the participants emphasised the importance of having strong leadership within the PHN to facilitate and broker relationships between stakeholders.

Engaging community and adapting to local community needs was seen as a key facilitator for developing a systems approach by the Black Dog Institute participants, and this required moving away from a top-down approach and taking community readiness in account during implementation.

Black Dog Institute participants reported knowledge sharing as central to establishing a systems approach. Knowledge sharing between local stakeholders at each Trial Site was important for familiarising them with the activities carried out by existing services in the community and establishing referral pathways. Knowledge sharing across Trial Sites also enabled Sites to learn from the processes of other Sites, including navigating PHN systems and the development of policies.

Black Dog Institute participants underscored the importance of a clearly defined focus population or geographical region to achieving “one thing really well”. Clarity around the bounds of the chosen systems framework and the approach was part of this. Building the capacity of the local workforce and the broader community were also seen as important for establishing a systems approach.

19.4.2 Implementing a systems approach – impacts

One Black Dog Institute participant reported increased community engagement, and noted that the Trial Sites were successful in working collaboratively with various stakeholders at local, state and

Commonwealth levels. They noted that success was mainly seen at Sites where the PHN had good internal support and staff who were skilful at creating links and building relationships. They also mentioned that considerable capacity had been built in the community organisations commissioned to deliver the Trial in smaller regions within the overall Trial Site, and that this will embed the learnings of the Trial within the community. One Black Dog Institute participant reported that PHNs had observed a shift towards a better understanding and appreciation of an outcome-based approach focused on data and evidence-based activities among community partners.

The Black Dog Institute participants considered that PHNs are well placed to drive the systems approach in suicide prevention. They have strengths in their commissioning role and access to data which supports a focus on evidence-based activities integral to a systems approach. One Black Dog Institute participant highlighted the need to have an ongoing coordinating role to prioritise suicide prevention, given the complex nature of this work. They considered that greater progress in adopting a systems approach was seen at Sites where the PHN maintained ownership and control over the Trial, rather than outsourcing it to local community organisations (noting that this did not include the two Aboriginal and Torres Strait Islander-specific Sites).

19.4.3 Developing and implementing a systems approach – challenges

Black Dog Institute participants identified several challenges to the establishment of a systems approach to suicide prevention. One challenge was the lack of existing service infrastructure and/or streamlined processes, particularly in regional or rural areas. For example, the internal processes of one PHN delayed the approval of the community action plan. At other Trial Sites, the lack of hospitals and essential services prevented the development of good referral pathways between Trial and other services. Black Dog Institute participants also described the low suicide prevention literacy of other services operated as a barrier; for example, the Trial had built the capacity of PHN staff and the community, but the broader health and social systems were slow to adapt or change.

Black Dog Institute participants reported that a lack of understanding of target group needs hampered adoption of a systems approach to suicide prevention. One participant stated that the health and social systems and associated services did not fully understand or accept the differences of focus population groups (e.g., Aboriginal and Torres Strait Islander peoples and LGBTI populations) and the importance of adapting universal suicide prevention strategies to meet their needs.

As was the case in the planning phase, tensions arose from the need to collaborate with intersectoral stakeholders to achieve a systems approach. Black Dog Institute participants described how some Trial Sites struggled with role definition for the PHN and other stakeholder groups regarding who was responsible for directing the scope of the Trial and had the final say on Trial activities. Activities that relied on the uptake of intersectoral stakeholders to achieve a systems approach were also challenging. Black Dog Institute participants explained that the lack of involvement of key government departments limited the scope of what the Trial Sites could achieve to those within the health sector. For example, at Sites attempting to implement school-based programs (e.g., YAM) the PHN had no influence over education sector stakeholders to ensure the approval and uptake of the program.

Poor understanding of a systems approach from key stakeholders was also another challenge to its implementation. Black Dog Institute participants were concerned that some Trial Sites were choosing activities that meant they were not implementing the whole LifeSpan framework. They also believed that some Trial Sites understood the concept but not the operationalisation of a systems-based approach.

Black Dog Institute participants were concerned that the Trial would not be long enough to see any impacts, particularly for focus populations in which more time was required to establish relationships and reach agreement on the scope of the Trial. They also underscored that the importance of community engagement and involvement in the planning phase of the Trial could not be underestimated, and that some Trial Sites did not factor in sufficient time or felt pressured to begin activities too quickly.

A lack of general data and the inability to link local successes on the ground to outcomes was reported as an inherent challenge for establishing a systems approach, because it may lead to frustration and feelings of dismissal of results among stakeholders.

Black Dog Institute participants mentioned staff turnover at some of the Trial Sites as a problem, because often the community relationships and momentum built are lost when key staff members move on. Consistent staffing was seen to help PHNs with building community trust and buy-in.

19.5 Aftercare services for people who attempt or are at risk of suicide

Black Dog Institute participants reported that most Trial Sites had not focused on follow-up aftercare services or postvention activities. One Black Dog Institute participant thought that the Trial Sites that most successfully targeted services to this group had implemented evidence-based frameworks. Black Dog Institute participants stated that Trial Sites were reluctant to adopt strategies targeted at people who had attempted or were at risk of suicide because of concerns that the initiation of new services during the Trial would not be sustained after it ended and would undermine community confidence.

19.6 Focus population – Aboriginal and Torres Strait Islander peoples

Black Dog Institute participants agreed that the only acceptable way to develop suicide prevention activities targeted at Aboriginal and Torres Strait Islander peoples was to adopt a co-designed or community-led approach.

One Black Dog Institute participant reported that despite ongoing challenges, the Trial Sites had done well in community engagement and relationship building. They reported that one Site had used community liaison officers, while another Site had been very open and transparent in their communication and reporting on the funding available. Genuine community involvement in the development and implementation of services was seen as key. They noted that rather than replicating specific services, Sites should learn from the successful principles and ways of working with Aboriginal and Torres Strait Islander peoples. They also highlighted the importance of SEWB approaches, promoting connection to culture, lived experience engagement and building the cultural competence of mainstream organisations.

One Black Dog Institute participant viewed the conceptualisation of Aboriginal and Torres Strait Islander suicide prevention activities as a national policy issue rather than a local issue as a key strength to this approach.

Black Dog Institute participants mentioned a range of challenges they observed at Sites with respect to Aboriginal and Torres Strait Islander-focused Trial planning. Time frames for action were identified as a key challenge to the development of suicide prevention activities for Aboriginal and Torres Strait Islander peoples. The Black Dog Institute participants reported that despite the relatively long duration of the Trial, substantial time was necessary to build credibility and reach consensus among stakeholder groups. One Black Dog Institute participant mentioned staff turnover and short timelines as a significant challenge in developing genuine community relationships. The Black Dog Institute participants also explained that the evidence-based approach to the Trial was perceived as a “white” decision and that Aboriginal and Torres Strait Islander communities experienced consultation and research fatigue.

19.7 Focus population – men

One Black Dog Institute participant highlighted partnerships with industry partners (e.g., Mates in Construction and Mates in Mining) as key strategies for targeting suicide prevention activities to men. These partnerships had included stakeholder engagement strategies such as roadshows. This participant stated that the biggest challenge of working with this focus population was that evidence is lacking, which limited the advice that Black Dog Institute could provide to Trial Sites.

19.8 Focus population – young people

Black Dog Institute participants thought that a lack of understanding of a systems approach prevented youth-focused Trial Sites from implementing parenting or education-based strategies. One also reported that access to schools was a challenge for youth activities. Another Black Dog Institute participant also explained that it was difficult to integrate suicide prevention activities with other strategies and programs targeting young people.

One Black Dog Institute participant stated that connecting existing resources for young people within the system, GPs and headspace centres, had been a successful strategy of one of the youth-focused Trial Sites. They also mentioned that young people particularly benefit from stigma reduction, improved help seeking and training the people around them to function as a safety net.

19.9 Focus population – ex-ADF members and their families

Black Dog Institute participants reported that there had been strong involvement of people with lived experience in planning and implementing suicide prevention activities targeting ex-ADF members and their families. One Black Dog Institute participant noted that involving peers and people with lived experience of suicide had been a key factor when targeting ex-ADF members; they play an important role in reducing the stigma around help seeking and vulnerability in the ADF. Furthermore, the Black Dog Institute participant mentioned that successfully targeting ex-ADF members involved an understanding of the psychology and language used within this group.

The involvement of high-level stakeholders who were well connected with the ADF and ex-ADF community was seen to facilitate the visibility and rollout of the Trial.

A lack of data on suicide among ex-ADF members was identified as a challenge for targeting this population.

19.10 Focus population – LGBTI people

Black Dog Institute participants highlighted the strong community readiness and existing collaborations within organisations servicing the LGBTI community as key to the development of suicide prevention activities targeting this population.

One Black Dog Institute participant reported that engaging with the LGBTI community and organisations had been very successful at two LGBTI-focused Trial Sites. These Sites were able to harness local expertise and achieve meaningful and diverse representation of the LGBTI community in their working groups and task force. This participant also noted that one of the LGBTI-focused

Trial Sites had enjoyed great success with its peer workforce, especially for LGBTI young people, and in upskilling mainstream services to understand the issues and risks that arise when LGBTI people try to access these services.

Lack of data on the rates of suicide amongst LGBTI people and their needs was a barrier to planning activities. A lack of evidence on the most effective, acceptable and feasible interventions for this group was also a challenge. One Black Dog Institute participant reported that there were misconceptions from general health service providers that this group had unique needs.

19.11 Focus population – older adults

Little information was provided about Trial activities focused on older adults. One participant mentioned that although there are a lot of issues around the lack of support for older adults across Australia, there is a lesser sense of urgency than for young people or adults with children. They also noted that focusing on reducing social isolation and stigmatisation are important elements for this particular population.

20 Consultations with aftercare service users (survey)

20.1 Summary of approach

A survey was developed to gather input from users of Trial-funded follow-up aftercare services. The survey was administered three times: first in October 2019 to all consenting service users since the inception of the services, and then in January 2020 and June 2020 to all new service users since the previous survey.

Service users were asked for their consent for their contact information to be accessed in order to send them an invitation to participate in the survey. If they consented, Strategic Data then sent either an email or a text message providing information about the evaluation and inviting them to participate in a brief online survey and providing a link to it. The questionnaire included basic demographic variables, closed-answer questions collecting information about their use of the service, current wellbeing and suicidality and three open answer questions on their opinion of the service. The survey was not designed to produce epidemiological data (which are available in the PMHC MDS and additional module and reported on in Chapter 11) but to gather qualitative feedback about user experience of the services. The questionnaire is available in Appendix 22.

20.2 Sample information

Two hundred and sixty-six invitations were sent across the three administrations of the survey. Thirty-two service users from four Trial Sites completed the survey (range 2–12 respondents per Site).

20.3 Data analysis

Numeric variable data was imported into Stata 16.0 for analysis and summary statistics generated. Results are reported as proportions. Qualitative data was imported into NVivo V.12 for analysis, and one evaluator identified themes and coded the data.

20.4 Service users – characteristics

Survey respondents were aged 19–58 years with an average age of 36 years. Most respondents were female, less than half identified as heterosexual and only one respondent identified as Aboriginal or Torres Strait Islander. Respondent characteristics are described in Table 20.1.

Table 20.1 Aftercare service user survey: Respondent characteristics

Respondent characteristics	Proportion (%)
State residence	
QLD	38
NSW	22
SA	34
VIC	6
Gender	
Male	34
Female	44
Transgender or genderqueer	15
Don’t know	<5
Missing	<5
Sexuality	
Lesbian, gay or homosexual	31
Straight or heterosexual	41
Bisexual	13

Respondent characteristics	Proportion (%)
Other	6
Don't know	6
Missing	<5

20.5 Service users – service use factors

Almost half the respondents indicated that this was their first use of a service to manage suicidal thoughts or behaviours, while 20% had used services for that reason within the past 12 months (Table 20.2).

Table 20.2 details respondents' responses to the question about why they chose to use the service. Respondents could select multiple reasons; the main reasons identified were increasing suicidality, feeling they were not coping and needing professional help, and being referred into the service.

In addition, three respondents provided free-text information. One indicated they attended the service because their previous service providers did not understand sexual identity and could not create a safe therapeutic environment, another mentioned the lack of availability/accessibility of mental health services, and the third explained that they had been referred to the service after a suicide attempt.

Table 20.2 Aftercare service user survey: Service use

Service use	Proportion (%)
First time service use	
Yes, this is the first time	44
No, used services in the past year	19
No, used services in the past, but more than one year ago	28
Missing	9
*Chose this service because**	
I felt I was not coping	63
My suicidal thoughts were getting worse	53
I experienced an event that was very upsetting	25
I felt I needed professional help	59
A family member/friend suggested it	<5
I was referred to the service (by the hospital, a health service or doctor etc.)	59
Other	<5

* Multiple responses permitted

20.6 Service users – satisfaction with service

Table 20.3 presents information on responses to survey questions about satisfaction with the service. Overall, respondents felt they did not have to wait too long to receive the service, that the service was considerate to cultural background, sexuality and gender, and 85% of respondents rated the service as good or very good.

Table 20.3 Aftercare service user survey: Satisfaction with service

Satisfaction with service	Proportion (%)
Waiting time	
Yes, waited longer than I felt was reasonable	19
No, did not have to wait too long	72
Missing	9
Service consideration of cultural background, sexuality and gender	
Very bad	<5
Bad	<5

Satisfaction with service	Proportion (%)
Neither good nor bad	0
Good	16
Very good	59
Not applicable	9
Missing	9
Overall service rating	
Very bad	6
Bad	0
Neither good nor bad	6
Good	16
Very good	69
Missing	<5

Fourteen respondents provided free-text comments on what they valued most about the service. They wrote:

- Particular qualities of the service were that service users felt heard, understood, respected for their experience/identity, the service provided a safe and flexible environment, the service was free, and the service was LGBTI specific (11 comments)
- Qualities of the staff members delivering the service included staff being friendly, empathetic, understanding, helpful, staff with lived experience of suicide, and the diversity of staff (9 comments)
- The usefulness and impact of the service (3 comments)
- Support to access the service (2 comments)
- The regular contact and support (1 comment).

One respondent responded with “nothing”.

20.7 Service users – impacts

Respondents reported on a range of impacts the service had on their daily life, wellbeing, changes in thoughts and feelings about suicide, and their feelings about the future. The results are described in Table 20.4. (Note: no information was collected on the respondents’ stage of engagement with the service when they undertook the survey. Respondents may have been at any stage, including having finished the program more than a year prior to completing the survey. The following results should be interpreted with this consideration in mind.

Table 20.4 Aftercare service user survey: Impacts of service use

	Proportion (%)
Changes in ability to manage day-to-day life	
Much worse	6
A little worse	0
About the same	13
A little better	50
Much better	28
Missing	<5
Changes in wellbeing	
Much worse	6
A little worse	0
About the same	16
A little better	44
Much better	28
Missing	6

	Proportion (%)
Change in in thoughts or feeling about suicide	
Much worse	6
A little worse	<5
About the same	9
A little better	25
Much better	50
Missing	6
Changes in feelings about the future	
Much worse	6
A little worse	6
About the same	16
A little better	34
Much better	31
Missing	6

20.8 Services users – suggested service improvements

Twenty-two respondents provided at least one additional free-text comment about what could be improved about the service. Comments included:

- They would like to receive more sessions (5 comments)
- Greater service availability (3 comments)
- A broader range of psychotherapy/psychiatric treatment options (2 comments)
- More practical assistance in dealing with, or more linkage with, relevant community services and agencies (2 comments)
- More engagement and follow-up (1 comment)
- Availability of face-to-face meetings (1 comment)
- Greater confidentiality (1 comment)
- Disclosure of potential conflicts of interest (1 comment)
- Staff being more helpful and reliable (1 comment).

Two respondents stated that they would improve nothing.

22 Aftercare service user minimum dataset

22.1 Summary of approach

The Primary Mental Health Care minimum dataset (PMHC MDS) enables the PHNs and the Department of Health to monitor and report on the services delivered by PHN-commissioned mental health services, including Trial-funded aftercare services. It includes information about the volume and type of services provided, as well as client outcomes from all 31 PHN regions. Information captured includes client demographics and clinical characteristics, referral date, episode start and end dates, treatment focus, referrals in and out of services, and the K10 and five psychological distress scale scores.

The PMHC MDS set holds data at three different levels: per client (each record representing an individual service user), per episode of care (each record representing a series of service sessions during a continuous period of time, referred to as an "episode of care") and per session (each record representing a single service session). A single client may receive more than one episode of care. The data model for the PMHC MDS is available at https://docs.pmhc-mds.com/projects/data-specification/en/v1/data-model-and-specifications.html. For the purposes of the evaluation, client-level data was the primary focus, but some data of interest, such as age, is captured at episode level and therefore was recoded from episode level to individual service user level for analysis. Those data may change over the course of an episode, which for Trial-funded services represents a period of 3–6 months. For the purposes of this report, clients' status at the first episode is used.

For the evaluation, a brief additional Trial-specific module was developed to collect supplementary information including additional socio-demographic and referral items as well as the SIDAS, a brief outcome scale. The SIDAS is designed to screen for the presence of suicidal thoughts and assess their severity. It consists of five items, each targeting an attribute of suicidal thoughts (i.e., frequency, controllability, closeness to attempt, level of distress associated with the thoughts and impact on daily functioning). The items are summarised, with a higher total score reflecting more severe suicidal thoughts. The SIDAS has been validated in an online survey of community-based Australian adults and has shown high internal consistency and adequate/good validity(22). The Trial-specific module data items are provided in Appendix 23. In order to report region of residence, Australian Statistical Geographical Standard – Remoteness Area classifications(23) were included in the dataset by matching service user postcodes using concordance files provided by the Australian Bureau of Statistics.

For the routinely collected PMHC MDS data, service providers seek consent from all clients at the beginning of an episode of care for their information to be used by the Department of Health or organisations commissioned by them for planning and research purposes. For the evaluation of the National Suicide Prevention Trial additional consent was sought from clients of Trial-funded services to collect the additional module information, to link that information to the routinely-collection PMHC MDS data, and provide the linked dataset to the University of Melbourne evaluation team. Service providers submit client data to the PHNs, who then upload it to the PMHC MDS, which is managed by Strategic Data. Strategic Data then provided the evaluation team with data from all consenting service users.

22.2 Sample information

Only data from service users who had provided consent as described above were included in the analysis. One aftercare service focused on Aboriginal and Torres Strait Islander people was excluded form analysis, because approval was not obtained from the Aboriginal and Torres Strait Islander Research Ethics committee to include the service in the evaluation.

The final dataset included data about aftercare services offered at four Trial Sites from the inception of services until 30 June 2020. Services for the general population were offered at two Sites, for Aboriginal and Torres Strait Islander peoples at two Sites and for LGBTI peoples at two Sites[5]. Inception date varied considerably between services (from August 2018 to January 2020); longer-running services contribute more clients to the dataset.

Data were available for 553 individual service users, who received 603 episodes of care. A total of 6140 service contacts were recorded, of which 5576 were attended by the client (91%) and 564 were “no shows” (9%). There was considerable diversity across Sites in the number of service users represented in the dataset (range 11–204). This was largely due to the start-up time of the services. Because service providers may also provide PHN-commissioned non-Trial services, and the PMHC MDS does not capture whether services are Trial-funded unless the client consents to the additional evaluation data module, information on the total number of clients who used the Trial services was not available.

22.3 Data analysis

Data were checked and cleaned to resolve any inconsistencies in coding. The routinely collected PMHC MDS and the additional module were merged using unique client and episode keys. Data were analysed in STATA using standard descriptive statistical procedures (e.g., frequencies, cross tabulations, means). For the SIDAS and the K10, item ratings and total scores for episode start, review and end (mean and standard deviation, SD) are reported, and statistical significance tested using a paired t-test. The SIDAS total score was calculated by adding responses to all five items (with item 2 reverse scored). Only episodes with answers to all five items were included. The K10 total score is provided as part of the PHMC MDS standard dataset. It is based on the sum of K10 item 1 through 10, which allowed for one missing value to be present. If more than one of items 1 to 10 was missing, the total score was recorded as missing.

22.4 Service user characteristics

22.4.1 Socio-demographic characteristics

Table 22.1 provides full details of service user characteristics as captured in the PMHC minimum dataset. Male service users were only a slightly lower proportion of the total than female service users.

The mean age of service users was 36 years (SD 17.8 years), and almost a third were aged 24 years or less. Almost all (94%) of service users were Australian born and 25% identified as Aboriginal and/or Torres Strait Islander. The high proportion of Aboriginal and Torres Strait Islander service users reflects the dedicated service for that population. Just over half of services users identified as heterosexual, again reflecting the LGBTI-specific services commissioned in two Sites. Consistent with the location of the Sites which implemented services, over 50% of service users were from regional or remote areas. Over half were in full or part-time employment, and 55% received some type of support pension.

---

[5] The number of actual service providers varies depending on the commissioning model of the PHN. For clarity refer to services by focus population type, not individual service here.

Table 22.1 PMHC MDS and additional NSPT module: Service user characteristics (n=553)

Characteristic	Value	Frequency	%
Age group (n=539; excludes missing n=14, 2.5%)	≤ 24	168	31.2
	25–29	62	11.5
	30–34	62	11.5
	35–39	46	8.5
	40–44	43	8.0
	45–49	44	8.2
	50–54	31	5.8
	55–95	25	4.6
	60–64	22	4.1
	65–69	13	2.4
	70+	23	4.3
Gender (n=549; excludes missing n=4, 0.7%)	Male	250	45.5
	Female	280	51.0
	Other	19	3.5
Sexual identity* (n=508; excludes missing n=45, 8.1%)	Lesbian, gay or homosexual	87	17.1
	Straight or heterosexual	267	52.6
	Bisexual	25	4.9
	Something else	29	5.7
	I don't know	100	19.7
Aboriginal or Torres Strait Islander (n=438; excludes missing n=115, 21%)	Aboriginal and/or Torres Strait Islander	111	25.3
	Not Aboriginal or Torres Strait Islander	327	74.7
Country of birth (n=491; excludes missing n=61, 11%)	Australia	461	93.7
	Other	31	6.3
Region of residence* (n=552; excludes missing n=1, 0.3%)	Major cities	236	42.8
	Inner regional areas	102	18.5
	Outer regional areas	164	29.7
	Remote or very remote	50	9.1
Labour force status* (n=473; excludes missing n=80, 11.5%)	Full time	116	24.5
	Part time	183	38.7
	N/A – not in the labour force	174	36.8
Source of income* (n=415; excludes missing n=138, 25%)	Other pension or benefit (not superannuation)	152	36.6
	Paid employment	101	24.3
	Disability Support Pension	76	18.3
	Nil income	63	15.2
	Other	23	5.5
Homelessness status* (n=523; excludes missing n=30, 5.4%)	Not homeless	486	92.9
	Sleeping rough or in non-conventional accommodation	13	2.5
	Short-term or emergency accommodation	24	4.6
Veteran status* (n=358; excludes missing n=195, 35.5%)	Yes	>5	0.8
	No	355	99.2

*May change over the course of an episode. Here status at the first episode is reported. If birth date was recorded as the same day as the referral, this was recoded as missing.

22.4.2 Clinical characteristics

For each episode, the any history of suicidality and the principal diagnosis, including any additional diagnosis, are captured in the PMHC minimum dataset. As shown in Table 22.2, as would be expected, most service users had a prior history of either suicide attempt (53%) or suicidal ideation (37%). Twenty-nine per cent of service users presented with subsyndromal symptoms, that is symptoms that did not reach the diagnostic threshold for a psychiatric disorder. Among those with a diagnosed psychiatric disorder, mood and anxiety disorders were the most common principal diagnosis and were present in similar proportions of service users (19.4% and 18.3% respectively). Among those with a diagnosed psychiatric disorder, 43% had a comorbid condition, most commonly anxiety disorder (14.5%). There was a low prevalence of substance use disorders as primary or secondary diagnoses among service users (4.3% and 5.4% respectively).

Table 22.2 PMHC MDS and additional NSPT module: Service user clinical characteristics (n=553)

Characteristic	Value	Frequency	%
Lifetime history of suicidality*† (n=492; excludes missing n=61, 11%)	Suicide attempt	260	52.8
	Suicide ideation, no attempt	180	36.6
	Neither suicide attempt nor ideation	52	10.6
Principal diagnosis* (n=444; excludes missing n=109, 19.7%)	Mood disorders**	107	24.1
	Anxiety disorders	101	22.7
	Substance use disorders	24	5.4
	Other	83	18.7
	Subsyndromal symptoms	129	29.1
Additional diagnosis* (n=425; excludes missing n=128, 23.3%)	No additional diagnosis	88	20.7
	Anxiety disorders	80	18.8
	Mood disorders**	39	9.2
	Substance use disorders	30	7.1
	Psychotic disorders	7	1.6
	Developmental disorders	7	1.6
	Other	72	16.9
	Subsyndromal symptoms	102	24.0

*May change over the course of an episode; here status at the first episode is reported. ** Mood disorders include major depression, bipolar disorder. † Includes the episode for which the client was referred to the service.

22.5 Treatment focus

The PMHC MDS records the main focus of treatment for all episodes, as well as the focus of the treatment plans developed for clients for each episode. This information is entered for the treatment episode rather than the client, because a single client may have more than one episode of treatment. As would be expected, for almost three quarters of episodes the main treatment focus was suicide mitigation (76%). The principal focus of the treatment plans was mainly psychological therapy (33%), low intensity psychological intervention (18%) or psychosocial support (11%). For 57% of episodes of care, the service user also had a GP mental health treatment plan. Full details of the main treatment focus and the principal focus of treatment plans is shown in Table 22.3.

Table 22.3 PMHC MDS and additional NSPT module: Treatment focus and treatment plans of services delivered (per episode, n=603).

Variable	Value	Frequency	%
Main treatment focus (n=589; excludes missing n=14, 2.3%)	Suicide mitigation	446	75.7

Variable	Value	Frequency	%
	Postvention	46	7.8
	Psychological therapy	39	6.6
	Culturally specific assistance	33	5.6
	Case management	9	1.5
	Other support[1]	16	2.7
Principal focus of treatment plan (n=553, no missing values)	Psychological therapy	199	33.0
	Low-intensity psychological intervention	107	17.7
	Psychosocial support	63	10.5
	Clinical care coordination	38	6.3
	Indigenous-specific mental health services	15	2.5
	Complex care package	12	2.0
	Child and youth-specific mental health services	<5	0.3
	Unspecified	167	27.7
Has GP mental health plan (n=436; excludes missing n=167, 27%)	Yes	247	56.7
	No	189	43.3

[1] Other services included psychosocial support, crisis support, case management, counselling support and referral support

22.6 Referrals and service use

22.6.1 Referrals into aftercare services

Referral information provides an indication of the types of linkages formed by aftercare services and the main service contact points for current service users. For each episode, the referral organisation and referrer profession are captured in the PMHC MDS. Most documented referrals came from private practice (19%), public hospitals (18%) or were self-referrals (18%). The most common referrer professions were psychologists (24%), GPs (20.2%) or clients themselves (18%). Table 22.4 shows the full list of organisations and the professions of those who referred people into the aftercare services.

Table 22.4 PMHC MDS and additional NSPT module: Referral organisation and referrer profession (per episode, N=603)

Variable	Value	Freq.	%
Referral organisation (n=355; excludes missing n=248, 31%)	Private practice	68	19.2
	Self-referral	63	17.7
	Public hospital	61	17.2
	General practice	47	13.2
	Community support organisation (not-for-profit)	44	12.4
	Indigenous health organisation	20	5.6
	Public mental health service	18	5.1
	Telephone helpline	5	1.4
	Private hospital	5	1.4
	School	4	1.1
	Community health centre	3	0.8
	Medical specialist consulting rooms	2	0.6
	ED	1	0.3
	Nursing service	1	0.3
	Tertiary education institution	1	0.3
	Other	12	3.4
Referrer profession (n=347; excludes missing n=256, 42.5%)	Psychologist	83	23.9
	General practitioner	70	20.2

Variable	Value	Freq.	%
	Self-referral	63	18.2
	Mental health nurse	36	10.4
	Other medical specialist	29	8.4
	Social worker	16	4.6
	Aboriginal health worker	9	2.6
	Psychiatrist	8	2.3
	Maternal health nurse	5	1.4
	Educational professional	4	1.2
	Obstetrician	1	0.3
	Other	23	6.6

22.6.2 Referrals made to other services

Table 22.5 details the referrals to other services made during the episode of care. The most frequent services referred to were public hospital services (23%), general practice (17%) and community support organisations (16%). Notably, 18% of episodes did not involve any additional referrals.

Table 22.5 PMHC MDS and additional NSPT module: Referrals made to other services throughout the episode of care (n=537)

Variable	Value	Freq.	%
Referral made[1] (n=537; excludes missing n=66, 11%)	Public hospital	140	26.1
	General practice	105	19.6
	Community support organisation NFP	97	18.1
	Telephone helpline	85	15.8
	Public mental health service	43	8.0
	Psychological therapies	43	8.0
	Centrelink	28	5.2
	Private practice	24	4.5
	Drug and alcohol service	23	4.3
	ED	16	3.0
	Indigenous health organisation	13	2.4
	Family support service	13	2.4
	Housing service	11	2.0
	Digital health service	9	1.7
	School	8	1.5
	Community health centre	7	1.3
	Private hospital	6	1.1
	Other	44	8.2
	None	113	21.0

[1] Multiple responses permitted. For one episode all the service options were selected; this was recoded as missing.

22.6.3 Services used in the past six months

The PMHC minimum dataset records services that clients used in the six months prior to the current episode. Full details are provided in Table 22.6. General practice (58%) was the main other service used, followed by public hospital services (22%) and public mental health services (18%). Notably, less than 5% had not been in contact with some kind of service in the six months prior to attending the aftercare service.

Table 22.6 PMHC MDS and additional NSPT module: Other services previously used (per episode, n=583)

Variable	Value	Freq.	%
Other services used in the past 6 months[1] (n=563; excludes missing n=20, 3.3%)	General practice	347	59.5
	Public hospital	132	22.6

Variable	Value	Freq.	%
	Public mental health service	108	18.5
	Medical specialist consulting rooms	85	14.6
	Community support organisation NFP	82	14.1
	Psychological therapies	61	10.5
	ED	49	8.4
	Centrelink	44	7.5
	Community health centre	41	7.0
	Private hospital	35	6.0
	Drug and alcohol service	27	4.6
	Indigenous health organisation	22	3.8
	Private practice	21	3.6
	Telephone helpline	20	3.4
	Veteran/defence support services	18	3.1
	School	16	2.7
	Child and maternal health	15	2.6
	Family support service	14	2.4
	Housing service	10	1.7
	Other	42	7.2
	None	25	4.3

[1] Multiple response permitted. For one episode all the service options were selected, this was recoded as missing.

22.7 Impacts

The PMHC MDS collects the K10 and the additional module developed for the evaluation of the SIDAS. For each episode of care, outcome measures may be recorded on three occasions: at the start of an episode, mid-episode (review) and at the end of an episode. An outcome measure may be undertaken at “review” for several reasons, including in response to critical clinical events or changes in the client’s mental health status, following a client-requested review, or other situations in which a review is indicated. Episode start data were available for 47.6% of clients for the SIDAS and 51.1% for the K10, and episode end data were available for 13.4% of clients for the SIDAS and 11.7% for the K10. There are various reasons why outcome measures may not have been available, including: the provider organisation did not consistently collect outcomes measures, the client declined to fill in the questionnaire, or the episode of care was closed before treatment completion for example, if the e client could not be contacted or declined further contact. Table 22.7 shows the mean outcome scores (standard errors) per collection occasion for the SIDAS and the K10.

A paired t-test was performed on the episode start and end outcome scores to determine whether there was a statistically significant difference between the episode start mean score and the episode end mean score. There were 73 matched pairs for the SIDAS and 69 matched pairs for the K10, meaning there was both an episode start and end score for each episode. Service users showed significant improvements in suicidal ideation and psychological distress, with SIDAS scores decreasing significantly between episode start (mean=30.9, SD=11.3) and end (mean=16.8, SD=11.5), t(72)=9.3, p<0.001, and K10 scores also showing a significant decrease between episode start (mean =35.0, SE=1.0) and end scores (mean=27.7, SE=1.1), t(67)=6.7, p<0.001.

Table 22.7 PMHC MDS and additional NSPT module: Change in mean outcome scores (per episode of care)

Variable	Value	Number	Total Score Mean (SD)
SIDAS total score[1]	Episode start	287	28.6 (11.0)
	Review	90	25.0 (10.0)
	Episode end	81	16.5 (11.1)

Variable	Value	Number	Total Score Mean (SD)
K10-plus total score[2]	Episode start	308	34.7 (8.0)
	Review	150	31.8 (8.4)
	Episode end	71	28.6 (11.0)

[1] Five scores were recoded as ‘review’ because they were incorrectly labelled as start or end measure. [2] Twelve scores were recoded as ‘review’ because they were incorrectly labelled as start or end measure, and one case was deleted because it was a duplicate case.

23 Community-based activities

23.1 Approach

A community-based activity dataset was created to capture information on all activities and programs funded by the Trial that were not individual client services (i.e., excluding follow-up aftercare services). The community-based activity data was collected using a data collection template that captured basic descriptive information about the activity. The data template recorded the following information about each activity:

- *Activity name*, brief description, start and end dates, location
- *Activity area* (workforce-related activities, media and communication strategies or community education and support services)
- *Activity type* (awareness raising and engagement, implementation of guidelines, standards and other quality improvements, capacity building, professional development and training, information, services or other activities for at-risk individuals and/or other)
- *Target population for activity* (whole-of-population or Trial-specific focus population)
- *Trial-specific focus population* (Aboriginal and Torres Strait Islander peoples, men, young people, LGBTI people, ex-ADF members and their families, adults aged 65 years and older, people with lived experience of suicide and/or other)
- *Target workforce for activity* (community health organisations and related services, Aboriginal and Torres Strait Islander service providers and other organisations, emergency or crisis response services, PHN-commissioned services, school or other educational institution personnel, police and law enforcement agencies, media, volunteer or community groups and/or other)
- Number of participants or attendees at each activity or an estimated reach for media activities.

The data items were based on those used to capture information in the National Suicide Prevention Project(24). Full specifications for the data items are provided in Appendix 24. The dataset was managed by Strategic Data, and PHN staff or staff from commissioned organisations providing activities uploaded activity data periodically. One Site did not provide any data; the evaluation team entered information obtained from documents provided for the document review.

The evaluation was not designed to assess the efficacy of interventions and activities, and thus it was outside the scope of the evaluation to systematically collect impact and outcome data from community-based activities. It was also outside the scope of the evaluation to capture demographic information on activity participants. There was variation across Sites in terms of the extent to which information on participant demographics and activity outcomes was collected, and also in how much of that information, when collected, was made available to the national evaluation.

23.2 Sample information

This report includes data pertaining to 12 Trial Sites, including Sites with Aboriginal and Torres Strait Islander focus populations. It includes all activities conducted since the inception of the Trial in each Site until August 2020, when the data were provided to the evaluation team. Figure 23.1 below displays the total number of activities at each stage of reporting and analysis. A considerable number of activities were excluded from the analysis because they:

- Were out of scope (i.e., core activities that were fundamental to the running of the organisation and/or the project rather than the delivery of a community-based activity, e.g., reported stakeholder meetings and consultations)
- Were duplicate entries for a single activity (i.e., repeated entries of a regular event, e.g., a “safe café weekly support night”, weekly sessions of a men’s group, regular support meetings with scholarship recipients) or separate entries for each day of a multiday training course
- Pertained to general promotion of the Trial rather than delivery of an activity
- Were not implemented due to COVID-19 restrictions.

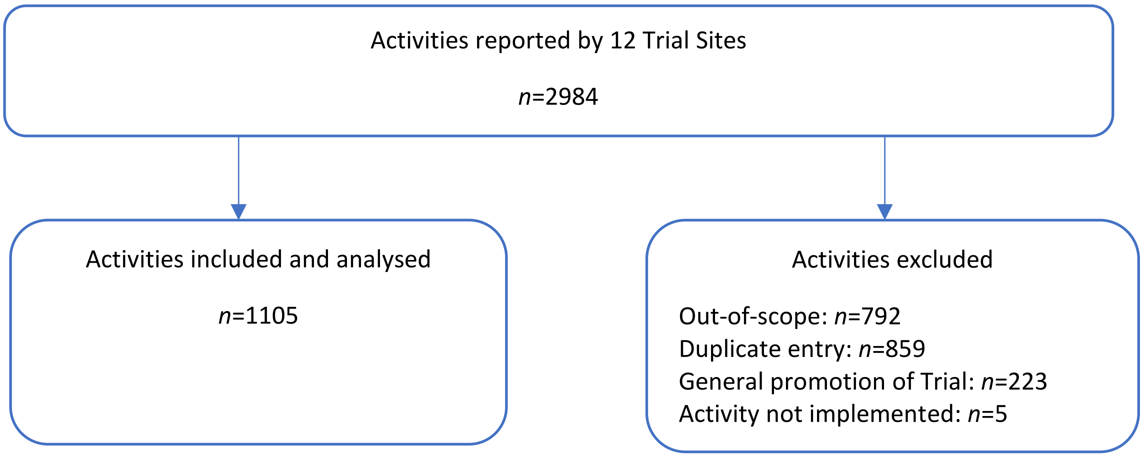


Figure 23.1 Community-based activities: Flow diagram of number of activities at reporting and analysis stages

23.3 Data analysis

Primary Health Network staff from 11 Trial Sites uploaded community-based activity data. Data from one Trial Site were extracted from documents supplied to the evaluation team by the PHN. Data were cleaned using Microsoft Excel to remove duplicate records and out-of-scope activities, to validate coding of activities and resolve any other data entry errors.

Stata 16.0 was used for the main data analysis. Summary statistics for all activities combined and each variable were computed, including number, percentage of total activities, and number of participants. For activities where multiple sessions were aggregated into a single activity record, the participant numbers for each session were summed. For media and communications activities, the number of participants reflects the number of hits or views on social media, or the audience reach for traditional media. For some analyses, media reach participant numbers are excluded because they are estimates based on population catchments and in some cases over-represent participation (indicated in the notes descriptor below each table). Multiple responses could be entered for some data items, such as target population, where programs for LGBTI young people might be coded as for both LGBTI and young people (noted in the tables if so). Aboriginal and Torres Strait Islander cultural strengthening activities are only for the Aboriginal and Torres Strait Islander focus population, not for other target populations where they have been double-coded (i.e., youth). Given the national focus of the evaluation, the findings are presented across all Trial Sites rather than for specific Sites with the range included to give an indication of the diversity of activities across Sites.

23.4 Activity description – all activities

Table 23.1 presents a summary of the community-based activity data provided by PHNs from all Trial Sites for the general area of activity and type of activity, including participant numbers.

A total of 33,072 people participated in at least one of the 1105 activities implemented as part of the Trial across all 12 Trial Sites. The number of activities entered into the dataset varied considerably across Sites, ranging from 11 to 182. Reasons for that variation include the overall activity levels at Trial Sites, the mix of strategies implemented at Sites (with some opting for fewer community-based activities), the extended planning processes delaying the start-up of activities well into 2019, and further delays in implementation at late-starting Sites due to COVID-19. Compliance with uploading data is also a potential reason, because some PHNs relied on local organisations commissioned to run the Trial to provide the data.

Table 23.1 Community-based activities database: Activity description and participant numbers

Activity information	Number	%	# of Participants*
Total number of activities	1105	100	33,072
Activity area			
Community education & support services	627	56.7	24,686
Workforce-related activities	434	39.3	8150
Media and communication strategies	44	4.0	236
Activity type			
Awareness raising and engagement	351	31.8	16,285
Capacity building	440	39.8	8339
Professional development and training	75	6.8	1884
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	69	6.2	1692
Aboriginal cultural activities	86	7.8	2607
Implementation of guidelines, standards and other quality improvements	31	2.8	694
Other**	53	4.8	1571

*Participant numbers were missing for two activities, and 62 media campaigns and large-scale promotional activities (e.g., posters, calendars, RU OK day and merchandise distributions) were excluded. **Other activity type included staff attending conferences, conducting research and responding to suicide hotspots.

23.4.1 Activity area – all activities

The activity area describes the primary area in which an activity has been undertaken including workforce related activities, media and communication strategies or community education and support services.

Fifty-seven per cent of all activities entered into the database were identified as community education and support services (see Table 23.1). Community education and support services were defined as activities tailored for or targeted to a group of people living in the same place or having a particular characteristic in common. This activity area included a wide range of activities and programs, such has awareness raising and engagement, implementation of guidelines, standards and other quality improvements, capacity building, professional development and training, information, and services or other activities for at-risk individuals. In total, 627 community education and support service activities were recorded across all Sites (range 9–114 activities across Sites), reaching 24,686 participants.

Workforce-related activities accounted for 39% of all activities across Sites (434 activities, range 1–117), reaching 8,150 participants (see Table 23.1). Workforce-related activities were defined as activities that were provided to an organisation, in a workplace setting and/or to a group of service providers to enhance their capacity to prevent and/or respond to suicide. Workforce-related activities included generic and specialised suicide prevention training to medical professionals and first responders, as well as awareness and general suicide prevention training delivered in workplaces. Table 23.2 shows activities and participant numbers by workforce, professional group or sector that the activity targeted or with which participants were affiliated. Note that more than one workforce could be identified for a single activity. Most community-based activities were targeted at community health organisations and related services (46%), volunteer or community groups (33%) and Aboriginal and Torres Strait Islander service providers and other organisations (24%). The large number of activities targeted at the workforce group coded as "other" (32%) were largely trainings delivered to specific workplaces, including local council staff, civil and construction industry workers, shift workers, hairdressers, pharmacists and aged-care facility workers.

Table 23.2 Community-based activities database: Workforces

Workforce	Number	%	# of Participants*
Community health organisations and related services	236	46.1	6230
Aboriginal and Torres Strait Islander service providers and other organisations	125	24.4	3548
Emergency or crisis response services	74	14.5	2548
PHN-commissioned services	102	19.9	2662
School or other educational institution personnel	85	16.6	2674
Police and law enforcement agencies	56	10.9	2151
Media	41	8.0	1762
Volunteer or community group providing services or support (including peer workers)	167	32.6	4845
Other	164	32.0	3261

Note: total n = 512; excludes activities not targeted at a workforce.

Forty-four activities (4% of total activity) were identified as media and communication strategies (range 0–10 activities across Sites) and involved 236 people (see Table 23.1). Media and communication strategies were defined as activities in which the primary focus was the production of content for dissemination via a form of media, and/or materials or activities that influenced how the media reports and deals with suicide-related matters. Activities in the area of media and communication strategies included radio and newspaper interviews and media and promotional campaigns. Sixty-four media campaigns and large-scale promotional activities (e.g., posters, calendars, RU OK day and merchandise distributions) reached an estimated 33,072 people across all 12 Trial Sites. As noted earlier, specific participant numbers from these activities are not reported in the main findings and tables.

23.4.2 Activity type – all activities

The activity type describes the activity in terms of its main aims including awareness raising and engagement, implementation of guidelines, standards and other quality improvements, capacity building, professional development and training, information, services or other activities for at-risk individuals and/or other.

Capacity building was the main type of community-based activity across all Trial Sites (see Table 23.1). Four hundred and forty capacity-building initiatives were reported to have been delivered across Trial Sites (range 4–110 activities), which reached 8,339 participants and accounted for over one third of total activities (40%). Four Trial Sites recorded implementing 50 or more capacity-building activities, with one Trial Site recording 110 capacity-building activities. Examples of capacity building activities include:

- Evidence-based suicide prevention training programs to community members including QPR, ASIST, SafeTALK, CORES, Mental Health First Aid (general population as well as Aboriginal and Torres Strait Islander specific), YAM
- Other suicide prevention training programs to community members for which the evidence base is yet to be established (e.g., Talking about Suicide, Wesley Lifeforce Training)
- Train the trainer courses for suicide prevention trainings described above
- Deadly Thinking suicide prevention workshop: an Aboriginal and Torres Strait Islander SEWB and suicide prevention workshop designed and delivered by, and for, Aboriginal and Torres Strait Islander peoples
- Scholarship programs for Certificate IV-level qualifications to build the capacity of the local workforce.

Awareness raising and engagement was the second most frequently reported type of community-based activity across Sites, accounting for 32% of total activities. Some 351 awareness-raising activities were implemented across Sites (range 2–63 activities), which reached 16,285 people (excluding audience reach estimates for media campaigns, etc.), the largest number of participants of all activity foci. Four Trial Sites recorded implementing 50 or more activities focused on awareness raising and engagement during the Trial. These activities included a wide range of innovative, localised approaches to raise awareness and engage communities in suicide prevention, such as:

- Community events (e.g., community walks to raise awareness, concerts, gatherings)
- Information workshops with guest speakers
- Large-scale media campaigns (e.g., billboard and radio campaigns)
- Media and promotional activities (e.g., fridge magnets and coasters with suicide prevention messaging).

Community-based activities focused on *Aboriginal and Torres Strait Islander cultural programs and activities* were the third most reported type of activity implemented across Sites, reflecting the strong community engagement approach of the seven Trial Sites working with Aboriginal and Torres Strait Islander peoples. Eighty-six Aboriginal cultural programs and/or activities were implemented (range 0–45 activities), involving 2607 participants and including on country camps, traditional healing, traditional art, connection to community and identity activities and activities to strengthen SEWB. While most of these activities were reported by two Sites focusing on Aboriginal and Torres Strait Islander peoples, eight Trial Sites documented undertaking Aboriginal and Torres Strait Islander cultural activities.

Sixty-nine *information, services or other activities for at-risk individuals or groups of people at higher risk of suicide* were implemented as part of the Trial (range 1–17 activities across Sites). These activities reached 1,692 people and included postvention support, a warm line, drop-in centres, social connection activities for individuals in high-risk groups and lived experience support groups.

The reported 75 Trial activities focused on *professional development and training* involved close to 1,884 people across all 12 Sites. Three Sites did not report any activities focused on professional development (range 0–21 activities). Examples of professional development activities included GP Training (i.e., Advance Training in Suicide Prevention, affirmative practice) and training delivered to specific mental health and allied health professional groups.

Thirty-one activities to bolster the *implementation of guidelines, standards and other quality improvements* (range 0–7 activities) involved 694 participants across all Trial Sites. These activities included the implementation of guidelines including a cultural safety framework, Mindframe training and the establishment of referral pathways.

Finally, PHNs reported 53 other activities, including PHN staff attending conferences, conducting research and responding to suicide hotspots (range 0–13 activities).

Figure 23.2 below displays the types of activity for each of the 12 Trial Sites. Given the national focus of this evaluation, individual Trial Sites are de-identified. As described in the text above, this Figure clearly displays the strong focus on capacity building and awareness raising across all 12 Sites.

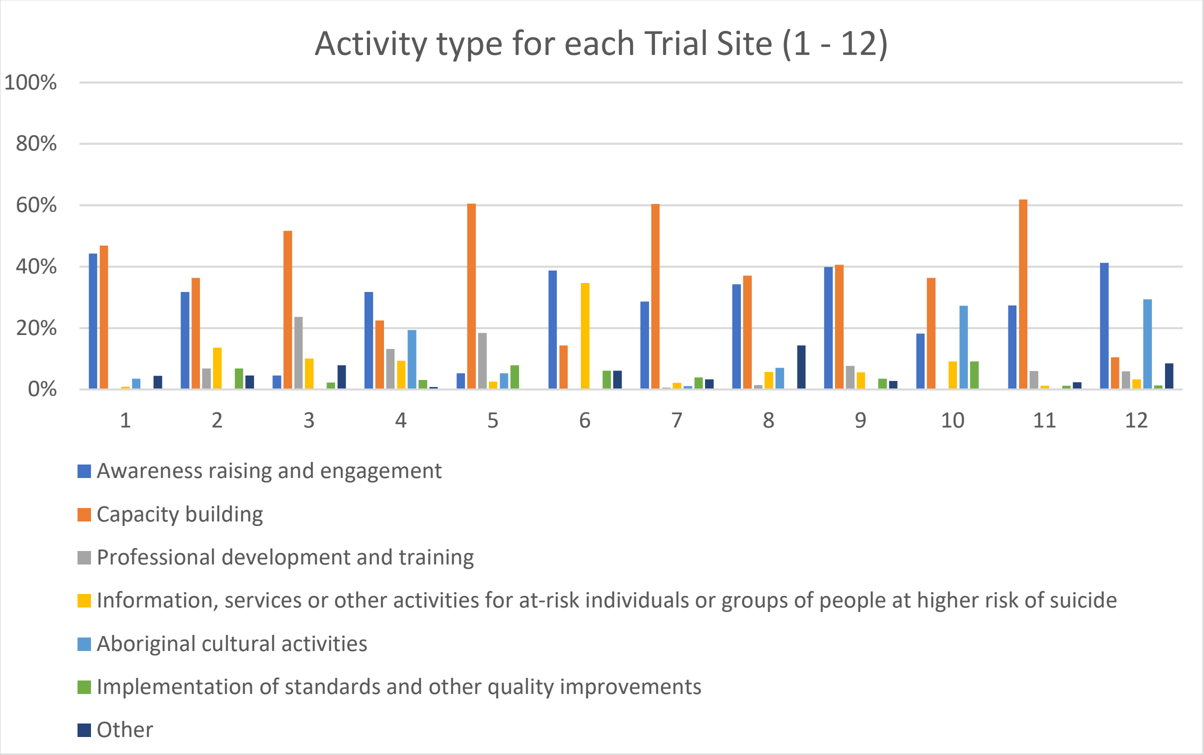


Figure 23.2 Community-based activities database: Type of activity by Trial Site

23.4.3 Focus populations – activity types and areas

Table 23.3 shows details of the target populations for activities across all 12 Trial Sites. Target population was defined as a group of people, population or audience for which the activity was tailored or to which it was targeted. Two-thirds of the activities included in the community-based activities dataset (65%) were aimed at Trial focus populations. A third of activities were targeted at the general population (35%), either at the national level or the general population of a specific community, town or geographical region.

