Analysis of Suicide Prevention Trials Evaluation Findings
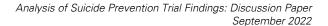
Discussion Paper

Department of Health and Aged Care

September 2022

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Executive Summary

The prevalence and impact of suicide on Australian society, particularly among vulnerable cohorts, makes preventing suicide a necessary priority for the Australian Government.

Three Australian suicide prevention trials have been undertaken over recent years in different parts of Australia, using diverse models and targeting various populations, and applying a systems-based approach. The Australian Government Department of Health and Aged Care (the Department) has commissioned a combined analysis of findings from these trials. Key insights and implications for future implementation, trial and evaluation design are presented in this discussion paper.

Systems-based suicide prevention is multisectoral and multicomponent, with elements interacting and working in synergy through community partnerships to achieve shared goals. Key themes identified across the three trials emphasised the importance of the following:

Model identification and adaptability to local communities, based on community engagement

Sequencing and timing of the multiple components making up systems-based approaches

Data collection and evaluation challenges around observing and measuring outcomes

Partnerships and relationships as a central enabler, dependent on adequate engagement

Workforce capacity and capabilities necessary to deliver trials, and retention challenges

Time and resourcing with time an important resource to enable effective implementation

This discussion paper explores some of the key considerations for designing and implementing a systems-based approach to suicide prevention, including:
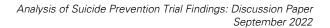
- **Acknowledging critical PHN priorities** around coordinating a network of partnerships, facilitating flexible governance structures and leading the translation of knowledge.

- **Adopting effective co-design and co-delivery practices** with local communities and people with lived experience of suicide, including the emerging Lived Experience (Peer) workforce.

- **Prioritising diverse and hard-to-reach cohorts** including Aboriginal and Torres Strait Islander communities through early and sustained engagement.

- **Incorporating continuous improvement from the outset**, allowing for the sharing of information across the system and the translation of knowledge into ongoing and future action.

- **Integrating evaluation approaches** that facilitate developmental evaluation and embrace implementation science approaches.

- **Allowing longer-term trials** to build the required partnerships and system buy-in for effective implementation and long-term sustainability.

- **Developing clear outcome measures** that can be monitored and measured as part of an evaluation framework that also considers preliminary and implementation outcomes.

The role of the Department in centralising the coordination of an overarching implementation strategy and outcomes framework for future suicide prevention trials is also explored. Although implementation and specific outcomes need to be tailored to the local community or region, providing overarching guidance will enable consistency and comparability between future trials.

Alongside development in this area, embedding data linkage processes will ultimately strengthen the evidence base for systems-based suicide prevention activity in Australia.

Contents

Glossary

AAD/ EAAD	Alliance Against Depression/ European Alliance Against Depression
AIHW	Australian Institute of Health and Welfare
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CALD	Culturally and linguistically diverse
CI	Collective Impact
GP	General practitioner
KTA	Knowledge to Action Framework
LGBTIQ+	Lesbian, gay, bisexual, trans, intersex, queer
LHD	Local Health District
MDS	Minimum Data Sets
NASWD	National Agreement for Skills and Workforce Development (2012)
NSPO	National Suicide Prevention Office
NSPT	National Suicide Prevention Trial
OSPI	Optimizing Suicide Prevention Programs and Their Implementation model
PBSPT	Place-Based Suicide Prevention Trials
PHN	Primary Health Network
VET	Vocational Education and Training
WHO	World Health Organization

1   Suicide prevention is a national priority

The impacts of each suicide are far-reaching, affecting not only family and friends but also the broader community. There are an estimated 65,000 suicide attempts each year in Australia with 3,139 people dying by suicide in 2020.[1] Strikingly, it is estimated that more than 500,000 Australians have attempted suicide at some time in their life.[2]

Suicide is more prevalent in certain groups, particularly young people, men and Aboriginal and Torres Strait Islander Peoples. Over one-third of deaths in people aged 15-24 years old are due to suicide.[3] Men are around three times more likely to die by suicide than females and Aboriginal and Torres Strait Islander Peoples are disproportionally represented in suicide statistics considering the population.[4]

Due to suicide frequently occurring at a younger age than other causes of death, it has consistently been the cause of death resulting in the highest number of potential years lost. In 2020, the potential years of life lost was 109,525 years.[5]

Suicide affects communities across Australia far too often with preventing suicide a necessary priority for the Australian Government. Suicide prevention is a whole of community challenge, requiring the various components to strategically align and work towards the aim of preventing all suicides.

Recent activity and investment demonstrate the priority of suicide prevention across the country. In 2019 the Australian Government appointed the first National Suicide Prevention Advisor to the Prime Minister, Christine Morgan, and established the National Suicide Prevention Taskforce. The shared intention of Commonwealth, state and territory governments to work in partnership to improve Australians' mental health, enhance mental health and suicide prevention services and systems, and reduce the rate of suicide was set out by the National Mental Health and Suicide Prevention Agreement, coming into effect March 2022.[6] A summary of the current plans and strategies relevant to suicide prevention at the national level is provided at **Appendix A**.

Three suicide prevention trials conducted across the country provide an important opportunity to build the evidence base on what works in preventing suicide and supporting Australians at risk of suicide. Evaluating and analysing the impact of the three trials is crucial in determining the next steps in national suicide prevention initiatives delivered by Primary Health Networks (PHNs), together with the ongoing engagement with people with lived experience of suicidal distress, researchers, providers, community leaders and all levels of government. In addition to the separate evaluations for each of the three trials, the Department, on recommendation of the National Suicide Prevention Advisor, has commissioned a combined analysis of findings from all three projects, to strengthen the coordination of this evidence and highlight the implications for future suicide prevention activity.

Purpose of this document

This discussion paper provides a summary of the insights, implications and priorities for suicide prevention emerging from the trials undertaken by the Australian Government, Victorian Government and the Black Dog Institute, as well as a review of published suicide prevention literature.

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[1] Australian Institute of Health and Welfare (2022). Retrieved from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time

[2] Suicide Prevention Australia. (2022) Statistics. Retrieved from: https://www.suicidepreventionaust.org/news/statsandfacts

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Australian Government. (2022). National Mental Health and Suicide Prevention Agreement. Retrieved from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf.

The three trials were undertaken in different parts of Australia, using diverse models and with various target populations. However, each of these trials have adopted a systems-based approach to suicide prevention which involves a mix of interventions being delivered through diverse local and community partnerships with the collective aim to strengthen community resilience to prevent suicide. More information on the context for the three trails, details on each trial and the scope and methodology for this analysis can be found at **Appendix B**.

This discussion paper explores the approach to suicide prevention initiatives, the implementation of suicide prevention trials and interventions, and the implications for the design and evaluation of future suicide prevention activity.

2 Suicide prevention requires a systems-based approach

The approach to all three suicide prevention trials had a systems or multicomponent approach as part of their design. While the trials differed in terms of models, regions and population cohorts, there was a consistent approach of incorporating a mix of interventions and a wide range of partners to deliver the various initiatives. A review of the literature indicates that most research about systems-based suicide prevention does not detail the essential or defining components of systems-based approaches, nor necessarily provide a common understanding of what systems-based approaches are. In order to understand the lessons learned from the three trials, it is useful to begin by examining the design features used across the three trials and explore the key components of a systems-based approach to suicide prevention.

2.1 Defining a systems-based approach

The objective of suicide prevention is to prevent suicidality; in this respect it is a community problem. It is widely understood that the causes that lead to suicidal distress are multifactorial and strongly linked to broader social determinants of health and wellbeing. There is a compelling evidence base that a systems-based approach is best suited to tackling complex social issues such as suicide prevention, where interventions can work synergistically to achieve greater effects than any single intervention alone.[7] The World Health Organization (WHO) emphasises the need for suicide prevention strategies to be multisectoral, involving not only the health sector but also sectors such as education, labour, social welfare, justice, business, the media amongst others.[8]

A systems approach recognises these needs and embeds the coordination and linkages to ensure not only that the different components of the approach work together but that they are targeted to the specific needs of the community they are operating in and towards supporting vulnerable cohorts within that community. Utilising an approach that touches on many aspects of the broader system increases the opportunity for identifying, and connecting with, at-risk individuals.

Features of a systems-based approach to suicide prevention

All the features or elements within a systems-based approach should interact with, and complement, each other to achieve an overarching goal. Elements may have a specific focus, but it is the synergy of the various parts of the system that are most critical to the overall effectiveness of the approach. Importantly, implementing a systems-based approach is not a linear process of working through each element but rather a process of identifying how each element will support the overall approach at different times. The opposite of a systems-based approach is a fragmented approach where interventions and activities are implemented in isolation from one another, limiting the opportunities for any synergistic or complementary effects.

Broadly speaking, a systems-based approach to suicide prevention incorporates multiple evidence-based preventative interventions implemented simultaneously or within a set time period, within a defined region. The interventions may focus directly on the individual or community at risk of suicide, the workforce that may support suicide prevention initiatives or the broader community.

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[7] Hofstra, E., van Nieuwenhuizen, C., Bakker, M., Özgül, D., Elfeddali, I., de Jong, S.J., van der Feltz-Cornelis, C. M., (2020). Effectiveness of suicide prevention interventions: A systematic review and meta-analysis, General Hospital Psychiatry, Volume 63, Pages 127-140. Retrieved from https://www.sciencedirect.com/science/article/pii/S0163834318305097

[8] National suicide prevention strategies: progress, examples and indicators. Geneva: World Health Organisation (2018).

The WHO described key elements to the success and sustainability of a comprehensive multisectoral strategy to suicide prevention.[9] They include:

- Identify stakeholders

- Undertake a situation analysis

- Assess resources

- Achieve political commitment

- Address stigma

- Increase awareness

- State clear objectives

- Identify risk and protective factors

- Select effective interventions

- Improve case registration and conduct research

- Conduct monitoring and evaluation.

Addressing these elements during the design phase of a systems-based approach to suicide prevention is critical to success and is explored further throughout this document.

2.2 Themes emerging from trialling a systems-based approach to suicide prevention

The respective evaluations of each of the three trials highlighted the challenges of adopting a systems-based approach. This section describes the key themes relating specifically to trialling a systems-based approach to suicide prevention.

Model identification and adaptability

Using an established systems-based suicide prevention model such as LifeSpan or the Alliance Against Depression (AAD) from the outset to guide planning was an effective strategy. Building on the chosen model to adapt interventions to the local context and the needs of the targeted population was critical for success and a challenge across the trials.[10]

The respective interim evaluations of the trials discussed the various challenges with adapting a model to focus on the needs of the local population. The applicability of some frameworks to regional contexts and population sub-groups is not yet established with more guidance on operationalising such frameworks required.[11] Some trials also experienced community resistance with engaging with a broad multifaceted approach that involved many partners. Adapting the model or framework for a given region required a flexible approach at each trial site and clear overarching guidance on implementation and operationalisation of the model. The trial evaluations identified the opportunities and challenges associated with implementing a localised systems-based approach.

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[9] National suicide prevention strategies: progress, examples and indicators. Geneva: World Health Organisation (2018).

[10] Currier, D. et al. (2020). *National Suicide Prevention Trial Final Evaluation Report*. University of Melbourne. Supplied to KPMG.

[11] Ibid.

Sequencing and timing

Evidence from the final evaluations of each of the trials points to the fact that while their stated aims were to embed a systems-based approach into suicide prevention activities, the activities were not always rolled out in a way that allowed the desired synergistic effects. Implementing interventions at separate points throughout the trials limited the ability to achieve some of the advantages of a multicomponent, multi-strategy systems approach within the timeframe of the trials. Although this limitation was observed, there are circumstances where it is important to embed one intervention type before implementing another. For example, an intervention focused on upskilling General Practitioners (GPs) on suicide prevention will likely be more effective if implemented prior to public awareness campaigns that promote the suicide prevention services of GPs. It is also important to note that implementing an intervention earlier that others does not mean there will be no synergistic effects. If the initial component is ongoing, the desired synergy with future interventions may occur as the systems-based approach expands and matures.

The importance of flexibility and adaptation emerged as a strong theme across all three trials and in various scenarios. This is also a critical aspect to the timing and sequencing of various interventions within the regional systems-based approach. An overarching desired sequencing is not always available and is highly dependent on the local priorities, partnerships and risk factors. This creates significant challenges when attempting to implement multiple interventions across a system within a timeframe that is determined by trial funding. As this was the circumstances faced by trial coordinators, the ability to remain flexible and adaptive throughout the trial period was critical for success. Additionally. the time-limited nature of each trial also inhibited the ability to implement the long-term strategies necessary for system-level change and potentially created a deterrent for sites in pursuing all elements of a multi-factorial approach.[12]

The trial evaluations highlighted the importance of allowing sufficient time to understand the unique behaviours and risk factors of a community, to build relationships within the community and to undertake adequate planning to design a locally tailored and community informed approach. The trials highlighted the importance of establishing an implementation plan in line with local priorities that includes the desired sequencing of interventions while allowing for flexibility. The implementation of systems-based approaches to suicide prevention is explored further in **Section 3.**

Data collection and evaluation

Significant challenges were observed across trials in detecting and interpreting ultimate outcomes of the trials due to various factors, including the complexity of systems-based approaches and the associated attribution challenges. The evaluation report for the NSPT notes: "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".[13]

Notwithstanding the challenges identified throughout the trials, designing future systems-based approaches should be informed by relevant outcomes measures and the evaluation process and activities that will be incorporated. Identifying the most relevant outcome measures and data collection opportunities will be part of the exploration process for understanding the local context. Information and data can help guide and drive understanding of local context, how and what is collected (beyond Minimum Data Sets) and how and what data is held or provided back to the community.

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[12] Currier, D. et al. (2020). *National Suicide Prevention Trial Final Evaluation Report.* University of Melbourne. Supplied to KPMG.
[13] Ibid.

It is important to recognise that while data collection is vital to help understand the impact and outcomes suicide prevention interventions, it does also place a burden on those required to collect it, particularly third-sector organisations. This necessitates a balance between accountability and actual time spent delivering services and providing support to those in need. Building these considerations into the design at the outset can help manage expectations, while providing an important lens to interpret success, challenges and lessons learned.

Partnerships and relationships

The success of a systems-based approach is dependent on strong working relationships across and within the system. The trial evaluations highlighted the large number of community-based partners and the different levels of government across various agencies and departments that are involved in the implementation of a widescale approach.

Building strong and effective relationships with a diversity of partners was consistently cited by the evaluation teams as a key enabler for successful implementation within the regional systems-based models. Engaging partners as early as possible in the planning process, allowing time to build relationships and having adequate engagement or 'buy-in' from partners were all seen as pivotal to success. The influence with partners across and within this system also significantly impacted on the overall effectiveness when implementing systems-based approach.

Workforce

The trial evaluations illustrated the importance of the role of suicide prevention coordinator to support an effective and broad reaching systems-based approach. Several factors were called out as being essential in allowing this role to be performed effectively. The required skill set for suicide prevention coordinators consisted especially of soft skills (interpersonal skills, collaboration, negotiation and community development, for example) and not necessarily to suicide prevention experience specifically. This has implications for the type of professional development and support needing to be offered to the suicide prevention workforce – workers with suicide prevention experience can be supported to develop soft skills such as coordination and community development, and vice versa.

Time and resourcing

The trials highlighted the importance of time and process to enable knowledge and research translation for localised service providers and communities across the system. These were important to enable the use of evidence-based approaches, as well as to ensure best practice informs localised tailored approaches, and vice versa. While there was minimal formal research to share between trial sites, there was evidence of significant knowledge gains within regions that may not have been shared due to the capacity of staff. Allowing for sufficient time within certain roles and/or considering resourcing dedicated roles to tasks such as knowledge sharing and translation is an important part of the design of future systems-based approaches to suicide prevention.

3 Implementing a systems-based approach is highly complex

The early and interim evaluations of the three trials emphasised the complexity of implementing a regional approach to suicide prevention. To effectively adopt a systems-based approach, the trials required strong local partnerships and community buy-in across a range of sectors. Achieving this was a critical aspect for successful implementation of the interventions and initiatives required for long-term and sustainable outcomes. The evaluation reports highlighted the limitations that were experienced by some of the trial sites that reduced the effectiveness of the implementation process.

This section explores some of the key considerations regarding the implementation of the Suicide Prevention Trials, along with findings from the broader literature.

