



A review of 156 local projects funded under Australia's National Suicide Prevention Strategy: Overview and lessons learned

Alan Headey¹, Jane Pirkis¹, Bronwen Merner¹, Adriana VandenHeuvel²,
Penny Mitchell¹, Jo Robinson³, Jennie Parham², and Philip Burgess⁴

1. Program Evaluation Unit, School of Population Health, University of Melbourne, Melbourne, Australia
2. Auseinet, Flinders University, Adelaide, Australia 3. ORYGEN Research Centre, Melbourne, Australia
4. Queensland Centre for Mental Health Research, School of Population Health,
University of Queensland, Australia

Abstract

This paper presents an overview of 156 local suicide prevention projects funded under Australia's National Suicide Prevention Strategy (NSPS), and describes lessons elicited from a content analysis of the projects' progress and final reports. The purpose of the analysis was to maximise gains in Australian suicide prevention activities by highlighting promising processes and impacts and minimise repetition of less successful elements. The projects targeted 11 groups (with the most common being young people, Aboriginal and Torres Strait Islander people and people in rural/remote areas); occurred in various settings (with community-based projects being particularly popular); and employed different approaches (with training and support for health/community professionals or carers being favoured, along with public health interventions aimed at enhancing well-being and building resilience). Certain processes augured well for project success, including: understanding contextual factors; investigating participants' needs; drawing on sound evidence; developing multi-faceted strategies; garnering stakeholder support; and employing capable staff. The projects achieved improvements in knowledge about risk and protective factors for suicide, social connectedness and mental health literacy, and reductions in depressive symptomatology. Projects' sustainability was constrained by their short-term funding. These findings are discussed in the context of the NSPS entering a new funding phase.

Keywords

suicide, suicide prevention, evaluation, sustainability, national strategies, Australia

Introduction

Australia's National Suicide Prevention Strategy (NSPS) began in 1999, and has been operationalised through the Living Is For Everyone (LIFE) Framework (Commonwealth Department of Health and Aged Care, 2000a, 2000b, 2000c). The LIFE Framework takes a population-based, risk factor-oriented approach

to suicide prevention, based on the work of Mrazek and Haggerty (1994) and Silverman and colleagues (Silverman & Felner, 1995; Silverman & Maris, 1995). It classifies suicide prevention initiatives as universal¹, selective² or indicated³ on the basis of how their target groups are defined. Within this context, the LIFE Framework has guided activities focused on

Contact: Jane Pirkis, Program Evaluation Unit, School of Population Health, The University of Melbourne, Victoria 3010, Australia j.pirkis@unimelb.edu.au
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reducing suicide and suicidal behaviour. The NSPS has provided funding totalling \$AUD10m annually over the past seven years for national initiatives and local projects. As of July 2006, the NSPS is moving into a new funding phase.

The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) is a national initiative funded by the Department of Health and Ageing to support the implementation of the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Commonwealth Department of Health and Aged Care, 2000d) and the LIFE Framework. In its current role, Auseinet has been responsible for undertaking a national consultation on the LIFE Framework, establishing a national suicide prevention website (<http://auseinet.flinders.edu.au/suiprev/index.php>) and undertaking an analysis of the lessons from the local projects funded under the NSPS since 1999. Auseinet contracted the Program Evaluation Unit of the University of Melbourne's School of Population Health to undertake the latter analysis, with a view to developing a resource to inform the field of the outcome.

The analysis considered all local suicide prevention projects funded under the first phase of the NSPS, which number 156 in total. As at December 2005, 100 (63%) of these projects had been completed and 56 (37%) were ongoing. Table 1 provides a summary of these projects by state/territory. Project-specific details can be found on the Auseinet website. The analysis drew on the projects' progress and final reports, and aimed to inform future efforts by highlighting promising processes and impacts as well as less successful elements.

The paper presents an overview of the projects that have been funded to date, in order to give a

sense of their scope and to provide a context for subsequent lessons. It then identifies some of the lessons learned by considering the processes by which these projects have been implemented, their impacts, and their likely sustainability. Reporting on the findings from the analysis is timely, given that the NSPS is moving into its new phase of development.

Method

The analysis relied on information provided in projects' reports; no additional information (e.g., the selection criteria upon which funding decisions were based; verbal reports from project officers) was available to the study team. At the time of analysis, final reports were available for 100% of the completed projects, and progress reports were available for 96% of the ongoing projects.

Relevant information was extracted from the reports and synthesised in a manner that permitted the projects to be systematically profiled in terms of their nature, processes, impacts and likely sustainability. Quantitative data on the nature of the projects (i.e., their target groups, their settings and their specific approaches) were entered into an Excel spreadsheet, and simple frequencies and percentages were calculated. Qualitative information (on projects' processes, impacts and sustainability) was recorded manually and coded for themes.