Table 23.3 Community-based activities database: Target population for activity

Population	Number	%	Participants
General population	386	34.9	10,214
Trial focus population	719	65.1	22,858

23.4.4 General population – all activities

Table 23.4 describes the activities and participant numbers for community-based activities aimed at the general population (i.e., Trial activities not targeted to a specific focus population).

Table 23.5 displays general population activities and participant numbers by workforce, professional group or sector. Multiple workforce types could be selected per activity. Almost half of the activities targeted community health organisations and related services, and 41% volunteer or community groups.

Table 23.4 Community-based activities database: General population activity numbers

Activity	n	% activities	Participants
Total number of activities	*386*	*100*	*10214**
Activity area			
Workforce-related activities	193	50.0	3358
Media and communication strategies	26	6.7	104
Community education & support services	167	43.3	6752
Activity type			
Awareness raising and engagement	117	30.2	5074
Capacity building	182	47.2	3647
Professional development and training	38	9.8	618
Implementation of guidelines, standards and other quality improvements	23	6.0	552
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	8	2.1	72
Other	18	4.7	251

* Participant numbers are missing for 22 activities.

Table 23.5 Community-based activities database: Activities targeted at the general population – workforces

Target workforce	% activities	Participants
Community health organisations and related services	49.4	2967
Aboriginal and Torres Strait Islander service providers and other organisations	23.6	2174
Emergency or crisis response services	21.1	1831
Primary Health Network commissioned services	24.9	1892
School or other educational institution personnel	26.2	2001
Police and law enforcement agencies	16.0	1610
Media	14.4	1389
Volunteer or community group providing services or support (including peer workers)	40.5	3117
Other	35.0	1284

* Participant numbers are missing for 3 activities.

23.4.5 Trial focus populations – all activities

Table 23.6 shows the eight Trial-specific focus populations that were targeted by community activities. Activities could be aimed at more than one focus population.

Forty-four per cent of recorded community-based activities were targeted at Aboriginal and Torres Strait Islander peoples. Community-based activities targeted at men (25%), young people (17%), and LGBTI people (21%) were the next most frequently reported activities. This distribution reflects the greater number of Sites who elected to focus on suicide prevention for Aboriginal and Torres Strait Islander people (7 Sites) and men (6 Sites). While only two Sites nominated young people as a specific focus, many other Sites also included activities aimed at young people within other focus population groups (e.g., LGBTI youth). Numbers of reported activities for ex-ADF members and their families and older adults are small because only one Trial Site focused on each of these populations.

Table 23.6 Community-based activities database: Trial-specific focus populations activity numbers

Trial-specific focus population*	Number	% of total activities	Participants*
Total number of activities	*719*	*100*	*22858*
Aboriginal and Torres Strait Islander peoples	317	44.1	10,151
Men	181	25.2	*4538*
Young people	123	17.1	*5795*
LGBTI people	152	21.1	*3632*
Ex-ADF members and their families	29	4.0	771
Older adults (aged 65 years and older)	12	1.7	759
People with lived experience of suicide#	35	4.9	806
Other	11	1.5	413

* More than one focus population per activity could be nominated; # people with lived experience of suicide includes carers, people who have experienced suicidal thoughts or attempts, and/or people bereaved by suicide.

23.5 Trial Focus populations – Aboriginal and Torres Strait Islander peoples

Most of the community-based activities recorded for focus populations across all 12 Sites were targeted at Aboriginal and Torres Strait Islander peoples (n=317, 44% of total activities). Table 23.7 displays the number of activities and participant numbers for community-based activities aimed at Aboriginal and Torres Strait Islander peoples. Most of these activities were in the area of community education and support services (76%). Most community-based activities targeted at Aboriginal and Torres Strait Islander peoples involved cultural activities (26%) and awareness raising (42%), reflecting the SEWB approach to suicide prevention for this focus population.

Table 23.7 Community-based activities database: Activities targeted at Aboriginal and Torres Strait Islander peoples

Activity	n	% activities	Participants
Total number of activities	*317*	*100*	*10151**
Activity area			
Workforce-related activities	65	20.7	896
Media and communication strategies	10	3.2	85
Community education & support services	239	76.1	8840
Activity type			
Awareness raising and engagement	132	42.0	5606
Capacity building	60	19.1	870
Professional development and training	8	2.6	69
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	12	3.8	519
Implementation of guidelines, standards and other quality improvements	3	1.0	22
Aboriginal cultural activities	85	26.1	2263
Other	17	5.4	472

* Participant numbers are missing for 23 activities.

Table 23.8 shows activities and participant numbers by workforce, professional group or sector that the activity targeted or with which participants were affiliated. The key workforce groups targeted in activities with this focus population were Aboriginal and Torres Strait Islander service providers (65%), community health organisations (60%) and volunteer groups (45%). A target workforce was not applicable to most of the activities for Aboriginal and Torres Strait Islander peoples (75%), reflecting the strong focus on community stakeholders.

Table 23.8 Community-based activities database: Activities targeted at Aboriginal and Torres Strait Islander Peoples – workforces

Target workforce	% activities	Participants
Community health organisations and related services	60.0	988

Target workforce	% activities	Participants
Aboriginal and Torres Strait Islander service providers and other organisations	65.0	871
Emergency or crisis response services	5.0	212
PHN-commissioned services	33.8	394
School or other educational institution personnel	5.0	55
Police and law enforcement agencies	7.5	233
Media	3.8	190
Volunteer or community group providing services or support (including peer workers)	45.0	744
Other	1.3	9

Note. Excludes activities not targeted at a workforce.

23.6 Trial Focus populations – men

Community-based activities aimed at men were the second most frequently reported activity type, accounting for 25% of all focus population activities (n=181). Table 23.9 shows the number of activities and participant numbers for community-based activities aimed at men. Male-specific community-based activities were primarily in the area of community education and support services (55%) and workforce-related activities (44%). Most activities directed at men were concerned with capacity building (65%) and a further third with awareness raising and engagement.

Table 23.9 Community-based activities database: Activities targeted at men

Activity	n	% activities	Participants
Total number of activities	*181*	100	*4538**
Activity area			
Workforce-related activities	79	43.7	1495
Media and communication strategies	3	1.7	43
Community education & support services	99	54.7	3000
Activity type			
Awareness raising and engagement	53	29.3	2063
Capacity building	117	64.6	2310
Professional development and training	5	2.8	71
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	3	1.7	58
Implementation of guidelines, standards and other quality improvements	1	0.6	13
Other	2	1.1	23

* Participant numbers are missing for 11 activities.

Of those activities with a target workforce, most were targeted at “other workforce” groups (see Table 23.10). These included local council staff, civil and construction industry workers, shift workers, main roads workers and lawyers, reflecting the strategy of delivering suicide prevention activities in male-dominated workplaces.

Table 23.10 Community-based activities database: Activities targeted at men – workforces

Target workforce	% activities	Participants
Community health organisations and related services	9.9	115
Aboriginal and Torres Strait Islander service providers and other organisations	7.7	103
Emergency or crisis response services	5.5	55
PHN-commissioned services	3.3	15
School or other educational institution personnel	6.6	123
Police and law enforcement agencies	3.3	26
Media	1.1	13

Target workforce	% activities	Participants
Volunteer or community group providing services or support (including peer workers)	8.8	134
Other	81.3	1477

Note: Excluded activities not targeted at a workforce; *for 2 activities participant # is missing.

23.7 Trial Focus populations – young people

Young people were the focus population with the third highest number of recorded community-based activities (17%, n=123). Table 23.11 details the number of activities and participant numbers for community-based activities aimed at young people. Most community-based activities for young people were in the area of community education and support services (83%), which is the highest proportion in this area across all focus populations. Over half of youth-specific Trial activities were focused on awareness raising and engagement.

Table 23.11 Community-based activities database: Activities targeted at young people

Activity	n	% activities	Participants
Total number of activities	123	100	*5795**
Activity area			
Workforce-related activities	20	16.3	468
Media and communication strategies	1	0.8	2
Community education & support services	102	82.9	5325
Activity type			
Awareness raising and engagement	67	54.5	3962
Capacity building	38	30.9	913
Professional development and training	0	0	0
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	11	8.9	16
Implementation of guidelines, standards and other quality improvements	1	0.8	2
Other	0	4.9	802

*for 2 activities participant # is missing.

The community focus of activities aimed at young people was shown by only 19% of reported youth-specific activities involving a target workforce. Table 23.12 shows activities and participant numbers by workforce, professional group or sector that the activity targeted or with which participants were affiliated. Workforce activities mostly targeted community health organisations and related services (45%) and/or school or other educational institution personnel (39%).

Table 23.12 Community-based activities database: Activities targeted at young people – workforces

Target workforce	% activities	Participants*
Community health organisations and related services	45.2	420
Aboriginal and Torres Strait Islander service providers and other organisations	29.0	284
Emergency or crisis response services	6.5	81
PHN-commissioned services	22.6	85
School or other educational institution personnel	38.7	334
Police and law enforcement agencies	9.7	52
Media	0	0
Volunteer or community group providing services or support (including peer workers)	35.5	234
Other	6.5	69

Note: Excludes activities not targeted at a workforce; * Participant numbers are missing for 1 activity.

23.8 Trial Focus populations – ex-ADF members and their families

Table 23.13 details the number of activities and participant numbers for community-based activities aimed at ex-ADF and their families. Twenty-nine of the recorded Trial activities focused on ex-ADF and/or their families (4% of total focus population activities), of which most (72%) were community education and support services. Over half of the community-based activities for ex-ADF and/or their families were information, services or other activities for at-risk individuals or groups of people at higher risk of suicide. One fifth of recorded activities for this population focused on awareness raising and engagement and 17% focused on capacity building.

Table 23.13 Community-based activities database: Activities targeted at ex-ADF and their families

Activity	n	% activities	Participants
Total number of activities	*29*	*100*	*771**
Activity area			
Workforce-related activities	6	20.7	189
Media and communication strategies	2	6.9	0
Community education & support services	21	72.4	582
Activity type			
Awareness raising and engagement	6	20.7	160
Capacity building	5	17.2	181
Professional development and training	0	0	0
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	16	55.2	402
Implementation of guidelines, standards and other quality improvements	1	3.5	8
Other	1	3.5	20

*for 1 large media campaign activity participant # is missing.

Fewer Trial activities were workforce focused, and of those volunteer or community groups were the primary targets.

23.9 Trial Focus populations – LGBTI people

Community-based activities targeted at LGBTI people comprised 21% of all activities for focus populations (n=152). Table 23.14 provides the number of activities and participant numbers for community-based activities aimed at LGBTI people. Almost half of the LGBTI community-based activities focused on workforce-related activities. LGBTI community-based activities placed a strong emphasis on capacity building (40%). Additional foci for activities aimed at LGBTI people were professional development and training (15%) and information, services and activities for at-risk individuals or groups (12%).

Table 23.14 Community-based activities database: Activities targeted at LGBTI people

Activity	n	% activities	Participants
Total number of activities	*152*	*100*	*3632**
Activity area			
Workforce related activities	81	53.3	1981
Media and communication strategies	4	2.6	4
Community education & support services	67	44.1	1647
Activity type			
Awareness raising and engagement	40	26.3	1068
Capacity building	61	40.1	887
Professional development and training	22	14.5	1063
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	18	11.8	498

Activity	n	% activities	Participants
Implementation of guidelines, standards and other quality improvements	3	2.0	99
Other	8	5.3	17

* Participant numbers are missing for 19 activities.

More than half of the activities were workforce targeted (48%). Table 23.15 shows activities and participant numbers by workforce, professional group or sector that the activity targeted or with which participants were affiliated. Community health organisations were the most targeted workforce for LGBTI-specific activities (70%), consistent with the strategy of building suicide prevention capacity in LGBTI specialist services.

Table 23.15 Community-based activities database: Activities targeted at LGBTI people – workforces

Target workforce	% activities	Participants
Community health organisations and related services	69.9	1634
Aboriginal and Torres Strait Islander service providers and other organisations	5.5	66
Emergency or crisis response services	12.3	158
PHN-commissioned services	6.9	67
School or other educational institution personnel	6.9	104
Police and law enforcement agencies	5.5	70
Media	0	0
Volunteer or community group providing services or support (including peer workers)	9.6	112
Other	2.7	66

23.10 Trial Focus populations – older adults

Trial activities reported for older adults made up a small subset of all community-based activities, largely because there was only one Trial Site focused on this population (12 activities, 2% of total focus population activities). Over 80% of older adult-specific community-based activities were in the area of community education and support services, of which 67% focused on awareness raising and engagement (see Table 23.16).

Table 23.16 Community-based activities database: Activities targeted at older adults

Activity	n	% activities	Participants
Total number of activities	*12*	*100*	*759**
Activity area			
Workforce-related activities	2	16.7	79
Media and communication strategies	0	0	0
Community education & support services	10	83.3	680
Activity type			
Awareness raising and engagement	8	66.7	641
Capacity building	2	16.7	92
Professional development and training	0	0	0
Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide	0	0	0
Implementation of guidelines, standards and other quality improvements	0	0	0
Other	2	16.7	26

* Participant numbers are missing for 1 activity.

24 Observation and participation

24.1 Summary of approach

As noted in Section 1, the Department of Health commissioned the Black Dog Institute to support the Trial. Part of that role was to run a series of workshops bringing together staff from the Trial Sites to build networks and enable transfer of knowledge about systems and evidence-based approaches to suicide prevention. Between February 2018 and July 2020, members of the evaluation team attended eight such events organised by the Black Dog Institute. During those workshops the evaluation team noted key points in relation to the evaluation questions. Notes were used to complete a report template, which also included information drawn from associated documentation such as agendas, minutes, papers and presentation slides. The reports were uploaded into NVivo, and the evaluators identified themes related to planning and implementation and adopting a systems approach.

24.2 Sample information

Eight events were attended between February 2018 and July 2020 (Table 24.1).

Table 24.1 Events attended for observation/participation data collection

Date	Event
February 2018	Trial Site Coordinators Workshop (Sydney)
May 2018	LGBTI Workshop (Sydney)
December 2018	Indigenous Resources Webinar (online)
May 2019	National Suicide Prevention Symposium (Canberra)
July 2019	Community Engagement & Engaging general practitioners Workshop (Adelaide)
December 2019	Trial Site Coordinators Workshop (Sydney)
April 2020	NSPT Trial Coordinators Workshop (Online)
July 2020	Workshop: Sustainability and Communicating Impact (Online)

Participants at events included:

- Trial Site coordinators
- Other PHN staff involved in the Trial
- Representatives from community organisations funded to manage the Trial locally
- Black Dog Institute representatives, including Indigenous advisors/collaborators
- Department of Health representatives
- University of Melbourne evaluation team members
- People with lived experience of suicide representatives
- Members from community organisations working in the suicide prevention area (e.g., Roses in the Ocean)
- Representatives from other suicide prevention Trials, including the LifeSpan Trial and the Victorian place-based Trials
- Evaluation team members from other Trials or NSPT local evaluations.

24.3 Planning

24.3.1 Planning – stakeholder involvement

The key theme of the presentations and discussions was the engagement of a broad spectrum of stakeholders in the planning process. Another was the importance of understanding community context, including regional factors or cultural and historical factors for particular focus populations.

Presentations identified a variety of forms of engagement, including the co-design of all aspects of the planning process (needs identification, identifying interventions, adapting interventions), using narrative and case study data to inform planning where statistical data were not available, conducting community surveys and forums, and forming working groups.

Presentations from Trial Sites described recruiting stakeholders to Trial working groups through a process of initially recruiting from established community groups and service providers, including those with links to the PHN from other work with community, and then snowballing from there to ensure wide representation. Linking with existing community-based suicide prevention groups or networks was also pursued.

24.3.2 Planning – facilitating factors

Presenters from Trial Sites described successful strategies they used in planning, including:

- Employing the right people, both at PHN and at local community organisations – identified as a critical success factor for mobilising local knowledge and getting buy-in
- Working with an engaged and activated community
- The importance of community-led design and co-design between the community and the PHN
- The involvement of people with lived experience of suicide
- Taking the time required to build relationships and trust and to design and/or select interventions
- Where there were gaps in data, drawing on narrative sources such as lived experience of suicide and case studies to provide insight.

24.3.3 Planning – challenges

A range of challenges were identified and discussed, including the:

- Length of time required to achieve community buy-in and engage all the relevant stakeholders
- Length of time required to undertake a genuine community consultation
- Time it takes to develop, design or select the appropriate interventions to roll out, particularly if a community-led decision-making approach is adopted
- Lack of existing collaboration across the sector and time it takes to develop collaborations and partnerships
- Lack of data on focus populations and smaller regional areas.

24.4 Systems approach

24.4.1 Developing a systems approach – strategies

In describing strategies used for developing a systems approach, the main focus was on adapting existing systems frameworks (LifeSpan and AAD) to accommodate local conditions in non-urban areas and the historical and cultural context of focus populations such as Aboriginal and Torres Strait Islander peoples and LGBTI people. Extensive stakeholder involvement and collaboration was the main method used to adapt systems frameworks.

A key facilitating factor for developing a more coordinated approach that was identified was having coordination staff, preferably in a separate role from commissioning, to manage relationships, help mediate co-design processes and manage grievances.

24.4.2 Implementing a systems approach – impacts

Improved collaborations and partnerships between services involved in the Trial – in planning and/or delivery of services – were noted as a significant impact of the Trial.

24.4.3 Developing and implementing a systems approach – challenges

Presenters and participants identified a range of challenges that had been encountered as they had worked to develop and implement a systems approach. One of the main challenges was garnering community buy-in. It was noted that adopting a systems approach involved a culture change, and that this took time and could bring up local conflicts. In addition, it was observed that community did not know about or understand systems approaches, and at times the activities they wish to implement don't fit within a systems approach. It was noted that where local community organisations had been commissioned to implement the Trial in their region, they lacked the capacity to link their local activities with the framework and strategy.

Challenges relating to understanding local conditions and working in the context of regional and community diversity were also raised, including the view that a "one size fits all" approach wouldn't work. The capacity of GPs to participate was noted as a challenge, as was the transience of the GP workforce in regional areas, which meant they often lacked community connection.

Challenges were identified relating to workforce capacity, both in terms of the availability of suitably qualified staff for regional services and demands on PHN staff implementing the Trial. The high level of stress involved in that role due to high levels of interaction with community, sometimes leading to burnout, was another problem mentioned.

Other challenges noted were the lack of an evidence base for LGBTI or Indigenous-focused interventions in existing systems-based frameworks, a lack of guidance or resources on implementation of a systems approach, and that current funding models don't support sustainability.

25 Epidemiological analysis – primary mental health care

25.1 Approach

This analysis sought to examine the effects of the implementation of the National Suicide Prevention Trial on utilisation of PHN-commissioned mental health services. Routinely collected clinical data on service utilisation was analysed to determine whether implementation of the NSPT resulted in an increase in use of services (i.e., the rate of new episodes of care and the rate of service contacts) in PHNs that implemented NSPT activities, relative to PHNs that did not. The impact of implementation of the NSPT on key at-risk populations, namely young people, men and Aboriginal and Torres Strait Islander people was also examined.

25.2 Method

The analysis used a controlled interrupted time series design with mirror-image pre- and post-implementation periods.

Primary Health Networks selected for participation in the NSPT were the intervention group, and PHNs with other, similar suicide prevention activity or no similar activity were the control groups.

The date of implementation of the NSPT or similar suicide prevention activity in a PHN was treated as an "interruption" in the time series and was used to distinguish between the pre- and post-implementation periods.

The design is "mirror-image" because the duration of the pre- and post-implementation periods was equivalent.

25.2.1 Primary data source

The primary data source for this analysis was the PMHC MDS(25) as well as its predecessor, the Access to Allied Psychological Services (ATAPS) MDS(26). The datasets were combined and hereafter are referred to as the PMHC MDS.

The PMHC MDS captures data on the consumers themselves (e.g., demographic and clinical characteristics), the services they receive (e.g., episode type, referred to as "principal focus of treatment plan", and service contact type), the organisational entities that deliver these services, and the PHN that commissioned the provider organisations.

The current analyses focused on the volume of new episodes of care commencing between 1 January 2010 and 30 September 2019 recorded in the PMHC MDS, and the volume of attended service contacts associated with those episodes. See Box 25. 1 for PMHC MDS key concepts relevant to the current analysis. Further details on the PMHC MDS and ATAPS minimum dataset, and the sampling frame, are available in Appendix 25 (Sections A25.1 and A25.2).

Box 25.1. PMHC MDS key concepts

Episode of care: a more or less continuous period of contact between a client and a PHN-commissioned provider organisation/clinician that starts at the point of first contact and concludes at discharge. Episodes comprise a series of one or more service contacts.

Discharge: discharge may occur clinically (at the end of treatment) or administratively, when contact has been lost with the client (e.g., client could not be contacted, declined further contact, moved out of area or was referred elsewhere). A new episode is deemed to commence if the person re-presents to the organisation.

Service contact: provision of a service by a PHN-commissioned mental health service provider for a client, where the nature of the service would normally warrant a dated entry in the clinical record of the client. Service contacts can be either with the client or with a third party (e.g., carer or family member) and/or other service provider, and do not include services of an administrative nature (e.g., telephone contact to schedule an appointment).

Attended service contact: an attended service contact is one that is not marked as “No show”.

Suicide referral flag: identifies those individuals where a recent history of suicide attempt, or suicide risk, was a factor noted in the referral that underpinned the person’s need for assistance at entry to the episode, as represented by a code.

Source: https://docs.pmhc-mds.com/en/v1/data-specification/data-model-and-specifications.html

25.2.2 Other data sources

PHN-level population estimates were sourced for the years of interest in this analysis (2013–19), including:

- The total estimated resident population (ERP)(27,28)
- The ERPs for selected target groups – youth, males and Aboriginal and Torres Strait Islander people[6](27,28)
- The age-standardised rate per 100 population aged 18 years and over with high or very high psychological distress, based on the K10(29-34) [7].

25.2.3 Defining the intervention groups

Several other suicide prevention initiatives occurred simultaneously with the NSPT. Appendix 25 (Table A25.1) summarises PHNs according to whether they implemented the NSPT or related activities, and the dates on which those activities commenced. Note that this date represents the date on which the activity was formally commenced, which is not necessarily when the activity reached full implementation. Using this information, PHNs were classified as NSPT PHNs and two control groups, one of which comprised PHNs that were involved in one of the other trials happening around the country (control (Other)), and the other PHNs that were not involved in any trial (control (None)). Areas with other trials, control (other), were included for control purposes only. Those trials are currently being independently evaluated and so while they were included in analyses no separate outcome statistics for that group are reported.

---

[6] Estimates for youth and males were available for all years of interest except 2013;[8-13] for 2013 counts from 2014 were applied. Because the ERP source data were published in 5-year age bands, a proportional (0.8) adjustment was made to the 15–24 age group to estimate the ERP for the 16–24 age group. ERP counts for Indigenous people were available for 2015 and 2016 only;[8,9] for other years we applied the count from the closest available year.

[7] These estimates were available for 2011–12, 2014–15 and 2017–18; for years of interest where they were not available, we applied the estimate from the closest available year.

As shown in Appendix 25 (Table A25.2), PHNs participating in the NSPT could elect to focus on specific target groups, noting that this focus was usually restricted to one or more subregions within the PHN catchment. Because the PMHC MDS captures information about the consumers' age, gender and Aboriginal and Torres Strait Islander status, a series of secondary intervention classifications were created to allow examination of effects due to having an enhanced focus on youth, males or Aboriginal and Torres Strait Islander people. NSPT sites were split according to whether they had a focus on these target populations. Thus, these secondary intervention classifications had four groups:

- Intervention group (Youth): NSPT with a focus on youth, NSPT without a focus on youth, control (Other), control (None)
- Intervention group (Males): NSPT with a focus on males, NSPT without a focus on males, control (Other), control (None)
- Intervention group (Aboriginal and Torres Strait Islander people): NSPT with a focus on Aboriginal and Torres Strait Islander people, NSPT without a focus on Aboriginal and Torres Strait Islander people, control (Other), control (None).

The PMHC MDS does not capture veteran status or LGBTI status, so it was not possible to create intervention classifications for these target groups.

25.2.4 Outcomes

Outcomes of interest were:

- New episodes per 100,000 population in each 28-day block. The count of new episodes in each 28-day block was derived directly from the sampling frame process (Appendix 25, Section A25.2)
- Service contacts per 100,000 population in each 28-day block. The count of service contacts was calculated as the sum of attended contacts associated with new episodes in each 28-day block in the sampling frame.

25.2.5 Statistical analysis

Negative binomial regression was used to model changes in episodes and contacts in the pre- and post-implementation periods. See Appendix 25 (Section A25.4) for details.

To explore the impact of the NSPT for target populations, subgroup analyses were conducted to model change in contacts separately for youth (aged 16–24 years), males, and Aboriginal and Torres Strait Islander people. For these models, the four-group intervention classification relevant to each target group (see section 25.2.3) was used. The log of the ERP for each target group in each PHN at the time of the episode was used as the offset term, with linear interpolation applied when the episode straddled two annual periods. There were insufficient numbers to conduct equivalent subgroup analyses for episodes.

For episodes, subgroup analysis of episodes for which a suicide referral flag was recorded was conducted. The model specification was the same as for the main episode model. Strengths and limitations of the analysis are provided in Appendix 25.

25.3 Results

25.3.1 Impact of implementation of the NSPT on the rate of new episodes of care

Figure 25.1 shows the average rate of new episodes per 100,000 population in each of the 66 28-day blocks in the observation period. In the NSPT sites, the average rate of new episodes per 100,000 population increased from 26.1 in the pre-implementation period to 29.6 in the post-implementation period. For the control (None) sites, the average rate of new episodes per 100,000 population increased from 17.7 to 23.3.

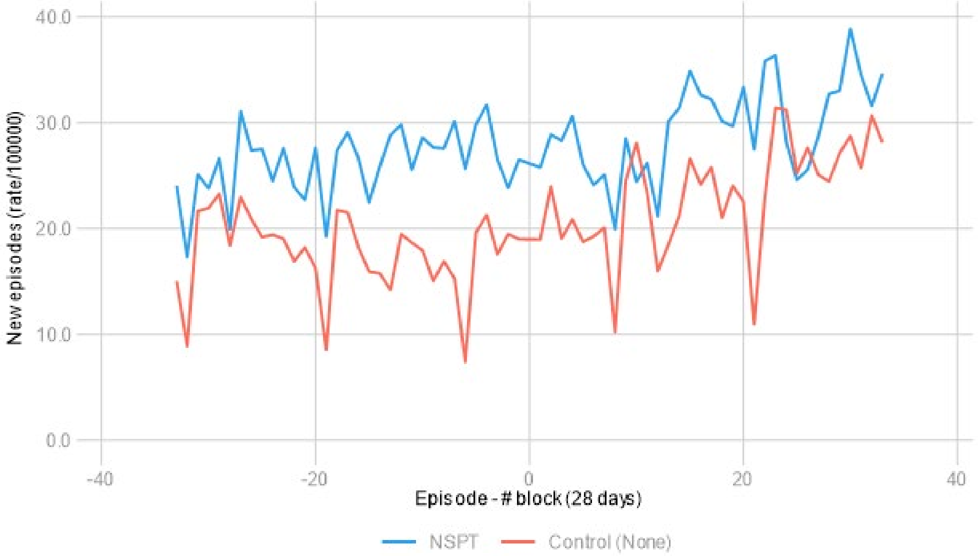


Figure 25.1 New episodes by time (28-day block) and intervention group

Appendix 25 (Section A25.5) provides detailed results of the negative binomial regression modelling of changes in the rate of episodes of care in the pre- and post-implementation periods.

25.3.2 Impact of implementation of the NSPT on the rate of service contacts

During the observation period, there were 2,293,083 attended contacts for PHN-commissioned mental health services through all 28 PHNs included in the analysis. Approximately 39% of contacts (n=900,151) were recorded in NSPT sites and 35% (n=801,656) in control (None) sites. In the NSPT sites, 40.2% of contacts were recorded in the period prior to implementation; this was similar for the control (None) (39.1%) sites.

As shown in Figure 25.2, in the NSPT sites, the average rate of contacts per 100,000 population increased from 141.9 per 100,000 in the pre-implementation period to 201.9 in the post-implementation period. For the control (None) sites, the average rate of contacts per 100,000 population increased from 102.8 to 152.7.

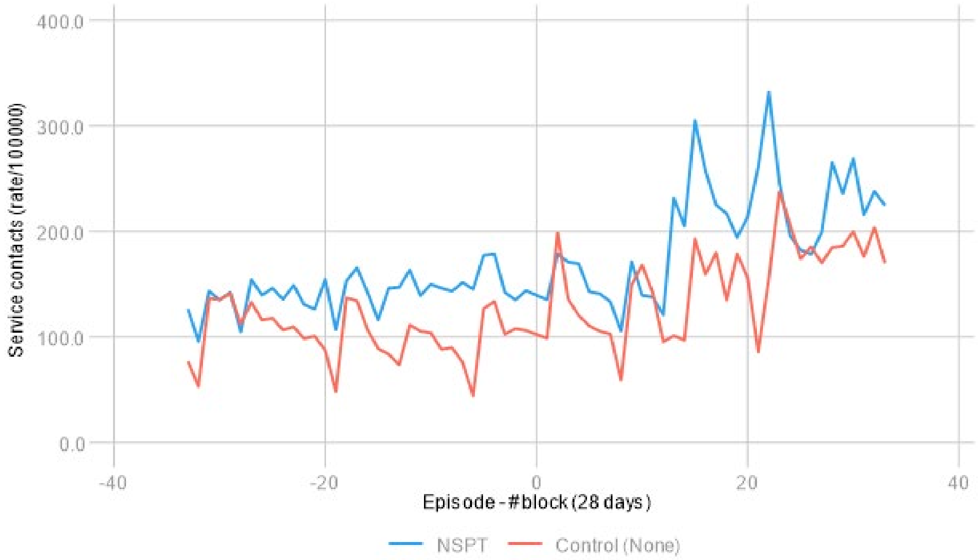


Figure 25.2 Service contacts by time (28-day block) and intervention group

Appendix 25 (Section A25.6) provides detailed results of the negative binomial regression model for all service contacts in the pre- and post-implementation periods. These were broadly similar to the findings for episodes.

25.4 Summary

In summary, there was no evidence that implementation of the NSPT resulted in an increase in either new episodes of care or service contacts in PHNs that implemented NSPT activities, relative to PHNs that did not. However, findings indicated that the NSPT sites had historically higher levels of service provision overall and that these levels were sustained, while sites with no suicide prevention activity tended to “catch up” over time.

Several patterns were observed in the analyses of episodes and contacts, as described below.

In both the main analyses and the subgroup analyses for youth, males and suicide referral episodes, the NSPT sites consistently had higher rates of episodes and contacts per population, regardless of time, than the control (None) sites. These higher rates were sustained over the entire observation period. This suggests that these are general background patterns of service provision in these PHNs. Possible explanations are that these PHNs have fewer alternative service options, or it may reflect operational characteristics such as resourcing levels.

There was no evidence that the NSPT sites experienced relatively greater increases in episodes or contacts overall for youth, males or suicide referral episodes. Rather, the findings indicated that the control (None) group tended to experience the greatest growth, relative to whichever intervention group had the highest rates. One interpretation is that these sites were able to “catch up”, while it was more difficult for sites that had already achieved higher levels of service provision to make significant further increases.

In contrast, only the NSPT sites with a specific focus on Aboriginal and Torres Strait Islander people had higher rates of episodes for Aboriginal and Torres Strait Islander people. Further, these sites showed significant growth in episodes and contacts for Aboriginal and Torres Strait Islander people over the entire observation period. Possible explanations for the higher rate of episodes may include those listed above, or that these PHNs had a focus on Aboriginal and Torres Strait Islander people even before the NSPT.

Regardless of intervention group, there were significant increases in episodes and contacts between the pre- and post-implementation periods for youth and Aboriginal and Torres Strait Islander people, and for contacts (but not episodes) for males. There was also a corresponding increase in episodes with a suicide referral flag. This suggests that, in the main, that there have been gains over time in PHN-commissioned mental health service provision to these important groups.

26 Epidemiological analysis – deaths and hospitalisations

26.1 Approach

National data on suicide deaths and hospital admissions for self-harm[8] were analysed to investigate potential impacts of the National Suicide Prevention Trial on suicide rates and rates of hospital admissions for self-harm. The key questions explored were:

1. Did the implementation of the Trial result in decreased suicide rates in Trial areas, compared to non-Trial areas?
2. Did the implementation of the Trial result in a decrease in hospital self-harm hospitalisation rates in Trial areas, compared to non-Trial areas?
3. Did the implementation of the NSPT result in different associations by key socio-demographic factors, specifically sex, age group, area socio-economic status, and urban–rural residence?

A secondary analysis explored if there were any delayed impacts of the Trial on suicide rates or rates of hospital admissions for self-harm, reflecting the potential lag between initial funding announcements and the implementation of suicide prevention activities.

26.2 Data

Suicide data (ICD-10 codes X60-X84) were obtained from the ABS for January 2010 to December 2018 (the latest available period) and hospital self-harm data (ICD-10 codes X60-X84) from the AIHW for January 2010 to June 2019 (the latest available period). Both datasets were stratified by sex, age group, and usual area of residence (SA2 or Statistical Local Area, resolved to SA2 2016 codes). Corresponding ERPs for the same period were obtained from the ABS. Socio-economic status was based on the Socio-Economic Indexes for Areas (SEIFA)(35), and each usual area of residence was categorised in area-based quintiles based on Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) scores. Similarly, urban–rural residence was defined by assigning each usual area of residence a score based on the ABS Statistical Geography Standard, categorising areas as Major City, Inner Regional, Outer Regional, Remote, or Very Remote(23). Finally, each usual area of residence was assigned to its corresponding PHN, based on ABS concordance files mapping SA2 codes to PHN codes.

Several other large suicide prevention initiatives occurred simultaneously with the NSPT. Appendix 25 (Table A25.2) summarises PHNs according to whether they implemented the NSPT or other related activity, and the dates on which those activities commenced. Note that this date represents the date on which the activity was formally commenced, which is not necessarily when the activity reached full implementation. PHNs were classified as NSPT PHNs and two control groups, one of which comprised PHNs that were involved in one of the other trials happening around the country (control (Other)), and the other PHNs that were not involved in any trial (control (None)). Areas with other trials, control (Other), were included for control purposes only. Those trials are currently being independently evaluated and so while they are included in analyses no separate outcome statistics are reported.

26.3 Data analysis

Monthly age-standardised rates (per 100,000) for both suicide and self-harm hospitalisations were investigated for the period January 2010 to November 2018 (for suicide) and for January 2010 to

---

[8] Hospital data do not distinguish between suicide attempts and non-suicidal self-harm, all of which are captured under the ICD-10 codes X60-X84 for intentional self-harm.

June 2019 (for self-harm hospitalisation), stratified by Trial Site status – NSPT, control (Other Trial), control (None) – and sex. The relative difference in suicide and self-harm hospitalisation rates between NSPT Sites and control (None) Sites was investigated using a difference-in-difference method in a series of negative binomial models, modelling counts of suicide or self-harm hospitalisation (offset by the logarithm of the population), adjusting for sex, age group, socio-economic status (SES), year and month. This approach compares the relative difference in rates of suicide and rates of self-harm hospitalisation in the period after the NSPT implementation to the period prior to implementation in NSPT Sites and control (None) Sites.

The incidence rate ratio (IRR) of the relative difference in the outcome between NSPT Sites and No-intervention Sites is presented, and was derived from each model's intercept term, the main effect of the intervention group (NSPT or control (None) group), the main effect of the period (pre- or post-implementation of the NSPT), and the interaction term between the intervention group and the period, using the *lincom* function in Stata Version 15.1.

Additional analyses also investigated whether the association between NSPT suicide prevention activities and suicide and self-harm hospitalisation rates differed by key socio-demographic factors, namely sex, age group (0–19 years, 20–34 years, 35–44 years, 45–54 years, 55–64 years, 65–74 years, 75+ years), area SES (population quintiles of IRSAD scores categorised as Low (20%), Middle (60%), and High (20%)), and urban–rural residence (Major City, Inner Regional, Outer Regional, Remote, or Very Remote).

Finally, analyses lagged the potential impact of NSPT suicide prevention activities, acknowledging that there was likely a scale-up period between onset and full implementation. These analyses lagged the start data of the NSPT by 12 months for suicide, and by 12 months and 24 months for self-harm hospitalisations. Lagged analyses were restricted to 12 months for suicide given the small number of cases, and the shorter time period of available data (the most recently available mortality data was for December 2018).

Strengths and limitations of the analysis are described in Appendix 26.

26.4 Results

26.4.1 Suicide deaths

Did the implementation of the Trial result in decreased suicide rates in Trial areas, compared to non-Trial areas?

There were no substantial differences in age-standardised suicide rates between NSPT Sites and control (None) Sites, for males or females, and the rate of suicide remained reasonably stable over time (Figure 26.1).

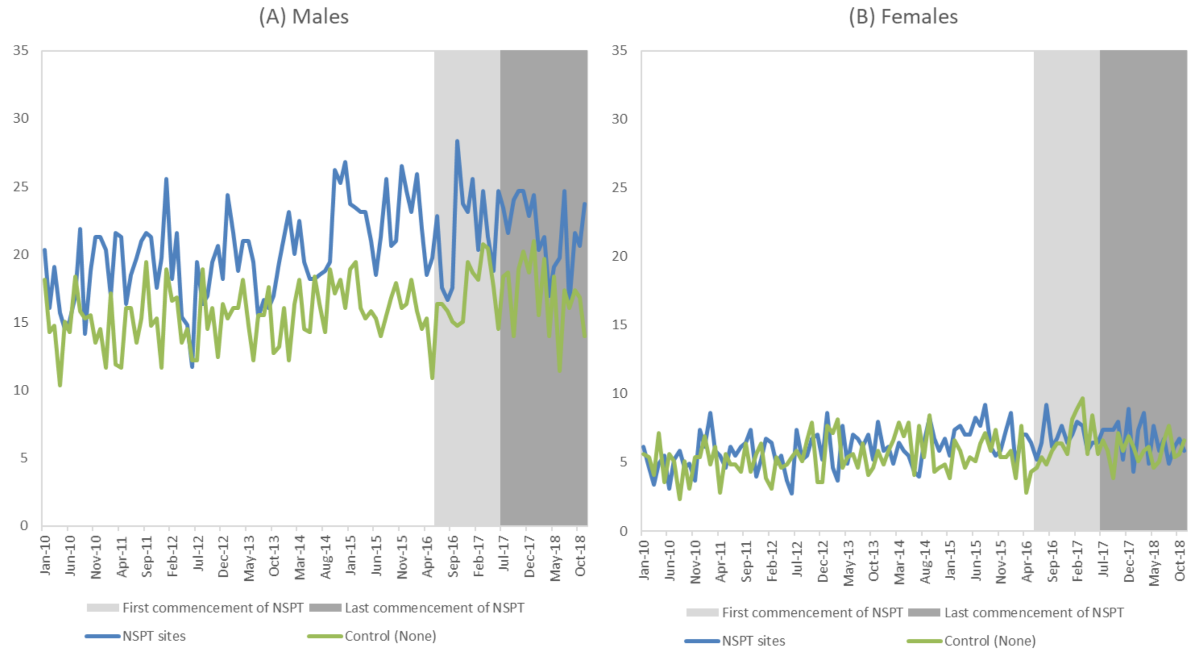


Figure 26.1 Age-standardised suicide rates per 100,000 by sex and Trial Site area NSPT Sites and control (None) Sites

Table 26.1 provides the age-standardised suicide rates for each group for males and females prior to the Trial period and during the Trial.

Table 26.1 Suicide rates pre-NSPT and during the Trial period for males and females by NSPT and control (None) group

Intervention group	Suicide rate per 100,000* (range) Pre-Trial (Jan 2010 – June 2016)	Trial period (July 2016 – Nov 2018)
NSPT		
Males	20.0 (range 11.7–26.8)	21.8 (range 16.3–28.4)
Females	6.0 (range 2.8–9.2)	7 (range 4.3–9.2)
Control (None)		
Males	15.4 (range 10.4–19.4	17.1 (range 11.4–21.0)
Females	5.4 (range 2.3–8.4),	6.2 (range 3.8–9.7)

* age-standardised

There were also no substantial differences in models investigating the relative difference between intervention and non-intervention areas (see Appendix 26, Table A26.1 for details). There was a 1% relative decrease (RR=0.99, 95%CI 0.92–1.06) for NSPT Sites, adjusting for sex, age group, SES, and period (year and month).

Did the implementation of the NSPT result in different associations by key socio-demographic factors?

There were some differences in suicide rates for selected socio-demographic factors in the period before implementation compared to post-implementation in NSPT Trial Sites compared to control (None) Sites, but these were not statistically significant.

Relative decreases in suicide rates appeared to be stronger among younger age-groups (0–19 years, 20–34 years), among those aged 65–74 years, among those in “Outer regional areas”, and in high-SES areas, though none of the differences were statistically significant. Relative increases in suicide rates were observed in NSPT Sites compared to control (None) Sites in remote areas and low-SES areas, although again these were not statistically significant.

Were there any lagged impacts of the NSPT on suicide rates, reflecting the lag between initial funding and implementation of suicide prevention activities?

Lagging models by 12 months for suicide, to reflect a comparison period when suicide prevention activities would have begun to scale up, did not substantially change the association in NSPT Sites before and after implementation (Appendix 26: Table A26.2). There was a 0% relative change (RR=1.00, 95%CI 0.92–1.09) for NSPT Trial Sites, adjusting for sex, age group and SES.

26.4.2 Hospitalisations for self-harm

Did the implementation of the National Suicide Prevention Trial result in decreased self-harm hospitalisation rates in Trial areas, compared to non-Trial areas?

Age-standardised self-harm hospitalisation rates appeared to be slightly higher in NSPT Sites than in control (None) Sites for males and for females (Figure 26.2).

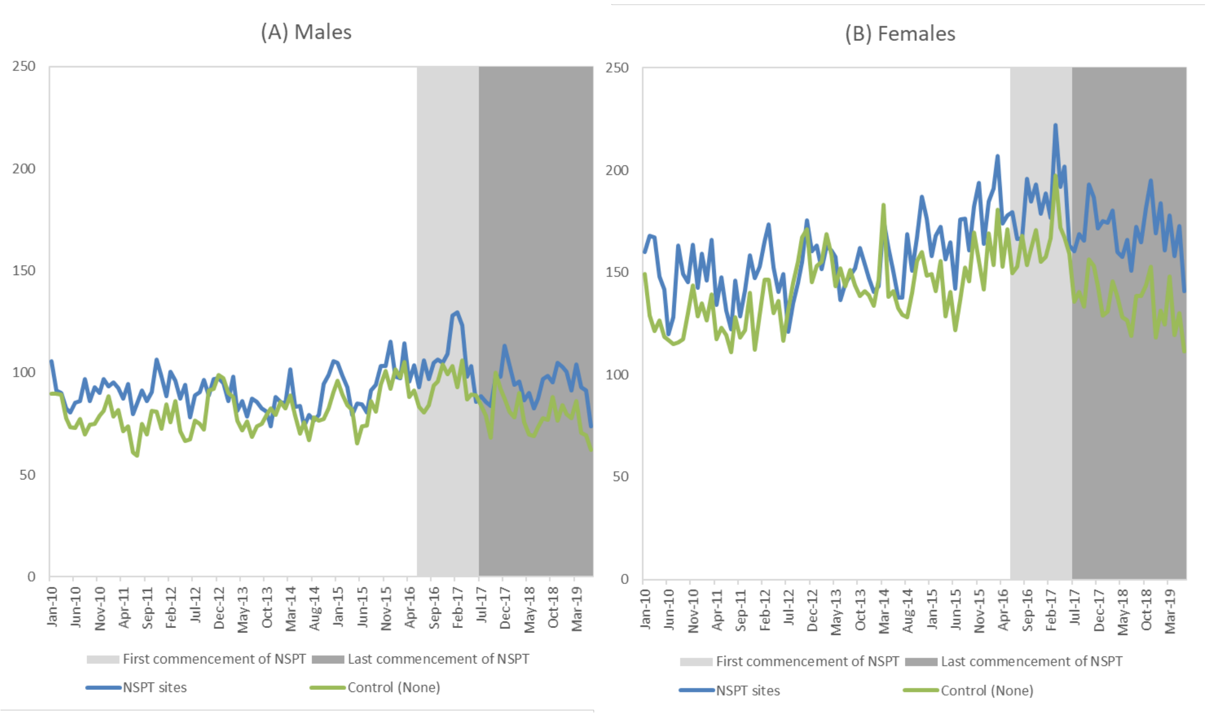


Figure 26.2 Age-standardised hospital self-harm hospitalisation rates per 100,000 by sex and Trial Site area (NSPT Sites and control (None) Sites)

Table 26.2 gives the age-standardised self-harm hospitalisation rates for males and females for the NSPT and control (None) groups.

Table 26.2 Self-harm hospitalisation rates pre-NSPT and during the Trial period or males and females by intervention group

Intervention group	Self-harm hospitalisation rate per 100,000* (range) Pre-Trial (Jan 2010 – June 2016)	Trial period (July 2016 – June 2019)
NSPT		
Males	91.0 (range 73.7–115.3)	98.6 (range 73.7–129.5)
Females	156.4 (range 119.9–206.9)	175.6 (range 141.0 t0 221.9)
Control (None)		
Males	80.8 (range 59.6–105.2)	86.0 (range 62.2–1.6.3)
Females	140.5 (range 110.9–183.1)	146.1 (range 111.4–197.4)

* age standardised

Significant differences between Trial Sites were evident in models investigating the relative difference between intervention and non-intervention areas, with higher self-harm hospitalisation rates evident among NSPT Sites, although the magnitude was consistently small (RR<1.10) (full details are in Appendix 26: Table A26.3). There was an 8% relative increase (RR=1.08, 95%CI 1.06–1.11) for NSPT Sites, adjusting for sex, age group, SES and period (year and month).

Did the implementation of the NSPT result in different associations by key socio-demographic factors?

There appeared to be different associations by selected socio-demographic factors for the periods before and after implementation in NSPT Sites compared to control (None). Relative decreases appeared to be stronger in remote and very remote areas. There were also relative increases in NSPT Sites compared to control (None) Sites among younger age-groups (0–19 years, 20–34 years), and low-SES areas.

Were there any lagged impacts of the NSPT on suicide rates, reflecting the lag between initial funding and implementation of suicide prevention activities?

Lagging models by 12 months and 24 months for self-harm hospitalisation, to reflect a comparison period when suicide prevention activities would have begun to scale up, did not substantially change the association in NSPT Sites before and after implementation (see Appendix 26: Table A26.4 and A26.5). At a 12-month lag there was a 9% relative increase (RR=1.09, 95%CI 1.06–1.11) for NSPT Sites, adjusting for sex, age group, SES and period (year and month).

Similarly, lagging models by 24 months did not result in any substantial differences in the magnitude of associations. At a 24-month lag there was an 6% relative increase (RR=1.06, 95%CI 1.03–1.10) for NSPT Sites, adjusting for sex, age group, SES and period (year and month).

26.5 Summary

In summary, there is little evidence to date that the NSPT has resulted in reductions in suicide or attempted suicide in comparison to non-intervention areas. There may be some evidence that suicide rates were lower in NSPT Trial Sites for younger age groups and high-SES areas and more rural areas (for attempted suicide only), but significant relative increases in attempted suicide among younger age groups and low-SES groups. Overall, both suicide and attempted suicide rates appear not to have changed substantially over the intervention period to date.

27 Systems modelling and simulation

27.1 Summary of approach

Suicidal behaviour and the service system that aims to provide effective care are complex. There are pathways from the determinants of mental health to psychological distress to engagements with the service system and to suicidal behaviour. The dynamic movement of psychologically distressed people through service pathways is dependent on population and demographic dynamics, social and economic circumstances, service capacity, and the effectiveness and experience of care. Interventions introduced into complex systems do not necessarily deliver the effects anticipated. Program logic approaches can be augmented by systems modelling approaches that can explore the delicate balance and interactions of core elements of the mental health system in a particular context, and the effects that programs and services acting on one part of the system can have on others. Evaluating the impact of programs and services introduced into complex systems have two key challenges:

- It is difficult to tease out the impacts delivered by individual interventions that are introduced simultaneously into a system
- Interventions can influence each other, and their effects are not simply additive (i.e., they can also be less than additive, antagonistic or synergistic).

Further, in the context of a rising trend in mental ill-health and suicidal behaviour (particularly as a corollary of the current COVID-19 crisis and looming recession) the effects of interventions can be masked. That is, they may seem ineffective in reducing current levels of suicidal behaviour, when in fact they are effectively mitigating what would otherwise be much higher levels of suicide.