3.1 An overarching implementation strategy supports consistency

The Suicide Prevention trials illustrated a gap in overarching guidance on implementation strategy for systems-based suicide prevention trials. This is particularly significant because there is little consensus on what constitutes a systems-based approach to this complex issue – and in particular, what constitutes best practice. In providing general guidance on implementing systems-based suicide prevention interventions, an overarching Strategy would likely contain:

- Guidance for consistent approaches to trial implementation

- A summary of key enablers which could be adapted to different regions and systems landscapes across Australia, such as approaches to increase uptake of program components

- Methods for facilitating continuous improvement/learnings from previous trials

- A communications strategy

For example, an implementation strategy might contain advice around which interventions are best adapted and delivered through community leadership, and which ones are best managed by others (e.g. school-based interventions are best delivered in partnership with education departments). This would provide guidance for PHNs seeking to understand whether they are best placed to manage different intervention components, or where some should be delegated to or delivered in partnership with another stakeholder.

Noted challenges or tensions to the development of such a strategy would relate to the complexity of the changing systems landscape, which directly impacts how systems-based trials should be approached and implemented. Guidance would therefore need to be general in nature, while emphasising noted key success factors. However, an overarching strategy should not be considered to replace planning or strategising at the level of individual interventions or sites.

An overarching implementation strategy would ideally be led by people involved in the leadership of Suicide Prevention trials, to ensure their key insights on barriers and enablers are captured and used to inform future strategies.

3.2 PHNs play a critical role in successful implementation

As described by the Black Dog Institute, the traditional role for PHNs in suicide prevention is in commissioning health services and primary care.[14] However, the role for PHNs in trialling regional systems-based suicide prevention extends beyond this, with PHNs required to engage with wider networks of community groups. Although sourcing and commissioning appropriate community-based services remains central to the coordination of suicide prevention, the PHN role may be thought of as a broader influencer and driver of change in the community. This section summarises the key priorities for PHNs in coordinating systems-based suicide prevention interventions.

It should be noted that the below roles stand to inform PHN priorities as they approach their role as systems-based trial coordinator. Rather than PHNs needing to absorb these tasks in addition to their existing role, the priorities below can be considered as being embedded into existing roles, or otherwise informing the PHN's approach to planning and implementation.

> **Priority area: Driving quality commissioning**
>
> The Suicide Prevention Australia Standards for Quality Improvement are an accreditation framework for suicide prevention providers and commissioners, and a new and emerging aspect of how commissioning can look to build quality. Most PHNs and a large number of suicide prevention providers are now accredited, making the standards a key consideration as PHNs look to build their systems-based suicide prevention capacity.
>
> The Standards cover a number of diverse and intersecting program considerations, relevant to many of the priority areas discussed below in relation to the Trials. These including stakeholder engagement and partnership-forming, incorporating lived experience, program logic and data protocols, and evaluation and knowledge translation. The Standards can be considered as a framework to guide commissioners and providers towards emerging best practice in the space of systems-based suicide prevention.[15]
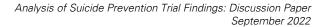
Coordinating a network of partnerships

While the central role of PHNs is to coordinate broader systems partnerships to support the delivery of trials, there are several ways PHNs may approach this role, as observed in the suicide prevention trials. Synthesis of the trials indicates that greater success was found where the trial coordinator moved from a hub-and-spoke model towards a network model, where partners formed relationships and engaged equally as strongly with each other as with the coordinator. In a network model, the PHN role is more closely aligned with establishing shared goals amongst partners, and generating community buy-in.

Synthesis of the evaluations also highlighted the importance of a central coordinator role, with experience and expertise in relationship-formed and complex project management being key enablers. Black Dog Institute recommends PHNs attach their suicide prevention activities to a local prevention action plan, which may consist of numerous elements, including surveys (of current workforce capacity and training, and local service providers' use of evidence-based therapies) and workshops to promote recommended therapies and activities to develop a shared care planning process.[16] In this model of relationship-forming, collaboration is mainly cross-agency in nature, with

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[14] Black Dog Institute. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring. Document for Primary Health Networks. Commonwealth of Australia. Retrieved from http://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0/

[15] Suicide Prevention Australia. (2020). Suicide Prevention Standards for Quality Improvement. Available from: https://www.suicidepreventionaust.org/wp-content/uploads/2021/04/Suicide-Prevention-Australia-Standards-for-Quality-Improvement_V5.pdf.

[16] Ibid.

PHNs taking the role of central coordinator to develop joint strategies to improve care. It is worth noting that this approach is more similar to a traditional hub-and-spoke model than a network model, but that there may be opportunities for PHNs to facilitate inter-agency coordination between partners while taking this approach.

Across the suicide prevention trials, it was observed that the more successful sites had stronger relationships with key partners prior to trial commencement, or factored in enough time to build these relationships during the pre-implementation period. Conversely, significant challenges emerged for some PHNs who had not established key relationships with community partners. Future suicide prevention activities may benefit from greater maturity amongst PHNs, who have had more time to build relationships with key community delivery partners. In particular, relationships with community groups or populations with higher suicide risk were observed to be challenging to establish in some instances. Some priority populations were found to be difficult to engage because of a lack of time, unwillingness to participate in an unpaid volunteer capacity, or lack of existing connection.

The broader literature around suicide prevention notes that education programs for GPs are a key influencing factor on the effectiveness of systems-based suicide prevention interventions. However, literature also notes that intervention sites frequently experience challenges in engaging GPs, an experience which was replicated across some suicide prevention trial sites. Tailored engagement and communicative strategies are required for GPs, accounting for the need to fit in amongst their time-heavy work commitments. Across trial sites, existing connections between advisory boards and local GP champions were found to facilitate more streamlined engagement and delivery of training to GPs. Where these connections do not yet exist, PHNs will need to consider the time and labour required to develop GP champions, prioritising practitioners with links into at-risk communities, or conducting other forms of targeted engagement.

It is also important that PHNs consider their existing relationships with and connections into other at-risk community groups prior to the commencement of suicide prevention activities. Health promotion outreach is best delivered through a broader range of community sites. Community hubs, religious sites, sporting clubs, schools and libraries all represent potential avenues for reaching wider audiences, in particular diverse cohorts (who may be disengaged from the health system and not in regular contact with their GP). PHNs hold an important knowledge base about their local community which should enable them to select the most appropriate sites to reach specific cohorts, depending on the objectives of their trial or intervention. PHNs entering into future suicide prevention trials or activities should as a priority identify gaps in key relationships and connections with key priority cohorts, and seek to build on these where required as early in the implementation stage as possible.

Facilitating inclusive governance structures

The nature of systems-based programs requires governance structures that are flexible yet tailored to the specific community setting. It is important to note that even in striving to establish a network of relationships between partners, there is still an important role for the PHN in facilitating the governance structure, and establishing and managing expectations.

Adherence to business-as-usual governance approaches has been noted to potentially come at the expense of genuine community engagement, which would be better leveraged by offering some level of shared decision-making and governance control to citizens.[17] Hierarchical structures of authority have also been found to present barriers to effective governance of systems-based interventions; "authority structures should be breathable and not impervious to change".[18] A systems-based approach should therefore involve governance arrangements which include delivery partners as part of ongoing governance. Inclusion and engagement with community members and lived experience

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[17] Renedo & Marston 2011, in De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.

[18] Calida, B.Y., Jaradat, R.M., Abutabenjeh, S. and Keating, C.B. (2016) 'Governance in systems of systems: a systems-based model', Int. J. System of Systems Engineering, Vol. 7, No. 4, pp. 235–257.

representatives are critical to achieving community endorsement, discussed in further detail in **Sections 4.3** and **4.4**. In the NSPT, PHNs which approached governance as a commissioning body were found to have more difficulty in facilitating community development and coordination than PHNs with more of an existing focus on community engagement and relationship-building.

Some suicide prevention trials we examined used established governance models, with the PBSPT designed to operate as a Collective Impact intervention and governance model. Inclusive governance was one of the most-improved system quality indicators between the formative and summative PBSPT evaluation reports, and the report notes that "more inclusive, effective and adaptive governance systems were strongly associated with higher self-reported individual suicide prevention capacity."[19]

Despite the reported improvements, governance-related factors were identified by stakeholders informing the evaluation as the most common barrier. Some of the key barriers highlighted included role ambiguity and inadequate inclusion of community members, which have both been frequent criticisms of CI programs.[20] [21] This illustrates that implementing an established governance model should not come at the expense of efforts to establish meaningful and sustained connections into community, and embed these into ongoing program governance where possible.

Calida et al. (2016) propose a systems-based conceptual model of governance for complex systems-based programs where overarching principles or values (a form of 'meta-governance' which 'govern how to govern') are agreed and implemented through an explicit governing system. In a systems-based environment, they note, "there is an apparent blurring of boundaries across operational, tactical and strategic levels of decision made feasible by interactions of relevant governance actors" engaging across different levels.[22] This is echoed in the National Action Alliance framework for systems-based suicide prevention which recommends "integrating suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs" and "establishing collaborative suicide prevention programming at the state/territorial, tribal, and local levels" as preliminary activities.[23]

To reduce role ambiguity and misalignment of expectations between the different contributing stakeholders, establishing clear roles and expectations is a requirement for effective collaborative governance. Owing to the complexity of these arrangements (particularly where there are many partners involved), this has the potential to be significantly more time- and labour-intensive than standard governance arrangements. It is therefore crucial to be strategic about the partnerships formed and invited into governance roles. Both the planned time and cost of interventions need to account for the delivery of this administrative role.

Leading knowledge translation

In keeping with a broader role of influencing change, PHNs should also consider their role to be one of developing and sharing knowledge about suicide prevention. Knowledge translation is important to secure a feedback loop to inform suicide prevention program delivery in Australia – ensuring evidence is not only generated, but utilised to improve the effectiveness, efficiency and appropriateness of systems-based approaches to suicide prevention.

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[19] Newell S, Redman A, Shawyer F, Johnson B, Bandara P, Rose S. (2021). Place-Based Suicide Prevention Trials: Summative Evaluation Report. Sydney: Sax Institute. (p. 5).

[20] Newell S, Redman A, Shawyer F, Johnson B, Bandara P, Rose S. (2021). Place-Based Suicide Prevention Trials: Summative Evaluation Report. Sydney: Sax Institute. (p. 51).

[21] Smart, J. (2017). Collective impact: Evidence and implications for practice. CFCA Paper No. 45. Australian Institute of Family Studies. Retrieved from: Collective impact in Australia (aifs.gov.au).

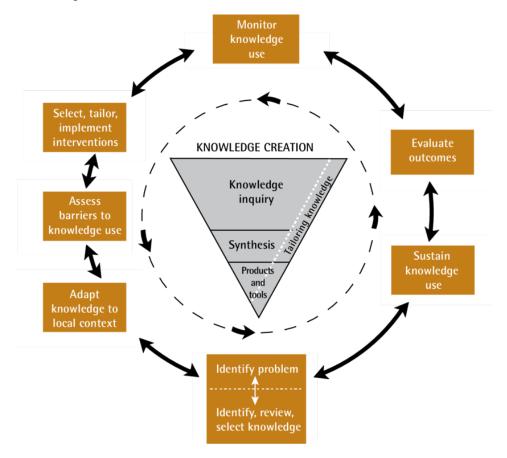[22] Calida, B.Y., Jaradat, R.M., Abutabenjeh, S. and Keating, C.B. (2016) 'Governance in systems of systems: a systems-based model', Int. J. System of Systems Engineering, Vol. 7, No. 4, pp. 235–257.

[23] National Action Alliance for Suicide Prevention. National Strategy for Suicide Prevention: Goals and Objectives. Retrieved from: https://theactionalliance.org/our-strategy/national-strateg/2012-national-strategy.

The Knowledge to Action (KTA) Framework provides a "practical yet flexible guide to getting research findings into practice."[24] Key components of the framework are Knowledge Creation feeding into an Action Cycle, as presented below.[25] One advantage of the KTA framework is that its real-world use can be adapted to a range of health settings and systems while maintaining theory fidelity.[26]

Figure 1: The Knowledge to Action Framework (Source: Graham et al., 2006)
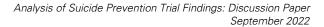

The role PHNs hold as incubators of knowledge means they also hold a responsibility for translating that knowledge into broader learnings. Knowledge generated and shared through trials or other suicide prevention interventions can enable not only more effective interventions within the same community or region in future, but may be shared cross-regionally, leading to improvements in suicide prevention approaches across jurisdictions. For this to yield value, context-specific factors connected to key program activities or indicators should be identified, even if the systems-based approach makes attribution to final outcomes challenging. Regions or organisations seeking to learn from suicide prevention trials should be able to understand what relationships were formed and how, what activities were carried out, how community and lived experience voices were embedded in the process, and how program activities influenced program outcomes (if attribution is possible).

Knowledge translation can occur in structured and unstructured ways through a variety of forums, but it is important to ensure structures to facilitate knowledge translation are in place to ensure

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[24] Field, B., Booth, A. Ilott, I. and Gerrish, K. (2014). Using the Knowledge to Action Framework in practice: a citation analysis and systematic review. Implementation Science, 9(172). https://doi.org/10.1186/s13012-014-0172-2.
[25] Graham I, Logan J, Harrison M, Strauss S, Tetroe J, Caswell W, Robinson N: Lost in knowledge translation: time for a map? The Journal of Continuing Education in the Health Professions 2006, 26, p. 19.
[26] Field, B., Booth, A. Ilott, I. and Gerrish, K. (2014). Using the Knowledge to Action Framework in practice: a citation analysis and systematic review. Implementation Science, 9(172). https://doi.org/10.1186/s13012-014-0172-2.

knowledge is utilised to its full advantage. PHNs may consider the following types of structured knowledge translation:

- Establishing Communities of Practice for the suicide prevention workforce, in particular for peer workers involved in program design, implementation or delivery

- Developing oversight tools, such as data visualisation dashboards (as developed for use in some Lifespan trials by PHNs and Local Health Districts)

To support the role of knowledge transfer, it is also essential to have PHN leadership in ensuring monitoring and evaluation is embedded from the trial design stage. Incorporating broader knowledge creation and knowledge sharing into the objectives of suicide prevention trials. Securing a PHN role in implementing in this will help to safeguard against monitoring and evaluation being overlooked as a crucial part of trial design.

3.3   Co-designing with communities builds local ownership

Community engagement is central to the delivery of systems-based approaches to suicide prevention and other health interventions. As summarised by Black Dog Institute:

> *"Local approaches to the issue of suicide should start and end with robust community engagement strategies. In short, services reflecting local cultural practices should be demanded by, embraced by, owned by, and driven by local communities."[27]*

It is important to have clarity about the intended purpose of community engagement in any health intervention which seeks to impact broader health outcomes in the community, but particularly for systems-based suicide prevention trials in which engagement with community partners is central to their activities and theory of change. However, community engagement can be inconsistently defined between programs and across literature. A robustness assessment performed against available literature highlighted a lack of detail in the evidence base around how community members participated in suicide prevention interventions. Furthermore, although all three suicide prevention trials utilised co-design approaches, they lacked a shared definition or methodology of co-design. This points to a need for an overarching implementation framework that establishes core activities and indicators for the implementation of co-design approaches.

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[27] Black Dog Institute. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring. Document for Primary Health Networks. Commonwealth of Australia. Retrieved from http://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0/

Priority area: Developments in co-design and co-delivery

The National Mental Health Commission Lived Experience (Peer) Workforce Development Guidelines that co-designed and co-produced services should be an increasing priority for funding and commissioning of mental health services. This is itself supported by embedding Lived Experience (Peer) workforce at all stages of the workforce pathway, from professional development (co-design of training and opportunities) to research and knowledge generation. The Guidelines suggest that effective uplift of Lived Experience (peer) roles includes improved role clarity, access to support and supervision opportunities, and opportunities to mentor other organisations.[28]

Not-for-profit organisation Roses in the Ocean has developed a suite of resources on Lived Experience of Suicide Informed and Inclusive Culture Change, developed to guide service providers, government and organisations to partner with people with lived experience of suicide. The resources include Lived Experience of Suicide Engagement (LESEP) Principles, Lived Experience of Suicide Engagement and Integration (LESEPI) Framework and Implementation Toolkit, Decision and Evaluation Tools.[29]

As an accompaniment to these, the organisation has also made available a Planning Guide for Co-designing with people with Lived Experience of suicide. The Guide emphasises an iterative, phased approach to co-design informed by the Experience-Based Co-Design (EBCD) method, in which lived experience is incorporated at every stage of the process. The Guide also identifies and navigates power imbalances, communicates clear expectations, and facilitates open and supported environments for sharing experiences and decision-making.[30] This guidance represents a significant step forward in the knowledge base around incorporating lived experience effectively into suicide prevention activities, and should be considered to inform future trials. Preceded by the Royal Commission into Victoria's Mental Health System recommendations, a new Victorian Suicide Prevention and Response Strategy is currently under development. The strategy seeks to deliver a systems-based approach to suicide prevention, based on the LifeSpan model. The Commission mandated that the strategy be developed in partnership (co-produced) with people with lived experience of suicide, and take an intersectional approach to inclusion of priority groups. This has led to a multi-layered engagement approach including a public submission process, co-design workshops and interviews with diverse communities, and self-determined suicide prevention approaches by Aboriginal communities and community-controlled organisations.[31]

Guiding principles of community co-design

Meta-analysis by De Weger et al (2018) led to development of a set of eight guiding principles for community engagement, across a range of community interventions (including mental health).[32] These are presented below, with additional information about the Principles available in **Appendix E.2.** A social equity perspective is central to these guiding principles, and the need to acknowledge (and where possible address) these prior to and during program implementation. In other words, the ideal program implementation will "assess and ideally address implementation and

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[28] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

[29] Roses in the Ocean. (2022). Lived experience of suicide informed and inclusive culture change suite of resources. Available from: https://rosesintheocean.com.au/lived-experience-of-suicide-informed-and-inclusive-culture-change-launch/.