It should be noted that the projects were funded to deliver interventions to individuals or communities, and not as academic, scientific studies. The projects were encouraged to conduct evaluations, and the majority of project reports (60%) presented some evaluative information. These reports were variable in terms of breadth and depth of information, and overall quality.

Table 1. Local suicide prevention projects funded under Australia's National Suicide Prevention Strategy, by state/territory

Projects	New South Wales	Victoria	Queens land	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory	Total
Completed	15	11	13	6	25	13	5	12	100
Ongoing	14	10	8	7	9	5	1	2	56
Total	29	21	21	13	34	18	6	14	156

Where projects had the capacity, they conducted relatively sound evaluations that tended to combine data from quantitative and qualitative sources, and assessed short-term and longer-term impacts using pre- and post-intervention measures. Where they did not have this capacity, they drew on less robust evaluation designs. Because of this variability, it was beyond the scope of the analysis to consider the effectiveness of projects delivered to different target groups, in different settings via different approaches, or to consider whether particular types of projects were 'better' than others. Instead, the analysis provided some learnings for those wishing to conduct, fund, manage or evaluate suicide prevention projects in the future, in terms of what seemed to work and what could be done better.

Results

I. Overview of the projects

The projects were provided to 11 different target groups, took place in eight different settings, and employed 11 different approaches. Table 2 provides a breakdown of the projects, using this taxonomy. It should be noted that a minority of projects straddled more than one target group or setting, and many used multiple approaches, so the totals exceed 156. An overview of the projects for given target groups is provided below.

Projects targeting young people (n=32)

Community-based settings

Nineteen projects targeted young people in community-based settings. Most commonly, these used public health interventions aimed at improving the well-being and resilience of young people by direct service provision (e.g., youth camps). Leadership programs were particularly popular, were often conducted at camps or in youth centres, and aimed to encourage 'personal development' (e.g., assisting young people to plan their actions) and 'social connectedness' (e.g., fostering networks between isolated young people).

Public health interventions delivered through media channels were also common in community-based settings, and typically involved a range of media (e.g., interactive web-based programs, videos, pamphlets). They

generally addressed mental health literacy (including information on mental health problems, where to seek help and how to assist peers in crisis), specific youth issues (e.g., teenage pregnancy, drug and alcohol use, petrol sniffing) and positive living skills (e.g., improving behaviours which contribute to well-being).

Other community-based strategies included providing training and support for carers and families of young people, peer support groups and the promotion of partnerships.

Three projects involved research into the support needs of young people in a community setting. Two of these investigated the needs of young people in specific sub-groups, namely young people with a mental illness and young people in rural areas. The other project convened a conference for policy makers, project officers and clinicians at which the research evidence on a range of issues affecting young people was presented.

Schools

School-based projects typically involved universal interventions aimed at improving resilience and reducing risk factors among all students. The majority trained parents, teachers and school counsellors (and sometimes young people themselves) in mental health related areas, often using multi-method, multi-target approaches with an established evidence base. For example, several projects employed the Resourceful Adolescent Program (RAP: Schochet & Osgarby, 1999) or the Triple P program (Sanders & Markie-Dadds, 1996). The former used cognitive behavioural therapy and interpersonal skills training to teach adolescents (RAP-A) and their parents (RAP-P) skills in stress management, problem-solving and strategies for preventing and managing conflict. The latter provided parents and teachers with behavioural strategies to deal with adolescent problem areas (e.g., smoking, alcohol and drug use, rudeness and disrespect), combining a broad public health approach (e.g., disseminating 24,000 tip sheets) and more specific, intensive education (e.g., via seminars and training workshops). One project screened students for anxiety, and then provided a follow up assessment.

Table 2. Projects by target groups, settings and specific approaches*

	Young people (n=32)	Older people (n=7)	Aboriginal and Torres Strait Islander people (n=43)	People from culturally & linguistically diverse backgrounds (n=12)	People in rural/remote areas (n=36)	People bereaved by suicide (n=5)	People who are gay, lesbian, bisexual or transgender (n=7)	People with mental health problems (n=23)	People who have deliberately self-harmed (n=5)	Men (n=21)	Veterans (n=2)
Settings											
Community-based settings	19	3	36	8	24	5	5	11	0	15	2
Schools	8	0	0	1	4	0	4	0	0	0	0
Tertiary institutions	2	0	0	0	1	0	0	0	0	0	0
Prisons	2	0	3	0	0	0	0	0	0	1	0
Workplaces	1	0	0	0	1	0	0	0	0	2	0
Emergency departments	0	0	0	0	2	0	0	1	5	0	0
Primary care settings	0	1	0	0	2	0	0	3	1	0	0
Other health care or community service settings	1	3	5	3	2	0	0	8	0	3	0
Specific approaches											
Providing direct clinical or counselling services	4	0	2	1	7	3	3	7	0	4	1
Running peer support groups	6	2	7	7	9	0	2	3	0	7	0
Providing training and support for health/community professionals or carers	14	5	10	4	18	3	2	17	5	10	2
Promoting partnerships	8	0	1		4	0	3	5	0	2	0
Conducting public health interventions aimed at enhancing well-being and building resilience	16	1	24	6	17	0	5	2	0	11	0
Conducting public health interventions aimed at improving mental health literacy (delivered via community education or media channels)	6	1	7	0	8	0	2	0	0	5	0
Developing common protocols	0	0	2	0	0	0	0	0	2	0	0
Developing a bereavement resource	0	0	0	0	0	3	0	0	0	0	0
Providing a crisis or bereavement response plan	0	0	2	0	0	1	0	0	0	0	0
Following up people discharged from emergency departments ('after care')	0	0	0	0	0	0	0	0	3	0	0
Conducting research	3	0	3	1	0	0	0	1	0	1	0