Systems modelling and simulation provides a method of bringing together diverse sources of evidence, such as research, expert and local knowledge, practice experience, and data, to inform the mapping and quantification of a complex system. The product is an interactive decision support tool for exploring, in a safe environment, the best targeting, timing, scale, frequency and intensity of interventions required to achieve impacts on suicidal behaviour – vital to supporting effective planning and implementation of suicide prevention strategies. In addition, systems models can support evaluation by forecasting a baseline trend against which the simulated population-level impacts on suicide behaviour and cost-benefit of interventions (both individually and in combination) can be compared, elucidating any intervention effects likely to be masked by rising trends. Finally, a systems model, embedded in an ongoing monitoring and evaluation process, allows continuous feedback between real-world and modelled mental health service systems. This facilitates further refinements to the model to improve its forecast capability over time, and enables it to support future investments in strengthening the mental health system.

The aim of the pilot application of systems modelling and simulation as part of the NSPT Site evaluation was to determine the feasibility and value of the approach in supporting traditional evaluation, as well as deliver key insights to the pilot sites. Two pilot Sites participated: Western NSW PHN and Perth South PHN. Sites were selected in order to capture regions with contrasting geographic, socio-demographic and service system characteristics. Full details of the method, findings and insights related to the application of systems modelling to the Western NSW PHN Trial site have been published and are available in Appendix 27. This chapter describes the systems model for the Perth South Trial Site.

27.2 Systems model structure, outcome indicators, and calibration (Perth South)

The core model structure included:

- A population component, capturing changes over time in the size of the population resulting from births, migration, and mortality for the Perth South PHN population catchment
- A psychological distress component that models flows of people to and from states of low or no psychological distress (K10 scores < 15), and moderate to very high psychological distress (K10 score 16−50)
- A mental health services component that models the movement of psychologically distressed people through one of several possible service pathways involving GPs, psychiatrists and allied mental health professionals (including psychologists and mental health nurses), psychiatric inpatient care, community mental health centres, and online services
- A suicidal behaviour component that captures self-harm hospitalisations and suicide deaths.

Figure 27.1 provides a high-level overview of the causal structure and pathways of the model.

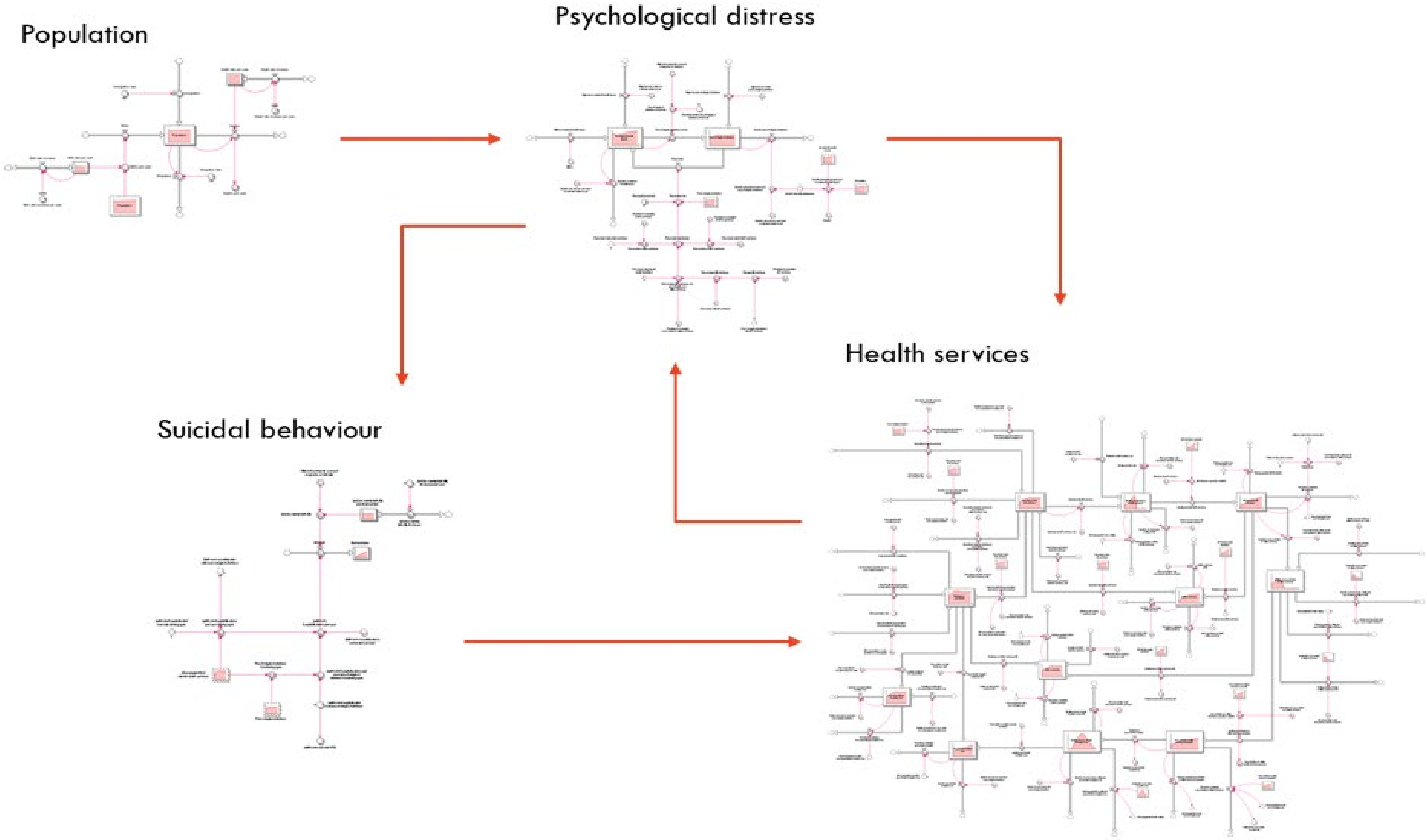


Figure 27.1 A high-level overview of the causal structure and pathways of the system dynamics model

The social and economic impacts of COVID-19 on psychological distress and downstream effects on service demand–capacity dynamics and suicidal behaviour were modelled drawing on insights and estimate derived from other national and regional models that included more detailed representation of the social determinants of mental health. Further details regarding those models can be found at:

https://www.sydney.edu.au/content/dam/corporate/documents/brain-and-mind-centre/supplementary-material---north-coast-phn-system-dynamics-model-for-suicide-prevention.pdf

and

https://www.sydney.edu.au/content/dam/corporate/documents/brain-and-mind-centre/youthe/road-to-recovery-v2.pdf

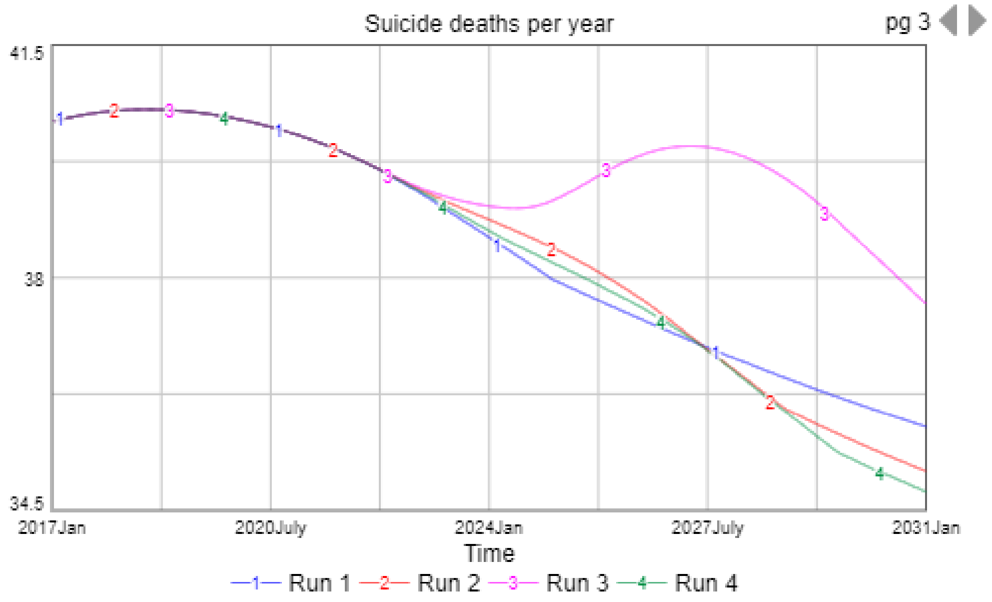
As the Western NSW PHN systems model was completed prior to the pandemic, the impact of COVID-19 in that region has not been modelled. Therefore, to facilitate comparisons of the impact of the same interventions applied in two diverse regions, a COVID-19 on/off switch was added to the Perth South model to enable the simulation of a trajectory for the Perth South region had COVID-19 not occurred. Primary model outputs included total (cumulative) numbers of self-harm hospitalisations and suicide deaths, and self-harm hospitalisation and suicide rates per 100,000 population. The model also provided estimates of the prevalence of moderate to very high psychological distress and the total (cumulative) mental health-related ED presentations and psychiatric hospitalisations, and a range of measures of mental health service usage (e.g., mental health-related general practice consultations, psychiatrist or allied mental health services capacity, services waiting times, and the numbers of psychologically distressed consumers that have disengaged from treatment). All outputs were calculated every 0.4375 days (i.e., one sixteenth of a week) over a period of 30 years, starting from 1 January 2011, permitting comparisons of model outputs with historic data from 2011–2017 and forecasts of the impacts of intervention scenarios implemented from 2021.

Parameter values that could not be derived directly from available data or published research were estimated via constrained optimisation, implemented in Stella Architect V.1.9.4, using historical time series data on the prevalence of psychological distress, self-harm hospitalisations and suicide rates, and mental health-related service usage (subsidised general practice consultations and allied mental health services claimed per year, psychiatric bed occupancy). Powell's method was employed to obtain the set of (optimal) parameter values minimising the sum of the mean absolute percentage error calculated for each time series separately (i.e., the mean of the absolute differences between the observed time series values and the corresponding model outputs, where each difference is expressed as a percentage of the observed value).

27.3 Demonstration scenarios

The two systems models developed for two very different regions of Australia demonstrate how some evidence-based interventions introduced in different regions can have markedly different and sometimes unexpected impacts, while others can have similar impacts. For example, research has shown that GPs trained to recognise high psychological distress and suicide ideation are 1.40–1.48 times more likely to (correctly) diagnose a mental illness than a GP who has not received training(36), leading to more referrals to mental health services. However, implementing GP training in both the Western NSW and Perth South regions delivers little impact in reducing psychological distress, mental health-related ED presentations, self-harm hospitalisations or suicide deaths (Figure 27.2: run 2). Combining GP training with mental health education programs (for which there is evidence that they can improve recognition of suicide risk and increase the rate of help seeking for mental health problems by more than 50%[(37)]) reduces suicide deaths in the Perth South region, but unexpectedly significantly increases suicide deaths in the Western NSW region (Figure 27.2: run 3).

Western NSW Primary Health Network



Perth South Primary Health Network

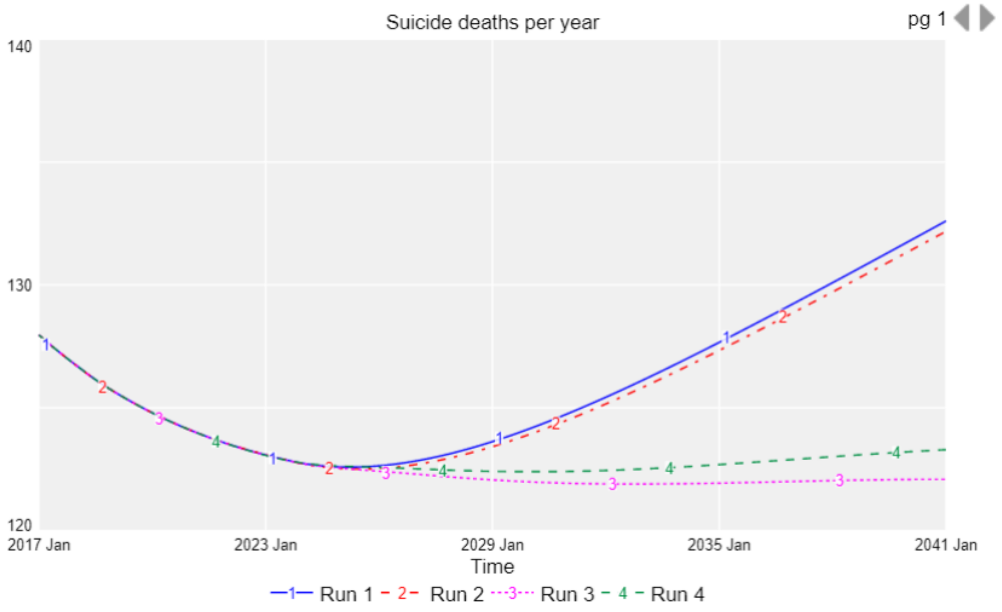


Figure 27.2 Model outputs (suicide deaths per year) for two regions demonstrating the impacts of intervention scenarios. Run 1 (blue): Baseline (without impact of COVID-19); Run 2 (red): Simulation of GP training alone; Run 3 (pink): Simulation of GP training plus

This unintended consequence arising from two “evidence-based” interventions applied in combination is explained by the imbalance they generate in the dynamics of service capacity versus demand for services, which is regionally specific. In the Western NSW region, the combination of the two evidence-based interventions (GP training and mental health education programs) generated mental health service demand beyond the availability of baseline service capacity, driving increases in the rate at which patients disengage from services as a result of increases in mean wait times and dissatisfaction with the quality of care they receive from a stretched service system. Disengagement from the mental health services prolongs heightened psychological distress and increases the risk of suicidal behaviour.

In addition to differential impacts of interventions (both individually and in combination), impacts are likely to be seen at different times. For example, mental health education programs implemented in 2021 in the Perth South catchment would be unlikely to demonstrate impact until at least early 2027, whereas in the Western NSW catchment a positive impact is unlikely to be seen until late 2027 after a period of negative impact (Figure 27.2: run 4). This has significance for the design of traditional evaluations. Potentially promising interventions may not show impacts within the traditional 2-3-year evaluation window (for reasons related to the demand–capacity dynamics, driven by local events and other interventions being implemented in parallel), and hence may be inaccurately and unnecessarily dismissed as ineffective.

These findings highlight the importance of a place-based approach to suicide prevention and the role of systems modelling and simulation to support traditional evaluation. Systems modelling and simulation provides essential local decision support capability that can help avoid unintended consequences and optimise targeting, timing, scale, frequency and intensity to realise the full potential of evidence-based interventions. The complexity of mental health service planning and suicide prevention at the regional level presents challenges (both analytically and politically) that demand a more sophisticated, disciplined and strategic approach to the allocation of limited resources. Systems modelling and simulation can therefore provide dual functions of decision support capability and supporting traditional evaluation methods by providing a priori estimates of the size, nature and timing of likely intervention effects.

27.4 Systems modelling in practice

The final model facilitates a priori evaluation of the impact range of programs, services and initiatives in the Perth South PHN population catchment individually and in different combinations. In addition to the ability to scale up or down the mental health services captured in the core model structure, a range of mental health and suicide prevention programs and initiatives prioritised by the PHN were integrated into the model. An interactive interface was developed (Figure 27.3) to facilitate direct interaction with the model by allowing the following programs, services and initiatives to be turned on/off, scaled up/down, and their implementation parameters to be modified through scenario testing to inform strategic planning. The model includes:

- Five specific suicide prevention interventions – post-attempt assertive aftercare, universally applied community support programs (to improve social connectedness), GP training, ED-based safety planning and community-based acute care services
- Three mental health interventions – community-based mental health education programs, family education and support, safe space alternative (i.e., safe haven café)
- Four service planning interventions – changes to GP mental health services capacity, psychiatrists and allied services capacity, psychiatric hospital care capacity, and community mental health care capacity.

The interface allows stakeholders to compare the impact of scenarios with a baseline (business as usual) scenario, in which existing policies and programs remain in place and current per capita mental health service capacity is maintained until the end of the simulation. Access to the model interface can be provided on request.

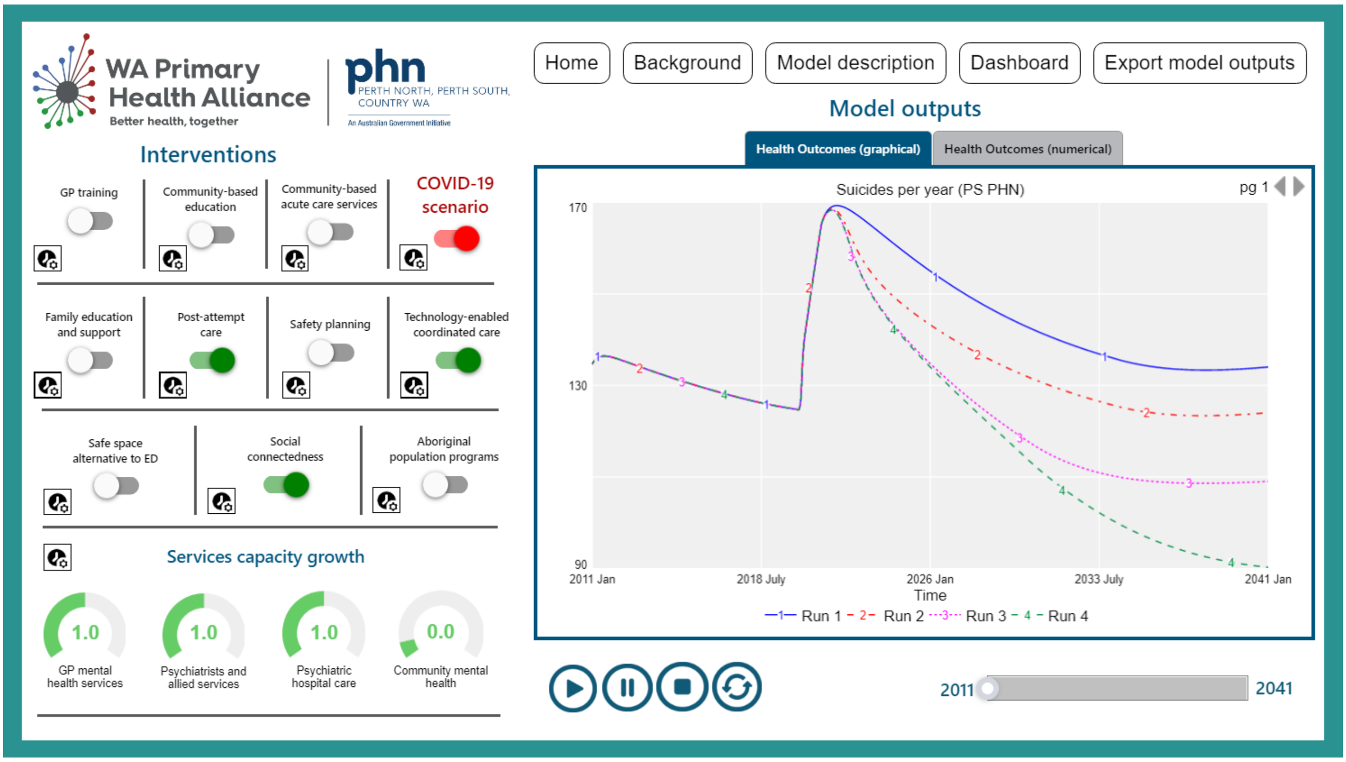


Figure 27.3 Interactive model interface facilitates a priori evaluation of intervention impacts against a business-as-usual baseline

28 Limitations

Like any evaluation of an ambitious, large-scale initiative, this evaluation had some limitations.

Outcomes

The key limitation is that it the key outcomes of reductions in suicide deaths and suicide attempts could not be assessed. This is addressed by developing a clear program logic for the evaluation and assessing whether lower-level objectives that might be expected to lead to these ultimate outcomes were being achieved. Although the evaluation did not detect any changes in either outcome, it would be worth re-examining these periodically in the coming years to see if changes emerge.

Data sources

There were some limitations relating to data sources accessed by the evaluation.

When assessing the impact of the Trial on service use, only data provided in the PMHC MDS, which covers mental health services that PHNs commission but not other primary mental health care services or specialist mental health care services was examined. Therefore, increases in help seeking from general practice or non-PHN funded services cannot be detected.

The amount and quality of information provided to the evaluation varied considerably by Site. This meant that for some data sources (e.g., the document review and the community-based activities database) the achievements of some Sites were under-represented. However, our general consultations with all Sites were extensive.

The extension of the Trial to June 2021 resulted in many Sites being allowed additional reporting time for their local evaluations, which meant that these reports were not available to the national evaluation. The aims and focus of these local evaluations differed from those of the national evaluation, but these reports would nevertheless have been informative.

With respect to suicide death and self-harm hospitalisation data a limitation of the analysis is not being able to ascertain what suicide prevention activity might have been implemented contemporaneously in the comparison Sites were no other major trials were occurring. It is important to note that PHNs would have received Commonwealth funding for the commissioning of local suicide prevention services and activities, the effect of which might have been to attenuate any differences between NSPT Sites and non-intervention Sites. However, based on secular trends of both suicide and attempted suicide in those, there appears to have been little decline in suicide or attempted suicide in non-Trial areas.

Although widely used, hospital self-harm admission data has limitations in terms of comprehensively capturing suicide attempts and self-harm. Not only are individuals who attempt suicide but do not require hospital treatment for the sequalae of their attempt not captured in those data, suicide attempt cases are not systematically captured in emergency departments, and among those who are recorded in hospital admissions data suicidal and non-suicidal self-harm are not distinguished.

Aftercare services

Only a small number of those who attended aftercare services completed the aftercare service user survey. People who have made a suicide attempt or are at risk for suicide are a vulnerable population who are experiencing a difficult time, so it is understandable that many were disinclined to participate in an evaluation.

The aftercare services at the four Sites which commissioned them got started at different times across the Trial, and different levels of oversight at PHN meant that only some services/Sites collected the service user data for the additional module developed for the PMHC MDS. Late-starting services contributed relatively few records, so the reporting largely reflects the Sites/services that got underway earlier and were more systematic in collecting data.

Evaluation of the Aboriginal and Torres Strait Islander-focused Sites

Consultations with Aboriginal and Torres Strait Islander stakeholders were significantly curtailed by COVID-19, resulting in fewer than anticipated community members participating. Moreover, these consultations took place late in the Trial so participants had little knowledge of the planning process in some cases.

The evaluation did not receive ethics approval from the South Australian Aboriginal Health and Research Ethics Committee. This was due to a local evaluation team seeking approval to evaluate the aftercare service concurrently and the Committee’s concern about burden and overlap. This means that consultations for the Aboriginal and Torres Strait Islander focus population at that Site did not occur, although information from documents and from PHN general consultations was included.

29 References

1. Horvarth J. Review of Medicare Locals: Report to the Minister for Health and Minister for Sport. Canberra: Department of Health, 2014.
2. Department of Health. Primary Health Network Mental Health Reform Lead Site Project Evaluation Framework. Canberra, 2016.
3. Black Dog Institute. LifeSpan Integrated Suicide Prevention. Summary Paper, 2016.
4. Hegerl U, Rummel-Kluge C, Värnik A, et al. Alliances against depression – A community-based approach to target depression and to prevent suicidal behaviour. *Neuroscience and Biobehavioral Reviews* 2013;37(10):2404-09. doi: 10.1016/j.neubiorev.2013.02.009
5. Dudgeon P, Milroy J, Calma T, et al. Solutions that work: what the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report (ATSISPEP). Crawley: University of Western Australia, 2016.
6. Owen J. Program Evaluation: Forms and Approaches. Sydney: Allen and Unwin 1999.
7. National Mental Health Commission. The National Review of Mental Health Programs and Services. Sydney, 2014.
8. Australian Government. Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services. Canberra: Australian Government, 2015.
9. Office of the National Suicide Prevention Advisor. A report detailing key themes and early findings to support initial advice of the National Suicide Prevention Advisor. Canberra: Department of Prime Minister and Cabinet, 2019.
10. Gee G, Dudgeon P, Schultz, et al. Aboriginal and Torres Strait Islander Social and Emotional Wellbeing. In: Purdie N, Dudgeon P, Walker R, eds. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Canberra: Australian Government Department of Health and Ageing 2010.
11. Department of Health. National Suicide Prevention Trial Evaluation Framework. Canberra, 2017.
12. Quinn Patton M. Utilization-Focused Evaluation (4th Edition). London: Sage Publications 2008.
13. Shadish W, Cook D, Leviton L. Foundations of Program Evaluation: Theories of Practice. London: Sage Publications 1991.
14. Baker ST, Nicholas J, Shand F, et al. A comparison of multi-component systems approaches to suicide prevention *Australas Psychiatry* 2018;26(2):128-31. doi: 10.1177/1039856217743888
15. Hawton K, Pirkis J. Suicide is a complex problem that requires a range of prevention initiatives and methods of evaluation. *British Journal of Psychiatry* 2017;210(6):381-83. doi: 10.1192/bjp.bp.116.197459
16. Holmes G, Clacy A, Hermens DF, et al. The Long-Term Efficacy of Suicide Prevention Gatekeeper Training: A Systematic Review *Arch Suicide Res* 2019:1-31. doi: 10.1080/13811118.2019.1690608

17. Zalsman G, Hawton K, Wasserman D, et al. Suicide prevention strategies revisited: 10-year systematic review *Lancet Psychiatry* 2016;3(7):646-59. doi: 10.1016/S2215-0366(16)30030-X

18. Platt S, Niederkrotenthaler T. Suicide Prevention Programs. *Crisis* 2020;41(Suppl 1):S99-S124. doi: 10.1027/0227-5910/a000671

19. National Health and Medical Research Council. Ethical conduct in research with Aboriginal and Torres Strait islander Peoples and communities: Guidelines for researchers and stakeholders. Canberra: Commonwealth of Australia, 2018.

20. Productivity Commission. Mental Health, Draft Report. Canberra: available at https://www.pc.gov.au/inquiries/completed/mental-health/draft, 2019.

21. Green J, Thorogood N. Qualitative Methods for Health Research. Los Angeles, California: Sage 2014.

22. van Spijker BA, Batterham PJ, Calear AL, et al. The suicidal ideation attributes scale (SIDAS): Community-based validation study of a new scale for the measurement of suicidal ideation *Suicide Life Threat Behav* 2014;44(4):408-19. doi: 10.1111/sltb.12084

23. Australian Bureau of Statistics. Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure. Canberra: Australian Bureau of Statistics 2013 Jan.

24. Australian Healthcare Associates. Evaluation of Suicide Prevention Activities: Final Report. Canberra: Department of Health and Ageing, 2014.

25. Department of Health. The Primary Mental Healthcare Minimum Data Set (PMHC MDS). Canberra: Australian Government, 2020.

26. Department of Health. Access to Allied Psychological Services (ATAPS) Minimum Dataset. Canberra: Australian Government, 2016.

27. Australian Institute of Health and Welfare. [Dataset] Cancer Statistics for Small Geographic Areas. Primary Health Network (PHN). Table 20: Estimated residential population of Australia (June 30), by sex and PHN, 2005 to 2014 and 2019 (projected). Canberra: AIHW; 2020.

28. Australian Institute of Health and Welfare. [Dataset] Mortality Over Regions and Time (MORT) books. Primary Health Network (PHN), 2014–2018. Table 1: Deaths due to all causes (combined), by sex and year, 2014–2018. Canberra: AHIW; 2020.

29. Public Health Information Development Unit (PHIDU). [Dataset] Social Health Atlas of Australia. "Data by Primary Health Network (incl. Population Health Areas)". September 2020. Adelaide, South Australia: PHIDU, Torrens University Australia; 2020.

30. Public Health Information Development Unit (PHIDU). [Dataset] Social Health Atlas of Australia. "Data by Primary Health Network (incl. Population Health Areas)". October 2019. Adelaide, South Australia: PHIDU, Torrens University Australia; 2019.

31. Public Health Information Development Unit (PHIDU). [Dataset] Social Health Atlas of Australia. "Data by Primary Health Network (incl. Population Health Areas)". November 2018. Adelaide, South Australia: PHIDU, Torrens University Australia; 2018.

32. Public Health Information Development Unit (PHIDU). [Dataset] Social Health Atlas of Australia. "Data by Primary Health Network (incl. Population Health Areas)". December

2017. Adelaide, South Australia: PHIDU, Torrens University Australia; 2017.

33. Public Health Information Development Unit (PHIDU). [Dataset] Social Health Atlas of Australia. "Data by Primary Health Network (incl. Population Health Areas)". December 2016. Adelaide, South Australia: PHIDU, Torrens University Australia; 2016.

34. Public Health Information Development Unit (PHIDU). [Dataset] Social Health Atlas of Australia. Data by Primary Health Network. May 2016 Release 2. Adelaide, South Australia: PHIDU, Torrens University Australia; 2016.

35. Australian Bureau of Statistics. Socio-economic Index for Areas (SEIFA) 2016. Canberra: Commonwealth of Australia, 2018.

36. Pfaff JJ, Acres JG, McKelvey RS. Training general practitioners to recognise and respond to psychological distress and suicidal ideation in young people *Med J Aust* 2001;174(5):222-6.

37. Jorm AF, Griffiths KM, Christensen H, et al. Providing information about the effectiveness of treatment options to depressed people in the community: a randomized controlled trial of effects on mental health literacy, help-seeking and symptoms *Psychol Med* 2003;33(6):1071-9. doi: 10.1017/s0033291703008079

List of Appendices

Appendix 1: Data sources relevant to primary evaluation questions

		Consultations								
Primary evaluation question	Document review	PHNs	Community	Service Providers	Service Users	Others	Observation/ participation	Community Activities Database	PMHC/ NSPT additional module	Epi analysis and modelling
Planning										
How did sites plan and develop suicide prevention strategies?	✓	✓	✓	✓		✓	✓	-	-	-
What strategies facilitated local planning?	✓	✓	✓	✓		✓	✓	-	-	-
What strategies were found to be effective in local planning?		✓				✓		-	-	-
What challenges were encountered?	✓	✓	✓	✓			✓	-	-	-
Developing a systems-based approach	✓							-	-	-
What strategies were used to develop and sustain a systems-based approach to suicide prevention?	✓	✓	✓	✓		✓	✓	-	-	-
What strategies facilitated development of a system-based approach?	✓	✓	✓	-		✓	✓	-	-	-
What strategies were effective in facilitating a systems-based approach?		✓				✓		-	-	-
What challenges were encountered?	✓	✓	✓	✓		✓	✓	-	-	-
Focus populations	✓							-	-	-
What strategies were used to enhance, target and deliver services and activities for [focus population]?	✓	✓	✓	✓		✓	✓	✓	-	-
What strategies were found to be effective in preventing suicidal behaviours and self-harm among people who had attempted or were at risk of suicide?		✓	✓	-	✓	✓	-	-	✓	✓
What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among focus populations?		✓	✓	-	✓	✓	-	-	✓	✓
What challenges were encountered?	✓	✓	-	✓		✓	✓		-	-
Policy Implications										
What are the policy implications?	✓	✓	✓	✓	✓		✓	✓	✓	✓

Appendix 2: Evaluation Framework primary and secondary evaluation questions

Table A2.1 Questions related to planning

PRIMARY QUESTION	SECONDARY QUESTIONS
How did sites plan and develop suicide prevention strategies?	What activities were undertaken by sites to understand local needs and identify service gaps? How were States and Territories involved? What role did Local Government play in fostering community support? How were community leaders, others representing the interests of people in the target populations and broader communities involved? How were consumers, their carers and people with lived experience of suicide engaged in service planning and development? Who was responsible for development of work plans and who was involved? Were key partners and their roles formally identified in work plans? Were there significant differences in approaches to service commissioning? Were particular workforce requirements identified and recruitment strategies developed?
What strategies were found to be effective in facilitating local planning?	To what extent were services planned jointly with other stakeholders? To what extent did planned services reflect service gaps and/or provide enhancements to existing services, including PHN mental health and suicide prevention base activities? What capabilities were required by PHNs and sites to develop work plans? Were any tools or resources used?
What barriers were encountered?	Were there barriers to the involvement of particular key stakeholders? How were these dealt with? Did any critically impact on the planning and development process? Did plans accurately reflect local needs and, if not, why not?
What are the policy implications?	Are there issues that were common across all sites? What factors are considered essential for effective planning?

Table A2.2 Questions related to developing a systems-based approach

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies did sites use to develop and sustain a system-based approach to suicide prevention?	Which service providers and other key stakeholders were consulted in development of strategies and when did this occur? What arrangements were made with States and Territories, LHNs and other state/territory-funded services to promote integrated service delivery? Were service arrangements and referral pathways supported by formalised agreements? How were GPs involved and were there formalised arrangements for referral, feedback and shared care? What strategies were used to promote engagement of other key stakeholders? What governance processes were developed and how did this involve key stakeholders?
What strategies were found to be effective in facilitating a system-based approach?	What factors facilitated engagement and cooperative arrangements with other services and organisations? Did arrangements facilitate a more integrated approach to suicide prevention activity locally and across the region? To what extent have services been integrated with related health and community support services?
What barriers were encountered?	Were there barriers to the involvement of particular key stakeholders? How were these dealt with? Did any critically impact on development of agreements or these being sustained as necessary for delivery of services or other activities?

PRIMARY QUESTION	SECONDARY QUESTIONS
What are the policy implications?	Are there issues that were common across all sites? What factors are considered essential for effective service integration? What are the elements that define a system-based approach within an Australian context?

Table A2.3 Questions related to people who have attempted or are at risk of suicide

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were used to enhance services for people who had attempted or were considered at risk of suicide?	What types of services were delivered? How did these enhance mental health and suicide prevention services already commissioned by PHNs? What processes were established for initial assessment, triage and review of consumers? What procedures were put in place for follow-up of new referrals and clients? How many people used services? What were the characteristics of people who used services? Did personnel require particular qualifications or training? Was additional training provided? What strategies were used to promote services? Were clear referral pathways and feedback mechanisms developed with GPs, LHNs, and other services, including state/territory community and other mental health service providers? Were there protocols in place or other strategies for referral of, and feedback to and from other providers involved in the care of mutual clients? What linkages were formed with other local services/organisations to provide complementary services and support? What other activities were undertaken, including postvention services and those to train professionals and increase community awareness, and who participated in these? How were people with lived experience involved in implementation and ongoing delivery of services? Were processes put in place for ongoing support of consumers where needed?
What strategies were found to be effective in preventing suicidal behaviours and self-harm among people who had attempted or were at risk of suicide?	Who referred clients and were they appropriate referrals? What proportion of referrals went on to use trial services and were follow-up strategies effective? What did consumers, their carers, and people with lived experience of suicide think about services and were their needs met? Were community expectations met? What strategies were effective in coordinating care with other service providers? Did services and other trial activities effectively complement and/or fill gaps in local services provided prior to the trial? Were other trial activities effective in improving awareness of and responsiveness to needs of people at risk of suicide and self-harm? Were the planned outcomes of activities and any targets identified in work plans met? Did people who had attempted or were considered at risk of suicide who used services show improved outcomes in relation to suicidal behaviour, self-harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related risk factors within the broader community over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with?

PRIMARY QUESTION	SECONDARY QUESTIONS
	Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful additional service and, if not, why not?
What are the policy implications?	Were there significant differences in approaches across sites and what were the implications of these in terms of services offered and links with other local services? What factors are considered essential in providing effective follow-up services and ongoing support for people who attempted or are at risk of suicide? What strategies have had a significantly positive impact and might be adopted in other regions?

Table A2.4 Questions related to Aboriginal and Torres Strait Islander peoples

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were used to prevent suicidal behaviour and self-harm among Aboriginal and Torres Strait Islander peoples?	Were Aboriginal and Torres Strait Islander peoples empowered to collaborate in the development, promotion and implementation of activities and how was this achieved? What types of services were delivered and how did these enhance those already provided for Aboriginal and Torres Strait Islander people? What other activities were undertaken, including postvention services and those to train professionals and increase community awareness? How were services and community activities tailored to be culturally safe and appropriate? Did personnel require particular qualifications or training? Was additional training provided? Were local Indigenous people employed? What processes were established to promote services and other activities, and encourage at-risk people to use them? How many people used services and/or participated in activities? What are the characteristics of people using these services? Are trial services being complemented by other mental health, vocational, educational and support programs? What linkages were formed with other Indigenous-specific services, including Social and Emotional Wellbeing Teams and Aboriginal Community Controlled Health Services?
What strategies were found to be effective in preventing suicidal behaviour and self-harm among Aboriginal and Torres Strait Islander peoples?	Did recruitment and training strategies work and what was most effective? Who referred clients and were they appropriate referrals? What did consumers, their carers and people with lived experience of suicide think of services and were their needs met? To what extent were the expectations of elders and the broader Indigenous community met? What strategies were effective in coordinating care with other services provided to Aboriginal and Torres Strait Islander consumers and targeting Indigenous communities more generally? Were strategies in line with the findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project? Were other trial activities effective in improving awareness of and responsiveness to Aboriginal and Torres Strait Islander people’s needs? Were the planned outcomes and any targets identified in work plans met? Did Aboriginal and Torres Strait Islander peoples using services show improved outcomes in relation to suicidal behaviour, self –harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related risk factors among Aboriginal and Torres Strait Islander peoples within the targeted communities over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with?

PRIMARY QUESTION	SECONDARY QUESTIONS
	Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful additional service and, if not, why not?
What are the policy implications?	Are there issues that were common across sites? What factors are considered essential in providing effective suicide prevention services for Aboriginal and Torres Strait Islander people? What strategies have had a significantly positive impact and might be adopted in other regions?

Table A2.5 Questions related to men

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were established for the targeting and delivery of services for men, particularly those between 25 and 54 years?	What types of services were developed for men? How were services tailored for men? Did personnel require particular qualifications or training? Was additional training provided? What processes were established to promote and encourage referrals? What strategies were used to promote initial service contact and to encourage service use? How many men used services and/or participated in activities? What were the age and other characteristics of men targeted and of those using these services? Were trial services complemented by other mental health, vocational, educational and other support programs? What other activities, including professional training and community education, were undertaken and who participated?
What strategies were found to be effective in preventing suicide deaths and suicidal behaviour among at-risk men?	Who referred men to the service and are they appropriate referrals? What proportion of referrals went on to use trial services and were follow-up strategies effective? What did men think of the services and were their needs met? What strategies were most effective in facilitating service use by at-risk men? Was clinical care enhanced by other services? Were other trial activities effective in improving awareness of and responsiveness to men's needs? Were the planned outcomes and any targets identified in work plans met? Did services and other trial activities effectively complement and/or fill gaps in local services provided prior to the trial? Did men using services show improved outcomes in relation to suicidal behaviour, self –harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related outcomes among men within the broader community over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with? Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful additional service and, if not, why not?
What are the policy implications?	Are there issues that were common across sites? What factors are considered essential in providing effective suicide prevention services for men at risk of suicide? What strategies have had a significantly positive impact and might be adopted in other regions?

Table A2.6 Questions related to young people

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were established for the targeting and delivery of suicide	What types of services were developed for young people? How were services tailored for young people? Did personnel require particular qualifications or training?

PRIMARY QUESTION	SECONDARY QUESTIONS
prevention services tailored for young people?	Was additional training provided? What processes were established to promote services and encourage at-risk young people to use services? What strategies were used to promote initial service contact and to encourage service use? How many young people used services and/or participated in activities? What were the characteristics of young people using these services? Were trial services complemented by mental health, educational and other support programs? What other activities, including professional training, community education and school-based programs, were undertaken and who participated in them? What linkages were formed with other youth-specific services, including state/territory, headspace, and schools and other educational institutions?
What strategies were found to be effective in preventing suicidal behaviours and self-harm among young people?	Who referred young people and were they appropriate referrals? What proportion of referrals went on to use trial services and were follow-up strategies effective? What factors facilitated engagement and cooperative arrangements with other services and organisations? What did young people think of services and were their needs met? What strategies were most effective in facilitating service use by young people? What strategies were effective in coordinating care with others providing services to a young person? Was clinical care enhanced by other services? Were other trial activities effective in improving awareness of and responsiveness to young people's needs? Were the planned outcomes and any targets identified in work plans met? Did services and other trial activities effectively complement and/or fill gaps in local services provided prior to the trial? Did young people using services show improved outcomes in relation to suicidal behaviour, self –harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related outcomes among young people within the broader community over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with? Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful addition and, if not, why not?
What are the policy implications?	Are there issues that were common across sites? What factors are considered essential in providing effective suicide prevention services for young people? What strategies have had a significantly positive impact and might be adopted in other regions?

Table A2.6 Questions related to ex-ADF people and their families

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were established for preventing suicide and improving support services for ex-ADF members?	What types of services were developed to meet the needs of ex-ADF members? Did personnel require particular qualifications or training? Was additional training provided? How were these services targeted to ensure that they complemented other services provided locally? How were services promoted and who referred clients? What are the characteristics of ex-ADF members using these services? What strategies were used to coordinate care with other providers?

PRIMARY QUESTION	SECONDARY QUESTIONS
	Were trial services complemented by other mental health, vocational, educational and other support programs? What other activities, including professional training and community education, were undertaken and who participated?
What strategies were found to be effective in preventing suicidal behaviour and providing ongoing support to ex-ADF members?	What strategies were the most effective in promoting service use among ex-ADF members? What did ex-ADF members think of services and were their needs met? What strategies were found to be effective in engaging and developing cooperative arrangements with other services and organisations? Was the Australian Defence Force and other representative organisations effectively engaged in the development of trial services and did they find new services useful? Was clinical care effectively complemented by related health and community support programs appropriate to the individual needs of ex-ADF members? What linkages were formed with other services, including housing, education, employment and the NDIS? Were other trial activities effective in improving awareness of and responsiveness to ex-ADF member's needs? Were the planned outcomes and any targets identified in work plans met? Did services and other trial activities effectively complement and/or fill gaps in local services provided prior to the trial? Did ex-ADF members using services show improved outcomes in relation to suicidal behaviour, self –harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related outcomes among ex-ADF members within the broader community over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with? Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful addition and, if not, why not?
What are the policy implications?	Are there issues that were common across sites? What factors are considered essential in providing effective suicide prevention and related services for ex-ADF members? What strategies have had a significantly positive impact and might be adopted in other regions?

Table A2.7 Questions related to LGBTI people

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were established for the targeting and delivery of suicide prevention services tailored for this group?	What types of services were developed for LGBTI people? How were services tailored for LGBTI people? Did personnel require particular qualifications or training? Was additional training provided? What processes were established to promote services and encourage LGBTI people to use services? What strategies were used to promote initial service contact and to encourage service use? How many LGBTIQ people used services and/or participated in activities? What were the characteristics of LGBTI people using these services? Were trial services complemented by mental health, educational and other support programs? What other activities, including professional training, community education, were undertaken and who participated?
What strategies were found to be effective in preventing	Who referred LGBTI people to the service and were they appropriate referrals?

PRIMARY QUESTION	SECONDARY QUESTIONS
suicidal behaviours and self-harm among young people?	What proportion of referrals went on to use trial services and were follow-up strategies effective? What factors facilitated engagement and cooperative arrangements with other services and organisations? What did LGBTI people think of services and were their needs met? What strategies were most effective in facilitating service use by LGBTQI people? Was clinical care enhanced by other services? What strategies were effective in coordinating care with others providing services to LGBTI people? Were other trial activities effective in improving awareness of and responsiveness to LGBTI people's needs? Were the planned outcomes and any targets identified in work plans met? Did services and other trial activities effectively complement and/or fill gaps in local services provided prior to the trial? Did LGBTQI people using services show improved outcomes in relation to suicidal behaviour, self –harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related outcomes among LGBTQI people within the broader community over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with? Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful addition and, if not, why not?
What are the policy implications?	Are there issues that were common across sites? What factors are considered essential in providing effective suicide prevention services for people in this group? What strategies have had a significantly positive impact and might be adopted in other regions?

Table A2.8 Questions related to other site-identified target groups

PRIMARY QUESTION	SECONDARY QUESTIONS
What strategies were established for the targeting and delivery of suicide prevention services tailored for this group?	What types of services were developed for this group? How were services tailored for this group? Did personnel require particular qualifications or training? Was additional training provided? What processes were established to promote services and encourage at-risk people in this group to use services? What strategies were used to promote initial service contact and to encourage service use? How many people in this group used services and/or participated in activities? What were the characteristics of people in this group using these services? Were trial services complemented by mental health, educational and other support programs? What other activities, including professional training, community education, were undertaken and who participated?
What strategies were found to be effective in preventing suicidal behaviours and self-harm among young people?	Who referred people in this group to the service and were they appropriate referrals? What proportion of referrals went on to use trial services and were follow-up strategies effective? What did people in this group think of services and were their needs met? What strategies were most effective in facilitating service use by people in this group? Was clinical care enhanced by other services?

PRIMARY QUESTION	SECONDARY QUESTIONS
	Were other trial activities effective in improving awareness of and responsiveness to people's needs? Were the planned outcomes and any targets identified in work plans met? Did services and other trial activities effectively complement and/or fill gaps in local services provided prior to the trial? Did people using services show improved outcomes in relation to suicidal behaviour, self –harm and related risk factors? Was there evidence of reductions in suicide deaths, attempts, self-harm and related outcomes among people within the broader community over the trial period?
What barriers were encountered?	What were the main factors adversely affecting the implementation of activities? How were any barriers dealt with? Did any of these significantly impact on services and other activities? Did key stakeholders consider trial services a useful addition and, if not, why not?
What are the policy implications?	Are there issues that were common across sites? What factors are considered essential in providing effective suicide prevention services for people in this group? What strategies have had a significantly positive impact and might be adopted in other regions?

Appendix 3: Types of documents reviewed

Document Type	Document
NSPT Trial Work Plans	
	National Suicide Prevention Trial Site Activity Work Plan 2016-2018
	National Suicide Prevention Trial Site Activity Work Plan 2018-2019
	National Suicide Prevention Trial Site Activity Work Plan 2019-2020
PHN Six-month Performance Report	
	Six-monthly Performance Report. March 2017
	Six-monthly Performance Report. March 2018
	Six-monthly Performance Report. March 2019
PHN Twelve-month Performance Report	
	Twelve-monthly Performance Report. September 2017
	Twelve-monthly Performance Report. September 2018
	Twelve-monthly Performance Report. September 2019
PHN Mental Health Work Plans	
	Primary Mental Health Care Activity Work Plan and Budget. Feb 2017
	Primary Mental Health Care Activity Work Plan and Budget. Feb 2018
	Primary Mental Health Care Activity Work Plan and Budget. Feb 2019
Other documents	
	Needs Analysis
	Service Mapping
	Community consultation documents
	Committee related documents
	Community action plans
	Service agreements with commissioned providers
	Provider performance reports
	Local evaluations
	Referral pathway documents
	Interagency agreements
	Trial implementation plans and updates
	Other additional documents (e.g. provider implementation plans, Mental Health Services updates)

Appendix 4: Consultation topics for PHN staff (Interviews)

(Round 1)

Service planning

1. What activities did you undertake to understand local needs and identify service gaps?
2. How did planning and implementation go?
3. How were States and Territories involved in your planning?
4. What role did Local Government play in fostering community support?
5. How were community leaders, others representing the interests of people in the target populations and broader communities involved?
6. How were consumers, their carers and people with lived experience of suicide engaged in service planning and development?
7. How did you use the BDI support?

Service integration

1. Which service providers and other key stakeholders were consulted in development of strategies and when did this occur?
2. What strategies were used to promote engagement of other key stakeholders?
3. Were there barriers to the involvement of particular key stakeholders? How were these dealt with?

Target population questions

People who have attempted or are at risk of suicide

1. **What types of services are/were planned to be delivered how did/will these enhance those already provided?**
2. **How did these enhance mental health and suicide prevention services already commissioned by PHNs?**
3. **How were people with lived experience involved in planning?**
4. What were the main factors adversely affecting the implementation of activities?
5. How were any barriers dealt with?

Other Target populations

1. What types of services are planned for [target population] how did these enhance those already provided?
2. How were [target population] people involved in planning?
3. What were the main factors adversely affecting the implementation of activities?
4. How were any barriers dealt with?

(Round 2)

Implementation

Work plans [programs of work] and workforce

1. Who was responsible for development of work plans and who else was involved?
2. What capabilities were required to develop work plans?

3. Were any tools or resources used?
4. Were particular workforce requirements identified and recruitment strategies developed?

Ongoing planning and the implementation

5. Have you had to change direction over the course of Trial because of changing community needs or expectations? If so, how was this managed?
6. How has stakeholder involvement changed over the course of the trial:
   a. Have particular stakeholders have dropped away?
   b. Are there gaps in stakeholder representation now?
7. Were there barriers to the involvement of particular key stakeholders over the course of the trial?
8. Did these barriers critically impact the delivery of services or other activities?
9. What were the main challenges involved in the implementation of planned activity?
10. What were the key facilitators for successful implementation of planned activity?

System-based approach

Integration – Individual services

1. What arrangements were made with States and Territories, LHNs and other state/territory-funded services to promote integrated service delivery?
2. Were service arrangements and referral pathways supported by formalised agreements?
3. How were GPs involved and were there formalised arrangements for referral, feedback and shared care?