[30] Roses in the Ocean. (2022). Co-designing with people with a lived experience of suicide: Planning Guide. Available from: https://rosesintheocean.com.au/wp-content/uploads/2022/03/6.-Co-designing-with-people-with-Lived-Experience-Planning-Guide-v1.0-FEB-2022.pdf

[31] Victorian Government. (2022). Discussion paper for the Victorian suicide prevention and response strategy. Available from: https://engage.vic.gov.au/download/document/27752.

[32] De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.

equity barriers simultaneously".[33] Social inequities are themselves associated with risk of suicide, with evidence suggesting suicide rates in Australia have increased in areas of low socioeconomic status and declined in areas of high socioeconomic status.[34] [35]

The Guiding Principles for Community Engagement (de Weger et al, 2018):

1. Ensure staff provide **supportive and facilitative leadership** to citizens based on transparency

2. Foster a **safe and trusting environment** enabling citizens to provide input

3. Ensure citizens' **early involvement**

4. **Share decision-making and governance control** with citizens

5. Acknowledge and address citizens' **experience of power imbalances** between citizens and professionals

6. **Invest in citizens** who feel they lack the skills and confidence to engage

7. Create **quick and tangible wins**

8. Take into account both **citizens' and organisations' motivations**

To most effectively embed these guiding principles into systems-based suicide prevention interventions, future systems-based suicide prevention initiatives should take the following steps:

1. **Assess the guidelines against the current state** of stakeholder relationships and community connections at the beginning of the planning phase. This should inform required activities to engage community effectively, which should begin as early as possible in the implementation of the program.
2. Build these principles into ongoing monitoring and evaluation by **including them as outcome measures**, consistent with a principles-focused approach to evaluation.

Through a combination of the above factors, a successful systems-based suicide prevention program should be to an extent self-sustaining – community members take the intervention forward to promote good health and wellbeing in themselves and others in their community (the creation of a 'virtuous cycle'). To do this, interventions need to establish trust in order to foster community support and buy-in. However, it is not a reasonable expectation that self-sustainability (particularly in marginalised communities) will develop in the presence of severely fragmented services and lack of funding – seeking to foster self-sustainability in these circumstances is likely to aggravate relationships.[36] This resembles the creation of a 'vicious cycle', characterised by a history where community collaboration was poor or non-existent, and trust has not been developed among the community.[37]

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[33] Woodward, E.N., Singh, R.S., Ndevele-Ngwenya, P., Castillo, A.M., Dickson, K.S. and Kirchner, J.K. (2021). A more practical guide to incorporating health equity domains in implementation determinant frameworks. Implementation Science Communications, 2021 2:61. https://doi.org/10.1186/s43058-021-00146-5.

[34] Hochhauser, S., Rao, S., England-Kennedy, E. et al. (2020). Why social justice matters: a context for suicide prevention efforts. Int J Equity Health, 19(76). https://doi.org/10.1186/s12939-020-01173-9

[35] Shand, F., Yip, D., Tye, M. and Darwin, L. (2020). What can be done to decrease suicidal behaviour in Australia? A call to action. "Chapter 2: The impact of social determinants on suicide and how policy settings can help". Retrieved from What-Can-Be-Done-To-Decrease-Suicide_Chapter-2-Social-Determinants.pdf (blackdoginstitute.org.au)

[36] De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.

[37] Brunton, G., Thomas, J., O'Mara-Eves, A. *et al*. Narratives of community engagement: a systematic review-derived conceptual framework for public health interventions. *BMC Public Health* 17, 944 (2017). https://doi.org/10.1186/s12889-017-4958-4.

Navigating contextual factors among priority groups

A recent meta-analysis has found that community engagement is variously used for utilitarian, social justice, or hybrid purposes in public health interventions. A key differentiating factor of social justice-inclined interventions is that power imbalances between the community and institutions (including, potentially, the institutions funding or delivering the program) are both acknowledged or addressed. Drawing from both utilitarian and social justice perspectives of community engagement, interventions which employ a hybrid approach have the following core elements:[38]

- Community engagement addresses utilitarian health issues and social inequities concurrently

- Changes to health outcomes are sought through changes to intermediate social outcomes (i.e. improved social and material conditions)

- There is co-production of outcomes, with some power being delegated to the community in the design and delivery of programs.

Social justice and hybrid models extend beyond provision of information (the least substantive form of community engagement) to delegate more decision-making power to community members, in terms of the model design, implementation and delivery. This is a way of breaking down power imbalances and granting ownership of not only the program, but also its solutions, to communities. The Public Participation spectrum should be considered as part of initial planning for more substantive community engagement, where forms of engagement which collaborate with or empower communities are more impactful than engagement which simply informs the public or uses community members in consultative roles (see **Figure 2: IAP2 Public Participation Spectrum**).[39]

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[38] Brunton, G., Thomas, J., O'Mara-Eves, A. *et al.* Narratives of community engagement: a systematic review-derived conceptual framework for public health interventions. *BMC Public Health* 17, 944 (2017). https://doi.org/10.1186/s12889-017-4958-4.

[39] International Association for Public Participation. (2014). IAP2's public participation spectrum. Retrieved from IAP2_Public_Participation_Spectrum.pdf.

Figure 2: IAP2 Public Participation Spectrum (adapted from Patton 2006)

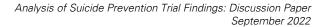|	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Increasing impact on the decision					
Goal	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solutions.	To place final decision making in the hands of the public.
Promise to the public	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influences the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influences the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Some power imbalances are inherent to suicide prevention trials given the presence of a commissioning body and the organisations funded to design and implement initiatives. Commissioning and governing bodies should acknowledge these power imbalances, but strive not to reproduce them uncritically. Coordinating organisations can, for example, ensure the scientific lens is not wholly privileged over the lens of lived experience or community perspectives, especially where those perspectives relate to priority groups (such as Aboriginal and Torres Strait Islander people).

> *"The literature suggests that 'meaningful participation' of citizens can only be achieved if organisational processes are adapted to ensure they are inclusive, accessible and supportive of citizens, for example by placing citizens in decision-making and leadership positions and providing relevant learning opportunities."[40]*

Although community engagement is commonly acknowledged as an important aspect for delivering health programs, in practice it not always well implemented. A review of the literature indicated how a 'business as usual' approach, seeking to engage community while maintaining traditional (unequal) organisational structures, resulted in failure to establish positive and constructive relationships or to empower community members.[41] On the other hand, an approach which puts open-ended decisions entirely on the community has its risks, namely of overestimating community members' level of knowledge about relevant community issues or understanding how to operationalise interventions. One strategy to prevent these risks may be to start with a smaller set of core intervention options, rather than taking a broad range of options into community engagement processes. This strategy was utilised in the AAD model, as well as other models including Optimizing Suicide Prevention Programs and Their Implementation (OSPI). Communities being able to name their own priorities has been

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[40] De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.
[41] De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.

observed in practice to shape the approach taken to suicide prevention. In the Tasmanian sites of the NSPT trial, community engagement found that awareness raising and capacity-building activities focused on the wider community were preferred to activities targeting specific populations.[42]

Many of the above guiding principles rely on acknowledging and unpacking contextual factors, in particular barriers to equity in the community. There are several key conditions identified in the literature which are relevant to suicide prevention trials:[43]

- Time taken to understand community motivations – and therefore developing an understanding of how community may be mobilised in creating a self-sustaining intervention.

- The economic climate, with unstable economic climate frequently causing communities' interest in the program participation to fluctuate

- The level of certainty over future funding for the program (or mainstreaming of the program), and whether the program is forced to compete for resources and visibility with other programs.

Ensuring diversity in community members engaged will support these aims, and move away from a community engagement which frames community perspectives as being homogenous. There is a need for more evaluation evidence for interventions targeting the following vulnerable cohorts, among priority cohorts targeted by existing suicide prevention activities across the country: [44]

- LGBTIQ+ people

- older Australians

- people with disability

- Aboriginal and Torres Strait Islander people (see below)

Engagement with Aboriginal and Torres Strait Islander communities

It is important to consider community engagement in the context of Aboriginal and Torres Strait Islander communities, who are at greater risk of suicide than the general population.[45] Aboriginal and Torres Strait Islander communities are also impacted by power imbalances and social inequities, making the Guiding Principles for Community Engagement useful in planning engagement approaches. Education approaches have been shown to be effective ways of empowering Indigenous communities to understand and respond to social issues, consistent with the Guiding Principles' priorities of empowering and investing in the capabilities of community.[46] In practice, effective co-design with Aboriginal and Torres Strait Islander communities should involve the engagement of Elders and other leaders throughout the design and delivery stages of the intervention, and where necessary providing capability uplift to community members to act in a peer support capacity.

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[42] Smith, L., Purton, T., Auckland, S., Iees, D., Mond, J. (2020). Local evaluation of the Tasmanian component of the National Suicide Prevention Trial—Preliminary learnings. The Australian Journal of Rural Health, 28(2), 218-223. https://doi.org/10.1111/ajr.12620.

[43] Brunton, G., Thomas, J., O'Mara-Eves, A. *et al.* Narratives of community engagement: a systematic review-derived conceptual framework for public health interventions. *BMC Public Health* 17, 944 (2017). https://doi.org/10.1186/s12889-017-4958-4.

[44] De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.

[45] Australian Institute of Health and Welfare. Suicide & self-harm monitoring: Deaths by suicide amongst Indigenous Australians. Retrieved from https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians.

[46] Dudgeon, P., Milroy, J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G. & Holland, C. (2016). Solutions that work: What the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. ATSISPEP: Crawley.

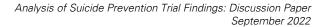**Priority area: Aboriginal and Torres Strait Islander suicide prevention**

In the Commonwealth Closing the Gap Implementation Plan, **Outcome 14: Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing** is underpinned by **Target 14**, which commits jurisdictions to 'significant and sustained' suicide reduction among Aboriginal and Torres Strait Islander people. The target acknowledges Aboriginal and Torres Strait Islander people's right to be socially and emotionally well, and supported by appropriate high-quality services. These commitments are to be furthered through ongoing partnerships and engagement with Aboriginal and Torres Strait Islander leaders, Elders and communities.[47]

Areas for government investment to support this target are outlined in the Commonwealth Government Implementation Plan, including the following key actions.[48] Accompanying the Commonwealth Implementation Plan are state and territory-specific Implementation Plans, which outline the roles and responsibilities of specific jurisdictions in supporting this overarching outcome.

- Co-design of a community-led National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS) and its Implementation Plan, in partnership with Gayaa Dhuwi

- Co-development of a National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing

- Maintenance of National Suicide Prevention Trial sites, including two Aboriginal and Torres Strait Islander-specific sites

- National survey to measure the prevalence of mental ill-health in the Aboriginal and Torres Strait Islander population

- Mental health scholarships, training and support for Aboriginal and Torres Strait Islander people in the mental health workforce

- Financial and wellbeing redress scheme for living Stolen Generations survivors, supporting intergenerational and community healing.

The four priority reforms contained in the National Agreement on Closing the Gap also have relevance for current and future systems-based suicide prevention activities:[49]

- **Formal Partnership and Shared Decision Making** - the partnership will 'establish a joined up approach between governments and Aboriginal and Torres Strait Islander representatives' in five areas including social and emotional wellbeing (mental health). Among implementation commitments for 2022 include a review of partnership arrangements in place of all jurisdictions; future suicide prevention activities should leverage the results of these efforts.

- **Building the Community-Controlled Sector** – sector strengthening is identified as a priority in areas of health, housing, disability, and early childhood care, all of which may have linkages into systems-based suicide prevention trial activities. Opportunities to leverage the expertise of this growing workforce should be undertaken as co-design processes.

- **Transforming Government Organisations** – governments commit to transform their engagement processes, agencies and institutions to become culturally safe. As part of this, governments must engage with community and respond to their concerns. This may result in broader capacity building in culturally safe engagement, which may have flow-on benefits to governments' approach to future suicide prevention activities which engage with community.

- **Shared Access to Data and Information at a Regional Level** – this priority reform aims to improve communities' access to, and capability in collecting and using, data relating to Closing the Gap requirements. Establishing this capacity will be sought through partnerships between communities and government agencies to improve the management and use of data. This may have implications for the readiness of communities to engage in monitoring and evaluation processes more broadly.

An example of effective community co-design during the NSPT trials was in the design and delivery of Australia's first Aboriginal aftercare service, developed over eight months via an Aboriginal Working Group which featured community members, people with lived experience of suicide, and representatives from the Aboriginal Community-Controlled Health Service and Local Health Network. The aftercare service embedded social and emotional wellbeing and traditional healing into the model of care was successful in preventing repeat admissions to the emergency department for people referred into the service. Importantly, the co-design process was also observed to improve collaboration between clinical and cultural workers, with implications for the strength of these ongoing relationships.[50]

Across the trials, interventions targeting Aboriginal and Torres Strait Islander people were observed to have the most significant barriers, indicating this is an area for further improvement. Consideration of prior community tensions or conflicts between key stakeholders, resourcing constraints, and culturally safe meeting points all need to inform community-specific responses. Across both the literature and the trial evaluations, there have also been noted limitations in the appropriateness of some individual-focused suicide prevention initiatives (including the LifeSpan and AAD models) for Aboriginal and Torres Strait Islander communities. This highlights the need to give communities the knowledge, opportunities and time to provide their insights about how suicide prevention approaches may be best adapted to suit local contexts. Adaptations to the model design need to be accompanied with consideration of how to adapt the trial and evaluation design (discussed further in Section 4).

Government plays an important role in co-design

Although co-design of suicide prevention interventions is ultimately in the hands of PHNs or other coordinating organisations, governments commissioning trials also play a role in terms of setting expectations and establishing prerequisites for funding (e.g. lived experience and community engagement). The Government's role should be considered as one of steward in ensuring community is properly included in the delivery of suicide prevention.

Governments involved in commissioning trials could include use of the Guiding Principles referred to above as program specifications, by requiring that PHNs or other commissioning bodies:

- **Assess the guidelines against the current state** as early as possible in the implementation of the program.

- **Include outcome measures** relevant to each of the Guiding Principles in order to build these principles into ongoing monitoring and evaluation.

For instance, funding could be made contingent on the commissioned organisation's ability to demonstrate a substantive approach to community engagement throughout all stages of the intervention, from design and implementation through to evaluation.

Additionally, governments may play a role in creating an authorising environment for initiatives requiring broader public sector support, which may be identified through co-design processes as key settings for suicide prevention activities. For example, in the LifeSpan trials, a key enabler of school-based suicide prevention program was the support of state education departments. Where this authorisation was lacking, sites needed to engage with schools individually, leading to a more challenging rollout. Commonwealth, state and territory, and local governments may all need to be involved depending on which initiatives are selected for inclusion in trials.

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[47] Australian Government. (2021). Commonwealth Closing the Gap Implementation Plan. Available from: https://www.niaa.gov.au/sites/default/files/publications/commonwealth-implementation-plan-130821.pdf

[48] Ibid.

[49] National Agreement on Closing the Gap. (2021). Priority reforms. Retrieved from https://www.closingthegap.gov.au/national-agreement/priority-reforms.