Overall trial outcomes

4. Did plans accurately reflect local needs and, if not, why not?
5. What has been the impact of trial activities, or the achievements of the trial? How were they measured?
6. Has the trial resulted in the outcomes identified in the planning phase?
7. Have there been things that didn’t work as you’d hoped/planned?

Systems-based approach

8. To what extent have Trial services and/or activities been integrated with related health and community support services?
9. Did arrangements with other services and organisations facilitate a more coordinated integrated approach to suicide prevention activity locally and across the region?
10. What strategies have you found effective in facilitating a coordinated approach to suicide prevention in your region.

Target population questions

Community-based Trial activities [all sites]

About the activities – for [Target Group]

1. How were activities tailored for [target group]?
2. Did people delivering the activities require particular qualifications or training? Was additional training provided?
3. How were people with lived experience involved?
4. How did activities enhance mental health and suicide prevention services already commissioned by PHNs?

Effectiveness

1. Did trial activities effectively complement and/or fill gaps in local services provided prior to the trial?
2. What did [target group] think of the activities and were their needs met?
3. What strategies were most effective in facilitating participation by [target group] in activities?
4. Were trial activities effective in improving awareness of and responsiveness to [target group] needs?
5. Were the planned outcomes met?

Barriers

6. What were the main factors adversely affecting the implementation of activities?
7. How were any barriers dealt with?
8. Did any of these significantly impact on delivery of the activities?

Trial Services for Individuals

About the Services

1. How were services tailored for [target group]?
2. How did these enhance mental health and suicide prevention services already commissioned by PHNs?
3. What strategies were used to promote services?
4. Were clear referral pathways and feedback mechanisms developed with GPs, LHNs, and other services, including state/territory community and other mental health service providers?
5. How were people with lived experience involved in implementation and ongoing delivery of services?

Effectiveness

6. Were community expectations met?
7. What did [target group] think of the services and were their needs met?
8. What strategies were effective in coordinating care with other service providers?
9. Did services and effectively complement and/or fill gaps in local services provided prior to the trial?
10. Were the planned outcomes of services and any targets identified in work plans met?
11. Did key stakeholders consider trial services a useful additional service and, if not, why not?

Barriers

12. What were the main factors adversely affecting the implementation of services?
13. How were any barriers dealt with?
14. Did any of these significantly impact on service delivery?

Sustainability

1. Which components of the trial do you think will continue after the trial ends?
2. What will be the legacy of the trial in your area?
3. What would be the role for PHN in suicide-prevention post-trial?

Appendix 5: Themes and sample quotations – PHN staff interviews

Table A5.1 Planning themes and sample quotations

Themes and subthemes	Sample quotations
PHN-related facilitators	
Skilled Trial Staff	‘Quality person in the Project Coordinator [role], who is negotiating the politics well and building relationships and has an eye on the endgame and has a good handle on how to make this successful’
Providing support and resources	‘There was an expectation the Working Groups could pull this together and make a plan. The bar was a bit too high. We now need to support the Working Groups to come up with a plan we can supply funding to and evaluate’
Working with existing organisations	‘The PHNs are in a unique position – they have the capacity to be linkage agents, to get people around the table.’ ‘Our approach is to do implementation though organisations who are already known and trusted in those communities.’
Time spent building relationships	‘Meeting to discuss barriers. Constant relationship stuff.’ ‘You need time to - to listen and do things with integrity – to do what you said you were going to do.’
Maintaining engagement through information sharing	‘ Managing community – keeping them engaged. We address this by continuous sharing of information and continual educating about the Alliance and the Trial.’
Community-related facilitators	
Motivated community	‘Community has been ready for a long time.’ ‘If I talk to someone then they talk to someone else. I’ve been blessed. It’s really about where the community is at. People have been offering to help.’
Pre-existing relationships with PHN	‘The benefit of a small community is that everyone is connected.’
Right people	‘You need to have the right people on the committee – the decision makers – the people in that Committee are senior people, including people with lived experience – they are the right people.’ ‘It took time to contact people and ensure the Taskforce had broad representation. It also took time to figure out the right people to have at the table, the right groups etc. That process sis still going on as new groups and people are identified.’
Stakeholder-related challenges	
Time to engage community	‘At least two years to get good planning. We tried to do it more quickly, but that just caused problems and damage and it took longer then, because we had to rebuild relationships and trust.’ ‘You need time to listen and do things with integrity, to do what you said you were going to do. That is the tension between Department timelines and workplan objectives and goals.’
Getting the right people on board	‘You need to make sure you get the right people in the room – people who can work on a broader agenda than their own particular issue or interest. It’s important to find the right channel for people who want to be involved….’
PHN-related challenges	

Themes and subthemes	Sample quotations
Staff recruitment and retention	'In regional areas getting quality staff at every level of a project is crucial to how successful you are going to be.' 'Hard to find people with the requisite skills.' 'The process slowed down because of staff turnover.'
PHN's relationship with community	'Because I was from the PHN they didn't trust me.' '[They] didn't know who the PHN were'
PHN systems and processes	'Community has been ready for a long time, but nothing has been happening… the PHN system has held everything up for months, the internal processes have just stopped everything and so nothing has rolled out.'
Operational challenges	
Time	'Timeline – because it is community driven everything takes much longer to get done than anticipated.' 'If anyone googles the Trial, they see the start date. We've got a bit pressure about what we've done in two years, when it is really only one.'
Geography	'The size of the region takes a lot of capacity in terms of travel and human resources to get around and do a proper consultation.' 'The value of the face to face conversations can't be overstated – you have to go, you have to be out there.'
Funding	'The downfall of primary health care is that everything is based on grants. All the positions are on grants. Service providers also. When contracts come up everyone looks for jobs. We lose capital due to loss of staff. We are ending a three-year cycle, about to begin another. We want to offer three years of funding to give service providers stability.'
Data-related challenges	
Lack of data	'Access to quality data…. when you are trying to design services, you'd use that as one of your main guides' 'There are no data on LGBTI suicidality. Not in the MDS or other datasets. In general, there is not a lot of evidence – there is population data, but we don't know how many suicides, or where people are presenting for services.'
Lack of real-time effectiveness data	'Need to work around predicting outcomes, need to find this out quickly, but evaluations take so long. Need to know we're on track.'

Table A5.2 Systems approach themes and sample quotations

Themes and subthemes	Sample quotations
Effective strategies	
Involving key stakeholders from across the sector	'Of all the successes of all of the trial sites, it has been the establishments of 2 tiers of governance. Where there is a working group and a steering committee - which has got representation from most of the key sectors to create a systems conversation.' 'We established a steering committee at the start of the trial that helps to drive the activity. That has had a consistent membership except for the Department of Education, engaging them was up and down at times.'

Themes and subthemes	Sample quotations
Adopting or adapting a systems-based framework	‘Having structured agendas and structured meetings that continually bring us back to Lifespan model and having the action plan structured around the LifeSpan model keeps you in touch.’
Existing PHN governance and processes	‘One of our strengths in our organisation is that we are one organisation that covers whole state. That makes it easier to engage with the state system compared to other states where one LHD will have multiple PHNs in their catchment.’
Linking with key local groups/organisations	‘We also have suicide prevention networks in each of the towns in our region who have played a big role in driving the activities.’
Community development approach	‘[…] now we are looking at investing in more community-oriented approaches. Because we will get better long-term outcomes. Overall, at a system level this has been very critical.’
Identifying system-level needs or gaps	‘Definitely we didn’t want to duplicate, so we looked at what was already happening and where the gaps were and worked with organisations already in the region or the suicide prevention networks and saw what they saw was a need and we engaged with them before we went into the community and rolled it out. We complemented what was already existing.’
PHN flexibility in commissioning	‘[…] we don’t have much funding to invest in that, so we are doing a lot of work with the Commonwealth to change to instead of specifying what we fund, specifying the outcomes we want the achieve. And giving us flexibility.’
The Trial coordinator role	‘Yes – I think we’ve had the most traction since the appointment of local coordinators in partnering organisations. It has probably just married up with when we finally got to the implementation phase as well.’ ‘Having a local coordinator is the glue that keeps everything together.’
Other	‘It was more about word of mouth and me [project officer] visiting services.’
Outcomes - service and activity integration	
Integration within and between commissioned providers	‘Across many commissioned organisations there is a direct link with the trial work. Many of them have created partnerships around the work they were doing.’
Partnerships and collaborations in delivery	‘[…] people with suicide ideation are referred and taken into the case manager and they [partner organisation] will assess them. The peer worker does life goal setting as well, broader than just a suicide work. They link them in with LGBTIQ safe services and touches base regularly. In the beginning, a lot was done by [other service provider] and [other service provider] who did a lot consultation with service providers and used that information to feed into the design of the program.’
Development of Referral Pathways	‘What it ended up with was the service providers negotiated referral pathways and MOUs with those various state government agencies, that is, police and ambulance and the various hospitals and touchpoints with community mental health teams.’
Outcomes - system-wide integration and coordination	
Built relationships and partnerships	‘Those partnerships have made sure that people are cared for during transition or waiting between services.’

Themes and subthemes	Sample quotations
	‘Relationships with organisations, community and providers. Relationships with other State and Federal stakeholders’
Transfer of knowledge	‘A key outcome is the contribution to the development of our regional mental health and suicide prevention plan. Recently released and will continue to drive the development of our comprehensive plan. That has been a direct result of the work we have done in the trial.’
Connected services and agencies: breaking down silos	‘that has a great impact on our work – bringing together agencies across the sector and breaking those barriers between them.’ ‘The trial has facilitated a clearer view of the activities happening, more dialogue around that, it has reduced duplication and has leveraged the benefit out of each of those services to lift a more seamless approach for consumers.’
Widened PHN scope of activities	‘From a commissioning point of view, some the contracts we have written through the trial have given us permanent enlightenment in terms of what our PHN capabilities are now, in terms of what PHN can commission and how we can do it.’ ‘And the work we did in negotiating the differences between the three local sites and allowing flexibility, but still working within the boundaries of what is expected of us.’
Other impacts	‘We’ve also seen collaboration across all three [suicide prevention] trials that the PHN is involved in.’
Implementation challenges	
Community resistance	‘Some tension at the outset. Got feedback from the [committee] that culturally the LifeSpan model doesn’t resonate or work’. ‘Getting groups to sign up to the Alliance. In the field we looked at mobilising natural groups, and their focus wasn’t/isn’t always aligned to the Alliance.’ ‘Community asks – why are you bringing this (systems-based framework) in? We already know what we’re doing.’ ‘The challenge is getting local working groups to understand the evidence behind suicide prevention. People with experience of suicide have their own experience. For example, QPR – they ask “can we change it?”… but if you change it you lose the evidence base.’
Lack of information and support	‘The materials are useful, but only to PHN – not community. They aren’t useful in supporting the decision-making process or in supporting implementation. The role of the PHN is to translate research into action.’ ‘Useful to have LifeSpan as a framework to facilitate discussion. But it needs a process guide on how to use it to get to a set of interventions. How to bring people together and how to facilitate making decisions together.’ ‘Process is more important than anything else – you need a guide. PHN’s responsibility - they have the resources, but they need guidance – a Process guide.’ ‘Operationalising guidelines weren’t there. Big gap between research and operationalisation. But it is beyond BDIs capacity to help. They haven’t operationalised yet either. When we do ask for

Themes and subthemes	Sample quotations
	help, we don't get the help we need, due to their capacity. Really good evidence base for us to launch but not operationalising.'
Coordinated approach challenges	
Conflict/competition between stakeholders	'People were coming in with lots of training. The PHN did a tender process to select five groups and one lead agency to manage the Trial in each site - a consortium approach – but the groups didn't want to collaborate. There is lots of competition in the sectors.' 'Various factions and tensions in communities.' 'There is mistrust of government funded initiatives and traditionally [the service organisations] don't get along with each other.'
Limited influence across the system	'The PHN has no authority to do anything. So, when you want to go the Department of Education and say we want to go in and talk to your schools, you have no authority. That's a big challenge.' 'We haven't been able to achieve outcomes when there was a misfit between the host organisation and the sector they needed to connect with – they didn't have that sphere of influence in some sectors.'
Stakeholder-related challenges	
State government	'State engagement – hard to get collaborative approach there working side by side.'
Local councils	'The local government is not strong on this… struggled to get these people on board.'
General practitioners/ hospitals	'Finding GPs who have capacity and willingness to step outside their usual day to do something different. We are remunerating them but maybe they think it's not worthwhile.'
Education sector	'Schools – Wheels turn slowly. Multi-layered. Can get support in department but it doesn't translate down to small regional schools. Staff turnover at schools is a problem. Keeping staff involved locally and integrating with state level.'
Other key stakeholders	'There are others we wish would be more collaborative and they aren't. In the [local region] distance is an issue, it is hard to get education, police, ambulance – I doubt we are on their radar.'
Capacity and logistic issues	'It's worked well in the metro region but when you get out to the regions – the reach is so large, makes it more difficult and fragmented to apply that system-based approach.' 'The length of the trial was a bit of an issue for some of the state government departments who didn't want to commit to more than 12 months of activity, but for other state government departments you needed that time to build relationships and manage the changing workforce that was happening at the time across the jurisdiction and across a wider sector.'
Other challenges	'Data is the other issue with the LGBTIQ community, because there is paucity of data. Which means the ability to create system change is constraint because people don't perceive there is a need.'

Table A5.3 Aftercare services themes and sample quotations

Themes and subthemes	Sample quotations
Tailoring services	

Themes and subthemes	Sample quotations
Promotion and recruitment	‘We have a webpage listing all of our commissioned services, but a lot of it has been through local networks and through referral pathways the providers has built engagement on.’
Linkages	‘Its [service provider organisation] so they are well engaged with other networks throughout the region.
Involvement of people with lived experience of suicide	‘Peer workers have lived experience and that is the key part of the whole program.’ ‘The community and service provider consultations formed an absolute part of that that allowed voices to come into the framework that would have never happened before.’
Outputs and impacts	
Complementing or filling a gap	‘Prior to that, the mainstream services weren’t always safe for both communities. We now have services that provide very specialised care.’ ‘Absolutely, the targeted clinical intervention for those two population groups is essential. Providing a safe space for Aboriginal and Torres Strait Islander and LGBTQI people is so important and considering their unique situations.’
Meeting needs and expectations	‘Overall things have worked well. The follow up care are all at capacity and went straight to capacity when they went online. We could quadruple the funding and we would still be a capacity, and there would still not be enough.’
Coordination with other services	‘I think in general that within service delivery agencies that are a part of the trial they have been very well integrated – each integrated with their own internal broader service delivery very well.’ ‘It’s providing better linkages with the hospital and health services.’
Challenges	
Referrals	‘Initially the service was having some trouble getting referrals at the start – there were trust issues, plus it’s a new service and people don’t know about it.’ ‘Setting up those referral pathways initially. Making people aware that there were services available.’
State and local hospital system issues	‘There is a reliance on the LHD to do a lot of the work – you need an internal project lead for that really. I manage that work internally.’
Provider operational issues	‘Part of the barriers we had there, was that intake process and needing follow up care quickly. So, in the second round of the contracts, we broke that contract up so they could specialise there work more. So, we had overcome some of those barriers that way.’
Sector capacity	‘Those referral points or clinical expertise doesn’t exist in those regions, so working through that and seeing what it would need to look like to ensure the safety of clients and also ensure that they were able to receive a service after a suicide attempt, and that the workforce was appropriate skilled for that.’
Other	‘[Peak organisation] were reluctant to put it on their website – they thought there was a safety issue.’

Table A5.4 General population suicide prevention activities themes and sample quotations

Themes and subthemes	Sample quotations
Tailoring services	

Themes and subthemes	Sample quotations
Promotion and recruitment	‘The approach that we took was going out in communities and finding champions that would be community champions, very much the community driven sense of I know this person, there out here talking about mental health and I feel comfortable to do that too.’
Involvement of people with lived experience of suicide	‘In every aspect, as part of our implementation groups. We have Roses in the Ocean sit in our partner groups.’ ‘We had lived experience on the state-wide advisory group and had input on the direction and the trial.’
Outputs and impacts	
Complementing or filling a gap	‘Every time we found something that was showing overwhelmingly through consultation or survey, we tried to match that need.’ ‘From what I know from our needs assessment, absolutely: there was a data need as well as a felt need in that area to really focus our attention.’
Coordination of activities	‘What we then learned is that there is added value because these activities are forming new partnerships.’ ‘All stakeholders involved right from the start, using the data in that and active participation in the modelling. That’s how we should approach this work, by sharing and supporting and enabling them to move through their work.’
Meeting needs and expectations	‘The community members have been very engaged particular with consumer or community education and a significant number of GPs engaged in the GP education that we rolled out as well.’ ‘They have definitely all had great traction and great uptake across the region and nationally’
Increased awareness and knowledge	‘Most of the outcomes have been around community awareness and equipping frontline staff and GP training.’ Increased awareness and level of conversation about the prevention of suicide. Increased skills and capacities on a different range of levels, from identifying people at-risk as a community member, a knowledge how to plan at a community level.’
Other impacts	‘For communities – better understanding of how systems work and being better connected to build that community safety net.’
Challenges	
Engaging general practice	‘GP engagement piece has not gone so well. For me that’s an area that requires probably a lot more innovation than what was done in the trial site to engage the GPs n the way that they would want to be engage with. So that for me has been something that needs further work.’ ‘I don’t feel we have achieved some of the real pressing issues around suicide prevention like access to emergency departments, health services that operate those hospital settings, minimum outcomes for GPs despite that being our bread and butter.’
Community-related challenges	‘The community wasn’t as engaged as we would have liked to. The coordinators that we appointed in the host organisations became the busy bees and doing most of the work and struggling to engage their working groups and the extended community.’ ‘There was confusion around community-led and community-development – we could not start from scratch and offer co-design, so our approach was build that trust and understanding.’

Themes and subthemes	Sample quotations
Trial design	‘We adopted a community-led model, but the restrictions on time (about 18 months) were challenging.’ ‘We didn’t allow enough space in the planning phase for the organisational set up and bedding down workers. There was a lot of pressure to get contracts out of the door.’

Table A5.5 Men themes and sample quotations

Themes and subthemes	Sample quotations
Men - approach	
Tailoring activities	‘From the get-go we designed activities on the premise that we know that men are not already connected to mental health or GPs the same way that women often are, so we should not rely on those channels. So, our approach was to connect to small business, places of work and sporting groups, i.e. local fishing group etc. where do we know that men are already showing up.’ ‘Mates in Construction - we have done work with them in the past. They do great work. All of those field officers are qualified support people and trained.’
Promotion and recruitment	‘We found that the voice of lived experience through a men’s road show that travelled the region and had lived experience speakers which was really well attended by males.’ ‘The young to middle-aged men, traditionally that’s a hard population to connect with. We thought sport would be a good way of connecting. We looked at several regions with high demand and…, we choose to access sporting codes.’
Involvement of people with lived experience of suicide	‘We actively searched for them and looked for males who were already engaging as advocates for RUOK, Beyond Blue, Roses in the Ocean, and had their support network.’
Men - outputs and impacts	
Complementing or filling a gap	‘It was a room full of service providers, we wanted make sure we were reflecting the real community need. We needed to target services to men who were not help seeking […] our action plan reflected that approach. ’
Coordination of activities	‘We have seen a number of services collaborating that weren’t previously.’
Meeting needs and expectations	‘We ran one training and we had a great turn up of people. It highlighted that our targeting was on the mark.’ ‘The feedback we get is always really good, that the training was helpful.’
Increased awareness and knowledge	‘A lot of businesses are now recognising that they have to look after people’s mental health. Building and construction, not just fishers and farmers, but those that have got young male employees who are often contractors who don’t know when they will get another contract, so they have uncertainty with finances.’
Other impacts	‘I think so given what the GPs are saying to us in that people are help seeking more. It is men not just women.’
Men - challenges	
	‘Men are hard to engage in steering committee; it’s not how they want to be engaged. Happy to be involved in a presentation or this stuff we’ve mentioned. They’ve given feedback on our other stuff.

Themes and subthemes	Sample quotations
	But how do you get a farmer to take timeout and come to a steering committee meeting?’ ‘Hard to find experts. Specially in regional areas. Keeping it in scope is hard. Nobody cares when a middle-aged man dies. Not a minority group. Hard to make it a priority for everyday people.’

Table A5.6 Young people themes and sample quotations

Themes and subthemes	Sample quotations
Young people - approach	
Tailoring activities	‘We have used media to target specific areas and groups after a suicide in the community, such as improved help seeking through social media for youth. We have been able to get people that we haven’t been able to get before.’ ‘The fact that they were working with youth services – predominantly headspace – makes a big difference, because it is really making it youth friendly.’
Linkages	‘I think it just enhanced them in terms of how they work together and their referral pathways in and out from each other.’
Promotion and recruitment	‘Understanding is that the approach through various community groups in terms engaging young people, obviously schools, various other activities and groups where youth hung out.’
Involvement of people with lived experience of suicide	‘We established the reference group which supported some activity. For youth, we reached out to Headspace so that the youth could have a supportive environment and if there was to escalate in their need, to have some direct support.’
Young people - outputs and impacts	
Complementing or filling a gap	‘Complementary also in terms of other things we commission in those community as well, because it provided us with the opportunity to create those links and pathway into those services in support of people who may struggle within those communities.’
Coordination of activities	Down in [local area] they focus on young people, that touches everybody, so they have been having a lot of community activities, based on the Lifespan model, and that’s had lots of buy-in – so other community groups are now linking in and holding joint events and so on.
Meeting needs and expectations	‘We have trained over 500 teachers in suicide prevention and found that the schools that undertook YAM where the teachers undertook QPR training we found that 100% of the students were made to feel supported.’
Increased awareness and knowledge	‘We have used media to target specific areas and groups after a suicide in the community, such as improved help seeking through social media for youth.’
Other impacts	‘The trial sites generate demand by encouraging people to use services.’
Young people – challenges	
	‘the process to get anything into schools is so lengthy the Trial wouldn’t have time.’ ‘Can get support in department but it doesn’t translate down to small regional schools’

Themes and subthemes	Sample quotations
	‘getting youth represented on the group is the biggest challenge. The group was concerned that having youth sitting on the group was a safety issue and also the scheduling of the meetings made it impossible for youth to attend. Even youth services were not engaged.’

Table A5.7 ex-ADF themes and sample quotations

Themes and subthemes	Sample quotations
Ex-ADF - approach	
Tailoring activities	‘One of the things we picked up. The CORES programs (Community Response to Eliminating Suicide*)*, we picked that up, that’s run up here with a local farmer, a North Queenslander. That’s very effective. So effective, we said OK let’s use that one-day CORES program, make it a one-hour video - our version of a QPR thing. We will produce that for the veteran community.’ ‘Not using the suicide brand as a keyword to keep the trial in a positive light rather than a negative light.’
Linkages	‘We got incredible synergies.’
Promotion and recruitment	‘We are well regarded in the veteran community we get them along. The thing we are starting to get involved in is to draw in the members of the general community who wouldn’t attend a veteran event. So, making those connections and getting people to see that they are all one, the solution is with the community and in the community.’ ‘Communications. We took a consciousness decision. How engage younger veterans, we need to speak in their language, on their devices, Facebook etc.. We decided to engage a local communications team.’
Involvement of people with lived experience of suicide	‘Yes, at every level. Steering committee, implementation team and advisory team. One of our programs, community response program, a success out of that was the DVA funded two positions for Veteran peers.’
Ex-ADF - outputs and impacts	
Complementing or filling a gap	‘I think trial has been successful for commencing that journey, which still has a way to go.’
Coordination of activities	‘If we didn’t have the commitment from each of those leaders in the community that are across those different elements, the police, ambulance, it wouldn’t have worked. So, unless you have commitment from those key players it won’t work.’
Meeting needs and expectations	‘There are lots of successes. Our community grants are successes in themselves for providing connection and engaging for people who might isolate themselves.’ ‘We have had many people coming back, especially with the community grants, saying that it saved their lives.’
Increased awareness and knowledge	‘They are now aware that it is an important cohort that some GPs have more experience in so others can refer to them for extra support.’ ‘I think the ex-ADF community are more visible in the community. There is more awareness in some of the first responders and there are members of the ex-ADF and the wider community.’

Themes and subthemes	Sample quotations
Other impacts	‘None of them have gone back to a private clinic since [participating in a community grant funded program]. Some of them have gone back for some day-care. But some of them previously would spend long times in there.’
Ex-ADF - challenges	
	‘The biggest challenge is to reach isolated veterans and how do you reach them.’ ‘The YAM [Youth Aware of Mental Health] program we tried for our cohort, but for all sorts of reasons it didn’t get off the ground.’

Table A5.8 LGBTI themes and sample quotations

Themes and subthemes	Sample quotations
LGBTI - approach	
Tailoring activities	‘With the LGBTI services/activities we were working with [LGBTI service provider] and other identified services providers who work with that population.’ ‘A Taskforce was set up in the beginning of the Trial composed of specialist LGBTI services, people with lived experience of mental health and suicidality, as well as community.’
Linkages	‘Definitely with GPs and the HHS. We have identified that there is the need to continue that work into other community-based services. Have done well with GPs and HHS in this region and they are pretty consistently well used. The next step is to map those referral pathways back to the community as well.’
Promotion and recruitment	‘It’s word of mouth, which is common in the LGBTIQ community. Those trust issues, if it comes from someone you know you’re more likely to try it.’ ‘We have a webpage listing all of our commissioned services, but a lot of it has been through local networks and through referral pathways the providers has built engagement on.’
Involvement of people with lived experience of suicide	‘The service uses peer workers who are all people with lived experience.’ ‘They sit on the taskforce. That’s where we get a lot of that input. The advisory groups also have lived experience in their organisation to help shape their projects.’
LGBTI - outputs and impacts	
Complementing or filling a gap	‘Significant service delivery on the ground where services weren’t available before.’ ‘With the LGBTQI community there is a lot of trauma which stops them from accessing services. All our services our full with waiting lists – this is indicating that we are meeting demand. And people are screaming out for training and upskilling. ‘
Coordination of activities	‘The most amazing synergies has been watching partnerships form between organisation, better linkages. Organisation that had traditionally not worked well together, some of those have been strengthened and wider partnership have been formed across the sector.’ ‘Lots of positive relationships. Being able to break down a bit of that ‘us against them’ mentality in services and services now understanding that working together is really valuable and also

Themes and subthemes	Sample quotations
	working with PHN – seeing we are not just a funder but we are a partner – we have really driven that home.’
Meeting needs and expectations	‘The mentoring programs are at full capacity and well received.’ ‘They have had really good engagement. It’s been really positive. It also been positive for the mainstream services, providing something that hasn’t been available and at no cost.’ ‘The training has a lot of momentum and has gotten good feedback.’
Increased awareness and knowledge	‘For us, it was about building capacity of the LGBTI community to respond to suicidality. And I think we are, that we are meeting a need and meeting that outcome.’ ‘The Affirmative Practices initiative has been able to get into EDs which has never been done before, and people are being trained in suicide prevention for LGBTI people in areas where it has never been done before – so that’s been a great outcome.’
Other impacts	‘Certainly, the relationships and collaborative working we had hoped to achieve – and we did achieve that.’
LGBTI - challenges	
	‘There are no data on LGBTI suicidality. Not in the MDS or other datasets. In general, there is not a lot of evidence – there is population data but we don’t know how many suicides, or where people are presenting for services.’ ‘Within the LGBTI community there is so much diversity – to try and capture all that in one Trial is difficult – you want to target broadly but also make sure it is relevant to all groups.’ ‘It took the [Trial committee] a long time to move from having a ‘problem’ focus to a ‘solutions’ focus.’ ‘Healing was needed.’

Table A5.9 Older people themes and sample quotations

Themes and subthemes	Sample quotations
Older people - approach	
	‘There was a little bit of work around the elderly population, some of the training was changed to ensure older people were better engaged, based on the suicide audit data.’
Older people - outputs and impacts	
	‘The [expert workshops] were the most successful but the number of people exposed to those events would be fairly minimum.’
Older people - challenges	
	‘We would have been more effective if we did not have as much reliance on community. Our position as the PHN is much stronger to have those inroads at the policy level and with service organisation. This was particularly with having inroads with the aged care sector.’

Appendix 6: Mid-trial PHN Staff Survey

1. Workforce
    a. What skills and experience do you think are most useful for a trial-coordinator role?
    b. What challenges, if any, have there been related to staffing during the planning and roll-out of the trial?
2. Implementation
    a. What have been the key challenges to the implementation of trial activities and services to date?
    b. What have been the key enablers in implementing trial services and activities to date?
3. Impact
    a. What do you think has been the impact of the trial so far?
    b. What do think will be the impact for the trial in the future?
4. Concerns
    a. What have been your concerns, if any, about the trial to date?
    b. What concerns, if any, do you have for the rest of the trial?
5. Anything else
    a. Is there anything else you would like to tell us about how the trial is going?

Appendix 7: Themes and sample quotations – PHN mid-trial survey

Table A7.1 Planning themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Challenges encountered	
Staff turnover	'There have been challenges when staff members have left their position and then the delays that occur during recruitment and handover.'
Co-ordinator role	'The role for each coordinator and project officer are extremely large in the sense of workload and management. I feel each position is under resourced. The networking and relationship building is not acknowledged in the sense of the time needed to do this work.'
Facilitators - Trial coordinator	
Project management skills	'Project management skills and knowledge of project management best practices. Knowledge of project management principles.' 'Governance and project management training including program logic, consultation and engagement, project planning, reporting and evaluation.'
Stakeholder management skills	'Excellent networking and relationship building abilities across levels of government, non-government, community services and agencies and cross-sectors.' 'Community development, high level of communication skill, ability to triangulate activity across different sectors.'
Suicide prevention experience	'Conducting community suicide prevention programs.' 'Ideally experience specific to suicide prevention.'
Sector knowledge	'Sound knowledge in community and sector development sector knowledge.'

Table A7.2 Systems approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Integrating coordinating services	
Building relationships/partnerships	'In the Commissioning process want to identify who can deliver the programs in a culturally safe way but also to see if other partnerships or activities might eventuate.' **'We brought all our 18 commissioned services together and asked them to share: 1. What service are you funded to deliver? 2. Eligibility criteria. 3. What is intended to be achieved by your service? This encouraged them to network. We allowed one hour afterwards for this. There was a lot of sharing of cards and phone numbers. Positive feedback was beyond what we expected.'**
Complimenting existing activities/integrating	'We are interested in value adding to existing services and fostering those collaborations – i.e. building in some suicide prevention capacity or seeking providers who can demonstrate some suicide prevention experience/training into other mental health services tenders.' 'There are existing PHN services that we can build on – fund an ecosystem of support in each community.' 'PHN tries to ensure that the various activity streams of the Trial are connected and connect with non-Trial funded activities.'
Referral pathways	**'We build referral pathways into all our contracts and ask for reporting on what ones are used and what aren't.**
Facilitators	

Themes and subthemes	Sample quotations
Stakeholders	‘Good partnerships. Strong commitment. Community involvement.’ ‘Finding and working with people that are passionate about preventing suicide in their communities.’
Coordinators	‘The coordinator position consistently driving activities and keeping momentum’
Funding	‘Availability of $ resources to fund the work’
Challenges	
Stakeholder barriers	‘Planning and establishing phase at start to gather the most appropriate people at the table. Then to decide what approach the community wanted to use in the Trial site area. The length of time to bring in community together in country regions’
Timelines	‘It takes more than a few months to mobilise a community, find the expertise to develop a realistic/achievable plan, understand what a systems approach is, engage other community providers to initiate and implement activities (we don't fund services per se), and know if anything is changing. This approach is a 5+-year undertaking however we initially had two years to complete this work. It is a huge expectation on communities and very complex.’
Systems approach	‘Operationalising and implementing multiple strategy and activity at the same time in a localised area. There was many moving parts to the Trial.’ ‘We need to focus on equity, social justice, social determinants and actual human/social resources to make change. The best models in the world (and LifeSpan may well be one of them) will not, in themselves, save lives.’
PHN capacity	‘Understanding our role as funder / partner / resource to Trial sites.’ ‘PHN administration workload and lack of knowledge about how to undertake suicide prevention initiatives.’

Appendix 8: Consultation topics for community stakeholders

(Round 1)

1. How were you involved in the trial planning?
a. Were you satisfied with the way your contribution was received?
b. Were all relevant stakeholders included? Why or why not?
2. Do you think that the trial will be a useful additional initiative, why or why not?
3. How do you think trial activities will fit in with other things happening in the suicide prevention space in your local area?
4. What challenges have there been in planning for the trial activities in your area?
5. What do you see as the strengths of the trial?
6. What are you hopes for the trial?
7. Is there anything else you'd like to share with us about your experience of the Trial planning?

(Round 2)

Planning

1. How has stakeholder involvement changed? Dropped away? Are there gaps?
2. Have there been barriers to the involvement of key stakeholders? Have these impacted on the delivery of activities/services.

Implementation

3. What were the key enablers of successful implementation?
4. What were the main challenges in implementing trial activities?
5. Did any of these impact on the roll-out of trial activities?

Outcomes

6. Do you think trial activities [your activity] addressed a local need or gap?
7. Do other stakeholders i.e. community, services, government, consider this a useful service/activity
8. What have been the results/impacts of trial services/activities?
a. If 'awareness', prompt: what exactly did people become aware of?
b. If 'connections', prompt: connections between who?
9. Are activities/services integrated with other health or social services?
10. Does this activity [trial activities] facilitate a more coordinated approach to suicide prevention in your region?
11. What factors do you think are essential for suicide prevention in you region/target group?

12. Are there things you would do differently?

Post-trial

13. Do you think this should be an ongoing activity?
14. What do you see as the role for PHN in suicide prevention after the trial?
15. What do you think will be the legacy of the trial in your area?

Appendix 9: Themes and sample quotations – community stakeholders

Table A9.1 Planning themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Stakeholder Challenges	
Getting stakeholders to work together	'Facilitating a process so a diversity of voices can be heard. There will always be leaders who will have louder voices. If looking at innovation or to do something different, the challenge is to create a safe space for that to be heard – space for more voices.' 'Many people started out as community activists which evolved into jobs in the NGOs. So, working in the NGO space and with groups of various levels of experiences and skills-mix presents challenges. For example, it impacts on decision making as people are overly cautious and reluctant to make decisions as they are unsure, they have the skills to do so. It is important to have those groups and people involved but they need to be upskilled.' 'As the service providers we have inside info. We hear the reality. This can be difficult to raise in a group like this.'
Stakeholder priorities	'The challenge was engaging these people and letting them know what their job was and not getting side-tracked by other stakeholders' goals. It requires good facilitation which is hard to do with a hot button issue like suicide.' 'A lot of different stakeholders say, "the problem is in this group", another group says, "no it's not, it's this group". No one has accurate evidence, only anecdotal stories. But people are passionate with their own stories. They are a hard group of people to manage with the very meagre resources that this project has.' 'With community, you can get smart but uninformed people who can become single issue zealots. But you can also have agencies saying I know what's best for you. You need a balance.'
Diversity	'A challenge is finding a common language for all the stakeholders – for example peer workers, clinicians, service providers and so on.'
Multiple 'hats'	'Multiple hats – there were a lot of people in that room who had a lived experience and were managing LBGTI services as well and trying to differentiate what hat they were wearing – being clear about that.' 'Always challenges when you have a sector come together and they are forming the areas that will tendering – so they are part of the co-design but also tendering. Some organisations have stronger voices and have a more strategic vision of where they could be involved and where they'd like to be involved – and just trying to balance those difficulties that sometimes arise.'
Missing stakeholders	'They didn't have the opportunity to engage. Many doctors and mental health workers should have been there. I wonder if one consultation between X and X on a weekday was the way to go. I don't think so.' Emergency departments and first responders are not there. Important especially given the amount of criticism they received in the meetings. There is someone there from [hospital] who is good but needs to be more represented. Maybe also general GP involvement. 'PHN has made a big effort. Can be hard. Education can be a hard one. Tend to send guidance offices, very hard to get principals. Overall school reps are hard. Police and ambulance are hard too. Always on call.'
Community-related challenges	

Themes and subthemes	Sample quotations
Competing priorities/preferences	'Service providers are not looking at it from the community point of view and there is a difference between what service providers [i.e. the Working Group] want for the community and what the community wants for the community.' 'Individual working group members letting go of their organisational obligations / constraints to focus on the overall aims of the Trial.' 'Everyone come with their own agenda and interests and it took a lot of talking to get people on the same page.' 'Sometimes the data tells you one thing and community tells you another, so you have to delve into it and tease out what is behind those differences.' 'There's a group there who have been around for a very long time. The leader of the group at a meeting said, we've been doing suicide prevention in [Town] for a long time, we just need money. We don't need you coming in to tell us what to do.'
Lack of capacity	'Existing workloads. Getting communities on board.' 'Sometimes within our own organisations there is not enough knowledge. Needs to be community ownership but community is not always aware of what is happening on the frontline.' 'People accepting the model. Understanding what can be done. People have different ideas in their head about what leads to suicide.'
Lack of buy-in/Trial fatigue	'Community apathy. 'I'm right mate'. Younger generation don't care, doesn't affect me.' 'People are fatigued by that (funding cycles, uncertainty).' 'Overlap with existing activities.'
PHN Related Challenges	
Not directive enough	'PHN knows what the Trial is about. and they seem to assume that we do but because we are not in the PHN loop we don't know what is going on.' 'We were confused about the purpose and how things would work.' 'There was a lot to take in at the beginning of the process and it was all a bit amorphous and unclear what the overarching purpose and direction where. [Trial Coordinator] held it together through this period of abstract activity through his communications with the taskforce, but it would have been more useful to have a bit more concrete information and structure up-front – because people who don't deal well with ambiguity peeled away. Needed a bit more of an overview at the beginning – to see the macro picture.' 'Needed more parameters and guidance generally in the earlier stage.' 'It wasn't so much the time pressure; we were quick to get it done fast. But we were doing that blind. It's all been iterative- now you've done that, you need to do this and that. We weren't fully informed about the process; it wasn't explained clearly. It impacted on what was in the activity plan.'
PHN not responsive to community	'It was a battle to reconcile what the community wants and is saying and what the PHN wants – they have their own agenda. But this has to be community led.' 'Some feeling that activities have largely been pre-prescribed – and that didn't leave a lot of space for consumer [community] voices.'

Themes and subthemes	Sample quotations
	‘There were some ideas/activities that we already had running but were then told ‘No, this is what we are doing’ - even though we consumers/peer workers had a better understanding of what would work locally.’ ‘The approach was – this is what we’re doing, suck it up if you don’t like it – then they left.’ ‘Generally felt that the PHN doesn’t take into account what the local SPN has been doing – isn’t supporting it, building on it or integrating with it, but starting out all over again.’ ‘Decisions have been made by PHN about what approaches to take without community consultation in the first instance. Suggestions have been made that aren’t a good fit for the community or are too soon. Being able to have honest conversations with community members - hearing that voice is important.’
Overlap with existing services/activities	‘Would have been a good idea to map services/activities first -then we would have had a better idea of what programs we could have gone out to organisations to deliver.’ ‘There is so much duplication. People did not look at what was on the ground and did not work with the office of the psychiatrist.’ ‘There has been a Suicide Prevention Network here for over 20 years. I’ve been the chair since 2007. So, when they come in, there is an already established network and the PHN comes in and they want to enhance things but sometimes it seems like they are coming and wanting to start all over again.’ ‘We’ve been delivering programs (safe talk, assist) through other funding. Why wouldn’t you look at how this is going already?’ ‘A lot of what PHN were doing was community work and local knowledge was already there, so why do we need the Trial to do it all again.’
Facilitators – stakeholder engagement	
Inclusiveness	‘When it started out the PHN looked across the sector to see who should be involved. It’s been very organised and well thought out. When they’ve thought things are needed to be added, they’ve done that.’ ‘Yes 100%. All have been asked to come but it’s not always reflected in our meetings. It’s been a fair process. More should be coming but it’s not for lack of trying.’ ‘It is a diverse group with representation from many different sectors – have been through the storming and norming phases and now each brings a different perspective to the table.’
Facilitators – community-related	
High level of commitment	‘Excitement about it – whenever you meet there’s excitement about what this can do for the community. Everyone sees the need.’ ‘I feel the members of working group are enthusiastic & committed to doing the best for community & individuals at risk.’
Trial community-owned and led	‘It was imperative that the community has control and not just have someone parachute in and say what they should do – it has to be grassroots.’ ‘The fact that it is community making these decisions, dictating our needs and our wants instead of outside people dictating, which happens often.’

Themes and subthemes	Sample quotations
Facilitators – PHN-related	
Collaborative approach	‘Building on capacities that are already there rather than coming in on top.’ ‘Trying to look at what is happening on the ground and seeing what the opportunities are there.’ ‘Using experienced local organisations who are able to deliver the services.’ ‘[PHN] have been respectful and used existing relationships and built on it.’
Bringing stakeholders together	‘The group has brought together all the different moving parts. For example, the PHN is bringing together different streams/buckets seamlessly to the point that you don’t know what is the Trial. It’s a holistic focus.’ ‘I haven’t seen linkage between health services like this before. It’s a very good thing.’ ‘Has to be a constant collaboration between business, and community and services – that’s why the PHN is valuable – they can manage that.’ ‘Capacity to harness so many organisations into a shared objective.’
Taking community input onboard	‘High quality of the PHN work – they really listened, documented what they heard, and returned it to community.’ ‘The PHN didn’t just say ‘this is what we are doing, and this is how we are going to do it’, they actually had a significant period of consultation and got in other people in to show other ways of doing things.’ ‘The focus has changed – broadened to emotional wellbeing – focusing on more upstream factors rather than emergency care. The PHN has allowed us to do that – now they are very flexible and allow the SC to evolve the Trial.’
PHN staff/team	‘Suicide prevention staff at PHN have been very supportive, more so than PHN staff I’ve dealt with in other areas. ‘ ‘Brilliant team at the PHN.’
Communication	‘They have been extremely open in sharing information and understandings and including us in decision making. They have been very open.’

Table A9.2 Developing and implementing a systems approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Strategies for facilitating a systems approach	
Community engagement approach	‘the reason that [PHN] have worked well is that they don’t treat every community the same they worked out (like we do) that local communities know what works in their area rather than having a top down approach.’ “I like the localised approach to what are the community needs, which will be different across communities. Our PHN is open and collaborative, well-considered. Focused on community needs and target some services to address those issues. That localised model works well.’ ‘There have been different funded activities across different sectors within communities. There has been a lot of support through individual grants across the trial region and that has been unique and diversely applied to communities.’

Themes and subthemes	Sample quotations
Communication strategy	‘And on a policy level ID33 [manager PHN] sits on the Premiers Council for Suicide Prevention as well, which creates another opportunity to share information with a broad range of stakeholders.’
PHN Flexibility	‘the communication, connections and relationships and utilising local community and the people on the ground, allowing them to come up with solutions, has all been key. And being able to negotiate that to fit in the framework and trial.’
Capacity building	‘Hopefully, the trial has contributed to ongoing sustainability of the community suicide prevention group. Because there has been training, upskilling and support has been provided by committee members outside of the meeting.’ ‘Supporting the community to be skilled up has been a great opportunity with this project.’
Interagency policies and agreements	‘All of our alcohol management plans now include mental health and suicide”. ‘We have some formal partnerships agreements; for example, Fraser Coast Mates – so that rather than duplicate activities we tap into some of the existing activities.’
Identifying needs and gaps	‘I think at the start we had no roadmap, no interagency involvement and we were working in silos. We now have identified the key players in mental health in our region. We understand the skill-set we need to look after someone involve in suicide or suicidal ideation.’
Funding	‘If people don’t get funding they don’t tend to be involved. When the funding is not there the work ends.’ ‘One of the main things on the funding we received through the trial, is the fact that we would have never been able to do a lot of things we have done locally and having members of our committee attend conferences. We are totally volunteer operated – the trial has enabled to so a lot of things that would otherwise not have been possible’ ‘It carries weight when you say is funded by the Department of Health, and that it was Lifeline who has contract because there is a brand there - it may be a bit narrow – but there is a brand there and that brings weight to the whole project.’
Place based approach	‘E.g. housing coordination with local councils who have inroads with community, community organisations and intersectoral agencies’
Monitoring and evaluation	‘We also do an action learning circle with the other trial sites through UTAS – we took learnings from each other, was helpful.’
Succession planning	‘We focused on the end right at the beginning of the process.’ ‘Services approach very rarely has, what the word, so in this initiative it was never thinking of how does it make sustainable aftermath? As part of the funding cycle, only at the end of the contract do you think about who can I hand it over too and services that you may want to hand it over too already have a lot of work. So, we now have asked ourselves where does it go after the trial? That’s when we went, we need a community initiative run by community people not a service-based delivery mechanism.’
Factors facilitating engagement and cooperation	
Bringing organisations together	‘Providing that platform for a coordinated response – the PHN doesn’t need to provide the coordinated response itself – but bringing people together across the region.’

Themes and subthemes	Sample quotations
	‘Keeping all stakeholders involved and informed and together and keeping it going.’
PHN Coordinator role	‘… coordinator draws together all of the streams of work and gives suicide prevention activities "a name and a brand"’ ‘Having a coordinator role just adds to the cohesiveness. … everyone to just do it in their spare time. Whereas having a coordinator in that lead role can draw all the threads together and gives it a name and a brand. It had to be a Trial, to test the waters etc, but it needs to be a part of a human response to the world.’
Enabling environment	‘The different non-government organisations that have been contracted to run some of the programs through the trial, has created a level of stakeholder engagement.’ ‘The networks have been a key link for the trial getting closer to the community’ ‘The other thing too with the trial and [trial coordinator] being on Premier’s Council is that we have the whole of government issue group. It has brought Suicide Prevention to the forefront for the PHN and the fact that they can tap into government resources when the need to, for example with drought, fires – they are there at the table and the PHN can get to senior executives within state government.’ ‘It has given them a boost and an ongoing purpose for the networks.’ ‘I also think a key enabler has been the way communities have welcomed the events and opportunities that have come to the remote and rural areas as part of the trial. People have wanted help and support for a long time and even just to talk about suicide.’
Involvement in planning, consultation, Trial Committees	‘That’s what really impressed me, it has been a very coordinated approach. The way that they set these campaigns, put people in charge of them. Regularly get action plans and goals. And if they campaigns haven’t been working, they stagnate them and don’t move them forward rather than continuing to put money into something that doesn’t seem to be effective. They have been focusing their attention on things that are effective…. I have been impressed by how organised this group has been, focusing on outcomes at every meeting’ ‘We are pretty grounded as a committee within community. Even though a number of us have significant positions in organisations, we haven’t gone to the tops of the organisations. We’ve involved hairdressers, butchers, community service events such as holiday programs. So, it is based around community rather than a top down approach. It is a ground swell of people who know who to go to and see and who have access to a range of people.’ ‘Asking people within the committees to rotate, rotate where the meetings are held so that different people in the community can have those meetings on site, the opportunity to welcome other community members. That is how you can create a place where they feel valued and appreciated to allow people to share more information.’

Table A9.3 Systems approach impacts themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Outcomes related to integration of Trial services and activities with existing services and activities	
Partnerships and collaborations in delivery	‘There is a health alliance between the HHS and the PHN looking at common themes’ ‘There are collaborations with mental health etc. by having people on the committee from different parts of the sector.’ ‘Then there is the bereavement response group. We set up a response group that involves community organisations, and also got police, fire brigade, and ambulance involved. … Now if there is an incident that group can mobilise and decide how and who to get involved.’
Referral Pathways	‘We have member from HHS on committee, have direct referral pathways to direct services from health as well, so I think those involved from Health would think it useful.’ ‘Anecdotally, in most communities there has been an improvement in integration between the State and NGO’s in terms of referral pathways.’ ‘The other achievement is about some of the processes, such as enhanced pathways.’
Provision of service information	‘So, we really had to engage and have all of the stakeholders aware and integrated into the program for it to have been successful’
PHN Governance bodies	‘Between our executive director of mental health for the region and the CEO and deputy CEO of the PHN, there has been a signed-up agreement on having a shared forward plan.’
Outcomes related to system-wide integration and coordination	
Building relationships and partnerships	‘I think there is a lot more collaboration in our sector than a few years ago. It is very common now in discussions to hear talk about not duplicating, not reinventing the wheel, who’s doing this already and how can we support them to expand and so on. The national trial can take credit for bringing up this need to work together.’ ‘It’s the relationships in the committee and out of the committee. Not necessarily in the committee, but the relationships that come from them. There has been an increase in cross-conversations in relation to suicide prevention… Coordination outside the meeting has increased.’ ‘A key thing would be the collaboration between stakeholders that evolved from this model, built from relationships.’
Connections between services and agencies	‘What this did was bring everyone together under one banner and create that dialogue and looked at what would and wouldn’t work, what the implementation difficulties would be.’
Information sharing	‘If I reflect on 2 years [ago… there was] a gap between State and Federal government. Reflecting on that now – a lot of that gap has been bridged by having the likes of PHN sitting on the Premier’s Council. That helps disseminate that commonwealth information’ ‘I stay connected to different groups people from youth services, health department, rotary and other service organisations. So yes it is definitely bringing community from different groups together with a specific focus. And some of the schools have been involved, they want to stay in the loop but not come to the meetings.’

Themes and subthemes	Sample quotations
Co-hosting events, aligning with other activities	'One of the activities we did in mental health week was to have a stall at the local market in town with reps from headspace, standby etc., all the services. Different people from community approached us and person from relevant service engaged with them. Through the [suicide prevention] network we have made other services accessible.' 'We ran a forum in Launceston as part of it, collaborating with a lot of people, and [inaudible] involved different training providers in the area, coordinating in order to make use of the skills people already had.'