[50] Currier, D., King, K., Oostermeijer, S., Hall, T., Cox, A., Page, A., Atkinson, J., Harris, M., Burgess, P., Bassilios, B., Carter, G., Erlangsen, A., Gunn, J., Kõlves, K., Krysinska, K., Phelps, A., Robinson, J., Spittal, M., & Pirkis, J. (2020) *National Suicide Prevention Trial: Final evaluation report. Part One: Overview.* University of Melbourne. Supplied to KPMG. (p. 33)

Governments (in particular Commonwealth, state and territory) also play a background role in supporting the structural conditions that create good mental health and wellbeing. Many of the drivers of social inequity and poor mental health and wellbeing lie outside of the remit of individual PHNs. Suicide prevention activities are likely to fail in the absence of key protective factors, and demonstrable government efforts to address related social issues are especially important so as not to undermine community engagement in the case of co-designed systems-based interventions. Government policies and programs that support effective suicide prevention include:[51]

- Policies to increase affordable housing and reduce housing insecurity

- Policies that address poverty, disadvantage, unemployment and underemployment

- Access to appropriate services and supports for people who have disabilities

- Access to appropriate services and supports for people who are Aboriginal and Torres Strait Islander, culturally and linguistically diverse, and/or LGBTIQ+ (with consideration of experiences at the intersections of these groups or communities).

- Efforts to reduce structural stigma and discrimination towards people with lived experience of mental ill-health and suicide.

3.4 Lived experience must be embedded in suicide prevention

Incorporating lived experience into suicide prevention initiatives is acknowledged as critical to the design and delivery of effective integrated multi-level suicide prevention programs.[52] [53] However, there is a need to further interrogate the quality and substantiveness of lived experience involvement to inform how future trials or programs are designed and implemented. A robustness assessment performed against available literature indicates there is an evidence gap around the role played by people with lived experience in suicide prevention interventions.

Lived experience should not be taken at face value in considering the value it adds to a suicide prevention trial or program – it may be tokenistic and low-value if there has not been careful consideration of involving lived experience representatives with diverse perspectives throughout the entire process of designing, implementing, delivering and evaluating suicide prevention programs.

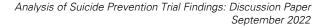## The existing Lived Experience (Peer) workforce should be leveraged

The value of the peer workforce has increasingly been demonstrated across the mental health system. These are positions in the workforce (paid or volunteer) where an individual's work is directly informed by their lived experience of mental ill-health and/or suicide, or of being a carer or support person to someone with personal lived experience. Future directions for the mental health system will continue to prioritise the expansion of Lived Experience (Peer) workforce, and Lived Experience (Peer) roles may already be embedded within some organisations involved in the delivery of suicide prevention programs. Where possible, suicide prevention initiatives should seek to leverage this expertise by involving Lived Experience (Peer) workers in the design, implementation and evaluation of suicide prevention trials.

However, it should be noted that not all Lived Experience (Peer) workers with lived experience of mental illness or mental ill-health will have lived experience of suicide. Suicide prevention activities

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[51] The Royal Commission into Victoria's Mental Health System. (2020). Final Report, Volume 1-3.

[52] Black Dog Institute. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring. Document for Primary Health Networks. Commonwealth of Australia. Retrieved from http://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0/

[53] Refels, L, Krishnamoothry, K., Kolves, K., Francis, J. (2022). Implementation Science in Suicide Prevention. Crisis, 43(1), 1–7. https://doi.org/10.1027/0227-5910/a000846.

should involve participation of people with lived experience of suicide (including personal lived experience of attempted suicide or lived experience having supported someone who attempted or died by suicide). A range of lived experience needs to be reflected at different phases of the program, representative of people with direct lived experience of a suicide attempt, people bereaved by suicide, and carers. This is an important consideration because of the importance of peer-matching to lived experience peer support in suicide prevention activities. As explained by Roses in the Ocean:

> *"The success of peer work across various suicide contexts relies on matching the nature of lived experience. For example . . . people who have experienced their own suicidal thoughts and/or made an attempt on their life are best placed to support others going through similar experiences; people bereaved through suicide are best placed to support people recently bereaved themselves; carers of people in suicidal crisis are best placed to provide insight and support to other carers."[54]*

Enablers of successful lived experience roles

The National Lived Experience (Peer) Workforce Development Guidelines set out guidance on embedding lived experience roles in the mental health workforce. While not specifically pertaining to systems-based suicide prevention trials, valuable insights can be adapted to the context of current and future systems-based trials. The Guidelines set out the following Priorities:[55]

1. Develop **shared understanding** of lived experience work among delivery partners and other key stakeholders
2. Support a **thriving lived experience workforce** through provision of appropriate supports and professional development opportunities for individuals in lived experience roles
3. Plan for lived experience representation to **diversify and grow,** by encouraging the participation of diverse candidates in the trials in a lived experience capacity
4. Integrate lived experience in **community settings**
5. Supporting **professionalisation** of the lived experience workforce and their ongoing role and expertise.

The above priorities illustrate that embedding lived experience perspectives into systems-based suicide prevention interventions is a multi-dimensional pursuit. PHNs or other coordinating bodies have an opportunity to drive the prominence and availability of Lived Experience (Peer) roles at several levels: recruiting individuals with lived experiences to participate in intervention design, delivery and evaluation; at an organisational level by embedding continuing Lived Experience (Peer) roles within their own staff or among delivery partners, and at broader community and systems levels.

The Guidelines indicate that Lived Experience (Peer) workers are best supported by a combination of formal support and mentorship, and opportunities to engage with and learn from their own peers. In a suicide prevention space, it is vitally important that Lived Experience (Peer) representatives are offered appropriate acknowledgement of the value of their insights and decision to share their story, and have access to practical and emotional forms of support. Importantly, these support systems must be multi-dimensional, embedded and authorised at all levels – individual, organisations, community and system. Research indicates that lived experience work in the suicide prevention space can take an emotional toll and that the system has not always prioritised necessary ongoing care. Support should be offered through formalised channels where appropriate, such as through a

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[54] Roses in the Ocean. Suicide prevention peer workforce development services. Retrieved from https://rosesintheocean.com.au/sp-peer-workforce/.

[55] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

combination of formal debriefing (particularly after engaging in activities where personal stories have been shared), access to counselling, and peer-led Communities of Practice.[56]

Professional development, which is a key enabler for lived experience roles, has been noted as a critical gap across the suicide prevention trials and the wider lived experience workforce. The PBSPT evaluation reports that although lived experience advocates were involved in the delivery of the trials, "the role, safety and contribution of lived experience advocates could be considerably enhanced by increased professionalisation of their role, with a further focus on workforce development". Professional development should be an ongoing consideration for future systems-based suicide prevention interventions, and can be embedded as part of trial outcomes. Investing in the professionalisation of the lived experience workforce can be considered an investment in the longer-term appropriateness of service delivery within the broader community, consistent with the National Lived Experience (Peer) Workforce Development Guidelines. [57] This is especially appropriate in settings where there further opportunities exist for ongoing lived experience roles to continue beyond the trials, for example within PHNs or key partner organisations.

Engaging diverse lived experience representatives

As with the community engagement challenges described earlier in this paper, engaging diverse lived experience voices entails a need to acknowledge and address power imbalances between lived experience representatives (citizens and service users) and the organisations or institutions involved in commissioning and implementing the intervention. The National Mental Health Commission notes that there is a need to diversify lived experience representation, which has the dual benefits of increasing the ability of suicide prevention initiatives to understand and respond to the needs of diverse communities, and preventing overreliance on a small number of already-engaged individuals. [58] Increasing the prominence of the peer workforce system-wide, although out of the direct remit of individual trial operators, is also important to support broader involvement of community members with lived experience in suicide prevention and other health programs.

However, across the suicide prevention trials, barriers were observed to attracting and engaging more diverse lived experience voices. Outside of designated peer workforce roles, it can be difficult to engage people with lived experience in the community, where there may be little awareness or understanding of lived experience roles in health promotion. This challenge is heightened for engaging lived experience voices from diverse communities and priority populations. In an attempt to overcome these barriers, trial coordinators should look to a combination of established peak bodies and adjacent community settings as sites for recruitment. It may be useful to target non-clinical sites, such as sports clubs, men's sheds, community groups, religious centres, or other sites specific to the community, drawing on previously established relationships wherever possible. Geotargeted social media advertising is another way of reaching wider audiences, including those who do not engage with many community services.

Recruiting lived experience representatives to suicide prevention trials should utilise clear position descriptions, following guidelines recently published by the National Mental Health Commission.[59]

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[56] Wayland, S., Maple, M., McKay, K. (2020). How is Participating in Suicide Prevention Activities Experienced by Those with Lived and Living Experiences of Suicide in Australia? A Qualitative Study. International Journal of Environmental Research and Public Health. 2020(17), 4635. doi:10.3390/ijerph17134635.

[57] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

[58] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

[59] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission. Available from: https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines.

Embedding lived experience into co-design

Engaging lived experience perspectives in suicide prevention activities should consider embedding a substantive role for people with lived experience in the co-design of initiatives. While lived experience representatives are involved in the delivery of many mental health and suicide prevention initiatives, this does not necessarily constitute meaningful involvement.

Co-design is an important means through which lived experience can be incorporated into health interventions. Accordingly, previous studies have indicated stakeholders are more likely to be involved in pre-implementation phases of programs (including co-design) than in implementation or evaluation stages. However, a recent systematic review of suicide prevention initiatives indicates that lived experience representatives remain on the fringes of interventions featuring multisectoral collaboration, in predominantly informant or reviewer roles. Consultant or advisory roles are not universally considered substantive co-design, and limiting involvement to these types of roles may limit the genuine empowerment of lived experience representatives and their impact on outcomes (see **Figure 2: IAP2 Public Participation Spectrum**).[60] The benefits of lived experience involvement in co-design can only be realised if the process involves end-users equitably, which is dependent on the type of approach used and the amount of power held by community and lived experience representatives.[61]

No official overarching framework exists for the co-design of suicide prevention interventions with lived experience representatives. Incorporating lived experience into systems-based initiatives is highly contingent on the specific and complex contextual factors within different communities. The core relationships involved in the delivery of each individual intervention will involve a different system of power differentials, which will affect the approach taken to establishing the relationships and collaborating with lived experience representatives.

To this end, not-for-profit organisation Roses in the Ocean have developed guidance materials and an Implementation Toolkit for integrating lived experience into suicide prevention engagements. The guidance materials are organised around five Principles (Trust & Safety; Respect & Compassion; Collaboration & Power Sharing; Transparency & Accountability; Diversity & Inclusion).[62] The guidance materials also recommend the use of the IAP2 Public Participation Spectrum as a decision-making tool for an appropriate level of engagement with people with lived experience (see **F**igure 2: IAP2 Public Participation Spectrum (adapted from Patton 2006)[63] The full Roses in the Ocean Lived Experience of Suicide Engagement, Participation and Integration (LESEPI) Implementation Toolkit is available online, including a dedicated Planning Guide for co-designing with people with lived experience of suicide.

The National Lived Experience (Peer) Workforce Development Guidelines, themselves developed in collaboration with people with lived experience of mental ill-health, state that meaningful co-production with people with lived experience is foundational to a reformed mental health system: "Co-production requires giving equal status to lived experience knowledge and acknowledging lived expertise in recovery-orientation, being person-directed, and better understanding the experiences

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[60] Pearce, T., Maple, M., Wayland, S., McKay, K., Woodward, A., Brooks, A. and Shakeshaft, A. (2022). A mixed‑methods systematic review of suicide prevention interventions involving multisectoral collaborations. Health Research Policy and Systems 20(40). doi.org/10.1186/s12961-022-00835-0.

[61] Pearce, T., Maple, M., Wayland, S., McKay, K., Woodward, A., Brooks, A. and Shakeshaft, A. (2022). A mixed‑methods systematic review of suicide prevention interventions involving multisectoral collaborations. Health Research Policy and Systems 20(40). doi.org/10.1186/s12961-022-00835-0.

[62] Roses in the Ocean. Lived Experience of Suicide Engagement Principles (LESEP) Guidance Document. Available from: https://rosesintheocean.com.au/wp-content/uploads/2022/03/1.-LESEP-Guidance-Document-V1.1-FEB-2022.pdf.

[63] Roses in the Ocean. Lived Experience of Suicide Engagement, Participation and Integration (LESEPI) Framework: Implementation Toolkit. Available from: https://rosesintheocean.com.au/wp-content/uploads/2022/03/3.-LESEP-Implementation-ToolKit-v1.1-FEB-2022.pdf

and views of people accessing services." [64] The Guidelines define meaningful co-production as having several elements: [65]

- Mutual sharing and respectful partnership between lived experience expertise, coordinators and other key stakeholders, contributing to shared problem solving

- An environment of equity, fairness and impartiality which includes lived experience voices in decision-making and shares power between designated Lived Experience roles and other roles

- Lived experience workers provide input at all stages of development and review

- Lived experience workers have the skills and confidence to contribute fully.

Since lived experience stakeholders are separate from the professional workforce, there is an ongoing need to balance their involvement with that of individuals who are experienced in the design and delivery of evidence-based programs. There is a noted challenge around divergent interests between researchers, service providers, and consumers. [66] Divergence of interests can cause distrust, acting as a barrier to meaningful engagement. Meanwhile, diverging from trial design runs the risk of undermining program fidelity and diluting effectiveness of the trial. Respectful transfer of knowledge between the two is critical, as all key stakeholders work towards shared goals of preventing suicide risks in the community.

3.5 Improving workforce sustainability supports long term outcomes

The suicide prevention trials highlighted challenges with workforce sustainability, with significant flow-on effects on continuity of knowledge and the ability of program activities to be carried out as planned. Therefore, a key learning from the trials is around prioritisation of workforce sustainability, through efforts to improve retention and attract skilled staff to suicide prevention programs.

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[64] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.
[65] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.
[66] Pearce, T., Maple, M., Wayland, S., McKay, K., Woodward, A., Brooks, A. and Shakeshaft, A. (2022). A mixed-methods systematic review of suicide prevention interventions involving multisectoral collaborations. Health Research Policy and Systems 20(40). doi.org/10.1186/s12961-022-00835-0.

Priority area: Workforce

A key priority for the new National Suicide Prevention Office is leading the development of a National Suicide Prevention Workforce Strategy. This will be informed by, and will apply to, all jurisdictions as part of the Office's whole-of-government mandate to reducing suicide rates. The Strategy will stand in addition to the broader workforce strategies identified below, and will be critical in driving cross-government improvement in suicide prevention workforce supply, capability and supports. [67]

A new National Skills Agreement, an update on the previous National Agreement for Skills and Workforce Development (agreed in 2012) is expected to be released in 2022. The most recent Productivity Commission report, based on a review of the NASWD, focused on the VET system as a way of scaling up workforce supply and capability, while improving Governments' ability to meet their policy aspirations. As strategies to enhance lifelong learning pathways, the Productivity Commission recommends prioritising improvements in foundation skills, credit pathways and recognition of prior learning, an expansion of VET Student Loans to Certificate IV courses, trialling of a new financing instrument for mature-age Australians reskilling and upskilling.[68]

The National Medical Workforce Strategy 2021-2031 identifies digital resources as an emerging strategy for clinical supervision and means of reducing professional isolation, and highlights the importance of flexible work practices as supporting workforce wellbeing as well as diversity and equal opportunity. The Strategy notes that Trials are underway for flexible employment models for GPs, and for targeted recruitment and wage equalisation models in remote regions. Additionally, The Strategy identifies that there is active consideration of opportunities to introduce portable benefits between healthcare services, which is expected to better incentivise mobility between roles (and into GP roles in particular).[69]

The Victorian Mental Health and Wellbeing Workforce Strategy 2021-24 echoes many of the above points on workforce supply and capability. To this, it adds a priority action area 'Establishing workforce wellbeing monitoring and supports' in recognition of the significant wellbeing challenges experienced by this workforce, and the need to address working conditions to support, attract and retain the workforce. This has resulted in pay increases and increased leave entitlements for mental health workers, strengthened career pathways and new capability training programs, the introduction of new professional leadership and training roles in some settings, and specific rural and regional incentives (incorporating both financial and non-financial integration supports).[70]
The National Agreement on Closing the Gap also includes the priority reform 'Building the Community-Controlled Sector' with governments committing to sustained capacity building and investment for a dedicated Aboriginal and Torres Strait Islander workforce. [71]

Suicide Prevention Australia's Accreditation program and Standards for Quality Improvement include a number of key tasks in order for eligible suicide prevention programs to meet workforce standards. These include processes to manage team capabilities, training and supervision, and to enable team members' self-care and wellbeing.[72]

[67] National Mental Health Commission. (2022). About the National Suicide Prevention Office. Available from: https://www.mentalhealthcommission.gov.au/national-suicide-prevention-office/about-the-national-suicide-prevention-office
[68] Productivity Commission. (2020). National Agreement for Skills and Workforce Development Review. Study Report: Overview. Australian Government.
[69] Department of Health. (2021). National Medical Workforce Strategy 2021-2031. Australian Government.
[70] Department of Health. (2021). Victoria's mental health and wellbeing workforce strategy 2021-2024. Victoria State Government.
[71] National Agreement on Closing the Gap. (2021). Priority reforms. Retrieved from https://www.closingthegap.gov.au/national-agreement/priority-reforms
[72] Suicide Prevention Australia. (2020). Suicide Prevention Standards for Quality Improvement. Available from: https://www.suicidepreventionaust.org/wp-content/uploads/2021/04/Suicide-Prevention-Australia-Standards-for-Quality-Improvement_V5.pdf.