Table A9.4 Challenges to implementing a systems approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Challenges – community resistance	
Not compatible with community-based approach	'PHNs heart is in it but they are still working out how to do suicide prevention. They are trying to overlay a medical model over a community model.' 'One challenge is that this is a community development agency … and a lot of LifeSpan is down the clinical end of the spectrum.' 'I took a while to get comfortable with the model, not comfortable with depression as part of the model, but have been able to use it to describe suicide as a social model, not pathologising. The model doesn't fit with the [our organisation's] model. Had to adapt it. But the evidence base is there.'
Ignores local knowledge/ current activities	'What we wanted didn't really fit with the Trial or with the Alliance Against Depression. None of the suicides that happened fitted into the model – 'it's not what we're experiencing in our community'. But that message didn't get across to begin with.' 'Not every aspect of our approach fits into the box – so alignment with other Trial sites [within PHN Trial site] is a bit of the challenge. [Organisation] is a wholistic approach and can be in conflict with the prescriptive approach of a model. But in the end, we have managed to reconcile the two.'
Inappropriate for local conditions/focus populations	'They didn't want to use anything from BDI/LifeSpan because there is a bit of exceptionalism i.e. "it's different up here; it's different for [target group]".' 'Ties in with the AAD – but that was a model taken out of high-density countries and I wonder about how it translate to regional and rural WA.' 'While it is good having a base model like LifeSpan and trying to work with the evidence-base it is a challenge – the evidence base doesn't relate to rural areas most of the time. The Data says one thing, but they are talking about models, structures and services that aren't relevant in rural areas. So where is the evidence for [Town] – this region is different, in terms of culture and environment.' 'Every region is different so just bringing in programs/activities that have been done outside won't work.'
Burden on community to understand	'We all had so much to learn and work through, and we were a bit slow off the starting blocks. It was a lot to go through to work out which one was best for us. It's been a lot of roadworks. Especially for people who have been involved to a lesser degree.'
Validity of the framework	'I think the rhetoric around evidence base may stifle innovation.' 'I'm really questioning this 'systems-based' approach.'

Themes and subthemes	Sample quotations
Engaging relevant stakeholders and sectors	‘Some of the big organisations and government organisations such as the Department of child safety. I know that they can be very busy and I don’t know if they would have the time to be as involved. I’m not sure whether they would.’ ‘The answer is somewhere in between, that different communities need different things off course, but also if we do too much there is a switching off that occurs.’
Trial scope and duration	‘Time. If you rush anything, if you take your time and built a relationship and walk alongside them, you have more cooperation. If we are there, we are having conversations and we are being real, meeting people where they are. They remember ‘that suicide bloke’ and it will get around and we get that phone calls and we have that capacity built in the community. If I come in from the coast – it doesn’t work. There is that buy-in because you’re local.’ ‘The biggest issue is the funding proposal for an activity. It is developed but then can take 6-7 months to get approved so there is frustration about the amount of time it takes to get things off the ground.’
Workforce	‘The biggest issue with direct contact with PHN was turnover of staff – not with other networks or organizations involved (RITO, MATES), but there has phenomenal turnover at PHN.’
Existing services and systems	‘Don’t think so at the moment. As far as the trial. We are more on the fringes. Suicide for us is a regular occurrence on our end, for our clients. I do think with adult mental health, which is where our clients end up after a suicide attempt, they are doing a good job, but they are bombarded with cases.’ ‘Follow on from that, it’s the outside support and that follow up help. We don’t have as much as we need here.’
Communication and information sharing	‘For me coming in more recently. I found it totally confusing to find out who was driving this whole thing, PHN? BDI? Whatever else. Very confusing the whole set up of it.’ ‘We haven’t been informed much at all around those things, probably more some small events where they pop up and go, here is a resource or something. But nothing where you go oh it’s there and there, and visual all the time.’
Measuring impact	‘I am not sure if I can add to that. Quantifying these things isn’t easy. Some networks have done very well. It’s a balance in getting evidence and getting the best out of each situation.’
External factors	
COVID-19	‘There is still some gaps in terms of the inter-agencies, clearly COVID got in the way but prior to that the interface with emergency services, housing, department of child safety, education.’
Natural disasters	‘At the moment we will be competing with bush fires and the corona virus.’
Other Challenges	
Lack of guidance on implementation	‘BDI LifeSpan – it’s a great concept but it is a bit overwhelming when first encountered. It generated a lot of ideas but there was no information or guidance on how to deliver it. It was sold as all ready to go, but that really

Themes and subthemes	Sample quotations
	isn't the case, plus they couldn't provide the supporting evidence for the figures they gave for the expected reduction in suicides if the program is adopted.'
Fidelity to framework	'We need to say that we're trying our best but we're not doing all parts of LifeSpan. We should not say we're implementing a system.' 'Picking and choosing which domains to focus on takes away from it being a systems approach.'

Table A9.5 General population suicide prevention activities themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Activity description	
Training and awareness raising activities	'Some of the ASIST and the SafeTALK activities have been really well received. And addressed a mental health gap in terms of community education regarding suicide prevention. The little postcards that everyone did, with the SPR training on them, we got good feedback and it is a quick way of learning about suicide prevention.' 'people like Mates in Construction and other community groups who are providing interventions or training programs, that creates stakeholder engagement '
Support services for individuals	'a Safe Space Warm Line manned from our office that covers whole geographical area.'
Community grants	'think we had eight proposals with the PHN. All of them but one so far have been successful so far. It's the unique ideas that work out here.' 'There have been different funded activities across different sectors within communities. There has been a lot of support through individual grants across the trial region and that has been unique and diversely applied to communities. '
Mapping of existing services and referral pathways	'Another great internal project that the Tweed Byron suicide prevention project has initiated and led is the local information kit they put together. So, we now have a factsheet with support services that you can refer too. So, after the training you are a connector and you are able to refer people on – we weren't able to do that in the past.'
Means restriction	'With the new project] now people will have much less easy access, instead of a direct path to from the carpark to the platform there is now curved approach to the site, and a two-tiered platform. Design changes have been made to make it a lot less easy to climb on.'
Linkages and coordination	'The other thing was it opened up support services that could provide for hospital avoidance strategies, so safe haven… So actually, mental health and addiction services said dropping into our hub so we can do assessments rather than going to the Emergency Department. Standby services post-suicide, they have had an increase in referrals ' 'We are working together with Lifeline and Suicide Prevention Committee. We are close with the police now.'
Activity promotion and recruitment strategies	'It's really important to get the faces, to talk about programs, and send out flyers, get the interviews on the ABC and the radio. How we use multi-media. We have a good liaison, she is awesome. We have to use every avenue to try and reach people.' 'social media is really helpful and the PHN media contacts'

Themes and subthemes	Sample quotations
	‘we had a list of radio interviews and because the trial site coordinator had built up a relationship with local radio station’
Involvement of people with lived experience of suicide	‘Working on the stigma around suicide. The more we talk about it and people stand up and share their stories. Also, public figures and community members with lived experience – people realise they aren’t alone and that encourages help seeking.’ ‘The lived experience program - I’d never seen that before and it is only through the trial that we had the opportunity to name it, learn what it means, and how to use it.’ ‘The voice of people lived experience of suicide is critical and we are finally starting to turn the corner to where people are starting to listen to what people are asking for.’
General population activities - outputs and impacts	
Complementing or filling a service gap	‘The trial was collaborative, meeting local needs – that has really stood out. The [name] site has got additional or different modification to the standard roll out, that benefitted the local area. It addressed a local gap and the modifications that were allowed was a huge value add’ ‘My general view of national trial is that it has been a bit hit and miss’
Met needs and expectations	‘I’m sure they do. When we have the committee meetings, there were always new people so word is out and about that this is doing good work in the community. I think it has been greatly accepted and utilised.’ ‘The short answer is no, but I wouldn’t say overall, there might be some things and some attempts, as people are working in these regions we have provided input into what we think is the right approach, some of those things have been taken up. But then the execution of them has been watered down to.. probably not what we expected, so we have been frustrated at that’
Increased knowledge and awareness	‘Yes, many people found it very useful in term of increasing level of knowledge and confidence to start more challenging conversations and navigate the service system with them.’ ‘A greater awareness within the community of where to go for services, where to get assistance, how to have the conversations.’
Increased openness and confidence to discuss suicide	‘Participants are more confident and able to have a conversation – to be a connector in the community, there is a lot of value in the community. The training gives them skills and confidence.’
Reduced stigma of suicide	‘It has assisted in breaking down stigma. I haven’t seen any evidence-based evaluations but I’d like to think I see more of an openness coming from those regions, breaking down stigma and raising awareness and it has provided education.’
Increased service usage and help seeking	‘I think a big one is the fact that people are more willing to engage with us and we get feedback that conversations are being had around mental health and help seeking’
Reduced suicide attempts and deaths (anecdotal)	‘Yes, the number and ideation has dropped.’
Improved wellbeing	‘Some people work in this space all the time, and my sense is that those people are feeling more supported now by saying I see you.’ ‘The program is definitely making a difference in the community. It helps the students and even the family, it gives a sense of pride and positive for

Themes and subthemes	Sample quotations
	their wellbeing. Also, the ability to help their ow families who often have been affected by suicide.'
Cultural shift	'It's that cultural change, these services reflect the willingness and changing perspectives on help seeking. Especially with those natural challenged that is key.'

Table A9.5 Focus population suicide prevention activities themes, subthemes and sample quotations (men, young people, LGBTI people, ex-ADF members and their families, older adults)

Themes and subthemes	Sample quotations
Activity description	
Training and awareness raising activities	'I think the use of champions is very powerful – to have key people within community to speak and represent those messages. That's why Mates in Construction is powerful to teach people to do that. For rural and remote people and men that's a key factor.' 'About the schools, they did the training with students and staff but also with families.' 'I'm involved in SafePlace, we have a van and we go out to areas and sit out and wait for people to come to us. That café started with 3 volunteers, took some time to build relationships between us but is going well now and we have more volunteers coming on.'
Community grants	'The next step was to do the grants program which enabled us to reach them and get them in with good ideas. The grants program, we ran two of those. We found some things that weren't worthwhile, which was the point - to try things. We wanted to empower people to take charge and do something about it. They need money to do something with their good ideas.'
Tailoring	'The LGBTI community is not great supporter of Lifeline, not very inclusive. Mainstream services are making some way in being more inclusive, but this needs to be continued…. Yes, and we have rolled [Livingworks] out with Switchboard and Thorne harbour – but their base material wasn't very inclusive – it's more because of the trainers being from the LGBTI community and they make it more inclusive.' 'We go out to people homes, so men don't have to come on-site and however you present, we will engage even if its wife or mother who engages on behalf. Then we might do a soft entry and meeting the men where they are most comfortable has been very beneficial.'
Linkages and coordination	'Through the inter-agencies, that has been a really important focus. [Location] Information and Network Provider provide counsellors that are not attached to the LHD. They are filling part of the gap that the local social worker can't meet. So, we really had to engage and have all of the stakeholders aware and integrated into the program for it to have been successful.' 'We have linkages with the Townsville Private Clinic who refer into the farmer program. We would like to build more concrete connections with other organisations to refer people in an out so that people have other options.'
Activity promotion and recruitment strategies	'The first group you touched through the social media. And then when those people had money to reach further into the community. We saw the effect through the grant program to find out what they found out about their own programs. That was a stepped access thing.'

Themes and subthemes	Sample quotations
	‘Marketing was a bit of a failure in the first year but in second and third it was much improved. We turned it into a night with blokes. Community campions became crucial – they advertise it at their clubs, brought their mates along. Without that it wouldn’t work.’
Involvement of people with lived experience of suicide	‘There is a big difference now and a willingness to be involved from people. The highlight for me was our local agricultural group of men who asked me to come and speak to them. That was what I hoped for when I first got involved. My passion comes from losing my dad to suicide, so to get a group of farming men to talk about suicide prevention, that was a huge win.’ ‘We have several kids at school with lived experience of suicidal ideation or self-harmers and interestingly one girl she tells everybody you should do the program and it helped me. So that positive to hear that from kids.’
Focus population activities - outputs and impacts	
Complementing or filling a service gap	‘The services we need already exist – what we didn’t have was connection’ ‘Yeah, I think they did. Absolutely. I think they looked at all of the different age groups and reached the broader community.’
Met needs and expectations	‘Definitely, should be ongoing, will always be a need of suicide prevention activities especially post-COVID – people are going to be isolated etc. especially more vulnerable cohorts. Because we spent a lot of time during this COVID period talking about the impacts and reflecting that it is time to think about what the ongoing impact of that will be and the need for training to give people the skills to address that in the right way.’
Increased knowledge and awareness	‘Kids that have done it are happy to talk about mental health… Them hearing from each other, it opens up their ears and gives power to sharing.’ ‘One of the things with ADF suicide is that it is still an emerging topic for people to be speaking about and until people have been affected by it people don’t realise. Operation Compass has helped to put the focus on where we are going in the future, raising community awareness and allowing more opportunities for recognition of ADF personnel particularly in the struggles they have when they leave’
Increased openness and confidence to discuss suicide	‘People feel lucky the trial is going on in their region and to know there is a community response group – made them hopeful that they could get easily involved and people want to have the conversation’
Reduced stigma of suicide	‘Men share their experiences and what the impact was and what worked and what didn’t work for them – rather than give advice. The group provides a stable structured environment in which men can open up to the extent they feel safe to. It can provide inspiration, belonging and hope.’
Increased service usage and help seeking	‘The number of referrals for case management has grown substantially. We are more able to do case management and the community knows it is available.’
Reduced suicide attempts and deaths (anecdotal)	‘Our results this year are quite dramatic locally. I think 2017/18 we had 19 suicides in the district, so far, we have none in the last 6 months.’
Improved wellbeing	‘And for our older community, that they have been reengaged. We have been able to touch them, contact them and get the community having conversations and looking out for each other.’ ‘What I see, I’ve seen it affect people personally. I know two or three people where the activities of Operation Compass and from Oasis have

Themes and subthemes	Sample quotations
	really impacted heavily on their mental health and their recovery. I think they have been really beneficial.’
Too early to tell	‘I’m supportive of the trial but at the moment it’s too early to judge the results – and some of those pilots are impacted by COVID.’

Appendix 10: Service provider survey

Organisation Name:

Role:

Commissioning PHN:

Thank you for agreeing to take part in this survey.

This survey is about the services or programs that your organisation delivers that are funded by the PHN as part of the National Suicide Prevention Trial.

You may be providing services to individuals such as follow-up aftercare following a suicide attempt, or programs such as training, capacity building or other community-based activities.

1. What services or programs funded by PHN as part of the National Suicide Prevention Trial are your organisation delivering?
2. Are your Trial funded services or programs specifically targeting any of the following groups of people:
    a. Aboriginal and Torres Strait Islander people
    b. LGBTI people
    c. Young people
    d. Men
3. If yes to 2 – have you had to adapt your services or programs to meet the needs of this target group?
4. What challenges has your organisation experienced in delivering Trial funded services or programs?
5. What has gone well in delivering the services or programs?
6. Was your organisation involved in the planning process for the National Suicide Prevention Trial? If Yes, how?
7. How have the Trial funded services or programs fitted in with other suicide prevention services or programs being delivered in your local area?
8. How have the Trial funded services or programs fitted in with other services or programs delivered by your organisation?
9. What outcomes have you seen for people receiving the services or participating in the programs?
10. Is there anything else you’d like to share about the National Suicide Prevention Trial?

Appendix 11: Themes and sample quotations – service provider survey

Table A11.1. Planning

Themes and subthemes	Sample quotations
Stakeholder involvement in planning	
Participated in community consultation or engagement	‘We participated in many meetings and consultations for our region’ ‘We were involved with PHN managers with the planning and keep an open communication and involvement throughout the whole process to ensure the planning addresses the education needs in that region’
Member of Trial Committee	‘We have been a member of the local Suicide Prevention Committee who are developing a strategic plan of action’
Local working groups	‘Yes, staff were involved in the working groups set up by the PHN’
Stakeholder partnerships	‘We have developed a strong working relationship with the local Council’ ‘both [organisation] and [organisation] have been fully active and supportive in partnerships and collaborations throughout the trial’
Co-designing process	‘Yes, there was a codesign process with other stakeholders and the university’
Local suicide prevention network, or action group	‘The Senior Project Officer is a member of the Suicide Prevention Community Network’ ‘Our program for the Trial has tapped into the already established Mental Health Planning Group to engage its members and cultivate the Suicide Prevention Action group’
Facilitators of planning	
Capitalising on existing networks	‘The project is benefiting from the already established professional and community networks cultivated by the other services and programs delivered across the LGA by our organisation’
Developing local project proposals	‘I have developed proposals and delivery projects to attract members form each of the target communities’
Data collection, review and sharing	‘This data collection is then shared with PHN for the purpose of strategic direction for current and future service provisions and actioning partners of the Suicide Prevention Working Group.’
Challenges encountered in planning	
Limited planning capacity and time	‘So, the challenge here is getting services and community members on board with the project within this short time frame’ ‘…implementing a model of service with limited capacity, no prior consultation and limited funding is a nonsense’
Engaging in genuine consultations and/or co-design with community	‘The community we consulted with were fairly clear about what they felt they needed, but in the ongoing version of the program they were given the services that had already failed them’ ‘Doing genuine engagement within community and not having people think this is tokenistic will be a challenge for me’
Maintaining stakeholder engagement	‘And the unusual method of providing the funds to support trial site activities and program delivery was extremely difficult for host organisation to retain working group due to the delay in having action on the ground’
Engaging with people with lived experience	‘It was acknowledged that the deep stigma surrounding mental health and suicide in CALD communities prevents people’s willingness to participate, particularly as Lived Experience Speakers’
Integrating with key stakeholder strategies and activities	‘the late notification of re-funding has had a flow on effect into planning trial activities, as schools have already locked in plans for key dates strategic planning’

Themes and subthemes	Sample quotations
Working with a prescribed service framework	‘Having to use a very 'unwieldy' prescribed model as an action plan was extremely difficult as an auspicing organisation to ensure working group remained involved in the trial’
Lack of PHN transparency and support	‘I don't believe our PHN has been transparent or indeed, very accountable for the Suicide Prevention Trials across our region. At best, we have local suicide prevention committees however, these are inadequately or opaquely supported by the PHN’
Insufficient input into planning process	‘We have had insufficient input into how the Trial would be designed and delivered..’

Table A13.2 Systems approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Strategies used for developing a systems approach	
Tailoring to local context and/or target group	‘Throughout the process we have adapted our service delivery to ensure that it is relevant and appropriate’ ‘It is all targeted and adapted to Aboriginal and Torres Strait Islander students’ ‘Both projects were designed to target rural farming men’
Developing cultural awareness and responsivity	‘The training is culturally responsive to meet the needs of the culture being trained at the time’ ‘Having a mix of professional mental health educators and cultural educators was a great adaption we had used’
Workforce development and training	‘The funding has mostly been used on train the trainer programs’
Building community capacity	‘We are an organisation primarily funded to build community capacity’
Engaging lived experience or peer workers	‘We have gathered terrific consumer input into training developed’
Building community awareness and engagement	‘To provide awareness and training we have been able to get this much needed knowledge out into the community’ ‘We have developed an awareness in the community about the programme and the Suicide Prevention Committee has developed a working relationship with service groups, shop owners across the region’
Other strategies	‘Our programs are part of a broader strategy that uses a strength-based approach to working with families and communities’ ‘The timely monitoring of incidents allows the identification of at-risk individuals and occurs through daily review of supervisor reports…’
Strategies for integrating services/activities	
Establishing or strengthening referral pathways	‘Establish and maintain effective communication with all internal and external stakeholders to complement multi-agency referral service delivery’
Local collaboration to deliver complementary services	‘We have communicated with other Education Providers to ensure there is no duplication around dates/topics etc and we share calendar of events so the region benefits from receiving the education it needs working across various organisations’
Service navigation support	‘…and support and advocacy in navigating services’
Funded a co-located position	‘The PHN has funded an administration officer to co-locate in the [organisation] office’
Participating in inter-agency training	
Leveraged funding with other services	‘We've also leveraged the funding with other stakeholders to provide national development initiatives’
Challenges	

Themes and subthemes	Sample quotations
Uncertainty or inability to continue activities and services	'The community and Steering Committee are extremely concerned about what will happen to any future suicide prevention measures once the trial date has ended' 'The only challenge is the threat of a loss of funding for this position once the trial concludes'
Limited funding available	'The funding has mostly been used on train the trainer programs which is of some benefit. There are many other strategies which are more contemporary and evidence based that should have been implemented but most of the funds are gone'
Community awareness and/or engagement	'The biggest challenge we have faced is engagement with our local community as mental health/ suicide prevention is not seen as a high priority by most people' 'It was been a challenge to have the large amount of work required for community engagement and community collaboration recognised'
High staff turnover	'Staff turnover within the partner organizations significantly impacted the Trial's ability to deliver services as anticipated at all levels of partner organizations' 'There have been 4 different [Trial] coordinators in our region…'
Restricted timelines in planning and delivery	'The timeline for delivery has been a challenge in some cases' 'Lack of lead in time for trial planning'
Limited service integration	'No one knows who is delivering, what, when or where (in a timely manner). We are trying to close this loop…' 'It would be beneficial to be able to see what other communities are doing under the trial as it is occurring.'
Locality/specificity versus scalability	'Localisation of the program makes efficient delivery much harder and messaging less effective' 'Local trials gain by local buy-in but also lose the benefit of scale - this is particularly significant in prevention (as opposed to service delivery) where awareness raising and engagement is key to success'
Lack of support from stakeholders	
Large geographical area and/or remoteness	'For the very reason that providing services over a large geographical area provides a challenge to service delivery…' 'There is also a reluctance to travel between towns. So, if an event is offered in one location and not in their town some people will not come to the event'
Finding staff with the appropriate skill-set	'Lack of culturally competent facilitators' 'The current provider has no experience in suicide prevention projects'
Accessing required tools and resources	'Accessing the tools we need' 'Accessing training venues'
Role and requirements of the PHN	'Understanding and meeting requirements of PHN at early stages of project, e.g. approval process for comms, spending of funds, reporting of progress…'
Lack of cultural competence or responsivity	'Due to lack of safety identified in the feedback the sessions were cancelled and postponed until culturally competent facilitators from inter-state could be flow in'
Meeting diverse needs of the community	'The ability to deliver [program] in 5 rural communities is unrealistic and not fit for purpose. The community requires a service response to their individual mental health needs, they may or may not be suicidal'

Table A13.3 Aftercare services for people who attempt or are at risk of suicide themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Outputs and impacts	
Increased access to support and services	‘We have seen an increase in access to other services - particularly with linking people to GPs to access a mental health care plan.’ ‘Clients have had to rely on government services less, they have been grateful for the links to other support networks they have received.’
Improvements in consumers’ wellbeing	‘They got better and remained alive throughout the trial.’
Challenges	
High staff turnover	‘The high turnover of staff within the EDs has been difficult.’
Accessing services for clients in regional areas	‘We have found that access to services in our regional area has been very difficult for our clients.’
Trial ending	‘Finally, a significant challenge was not knowing what our transition plan would look like at June 30 2019. […] the spin off effect was destabilizing to some clients.’

Table A13.4 General population suicide prevention activities themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Activities	
Building community capacity	‘We mainly deliver the Youth and Standard MHFA courses and have been running other courses simultaneously.’ ‘The trial funded services have been focused on the core programs of LivingWork: ASIST, SafeTALK and Train the Trainer workshops.’
Localised and placed-based approaches	‘We have tailored the training to reflect the needs of the community, context, demographic and issues on the ground.’
Providing outreach services	‘Particularly targeted workshops funded through the trial and as we are a rural and remote area the newly implemented outreach programs’
Workforce suicide prevention training	‘[…] a program designed to be an education and engagement day for all frontline police officers.’
Capacity building of people with lived experience of suicide	‘Voices of In-Sight lived experience capacity building workshop’
Outputs and impacts	
Boosting local suicide prevention activities	‘The suicide prevention funds were and add on to boost funding for our region.’
Building local community and PHN relationships	‘[Organisation] have participated in a number of facilitated forums with other PHN funded organisations. [..] Secondary projects have been developed through these partnerships.’
Positive impact on participants	‘A feeling that the participants are not alone, able to voice their concerns / issues and seek support’ ‘It has helped to save lives’ ‘The service model delivered was a huge success with clients.’
Increased local workforce	‘The people trained have been available for the PHN and have engaged with their local suicide prevention community activities.’ ‘More trained people on the ground in local areas where needed.’
Challenges	
Poor uptake and/or engagement with activities	‘The main challenge was engaging participants in the Mentoring program after the workshop.’
Turnover of Trial Coordinator staff	‘To date trial has employed 3 coordinators. First two coordinators resigned citing too much bureaucracy from funding body.’
Lack of resources to provide programs	‘The expectation of providing a [program] in 5 rural communities i.e. implementing a model of service with limited capacity, no prior consultation and limited funding is a nonsense. ‘
Inability to meet high demand	

Table A13.3 Focus population men: themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Tailoring activities	
Delivering programs that were already male-specific	‘Programs were targeted for this group and did not need modification.’
Delivering program in predominantly male workplaces	‘Our program is generally industry based - considering the industry, the local community nationally or across a state.’ ‘Both projects were designed to target rural farming men’
Engaging men	We have ensured that men are part of all the processes such as guest speaking, the audience and part of the information content.’
Outputs and impacts	
Improved community awareness, engagement and capacity	‘It has allowed further discussions in relation to suicide, an awareness of services in particular for rural and remote males’ ‘It has allowed the participants to be aware and have greater knowledge of supports available and what services are in the local area’
Positive impacts on the knowledge, skills and wellbeing of participants	‘Connection and growth of men attending. Lives saved.’ ‘The final content has been life changing. We have had a lot more males seeking help and talking to their families about their mental health.’
Increased capacity in the local workforce	‘More trained people on the ground in local areas where needed.’
Increased local stakeholder collaborations	‘There has been a great collaboration between this project and other Council led initiatives being carried out.’
Challenges	
Accessing/attracting participants	‘The challenge faced was to find men willing to participate and to attend groups.’
Funding	‘It has been difficult to gain a clear view of what can or cannot be funded.’ ‘Our organisation is a Suicide Prevention Network run wholly by volunteers.’
Distances in Trial Site	‘The distance between all students has been a challenge.’
Community engagement/ readiness	‘The biggest challenge we have faced is engagement with our local community as mental health/ suicide prevention is not seen as a high priority by most people.’
Time related challenges	‘[...] its time consuming to build trusting relationships and work collaboratively to produce outputs that have impact and outcomes desired by the community.’
Accessing resources	‘Accessing the tools we need.’

Table A13.4 Focus population young people: themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Tailoring activities	
Engaging young people	‘Local schools have also been supportive of encouraging opportunities for those within the Schools Network to directly engage to young people through school programs and activities to ensure that young people have input and direction in all objectives and planning.’
Building community capacity	‘Our program is based on raising awareness, help offering rather than help seeking and building community resilience.’
Outputs and impacts	
Increased community awareness, engagement and capacity	‘The Youth Services program we deliver has worked well for youth engagement.’
Good attendance and participation	‘Positive response and involvement from all parts of community. Including an outstanding number of local communities who have completed ASIST and MHFA training.’
Positive impacts on the knowledge, skills and wellbeing of participants	‘Survey of participants over the first 6 months indicated […] 94% of participants indicate the training improved their confidence to respond to someone in crisis, 85% felt the would enable them to be part of a change in their community.’

Themes and subthemes	Sample quotations
Increased local workforce	‘So, locals been able to obtain this much needed career path has been very positive.’
Increased local stakeholder collaborations	‘Collaboration involving local Medical Centres, Community and Family Services now being successfully maintained to meet the needs of professionals and wider community.’
Challenges	
Limited uptake of activities or services	‘Attendance’
Balancing locality/specificity and scalability	‘Maintaining a balance of youth and wider community in all parts of our local plan strategies and delivery.’

Table A13.4 Focus population ex-ADF members: themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Tailoring activities	
Building community capacity	‘[Organisation] provides specific Suicide Intervention and Prevention training.’
The involvement of people with lived experience	‘Our programs are written by veterans and for veterans.’
Engaging the ADF community	‘We have been required to work in collaboration with the Veteran community to understand the target market and to ensure that the strategies and tactics meet the project objectives.’
Outputs and impacts	
Increased community awareness, engagement and capacity	‘There has been an increase in awareness, an increase in engagement, an increase in participation of programs and activities.’
Increased knowledge and confidence of participants	‘Improved confidence in recognising the need for a conversation and in having that conversation.’
Good attendance and participation	‘Attendance and participations rates have been good.’
Challenges	
Limited funding	‘[Organisation] committee struggles as many small veteran organisations do, to keep the programs going. Fund raising is difficult.’
Lack of support from stakeholders	‘The inability to get any support whatsoever from [key stakeholder], who are the biggest beneficiaries of our work second to the veterans.’
Limited activity or service uptake	‘Access to Defence and ex-ADF families for the information night.’

Table A13.4 Focus population LGBTI people: themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Tailoring activities	
Offering specialist LGBTI services/activities or delivery of generic activities services by an LGBTI-specialist organisation	‘We are an LGBTI health organisation and we already have experience in training mainstream service providers in LGBTI affirmative practice.’ ‘Our service is already a specialist service providing support and programs to LGBTIQAP+ Sistergirl and Brotherboy young people.’
Engaging LGBTI people in the planning and delivery of services or activities	‘The campaign has been designed with and for LGBTI people, who have been involved in advisory roles, and campaign messaging and creative development.’
Outputs and impacts	
Improved awareness of engagement with and capacity in LGBTI suicide prevention of the general community	‘[…] increased awareness of the specific needs of LGBTI community members experiencing risk of suicide.’
Positive impacts on the knowledge, skills and wellbeing of activity participants	‘We have seen positive outcomes for participants of training, with significant shifts in skills, confidence and self-reported readiness to start a conversation and intervene with people thinking of suicide.’
Availability of appropriate and LGTBI-affirmative services	‘Increased access to psychological services that are affirming and responsive to marginalised identities and experiences.’
Successful collaboration with key LGTBI partners	‘we have gone through a process to ensure effective collaboration with key LGBTI partners.’
Challenges	
Insufficient community awareness and/or engagement	‘Hesitation from schools to participate in certain school-based activities that engage directly with students.’

Themes and subthemes	Sample quotations
Integrating with key stakeholder strategies and activities	‘Schools require more than one year to integrate trial activities into broader school strategies and planned activities.’
Restricted timelines in planning and delivery	‘The timeline for delivery has been a challenge in some cases.’
High staff workloads and turnover	‘Staff turnover within the partner organizations significantly impacted the Trials ability to deliver services as anticipated at all levels of partner organizations.’
A prolonged change-management process	‘While many orgs respond positively and are willing, it's a change management process that requires input and commitment at all levels - it's not just a matter of getting staff to complete a 2-hour training session.’
PHN administrative processes and requirements	‘One of the challenges with reporting has been the lack of a consistent quarterly and financial reporting template across PHNs.’
Lack of cultural competence or responsivity in the sector	‘Lack of culturally competent facilitators of ASIST, CALM & SafeTALK.’
Lack of lived experience of suicide consultation	‘Not enough consultation with key target populations including LGBTIQAP+ Sistergirl and Brotherboy young people and parents and carers.’

Appendix 12: Consultation topics for service providers

Questions for Providers of Community-based Activities

1. What kind of activities/programs have you been providing as part of the Trial?
2. How were activities tailored for [target group]?
3. Did you or your staff need particular qualifications or training? Was additional training provided?
4. How did you promote activities?
5. What was the best way of getting people to participate in your program/activity?
6. How were people with lived experience involved?
7. Did you link with other services and/or organisations?
8. What do you think have been the benefits of the program/activity?
9. What do you think will be the legacy of the trial?
10. Anything else?

Questions for Providers of individual Services

1. Can you briefly describe the service?
2. How did you tailor the service to suit your local area [or target population]?
3. What strategies were used to promote services?
4. Who referred clients and were they appropriate referrals?
5. What processes were established for initial assessment, triage and review of clients?
6. What procedures were put in place for follow-up of new referrals and clients?
7. Who were the main types of service users?
8. Did personnel require particular qualifications or training? Was additional training provided?
9. Were clear referral pathways and feedback mechanisms developed with GPs, LHNs, and other services, including state community and other mental health service providers?
10. What linkages were formed with other local services/organisations to provide complementary services and support?
11. What strategies were effective in coordinating care with other service providers?
12. How were people with lived experience involved in implementation and ongoing delivery of services?
13. What were the main challenges involved in establishing and delivering the service?
14. What do you think have been the benefits of the service?
15. Do clients and other stakeholders consider this a useful additional service?

Appendix 13: Themes and sample quotations – service provider interviews

Table A13.1 Systems-based approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
29.1.1.1 Aftercare services – effective strategies for coordinating	
Advocacy and information sharing	**‘We did a lot of advocacy work and information sharing about the population and ways to navigate the existing system’**
PHN bringing service providers together	‘The PHNs have had to sit through some difficult meetings between organisations and they have had to bridge those relationships so that everyone is working well together.’
Providing warm referrals between services	**‘Warm handover when stepping up or down, meetings that included the consumer and clarified their needs for the next step, ongoing respectful care coordination for vulnerable clients…’**
Collaboration agreement	‘We have a contract with each partner organisation’
Other Trial activities – effective strategies for coordinating	
Collaboration/partnerships	‘We work closely with the other partner providers. We link with a number of people in the implementation group and there were multiple partners along the way’ ‘We looked at the main suicide prevention networks and community organisations to collaborate with them. Everything was done in collaboration not isolation’ ‘Those partnerships are really important’
Providing referrals pathways	‘The campaign was about getting referral pathways from the community into trial sites, the clinical services’
Avoiding duplication/ensuring complementing activities	‘Those link ups are knowing that these organisations are able to provide counselling and they are to ensure that future postvention is coordinated and thorough and united. A shared understanding.’ ‘We do an environmental scan to see who else is running what. We don’t want to double up’
Aftercare services – challenges	
Misaligned of values and/or service approaches	‘The biggest difficulty was in the incongruence in how we both approach client services.’
Lack of collaboration with hospital and emergency services	‘We missed the opportunity from the start, when we didn’t go to the Emergency services and hospital mental health unit. A lot of people fall through the gaps there’
Short timeframe of the service	‘Waitlists and wait times at other services were a big barrier given the 12-week timeline of the program.’
Integrating clinical and non-clinical service components	‘I think that barrier with integration between the two systems of clinical and psych-social, creates that concern around risk – great deal of difficulty in understanding that.’
Other Trial activities – challenges	

Themes and subthemes	Sample quotations
Lack of (central) coordination of local suicide prevention activities	‘At the moment there are 3 or 4 different organisations doing stuff for people with bereavement with the same kinds of program. […] all going into the same region, but there has been no coordination.’
Choice of local priority populations	‘The trial is up and down in its priorities. Are the trial sites actually reflecting what is happening on the ground and what needs are, how much of that is it about which consultations are happening?’

Table A13.2 Aftercare services themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Clinical qualifications	‘For clinicians we required them to be either a psychologist, clinical psychologist, accredited mental health social worker, or a mental health occupational therapist’
Non-clinical qualifications or training	‘So, because its psycho-social program, we are targeting Cert-IV mental health.’
Short training courses provided	‘Roses in the Ocean did training and that was mandatory’ ‘We also needed to do peer work training and also did ASIST training’
Tailoring services	
Adjusting elements of the service model	‘We still had to tailor a lot of documents […] and had to revise or create new documents. We also had to change ways we could engage’ ‘We kept it open and supportive. If they don’t like the practitioner they were set up with for example, they can go to someone else.’
Consultations with focus populations groups	‘We have an LGBTI advisory group to meet regularly to discuss process.’
Responding to client feedback	‘Often consumers are very clear about […] and that is taken into account for the individual and incorporated into practice.’
Working with local key stakeholders	‘A lot of that was collaboration, working with key stakeholders in the governance committee as a forum to do that.’
Few adjustments	‘We didn’t require much tailoring for the target group because we are placed really nicely for accessing the target group’ ‘They’re all already LGBTIQ specifically tailored and are inclusive services. So, it was already there.’
Links and referrals	
Community organisations	‘Community organisations like [list community organisations] are often interacted with and can be a source of referral in and out of NSPT program’
General practitioners	‘We get referrals from the GP clinics’
Hospitals and/or emergency departments	‘We have had varied levels of consistency with referrals from the hospital and health services.’ ‘We rarely had any inappropriate referrals because they were coming from ED and community mental health’
Self-referral	‘And people referring friends as well and self-referrals.’
Other referral sources	‘Many referrals have come from community groups and teachers.’
Internal referrals	‘Many of the referrals I have seen have been from within the organisation rather than external referrals.’
Service promotion and recruitment	

Themes and subthemes	Sample quotations
Local sector networks	‘Through our own networks we advertised’ ‘Our affiliated youth organisation also promoted the service’
Websites and/or social media	‘We used Facebook and launched the website’
Word of mouth	‘We are fortunate that it is a pretty small community in [PHN region] so word travels very fast’
Community campaigns	‘We build a campaign targeting direly to our community with posters, cards, billboards, tea towels with beautiful imagery.’
Involvement of people with lived experience of suicide	
Planning and implementation	‘Having a lived experience focus group was important in developing the program and so we want to continue that.’
Recruiting a lived experience of suicide workforce	‘Throughout the life of the program we had several workers that identify as lived experience people’
Consumer feedback	‘We ask them to provide feedback on the service and when we pick things up in ongoing conversations, we act on that.’
Outputs and impacts	
Service user benefits	‘We’ve kept people alive.’ ‘Helping young people access therapeutic support which has been difficult for us previously because of funding.’ ‘They don’t have to fit in a box, and we discuss this with hem. It’s tailored to them’ ‘There are additional barriers to mainstream services, so peer services are more accessible to existing service users ‘
Service benefits	‘We have also built some great partnerships with other providers – a huge benefit for us.’ ‘There were not very many resources so to have the two trial sites in the NSPT focusing on LGTIQ has been the first time we have seen an investment in LGBIT suicide prevention activities.’
Challenges	
Stakeholder engagement and buy-in	‘Historically – the main focus is discharge from the hospital but that has a lot of challenges traditionally. Hospital don’t want to do the direct referral.’ ‘We got a lot of resistance in the beginning from clinicians. Some thought we were taking from them.’ ‘With the GP there, they don’t take it seriously – incidences where […] they have not followed those referrals.’
Coronavirus-related challenges	‘COVID has impacted the referral pathways, as a lot of them were closed.’ ‘COVID makes it more difficult to make those [key stakeholder] connections’

Themes and subthemes	Sample quotations
Finding suitable staff and/or staff retention	‘We had some turnover of staff which has impacted the program. To make sure the support coordinators have a background in mental health and case management.’ ‘Finding suitable staff specifically in the LGBTIQ space is very challenging. We don’t want to employ people that don’t get the language right.’
Access barriers for clients	‘I haven’t received any referrals from GPs. There is the additional barrier about whether it is safe to disclose to GPs.’ ‘But what we discovered talking to people, a lot of people don’t want to go to [Trial Site region], so they fall through the gaps and they could really benefit from the service.’
Other workforce related challenges	‘Because of workers leaving, they have to start over with that promotional work.’ ‘One of the challenges is that the peer companions are not paid.’
Internal processes and logistics	‘There were some logistical issues with getting the case worker access to [PHN client database] to access referrals.’ ‘There is also confusion about the referral pathway to the psychologist and who is responsible for making the appointment.’
Lack of local services for referral	‘They aren’t part of our eligibility […] sometimes we get clients where we do some short-term work but then we don’t have any services to refer them on to.’
Administration and paperwork burden	‘A lot of the feedback from staff and participants was that it was very admin heavy’

Table A13.3 Other suicide prevention activities themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Tailoring activities	
Consultations with local key stakeholders	‘We also did some clinical consultations. We started with one clinical site because we had to develop the training from scratch so it made sense to start with one organisation’
Consultations with the focus populations groups	‘We also consulted young people about their experiences with suicide prevention and what they needed as a youth community’ ‘That involved consulting with the LGBTI community - engaging with both community leaders representing different groups in the LGBTI community’
Adjusting elements of the activity	‘A lot of the adapting was about how to make the existing content relevant – the basic models were fine, but how to apply to their community, to make it inclusive’ ‘We usually remove the construction component, for example we went to a high school and we did training with the teachers, so we put in youth statistics around suicide’
Consultations with potential participants	‘[…] hearing what some of their experiences of accessing services and barriers accessing services have been’
Activities delivered by organisations with existing expertise	‘[Name organisation] is an LGBTIQ+ organisation, we run peer-led programs. We are well-known for two of our programs’
Promotion strategies	
PHN and/or local sector networks	‘We have lots of relationships with different services we have had for many years and we sent it out through them.’

Themes and subthemes	Sample quotations
	‘The PHN helped us to get in contact with services.’
Websites and/or social media	‘We have also recently done some geo-targeted posts via Facebook etc.’ ‘The clients came through the website’
Word of mouth	‘And word of mouth, for example we started with the [local] council and when they talked to other councils it trickled down to all of the councils in that region.’
Promotional materials (e.g. flyers)	‘He went to workwear stores, gave our flyers, put up posters.’
Public events	‘We did have a big launch event with the target audience.’
Directly approaching focus population group or organisation	‘We just rang them, starting with the councils as we think this is best place to access the community’ ‘We called, emailed and visited a number of clubs in the region’
Facilitating participation	
Taking activities to audience	‘[…] in a space their comfortable with i.e. sporting clubhouses, sheds – going to their space not asking them to come to us.’ ‘The best way was for us to go to them to the activities they were already engaged with’
Involvement of people with lived experience of suicide	
Lived experience workforce	‘I have lived experience as a bereaved person, everyone in our organisation has lived experience of suicide in different ways.’ ‘And our staff have lived experience, either themselves or they have lost someone to suicide.’
Consulted during planning	‘I think the consumer consultations were essential in making sure that the training was developed with the LGBTI community in mind.’
Formal role via advisory groups or MOUs	‘Lived experience young people have been involved with the program advisory groups. They have been involved throughout’ ‘We have MOU with Roses in The Ocean’
Outputs and impacts	
Coordination of activities	‘Developing connections – there are a lot more collaborations between organisations involved.’
Met needs and expectations	‘[…] that it is an opportunity to include people in training who might ordinarily opt out because they don’t feel safe, or it doesn’t seem inclusive.’ ‘It has helped a sense of connection with peers and community and mood changes of young people to more positive after sessions.’
Increased awareness and knowledge	‘The discussion has been opened up around suicidality within the LGBTIQ community.’ ‘People have given feedback that after the training they know how, and feel comfortable to ask about suicide, and that’s what you want.’
Challenges	
COVID-related delays or disruptions	‘With COVID it has been hard to link people together and having them in the same space together’ ‘Now the trick is are other organisations allowing people to travel’

Themes and subthemes	Sample quotations
Limited resources	‘We are operating in 15 communities and are getting requests from other communities that we don’t have resources to respond to. These are missed opportunities.’ ‘We had a big issue with under resourcing, I was working two days another person one – trying to meet the need was very hard and complex.’
Workforce related challenges	‘We had a lot of people accessing the service and not as many mentors as needed, in particular around identities.’
Timelines and delays	‘The project itself was delayed bit, there were delays with confirming the contract with the PHN, so we have always been 3-4 month behind.’
Mental health and/or suicide stigma	‘There is always a reluctance. The first person you speak to, if they have a bias or they don’t want to talk about death or suicide, it’s hard to get past that.’
Key stakeholder engagement and buy-in	‘We did some work in schools but not a lot due to red tape.’ ‘Managing different complexities within that community is difficult.’ ‘We still find some barriers with local governments – they are a hard one to crack.’
Unmet demand or need	‘The workshops are often over-subscribed. […] we try to get a balance, so people aren’t missing out’.
Parental consent (youth-specific services)	‘We don’t get a lot of informed consents back, we have to put in a lot of effort, but parents just don’t sign them.’
Geographical distance (activities off-site)	Trying to do this from the other side of the country. We have been to [region] a few times. Not being on the ground full time has been a real challenge.’
Lack of services for referral	‘There are such giant wait lists for support and care it means that we are supporting people beyond the support of our program.’
Local tensions between stakeholders	‘There are some clubs that are funded very well so those dynamics are things you need to learn about on the ground.’
Scope and scale of project to big	‘The scope and scale of the project was so big. I would have narrowed it down and focused it rather than trying to do it all.’
No clear funding directions	‘Not having clear direction on funding. We only found out a few weeks ago that we have funding post June this year.’

Appendix 14: Aboriginal and Torres Strait Islander-focused consultation topics for PHN staff and ACCHO staff

Planning

1. How were local needs and gaps identified?
2. Did needs analysis consider what services community actually use not just those that are available.
3. Describe the planning process? Did you have enough time to do it properly?
4. Did the governance of the trial support Aboriginal and Torres Strait Islander ownership and/or partnership? If so, how?
5. Which stakeholders were involved in identifying needs and planning activities?
   [Prompt: if not mentioned ask about Local & State government; community members; people who used services, people with lived experience, Elders, young people; service providers, community organisations]
6. What strategies were used to get the key stakeholders involved and stay involved?
7. Were there barriers to certain stakeholders being involved? How were these managed?
8. How were the activity plans/work plans developed?
   a. Did PHN have the necessary knowledge and capabilities to develop work plans?
   b. What resources or tools were used to help develop the work plans?
   c. Did the trial use learnings already achieved in the community about what works to guide planning for trial activities?
9. What were the main challenges for planning?
   a. How were these managed?
10. What were the key facilitators for planning?

Appropriateness

1. Did plans accurately reflect local needs and, if not, why not?
2. To what extent was the trial community driven and/or responsive to community wants?
3. Were strategies in line with the findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project?

Coordinated suicide prevention approach / service integration

1. To what extent have services and activities been integrated with related health and community support services, including both mainstream and Aboriginal and Torres Strait Islander specific services?
2. What factors facilitated engagement and cooperative arrangements with other services and organisations?
3. Has the trial resulted in a more coordinated approach to suicide prevention for Aboriginal and Torres Strait Islander people/communities in your region?

About the trial funded services and activities

1. How did the services and programs/activities improve or enhance what was already available?
2. Were initiatives that were in place and already working funded through the trial?
3. What was done to make sure services and activities were culturally safe?
4. How were services and activities promoted?
   a. What prompted people to participate in activities/attend services?
   b. What approach worked best to gain buy-in from community?
   c. If people are not participating, or using services, why not?
5. Does the community know about the trial activities going on in their area?

    a. Do community support the activities?
6. What were the main challenges in rolling out services and activities?
    a. How were these managed?

Results of the trial

1. Was capacity built in Aboriginal and Torres Strait Islander people to deliver suicide prevention activities?
2. Overall, what have been the results of the activities, the impacts you have seen or heard about?
3. Does the community have increased knowledge about how to support people?
4. Does the community have increased knowledge of where to get help?
5. Was there in increase in knowledge of where to go for support after there has been a suicide in the community?
6. Has there been an improvement in people's competence and confidence – including peers, community people, service providers?
7. Are services more accessible, that is culturally safe and friendly to Aboriginal and Torres Strait Islander people including kids?
8. Did key stakeholders consider trial services a useful additional service and, if not, why not?
9. Were the planned outcomes and any targets identified in work plans met?
10. What will be the legacy of the Trial?

Appendix 15: Aboriginal and Torres Strait Islander-focused PHN consultations – themes and sample quotations

Table A15.1 Aboriginal and Torres Strait Islander-focussed activities planning themes, subthemes and sample quotations

Themes and subthemes	Sample quotation
Stakeholder involvement	
	'A working group was established for the trial with representatives from the key regional Aboriginal organisations, an Aboriginal community representative from each town and representatives from regional government agencies.' 'There were also more formalised meetings, but once started doing the work the meetings weren't enough because they didn't give time for discussion – so had workshops to get people in the room to discuss it.' '[service organisation] took a very grassroots community approach in the Trial, focussing on working with Aboriginal community members with lived experience of suicide impacting them in some way.'
Facilitating factors	
Strategies	'The respect and acknowledge of the time that Elders bring to the table. People expect Elders to turn up, give their time and knowledge. This has to be acknowledged and remunerated.' 'The key facilitator to planning was the fact that the Aboriginal community knew and trusted [organisation]; we provided a culturally known and secure space. Local Aboriginal people who were trusted and had the right skills being employed was also a key facilitator.'
Workforce-related factors	'Using local staff and working in a culturally responsive way.' 'Most challenges were mitigated by the community development approach we took and the involvement of local and skilled Aboriginal staff.'
Maintaining community buy-in and engagement	'[PHN] was very open to the advice and direction provided by [local AMS] and the various working groups and took its advice on commissioning from these Aboriginal community-based governance mechanisms.' 'The community development approach also seemed to meet local needs with community members becoming very keen to take community ownership of many of the initiatives.'
PHN role	'PHN has been a facilitator of discussions, bit of a neutral person on the ground – did allow for some conversations that needed to be pushed to be a bit more constructive.'
Administrative and commissioning strategies	'To help build capacity for places on the ground to do it themselves, which is why we have commissioned the AMS – but we have worked closely with them to support them to do the work.'
General strategies	'The value of the face to face conversations can't be overstated – you have to go, you have to be out there.' 'When we realized that we didn't have enough time to have true co-design, we stopped and took a step back and allowed for that time to take place.' 'Community consultations, way we've allowed true co-design to unfold. We have allowed the time needed to do it right rather than doing it quick.'
Challenges	
Community readiness	'Consultation fatigue – people get sick of telling their story again, especially when it's still really raw and they're still trying to deal with it all.'