Addressing workforce wellbeing challenges

Staff turnover was described as "dramatic" across Trial sites, pointing to retention issues and a problem of burnout. [73] [74] Throughout the trials, drivers of burnout included the stress provoked by significant community interaction in the role, particularly among Trial Coordinators;[75] lack of role clarity, role complexity, and insecurity of tenure; [76] and a lack of support and momentum leading to the perception of staff being "left to their own devices".[77] Turnover itself was also named as a driver of burnout, as key knowledge, relationships and momentum were lost.[78] Related challenges included limited workforce capacity and the expectation that staff absorb additional work on top of existing jobs. This was particularly notable in the example of lived experience representatives being asked to contribute on a voluntary basis to Trial activities, including peer workers who were expected to complete this work unpaid on top of other commitments.[79]

Increasing professional wellbeing supports to minimise burnout risk is an important consideration and should be factored into trial planning and funding. All of the above-named factors are important to address in future trials – through appropriate support from commissioning bodies, dedicated supports and debriefing for high-stress roles, clear setting of roles and responsibilities, and wherever possible establishing secure, ongoing, fairly compensated positions for service delivery staff and peer workers alike.

The Suicide Prevention Australia Accreditation program notes that self-care is protective of wellbeing, and that suicide prevention team members should be assisted to develop a self-care plan as part of induction and given the opportunity to prioritise self-care where needed.[80] Also relevant are flexible workplace strategies, named in the Lived Experience (Peer) Workforce Development Guidelines as a primary strategy to support whole-of-workforce wellbeing:[81]

> *Flexibility is beneficial for all staff members. When organisations address flexibility on behalf of Lived Experience workers, this often has a flow-on effect to the whole workforce. Workplace flexibility enables employees to deal with unforeseen and changing circumstances. Organisations implementing workplace flexibility are likely to increase employee productivity, increase loyalty, and a higher quality of work/life balance for employees.*

Further to the above, mental health professionals are more susceptible to moral distress, which arises when health professionals struggle to fulfil their moral obligations to service users. Although moral distress was not specifically named in the trial evaluation reports as a cause of staff turnover, it is known that moral distress contributes to job dissatisfaction, burnout, turnover and early retirement,

[73] Newell S, Shawyer F, Redman A, Johnson B. (2020). Place-Based Suicide Prevention Trials: Formative Phase Evaluation Report. Sydney: Sax Institute.

[74] University of Melbourne. (2020). National Suicide Prevention Trial. Interim Evaluation Report: Planning and implementation. Australian Government.

[75] Ibid.

[76] Ibid.

[77] Newell S, Shawyer F, Redman A, Johnson B. (2020). Place-Based Suicide Prevention Trials: Formative Phase Evaluation Report. Sydney: Sax Institute.

[78] University of Melbourne. (2020). National Suicide Prevention Trial. Interim Evaluation Report: Planning and implementation. Australian Government.

[79] Currier, D., King, K., Oostermeijer, S., Hall, T., Cox, A., Page, A., Atkinson, J., Harris, M., Burgess, P., Bassilios, B., Carter, G., Erlangsen, A., Gunn, J., Kõlves, K., Krysinska, K., Phelps, A., Robinson, J., Spittal, M., & Pirkis, J. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.

[80] Suicide Prevention Australia. (2020). Suicide Prevention Standards for Quality Improvement. Available from: https://www.suicidepreventionaust.org/wp-content/uploads/2021/04/Suicide-Prevention-Australia-Standards-for-Quality-Improvement_V5.pdf.

[81] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

and has been noted to be heightened during the COVID-19 pandemic.[82] [83] The causes of moral distress are systemic and interdisciplinary in nature, making systems-based suicide prevention trials uniquely well-suited to collaboratively identify and tackle the root causes. To take a proactive approach to reducing the risk of moral distress, suicide prevention coordinating bodies and delivery partners should consult with key stakeholders on barriers and enablers, and establish forums to identify, discuss and plan for action against these factors on an ongoing basis.[84]

Broader literature indicates the existence of associative stigma towards mental health professionals, where they experience stigmatisation because of their relationship to people with lived experience of mental ill-health and suicide. This is important to address because it can lead to workforce wellbeing challenges such as internalised stigma, emotional exhaustion, and reduced job satisfaction.[85] There is some evidence that this presented an issue at some Trial sites; for instance, evaluation reports noted stigma as a possible cause of limited GP involvement, as discouraging community members from attending trial activities, and as a barrier to initial cooperation with community partners.[86] [87] On one hand, exposure to associated stigma is a near-inevitable aspect of suicide prevention delivery given the prevalence and difficulty of addressing stigmatising attitudes among potential partners and communities. It is furthermore not known to what extent this affected recruitment across the Trial sites. However, the development of collaborative, cooperative relationships was noted as effective in breaking down stigma.[88] On a more individual level, where appropriate, service providers sharing their lived experience with participants was also noted to break down stigma.[89]

Engaging Lived Experience (Peer) roles is also identified as a factor for improved staff wellbeing, safety and retention across the organisation, and should be considered complementary to other efforts. Internalised stigma experienced through exposure to external stigmatising attitudes is a particular problem for the peer workforce, who also have a personal lived experience of mental ill-health and/or suicide. To minimise this risk, peer workforce roles should be fully embedded and supported in non-stigmatising ways, as explained in the National Mental Health Commission's Lived Experience (Peer) Workforce Development Guidelines.[90] Since expectations that peer workers work unpaid were associated with burnout and high turnover,[91] it is important that future trials consider fair compensation for the role and expertise of people with lived experience.

Building the employee value proposition

Efforts to improve the employee value proposition for people involved in key delivery roles will support both attraction of skilled staff, and retention of existing staff. Recruitment should seek candidates experienced in project management and/or community organising, which across the Suicide Prevention Trials was indicated as being just as important as experience in suicide prevention.

[82] Hossain, F. and Clatty, A. (2021). Self-care strategies in response to nurses' moral injury during COVID-19 pandemic. Nurs Ethics. 28(1), 23-32. doi:10.1177/0969733020961825.

[83] Shehadeh, J., Almaraira, O., Hamdan-Mansour, A. (2022). Determinants of Moral Distress Among Mental Health Professionals. The Open Nursing Journal, 2022(16). e187443462203030.pdf.

[84] Epstein, E., and Delgado, S. (2010). Understanding and Addressing Moral Distress. The Online Journal of Issues in Nursing, 15(3). https://doi.org/10.3912/OJIN.Vol15No03Man01.

[85] Verhaeghe M, Bracke P. Associative stigma among mental health professionals: implications for professional and service user well-being. J Health Soc Behav. 2012 Mar;53(1):17-32. doi: 10.1177/0022146512439453.

[86] Newell S, Shawyer F, Redman A, Johnson B & Kennedy H. (2019). Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report. Sydney: Sax Institute.

[87] Currier, D. et al. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.

[88] Newell S, Shawyer F, Redman A, Johnson B & Kennedy H. (2019). Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report. Sydney: Sax Institute.

[89] Currier, D. et al. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.

[90] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines. National Mental Health Commission.

[91] Currier, D. et al. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.

Opening the field to represent a range of sector and project management expertise across key roles may help to resolve workforce supply challenges. As indicated above, appropriate rewards and recognition are important factors in not only prevention wellbeing challenges among staff but increasing the value proposition for current and future workforce.

Providing professional development opportunities offers candidates further value and may help to attract more diverse candidates for the role. Alongside suicide prevention skills training offered at many Trial sites, professional development should also target soft skills, such as partnership-building and project management skills. Evaluation reports across the Trial sites indicate that staff wished to receive more specific training on managing complex projects and PHN support for operationalising complex project models,[92] while evaluation findings indicate that staff involvement in upskilling each other was a key enabler of successful engagement.[93]

At some NSPT sites, this was approached by prioritising local knowledge and community connection as a skill and providing training in secondary skills, such as administration and reporting.[94] This suggests that in seeking to attract skilled staff, both formal professional development and on-the-job learning should be emphasised and backed up by efforts to foster teams which actively share knowledge and provide mentorship opportunities to less-experienced staff. This should also be supported by broader communities of practice, which the Trials demonstrated were important in building confidence and professional development opportunities. Access to project management short courses, offered by a number of tertiary institutions across Australia, may be offered as a further incentive to prospective employees. Suicide prevention-specific training (such as Question Persuade Refer and Applied Suicide intervention Skills Training) are likewise important to emphasise as an upskilling opportunity for people with mainly non-suicide prevention project management experience.

It is important that recruiting for a service delivery team account for the fact that no one individual will possess all the skills necessary to deliver the Trials, and that team member skillsets can play complementary roles while providing on-the-job, bottom-up support to each other to result in gradual upskilling.[95] The literature also indicates flexibility in training is another key consideration, for example by tailoring approaches to gatekeeper training depending on the existing capabilities of cohorts between trial sites.[96]

Trial evaluations found that professional development opportunities available through Trial activities were particularly important in rural and regional sites.[97] Challenges in recruiting skilled staff were observed in rural and remote areas, particularly in terms of attaining the right skill mix to deliver the trials, corresponding with broader acknowledged challenges in recruiting regional and rural mental health professionals.[98] Challenges were attributed to the smaller pool of skilled workers, distance from major hubs, and lack of service infrastructure or lack of capacity of existing services to deliver new interventions in these areas.[99] Gaps observed across Trial sites also indicate the need to actively develop a more extensive and skilled peer workforce in regional and rural areas, which can be

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[92] University of Melbourne. (2020). National Suicide Prevention Trial. Interim Evaluation Report: Planning and implementation. Australian Government.

[93] Newell S, Shawyer F, Redman A, Johnson B & Kennedy H. (2019). Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report. Sydney: Sax Institute.
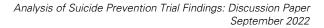
[94] Currier, D. et al. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.

[95] Ibid.

96 Coppens, E., Van Audenhove, C., Iddi, S., Arensman, E., Gottlebe, K., Koburger, N., Coffey, C., Gusmão, R., Quintão, S., Costa, S., Székely, A., & Hegerl, U. (2014). Effectiveness of community facilitator training in improving knowledge, attitudes, and confidence in relation to depression and suicidal behavior: results of the OSPI-Europe intervention in four European countries. Journal of affective disorders, 165, 142–150. https://doi.org/10.1016/j.jad.2014.04.052

[97] Currier, D. et al. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.

[98] University of Melbourne. (2020). National Suicide Prevention Trial. Interim Evaluation Report: Planning and implementation. Australian Government.

[99] Ibid.

incorporated as an objective it itself into future suicide prevention trials.[100] Areas where capacity building was valued by regional and remote staff included operationalising service frameworks and working with stakeholders to tailor model towards focus populations.[101] It was also discovered through the Trials that the type of approach taken by PHNs or commissioning bodies in engaging regional staff was important, with more value placed on collaborative working relationships rather than a contract management-like role; this should be emphasised in seeking to build the employee value proposition.[102]

The Suicide Prevention Australia Accreditation program provides an emerging evidence base around quality suicide prevention services, including effective workforce processes. The program emphasises setting and communication of clear roles and responsibilities to team members as essential to meet capability standards and effectively support workers. For an effective working environment that meets standards, this should be coupled with ongoing education and training appropriate to these roles and responsibilities, and ongoing supervision and support.[103]

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[100] Currier, D. et al. (2020) National Suicide Prevention Trial: Final evaluation report. Part Two: Evaluation Details. University of Melbourne. Supplied to KPMG.
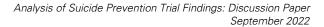
[101] Ibid.

[102] Newell S, Shawyer F, Redman A, Johnson B & Kennedy H. (2019). Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report. Sydney: Sax Institute.

[103] Suicide Prevention Australia. (2020). Suicide Prevention Standards for Quality Improvement. Available from: https://www.suicidepreventionaust.org/wp-content/uploads/2021/04/Suicide-Prevention-Australia-Standards-for-Quality-Improvement_V5.pdf.

4   Implications for trial design, evaluation and monitoring of future systems-based suicide prevention initiatives

The trial evaluation reports have consistently noted challenges in trial and evaluation design in systems-based suicide prevention trials. At a high-level, future systems-based approaches to suicide prevention initiatives require a consistent design methodology and must be locally tailored and community led. Greater emphasis must be placed on the evaluation process and should inform trial design to better understand the effectiveness of systems-based interventions.

Suicide prevention outcome data is difficult to collect and interpret due to various factors. Despite the devastating impact, suicide deaths are a low percentage of total deaths across the population leading to a small sample size. Statistical caution is therefore required when assessing outcomes relating directly to suicide deaths, particularly within small geographical regions and also within short timeframes. There is also a high prevalence of confounding variables and other attribution challenges, and often barriers to including a counterfactual in trial design.

This difficulty is heightened in a systems-based trial environment, where a number of variables interact with each other to produce the intended effect, and their effect on final outcomes is expected to take a significant amount of time to become observable. The complexity and challenges inherent to systems-based suicide prevention trials have resulted in a limited evidence base for the effectiveness of systems-based interventions. Future design of suicide prevention trials should consider ways to reduce these barriers to produce a clearer understanding of the effectiveness of systems-based suicide prevention program components both individually and in synergy.

This section explores ways in which future trial and evaluation design for systems-based suicide prevention programs can respond to challenges observed in the suicide prevention trials. This will focus on the design of the trial itself, including evaluation design as a core element. As illuminated by some experiences across the suicide prevention trials, both trial design and evaluation design need to be considered alongside one another, and designed in complementary ways that are aligned to the program logic and theory of change.

4.1   Use a consistent design that is locally tailored and community-led

Systems-based suicide prevention trials need to strike a balance between a defined program design and methodology, and the specific contextual factors around local systems, services and relationships which will differ from region to region. A key theme emerging from synthesis of the suicide prevention trial evaluations was an inherent barrier to the standardisation of suicide prevention approaches and interventions across the localised regions. This local context helps determine whose input is needed to develop a systems-based approach and how to go about establishing the necessary relationships. However, although PHNs will ultimately need to make implementation decisions, there remains an opportunity to drive consistent approaches at a national level. The Department of Health and Aged Care and/or the National Suicide Prevention Office (NSPO) can play a role in defining the most important questions to be posed to key stakeholders and establish a step-by-step approach to implementing suicide prevention initiatives within a systems-based approach. The National Suicide Prevention Outcomes Framework currently under development by the NSPO, informed by lived experience, will apply nationally down to the program and service-level, and will be instrumental in strengthening a consistent cross-government approach to collecting meaningful outcomes data to measure the effectiveness of suicide prevention initiatives.

Any guidance developed and disseminated at a national level should acknowledge the role of diversity and highlight the key decision points where PHNs will need to account for the specific demographics,

stakeholder relationships or other contextual factors within their local community. For instance, overarching guidance may suggest a diverse range of community representatives that could provide the input needed to inform appropriately tailored interventions, but decisions are ultimately left up to the local PHNs to determine whose input is most valuable.

To engage with community and obtain community input, PHNs need to have the capability to perform outreach into diverse communities. This has both personal and structural dimensions as outreach relies on both the coordination and relationship-building capabilities of key personnel but is also strongly influenced by existing contextual factors around the level of trust, social inequity in the community, and power imbalances between community and institutions. When applying a systems-based approach, PHNs need to establish or continue to build strong relationships beyond the traditional health settings, including linkages with schools, community groups, sporting clubs, and local services and hubs. These can all be used as sites for delivering capacity building and awareness, as well as sites of recruitment for community engagement and lived experience representatives to participate in co-design or other processes (see **Sections 4.3** and **4.4** for more detail).

The benefits of a community-led approach are twofold: the interventions are more tailored to that community's needs; and builds the community buy-in and ownership over the program and its outcomes. Importantly, this sense of ownership and responsibility can assist with data collection activities which may help evaluate interventions and potentially promote further investment from the community. It can also assist with the longevity of interventions as community members are more aware of the outcomes and more willingly to continue their role within the broader system.

It is important to acknowledge the breadth and duration required for adequate community engagement and the inevitable variation across different PHNs. There is a need for commissioning bodies to ensure that the time and resourcing allocated is proportionate to the needs of that community, their existing structures, capacity for coordination (or lack thereof) and the level of existing information (both what is available about the community, and what is accessible by the community). The Department of Health and Aged Care and/or the NSPO can provide guidance on the approach to effective community engagement but must also recognise the variability across regions. There is also a role for PHNs with more established community partnerships to support and guide those PHNs that are still in process of forming these critical relationships.
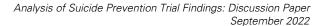
4.2   Facilitate and promote continuous improvement from the outset

Evaluation approaches and methodology selected for suicide prevention trials are important for enabling continuous improvement, an important consideration in any trial. Continuous improvement ensures that learnings generated throughout the program lifespan are captured and used to inform future phases of the program, and more broadly to inform future suicide prevention trials and interventions.

Developmental evaluation embeds continuous improvement into the Evaluation Framework

Developmental evaluation is an adaptive approach to evaluation, which enables continuous reflection and learning as evaluation findings are generated throughout the program lifespan. This approach is increasingly used as a way to embed a feedback loop into programs (both the evaluation and the program itself), facilitating continuous improvement. It is particularly useful for systems approaches which encompass innovative and collective problem-solving and decision-making processes.[104] Rather than attempting to control complexity and uncertainty which is inevitable in systems-based

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[104] Bailie, J., Laycock, A.F., Peiris, D. et al. (2020). Using developmental evaluation to enhance continuous reflection, learning and adaptation of an innovation platform in Australian Indigenous primary healthcare. Health Res Policy Sys 18(45). https://doi.org/10.1186/s12961-020-00562-4.

environments, developmental evaluation approaches assess and respond accordingly to situations of ambiguity through maintaining methodological flexibility.[105] The key aspects of developmental evaluation, contrasted with traditional forms of evaluation, are presented in **Appendix E.1**.[106]

A developmental evaluation approach featuring adaptive learning was recommended for the design of a statewide evaluation framework for the PBSPT trial sites. However, evaluation reporting does not establish clearly that the establishment evaluation was adaptive or developmental in its approach. While trial sites provided quarterly implementation updates that informed the evaluation, it is not apparent that these were used on a continuous basis to drive improvements in the trials themselves.[107] There may be opportunities to improve on this approach to move away from a standard, point-in-time formative evaluation towards more active utilisation of trial learnings.

While the PBSPT evaluation reports do not clarify why a developmental evaluation was planned for the trials, but not ultimately commissioned, it is important to note that commissioning which requires pre-determined and fixed evaluation outcomes may be contradictory to how developmental evaluation is performed. Embedding continuous improvement, such as through a developmental evaluation approach, requires an authorising environment in order for evaluative evidence to inform decision-making processes. Developmental evaluation needs to be supported by requisite levels of authorisation and time to engage in this more complex style of evaluation, as well as funding, in future suicide prevention trial and evaluation design.

Implementation science applies systems thinking to complex environments

While impact evaluation approaches enable rigorous measurement and support attribution of outcomes to a particular program, they require consistent measurement of defined outcomes before and after a clear intervention has occurred. In a highly complex systems environment where program elements work in synergy and evolve over time, there is uncertainty around program participation and exposure to intervention components differs across individuals within the target population. Future approaches to suicide prevention can consider adopting implementation science approaches, which are useful for understanding multi-component interventions in complex systems environments.[108]

Implementation science brings together complexity science and systems thinking, and has increased in prominence in the field of suicide prevention in recent years. Systems thinking and complexity science introduce new ways of conceptualising, carrying out and evaluating the following: [109]

- supporting social problem solving;

- framing interventions and contexts;

- selecting and using methods;

- engaging in valuing;

- producing and justifying knowledge; and

- facilitating use.

Evidence suggests implementation science is an opportunity for policy makers in the field of suicide prevention specifically.[110] Hybrid effectiveness-implementation trial design in particular provide a

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[105] Better Evaluation. Developmental Evaluation. Retrieved from:
https://www.betterevaluation.org/en/plan/approach/developmental_evaluation.
[106] Patton, M.Q. (2006) Evaluation for the Way We Work. The Nonprofit Quarterly. Vol. 13 (1): 28-33. Retrieved from Developmental Evaluation | Better Evaluation
[107] Newell S, Shawyer F, Redman A,Johnson B& Kennedy H. (2019). Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report. Sydney: Sax Institute.
[108] World Health Organization. (2021). LIVE LIFE: An implementation guide for suicide prevention in countries.
[109] Gates EF. (2016). Making sense of the emerging conversation in evaluation about systems thinking and complexity science. Eval Program Plann. 2016(59), 62-73. doi: 10.1016/j.evalprogplan.2016.08.004.
[110] Refels, L, Krishnamoothy, K., Kolves, K., Francis, J. (2022). Implementation Science in Suicide Prevention. Crisis, 43(1), 1–7. https://doi.org/10.1027/0227-5910/a000846.

promising approach for future suicide prevention trials, given that they enable effectiveness and implementation outcomes to be examined simultaneously. Trial coordinators adopting this approach have varying options for how much emphasis is placed on implementation and intervention effectiveness, making them applicable for a variety of suicide prevention trials where varying levels of observable effectiveness is expected. This was the case for the suicide prevention trials synthesised for this report, in which it was not always possible in practice for evaluation to demonstrate a link between implementation and the intended outcomes of the suicide prevention trials (reduced suicide attempts and deaths) - and in one trial, the PBSPT, these outcomes were considered out of scope altogether.

Although implementation of the programs was considered in all three suicide prevention trial evaluations synthesised for this report, none of the evaluations explicitly refer to an implementation science approach. There is an opportunity to incorporate this approach more explicitly into trial and evaluation design. A strategic implementation science approach could include clear and structured implementation indicators as part of the evaluation framework. Opportunities to embed evaluation throughout the implementation process, generating continuous evaluation findings that inform ongoing implementation and delivery, should also be considered.

Key considerations of implementation science approaches include the inclusion of lived experience and community representatives in the co-design, implementation and delivery of suicide prevention programs, and "can in many ways be regarded as the ultimate arbiters of implementation success".[111] Involving lived experience voices in trial design, as discussed elsewhere in this report, is an important aspect of determining what demonstrates effective implementation.

4.3 Embrace emerging best practice for systems-based approaches

Knowledge and evidence for what represents best practice in trialling systems-based suicide prevention interventions is still emerging and will be built upon further as future programs and trials are conducted. However, it is possible to identify some key learnings from the current trials which indicate future directions for trial and evaluation design in suicide prevention.

Monitoring processes should be established early in the implementation phase

An outcomes focus should be incorporated into the design and implementation of suicide prevention trials from the beginning. Because change in the final outcome of suicide prevention activities – reduced deaths by suicide – is difficult to observe over the relatively short time scale of suicide prevention trials, trial design should incorporate interim outcomes that:

- Measure prevalence of key risk factors associated with suicide outcomes

- Measure increase or improvement in protective factors against suicide

- Measure increased community awareness of suicide and suicide prevention

- Align with the Theory of Change and have clear data sources.

Evaluation of suicide prevention initiatives may also contain qualitative outcomes relating to the strength of relationships formed, the types of activities they led to, and the impact these had on the community. This will enable evaluations to take a wider lens in interpreting the effectiveness of programs, even in the case where final outcomes data is not available or significant change in suicide rate is not observable. For instance, evaluations should use mixed-methods evaluation approaches to

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[111] Refels, L, Krishnamoortrhy, K., Kolves, K., Francis, J. (2022). Implementation Science in Suicide Prevention. Crisis, 43(1), 1–7. https://doi.org/10.1027/0227-5910/a000846.

identify the extent to which community engagement worked or not, for whom, how, and in which contexts – helping to fill a significant gap in the evaluation research.[112]

Trial length should act as an enabler and not a barrier to effectiveness

Time was identified as one of the most important resources enabling the effective implementation of the suicide prevention trials. The broader literature suggests a lengthy implementation period of at least two years is required in order to "provide statistical power for comparison and/or to allow establishment and sufficient penetration".[113] However, significant limitations were identified from the Suicide Prevention trials stemming from time constraints, which were a feature of the trial design. The complexity of systems-based approaches comes with a time burden, noted throughout all Suicide Prevention trials evaluations. Tension was observed between the nature of systems-based approaches – which rely on relationships built and sustained over an extended period – and the constrained timeline of the trials, which typically ended after several years.

Moreover, a key theme throughout the literature suggests that the time required to implement the essential components of a systems-based approach, particularly meaningful engagement with key stakeholders and community, is often not reflected in planning. Additional trial elements which support community engagement and knowledge sharing (such as lived experience or community-involved co-design, professional development opportunities, or establishing communities of practice) entail additional time commitments. Forgoing these elements runs the risk of reduced effectiveness, as well as challenges to workforce capacity and sustainability.

There were also observed instances where trial delivery partners were unwilling to offer particular supports to community members, due to an assumption these supports would not continue post-trial. This implies that short-term piloting approaches run the risk of sacrificing some efficiency as well as effectiveness.

Eliminating these issues may involve longer-term trialling of suicide prevention interventions, with a plan for embedding trial elements longer-term into the communities where the trial takes place. It is necessary to ensure funding for key supports for consumers, in particular, will continue beyond the trial (and beyond the four-year budget cycle).

If funding or other factors do not allow for a long-term trial, an approach that does not require broader system involvement or partnership could be considered. For example, a single evidence-based intervention targeting a defined cohort could be introduced with the potential to observe short-term outcomes. However, as highlighted throughout this paper, systems-based approaches with a long-term timeframe should be prioritised.

Evaluators should consider measuring preliminary outcomes on the pathway

With difficulties noted in collecting and interpreting final outcomes data for suicide prevention initiatives, there is a clear rationale for including both primary and secondary evaluation outcomes to take a broader approach to measuring suicide risk, as well as suicide behaviours. This allows for some evaluation of program effectiveness to be conducted even in the absence of robust final outcomes data. Understanding how suicide prevention trials affect the drivers and consequences of suicide is an important insight in its own right.

Evaluators can consider including outcomes around community or local systems suicide prevention capacity, as was done in the PBSPT and NSPT summative evaluations. Robust evaluation of these environmental factors relies on the precise monitoring and documentation of environmental

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[112] De Weger, E., Van Vooren, N., Luijkx, K.G. and Drewes, H.W. (2018). Achieving successful community engagement: a rapid realist review. BMC Health Services Research, 18:285, pp. 1-18. https://doi.org/10.1186/s12913-018-3090-1.
[113] Collings, S., Jenkin, G., Stanley, J., McKenzie, S., & Hatcher, S. (2018). Preventing suicidal behaviours with a multilevel intervention: a cluster randomised controlled trial. BMC public health, 18(1), 140. https://doi.org/10.1186/s12889-018-5032-6

conditions before and during the trial.114 Where the drivers of suicide are known to be long-term, shorter-term outcomes could be included which provide an initial indication of the level of impact of the intervention on that driver. In addition, mental health outcomes adjacent to suicide can be used to demonstrate an impact of suicide prevention interventions on community health and wellbeing more broadly. These could include levels of distress, rates of diagnosed mental illness, or rates of stigmatising attitudes held within the community around mental illness and suicide. Outcomes and indicators selected may relate to the mental health or quality of life of people with suicidality; other preliminary outcomes may also relate to known risk or protective factors for suicide (e.g. housing, employment, education, community engagement, social and economic participation outcomes). Ultimately, outcomes and indicators should be chosen that relate to specific program activities or priority areas, which will differ based on the community and on the suicide prevention approach/model.

As with all elements of trial and evaluation design, community engagement should be a core element in identifying priority outcomes. Evaluators should determine the appropriate level of participation for community members (and strive to include representatives with lived experience of suicide), based on the public participation spectrum (see **Figure 2: IAP2 Public Participation Spectrum**). As has been noted elsewhere, community engagement is unlikely to be considered truly substantive if it is purely consultative (or informative) in nature, although evaluators must weigh up these concerns against the practical realities of timing and funding constraints.

Evaluation maturity should be considered

Evaluation maturity, or the ability for interventions to be effectively evaluated, is contingent on a range of factors. Using an evaluability assessment tool at various points throughout the program life cycle may help to guide the trials towards an assessment of evaluation maturity. The evaluation maturity matrix uses a continuum perspective to conceptualise evaluation maturity, from the lowest maturity level (beginning) through to developing, embedded and leading (see **Appendix E.53**).[115]

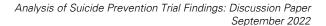# 4.4   Provide centralised coordination and guidance

In a crowded policy and system landscape, there is a need to consider the value of centralising strategic activity and establishing shared definitions of core concepts (such as co-design), intended outcomes and measures. This could lead to efficiencies being realised as duplicative efforts are identified. A centrally coordinated outcomes framework, such as the National Suicide Prevention Outcomes Framework under development by the National Suicide Prevention Office, is a potential form of continuous improvement more broadly across the system landscape. This could be considered as a potential means of capturing learnings from the suicide prevention trials and using these to inform future initiatives. It is related to calls for an overarching implementation framework (which provides advice on the steps to effectively implement systems-based suicide prevention programs), and should integrate with this framework by incorporating implementation outcomes into standard evaluation practices.

Evaluation approach and data linkage

The National Suicide Prevention Outcomes Framework will apply nationally down to the program and service-level, and its development will be informed by lived experience. This Framework would enable a centrally coordinated evaluation approach, likely including a set of agreed outcomes and indicators at both the national and program level, which informs the monitoring and evaluation of all future suicide

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[114] Hegerl, U., & Wittenburg, L. (2009). Focus on mental health care reforms in Europe: the European alliance against depression: a multilevel approach to the prevention of suicidal behavior. Psychiatric Services, 60(5), 596-599.

[115] ACT Government. (2010). Evaluation Policy and Guidelines. Retrieved from: ACT Government Evaluation Policy and Guidelines

prevention trials and programs. A best-case national evaluation approach based on this Outcomes Framework may also indicate pathways for centrally coordinated linkage of national datasets with local level data, to streamline the efficiency of these processes and provide a common approach.

Standardised resources for trial sites to build evaluation and research capacity may also be included, with an objective to facilitate more effective knowledge translation. Establishing the centrally coordinated evaluation approach aligns with the National Mental Health and Suicide Prevention Agreement (National Agreement) and may be a role for the National Suicide Prevention Office (NSPO). The Agreement promotes nationally consistent evaluation principles, and commits State Parties to "work in partnership to develop and implement common measures and domains" for mental health, to enable comparison across programs, services and jurisdictions. State Parties, through a series of Bilateral Agreements, also agree to work in partnership with the NSPO to incorporate lived experience into evaluation, avoid duplicative data-sharing efforts.[116]

The benefits of a coordinated evaluation approach are also highlighted by the National Evaluation Strategy, also established as a recommendation of the National Mental Health and Suicide Prevention Plan. The National Evaluation Strategy oversees knowledge translation from research into practice, as well as overseeing linkage of existing and future datasets. This coordination would enable more effective synthesise or meta-evaluation between trials and suicide prevention activity. Relevant current works to establish the necessary data infrastructure include the Suicide and Self-Harm Monitoring Project (linking key suicide-related datasets), and data integration projects led by the AIHW to link a range of national health datasets to inform the Royal Commission into Victoria's Mental Health System. [117] [118]

The National Suicide Prevention Office also has the opportunity to improve data linkage processes, through identifying common indicators and data sources. Examples where existing datasets could be utilised more effectively include the National Suicide and Self-harm Monitoring system (a cooperative effort by AIHW and ABS) and the National Suicide Prevention Leadership and Support Program minimum data set (MDS), led by Australian Healthcare Associates as part of the National Suicide Prevention Plan. Data linkage was used in the LifeSpan trial, which utilised public quantitative datasets to measure impact on primary and secondary outcomes. This allows the trial to show an effect on rates of intentional self-harm and suicide across the four trial sites.[119]

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[116] Australian Government. (2022). National Mental Health and Suicide Prevention Agreement. Available from: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf
[117] Flego, A., Dempster, G., Cutler, T., Robinson, J., & Pirkis, J. (2021). Evaluation of the National Suicide and Self-harm Monitoring Project and System: Interim Report. Retrieved from https://www.aihw.gov.au/getmedia/86365084-83a5-4097-823e-7e9e5f8f0029/Interim-Report_Evaluation_NSSHMS_UoM_May-21.pdf.aspx
[118] Ibid.
[119] Linked datasets used for the LifeSpan trial include NSW ED data and admitted patient data, RBDM cause of death, MBS and PBS data as well as cost data.

5   Conclusion and next steps

This discussion paper explores the fundamental role of a systems-based approach for suicide prevention programs. The themes emerging from the three suicide prevention trials provided great insight into the challenges of implementing a systems-based approach to suicide prevention. Despite these challenges, future suicide prevention programs and initiatives should be supported to embrace a systems-based approach with adequate time and funding to observe outcomes and build the evidence based.