Themes and subthemes	Sample quotation
	‘So that is an acknowledge that there are times we have to stop and not proceed with the work when sorry business is happening. Acknowledging that when sorry business happens, it often means that people need to go to offline for quite some period of time.’
Staffing	‘We often had to prioritise local employment which sometimes meant we didn’t have people who had all the necessary skills to plan, implement and report on their projects and activities. Significant time was put into supporting, training and mentoring the Community Liaison Officers.’ ‘Finding staff that are skilled in two ways’ Aboriginal ways of working and clinical ways of working is difficult.’
Funding/resources	‘A lot of people contributing on a voluntary basis.’ ‘There is a single young person coordinating the entire [local] region based in [town].’ ‘We want more funding for the training, upskilling of community, key connectors in our community.’
Other community factors	‘Diversity of community. Multiple families and mobs. Everything has to be created specifically for a family or mob. Offence is taken in we try to bring in a model that works elsewhere.’
Trial design factors	‘We didn’t have enough time to plan properly. We were constrained by inter-partners guidelines’

Table A15.2 Aboriginal and Torres Strait Islander-focussed activities systems approach themes, subthemes and sample quotations

Strategies	
Systems-based frameworks	‘The European Alliance Against Depression and the Black Dog LifeSpan models were presented as approaches but neither had any evidence of efficacy with Aboriginal and Torres Strait Islander people. […] The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISIPEP) was seen as the best approach’
Overall approach	‘Time spent in conversation was emphasising the concept of wellbeing, unpacking what is suicide, conversations about spiritual, intergenerational trauma, SEWB.’
Promoting coordination and service integration	‘They were also directly involved in the “no wrong door” project which aimed to develop standard referral and follow up practices for services as well as ensure all clients were welcomed into the service and provided with a warm referral to the appropriate agency if they did not fit the profile of the service.’ ‘Having senior staff from various agencies attend the working group resulted in their staff participating cooperatively in other forums related to trial work.’
Impacts	
Building relationships, coordination	‘There are people who are working together really well now who wouldn’t even stay in same room at the beginning – that is one of the good things about the trial it has given some time and a space for those relationships to be built.’ ‘For a long time, we found it difficult to get access to working with this Team, however we are now starting to build a stronger relationship with them and meet with them on a weekly basis. […] The relationship is proving to be very effectual for clients and has led to improved worker relationships and satisfaction as well.’

Strategies	
Challenges	
	‘There is often one Aboriginal liaison officer who wasn’t supported by the system, tokenistic thing that happens that everyone goes to that person for Aboriginal and Torres Strait Islander related issues whether it is relevant or not.’ ‘This may have been due to poor relationships or time pressures.’ ‘There is still work to be done integrating services into the broader services sector and wider community – that will be part of work in transition. This is particularly challenging given that key outcome identified is the cultural safety and cultural appropriateness of the services.’

Table 15.3 Aboriginal and Torres Strait Islander-focussed activities themes, subthemes and sample quotations

Tailoring activities	
	‘Having Aboriginal people play a lead role in the governance.’ ‘All staff involved in the activities were/are Aboriginal.’ ‘It took time for us to go back and forth with the community to make sure we had the right people and working together to develop the model and get approved from them. It took longer than expected but it was worth it.’
Meeting needs and expectations	
	‘They have definitely all had great traction and great uptake across the region and nationally.’ ‘Yes, because all of the [aftercare] services went to capacity when they came online. They are working with more people than they are targeted to work for.’
Promotion and recruitment strategies	
	‘Through a range of ways; local grape-vine, local radio and newspapers/newsletters, posters, on the back of playing cards and just through community yarning.’ ‘Various including Facebook, radio, regular newsletters, emails, presentations at meetings, workshops, conferences, word of mouth. ‘Specific communications through [PHN] and the local level; a newsletter targeted at service providers.’
Impacts	
Capacity building	‘I think the capacity building has been really crucial – how the young leaders have been placed across all levels of the Trial has had a positive impact.’ ‘One of the beautiful outcomes of the trial is that we are improving people’s competence and absolutely their confidence. Prior to being giving suicide prevention training, the Elders didn’t have the language. They had been to lots of consultations but not the language. Now Aunty or Uncle who someone comes to now has the tools and language to use in those conversations and referral and care pathways to direct people to as part of those conversations.’ ‘Upskilling of Aboriginal people on delivering the programs so they don’t have to get the facilitator in.’

Tailoring activities	
Increased community knowledge and awareness	‘There has been some improved understanding around what type of support people can seek if they are feeling no good and need support in the mental health space.’ ‘One of the greatest impacts has been the increase in community awareness, knowledge and understanding of how and where to get support from if they need it.’
Complimenting or filling a gap	‘Good relationships developed with relevant agencies and other funding agencies to minimise duplication so that things work.’
Other impacts	‘The PHN has learned that about sensitivity in community, as relationships have built more of an understanding of widespread trauma in community.’
Challenges	
	‘The complexity of individual work where one client equals five or six other clients. The work is not reflected in the numbers being seen.’ ‘There were a couple of people who were trained and offering it in communities, but one was not indigenous she was supporting, but now rules have changed both need to be Aboriginal.’

Appendix 16: Aboriginal and Torres Strait Islander-focused consultation topics for community stakeholders

Planning

1. How were community involved in the planning the trial [activity]?
2. Who was involved?
3. Who wasn't involved but should have been? Why weren't they included?
4. Did [PHN/community org/ACCHO] take enough time to do it properly?
5. Were community voices listened to? Did they take community advice of what was needed?
6. Did they listen to your knowledge about what would work in your community?
7. Was it grass roots?
8. Were there problems with how the planning was done for the [trial/activity]?
9. Should they have done things differently? If so, what would have been better?
10. What things did they do well?

About trial activities

1. Do community know about what's going on - [the trial activities]?
2. Did the [activities] improve what was already available? How?
3. Was the [trial/activity] something that was needed?
4. Did local people get trained up to run the activities?
5. How did people find out about the activity/activities?
6. What made people come and take part in the activity?
7. Did people feel comfortable and safe participating in [activity]?
8. For people who didn’t take part – why not?

Results of activities

1. Does community have increased knowledge about how to support people?
2. Do people feel more confident and capable in helping people who are feeling suicidal?
3. Does community have increased knowledge of where to get help for themselves or others?
4. Do more people now know where they can go for support after there has been a suicide?
5. Are local services more culturally safe and friendly to Aboriginal and Torres Strait Islander people including kids?

Overall results

1. Do you think [the services/activities] have helped people? How?
2. What did people who participated in activities and/or used services think of them?

Appendix 17: Aboriginal and Torres Strait Islander-focused community consultations – themes and sample quotations

Table A17.1 Planning themes, subthemes and sample quotations

Themes and subthemes	Sample quotation
Planning	
Community participation	'Absolutely, every voice that was included in the consultations was listened to. The quiet people were also encouraged to have a say. Because of the comfort in the groups that was established, people felt emotionally and culturally safe and secure to speak up.' 'Enough of the community wasn't involved in the planning of the Trial and because of short timeframes that disadvantaged us.'
Mechanisms for planning	'Running the [activity], it was Suicide Prevention Network and [the PHN]. They consulted with the local men and community, local service providers. Depends on the program you want to run who you involve and speak to. It has to be a collaboration.' 'With our NAIDOC day, we had a planning day with service providers and our interagency group in the community [which was] pretty good. We are all in it for the community.'
Facilitating factors	
Enough time and flexibility to achieve due process	'At times it got heated. There was that period. PHN also respected our process. They even gave us time, left the room, we sat there and openly discussed our concerns. Very community driven and people with great connection to community were at the forefront of that process, which I thought was really good.'
Community buy-in and readiness	'The community with local agencies had also been advocating for some time about the need to have some support for suicide focussed services in [region].'
Common goal	'[The Trial has] complemented and also added. It's a value add because now we can be focused on suicide as a priority. In the past, they've [the government] come in [to community] for something else, then suicide has taken away from that focus. Good to have something to focus on suicide.'
Community champion	'it worked because [they know] everyone and because it was [Community leader]. […] It's all about relationships and connections. PHN allowed that to happen. We all came together as a massive group. [They] got all the people who [they] knew could get along, even if we didn't know each other.'
Responsive to feedback	'Evaluator: Did they listen to your knowledge about what would work in your community? 'Yes definitely. With the debrief as well, with the feedback on what works and didn't and that was taken into account. Also, the feedback from clients. We take that into account.'
Challenges	
Challenges with engaging relevant stakeholders and the Representativeness of engaged stakeholders	'Our black bureaucrats are so caught up in listening to the mainstream processes and they're failing our people miserably. We want changes at a grassroots level.' 'Often the voices that point to the need to be both clinically and culturally prepared are missing in "community" planning.'
Ineffective or inappropriate approach to planning and consultation	'The funding seems to have evolved around the players sitting at the table for the Steering Committee, with everything seeming to be pre-ordained; and following that everything was scripted.'

Themes and subthemes	Sample quotation
	‘The meetings were also very formal and so as Community we didn’t have the opportunity to ask questions or contribute more fully - it was ‘business as usual’ and this was disheartening because we’d waited so long for this opportunity’
Stakeholders not listened to	‘As an Elder, you want to put in what we see that works. And that was pretty much rejected, what I know works… All those rules and regulations. That’s very frustrating.’ ‘We have tried to implement processes that empower our people, but there is rejection. The Department only listens to the ones at the table that say yes. The don’t want the challenges, the hard questions. You are labelled as a troublemaker and they don’t want to work with you.’
Trial scope	‘What we see consistently is the absence of talking about the impact of racism and colonisation and the impact that’s had on us as Aboriginal people, and by extension our children, our Elders, our men, our mothers - all aspects of our lives.’ ‘For black fellas [the Lifespan model] feels weird. Like we’re coming at it from the back end. Wouldn’t you do the connection first? Then offer individual services? [The Trial is] coming from the crisis [perspective] rather than preventative.’
Red tape	‘Medical organisations have the power. You have to fit in with that model to get the money. I’m not sure about putting money into organisations like that.’ ‘The way we do codesign is about communities not KPIs. Rather than PHNs dictating KPIs. It doesn’t do our mob any good. There are all those other social determinants, we’re just catching people at crisis. We won’t be intimidated or bullied into a structure by the PHN. They tried. They bullied but we pushed back.’
Timeframes	‘More time should have been supported to do things better and take a more proactive and purposeful community development approach that was truly inclusive.’ ‘From my knowledge I feel like everything was rushed; it all just seemed to be happening around me.’
Lack of communication	‘It should have been advertised more to community, more people could have been there.’ ‘Nothing was ever fed back and we would ask what was happening but nothing was ever fed back.’
Lack of culturally appropriate planning tools and resources	‘In the Aboriginal space there were very little culturally appropriate tools and resources to undertake local activities.’

Table A17.2 Aboriginal and Torres Strait Islander Trial activities themes, subthemes and sample quotations

Activity description	
Men’s programs	‘We started a men’s group in Brewarrina about 3 weeks ago and suicide came up. Several people expressed suicidal ideation.’ ‘We have got 15 – 20 people in our men’s group. Now we have up to 40 people.’ ‘The camps helped the people to learn more about the other things available in our community. He learned about men’s shed and the networks here.’

Activity description	
Community awareness raising events	‘Events include: walk for awareness, we have done a festival called Googuren (Healing), we put in a boulder with a plaque payed by the network and we do RUOK day. We organized a big cricket game/day and give out medals to the young people – as a memorial for a young person who suicided last year. There were lots of games, play groups with young kids and art.’ ‘[…] we did the ASIST and Aboriginal MHFA and the Wesley Lifeforce’
Promotion and recruitment strategies	
Word of mouth	‘Best outcomes seen in terms of that [Aboriginal people getting help] has been through having Aboriginal people on the ground, that are a link between service and community and through word-of-mouth of good experiences. It’s about trust, you’re link, not a clinician.’ ‘Through local paper, word-of-mouth is big, through the networks, and us and the workers and through Elders. We did door-knocking.’
Promotional materials	‘To get people interested I handed out t-shirts.’ ‘We have flyers and beer-coasters.’
Local networks	‘A lot was through using existing networks well.’ ‘We meet with interagency and stakeholders and we try and invite each other to events and team up, so we promote through other stakeholders as well.’
Social media	‘We also have a private [Facebook] page for men, because of COVID. We engage through there. The private page is to keep my stats up but also to share what happens in the community and check in with the men.’ ‘Social media has been our biggest connection to community during COVID. I post videos. ‘
Providing food	‘Buying and cooking the food, there was plenty and it was good.’
Radio, TV and newspaper	‘Yes. We use local radio and newspapers, flyers.’
Other	‘We pick up the men and we supply the gear, otherwise they won’t come.’
Involvement of people with lived experience of suicide	‘Sitting down, listening and talking to people. Talking to people with lived experience and those not ordinarily asked their viewpoints. It was very community driven and provided a good basis to understanding community need, issues and trends.’ ‘We have a someone who was in our program and wanted to return back, he is helping us now.’
Implementation facilitating factors	
Community readiness and buy-in	‘There have been, over the past 10-15 years, many Coroner’s reports and community have come together over many years and on many occasions to try and do something about this. This is something the Community have always wanted to have happen; the last Coroner’s Report has been the trigger for Government to come to the table and so from a Community perspective this is something we have wanted for a long time.’ ‘I think people just got sick of hearing things all the time about people dying through suicide. All the families impacted just wanted to come together and try to stop it.’
Locally run	‘Our people don’t want to travel 400 KM for help – to get bad [mainstream] treatment. We need our people giving local help.’

Activity description	
	Evaluator: What made people come and take part in the activity? Stakeholder: Me, because they trust me. It needs a local person who has the communities trust and respect [like role models and mentors].
Trial coordinator	‘With [Trial staff], it’s been totally different – they have said at the beginning, it’s your business and you tell us what you want to do – as long as it’s safe.’ ‘We’ve been very lucky with our PHN and project officer.’
Time	‘The most valuable thing you can put in to help our people that are lost [drugs/mental health] is time, spending time with them and taking them out to country. We look after them, we don’t want money. It’s not [a] 9 to 5 job.’
Resources	Evaluator: What do you or others need to deliver this program? Stakeholder: Funding and resources (like swags and camping gear) – we have the knowledge and know how.
Implementation challenges	
Structural challenges and the ecology of suicide	‘We must empower the child from birth. Not shove the services down their throat later on, services that don’t work. Our people die so young. Need to address intergenerational trauma, we need the true history of Australia – if we don’t address that for our children, we can’t expect them to participate in society.’ ‘Still stigma and shame. It’s not getting better, because non-Indigenous people don’t understand and don’t accept an Indigenous person. We still face that barrier, that racism.’ ‘The Government bodies/PHN systems and policies are colonial and continue to affect our people, disempower us.’ ‘Distrust of Government – they spend money but set Aboriginal people up to fail. If something is going right [community-run], they don’t want to spend money on it.’ ‘There are many variables, but the overriding issues are around systemic racism; it is alive and well in [site] and across the region.’ ‘We must transfer the knowledge to our people and the conversation with our people about why this mess it about. But it is hard with lateral violence.’
Engaging relevant stakeholders and sectors	‘There needs to be more accountability of senior people representing the community to feed back down to the workers so that the workers on the ground can be better connected for their clients.’ ‘I think people participated if they could, however the reality is that many people have conflicting responsibilities and calls on their time so may not have been able to.’ ‘Depends on the day. A good day, they come along but other days they don’t want to. You plan as much of you can. We have 20 people on our list, and we walk away with 8.’
Existing services and systems	‘The waiting times for services and service responses are not acceptable, and often the time taken to educate people is not sufficient – trust needs to be built in order to actually get people to engage in their own treatment.’ ‘[Organisation] do carer support, however because my sister didn’t go through a formal process, we as a family couldn’t access the support. The

Activity description	
	paperwork was also overwhelming and very intrusive. It's a big step to ask for help- it needs to be made easier.' 'Even though those working through the Trials may not have the clinical skills the service is still much needed. There is never one service that meets the entire/holistic needs of one person- they get passed through a variety of services.' 'Mainstream services are often quite racist and do not treat Aboriginal people well. As a result, Aboriginal people often do not seek support from them.' 'Non-indigenous/ white workforce (psychologist etc.) are not capable of helping our people – they do not comprehend our experience, our mental health. They can't help us. Our people don't feel welcome or safe in the services we have. But it's also our own people who do it, but they have been silenced. You don't get a job, if you speak up. So, we do it voluntarily.' 'There is mainstream stuff like Lifeline, headspace. But people aren't confident to use. Some have used and experiences have not been positive.'
Communication challenges	'I have seen some programs pop-up but unless you read the 'small print' it is not clear that they are related to the Suicide Prevention Trial.' 'As a worker on the ground very little was seen or heard about what activities were being done through the Suicide Prevention Trial; as a result, it is unclear around how to access any services that are provided through the Trial.' 'As a worker in the community (having worked across 2 communities) I am unaware of what is going on with the Trial activities. One of my colleagues has some understanding but is still largely unaware.' Evaluator: Do community know about what's going on - [the trial activities]? Stakeholder: No, not really. Some would do but not widespread community knowledge.
Workforce challenges	'What I know is the position they have at the AMS, they just re-advertised that. People keep leaving, I don't know why. Just because I am don't have a piece of paper doesn't mean I can't do it.' 'I think recruitment to the position that was promised ASAP and having the person out there doing the activity straight away would have been of benefit and better met the expectations of community.' 'The problem is the local people don't get the opportunity to do this [service provider] work.'
Data and evaluation	'Will I hear about the results? We are not going to read journal articles, reports or go to seminars. Non-indigenous people don't realise they don't listen. We give that IP and knowledge for free continuously and we need to see the results in a form that reaches us and is accessible.'
COVID-related	Evaluator: Effects of COVID?

Activity description	
	Stakeholder: We haven't been able to go out to the communities. It has affected me health wise, it has caused me stress – stopped me from doing what I do.
Trial scope	'This is a silo type activity, but they need to take their hat off and recognize that the community have the knowledge. All core business is a service to community – so they questions should be around having the elders and community in the conversation. 'People are frustrated with the PHN, they can train people and support us, but that's it. It's frustrating.' 'One of the challenges is timelines, it was 6 months at first and we got it extended to 12 months.'
Resource challenges	'It's about what bang you can get for budget. The budget has been a very limiting factor in what we can do. Very limited budget and there's no more money.' 'We do need more resources/equipment [swags etc.].' 'We [staff] put in money from our own pockets to help our men and our families.'
Contextual challenges	'Had to postpone training due to community losses.'
Community priorities	
Aboriginal and Torres Strait Islander led	'All core business is a service to community – so the questions should be around having the Elders and community in the conversation.' 'But Aboriginal people respond much better to Aboriginal organisations and services – we can provide far better services.' 'This is community-run, not PHN.'
A focus on healing and trauma informed approaches	'The one thing that I know about working in [here] is that you need to come from a healing perspective. The pain that exists in the community is palpable because no-one talks about their pain, learns to sit with it, etc. Because this topic [suicide] has such pain attached service providers need to be able to sit with silence and the pain before the sharing can start.' 'I don't believe it could have been done differently, it was very emotionally and culturally respectful of all the community members involved- all who had been directly impacted through or by suicide.' 'When we have these meetings [with PHN] we always have a safe place. We look out for each other. We have the solutions to the problems you made. The PHN has been really supportive and we've been able to express our views. It's fantastic. This is about our people and where we need to be.' 'Talking is healing. Stopping them from committing suicide. Lots of that is invisible to others.'
Community engagement approach	'…a cup of coffee and a biscuit can change someone's life, prevent someone from suicide – it is giving your time, being available.' 'The need for relational approach to service delivery, taking the time and care for our people.' 'The most valuable thing you can put in to help our people that are lost [drugs/mental health] is time, spending time with them and taking them

Activity description	
	out to country. We look after them, we don’t want money. It’s not a 9 to 5 job.’ ‘Sitting down, listening and talking to people.’ ‘Any activity we want to run – I go and see people and talk to them about what we are doing. People are happy with that, creating awareness.‘
Social and emotional wellbeing approach	‘Western constructs are different to the way that I construct my identity through my family; it is connected to Country; what is considered a ‘Western’ clinical approach is not always beneficial for Aboriginal people. Connection means something difference for all Aboriginal people - in Broome it is Liyan, in other places it is constructed in slightly different ways.’ ‘When you look back; it always comes back to grief; dealing with grief in a private way is a Western construct. It’s not our way as collective peoples.’ Evaluator: What made people come and take part in the activity? Stakeholder: They needed the change and that yarn, that men’s business and connect to country.
Cultural competence and safety	‘Cultural awareness is important and the freedom to do what we do, the men’s business – that’s private and cultural and so we can’t say/explain what we want to do exactly in the meetings [with the org/white people].’ ‘The local hospital and health services has started a campaign about ‘we will ask you if you are Aboriginal or Torres Strait Islander’. They’ve had a campaign so higher numbers are presenting because of that.’ ‘Often many Aboriginal people are clinically unprepared for the complex work of suicide but thrust into clinical roles - the approaches [SEWB and clinical] are not integrated or consistent as they need to be. I think this is a bit what seems to have happened through this Trial.’
Client-centred	‘Our communities have the right to choose what services they access. Some [people] are after a medical service delivery. We offer community. I think there should be diversity, as there’s diversity in our community.‘ ‘Some of the activities don’t interest them, like making the artefacts – so depends on the community, catering to their needs and interests. We also ask for their feedback to improve. The guest speakers were an example of a community suggestion and we did that.’
Wrap around holistic care	‘Yes, for the combined men camps, we got NSW police come in to talk about domestic violence and we had another guy talking about sexual assault. Financial stuff too. Community members that talk about their passion, what they do in the community. I give a warning beforehand, making sure they know what we are going to talk about. It raises that awareness.’
Sustainable	‘In any community, you get a saturation with fly-in/out services – it needs to be sustainable.‘ ‘When you pull funding out, it’s traumatising, it’s health related.’
Non-clinical approach	‘Community will rather ask her – a 66-year-old women – for help than go to a service.’ ‘I shy away from paperwork and stuff. We want to have a yarn. Focus needs to be yarns and conversation, which isn’t necessarily an official circle

Activity description	
	going around but can be a BBQ with people standing around. That’s important. Not clinical, people are opening up and connecting.’

Table A17.3 Aboriginal and Torres Strait Islander-focussed activities impacts themes, subthemes and sample quotations

Outputs and impacts	
Increase community knowledge and awareness	‘I really enjoyed the talking on the overnight camp, I didn’t know about suicide prevention previously.’ ‘I think so yes. I have learned now how much help is out there.’ ‘I think so as people are more openly talking about it, including where to go and get support if they need it.’
Increased service provider knowledge and awareness for service providers	Evaluator: Does community have increased knowledge about how to support people? Stakeholder: Certainly, people working in the system do without a doubt.
Increased help seeking	‘Men talk to me now and I take them to the hospital and they get rehab. I can see the change, because of the education and awareness,’ ‘Men have come up to me and engaged with me and they come look for professional help, which they wouldn’t have done before. I point them to Aboriginal Health.’
Improved wellbeing of participants	‘The process of yarning circles has been incredibly healing and powerful. We’ve seen people leave more positive.’ ‘Yes. I felt safe and well looked after.’ ‘Yes. It has definitely helped me and others. I wish there was more. It brings people together and you start talking.’
Cultural impacts	‘We’ve seen new emergence of local leaders. That’s been quite a big thing to juggle. Our program is also about building our Elders to tell their stories and support families.’
Build capacity	‘Yes, we learned how to self-care, we learned how to deal with people with depression and who are not OK [suicidal].‘ ‘I personally look out to help people and link them in with the right services, etc.’
Increased coordination and integration	‘For [region], there is a massive gap in suicide prevention. On the ground it’s created a space for organisations to come together and work collaboratively, that wasn’t happening before. With stronger relationships that feeds into other work.’ ‘The initial yarning sessions, where there were other stakeholders involved, did assist to bring agencies and community members together.’ ‘It got everyone in the room. We talked about what services we have, what we’ve got, what we want. We didn’t have that before and the PHN brought us into the room to do that.’ ‘When we have men’s shed I try to encourage other organisation to come along. If they give us notice we can get the BBQ going and we get them to have yarn.’
Reduced stigma	‘Yes, we learned how to self-care, we learned how to deal with people with depression and who are not OK [suicidal]. The stigma is reduced.’

Outputs and impacts	
Met needs/Expectations	‘Yes, with the immediate community. Elders come up to me yesterday and said, ‘you’re doing deadly work’.’ Evaluator: Do you think [the services/activities] have helped people? How? Stakeholder: Not really sure - haven’t seen anything obvious in this regard. ‘No. They are at a total loss.’

Appendix 18: Aboriginal and Torres Strait Islander-focused consultation topics for service providers

1. What kind of activities/programs have you been providing?
2. How were activities tailored for local Aboriginal and Torres Strait Islander people/communities?
3. How were activities tailored to be culturally safe and appropriate?
4. Were local Indigenous people employed?
5. How did you promote your activities?
6. What was the best way of getting people to participate in your program/activity?
7. How does your program fit in with other social and emotional wellbeing programs and other services in the area?
8. What have been the challenges in providing the activity?
9. What do you think have been the benefits of the program/activity?
10. Is there anything else you’d like to share?

Appendix 19: Aboriginal and Torres Strait Islander-focused service provider consultations – themes and sample quotations

Table A19.1 Planning themes, subthemes and sample quotations

Themes and subthemes	Sample quotation
Stakeholder involvement	
	‘The co-design was planned to capture promising practices on the ground of Aboriginal and Torres Strait Islander communities in Brisbane North. We wanted them to be part of the design to allow and empower our self-determination for localised voices to provide local solutions to suicide prevention. We had 13 community consultations.’ ‘That was why it was never co-designed because they came back with something already structured.’
Facilitating factors	
	‘This trial demonstrated that when you have the local governance structure in place, it is these relationships that drive the work.’ ‘Reference group made up Aboriginal people who were reimbursed for their time.’
Challenges	
	‘There has been a lot of uncertainty, it wasn’t a co-designed process and then it went pear shaped.’

Table A19.2 Aboriginal and Torres Strait Islander Trial system-based approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotation
Effective strategies for coordinating activities	
Partnering with other providers	‘I think the unique thing about it is each organisation plays its own role – we don’t try and compete with each other – we each bring our own skills to it and it works.’ ‘We partnered with the [service organisation] and [local] mob to deliver group therapy sessions, individual therapy, building connection and belonging, sharing stories of hope and survival, drumming.’
Establishing referral pathways	‘Referrals with these organisations go both ways, where they refer to us and we refer back.’ ‘We have been able to establish a safe referral pathway. We get warm referrals through the [program] page and they can go through the [local] Council for LGBTI health […] We are at 100% capacity, so we are having to say that can we navigate the space with wrap around support.’
Complementary services	‘Men’ s groups and topics – nobody had heard about them. But now they are popping up everywhere. Men usually get left out. Now things are available.’ ‘There is a gap – when you work in this area you find out those gaps. The services we have are very specific and none of them really target mental health or suicide prevention. We target that very specific suicide prevention element – so we fit in in that way.’ ‘This program picks up the mental health area, which a lot of other programs haven’t done before.’
Facilitating factors	

Themes and subthemes	Sample quotation
Bringing stakeholders together	‘We keep an eye out what others are doing. […] When we have men’s shed I try to encourage other organisations to come along. If they give us notice, we can get the BBQ going and we get them to have yarn.’ ‘We all just work together and take a part, because we are so small – interagency meetings. When I first started, 18 months ago, no one worked together. I just addressed that head on and spoke up.’ ‘A 100% there needs to be collaboration – Indigenous, non-indigenous – we all need to work together.’
Community buy-in	‘You need a lot of time to develop relationships with communities if you want to make these projects work.’ ‘I think that is another key thing. Just sit down – even if it is yarning circle or one of the Elders group or a suicide prevention group for the community – just sit and talk. Get to know the people you are working with.’
Locally run and grass-roots programs	‘Invest in what is already going on at a local level, invest in that because it works.’ ‘That was good with suicide network saying we have the funding, you lead the way. They left it up to us to run it.’ ‘I guess because we are the traditional owners for this country we just knew what to do.’
Challenges	
	‘Schools were resistant that they don’t do cultural programs, arts sector saying that they only do formal art not doing cultural activities while you paint.’ ‘Getting engagement with the first responders – police, ambulance, community health – they don’t consider this as part of their role and they don’t see the bigger picture. That’s difficult.’

Table A19.3 Aboriginal and Torres Strait Islander-focused activities and services themes, subthemes and sample quotations

Themes and subthemes	Sample quotation
Workforce requirements	
	‘All staff on camp are Indigenous which meant it became a very culturally safe place, they also had three Elders present of the camp that were able to teach the kids.’ ‘We prefer to have Aboriginal trainers, but there are occasions when we have a non-Indigenous person but they are accepted within the community by our Aboriginal and Torres Strait Islander people – they have been chosen as accepted people to do the workshop.’ ‘The story telling was all local stories. Using local indigenous people.’
Tailoring activities	
Developed and/or operated by local Aboriginal and Torres Strait Islander community	‘The co-design was planned to capture promising practices on the ground of Aboriginal and Torres Strait Islander communities in [local area]. We wanted them to be part of the design to allow and empower our self-determination for localised voices to provide local solutions to suicide prevention.’

Themes and subthemes	Sample quotation
	‘This program is demonstrating co-design and is built on Aboriginal ways of working, embedding cultural security into all aspects of it. All staff are Aboriginal and local people are being trained and employed to run the Program. The Program has a 100% Aboriginal client base.’ ‘It is created by Aboriginal people, run by Aboriginal people.’
Healing, trauma-informed and strength-based approaches	‘It’s about building communities, it’s about connecting the Elders with the young, it’s about all those things. I think that is an enormously healing thing. Finding ways to work together, to share knowledge.’ ‘The trauma and healing focus in mental health programs was missing which is why I have created and alternative mental health service.’
Community involvement	‘Liaising with those community organisations and with the Elders to be sure they are safe.’ ‘But also, our individual programs within the high schools we have an advisory committee, and that committee has our local Elders, organisations and parents. Anything we do is run past them – and if they disagree they’ll say so.’ ‘We have a good level of engagement. Every piece of our product has had a high level of community engagement.’
Social Emotional Wellbeing approach	‘The first two weeks of the programs are cultural and bonding, the third week is emotional wellbeing, the fourth week is a celebration of culture and we have now added the fifth week.’ ‘We took a SEWB approach and had local people on the phones.’
Non-clinical approaches	‘We understand that counselling and clinical approaches are an important part of the solution but are not the answer in isolation.‘ ‘Yarning circles tailored to break the mould of what they are used to experiencing in traditional clinical approaches.’
Tailored to needs and interests	‘If we thought that a kid needed some support from someone we knew, we would grab them and bring them in. The program gets tweaked and is flexible. We have lesson plans and modify those.’ ‘Finding out what the actual clients want and providing the activities in the way that suits them.’
Safety plans and procedures in place	‘They created and have implemented a cultural safety policy.’ ‘We did care and safety plans for every community consult that were reviewed by Elders.’ ‘We make sure we have safe community people in the background – who can follow people if they walk out and feel unsafe.’
Embedding cultural practices	‘We do cultural programs and make Aboriginal artworks and artefacts. Sourcing wood from the local community. Trying to create a cultural program for men to sit around and take them to the river, make the artefacts, take them away from town and have a yarn.’ ‘Take boys out fishing, teach about hunting, show them things on the country. Try and bring in as much of the culture as we can from the community.’ ‘One of the things that has worked consistently is smoking ceremonies at the cultural healing retreats, at any of the campaigns and any of the events that we go to. People need to be able to cleanse their spirit.’

Themes and subthemes	Sample quotation
Focusing on cultural safety more broadly	'Cultural safety is always at the top for everyone, including the non-Indigenous people involved in the program as volunteers. It is about making sure all members can explore their cultural background with no judgement, including people who have strong connections and identity to culture and also people who don't have that connect. Non-Indigenous people need to be aware of that as well.'
Applying the National Indigenous Suicide Prevention Strategy	'Activities were tailored through National Indigenous Suicide Prevention Strategy.'
Promotion and recruitment strategies	
Through local sector networks	'We also lean on our PHN, and organisations like that.' 'Building and utilizing the good relationships they already have; using these contacts to find the best people to support and generate the buy in required in activities.'
Word of mouth	'The schools talk to other schools, word of mouth.' 'We are using local trainers who have connections to talk to mob.' 'We had the Elders and the Aunties coming along and spread through the grapevine.'
Social media	'Social networking – Facebook and Instagram are the main methods.' 'The social media helped to get other schools know about it.'
Promotional materials	'Promotion of activities are done through post, brochures, posters, playing cards and other promotional material.' 'Giving out flyers to the community and other organisations.'
Building rapport and trust with community/participants	'We did the training on a designated safe space that the community nominated.' 'Need to build relationship and trust with the school to convince them.' 'If you don't have that trust in the community they aren't going to want to be a part of your workshops and the message is not going to come across as clear, and it is not going to come across as collaboration at all. It is the key thing.'
Providing resources/ incentives	'Just encouraging them – just to tell them it's beneficial for them. Usually the BBQs work, having a feed, that's the incentive. That's when numbers spike – food in their bellies.' 'We pick up the men and we supply the gear, otherwise they won't come.'
Face to face engagement	'Word of mouth and face-to-face engagement. Not sitting behind a desk.' 'One of the big success was a gathering day – I knocked on all their doors, driving around – the best way to get them engaged.'
Non-clinical approach and settings	'I shy away from paperwork and stuff, we want to have a yarn. Focus needs to be yarns and conversation, which is necessarily an official circle going around but can be a BBQ with people standing around. That's important. Not clinical, people are opening up and connecting.'
Promotion or information events	'We have done lots of presentations to schools to promote. We launched it in an old amphitheatre because that was the only place we could get a smoking ceremony in there.'
Radio, TV and newspapers	'Through numerous radio stations leading up to the date, speaking about the co-design process.' 'Advertising in the local paper.'

Themes and subthemes	Sample quotation
Place-based approaches	‘Allowing community to define what that safe space looked like and using a centralised point for community.’
Others	‘We also streaming live billboards on the side of the highways.’ ‘Using well known Aboriginal footballers and getting them on board as ambassadors who have struggled and getting them to promote the programs’
Outputs and impacts	
Increased collaboration and connection	‘Increased connection with the community.’ ‘We merged all of these communities in this artwork to show that there is unity and we are in this together.’
Met needs and expectations	‘Giving the men an avenue, pathways and resources to help them.’ ‘In the first year we ran the program we saw 360 young people, all of whom got something positive from the Program. ‘ ‘The first workshop I went to had about 15 families which is unheard of.’
Increased awareness and knowledge	‘Capacity of our community has increased, knowledge and skills. The ability to be able to talk about it and connect with others.’ ‘It has raised community awareness significantly and gives community members a culturally safe place to be supported and understood- especially the call centre after hours when the call goes through to an Aboriginal person at a time of need.’ ‘The beauty is having the conversations with family when you’re out there. People are being more aware of local services, its more local.’
Improved social and emotional wellbeing	‘We have seen improvements in self-esteem, reasons for living, positive about the future, feelings of cultural connectedness of identity and social conceptualisation of self, feeling accepted by the community.’ ‘But inadvertently they all came out with talking about suicidal thoughts and troubles, and all of them had a life-changing experience that they are still talking about a year and a half on.’
Cultural awareness and safety	‘Each of the schools had a shift in their culture, more Aboriginal paintings appearing. So as an Aboriginal person that’s important. For some parents, school is a bad memory so to see the language and paintings appear is important. You know it is genuine then, making a shift in that school.’
Community empowerment	‘This will increase their ability to participate in localised community scopes of work or workshops outside suicide prevention, which makes us feel a sense of hope and inclusion.’
Increased capacity	Evaluator: What do you think have been the benefits of the program/activity? Participant: Definitely the education and getting people trained.
Reduced stigma	‘Getting people to talk, to break down that stigma of mental illness and suicide, talk about that elephant in the room. Especially for men.’
Challenges	
COVID-related challenges	‘We need to keep the momentum going. Running camps every couple of months. COVID is a challenge.’ ‘People are still in lock-down mode, people are staying home regardless of the restriction lifting. People aren’t ready to commit, too much uncertainty.’ ‘Drastic yes – we had to close down a lot our programs and events. It will be a setback for a lot our initiatives.’

Themes and subthemes	Sample quotation
Lack of/inconsistent funding	You can't stick a timeframe around it. I told PHN that you want us to fix 200 years of colonisation in 3 months? The three months is supposed to be for them in the crisis and then after the risk period but when they realise that the supports are going to leave them they go back into crisis.' 'It is a challenge because young people want us to come back next year but we don't how, we'll try. And the young Indigenous person saying "trying means no", they had already internalised the message of let-down.' 'Funding is a problem which reduces number of staff .' 'Funding is a challenge, keeping people on and investing in local communities. '
Uptake and/or access	'Getting the men who come and help out is a challenge in that it's all very fluid up until the day it happens.' 'There's been some approaches from people like Youth Justice that have wanted to refer boys in, but then their referrals come with conditions that don't fit with what we do.'
Community engagement	'The politics is challenging.' 'For smaller communities that can be hard, there are a lot of factions – but with suicide prevention they do come together and get on with it.'
Workforce	'I am the only person out here alone on Suicide Prevention, I have to run it by myself – can be challenging.' 'All the networks are volunteers, so it's hard to keep momentum and it's my job to keep that going.' 'Finding good staff with good experience.'
Managing relationships with the PHN	'You need to have a bit more communication around what they are doing around the Trial – more open communication around what is actually happening.' 'PHN did nothing to help promote to the services that they could send someone to us, they didn't link us with the hospitals.'
Lack of data	'This is the big challenge for this program. It is unique and there is no evidence for stuff like this in Australia. There isn't a clear avenue for where this program would go, it is very novel.' 'No real-time suicide or self-harm data so don't know their impact on that – would love that data.'
Lack of resources	'It has been under resourced to deliver so we become dependent on volunteers.' 'People don't have computers.' 'It has been extremely challenging to get sufficient funding and infrastructure support to run the program.'
Structural and systemic challenges	'Try to explain to people that when white people first came into this country the first thing they did was disarm all the Aboriginal men. And once that happened those men stopped being warriors, hunters, leaders and protectors and ever since then Aboriginal men have been disarmed. They've lost their identity and they've lost their role in life.' 'There are a lot of challenges in this space and you are not only dealing with the suicide, but all the other structural (housing, poverty, etc.) and

Themes and subthemes	Sample quotation
	relationship issues (child protection etc.) and physical health issues clients often face.’
Other challenges	‘Lack of Indigenous suicide prevention expertise as part of the Trial lead.’ ‘Protocols provide a barrier, they don’t always have the time needed to set aside to engage before an engagement.’

Appendix 20: Consultation topics for other stakeholders

Involvement

1. How have you been involved in the trial so far (briefly)?
2. What do you see as the strengths of the trial?
3. What are your hopes for the trial/successful outcomes?
4. What are your concerns for the trial?
5. Overall were you satisfied with how your contribution was received by trial sites?

Observations/Insights

6. PHN understanding of and uptake of systems-based approach
7. PHN strategies that were found to be effective in facilitating a system-based approach
8. PHN staffing and trial governance
9. Key success factors
10. Key challenges/barriers
11. Reflections on Black Dog Institute's role
12. Future directions/recommendations

Target Groups

People with a recent suicide attempt or at high risk of suicidal behaviour

- Success factors/what went well
- Challenges and actions to overcome them

Aboriginal and Torres Strait Islander people

- Success factors/what went well
- Challenges and actions to overcome them

Men

- Success factors/what went well
- Challenges and actions to overcome them

Young people

- Success factors/what went well
- Challenges and actions to overcome them

LGBTIQ people

- Success factors/what went well
- Challenges and actions to overcome them

ex ADF and their families

- Success factors/what went well
- Challenges and actions to overcome them

Appendix 21: Themes and sample quotations – other stakeholders

Table A21.1 Planning themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Planning	
Identifying local needs and service gaps	‘For example, the pathways project at [PHN], spent money on consultants to look at how people move through the system if they are LGBTI or Indigenous – looked at what are the points where you could intervene in a different way, where could you intervene to facilitate better movement between different parts of the system.’
Stakeholder involvement in planning	‘… that have invested in governance, that is the ones that have developed strong implementation groups that are really representative of the communities that they are representing have done well.’ ‘ strong implementation groups that meet regularly. Regularity is important in order to basically walk through every step of the process, rather than just having the PHN handing down the strategies and actions from above.’
Facilitating factors	
Tailoring to local context	‘The community design. We come from LifeSpan but we supported sites taking different approaches. The Department has allowed them to veer from this if there is support of the community. To be able to locally tailor. The strategies that come out of that are much more relevant than plonking something on top.’ ‘Slowing things down and actually listening to the communities.’
Good governance and strong leadership	‘Governance – success entirely dependent on capacity to get the right people in the room. Most success is when governance includes senior people, and then a working group that progresses the work.’
Challenges	
Governance challenges	‘Coordinator may not have the authority within community and is not able to community effectively the evidence-based approach.’ ‘Because some of the PHNs have been hands off in implementation and generally, we get a lot of Trial sites coming to us…. They ask lots of questions beyond our remit. Not specifically our task. Contextual and other questions.’ ‘With the priority populations the question of lived experience is more complex in that you would have a lived experience of your cultural identity and if you have multiple identities, i.e. Indigenous/LGBTI/suicide and I think that each individual places their primary identity in a different place.’
Use of evidence	‘I think that the evidence around what works is not nuanced enough to actually have an impact.’ ‘Some recommended interventions– i.e. YAM - are very difficult to implement in the real world, it may have a really strong evidence base but it is not appealing to many of the sites from a logistical point of view.’
Logistical challenges	‘Some sites are too geographically dispersed and are struggling to try and achieve a systems-based approach where there is no existing system.’ ‘Places with success of setting up working groups are probably more metropolitan areas. In more remote regions its harder to get common buy-in and regular attendance.’ ‘The community engagement and planning phase cannot be underestimated. There was a lot of pressure from everyone to get the Trial

Themes and subthemes	Sample quotations
	going which was to the detriment.’
Staffing	‘There has been massive [staff] turnover, and this results in a huge loss of knowledge when people leave and then the new people have a big catch-up before they can move the project on.’ ‘It’s hard to get people, for the pay grade, for the complexity of the project – who can fill that role. It requires so much understanding of the system. So, it depends a lot on the people on the ground.’

Table A21.2 Systems-based approach themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
Strategies	
Advisory role by Black Dog Institute	‘The workshops and webinars [provided by Black Dog Institute] were well received and had great participation in those, I think we’ve been able to gather some great speakers and get good contributions from the sites - they were the most positive thing.’ ‘[…] to bringing people together online or through events or workshops, that has been a huge for support for a pretty new workforce.’
Emphasis on evidence-based framework	‘Because it’s a complex undertaking and a new approach and many people haven’t worked on this scale before – so having a framework [like LifeSpan] to guide is a strength.’
Knowledge sharing	‘Sharing knowledge and connecting sites will also increase capacity to deliver evidence-based practice but also to work together to navigate systems, policies etc. Coordinated efforts on the ground are happening, if that was expanded regionally, nationally that would be great.’ ‘Sites want to hear from each other. Capacity to learn off each other’s learnings.’
Clearly defined focus	‘That it is looking at diverse groups, at how a systems-based approach might impact on different population groups, and that they are trying to do something different from the past – in particular trying to organise a whole system around a specific population rather than just a general universal approach.’ ‘clarity of model and boundaries of it, what’s achievable and appropriate.’
Engaging community and adapting to local community needs	‘Connecting strategies is really important in a systems-based approach, seeing how they need to be synchronised. Running a community campaign in isolation is not going to make best use of the resources and evidence.’ ‘Adapting to community need has been really important. When the systems-based approach was developed it is quite rigid and top down and doesn’t take into account readiness.’
Outcomes	
Community engagement and collaboration	‘Anecdotally we hear increased community engagement and local connections. A powerful outcome is that this work has pulled together key groups, powerful collaboratives and even without funding, those connections will remain.’
PHNs role	‘The PHNs are still a strong vehicle and the right body to do be doing the systems approach.’
Challenges	

Themes and subthemes	Sample quotations
Existing service infrastructure and processes	‘PHNs vary a lot in their operation. Some have far easier procurement or the staff are better embedded. Some staff are isolated in their PHN, there is bureaucracy, red tape.’ ‘Geographical factors and diversity of population, but also because there aren’t hospitals or essential services that cover all those areas’
Lack of understanding of target group needs	‘The Trial is possibly not long enough to see the any impacts, especially in certain populations such as Aboriginal and Torres Strait Islanders and LGBTI populations where there is a need for much more education for the rest of the system to be accepting of the differences and to understand that a universal approach is not necessarily going to work for everyone they encounter.’
Governance challenges	‘Has been a frustration working with PHNs who don’t have much influence within the system. They are not hugely experienced about their role, staff aren’t experienced about their role, there aren’t the connections, the networks. Probably this is a point-in-time thing where they [PHNs] are not mature as a system themselves. Therefore, they don’t have the influence with the parts of state government that matter. For example, rolling out YAM has to involve State Departments of Education, but departments say they are already taking care of it and PHN has no influence over the matter. PHNs also have only limited influence over hospitals etc.’
Poor understanding of systems-based approach	‘Don’t really understand systemic integration through all aspects of the Trial – e.g. planning, implementation.’ ‘A lot of them understand the framework/approach, and some are following it more - but others are just about what the community wants. I think they are doing what the Trial was set-up to do i.e. take a community-led approach - but I don’t think many sites can say they are doing a full LifeSpan approach, or systems approach.’
Insufficient time	‘The timeframe is an issue even though it is four years which is a pretty decent length.’
Lack of data and inability to link local successes	‘Not being able to link successes to hard outcomes, such as reduces suicides, that’s really hard too. […] That can be inherently hard in the system-based approach and capturing the data across that.’
Staff turnover at Trial Sites	‘Consistent staffing. Sites with staff turnover have had difficulty building community trust.’

Table A21.3 Focus population themes, subthemes and sample quotations

Themes and subthemes	Sample quotations
People who attempt or are at risk of suicide	
strategies and challenges	‘[Follow-up aftercare] is a weak spot for the Trial generally. Partly because *beyondblue* funding is dangling and so Sites are holding off to see if they can secure that. […] Technically it is part of the systems-approach, but it is more difficult to implement and needs more funding. PHNs don’t want to fund a service that they will have to defund at the end of Trial.’
Aboriginal and Torres Strait Islander people	
Strategies	‘Having opportunity for community not putting the PHN time limits on them. You have to allow for engaging on their terms.’ ‘We have seen more drawing on social and emotional wellbeing, connection to culture.’

Themes and subthemes	Sample quotations
Challenges	‘That the trial is possibly not long enough to see the any impacts, especially in certain populations such as Aboriginal and Torres Strait Islanders …’ ‘the whole decision-making process is around a very white approach.’ ‘I think all the sites, even the ones that have struggled to get things happening, have worked hard to get [community] engagement.’
Men	
Strategies	‘Industry partners involved (high in men, steel work, mining etc.) and being targeted, trying to narrow it down. Figuring out how to get in touch with men maybe through their employer, thinking creatively about that engagement.’
Challenges	‘I don’t think there has been any headway made with this group. At [Site name], there has been lots of training and visits but haven’t seem a huge amount of engagement or any paradigm shift.’ ‘Men are not a singular group – often when we think about them in the suicide space it is about rural men, working men, men who can’t cry. Whereas when you look at the other priority populations there are men involved with that. When they think that doing men is doing mates in construction and blokey stuff, sometimes the issue is limited by our understandings of masculinity.’
Young people	
Strategies	‘[Site name] recognised the need and carved them off. They are the only site to implement YAM.’ ‘Any stigma reduction or help seeking would have more impact on young people communities because it is all they have is to ask for help. Training of the safety net around them.’
Challenges	‘I tried to encourage to focus on not individual young people try to target parents or teachers how come in contact with young people. Integrating other strategies around young people.’ ‘Not being able to get into the schools is a challenge.’
Ex-ADF members and their families	
Strategies	‘Strong community – everyone understands the ADF and has some connection with that community.’ ‘Success is they have a lot of involvement of high level of community representations, army officers, police officers, politicians. This is good for visibility of the Trial.’ ‘Lived experience and peer is very important.’
Challenges	‘We don’t know how effective it will be. We don’t know if there is a high rate of ex-ADF suicide.’
LGBTI people	
Strategies	‘The interconnectedness of all the services agencies and the PHNs having implementation groups where they all get together and talk from their own perspective, engage and then collectively working out that they are complimentary and resolving over time any competition’ ‘Upskilling mainstream services at understanding the risk and issues that

Themes and subthemes	Sample quotations
	come up for LGBTI people and their mental health.’
Challenges	‘The big challenge is in convincing health and hospital departments that it is still a vulnerability i.e. post the YES vote there is an attitude that it is all OK – but that is not the experience of individuals especially transgender people, gender fluid people and young people. There is a bit of a hierarchy within the community’

Appendix 22: Aftercare service user survey

Service user online survey

Thank you for agreeing to complete this survey. It will take you between 5 and 15 minutes. Your responses will be confidential. If you don't want to continue with the survey, you may stop at any time.