Several considerations were identified as critical when implementing a systems-based approach to suicide prevention on a national scale:

- Developing an overarching implementation strategy to support consistency

- Supporting the critical role of PHNs in coordinating community partnerships and driving initiatives

- Co-designing the implementation approach with local communities to build ownership

- Embedding lived experience in all aspects of planning and implementation

- Improving workforce sustainability to build long term outcomes.

The considerations for implementation lead into the implications for future suicide prevention trials and initiatives explored in this paper. The implications will continue to evolve and become more nuanced as further systems-based suicide prevention initiatives are supported. The high-level implications for trial design, evaluation and monitoring of future systems-based initiatives include:

- Developing a consistent overarching design that can be adaptive to the local setting

- Embedding continuous improvement into the evaluation approach

- Embracing emerging best-practice

- Provide centralised coordination and support.

The considerations and implications discussed are a starting point for further exploration and discussion on the highly complex and multifaceted challenge that is suicide prevention. It is a challenge that requires a system wide and whole-of-government approach.

Next steps

The considerations identified in this discussion paper are intended to support PHNs in the rollout and implementation of future regional initiatives for suicide prevention. Led by the recently established National Suicide Prevention Office and commitments to the National Suicide Prevention Agreement, PHNs and other jurisdictions across the country have committed to ongoing development of suicide prevention policy and programs through a systems-based lens.

The main priorities of the NSPO will be the development of a National Suicide Prevention Outcomes Framework, with the potential to drive a nationally consistent approach to understanding and measuring success of systems-based suicide prevention programs; and a National Suicide Prevention Workforce Strategy, which will establish a whole-of-government approach to the unique capabilities and needs of the suicide prevention workforce. These priorities, alongside the considerations identified in this discussion paper, have the potential to be transformative in how initiatives are designed, implemented, delivered and evaluated.

Appendix A: Context for the broader suicide prevention landscape
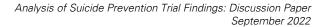
Priority area: Overall national lens

The National Mental Health and Suicide Prevention Agreement, between the Commonwealth Government and Australia's State and Territory Governments, sets out national objectives, outcomes and outputs for mental health and suicide prevention and nominating areas for immediate reform.[120] It is accompanied by state and territory Bilateral Agreements which detail jurisdiction-specific objectives, outcomes, outputs and funding contributions. Among the shared outcomes contained in the Agreement, governments commit to work together to:

• Reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports;

• Provide a balanced and integrated mental health and suicide prevention system for all communities and groups;

• Improve quality, safety and capacity in the Australian mental health and suicide prevention system;

• Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress.

Individual states and territories are allowed some flexibility to deliver state reform directions for policy and service delivery, but all commit to developing, measuring and reporting on outputs and Priority Data and Indicators. Key outputs include establishment of a National Suicide Prevention Office, the development of a National Evaluation Framework, and progress reporting against key measures. Overall, state and territories must also commit to the following common principles (summarised for brevity):

a) Working together towards a person-centred system that embeds lived experience
b) Effective investment, policy and service mix
c) Reducing system fragmentation, gaps and duplication
d) Support for workforce capability, particularly in priority areas and communities
e) Evaluating new models of care to drive improvement
f) Clear roles, responsibilities and accountabilities for funding and delivery
g) Person-centred and evidence-based system design changes
h) Recognition of all governments' roles in policy and service deliver
i) Equity for rural, regional and remote communities
j) Planning and reform across entire spectrum of care
k) Effective regional and national cooperation between providers, systems and governments
l) Improved and more transparent data collection/linkage and evaluation
m) Recognition of social determinants and integration with broader government services
n) Improving outcomes for priority communities through culturally and locally appropriate service delivery (Aboriginal and Torres Strait Islander, CALD, LGBTQIA+SB, co-occurring disability and/or problematic substance use)

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[120] Australian Government. (2022). National Mental Health and Suicide Prevention Agreement. Retrieved from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-05/nmh_suicide_prevention_agreement.pdf.

The Agreement is accompanied by a National Mental Health and Suicide Prevention Plan[121] which contributes $298.1 million over four years (from 2021-22) to suicide prevention, to respond to recommendations from the Productivity Commission and Suicide Prevention Officer. Among the key actions funded through the Plan are investment in national postvention services for people bereaved or impacted by suicide; expansion of the National Suicide prevention Leadership and Support program, which will drive innovation in building awareness, resilience and community suicide prevention capacity at a whole-of-population level; and continuation of local National Suicide Prevention Trial sites.

Further actions seek to reduce disproportionately high suicide rates among the Aboriginal and Torres Strait Islander population by empowering communities to co-design solutions, with investment going to:

- Co-designed aftercare services through regionally-based organisations

- Establishment of regional suicide prevention networks

- Establishment of a culturally appropriate and self-governed 24/7 crisis line

- Support for the Aboriginal and Torres Strait Islander Lived Experience Centre

- Review of the Aboriginal and Torres Strait Islander mental health sector.

There are many ongoing and planned initiatives within the suicide prevention landscape and the broader system. Work is underway to increase the coordination of activity across the landscape to promote shared outcomes and indicators of success.
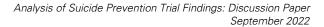
This section provides an overview of suicide prevention activity initiatives at the national level and a summary of the relevant strategies, plans and initiatives.

National initiatives and programs

The Commonwealth Department of Health and Aged Care funds various initiatives and programs to support people at risk of suicide and those affected by the suicide of a loved one. These include:

- headspace – supports young people with mental or physical health issues and with managing work and study

- Kids Helpline – provides a free, private and confidential telephone and online counselling service specifically for young people aged 5 to 25 years

- Suicide Call Back Service – provides 24-hour free nationwide telephone, video and online counselling for anyone who is affected by suicide

- Beyond Blue – provides information and immediate phone support 24 hours a day, 7 days a week; this includes its Way Back Support Service, which supports people who have attempted suicide

- Lifeline – provides information and immediate phone support to people who are struggling, 24 hours a day, 7 days a week

- Life in Mind – connects suicide prevention services to each other and the community

- MindSpot – provides information about mental health, online assessments, and online treatment to adults with anxiety, stress, depression and chronic pain

- Stand By Support After Suicide Program – supports people and communities who have been affected by suicide

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[121] Australian Government. (2021). Prevention, Compassion, Care: National Mental Health and Suicide Prevention Plan.

- [National Suicide and Self-Harm Monitoring System](#) – collects and coordinates information on suicide and self-harm

- [Prevention Hub](#) – a collaboration of the Black Dog Institute and Everymind to deliver a research program that targets people at greater risk of mental health conditions and suicide.

- [DRs4DRs](#) – offers an independent, safe, supportive and confidential referral service and online resources to medical professionals, promoting health and wellbeing of doctors and medical students across Australia.

- [The Essential Network (Black Dog Institute)](#) – a blended care mental health support service for healthcare workers that offers specialist, individualised mental health advice.

National Suicide Prevention Office

The National Suicide Prevention Office was established in in response to recommendations in the National Suicide Prevention Final Advice and the Productivity Commission into mental health and suicide prevention.[122] The Office is responsible for:

- Developing a National Suicide Prevention Strategy.

- Leading the development of a national outcomes framework for suicide prevention, which is informed by lived experience, and applied nationally and down to program & service level.

- Working with all jurisdictions to set priorities for suicide prevention research and knowledge sharing.

- Working with all jurisdictions and stakeholders to lead the development of a National Suicide Prevention Workforce Strategy.

- The Policy Implications report delivered by KPMG highlighted the opportunities presented through the Office for coordinating and leading a national approach to suicide prevention.

Royal Commission into Defence and Veteran Suicide

The Royal Commissions into Defence and Veteran Suicide was established in in July 2021 with Mr Nick Kaldas APM, the Hon James Douglas QC, and Dr Peggy Brown AO appointed as Royal Commissioners. The Commissioners are required to inquire into various matters, including the systemic issues and any common themes among defence and veteran deaths by suicide, or defence members and veterans who have other lived experience of suicide behaviour or risk factors (including attempted or contemplated suicide, feelings of suicide or poor mental health outcomes) and a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation and post-service issues.[123]

The commission is required to produce an interim report by 11 August 2022 and a final report by 17 June 2024.

Relevant strategies, plans and initiatives

A summary of relevant national plans, strategies, frameworks, and key initiatives is proved below. The list demonstrates the broad range of activity across the suicide prevention landscape.

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[122] National Mental Health Commission. (2021).
[123] Commonwealth of Australian (2022), Royal Commission Terms of reference. Retrieved from: https://defenceveteransuicide.royalcommission.gov.au/about/terms-reference

Current plans, strategies, and policy initiatives relevant to suicide prevention at the national level

Focus area	National Plans, Strategies, frameworks, and key initiatives
Overarching mental health/ suicide prevention	• Australia's Long Term National Health Plan: to build the world's best health system • The Fifth National Mental Health and Suicide Prevention Plan 2017-2022 (2021 TBC) • National Suicide Prevention Strategy for Australia's Health System: 2020–2023 • National Suicide Prevention Strategy (includes • - Living is for Everyone (LIFE) framework, • - NSPS Action Framework, • - National Suicide Prevention Program) • National Mental Health and Suicide Prevention Agreement & associated Bilateral Agreements • National Mental Health and Wellbeing Pandemic Response Plan • Vision 2030 for Mental Health and Suicide Prevention • National Children's Mental Health and Wellbeing Strategy 2021 • National LGBTI Mental Health and Suicide Prevention Strategy (produced by National LGBTI Health Alliance) • Mentally Healthy Workplaces Alliance • National Suicide Prevention Workforce Strategy and Outcomes Framework (in development) • National Disaster Mental Health and Wellbeing Framework (in development) • National Workplace Initiative (in development) • National Stigma and Discrimination Reduction Strategy (in development)
Workforce	• National Peer Workforce Development Guidelines • Commonwealth Aboriginal and Torres Strait Islander Workforce Strategy 2020 - 2024 • Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016 – 2026 • National Medical Workforce Strategy 2021-2031 • Every Doctor, Every Setting: A National Framework • Mental Health Workforce Strategy (in development) • National Suicide Prevention Workforce Strategy (in development) • National Peer Workforce Professional Network (in development). • National Consumer and Carer Scoping Study (in-development)[124]
Financing	• Federal budget response to the Productivity Commission and Christine Morgan advice: National Mental Health and Suicide Prevention Plan funding across five pillars • The LIFEWAYS Project: Leading research into suicide prevention
Information systems	• National Suicide and Self-Harm Monitoring System • Turning Point to develop the National Ambulance Surveillance System (NASS) for overdose and suicidal behaviour • Mental Health Information Strategy Standing Committee (ED suicide and self-harm related presentations) • Multi-Agency Data Integration Project • Suicide Prevention Intelligence System (Black Dog; LifeSpan) • National Mental Health Research Strategy

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[124] The 2021-22 Budget measure provided funding for enhancing consumers and carers participation, and supporting the Peer workforce. This includes scoping and co-design of national mental health consumer and carer peak body arrangements, and developing a national peer workforce professional network. These activities will provide independent mechanisms for the Australian Government to seek the views of all parties to ensure all stakeholder voices are heard equally through a transparent consultation process.

Focus area	National Plans, Strategies, frameworks, and key initiatives
	• Minimum data set of National Suicide Prevention Leadership and Support Program (now LIFEWAYS Project)
Leadership & governance	• Australian Mental Health Leaders Fellowship • National Suicide Prevention Office • National Mental Health Commission
Access to essential treatments	• Suicide Prevention Quality Improvement Program (Suicide Prevention Australia) • ALIVE research centre (in development)
Service delivery	• Safe in Care, Safe at Work (Reducing Restrictive Practices)

Appendix B: Suicide Prevention trials

Context

The Australian Government has made suicide prevention a key focus of its agenda for strengthening the physical and mental wellbeing of Australians. With Australia's suicide rate having been relatively static over the past decade and around 65,000 people a year attempting to take their own lives, there is a recognition among policymakers, service providers and the community that new approaches are needed.

There are several Commonwealth and state government initiatives that have been undertaken, are in progress or are being planned. These initiatives are adding to the national conversation about suicide and how to reduce its toll over time. Alongside broader strategic initiatives, governments and sector partners have also been exploring ground-up opportunities for reform through a series of regional and place-based suicide prevention trials. The Australian Government has funded 11 Primary Health Networks (PHNs) to lead community-driven interventions through the NSPT. The Victorian Government commissioned the PBSPT sites and the Black Dog Institute has been delivering five trials of its LifeSpan model in communities across New South Wales (NSW) and the Australian Capital Territory (ACT).

Each of these trials has adopted a regional systems-based approach to suicide prevention. This is a promising emerging approach which involves a mix of interventions being delivered through diverse local and community partnerships, which collectively aim to strengthen community resilience to suicide. Each of the suicide prevention trials has been evaluated or is currently being evaluated separately, with several PHNs also commissioning local evaluations on the activities in their region.

KPMG has been commissioned to synthesise and analyse the combined findings from these evaluations to inform the ongoing development of suicide prevention policy and initiatives. This includes undertaking a structured comparison of findings from these trials and the broader available research literature. The development and reporting of the various evaluations have different timelines for completion, directly impacting on what information is available for analysis at the time of developing this report.

Suicide Prevention trials

A brief description of the approach taken by each trial is provided below.

National Suicide Prevention Trials

The National Suicide Prevention Trials (NSPT) was delivered in 12 regions across Australia, which are overseen by 11 PHNs, from 2016 to 2020. The Trial was designed to provide evidence on how the regional systems-based approach to suicide prevention might best be undertaken within the Australian context and identify new learnings in relation to effective suicide prevention interventions.[125]

Sites within the NSPT selected their preferred systems-based model. The Black Dog institute was commissioned to assist PHNs to undertake scoping and community planning. Eight sites adopted the

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[125] (No author). (2017). *National Suicide Prevention Trial Evaluation Framework: Guide for the conduct of the evaluation.* p 12. Supplied to KPMG.

LifeSpan model which has been developed by the Black Dog Institute, [126] and two adopted the Alliance Against Depression (AAD) model which is widely used in Europe and has been adopted in some parts of Australia.[127] A further two sites which have a specific focus on Aboriginal and Torres Strait Islander communities adopted an approach guided by the principles set out through the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP).[128]

Across the 12 Trial locations, PHNs have commissioned and overseen the implementation of a wide range of evidence-based and novel initiatives. These included delivering new services for individuals such as aftercare services for those attempting suicide, supporting community capacity building activities, and initiatives aimed at increasing integration and coordination among existing suicide prevention services and providers.

Place-based Suicide Prevention Trials

The Place-Based Suicide Prevention Trials (PBSPT) took place in 12 communities spanning all six Victorian PHN regions with a focus on improving individual and community resilience and wellbeing and improving the systems to prevent suicide in an ongoing way.[129] An improved system for preventing suicide was defined as one which has locally-tailored partnerships; is inclusive, effective and adaptive; is coordinated and evidence informed; has capable leadership and stakeholders, and a supportive community.[130]

By taking a place-based approach, the specific combination and extent of activities delivered through the trials was locally tailored to each site. The activities selected and designed for each site fall within three broad categories:

- Collective backbone – activities targeting all potential stakeholder groups, aimed towards strengthening the local suicide prevention system through training, resources and other initiatives which make the system more connected and cohesive.

- Capacity building – training, media and other resources tailored to community needs and priorities across a variety of themes, aimed towards building community and stakeholder capacity to understand suicide and effectively implement evidence-informed prevention strategies.

- Resilience promotion – programs and resources targeting priority groups, people with lived experience, young people and schools, and the broader community, aimed towards improving individual and community resilience and protective factors.[131]

The Collective Impact (CI) model was used as a structured approach to collaboration throughout the PBSPT. CI is primarily adopted when addressing complex social issues and stipulates five components in partnership: a common agenda; continuous communication; mutually reinforcing activities; backbone support; and shared measurement.[132]

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[126] Black Dog Institute. (2020). *LifeSpan: Integrated Suicide Prevention*. Retrieved from https://www.blackdoginstitute.org.au/education-services/lifespan-integrated-suicide-prevention/#:~:text=Lifespan%20is%20a%20comprehensive%20systems,multiple%20sectors%2C%20communities%2C%20organisations

[127] WA Primary Health Alliance. (n.d.). *The Alliance Against Depression: An integrated, community-based approach to tackling depression and suicide.* Retrieved from https://www.wapha.org.au/wp-content/uploads/2019/06/AAD-Easy-Guide-Brochure.pdf

[128] ATSISPEP. (2016). *Solutions that work: what the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. Crawley: University of Western Australia. Retrieved from https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

[129] Newell, S., Shawyer, F., Redman, A., Johnson, B. & Kennedy, H. (2019). *Place-Based Suicide Prevention Trials: Establishment Phase Evaluation Report*. p. 15. Sydney: Sax Institute.

[130] Newell, S. et al., (2019). p. 15.

[131] Newell, S. et al., (2019). p. 14.

[132] Smart, J. (2017). Collective Impact: Evidence and implications for practice. Australian Institute of Family Studies. 45. Retrieved from https://aifs.gov.au/cfca/publications/collective-impact-evidence-and-implications-practice

LifeSpan Suicide Prevention Trials

The LifeSpan trials were delivered in four locations across NSW between 2017 and 2021, with an additional trial of the model established in the Australia Capital Territory. LifeSpan aims to build a safety net for the community by connecting and coordinating new and existing interventions and programs, and building the capacity of the community to better support people facing a suicide crisis.[133]

LifeSpan is an integrated framework for suicide prevention combining nine evidence-based strategies that are categorised at two levels (individual level and population level). It incorporates activities and interventions delivered through health, education and frontline services, business and the community.[134] Initiatives within each component of the framework are intended to be implemented simultaneously in a localised area, to strengthen and expand available supports and better connect people with these. Components of the model also address whole-of-population level interventions such as means restriction and media reporting, providing an integrated and multi-layered response to suicide.

Analysis scope and methodology

The scope and methodology have been adapted throughout this engagement due to the availability of evaluation reports required for this analysis. The scope and methodology outlined below details the updated scope of this report and the methodology for the collection and analysis of information.

Scope

The purpose of this Final Report is to build on the previous rounds of analysis to connect findings from the literature and the findings in the final evaluation reports (including any relevant local evaluations) to provide a summary of the implications for suicide prevention activity in Australia. The analysis primarily focuses on common themes and key learnings relating to the *establishment and implementation* of the regional systems-based approaches to suicide prevention.

Methodology

The primary research inputs for this analysis were the PBSPT Summative Evaluation Report and NSPT Final Evaluation reports, and relevant selected literature on systems-based models of suicide prevention identified through a literature scan review (Appendix D).
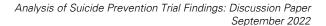
As part of reviewing research inputs, members of the Expert Advisory Panel (Appendix C) undertook a robustness assessment of the PBSPT Summative Evaluation Report and NSPT Final Evaluation reports. This assessment was undertaken using the Bond Evidence Principles, to allow KPMG to form judgements about how much weight to put on individual findings within the broader analysis. The robustness assessment key used in this process can be found at Appendix E.

Research questions

This project sought to address a series of research questions which explore the collective findings and outcomes of the trials, and the implications of these for suicide prevention policy and practice in Australia. Despite the required variations from the initial schedule of deliverables, the research questions have continued to guide the analysis that has been undertaken were applicable.

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[133] Black Dog Institute. (2020). *LifeSpan Trials*. Retrieved from https://www.blackdoginstitute.org.au/research-centres/lifespan-trials/
[134] Black Dog Institute. (2020). *LifeSpan Trials*. Retrieved from https://www.blackdoginstitute.org.au/research-centres/lifespan-trials/

Key research questions:

1. What are the common themes occurring across suicide prevention trials, both at the overall coordination level and in relation to specific interventions, including barriers and enablers?
2. What themes has each evaluation drawn out that are unique?
3. What themes are specific to particular regions and/or population groups?
4. How do findings from these trials compare with broader available evidence on effective suicide prevention practice?
5. What conclusions or recommendations can be made about interventions that are best coordinated, implemented and delivered at the regional level?
6. What questions emerged through the synthesis and analysis of evaluation findings and how might the Department seek to address these?
7. What are the implications for suicide prevention policy and implementation of regional approaches to suicide prevention in Australia?

Appendix C: Expert Advisory Panel

The Expert Advisory Panel comprises KPMG and academic specialists with key skills that add genuine insight. The expert panel members are engaged when required throughout the project to contribute their relevant expertise.

Andrew Dempster: Andrew leads KPMGs Mental Health Advisory business conducting strategy, evaluation, review and improvement projects across Australia. He has experience consulting across the spectrum of health and human service sectors including: child and family services, health (acute and community), Aboriginal and Torres Strait Islander health, mental health, child protection, disability services, alcohol and other drug services, and justice.

Project role: Mr Dempster provides subject matter expertise regarding mental health, suicidality, health and social systems throughout the life of the project.

Lucio Naccarella: A/Prof Naccarella is a leading health care services researcher and evaluator, with interests in system change, health system literacy, health care design, care coordination, teamwork, professional development, primary care organisations and health workforce reforms, from a policy, research and practice perspective. He has published as first author in peer-reviewed journals and as part of project teams over 70 publications. Over his career he has won over 70 research and evaluation grants at a national, state, regional and local levels. A/Prof Naccarella has largely focused on four key areas:

- Building evaluation capability within public sector organisations

- Evaluating health workforce models of care and development

- Evaluating population health, health literacy and community based professional development initiatives;

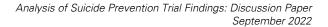- Researching health care facility design to optimise health care workforce.

Project role: A/Prof Naccarella provides health program evaluation expertise throughout the life of the project and has conducted the robustness assessment using the Bond Evidence Principles, to establish an agreed baseline for how evaluation findings should be weighted in the subsequent analysis.

Sarah Wayland: Dr Sarah Wayland is an early career researcher with a strong vision for her research and teaching focus. She has spent the last 21 years working and then researching the complexity of trauma and loss through a social work lens. In her current role, her primary research focus is building the evidence base surrounding lived experience inclusion in the fields of suicide prevention and mental health service delivery.

In the national suicide prevention space, Dr Wayland's research has led to:

- Enhanced awareness of supportive interventions to better support carers of people who attempt suicide by ensuring research translation in academic, technical reports and website development embedded in each project;

- Implementation science and research evaluation honouring inclusion of lived experience voice in interpreting the complexity of knowledge, leading to awareness about how suicide attempting needs to be supported via workforce improvements.

- Inclusion in the Prime Minister's Suicide Prevention Taskforce due to a focus on evaluation of services, and to development of policies that aim to reduce the rate of deaths by suicide.

Project role: Dr Wayland provide expertise in lived experience research and inclusion and has conducted the robustness assessment using the Bond Evidence Principles, to establish an agreed baseline for how evaluation findings should be weighted in the subsequent analysis.

Greg Armstrong: Dr Greg Armstrong is a multidisciplinary mental health and suicide prevention researcher. He holds a prestigious Early Career Fellowship with the National Health and Medical Research Council (NHMRC) in Australia and is a Senior Research Fellow with the Melbourne School of Population and Global Health, University of Melbourne. While based at University of Melbourne, Dr Armstrong has undertaken public health research and consultancies in Australia and in low and middle-income countries (LMICs) over more than 10 years with specialisations in mental health, suicide prevention, substance misuse and the social determinants of health.

In the international mental health and suicide prevention space, Dr Armstrong has been involved in research and publications in Southeast Asia, India and Timor-Leste and has done considerable work with Aboriginal and Torres Strait Islander communities.

Project role: Dr Armstrong brings a wealth of knowledge and expertise in suicide prevention and will be specifically be involved by providing specialist technical advice on tailored approaches to meta-analysis as well as contributing the latest findings from suicide prevention evidence and best practice.

Appendix D: Literature Scan

Several literature reviews and scans were completed during the course of this engagement. A comprehensive review was completed as part of Progress Report 2 with a structured approach to the selection and assessment of evidence with an open-ended review method. Subsequent reviews were completed to include any new or updated research and to explore any emerging areas of relevance. The methodology detailed below remained consistent throughout the engagement. See **Appendix B** (page 45) for further detail on the specific methodology for this discussion paper.

Methodology

Databases relevant to health and social sciences were systematically searched for systems/place-based suicide prevention approaches and models, and for specific models and approaches that are known to be relevant to Australia's Suicide Prevention Trials, e.g. European Alliance Against Depression. These databases were selected because they are publicly available through subscriptions held by the National Library of Australia and the various State Libraries. This ensures underlying research inputs are accessible to APS agencies, stakeholders and members of the community as necessary. Academic databases included:

- Cochrane Library
- EBSCO Academic Search Complete
- ERIC
- JSTOR
- PubMed.

Grey literature was also located through systematic searches of key Australian suicide prevention organisation websites, and through targeted Google searches. These organisations were selected because they are major contributors to the national conversation about suicide prevention. Online searches were conducted within:

- ATSISPEP
- Australian Institute for Suicide Research and Prevention
- Beyond Blue
- Black Dog Institute
- Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
- Department of Health and Aged Care
- Headspace
- National Mental Health Commission
- Productivity Commission
- Roses in the Ocean
- Sax Institute
- Suicide Prevention Australia.

Finally, snowball searches were conducted using the reference lists of a sub-set of articles identified in initial database searches.

Appendix E: Robustness assessment

This project has aimed to support informed decision-making by government on future suicide prevention policymaking and investment. Due to the reliance on the inputs received from evaluation teams in developing the various outputs, it is important to understand how robust each of these inputs are. Below are the robustness assessments of the two final evaluation reports received at the time of writing: the evaluation of the NSPT by the University of Melbourne and the evaluation of the PBSPT by the Sax Institute.

Methodology

The robustness assessments have been undertaken by two members of this project's Expert Panel:

- Dr Lucio Naccarella – University of Melbourne; Lucio brings expertise in the formal evaluation of health, mental health and social sector programs.

- Dr Sarah Wayland – University of New England; Sarah brings expertise in understanding lived experience perspectives and incorporating these into academic and policy research.

Scoring: Bond Evidence Principles

The Bond Evidence Principles were used as the underpinning methodology for the robustness assessment of identified literature. These principles allow for the assessment of quality of evidence in a structured way. This methodology assesses the robustness of research in relation to the following domains:

- **Voice and inclusion** of beneficiaries' views of the effects of the intervention, and who has been affected and how

- **Appropriateness** of methods to the nature of the intervention and purpose of the assessment

- **Triangulation** of findings across a mix of methods, data sources and perspectives

- **Contribution** of variables and factors which cause the observed change

- **Transparency** about data sources, methods, results and strengths and limitations of the evidence.

Each of the five principles has four questions and each question can be answered on a scale of 1 to 4. To aid with the scoring and to ensure consistency, scales have been developed for each question. Table 1 shows an example of the scoring scale.

Table 1: Bond Evidence Principle scoring scale

Score:	1	2	3	4
Question: Are the perspectives of beneficiaries included in the evidence?	No beneficiary perspectives included	Beneficiary perspectives presented, but not integrated into the analysis	Beneficiary perspectives presented and integrated into the analysis	Beneficiary perspectives presented and integrated into the analysis, and beneficiaries have validated the findings

Scores for each of the questions are then combined and an overall score out of 16 is provided for each article against each the principles. Depending on the score, the principle is then assigned a colour, as shown in Table 2.

Table 2: Overall scoring scale: Bond Evidence Principles

An overall score for the principle of **4 – 6**	Evidence is **weak** in this area
An overall score for the principle of **7 – 10**	Evidence meets a **minimum standard** in this area
An overall score for the principle of **11 - 13**	Evidence meets a **good standard** in this area
An overall score for the principle of **14 – 16**	Evidence meets **gold standard** in this area

Assessment outcomes

The Expert Reviewers provided individual assessments and scores on each research input. Aggregating these highlights some useful observations about the primary evaluation reports. Table 3 provides a summary of the aggregate scores against each Bond domain for the two final evaluation reports received.

Table 3: Robustness assessment results for the final evaluation reports

National Suicide Prevention Trial		
Principle	**Agreed weighted score**	**Quality assessment**
Voice and inclusion	11/16	69%
Appropriateness	14/16	88%
Triangulation	12/16	75%
Contribution	13/16	81%
Transparency	11/16	69%
Place-Based Suicide Prevention Trials		
Principle	**Agreed weighted score**	**Quality assessment**
Voice and inclusion	13/16	81%
Appropriateness	15/16	94%
Triangulation	13/16	81%
Contribution	15/16	94%
Transparency	11/16	69%

Appendix F: Tables

Developmental evaluation

Table 4: Criteria for Developmental and Traditional evaluation (Patton, 2006)

	Developmental evaluation	Traditional evaluation
Purpose	Supports development of adaptation and innovation in dynamic environments	Supports improvement, summative tests and accountability
Roles, relationships and accountability	Internal team integrated into the process of gathering and interpreting data, framing issues, surfacing and testing model developments. Centred on the evaluators' values and commitment to make a difference	Evaluation team positioned as outsiders to assure independence and objectivity; focused on external authorities and funders based on explicit and pre-ordinate criteria
Measurement	Develops measures and tracking mechanisms quickly as outcomes emerge; measures can change during the evaluation	Measures performance and success against pre-determined goals and outcomes
Evaluation results	Rapid, real-time feedback in diverse and user-friendly forms.	Detailed formal reports, validated best practice, generalisable across time and space
Standards	Methodological flexibility, adaptability, creative and critical thinking. High tolerance for ambiguity; open and agile, leveraging teamwork and people skills. Able to facilitate rigorous evidence-based perspectives.	Methodological competence and commitment to rigour and independence; credibility with external authorities and funders; critical analytical thinking.

Guiding Principles for Community Engagement

Table 5: Guiding principles for Community Engagement (de Weger et al, 2018)

	Guiding principle	Conditions
1	Ensure staff provide supportive and facilitative leadership to citizens based on transparency	Engagement avoids being directive or restrictive Clarity of outcomes Acknowledging constraining factors (and where possible addressing them)
2	Foster a safe and trusting environment enabling citizens to provide input	Reduction of cultural and practical barriers (meeting needs around language and cultural safety) Environment where it is safe to ask questions Acknowledging contextual constraining factors (e.g. marginalisation, mistrust of institutions, failed past engagements)
3	Ensure citizens' early involvement	Involvement of community in earliest stages, ideally in identification and prioritisation of needs Avoiding tokenistic involvement Contextual power imbalances between progressions and citizens

	Guiding principle	Conditions
4	Share decision-making and governance control with citizens	• Organisational willingness to share control • Embedded community members in decision-making roles • Enabling community members to choose their own representatives in decision-making process
5	Acknowledge and address citizens' experience of power imbalances between citizens and professionals	• Valuing community members' unique perspectives and contributions • Understanding citizens' lived experience of disempowerment • Willingness to shift the status quo
6	Invest in citizens who feel they lack the skills and confidence to engage	• Learning and development opportunities to build skills and confidence • Cultural sensitivity through peer engagement, and focus on empowerment
7	Create quick and tangible wins	• Coming together in pursuit of tangible and achievable goals to mobilise broader community engagement
8	Take into account both citizens' and organisations' motivations	• Acknowledging and working towards community motivations, not simply channelling community towards program outcomes

Evaluation Maturity Matrix

Table 6: Evaluation Maturity Matrix (ACT Government Evaluation Policy and Guidelines)

Element	Maturity Level			
	Beginning	Developing	Embedded	Leading
Culture	Evaluation awareness is low and is as a response to identified problems.	Widespread awareness of the benefits of evaluation.	Evaluation perceived as an integral component of sound performance management.	Demonstrated commitment to continuous learning and improvement throughout the agency.
Capacity	Evaluation skills are limited. No formal evaluation procedures and structures are in place.	Targeted training and recruitment is used to develop staff skills. Formal evaluation policies and structures are in place.	General evaluation skills are widespread. Relevant staff have higher order skills and experience, which is leveraged by the agency. Evaluation systems, structures and procedures are robust, integrated and of proven effectiveness.	The agency is recognised for its evaluation expertise and innovative procedures and systems.

Element	Maturity Level			
	Beginning	**Developing**	**Embedded**	**Leading**
Planning	Evaluation planning occurs for some programs/policies, mainly after implementation. No, or very basic, Agency Evaluation Plan.	Policies/programs have well defined objectives and performance indicators as a baseline for future evaluation. Evaluation activity is coordinated and an Evaluation Plan is in place.	Evaluation planning is an integral component of policy development.	Evaluation plans are in place for most policies and programs.
Strategy	Programs with identified problems are prioritised.	Large and risky programs are prioritised.	Guidelines for prioritising and scaling evaluation activity are used.	Sophisticated risk index and guidance material are used to prioritise and scale evaluation.
Conducting	Evaluation occurs but is infrequent and ad hoc.	Priority programs are evaluated.	Evaluation of policies is widespread and conforms to agency quality standards.	Evaluation is almost universal and conforms to recognised standards of quality.
Using	Evaluation findings disseminated within the agency. Significant recommendations are implemented.	Evaluation findings routinely inform decision making and are often disseminated outside the agency.	Evaluation findings are widely disseminated, and used to drive better performance.	Findings are used to optimise service delivery and have influence outside the agency.

KPMG

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