First, we would like to collect a little background information.

Age in years:

State of residence: QLD, NSW, VIC, SA

Do you identify as Aboriginal or Torres Strait Islander: Yes, No

What is your current gender identity? [check one]

- Male
- Female
- Transgender male
- Transgender female
- Genderqueer or gender non-conforming
- Other, please specify___
- Don't want to answer

How would you describe yourself?

- Lesbian, gay or homosexual
- Straight or heterosexual
- Bisexual
- Something else
- Don't know
- Don't want to answer

Now, we would like you to think about the services you have received in the past few months from [service name].

1. Why did you choose to use this service? [Check all that apply]
   - I felt I was not coping
   - My suicidal thoughts were getting worse
   - I experienced an event that was very upsetting
   - I felt I needed professional help
   - A family member/friend suggested it
   - I was referred to the service (by the hospital, a health service or doctor etc.)
   - Other (specify):___________________________

2. Is this the first time you have ever used a service because of suicidal thoughts or behaviours? [Check one only]
   - Yes, this is the first time
   - No, I have used services in the past year
   - No, I have used services in the past, but more than one year ago

3. Did you wait longer than you felt was reasonable to be able to use this service? [Check one only]
   - Yes - I waited longer than I felt was reasonable
   - No – I did not have to wait too long

4. How good was the service at being considerate of your cultural background, sexuality and gender? [Check one only]

- Very bad
- Bad
- Neither good nor bad
- Good
- Very good
- Not applicable

The next five questions are about changes that you may have experienced as a result of using this service. [Check one answer only]

5. How do you now feel about how you can manage your day-to-day life?

- Much worse
- A little worse
- About the same
- A little better
- Much better

6. How do you now feel about your wellbeing?

- Much worse
- A little worse
- About the same
- A little better
- Much better

7. How have you thoughts or feelings about suicide changed?

- Much worse
- A little worse
- About the same, no change
- A little better
- Much better

8. How do you now feel about your future?

- Much worse
- A little worse
- About the same
- A little better
- Much better

[Question 9 will only be asked of participants who indicate that they are Aboriginal or Torres Strait Islander]

9. Has your connection to your family and community changed? Do you feel:

- Much less connected
- A little less connected
- No change in connection
- A little more connected
- A lot more connected

10. Overall, how would you rate the service you received? [Check one only]

- Very bad
- Bad
- Neither good nor bad
- Good
- Very good

Please complete the next two sentences in your own words:

10. The service would have been better if …

____
____

11. The best thing about the service was …

____
____

12. Do you have any other comments about the service you received?

____
____

The last two questions are just to check in that you are doing okay, they are not part of the survey.

1. Have any of the questions in this survey caused you distress?

Yes

2. Would you like us to have the team psychologist call and check in with you?

Yes

Thank you for participating in the survey.

Appendix 23: PMHC MDS NSPT additional module data items

For full specifications go to https://docs.nspt.info/index.html

Data element (field name)	Format/Values
Episode - Consent NSPT evaluation	1: Yes 2: No
Episode - Consent Consumer Survey	1: Yes 2: No
Episode – Sexual identity	1: Lesbian, gay or homosexual 2: Straight or heterosexual 3: Bisexual 4: Something else 5: Don’t know 6: Not stated
Episode – Veteran	1: Yes 2: No 3: Not stated
Episode – Suicide Trial Treatment Focus	1: Assessment only 2: Suicide mitigation, including suicide prevention plan or patient safety plan 4: Psychological intervention or other clinical service with the client 5: Case planning and other sessions with carers and families relating to the client 6: Support service with another third party relating to the client 7: Care coordination and case planning with another service provider 8: Postvention and related services 9: Crisis management 10: Culturally specific assistance 11: Information only 12: Assistance accessing another service only 13: Other client support service (*Please specify)*
Episode – Other services used in the last six months	0: None 1: General Practice 2: Medical Specialist Consulting Rooms 3: Private practice mental health service 4: Public mental health service 5: Public Hospital 6: Private Hospital 7: Emergency Department 8: Community Health Centre 9: Drug and Alcohol Service 10: Community Support Organisation NFP 11: Indigenous Health Organisation 12: Child and Maternal Health 13: Nursing Service 14: Telephone helpline 15: Digital health service 16: Family Support Service 17: School 18: Tertiary Education institution 19: Housing service 20: Centrelink 21: Another service commissioned by the PHN

Data element (field name)	Format/Values
	22: Veteran/defence support services 23: Other 99: Not stated
Episode - Lifetime suicide attempt and ideation	1: Suicide attempt 2: Suicide ideation, no attempt 3: Neither suicide attempt nor ideation 4: Not stated
Episode – Referral made	0: None 1: General Practice 2: Medical Specialist Consulting Rooms 3: Private practice 4: Public mental health service 5: Public Hospital 6: Private Hospital 7: Emergency Department 8: Community Health Centre 9: Drug and Alcohol Service 10: Community Support Organisation NFP 11: Indigenous Health Organisation 12: Child and Maternal Health 13: Nursing Service 14: Telephone helpline 15: Digital health service 16: Family Support Service 17: School 18: Tertiary Education institution 19: Housing service 20: Centrelink 21: PHN psychological therapies 22: Veteran/defence support services 23: Other 99: Not stated
SIDAS – collection occasion: reason	1: Episode start 2: Review 3: Episode end
SIDAS item 1: In the past month, how often have you had thoughts about suicide?	0 – 10: never – always 99 = Not states
SIDAS item 2: In the past month, how much control have you had over these thoughts?	0 – 10: never – always 99 = Not states
SIDAS item 3: In the past month, how close have you come to making a suicide attempt?	0 – 10: never – always 99 = Not states
SIDAS item 4: In the past month, to what extent have you felt tormented by thoughts about suicide?	0 – 10: never – always 99 = Not states
SIDAS item 5: In the past month, how much have thoughts about suicide interfered with your ability to carry out daily activities, such as work, household tasks or social activities?	0 – 10: never – always 99 = Not states

Appendix 24: Community-based activities data items

For full specifications go to https://docs.nspt.info/index.html

Data Element	Format / Values
NSPT Activity - Name	Short descriptive title identifying the activity.
NSPT Activity - Summary	Brief description of the activity.
NSPT Activity - Start Date	Day, month and year the Activity commenced.
NSPT Activity - End Date	Day, month and year the Activity is expected to end.
NSPT Activity - Area	1: Workforce related activities 2: Media and communication strategies 3: Community education and support services
NSPT Activity - Location	Location or area in which the activity is undertaken or that it targets when not undertaken face to face.
NSPT Activity - Mode of Delivery	1: Face-to-face 2: Telephone 3: Video-link 4: Online 5: Print media 6: Radio 7: Television 8: Other Multiple space separated values allowed
NSPT Activity - Mode of Delivery Other	Description of other activity mode of delivery.
NSPT Activity - Focus	1: Awareness raising and engagement 2: Implementation of standards and other quality improvements 3: Capacity building with service providers, organisations, communities or other groups to identify and/or support with people at risk or affected by suicide 4: Professional development and training 5: Information, services or other activities for at-risk individuals or groups of people at higher risk of suicide 6: Other Multiple space separated values allowed

Data Element	Format / Values
NSPT Activity - Focus Other	Description of other activity focus.
NSPT Activity - Target group	1: Generic or national 2: Community, town or other geographical area 3: People from an at-risk population
NSPT Activity - At-Risk Population	0: N/A (not an at-risk population group) 1: Aboriginal and Torres Strait Islander peoples 2: Veterans and/or their families 3: Young people (aged 16-25 years) 4: Lesbian, gay, bisexual, transgender or intersex (LGBTI) people 5: Men aged 25-54 years 6: People aged 65 years and older 7: People who have previously attempted suicide 8: People with lived experience of suicide 9: Other Multiple space separated values allowed
NSPT Activity - At-Risk Population Other	Description of other at-risk target group.
NSPT Activity - Target Workforce	0: N/A not a Workforce related activity 1: Community health organisations and related services 2: Aboriginal and Torres Strait Islander service providers and other organisations 3: Emergency or crisis response services 4: Primary Health Network commissioned services 5: School or other educational institution personnel 6: Police and law enforcement agencies 7: Media 8: Volunteer or community group providing Services or support (including peer workers) 9: Other Multiple space separated values allowed
NSPT Activity - Target Workforce Other	Description of target workforce.
NSPT Activity - Number Participating	0 – 30000000

Appendix 25: Epidemiological analysis – Primary mental health care minimum data sets

A25.1. Data Sources – PMHC and ATAPS

The complete PMHC MDS from inception (2016) to 2020 as well as ATAPS minimum dataset which captured the same data from 2010 before it was redesigned as the current PMHC MDS was provided. Although there are some differences in the information collected, the two MDSs are functionally a single dataset. In the following PMHC MDS is taken to refer to the merged ATAPS and PMHC minimum datasets. The supply of PMHC MDS and ATAPS MDS data included only those records where the patient had consented to the supply and use of their data for evaluation and related purposes.

The PMHC MDS captures data on PHN-commissioned mental health services delivered to individual consumers. All PHNs are required to submit data on mental health services that are delivered to individual consumers, including group-based services delivered to individual consumers. Data can be uploaded into the PMHC MDS website portal from PHNs' and/or commissioned service providers' local client management systems or pre-defined template spreadsheets, or directly entered into the PMHC MDS web interface by service providers.

A25.2. Defining the sampling frame

Initially, all episodes commencing between 1 January 2010 and 30 June 2020 were identified. In the PHMC MDS, an episode is defined as a period of contact between an individual and a PHN-commissioned mental health service that starts at the point of first contact and concludes at discharge. Episodes for which at least one attended contact was recorded were included in the analysis. Inspection of episode counts over time showed a steady decrease in the number of episodes recorded after 30 September 2019, likely due to time lags in data entry. Because including this data would bias the results, the sampling frame was restricted to episodes commencing between 1 January 2010 and 30 September 2019.

Next, the mirror-image observation periods were determined. Because implementation was staggered in the NSPT and control (Other) sites, the observation period was centred around the implementation date of the NSPT or similar activity in the PHN to which the episode belonged. For the control (None) sites there was no implementation date, so the earliest implementation date among PHNs in the NSPT (1 June 2016) was applied.

Then, a time series was produced from episode records in each PHN aggregated into 28-day blocks centred around the assigned implementation date. For interrupted time series designs based on monthly time periods, at least 24 time points are recommended (in the current study, 28-day blocks) to allow adjustment for seasonality (preferably, with equal numbers of time points in the pre- and post-implementation periods), and at least 100 observations at each data point. The minimum number of 28-day blocks in the post-implementation period for which there were at least 100 observations in all intervention groups was calculated and set as the end of the post-observation period. The mirror-image for the pre-implementation period was then taken. Using this method, the observation period for each PHN comprised a total of 66 28-day blocks – 33 in the pre-implementation period and 33 in the post- implementation period. The staggered implementation design meant that the observation period, in terms of historical time, was specific to each PHN, but the minimum and maximum episode start dates fell between 20 November 2013 and 30 September 2019.

Primary Health Networks that did not report data to the PMHC MDS consistently over the observation period were excluded from the analysis. Of the 31 PHNs, three reported nil episodes in at least one block (one PHN reported nil episodes in five blocks, one in six blocks, and one in 10 blocks) so were excluded from analysis. All three excluded PHNs were control (None) sites.

A25.3 Defining the intervention groups

As shown in Table A25.1, the implementation of the NSPT and other suicide prevention activity was staggered over time. For NSPT sites, implementation dates ranged from June 2016 to February 2017. For PHNs in the control (Other) group, implementation dates ranged from October 2016 to September 2017. The analysis required assigning a single implementation date to each PHN. For PHNs that implemented both NSPT and other similar activities, the NSPT implementation date was assigned. One PHN in the control (Other) group implemented activities at different times in different subregions; in this case the earliest date was applied.

Table A25.1 PHNs – NSPT Trial Sites and other suicide prevention activity

PHN NAME	STATE	TRIAL STATUS	1ST SITE	START MONTH	START YEAR	2ND SITE	START MONTH	START YEAR
Central and Eastern Sydney	NSW	NONE						
Northern Sydney	NSW	NONE						
Western Sydney	NSW	NONE						
Nepean Blue Mountains	NSW	NONE						
South Western Sydney	NSW	NONE						
South Eastern NSW	NSW	OTHER		Feb	2017			
Western NSW	NSW	NSPT		Feb	2017			
Hunter New England and Central Coast	NSW	OTHER	Newcastle	Oct	2016	Central Coast	May	2017
North Coast	NSW	NSPT		June	2016			
Murrumbidgee	NSW	OTHER		Sep	2017			
North Western Melbourne	VIC	NSPT		June	2016	OTHER	April	2017
Eastern Melbourne	VIC	OTHER		April	2017			
South Eastern Melbourne	VIC	OTHER		April	2017			
Gippsland	VIC	OTHER		April	2017			
Murray	VIC	OTHER		April	2017			
Western Victoria	VIC	OTHER		April	2017			
Brisbane North	QLD	NSPT		June	2016			
Brisbane South	QLD	NONE						
Gold Coast	QLD	NONE						
Darling Downs and West Moreton	QLD	NONE						
Western Queensland	QLD	NONE						
Central Queensland, Wide Bay and Sunshine Coast	QLD	NSPT		Feb	2017			
Northern Queensland	QLD	NSPT		August	2016			
Adelaide	SA	NONE						
Country SA	SA	NSPT		June	2016			
Perth North	WA	NONE						
Perth South	WA	NSPT		June	2016			
Country WA	WA	NSPT	Kimberley	August	2016	MidWest	Feb	2017
Tasmania	TAS	NSPT		June	2016			

PHN NAME	STATE	TRIAL STATUS	1ST SITE	START MONTH	START YEAR	2ND SITE	START MONTH	START YEAR
Northern Territory	NT	NSPT		Feb	2017			
Australian Capital Territory	ACT	OTHER		July	2017			

Table A25.2 shows the specific target groups that PHNs participating in the NSPT chose to focus on.

Table A25.2 NSPT sites – target groups

PHNs	Region	Target groups
Northern Territory	Darwin	Aboriginal and Torres Strait Islander peoples
Brisbane North	Brisbane North PHN region	Aboriginal and Torres Strait Islander peoples Men LGBTI people
Central QLD, Wide Bay, Sunshine Coast	Gympie, Maryborough, North Burnett	Aboriginal and Torres Strait Islander peoples Men
North Queensland	Townsville	Veterans
Western NSW	Bourke, Brewarrina, Cobar, Lachlan, Walgett, Weddin LGAs	Aboriginal and Torres Strait Islander peoples Men
North Coast NSW	Clarence Valley, Tweed/Byron, Lismore and Kempsey LGAs	General population (different sub-regions have different focus pops)
North Western Melbourne	North Western Melbourne PHN region	LGBTI people
Tasmania	Launceston, Northwest Coast (Burnie, Central Coast, Devonport), Break O'Day	Men 40-64 Older adults 65+
Country SA	Port Pirie, Whyalla, Port Augusta, Port Lincoln, Yorke Peninsula	Aboriginal and Torres Strait Islander peoples Men Youth
Perth South	Rockingham, Mandurah, Kwinana, Murray, Waroona	Youth
Country WA	Kimberley (Broome, Derby, Fitzroy Crossing, Halls Creek, Kununurra, Wyndham)	Aboriginal and Torres Strait Islander peoples
Country WA	Mid-West WA (Geraldton, Carnarvon, Meekatharra, Mullewa, Mt Magnet, Morawa)	Aboriginal and Torres Strait Islander peoples Men

A25.4 Negative binomial regression modelling

The IRR provided an estimate of the relative difference in the outcome of interest between intervention groups and across time. The log of the total ERP for each PHN at the time of the episode was used as the offset term. Where an episode straddled two annual periods, linear interpolation was used to estimate the population.

Each model included the following terms:

- TIME - a linear variable representing time (in 28-day blocks) to account for time trends due to unmeasured regional characteristics;
- TRIAL - an intervention group variable with three levels (NSPT, Other, None);
- FRAME - a variable to indicate the pre- and post- implementation periods;
- TIME x FRAME – an interaction term indicating any difference in overall post-implementation trend compared to the pre-implementation trend;
- TIME x TRIAL – an interaction term that allows for different trends over time for the intervention groups;

- TRIAL x FRAME – an interaction term that estimates any differential changes from pre- to post-implementation between intervention groups; and
- TIME x TRIAL x FRAME – a three-way interaction term that allows for the rate of change for intervention groups to differ between the pre- and post-implementation periods;
- QUARTER - a term to control for effects due to seasonality; and

The two interaction terms - TRIAL x FRAME and TIME x TRIAL x FRAME - were of key interest as they allowed the quantification of changes in the NSPT sites pre- and post-implementation, relative to control sites.

A25.5 Impact of implementation of the NSPT on the rate of new episodes of care

During the observation period, 376,780 new episodes of PHN-commissioned mental health care commenced through all 28 PHNs included in the analysis. Approximately 38.7% of new episodes (n=145,638) were recorded in NSPT sites and 34.1% (n=128,551) in control (None) sites. In the NSPT sites, 45.8% of new episodes were recorded in the period prior to implementation; this was similar for the control (None) (42.1%) sites.

Table A25.3 shows the results of the negative binomial regression model for all new episodes:

- In terms of background trends, the estimates for TRIAL confirmed that, across the entire observation period, the NSPT recorded 45% higher rates of new episodes than the control (None) sites. However, the estimates for TIME and FRAME indicated that there was no significant change over the observation period in the rate of new episodes across all intervention groups combined.
- Although there was no overall change in the rate of new episodes, the interaction of TRIAL x FRAME indicated that there was *relatively less* pre/post growth in the rate of new episodes in NSPT sites than for the control (None) sites.

Table A25.3 Negative binomial model estimates: episodes (main model)*

	ALL EPISODES (N=376,780)		
Variable	IRR	95% CI	p-value
TIME	1.006	0.999, 1.013	0.078
TRIAL	-		
NSPT	1.456	1.214, 1.746	<0.001
Other	-	-	-
FRAME	1.177	0.982, 1.411	0.078
TIME x FRAME	1.002	0.993, 1.012	0.633
TIME x TRIAL	-		
NSPT	1.003	0.994, 1.013	0.494
Other	-	-	-
TRIAL x FRAME	-		
NSPT/post-implementation	0.699	0.542, 0.903	0.006
Other/post-implementation	-	-	-
TIME x TRIAL x FRAME	-		
NSPT/post-implementation	0.999	0.986, 1.012	0.857
Other/post-implementation	-	-	-

IRR, incident rate ratio. CI, confidence interval. Model controlled for quarter and population level of high/very high psychological distress.*results are not reported for control group ‘Other’

Table A25.4 shows the results of the subgroups models for the three target populations: youth, males and Aboriginal and Torres Strait Islander people. In these models, NSPT sites are further divided into those with a focus on the target population and those that did not.

- In the model for youth:
  - the background trends were that, across the entire observation period, NSPT sites with and without a youth focus had approximately twice the rate of new episodes for youth, compared to the control (None) sites (TRIAL). Across all sites combined, growth in new episodes was significantly greater in the post-implementation period than in the pre-implementation period (TIME x FRAME); and
- In the model for males:
  - similar to youth, there was a background trend showing that, across the entire observation period, NSPT sites with and without a focus on males had approximately 50% higher rates of new episodes for males, compared to the control (None) sites (TRIAL). However, unlike youth, overall rates did not increase significantly over time; and
  - although there was no overall change in the rate of new episodes, there was *relatively less* pre/post growth in the rate of new episodes in NSPT sites with a focus on males than in the control (None) sites (TRIAL x FRAME).
- In the model for Aboriginal and Torres Strait Islander people:
  - the background trends were that, across the entire observation period, NSPT sites with a focus on Aboriginal and Torres Strait Islander people had 54% higher rates of new episodes for Aboriginal and Torres Strait Islander people, compared to the control (None) sites (TRIAL). Across all sites, growth in new episodes was significantly greater in the post-implementation period than in the pre-implementation period (TIME x FRAME);
  - there was *relatively less* pre/post growth in the rate of new episodes in NSPT sites with a focus on youth than in the control (None) sites (TRIAL x FRAME); and
  - the amount of growth in the post-implementation period was *relatively lower* among NSPT sites with a focus on males(TIME x TRIAL x FRAME).

Table A25.4 Negative binomial model estimates: episodes (subgroup models for youth, males and Aboriginal and Torres Strait Islander peoples)*

	YOUTH (N=64,063)			MALES (N=137,767)			ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES (N=38,723)		
Variable	IRR	95% CI	p-value	IRR	95% CI	p-value	IRR	95% CI	p-value
TIME	1.005	0.998, 1.011	0.201	1.004	0.998, 1.011	0.195	1.002	0.995, 1.010	0.542
TRIAL									
NSPT with focus	2.215	1.598, 3.069	<0.001	1.526	1.234, 1.887	<0.001	1.544	1.202, 1.982	0.001
NSPT without focus	1.876	1.545, 2.278	<0.001	1.509	1.197, 1.902	<0.001	1.008	0.794, 1.281	0.947
Other	-	-	-	-	-	-	-	-	-
FRAME	1.027	0.852, 1.238	0.778	1.105	0.923, 1.324	0.278	1.124	0.916, 1.379	0.263
TIME x FRAME	1.018	1.008, 1.027	<0.001	1.005	0.996, 1.014	0.297	1.027	1.016, 1.038	<0.001
TIME x TRIAL				-					
NSPT with focus	1.006	0.989, 1.023	0.501	1.002	0.991, 1.013	0.732	1.018	1.005, 1.031	0.007
NSPT without focus	1.010	1.000, 1.020	0.051	1.008	0.996, 1.019	0.209	1.009	0.997, 1.021	0.160
Other	-	-	-	-	-	-	-	-	-
TRIAL x FRAME				-					
NSPT with focus/post-implementation	0.729	0.465, 1.142	0.167	0.683	0.506, 0.921	0.013	0.514	0.364, 0.727	<0.001
NSPT without focus/post-implementation	0.756	0.583, 1.005	0.054	0.786	0.572, 1.080	0.137	0.879	0.630, 1.226	0.448
Other/post-implementation	-	-	-	-	-	-	-	-	-
TIME x TRIAL x FRAME									
NSPT with focus/post-implementation	0.978	0.956, 1.000	0.053	0.996	0.981, 1.011	0.584	0.972	0.955, 0.990	0.002
NSPT without focus/post-implementation	0.989	0.976, 1.003	0.131	0.997	0.981, 1.014	0.722	0.990	0.982, 1.017	0.906
Other/post-implementation	-	-	-	-	-	-	-	-	-

IRR, incident rate ratio. CI, confidence interval. All models control for quarter and population level of high/very high psychological distress.* results not reported for control group ‘Other’.

Table A25.5 shows the results of the negative binomial regression model for new episodes with a suicide referral flag:

- In terms of background trends, the estimates for TRIAL confirmed that, across the entire observation period, the NSPT sites recorded approximately 75% higher rates of new episodes with a suicide referral flag than the control (None) sites. Across all sites combined, growth in new episodes with a suicide referral flag was significantly greater in the post-implementation period than in the pre-implementation period (TIME x FRAME).
- The interaction of TRIAL x FRAME indicated that there was *relatively less* pre/post growth in the rate of new episodes with a suicide referral flag in NSPT sites compared to the control (None) sites. The interaction of TIME x TRIAL x FRAME showed that growth in rates in the post-implementation period was relatively lower in NSPT than in the control (None) sites.

Table A25.5 Negative binomial model estimates: episodes (subgroup model for episodes with suicide referral flag)*

	ALL EPISODES WITH SUICIDE REFERRAL FLAG (N=41,907)		
Variable	IRR	95% CI	p-value
TIME	1.002	0.994, 1.010	0.634
TRIAL	-		
NSPT	1.746	1.418, 2.151	<0.001
Other	-	-	-
FRAME	1.030	0.837, 1.268	0.780
TIME x FRAME	1.037	1.026, 1.048	<0.001
TIME x TRIAL	-		
NSPT	1.007	0.996, 1.017	0.234
Other	-	-	-
TRIAL x FRAME	-		
NSPT/post-implementation	0.721	0.539, 0.963	0.027
Other/post-implementation	-	-	-
TIME x TRIAL x FRAME	-		
NSPT/post-implementation	0.976	0.962, 0.991	0.001
Other/post-implementation	-	-	-

IRR, incident rate ratio. CI, confidence interval. Model controlled for quarter and population level of high/very high psychological distress.* results not reported for control group ‘Other’

Table A25.6 shows the results of the negative binomial regression model for all contacts. These were broadly similar to the findings for episodes:

- in terms of background trends, NSPT sites had 46% higher rates of service contacts than the control (None) sites than the control (None) sites (TRIAL). The average rate of contacts was 28% higher in the post-implementation period, compared to the pre-implementation period for all sites combined (FRAME); and
- in terms of relative change in the NSPT sites, average growth in contacts from pre- to post-implementation was *relatively smaller* for the NSPT sites than for the control (None) sites (TRIAL x FRAME).

Table A25.6 Negative binomial model estimates: contacts (main model)*

	ALL CONTACTS (N=2,293,083)		
Variable	Est.	95% CI	p-value
TIME	1.004	0.998, 1.010	0.240
TRIAL			
NSPT	1.458	1.225, 1.735	<0.001
Other	-	-	-
FRAME	1.284	1.082, 1.524	0.004
TIME x FRAME	1.008	0.999, 1.017	0.076
TIME x TRIAL	-		
NSPT	1.005	0.996, 1.014	0.298
Other	-	-	-
TRIAL x FRAME	-		
NSPT/post-implementation	0.648	0.507, 0.829	0.001
Other/post-implementation	-	-	-
TIME x TRIAL x FRAME	-		
NSPT/post-implementation	1.003	0.990, 1.016	0.659
Other/post-implementation	-	-	-

IRR, incident rate ratio. CI, confidence interval. All models control for quarter and population level of high/very high psychological distress. * results not reported for control group ‘Other’

Table A25.7 shows the results of the subgroup models for service contacts for the three target populations: youth, males and Aboriginal and Torres Strait Islander people. In these models, we further divided the NSPT sites into those with a focus on the target population and those that did not. We found that:

- In the model for youth:
  - the background trends were that, across the entire observation period, NSPT sites with and without a youth focus had approximately double the rate of contacts for youth, compared to the control (None) sites. Across all sites combined, growth in new episodes was significantly greater in the post-implementation period than in the pre-implementation period (TIME x FRAME). Also, NSPT sites without a focus on youth (TIME x TRIAL) experienced more growth in service contacts than the control (None) sites;
  - there was *relatively less* pre/post growth in the rate of new episodes in NSPT sites with a focus on youth than in the control (None) sites (TRIAL x FRAME); and
- In the model for males:
  - there was a background trend showing that, across the entire observation period, NSPT sites with and without a male focus 39-65% higher rates of new episodes for males, compared to the control (None) sites (TRIAL). Overall, contact rates were 20% higher in the post-compared to pre-implementation period (FRAME) and that the rate of growth in contact rates was higher in the post-implementation period (TIME x FRAME); and

  - there was *relatively less* pre/post growth in the rate of contacts in NSPT sites with and without a focus on males than in the control (None) sites (TRIAL x FRAME).
- In the model for Aboriginal and Torres Strait Islander people:
  - overall, contact rates were 30% higher in the post- compared to pre-implementation period (FRAME) and that the rate of growth in contact rates was higher in the post-implementation period (TIME x FRAME). Also, NSPT sites with a focus on Aboriginal and Torres Strait Islander people experienced more growth in service contacts than the control (None) sites (TIME x TRIAL); and

Table A25.7 Negative binomial model estimates: contacts (subgroup models for youth, males and Aboriginal and Torres Strait Islander peoples)*

	YOUTH (N=370,049)			MALES (N=822,502)			ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES (N=233,944)		
Variable	IRR	95% CI	p-value	IRR	95% CI	p-value	IRR	95% CI	p-value
TIME	1.004	0.997, 1.011	0.228	1.003	0.996, 1.009	0.428	1.001	0.991, 1.010	0.906
TRIAL				-					
NSPT with focus	2.435	1.713, 3.459	<0.001	1.388	1.118, 1.702	0.003	1.269	0.919, 1.751	0.148
NSPT without focus	1.795	1.465, 2.199	<0.001	1.649	1.310, 2.050	<0.001	1.067	0.794, 1.434	0.669
Other	-	-	-	-	-	-	-	-	-
FRAME	1.043	0.860, 1.264	0.672	1.190	1.001, 1.414	0.049	1.292	1.004, 1.664	0.046
TIME x FRAME	1.029	1.019, 1.040	<0.001	1.010	1.001, 1.019	0.026	1.039	1.026, 1.053	0.001
TIME x TRIAL									
NSPT with focus	1.010	0.992, 1.029	0.274	1.002	0.991, 1.012	0.783	1.018	1.001, 1.035	0.036
NSPT without focus	1.012	1.002, 1.023	0.020	1.009	0.997, 1.020	0.132	1.013	0.998, 1.028	0.098
Other	-	-	-	-	-	-	-	-	-
TRIAL x FRAME									
NSPT with focus/post-implementation	0.519	0.323, 0.836	0.007	0.647	0.482, 0.870	0.004	0.380	0.242, 0.597	<0.001
NSPT without focus/post-implementation	0.752	0.563, 1.004	0.054	0.708	0.519, 0.966	0.029	1.205	0.791, 1.834	0.386
Other/post-implementation	-	-	-	-	-	-	-	-	-
TIME x TRIAL x FRAME									
NSPT with focus/post-implementation	0.985	0.961, 1.009	0.221	1.007	0.993, 1.023	0.337	0.991	0.968, 1.015	0.465
NSPT without focus/post-implementation	0.988	0.973, 1.003	0.115	0.994	0.978, 1.010	0.461	0.983	0.962, 1.004	0.114
Other/post-implementation	-	-	-	-	-	-	-	-	-

IRR, incident rate ratio. CI, confidence interval. All models control for quarter and population level of high/very high psychological distress. * results not reported for control group 'Other'

A25.7 Strengths and limitations of the analysis

This analyses attempted to account for background time trends and level of mental health need in the community. It also considered the conduct of concurrent non-NSPT suicide-prevention activity in some PHNs. For the episodes and contacts analyses, the analysis was also able to examine change over an equivalent period pre- and post-implementation, which improves the robustness of the results.

However, important limitations should be taken into account when interpreting the findings. Although the PMHC MDS data extract supplied included data through to June 2020, episodes that commenced later than September 2019 were not included due to likely data entry time lags.

Some PHN-level population estimates (i.e., estimates of psychological distress and target population size) were not available for all years of interest, and this may have affected the results although it is not possible to predict any direction of bias. Although the analysis attempted to allow for background trends, there may have been additional unmeasured factors that accounted for the results (e.g., other population-level interventions that impacted the likelihood of seeking help from PHN-commissioned mental health services; and the availability of alternative services or access barriers in the region).

The analysis is unable to include any suicide-specific contact or outcome measures. Although the PMHC MDS includes an option for reporting a service contact as ‘suicide prevention specific assistance’; initial inspection of the data showed that this code was used only in approximately 2% of service contacts in the post-implementation period.

There were no suicide-specific items in any of the outcome measures that could have been used as a dependent variable.

The count of contacts in each 28-day block was derived from the new episodes included in the sampling frame. This will bias the count of contacts downwards for earlier blocks because contacts associated with already open episodes were not counted, and therefore may overestimate the extent of change in contacts in the pre-implementation period and from pre- to post-implementation.

Finally, subgroup analyses for some target groups (veterans and LGBTI people) were not possible.

Appendix 26: Epidemiological analysis – suicide deaths and self-harm hospitalisations

Table A26.1 Relative differences in suicide rates pre- and post-implementation of NSP) activities. [Pre-program period: January 2010 - June 2016; Post-program period: July 2016 - November 2018.]*

	N (a)				Rate per 100,000				Unadjusted (b)		Adjusted (c)	
	Pre/No Int.	Post/ No Int.	Pre/ Int.	Post/ Int.	Pre/No Int.	Post/No Int.	Pre/ Int.	Post/ Int.	RR (95%CI)	P-value	RR (95%CI)	P-value
Overall												
NSPT only	6015	2751	6494	2632	10.6	11.2	13.3	13.5	0.96 (0.90-1.03)	0.267	0.99 (0.92-1.06)	0.785
NSPT and other trials	-	-	-	-	-	-	-	-	-	-	-	-
Other trials only	-	-	-	-	-	-	-	-	-	-	-	-
Sex												
Males	4409	2012	4970	2015	15.6	16.5	20.4	20.8	0.97 (0.90-1.05)	0.437	1.01 (0.93-1.09)	0.871
Females	1606	739	1524	617	5.6	5.9	6.3	6.3	0.95 (0.84-1.08)	0.462	0.94 (0.82-1.09)	0.431
Age group												
0-19 years	293	157	431	160	2.0	2.6	3.5	3.3	0.76 (0.58-1.00)	0.046	0.77 (0.58-1.03)	0.083
20-34 years	1543	735	1771	729	11.7	12.8	16.8	17.1	0.93 (0.82-1.06)	0.266	0.98 (0.86-1.12)	0.790
35-44 years	1285	518	1329	496	15.8	15.1	19.7	19.3	1.02 (0.88-1.18)	0.774	1.09 (0.93-1.28)	0.288
45-54 years	1174	516	1216	484	15.6	16.4	18.6	19.3	0.99 (0.86-1.15)	0.917	0.95 (0.80-1.12)	0.515
55-64 years	785	387	813	380	12.7	14.4	14.4	16.7	1.02 (0.86-1.22)	0.798	1.10 (0.91-1.34)	0.321
65-74 years	431	238	488	207	10.4	12.0	12.5	12.0	0.83 (0.66-1.04)	0.102	0.81 (0.63-1.04)	0.098
75+ years	504	200	446	176	15.0	13.2	15.1	14.0	1.06 (0.83-1.34)	0.657	1.12 (0.85-1.47)	0.413
Area socio-economic status (d)												
High SES	1222	544	1245	484	11.4	11.8	12.2	11.9	0.94 (0.81-1.08)	0.376	0.95 (0.82-1.10)	0.499
Mid SES	2164	1030	2477	962	10.5	11.2	12.7	12.4	0.91 (0.82-1.01)	0.089	0.92 (0.83-1.02)	0.109
Low SES	1113	492	2231	953	12.6	13.0	16.5	18.8	1.10 (0.96-1.26)	0.154	1.11 (0.98-1.27)	0.108
Remoteness												
Major City	5426	2492	2667	1134	10.3	10.8	11.2	10.8	0.92 (0.84-1.00)	0.044	0.93 (0.85-1.03)	0.161
Inner Regional	424	200	1760	715	13.1	14.6	14.0	15.6	1.00 (0.83-1.21)	0.997	1.00 (0.83-1.22)	0.964
Outer Regional	64	30	1535	616	14.5	19.7	16.0	17.6	0.82 (0.52-1.28)	0.379	0.84 (0.54-1.31)	0.434
Remote	64	12	282	99	28.0	14.3	17.1	18.1	2.07 (1.07-4.00)	0.031	2.02 (1.04-3.90)	0.037
Very Remote	37	17	250	68	22.8	26.5	22.1	18.9	0.73 (0.39-1.39)	0.346	0.76 (0.40-1.45)	0.400

(a) Number of suicides and crude suicide rates provided for non-intervention areas (i.e. non-NSPT or other trial sites) and intervention areas, pre/post study period; (b) RR: Relative difference between intervention and control areas, estimated from interaction term of difference-in-difference model (c) Variously adjusted for sex, age group, area SES, year and month. (d) Area SES based on Index of Relative Socio-economic Advantage and Disadvantage. Low SES (20% of population), Middle SES (60% of population), High SES (20% of population).* results not reported for control group 'Other' or NSPT and other trials combined.

Table A26. 2 Lagged (by 12-months) relative differences in suicide rates pre- and post-implementation of National Suicide Prevention Trial Site (NSPT) activities. [Pre-program period: January 2010 - June 2017; Post-program period: July 2017 - November 2018.]*

	N (a)				Rate per 100,000				Unadjusted (b)		Adjusted (c)	
	Pre/No Int.	Post/ No Int.	Pre/ Int.	Post/ Int.	Pre/No Int.	Post/No Int.	Pre/ Int.	Post/ Int.	RR (95%CI)	P-value	RR (95%CI)	P-value
Overall												
NSPT only	7132	1634	7626	1500	10.8	10.7	13.5	13.0	0.97 (0.89-1.05)	0.400	1.00 (0.92-1.09)	0.965
NSPT and other trials	-	-	-	-	-	-	-	-	-	-	-	-
Other trials only	-	-	-	-	-	-	-	-	-	-	-	-
Sex												
Males	5213	1208	5842	1143	15.8	16.0	20.6	19.8	0.96 (0.87-1.05)	0.317	1.00 (0.90-1.10)	0.943
Females	1919	426	1784	357	5.7	5.5	6.3	6.1	1.01 (0.87-1.18)	0.886	1.00 (0.84-1.19)	0.975
Age group												
0-19 years	363	87	505	86	2.2	2.3	3.5	3.0	0.81 (0.58-1.13)	0.210	0.82 (0.57-1.17)	0.271
20-34 years	1841	437	2090	410	12.0	12.3	17.1	16.1	0.92 (0.79-1.07)	0.266	0.94 (0.80-1.11)	0.498
35-44 years	1501	302	1542	283	15.9	14.3	19.8	18.5	1.04 (0.87-1.24)	0.675	1.15 (0.94-1.39)	0.170
45-54 years	1380	310	1422	278	15.8	16.0	18.8	18.8	0.99 (0.83-1.18)	0.904	0.99 (0.81-1.20)	0.912
55-64 years	944	228	962	231	13.1	13.7	14.7	17.1	1.12 (0.91-1.37)	0.294	1.16 (0.92-1.46)	0.212
65-74 years	521	148	588	107	10.7	12.0	12.8	10.4	0.72 (0.54-0.94)	0.018	0.72 (0.53-0.99)	0.040
75+ years	582	122	517	105	14.8	13.0	14.9	14.0	1.07 (0.80-1.43)	0.644	1.11 (0.80-1.53)	0.532
Area socio-economic status (d)												
High SES	1434	332	1457	272	11.4	11.6	12.3	11.3	0.91 (0.76-1.08)	0.285	0.93 (0.78-1.11)	0.418
Mid SES	2580	614	2874	565	10.7	10.8	12.7	12.2	0.95 (0.84-1.08)	0.426	0.96 (0.85-1.09)	0.551
Low SES	1322	283	2663	521	12.8	12.1	17.1	17.5	1.08 (0.92-1.27)	0.321	1.12 (0.95-1.31)	0.176
Remoteness												
Major City	6440	1478	3118	683	10.5	10.4	11.2	10.6	0.96 (0.86-1.06)	0.379	0.96 (0.86-1.08)	0.532
Inner Regional	503	121	2092	383	13.4	14.3	14.4	14.6	0.95 (0.75-1.19)	0.627	0.97 (0.77-1.22)	0.799
Outer Regional	75	19	1803	348	15.0	20.3	16.2	17.3	0.79 (0.47-1.33)	0.379	0.84 (0.50-1.41)	0.500
Remote	69	7	322	59	26.4	13.7	17.0	19.1	2.16 (0.94-4.94)	0.068	2.22 (0.97-5.09)	0.061
Very Remote	45	9	291	27	24.0	23.0	22.5	13.4	0.62 (0.27-1.41)	0.256	0.70 (0.30-1.61)	0.401

(a) Number of suicides and crude suicide rates provided for non-intervention areas (i.e. non-NSPT or other trial sites) and intervention areas, pre/post study period; (b) RR: Relative difference between intervention and control areas, estimated from interaction term of difference-in-difference model (c) Variously adjusted for sex, age group, and area SES. (d) Area SES based on Index of Relative Socio-economic Advantage and Disadvantage. Low SES (20% of population), Middle SES (60% of population), High SES (20% of population).).* results not reported for control group 'Other' or NSPT and other trials combined.

Table A26.3 Relative differences in self-harm hospitalisation rates pre- and post-implementation of National Suicide Prevention Trial Site (NSPT) activities. [Pre-program period: January 2010 - June 2016; Post-program period: July 2016 - June 2019.]*

	N (a)				Rate per 100,000				Unadjusted (b)		Adjusted (c)	
	Pre/No Int.	Post/ No Int.	Pre/ Int.	Post/ Int.	Pre/No Int.	Post/No Int.	Pre/ Int.	Post/ Int.	RR (95%CI)	P-value	RR (95%CI)	P-value
Overall												
NSPT only	62945	33810	61797	31707	111.8	114.4	125.9	134.8	1.07 (1.05-1.09)	<0.001	1.08 (1.06-1.11)	<0.001
NSPT and other trials	-	-	-	-	-	-	-	-	-	-	-	-
Other trials only	-	-	-	-	-	-	-	-	-	-	-	-
Sex												
Males	22754	12268	22762	11304	81.4	83.7	92.6	96.5	1.03 (1.00-1.07)	0.081	1.06 (1.02-1.10)	0.005
Females	40191	21542	39035	20403	141.7	144.6	159.2	172.9	1.09 (1.06-1.12)	<0.001	1.10 (1.07-1.13)	<0.001
Age group												
0-19 years	12809	7627	12715	7369	90.2	103.7	101.2	125.8	1.12 (1.06-1.17)	<0.001	1.09 (1.04-1.15)	<0.001
20-34 years	21944	12038	20332	10749	167.7	174.5	192.2	208.9	1.07 (1.03-1.11)	<0.001	1.09 (1.05-1.14)	<0.001
35-44 years	12094	5443	12306	5161	149.7	132.5	181.6	166.5	1.06 (1.01-1.11)	0.030	1.07 (1.01-1.13)	0.012
45-54 years	9164	4704	9606	4657	123.3	124.7	145.9	153.9	1.07 (1.02-1.13)	0.011	1.09 (1.03-1.16)	0.004
55-64 years	4143	2351	4226	2253	67.9	72.9	74.4	81.7	1.03 (0.95-1.11)	0.448	1.01 (0.93-1.10)	0.816
65+ years	2791	1647	2612	1518	37.7	39.3	37.8	41.8	1.07 (0.98-1.17)	0.146	1.07 (0.97-1.18)	0.201
Area socio-economic status (d)												
High SES	12746	6645	13186	6172	108.3	119.2	120.6	124.1	0.95 (0.91-1.00)	0.030	0.97 (0.92-1.01)	0.176
Mid SES	22892	12187	23203	11348	116.3	111.3	115.8	120.6	1.10 (1.06-1.14)	<0.001	1.11 (1.07-1.15)	<0.001
Low SES	12710	7490	20404	11080	156.5	166.2	159.4	180.9	1.10 (1.05-1.15)	<0.001	1.11 (1.07-1.16)	<0.001
Remoteness												
Major City	57989	30739	27173	13486	109.9	111.6	112.6	107.1	0.95 (0.93-0.98)	0.001	0.92 (0.90-0.95)	<0.001
Inner Regional	3780	2286	17164	8769	135.2	138.9	137.7	157.2	1.11 (1.04-1.18)	0.002	1.08 (1.02-1.15)	0.015
Outer Regional	574	370	13218	7531	156.1	203.0	136.7	177.9	1.00 (0.86-1.16)	0.986	1.00 (0.86-1.15)	0.962
Remote	418	279	2382	1153	182.8	279.7	139.8	170.7	0.89 (0.72-1.09)	0.263	0.86 (0.70-1.06)	0.151
Very Remote	184	136	1860	768	113.2	177.9	167.6	175.7	0.68 (0.52-0.89)	0.004	0.69 (0.53-0.90)	0.006

(a) Number of attempted suicides and crude attempted suicide rates provided for non-intervention areas (i.e. non-NSPT or other trial sites) and intervention areas, pre/post study period; (b) RR: Relative difference between intervention and control areas, estimated from interaction term of difference-in-difference model (c) Variously adjusted for sex, age group, and area SES. (d) Area SES based on Index of Relative Socio-economic Advantage and Disadvantage. Low SES (20% of population), Middle SES (60% of population), High SES (20% of population).).* results not reported for control group 'Other' or NSPT and other trials combined.

Table A26.4 Lagged (by 12-months) relative differences in self-harm hospitalisation rates pre- and post-implementation of National Suicide Prevention Trial Site (NSPT) activities. [Pre-program period: January 2010 - June 2017; Post-program period: July 2017 - June 2019.]*

	N (a)				Rate per 100,000				Unadjusted (b)		Adjusted (c)	
	Pre/No Int.	Post/No Int.	Pre/ Int.	Post/ Int.	Pre/No Int.	Post/No Int.	Pre/ Int.	Post/ Int.	RR (95%CI)	P-value	RR (95%CI)	P-value
Overall												
NSPT only	75095	21660	73305	20199	114.3	107.6	128.7	129.1	1.08 (1.06-1.11)	<0.001	1.09 (1.06-1.11)	<0.001
NSPT and other trials	-	-	-	-	-	-	-	-	-	-	-	-
Other trials only	-	-	-	-	-	-	-	-	-	-	-	-
Sex												
Males	27105	7917	26925	7141	83.1	79.3	94.5	91.7	1.03 (0.99-1.07)	0.117	1.03 (0.99-1.08)	0.117
Females	47990	13743	46380	13058	145.0	135.3	162.9	166.3	1.11 (1.08-1.15)	<0.001	1.12 (1.08-1.16)	<0.001
Age group												
0-19 years	15632	4804	15404	4680	94.4	96.1	106.0	120.6	1.15 (1.09-1.21)	<0.001	1.14 (1.08-1.21)	<0.001
20-34 years	26239	7743	24096	6985	171.7	164.8	196.0	203.7	1.11 (1.06-1.16)	<0.001	1.10 (1.05-1.16)	<0.001
35-44 years	14098	3439	14219	3248	150.2	122.9	181.9	157.4	1.08 (1.02-1.15)	0.008	1.08 (1.01-1.15)	0.015
45-54 years	10879	2989	11368	2895	125.9	116.7	149.4	144.7	1.07 (1.01-1.14)	0.029	1.07 (1.00-1.15)	0.044
55-64 years	4902	1592	5045	1434	68.8	72.3	76.4	78.2	0.98 (0.90-1.07)	0.629	0.97 (0.88-1.06)	0.509
65+ years	3345	1093	3173	957	38.3	38.0	39.1	39.3	1.02 (0.92-1.13)	0.667	1.00 (0.89-1.12)	0.947
Area socio-economic status (d)												
High SES	15203	4188	15485	3873	112.1	110.9	122.7	118.1	0.99 (0.94-1.05)	0.733	1.00 (0.95-1.05)	0.923
Mid SES	27136	7943	27393	7158	117.3	106.0	118.2	114.4	1.08 (1.03-1.12)	<0.001	1.08 (1.04-1.12)	<0.001
Low SES	15406	4794	24418	7066	161.3	155.8	164.0	175.1	1.14 (1.08-1.19)	<0.001	1.15 (1.09-1.20)	<0.001
Remoteness												
Major City	69080	19648	32068	8591	112.3	104.6	113.8	100.5	0.96 (0.93-0.99)	0.006	0.91 (0.88-0.94)	<0.001
Inner Regional	4639	1427	20478	5455	139.5	127.9	142.0	150.4	1.17 (1.08-1.25)	<0.001	1.13 (1.05-1.21)	0.001
Outer Regional	690	254	15825	4924	161.8	205.6	142.0	178.7	1.00 (0.85-1.18)	0.975	0.98 (0.83-1.15)	0.770
Remote	469	228	2797	738	179.3	340.8	143.3	172.3	0.71 (0.57-0.90)	0.004	0.69 (0.56-0.86)	0.001
Very Remote	217	103	2137	491	115.7	200.3	168.8	175.1	0.62 (0.46-0.82)	0.001	0.59 (0.44-0.78)	<0.001

(a) Number of attempted suicides and crude attempted suicide rates provided for non-intervention areas (i.e. non-NSPT or other trial sites) and intervention areas, pre/post study period; (b) RR: Relative difference between intervention and control areas, estimated from interaction term of difference-in-difference model (c) Variously adjusted for sex, age group, and area SES. (d) Area SES based on Index of Relative Socio-economic Advantage and Disadvantage. Low SES (20% of population), Middle SES (60% of population), High SES (20% of population).).* results not reported for control group 'Other' or NSPT and other trials combined.

Table A26.5 Lagged (by 24-months) relative differences in self-harm hospitalisation rates pre- and post-implementation of National Suicide Prevention Trial Site (NSPT) activities. [Pre-program period: January 2010 - June 2018; Post-program period: July 2018 - June 2019.]*

	N (a)				Rate per 100,000				Unadjusted (b)		Adjusted (c)	
	Pre/No Int.	Post/ No Int.	Pre/ Int.	Post/ Int.	Pre/No Int.	Post/No Int.	Pre/ Int.	Post/ Int.	RR (95%CI)	P-value	RR (95%CI)	P-value
Overall												
NSPT only	85832	10923	83933	9571	114.0	103.5	129.2	125.2	1.08 (1.05-1.12)	<0.001	1.06 (1.03-1.10)	<0.001
NSPT and other trials	-	-	-	-	-	-	-	-	-	-	-	-
Other trials only	-	-	-	-	-	-	-	-	-	-	-	-
Sex												
Males	31043	3979	30659	3407	83.1	76.0	94.4	89.6	1.05 (1.00-1.11)	0.069	1.03 (0.97-1.09)	0.364
Females	54789	6944	53274	6164	144.4	130.4	164.0	160.6	1.10 (1.05-1.14)	<0.001	1.09 (1.04-1.14)	<0.001
Age group												
0-19 years	18012	2424	17943	2141	95.1	92.6	108.5	113.5	1.10 (1.03-1.18)	0.006	1.07 (0.99-1.15)	0.069
20-34 years	30090	3892	27669	3412	171.8	158.2	197.2	201.6	1.13 (1.07-1.20)	<0.001	1.11 (1.04-1.18)	0.001
35-44 years	15812	1725	15955	1512	147.5	117.5	180.0	149.3	1.06 (0.98-1.15)	0.154	1.06 (0.97-1.15)	0.180
45-54 years	12349	1519	12905	1358	125.2	113.7	149.3	140.0	1.05 (0.97-1.15)	0.211	1.02 (0.93-1.12)	0.639
55-64 years	5690	804	5794	685	69.6	69.6	76.8	77.0	1.01 (0.90-1.13)	0.880	1.01 (0.89-1.14)	0.891
65+ years	3879	559	3667	463	38.5	36.8	39.2	38.9	1.05 (0.91-1.20)	0.523	1.03 (0.89-1.20)	0.667
Area socio-economic status (d)												
High SES	17347	2044	17595	1763	112.9	103.4	122.7	112.5	1.02 (0.95-1.09)	0.649	1.02 (0.94-1.09)	0.667
Mid SES	31009	4070	31155	3396	116.2	103.5	118.2	110.5	1.05 (1.00-1.11)	0.055	1.05 (1.00-1.11)	0.068
Low SES	17702	2498	28189	3295	160.7	155.2	165.9	170.7	1.09 (1.02-1.16)	0.008	1.10 (1.03-1.17)	0.004
Remoteness												
Major City	78881	9847	36315	4344	112.0	100.0	112.3	98.6	0.99 (0.95-1.03)	0.633	0.92 (0.88-0.97)	0.001
Inner Regional	5316	750	23525	2408	137.9	128.3	143.5	145.6	1.10 (1.00-1.21)	0.054	1.06 (0.97-1.17)	0.213
Outer Regional	809	135	18453	2296	166.6	210.1	146.1	180.8	0.97 (0.78-1.20)	0.765	0.94 (0.77-1.16)	0.561
Remote	572	125	3229	306	194.6	361.7	147.4	162.1	0.65 (0.49-0.87)	0.004	0.63 (0.48-0.84)	0.002
Very Remote	254	66	2411	217	119.6	247.7	169.3	176.7	0.51 (0.36-0.72)	<0.001	0.54 (0.38-0.76)	0.001

(a) Number of attempted suicides and crude attempted suicide rates provided for non-intervention areas (i.e. non-NSPT or other trial sites) and intervention areas, pre/post study period; (b) RR: Relative difference between intervention and control areas, estimated from interaction term of difference-in-difference model (c) Variously adjusted for sex, age group, and area SES. (d) Area SES based on Index of Relative Socio-economic Advantage and Disadvantage. Low SES (20% of population), Middle SES (60% of population), High SES (20% of population).*results not presented for other trials or NSPT and other combined.

Strengths and limitations

A key strength of the analysis is the use of small-area codes, stratified by key socio-demographics, allowing detailed analyses within and between Trial Site areas over time. This partial-ecologic design allows analyses to capture, and adjust for, some of the heterogeneity within Trial Site areas (and indeed, within each usual area of residence). While there were geographic coding changes over the study period, these were accounted for to ensure comparability within small areas (in both the numerator and denominator) over the study period. A limitation of resolving small-area codes to SA2 2016 codes, and the use of SEIFA and RA codes for the same period, meant that any large changes in SES and urbanisation within small areas over the study period, may not have been captured. However, aggregating these small-areas into larger strata for analyses would mitigate against misclassification of SES and/or urban-rural residence over time.

The analysis also covered an extensive period (107 months for suicide, and 114 months for attempted suicide), allowing a clear assessment of secular changes in both suicide and attempted suicide in the lead up to the intervention, and during the immediate implementation period. The analysis also examined different lag periods in an attempt to reflect the differing onset times of activities in different areas.

A key limitation of the analysis is not being able to ascertain what suicide prevention activity might have been implemented contemporaneously in the control (None) Sites. It is important to note that PHNs would have received Commonwealth funding for the commissioning of local suicide prevention services and activities, the effect of which might have been to attenuate any differences between NSPT Sites and non-intervention Sites. However, based on secular trends of both suicide and attempted suicide in these control (None), there appears to have been little decline in suicide or attempted suicide in these areas.

Additionally, this analysis was also not able to ascertain impacts of the NSPT for specific at-risk groups, based on the routinely available mortality and hospital data that was available, particularly those with a mental disorder, those of Indigenous background, and those identifying as LGBTI. While Aboriginal and Torres Strait Islander status is captured in mortality and hospital data, establishing corresponding small-area denominators for this group is problematic. Similarly, there is little routinely collected information in suicide or attempted suicide data relating to LGBTI status, or history of current or previous mental illness or substance use, in order to stratify analyses by these sub-groups.

This analysis has shown limited changes in suicide and attempted suicide in the period after the implementation of the NSPT. One interpretation of the findings is that it is premature to try and ascertain large NSPT impacts based on the currently available follow-up period in the mortality and hospital admissions data. While NSPT Trial Sites were funded to begin in 2017, it wasn’t until the second half of 2018 and 2019 when substantial community-based activities and aftercare services began to be implemented at scale. It may be that the impacts of these prevention activities will not emerge for some time. The implication of this is that continued monitoring of trends in suicide and attempted suicide with timely data is imperative over the next two to three years to ascertain whether there are any subsequent impacts of the NSPT (and other) Trial Site activities.

Research

ANZJP

Australian & New Zealand Journal of Psychiatry
1–10
DOI: 10.1177/0004867420932639

SAGE

Systems modelling and simulation to inform strategic decision making for suicide prevention in rural New South Wales (Australia)

Jo-An Atkinson[1,2,3,4,5], Adam Skinner[1,3], Sue Hackney[6], Linda Mason[6], Mark Heffernan[7,8], Dianne Currier[9], Kylie King[9] and Jane Pirkis[9]

Abstract

Background: The need to understand and respond to the unique characteristics and drivers of suicidal behaviour in rural areas has been enabled through the Australian Government's 2015 mental health reforms facilitating a move to an evidence-based, regional approach to suicide prevention. However, a key challenge has been the complex decision-making environment and lack of appropriate tools to facilitate the use of evidence, data and expert knowledge in a way that can inform contextually appropriate strategies that will deliver the greatest impact. This paper reports the co-development of an advanced decision support tool that enables regional decision makers to explore the likely impacts of their decisions before implementing them in the real world.

Methods: A system dynamics model for the rural and remote population catchment of Western New South Wales was developed. The model was based on defined pathways to mental health care and suicidal behaviour and reproduced historic trends in the incidence of attempted suicide (self-harm hospitalisations) and suicide deaths in the region. A series of intervention scenarios were investigated to forecast their impact on suicidal behaviour over a 10-year period.

Results: Post-suicide attempt assertive aftercare was forecast to deliver the greatest impact, reducing the numbers of self-harm hospitalisations and suicide deaths by 5.65% (95% interval, 4.87−6.42%) and 5.45% (4.68−6.22%), respectively. Reductions were also projected for community support programs (self-harm hospitalisations: 2.83%, 95% interval 2.23−3.46%; suicide deaths: 4.38%, 95% interval 3.78−5.00%). Some scenarios produced unintuitive impacts or effect sizes that were significantly lower than what has been anticipated under the traditional evidence-based approach to suicide prevention and provide an opportunity for learning.

Conclusion: Systems modelling and simulation offers significant potential for regional decision makers to better understand and respond to the unique characteristics and drivers of suicidal behaviour in their catchments and more effectively allocate limited health resources.

Keywords
Rural mental health services planning, suicide prevention, strategic planning, systems modelling, simulation

[1]Systems Modelling and Simulation, Brain and Mind Centre, Faculty of Medicine and Health, The University of Sydney, Camperdown, NSW, Australia
[2]Computer Simulation & Advanced Research Technologies (CSART), Sydney, NSW, Australia
[3]Decision Analytics, Sax Institute, Sydney, NSW, Australia
[4]Menzies Centre for Health Policy, The University of Sydney, Sydney, NSW, Australia
[5]Translational Health Research Institute, Western Sydney University, Penrith, NSW, Australia
[6]Western New South Wales Primary Health Network, Orange, NSW, Australia
[7]Dynamic Operations, Sydney, NSW, Australia
[8]School of Computer, Data and Mathematical Sciences, Western Sydney University, Penrith, NSW, Australia
[9]Mental Health Policy and Practice Unit, Centre for Mental Health, The University of Melbourne, Melbourne, VIC, Australia

Corresponding author:
Jo-An Atkinson, Systems Modelling and Simulation, Brain and Mind Centre, Faculty of Medicine and Health, The University of Sydney, Building F, Level 5, 94 Mallet Street, Camperdown, NSW 2050, Australia.
Email: Jo-An.Atkinson@sydney.edu.au

Introduction

In Australia, the rates of self-harm and suicide increase with remoteness, with those living in combined remote and very remote areas being 2.0 times as likely to die by suicide (age-standardised rate of 21.4 per 100,000 population) compared to those living in major cities (age-standardised rate of 10.5 per 100,000 population) (Australian Institute of Health and Welfare, 2019). A range of explanatory factors have been proposed to account for the increased rates of suicide in rural and remote areas, including socioeconomic circumstances (Taylor et al., 2005); changing climatic conditions such as drought (Hanigan et al., 2018); higher proportions of populations known to be at increased risk of suicidal behaviours (e.g. Aboriginal and Torres Strait Islander Australians) (Kolves et al., 2015; Procter, 2005); increased access to lethal means of suicide such as firearms (Burnley, 1995; Klieve et al., 2009; Taylor et al., 2005); low population density, higher rates of migration and eroded social infrastructure that contribute to social isolation (Hirsch, 2006); heightened stigma of mental illness (Hirsch, 2006); and lower rates of mental health service access or utilisation (Caldwell et al., 2004; Taylor et al., 2005).

The need to understand and respond to the unique characteristics and drivers of suicidal behaviour in rural areas and leverage positive dimensions of rural life (such as increased civic participation and volunteering, social cohesion and informal community support networks) (Ziersch et al., 2009), has been enhanced through the Australian Government's establishment of 31 Primary Health Networks (PHNs) across the country in 2015 (Department of Health, Australian Government, 2015; National Mental Health Commission, 2014; The Department of Health, 2016). These not-for-profit organisations have responsibilities to undertake needs analysis, planning, coordination and commissioning of primary health care services and supports across their designated region. Although PHNs do not directly deliver services, they are provided with funding to contract other organisations to deliver initiatives, including mental health and suicide prevention programmes, in accordance with local population needs, contexts and priorities. This approach facilitates a balance between national leadership and regional variation through a flexible funding stream to facilitate the commissioning of programmes that meet the unique and diverse needs of communities as well as fostering collaboration among local stakeholders. However, a recent Australian Government Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia highlighted wide variation in the effectiveness of the PHN-based approach in improving service access and delivery, citing challenges arising from funding insecurity, resource allocation, re-allocation and programme turnover, a lack of workforce capacity and variation in training, supervision and retention rates (Community Affairs Reference Committee, 2018). Added to these challenges are the vast array of suicide prevention interventions that are available, supported variably by the evidence (Kõlves et al., 2012; Krysinska et al., 2016; Ridani et al., 2016; Robinson et al., 2018) and differing expert, local and national views on the efficacy of alternative suicide prevention strategies. Moreover, PHNs can experience intense lobbying and influence from various professional, service provider and community actors vying for funding and/or the delivery of one service model in preference of others. Challenging decision-making environments such as these often give rise to comprehensive approaches that spread limited resources across too broad a range of programmes and services, diluting their potential impact (Atkinson et al., 2015). Without the appropriate decision support tools to guide effective, targeted investments to reduce suicidal behaviours, the significant potential of the regional approach to suicide prevention will not be realised and the Australian Government's 2015 reforms run the risk of further exacerbating the already crowded, fragmented, difficult to navigate and complex environment of mental health systems in this country.

Applications of systems modelling and simulation to provide decision support capability in addressing complex and persistent public health problems have demonstrated their utility (Atkinson et al., 2018, 2019a, 2019b; Loyo et al., 2013; Page et al., 2017, 2018b; Roberts et al., 2019). These tools combine local and expert knowledge with best available data and the body of research evidence, and have the unique feature of being able to capture population and demographic dynamics, changes over time in behavioural drivers, service interactions and workforce capacity and the potentially non-additive effects of intervention combinations. The final product is an interactive decision support tool that enables regional decision-makers and their stakeholders to explore the likely impacts of intervention combinations before implementation in the real world.

This study was conducted as part of a national evaluation of a key element of the Australian Government 2015 reforms; namely the National Suicide Prevention Trial, a major initiative that involves 11 PHNs taking a systems-based approach to commissioning enhanced services for people at risk of suicide. This study describes the development and application of systems modelling and simulation undertaken as a research-practice partnership between a rural PHN and several academic institutions. The study aimed to identify (1) the likely impact over time of a range of locally prioritised interventions being considered for commissioning and (2) the interaction between interventions that generate service demand, those that increase service capacity, and the impact of this interaction on self-harm hospitalisations and suicide deaths in Western NSW PHN population catchment over the 10-year period 2021–2030.

Methods

Context

Western NSW PHN supports a population of 307,402 (as at 2016), distributed over a geographic area of approximately 433,379 square kilometres (Department of Health, Australian Government, 2018). Nearly 1 in 10 people in the Western NSW PHN catchment (9.1%) reside in Level 2 Statistical Areas (SA2s) classified as remote or very remote (Australian Bureau of Statistics, 2016), and approximately one third of the population (33.9%) lives in SA2s that are socio-economically disadvantaged (with Index of Relative Socio-Economic Disadvantage scores in the lowest quintile for NSW (Australian Bureau of Statistics, 2018). Aboriginal and Torres Strait Islander Australians comprise a substantial proportion of the population (11.6%, compared to 3.0% of the NSW population), while the proportion of the population born overseas is comparatively low (6.3% versus 25.7% for NSW) (Hopkins et al., 2017). From 2011 to 2015, the mean annual age-standardised suicide rate for Western NSW PHN (11.5 per 100,000 population) was higher than that for the NSW population (9.8 per 100,000), but is the same as the national estimate (Public Health Information Development Unit, 2019).

Model development

The system dynamics model presented here is based on a similar model recently developed for Western Sydney PHN using a participatory modelling approach that involved diverse stakeholders, including representatives from health and social policy agencies, local government, non-government organisations, primary care providers, emergency services, research institutions, community groups and people with lived experience of suicide (Page et al., 2018a). The Western Sydney model was adapted to the Western NSW context in consultation with Western NSW PHN staff to ensure that the model structure, assumptions and outputs aligned with the local context and policy priorities. Parameter estimates and other numerical inputs were derived (where possible) from published research or publicly available data or were estimated via constrained optimisation (see below and Supplementary Material). Model construction and analysis were performed using Stella Architect ver. 1.8.3 (www.iseesystems.com).

Model structure, outputs and calibration

The core model structure included (1) a population component, capturing changes over time in the size of the population resulting from births, migration and mortality; (2) a psychological distress component that models flows of people to and from states of low psychological distress (Kessler 10 [K10] score 10–15), vulnerable due to socio-economic disadvantage but not distressed (K10 score 10–15) and moderate to very high psychological distress (K10 score 16–50); (3) a mental health services component that models the movement of psychologically distressed people through one of several possible service pathways involving (potentially) general practitioners, psychiatrists and allied mental health professionals (including psychologists and mental health nurses), psychiatric inpatient care and online services; and (4) a suicidal behaviour component that captures self-harm hospitalisations and suicide deaths. A detailed description of the core model structure is provided in the Supplementary Material.

Primary model outputs included total (cumulative) numbers of self-harm hospitalisations and suicide deaths, and self-harm hospitalisation and suicide rates per 100,000 population. The model also provided estimates of the prevalence of moderate to very high psychological distress, the proportion of the population vulnerable to becoming distressed, and a range of measures of mental health service usage (e.g. mental-health-related general practice consultations, allied mental health services capacity, non-secondary and secondary services waiting times, numbers of psychologically distressed consumers that have disengaged from treatment). All outputs were calculated every 0.4375 days (i.e. one sixteenth of a week) over a period of 20 years, starting from 1 January 2011, permitting comparisons of model outputs with historic data from 2011 to 2017 and forecasts of the impacts of intervention scenarios described below simulated from the time of implementation to the end of 2030 (see Supplementary Material).

Parameter values that could not be derived directly from available data or published research were estimated via constrained optimisation, implemented in Stella Architect ver. 1.8.3, using historical time series data on the prevalence of psychological distress, self-harm hospitalisations and suicide rates and mental-health-related service usage (subsidised general practice consultations and allied mental health services claimed per year, psychiatric bed occupancy). Powell's method was employed to obtain the set of (optimal) parameter values minimising the sum of the mean absolute percent error calculated for each time series separately (i.e. the mean of the absolute differences between the observed time series values and the corresponding model outputs, where each difference is expressed as a percentage of the observed value).

Policy testing and sensitivity analyses

We modelled the potential impacts on suicidal behaviour of a set of interventions identified by PHN staff as most relevant to the Western NSW context. Interventions were identified based on alignment with current policy priorities, feasibility of implementation and so on and included the following: (1) four specific suicide prevention interventions (post-attempt assertive aftercare, universally applied community support programmes, general practitioner

Table 1. Suicide prevention and other intervention scenarios examined in the simulation analyses (additional details are provided in the Supplementary Material).

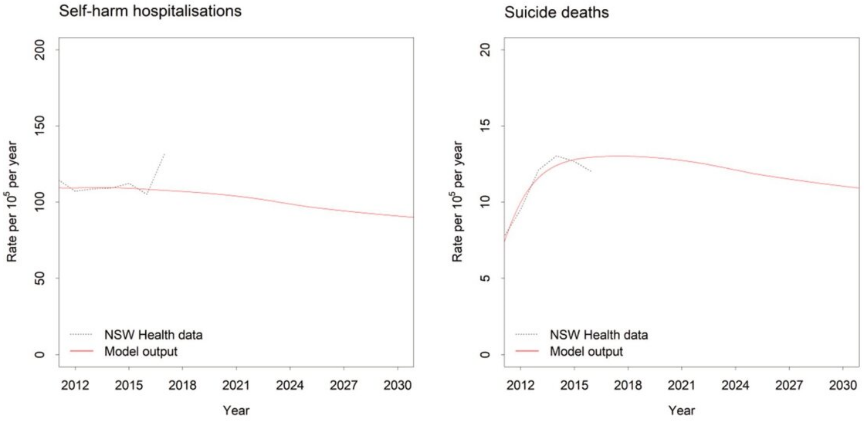
Intervention	Description
1. Specific suicide prevention interventions	
(a) Post-attempt assertive aftercare	An active outreach and enhanced contact programme that aims to reduce re-admission among consumers presenting to services after a suicide attempt, introduced at the start of 2021.
(b) Community support programmes	Programmes designed to increase community connectedness, reducing isolation and enhancing resilience and applied universally. No assumptions are made about the details of the particular programmes implemented, and these may differ across communities. All programmes are introduced at the start of 2021.
(c) GP training programme	A general practitioner training programme aimed at reducing suicidal behaviour through appropriate referral to mental health services, introduced at the start of 2021.
(d) Suicide helpline services	Increased investment in suicide helpline and call-back services from the start of 2021.
2. Mental health interventions	
(e) Community management of severe disorders	Programmes aimed at increasing the effectiveness of community-based management of consumers with severe, persistent mental disorders, introduced at the start of 2021.
(f) Mental health education programmes	Mental health education programmes aimed at reducing stigma, improving recognition of suicide risk, and encouraging help-seeking, introduced at the start of 2021.
(g) Mental health education programmes plus GP training programme	Mental health education programmes aimed at reducing stigma, improving recognition of suicide risk, and encouraging help-seeking, plus a general practitioner training programme aimed at reducing suicidal behaviour through appropriate referral to mental health services; introduced at the start of 2021.
(h) Services re-engagement programme	A programme designed to re-engage psychologically distressed consumers who have disengaged from treatment and are at increased risk of suicidal behaviour, introduced at the start of 2021.
(i) Online services	Increased investment in online services providing support to people with relatively low care needs from the start of 2021.
3. Services planning interventions	
(j) Hospital staff training	Public hospital staff training and capacity expansion designed to reduce workload pressure and facilitate more effective, 'trauma-informed' care, commencing at the start of 2021.
(k) Services capacity increase	An increase in mental health services capacity of 2 additional allied mental health service providers and psychiatric hospital beds per 100,000 population from the start of 2021.
(l) Services capacity increase plus (c) and (f)	An increase in mental health services capacity from the start of 2021 (as in scenario j), combined with general practitioner training and mental health education programmes, both introduced at the start of 2021.

GP: general practitioner.

training, suicide helpline services); (2) four mental health interventions (community management of severe mental disorders, mental health education programmes, re-engagement of consumers who have disengaged from treatment, online treatment services); and (3) two services planning interventions (hospital staff training, increasing non-secondary and secondary services capacity). Details of each intervention are provided in the Supplementary Material. Twelve alternative intervention scenarios were compared with a baseline (business as usual) scenario, in which existing policies and programmes remain in place and current per capita mental health service capacity is maintained until the end of the simulation (Table 1).

Sensitivity analyses were performed to assess the impact of uncertainty in estimates of the direct effects of each intervention on the simulation results. This uncertainty includes possible variation in implementation burden that can influence intervention reach, and fidelity to the models of care detailed in the research papers from which the default effects sizes were taken. We used Latin hypercube sampling to draw 100 sets of values for selected model parameters determining the direct effects of the interventions on psychological distress, suicidal behaviour and the movement of consumers through mental health service pathways from a uniform joint distribution spanning +/−20% of the default values (see Supplementary Material).

Figure 1. Self-harm hospitalisation and suicide rates (per 100,000 population) for the Western NSW PHN population catchment under the baseline scenario (i.e. business as usual). The dotted grey lines show estimates derived from data published by the NSW Department of Health (see www.healthstats.nsw.gov.au); the solid red lines show the modelled rates.



Differences in projected (cumulative) numbers of self-harm hospitalisations and suicide deaths between the baseline and intervention scenarios were calculated for each set of parameter values and summarised using simple descriptive statistics (note that all intervals reported in this paper are derived from the distributions of model outputs calculated in the sensitivity analyses; they provide a measure of the impact of uncertainty in the intervention effect estimates, but should not be interpreted as confidence intervals).

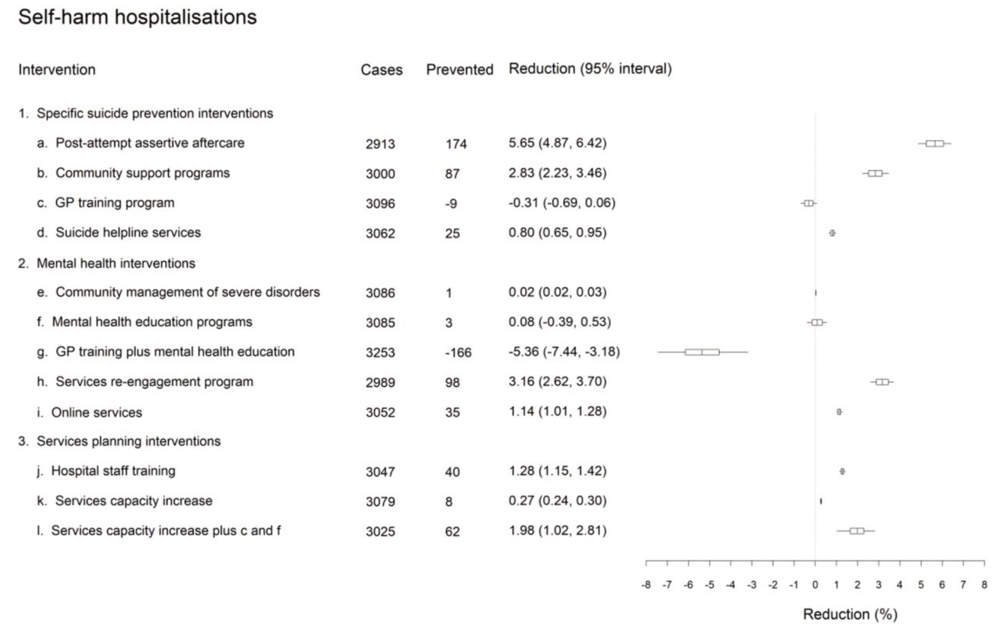
Results

Figure 1 shows the modelled self-harm hospitalisation and suicide rates for the total population under the baseline (business as usual) scenario. Projected rates decline gradually over the forecast period with the self-harm hospitalisation rate decreasing from 105.70 to 90.00 per 100,000 population per year and the suicide rate declining from 12.92 to 10.91 per 100,000 population per year.

Under the baseline scenario, a total of 3329 self-harm hospitalisations and 376 suicide deaths were projected over the post-intervention period (1 January 2021 to the end of 2030). Reductions in the numbers of self-harm hospitalisations and suicide deaths relative to these baseline estimates for each intervention scenario are presented in Figures 2 and 3. Post-suicide attempt assertive aftercare had the greatest impact on suicidal behaviour in the total population, reducing the numbers of self-harm hospitalisations and suicide deaths by 5.65% (95% interval, [4.87%−6.42%]) and 5.45% [4.68%−6.22%], respectively. Relatively large reductions in numbers of self-harm hospitalisations and suicide deaths were also projected for community support programmes (self-harm hospitalisations: 2.83%, 95% interval, [2.23%, 3.46%]; suicide deaths: 4.38%, 95% interval [3.78%, 5.00%]) and a treatment re-engagement programme (self-harm hospitalisations: 3.16%, 95% interval, [2.62%−3.70%]; suicide deaths: 3.73%, 95% interval [3.08%−4.37%]).

Hospital staff training and increased investment in online treatment and suicide helpline services all had a very modest impact on suicidal behaviour, reducing projected numbers of self-harm hospitalisations and suicide deaths by 0.80−1.28% and 0.75−1.20%, respectively (see Figures 2 and 3). Service capacity increases alone had little effect on suicidal behaviour (self-harm hospitalisations: 0.27%, 95% interval, [0.24%, 0.30%]; suicide deaths: 0.24%, 95% interval, [0.21%, 0.26%]). Surprisingly, general practitioner training combined with mental health education programmes increased suicidal behaviour (self-harm hospitalisations: -5.36%, 95% interval, [-7.44%, -3.18%]; suicide deaths: -4.24%, 95% interval, [-6.12%, -2.28%]). However, when service capacity increases were combined with general practitioner training and mental health education programmes, moderate reductions in projected numbers of self-harm hospitalisations and suicides were observed (self-harm hospitalisations: 1.98%, 95% interval, [1.02%, 2.81%]; suicide deaths: 2.36%, 95% interval, [1.59%, 3.03%]). Programmes aimed at improving community-based management of severe mental illness have minimal impact on numbers of self-harm hospitalisations and suicide deaths in the total population, due partly to the relatively low prevalence of severe mental disorders (estimated to be 4.1%) (Slade et al., 2009).

Figure 2. Differences in projected total (cumulative) numbers of self-harm hospitalisations between the business as usual and intervention scenarios over the period 2021–2031. Numbers of cases (i.e. hospitalisations) and cases prevented are rounded to the nearest integer and were obtained assuming the default parameter values. Mean percentage reductions and 95% intervals reported in the rightmost column were derived from the distributions of projected outcomes calculated in the sensitivity analyses (note that the 95% intervals provide a measure of the impact of uncertainty in the assumed intervention effects but should not be interpreted as confidence intervals). The plot on the right shows the mean reductions and 50% and 95% intervals.



Self-harm hospitalisations

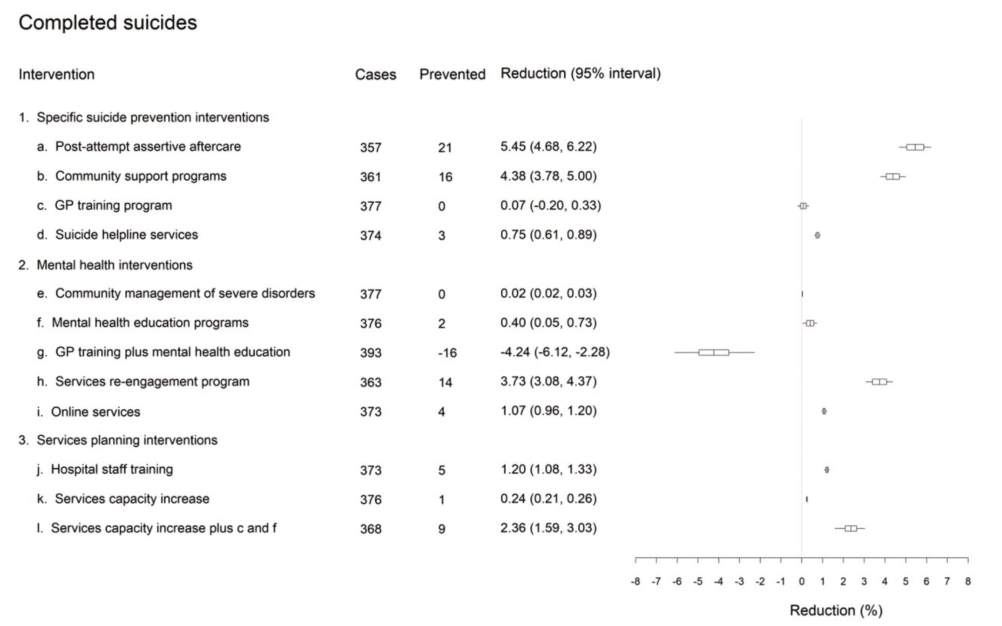
Intervention	Cases	Prevented	Reduction (95% interval)
1. Specific suicide prevention interventions			
a. Post-attempt assertive aftercare	2913	174	5.65 (4.87, 6.42)
b. Community support programs	3000	87	2.83 (2.23, 3.46)
c. GP training program	3096	-9	-0.31 (-0.69, 0.06)
d. Suicide helpline services	3062	25	0.80 (0.65, 0.95)
2. Mental health interventions			
e. Community management of severe disorders	3086	1	0.02 (0.02, 0.03)
f. Mental health education programs	3085	3	0.08 (-0.39, 0.53)
g. GP training plus mental health education	3253	-166	-5.36 (-7.44, -3.18)
h. Services re-engagement program	2989	98	3.16 (2.62, 3.70)
i. Online services	3052	35	1.14 (1.01, 1.28)
3. Services planning interventions			
j. Hospital staff training	3047	40	1.28 (1.15, 1.42)
k. Services capacity increase	3079	8	0.27 (0.24, 0.30)
l. Services capacity increase plus c and f	3025	62	1.98 (1.02, 2.81)

Discussion

This study used systems modelling and simulation to undertake *a priori* testing of the likely impact of prioritised interventions for a rural PHN catchment. Of the intervention scenarios examined, post-suicide attempt assertive aftercare was the single most effective intervention in reducing suicidal behaviour across the total population over the next 10 years, followed closely by universally applied community support programmes and a programme aimed at re-engaging those known to the mental health system but lost to follow-up. While only the broad strategy of achieving re-engagement of those lost to follow-up was modelled here, there is a potential role for the use of technology in the specific implementation of this intervention to ensure services remain more effectively connected with individuals who have previously made contact with mental health services. The relatively large forecasted impacts of community support programmes are congruous with studies highlighting social isolation as an important contributor to suicide (Dorling and Gunnell, 2003; Siahpush and Singh, 1999). The decision support tool provided through this action research has not only contributed to making a stronger case for investment in community support programmes, it has provided this case in the context of its estimated impact over the next decade compared to a suite of other commonly prioritised strategies such as increasing mental health service capacity. While the forecasted impacts of some interventions were unsurprising, others were initially unintuitive and delivered results that were significantly less than what is being anticipated under the evidence-based approach to suicide prevention being trialled across Australia (Black Dog Institute, 2015, 2018; Krysinska et al., 2016), and hence provides an opportunity for learning.

Based on evidence provided by a randomised, controlled trial conducted in an island district of Copenhagen, Denmark with an urban population (Hvid et al., 2011), and estimated using the traditional Population Preventable Fraction (PPF) method (Rockhill et al., 1998), assertive aftercare is expected to deliver a 19.8% reduction in suicide attempts in Australia (Black Dog Institute, 2015; Krysinska

Figure 3. Differences in projected total (cumulative) numbers of suicide deaths between the business as usual and intervention scenarios over the period 2021–2031. Numbers of cases (i.e. suicides) and cases prevented are rounded to the nearest integer and were obtained assuming the default parameter values. Mean percentage reductions and 95% intervals reported in the rightmost column were derived from the distributions of projected outcomes calculated in the sensitivity analyses (note that the 95% intervals provide a measure of the impact of uncertainty in the assumed intervention effects but should not be interpreted as confidence intervals). The plot on the right shows the mean reductions and 50% and 95% intervals.



Completed suicides

Intervention	Cases	Prevented	Reduction (95% interval)
1. Specific suicide prevention interventions			
a. Post-attempt assertive aftercare	357	21	5.45 (4.68, 6.22)
b. Community support programs	361	16	4.38 (3.78, 5.00)
c. GP training program	377	0	0.07 (-0.20, 0.33)
d. Suicide helpline services	374	3	0.75 (0.61, 0.89)
2. Mental health interventions			
e. Community management of severe disorders	377	0	0.02 (0.02, 0.03)
f. Mental health education programs	376	2	0.40 (0.05, 0.73)
g. GP training plus mental health education	393	-16	-4.24 (-6.12, -2.28)
h. Services re-engagement program	363	14	3.73 (3.08, 4.37)
i. Online services	373	4	1.07 (0.96, 1.20)
3. Services planning interventions			
j. Hospital staff training	373	5	1.20 (1.08, 1.33)
k. Services capacity increase	376	1	0.24 (0.21, 0.26)
l. Services capacity increase plus c and f	368	9	2.36 (1.59, 3.03)

et al., 2016). This estimate is more than three times higher than the impact forecasted by the system dynamics model for the rural catchment of Western NSW. In addition, based on an evaluation of a medical education programme for general physicians (GPs) on depression implemented in a primarily rural county of Sweden (Henriksson and Isacsson, 2006), GP training as been estimated to deliver a 6.3% reduction in suicides in Australia (Black Dog Institute, 2015; Krysinska et al., 2016). This estimate of impact is significantly higher than the negligible impact of GP training forecasted by the system dynamics model of Western NSW, and even when coupled with population-based mental health education and service capacity increases the forecast impact on suicide deaths for the Western NSW catchment remains almost two thirds lower than the estimate derived from the PPF method.

While estimates of impact at a national level are not necessarily indicative of regional-level effects, findings such as a lack of impact of GP training unless coupled with other interventions and the synergistic effects of certain intervention combinations suggest that the discrepancy in anticipated impacts are better explained by the difference in methods applied. The static, linear approach of application of the PPF method has been shown provide unrealistic estimates of impact of interventions when applied to complex systems (Page et al., 2018b). This is because each of the parameters used in the calculation of the preventive fraction is likely to change over time, as a function of demography, behavioural factors, contextual factors and health service quality and availability (Page et al., 2018b). In contrast, systems modelling and simulation can capture such complexity and account for real-world sources of inertia and delay, feedback loops (i.e. vicious and virtuous cycles), contextually specific interactions between service demand and supply, implementation challenges in resource-constrained environments and varying intervention effects over time (Page et al., 2018b; Sterman, 2006).

The surprising, unintended increase in suicidal behaviour generated by implementing general practitioner training combined with mental health education programmes provided an opportunity for learning about likely system behaviour in the Western NSW region. Interrogation of the model revealed that this intervention combination generated mental health service demand beyond the availability of baseline service capacity, driving increases in the rate at which patients disengage from services as a result of increases in mean wait times and dissatisfaction with the quality of care they receive. In the model, disengagement from the mental health care system is assumed to increase the risk of suicidal behaviour (due to a loss of hope that effective treatment is available, or trauma associated with inadequate care), so that an increase in the disengagement rate leads to the unintended increase in self-harm hospitalisation and suicide death rates. Similarly, service capacity increases on their own beyond baseline service demand will have little impact (as results demonstrate). However, the results highlight the extent to which building mental health service capacity ahead of implementing interventions that increase service demand has synergistic effects in reducing suicidal behaviour.

Exploration of such supply versus demand dynamics in a population catchment are exceedingly difficult with the application of static, linear analytic approaches and mental models alone. The systems modelling and simulation approach provides valuable decision support capability that can help avoid unintended consequences, inform the timing and scaling of interventions, and realise the full potential of evidence-based interventions. The complexity of mental health service planning and suicide prevention at the regional level presents challenges (both analytically and politically) that demand sophisticated, transparent and interactive decision support tools that will support a more disciplined, strategic approach to the allocation of limited resources, will help manage expectations with regards to the size, nature and timing of intervention effects, and facilitate the navigation of effective partnerships to achieve aligned collective action across local stakeholder groups.

Limitations

There are a number of limitations that require consideration when interpreting the findings of this study. There is potential measurement bias in the range of secondary data used to parameterise the model including the NSW population health survey, Medicare Benefits Schedule, PHN and Local Health District (LHD) datasets and the Australian Bureau of Statistics (ABS); and, these data vary considerably in quality. The model acknowledges these potential sources of measurement bias, and a number of commonly used strategies were employed to address them, including the triangulation of multiple data sources, parameter estimation via constrained optimisation, and local verification to identify plausible estimates.

In addition, there is potentially an under-enumeration of suicide cases used to calibrate the model, due to the misclassification of suicides to International Classification of Diseases (ICD) codes relating to unintentional injury and events of ‘undetermined intent’ (Harison et al., 2009). In addition, hospital suicide attempts (from hospital admissions) likely only capture those cases serious enough to warrant medical intervention and instances of self-harm where the intent wasn’t clear may be not coded as suicide attempts; hence, potentially under-enumerating the total population burden of attempted suicide in the population catchment. However, these limitations were consistent across simulations of the baseline case and intervention scenarios and as such are unlikely to affect the forecast estimates of impact (i.e. the % reduction in suicidal behaviour) of intervention strategies or the strategic insights derived from the model. As intervention effect sizes are subject to the population, demographic, behavioural, and service dynamics of the modelled region, they should not be considered generalisable to other regions. However, qualitative insights regarding system behaviour, for example, the importance of the supply–demand dynamics in influencing the outcomes strategies to reduce suicide have broader relevance to regional commissioning of suicide prevention initiatives.

Strengths

The findings reported in the current study represent a set of intervention scenarios deemed a priority for informing the next round of commissioning of programmes and services to reduce suicidal behaviour in the rural and remote population catchment of Western NSW. The prioritised programmes and services do not represent the full scope of potentially effective strategies to reduce suicidal behaviour in the region. However, the model can be updated and expanded to include additional initiatives based on interest or new evidence that becomes available, making it a longer-term decision support asset. Within the current model, there is also scope to investigate alternative scenarios related to the timing of implementation of interventions, their scale and intensity, alternative assumptions of level of participation and uptake, and alternative combinations to provide further insights to support local stakeholder engagement and implementation of the suicide prevention strategy. Embedded in a monitoring and evaluation cycle, such models can be used to iteratively determine the extent to which the modelling corresponds with real-world outcomes over time and how implementation strategies can be enhanced to improve performance. Information from monitoring and evaluation activities can also be used to refine model parameters to improve its forecast capabilities and guide subsequent decision-making in a timely and proactive way.

Conclusion

Suicide is a complex phenomenon driven by a range of demographic, behavioural, contextual, socio-cultural and health service factors. Efforts to reduce suicide over the past decade through reforms aimed at making services and preventive interventions more effective, efficient and culturally and contextually appropriate, have not delivered the anticipated impacts. The new reforms focus on a renewed regional approach to suicide prevention. Their success will depend on the ability of PHNs to understand and respond to the unique characteristics and drivers of suicidal behaviour in their catchments, their ability to foster collaboration among local stakeholders to support implementation, and access to leading advances in decision analytic tools and methods that will help them navigate the challenging decision-making environment in which they operate. Dynamic systems modelling and simulation is unhindered by the constraints of static, linear analytic approaches and is able to bring together the many pieces of a complex puzzle in a given context, including determinants and pathways to suicidal behaviour, dynamics of service needs and supply, barriers and facilitators of access to care, and intervention effects, and deliver new insights for decision makers and their stakeholders. The interactive nature of the decision support tool enables regional decision makers and their stakeholders to explore the likely impacts of their commissioning strategies before implementation in the real world, an approach that offers significant potential for the more effective use of limited health resources.

Acknowledgements

This model was developed by the Sax Institute in partnership with Western NSW Primary Health Network, Western Sydney University and The University of Melbourne. Importantly, this work was made possible by generous contributions of time, local knowledge, data and content area expertise by Professor Andrew Page (Translational Health Research Institute, Western Sydney University), Western NSW PHN staff, the Western NSW Health Intelligence Unit, Western NSW Local Health District and Far West Local Health District.

Author Contributions

Manuscript concept and drafting: J.A. and A.S.; model development: A.S.; data analysis: A.S. and J.A.; critical revision of manuscript for important intellectual content: all authors.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This decision support tool was developed as a part of the National Suicide Prevention Trial Evaluation funded by the Commonwealth Department of Health.

ORCID iDs

Jo-An Atkinson https://orcid.org/0000-0002-2380-1092
Jane Pirkis https://orcid.org/0000-0002-2538-4472

Supplemental Material

Supplemental material for this article is available online.

References

Atkinson J-A, Page A, Heffernan M, et al. (2019a) The impact of strengthening mental health services to prevent suicidal behaviour. *Australian and New Zealand Journal of Psychiatry* 53: 642–650.

Atkinson J-A, Page A, Prodan A, et al. (2018) Systems modelling tools to support policy and planning. *Lancet* 391: 1158–1159.

Atkinson J-A, Page A, Skinner A, et al. (2019b) The impact of reducing psychiatric beds on suicide rates. *Frontiers in Psychiatry* 10: 448.

Atkinson J-A, Page A, Wells R, et al. (2015) A modelling tool for policy analysis to support the design of efficient and effective policy responses for complex public health problems. *Implementation Science* 10: 26.

Australian Bureau of Statistics (2016) *Australian Statistical Geography Standard* (Correspondences, July 2011). Canberra, ACT, Australia: Australian Bureau of Statistics.

Australian Bureau of Statistics (2018) *Technical Paper: Socio-Economic Indexes for Areas, 2016*. Canberra, ACT, Australia: Australian Bureau of Statistics.

Australian Institute of Health and Welfare (2019) *MORT (Mortality Over Regions and Time) Books: Remoteness Area, 2013–2017*. Canberra, ACT, Australia: Australian Institute of Health and Welfare.

Black Dog Institute (2015) *Implementation Plan for the Systems Approach to Suicide Prevention in NSW: Summary Paper*. Sydney, NSW, Australia: Black Dog Institute. Available at: https://nswmentalhealthcommission.com.au/sites/default/files/BDI_Systems%20Approach%20Summary%20Paper_FINAL%20October%202015.pdf (02 May 2020).

Black Dog Institute (2018) *LifeSpan Sites*. Sydney, NSW, Australia: Black Dog Institute.

Burnley IH (1995) Socioeconomic and spatial differentials in mortality and means of committing suicide in New South Wales, Australia, 1985-91. *Social Science & Medicine* 41: 687–698.

Caldwell TM, Jorm AF and Dear KB (2004) Suicide and mental health in rural, remote and metropolitan areas in Australia. *Medical Journal of Australia* 181: S10–S14.

Community Affairs Reference Committee (2018) *Senate Committee Report: Accessibility and Quality of Mental Health Services in Rural and Remote Australia*. Canberra, ACT, Australia: Parliament of Australia. Available at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report (02 May 2020).

Department of Health, Australian Government (2015) *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. Canberra, ACT, Australia: Australian Government.

Department of Health, Australian Government (2018) *Western NSW PHN Fact Sheet*. Canberra, ACT, Australia: Australian Government.

Dorling D and Gunnell D (2003) Suicide: The spatial and social components of despair in Britain 1980-2000. *Transactions of the Institute of British Geographers* 28: 442–460.

Hanigan IC, Schirmer J and Niyonsenga T (2018) Drought and distress in Southeastern Australia. *EcoHealth* 15: 642–655.

Harison JE, Pointer S and Elnour AA (2009) *A Review of Suicide Statistics in Australia* (Injury research and statistics series no. 49, Cat. no. INJCAT 121). Adelaide, SA, Australia: Australian Institute of Health and Welfare.

Henriksson S and Isacsson G (2006) Increased antidepressant use and fewer suicides in Jamtland County, Sweden, after a primary care educational programme on the treatment of depression. *Acta Psychiatrica Scandinavica* 114: 159–167.

Hirsch JK (2006) A review of the literature on rural suicide: Risk and protective factors, incidence, and prevention. *Crisis* 27: 189–199.

Hopkins J, Salvador-Carulla L, Stretton A, et al. (2017) *The Integrated Mental Health Atlas of Western NSW – Version for Public Comments*. Sydney, NSW, Australia: The Menzies Centre for Health Policy, University of Sydney and ConNetica.

Hvid M, Vangborg K, Sorensen HJ, et al. (2011) Preventing repetition of attempted suicide – II: The Amager project, a randomized controlled trial. *Nordic Journal of Psychiatry* 65: 292–298.

Klieve H, Sveticic J and De Leo D (2009) Who uses firearms as a means of suicide? A population study exploring firearm accessibility and method choice. *BMC Medicine* 7: 52.

Kõlves K, Milner A, McKay K, et al. (2012) *Suicide in Rural and Remote Areas of Australia*. Brisbane, QLD, Australia: Australian Institute for Suicide Research and Prevention.

Kõlves K, Potts B and De Leo D (2015) Ten years of suicide mortality in Australia: Socio-economic and psychiatric factors in Queensland. *Journal of Forensic and Legal Medicine* 36: 136–143.

Krysinska K, Batterham PJ, Tye M, et al. (2016) Best strategies for reducing the suicide rate in Australia. *Australian and New Zealand Journal of Psychiatry* 50: 115–118.

Loyo HK, Batcher C, Wile K, et al. (2013) From model to action: Using a system dynamics model of chronic disease risks to align community action. *Health Promotion Practice* 14: 53–61.

National Mental Health Commission (2014) *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services*. Canberra, ACT, Australia: National Mental Health Commission. Available at: www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF (02 May 2020).

Page A, Atkinson J-A, Campos W, et al. (2018a) A decision support tool to inform local suicide prevention activity in Greater Western Sydney (Australia). *Australian and New Zealand Journal of Psychiatry* 52: 983–993.

Page A, Atkinson J-A, Heffernan M, et al. (2017) A decision-support tool to inform Australian strategies for preventing suicide and suicidal behaviour. *Public Health Research and Practice* 27: 2721717.

Page A, Atkinson J-A, Heffernan M, et al. (2018b) Static metrics of impact for a dynamic problem: The need for smarter tools to guide suicide prevention planning and investment. *Australian and New Zealand Journal of Psychiatry* 52: 660–667.

Procter NG (2005) Parasuicide, self-harm and suicide in Aboriginal people in rural Australia: A review of the literature with implications for mental health nursing practice. *International Journal of Nursing Practice* 11: 237–241.

Public Health Information Development Unit (2019) *Social Health Atlas of Australia: Data by Primary Health Network*. Adelaide, SA, Australia: Public Health Information Development Unit.

Ridani R, Torok M, Shand F, et al. (2016) *An Evidence-Based Systems Approach to Suicide Prevention: Guidance on Planning, Commissioning, and Monitoring*. Sydney, NSW, Australia: Black Dog Institute.

Roberts N, Li V, Atkinson J-A, et al. (2019) Can the target set for reducing childhood overweight and obesity be met? A System Dynamics Modelling Study in New South Wales, Australia. *Systems Research and Behavioral Science* 36: 36–52.

Robinson J, Bailey E, Witt K, et al. (2018) What works in youth suicide prevention? A systematic review and meta-analysis. *EClinicalMedicine* 4–5: 52–91.

Rockhill B, Newman B and Weinberg C (1998) Use and misuse of population attributable fractions. *American Journal of Public Health* 88: 15–19.

Siahpush M and Singh GK (1999) Social integration and mortality in Australia. *Australian and New Zealand Journal of Public Health* 23: 571–577.

Slade T, Johnston A, Teesson M, et al. (2009) *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. Canberra, Act, Australia: Department of Health and Aging.

Sterman JD (2006) Learning from evidence in a complex world. *American Journal of Public Health* 96: 505–514.

Taylor R, Page A, Morrell S, et al. (2005) Social and psychiatric influences on urban-rural differentials in Australian suicide. *Suicide and Life-Threatening Behavior* 35: 277–290.

The Department of Health (2016) National suicide prevention strategy. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps (02 May 2020).

Ziersch AM, Baum F, Darmawan IG, et al. (2009) Social capital and health in rural and urban communities in South Australia. *Australian and New Zealand Journal of Public Health* 33: 7–16.