* Multiple target groups, settings and specific approaches sometimes applied to the same project, so the sum of target groups exceeds 156, and the sum of settings and/or specific approaches within a given target group may exceed the number of projects listed for that target group.

Tertiary institutions

Two projects targeted young people in tertiary institutions by providing public health information to university students through a variety of methods (e.g., by including contact details of mental health services in student diaries). Both projects also delivered suicide prevention training to students and/or staff. One provided Gatekeeper Workshops to university staff (e.g., Aboriginal health workers) and postgraduate students, with the aim of increasing participants' awareness and knowledge of the risk factors for suicide and providing them with basic suicide intervention skills. The other provided students with the Applied Suicide Intervention Skills Training (ASIST) program and encouraged students to pass on their knowledge to others through small projects of their own devising.

Prisons

Two projects provided services to young people in juvenile detention facilities. One provided drama workshops and the production of plays focused around building hope in at risk young people. The other offered training in suicide risk identification and management for facility staff.

Workplaces

One project targeted young people in workplaces. Specifically, it targeted young male apprentices and trainees in the building, construction, forestry, mining and energy industries. The project initiated a compulsory training package which provided information on: mental health issues (e.g., alcohol and drug use, depression); workplace challenges for young apprentices (e.g., bullying); and details of how to access assistance.

Other health or community service settings

One project was delivered to young people via health services. This involved providing training for youth mental health service clinicians aimed at developing a more family-inclusive approach to treatment. It also incorporated direct family counselling. The project relied on referrals from community mental health providers who worked with young people, and provided secondary consultation and direct care interventions to families identified by these referral sources.

Projects targeting older people (n=7)

Community-based settings

Three projects targeting older people were conducted in community settings. Typically, these provided mental health promotion (through radio interviews, written material which was distributed through community health providers, and 'well-being workshops' for older persons) or ran peer support activities (e.g., a walking group) for socially marginalised older people (e.g., from culturally and linguistically diverse backgrounds).

Primary care settings

One project targeted older people via primary care settings. This project developed a resource for GPs entitled 'Identifying and Managing Suicidal Risk in Older Adults: A Desktop Reference Guide for General Practitioners'. The resource was based around a screening, diagnosis and management (SDM) approach, and aimed to assist GPs to identify and respond to older consumers with depression or suicidal ideation.

Other health care or community service settings

Projects targeting older people via health or community services setting typically trained health or community professionals in suicide prevention skills. For example, one project employed a project manager with expertise in suicide prevention to develop a suicide prevention kit entitled 'How to Thrive Past 55'. The project manager then trained project workers in several sites, who in turn delivered suicide prevention training to people who worked with or cared for older people, as well as older people themselves. In other cases, project officers delivered pre-existing materials on suicide prevention (e.g., ASIST) to relevant health and community professionals and to older people themselves.

Projects targeting Aboriginal and Torres Strait Islander people (n=43)

Community-based settings

Projects targeting Aboriginal and Torres Strait Islander people via community-based settings were popular, and most commonly used public health interventions aimed at improving well-being and resilience through direct service provision. The largest number of these involved promoting social and emotional wellbeing

among young people and/or providing them with support. Many of these projects included cultural activities aimed at fostering social connectedness and pride in Aboriginal culture (e.g., Aboriginal dance groups, trips to other Aboriginal communities, camps with Aboriginal elders). Sporting and recreational activities for Aboriginal youth aimed at increasing self-esteem and relieving boredom were also popular (e.g., sporting competitions, youth drop-in centres). Other common community-based programs included men's and women's groups. These primarily targeted building self-esteem, leadership skills and conflict resolution strategies.

Several projects targeted Aboriginal and Torres Strait Islander people via media channels, including through radio programs about suicide prevention or a broader sense of social connectedness. Several projects also produced their own culturally-specific education or training materials targeting suicide prevention (such as videos, resource manuals and websites).

Two projects developed crisis management plans that were tailored to the needs of the local community. These projects involved asking the community to identify locals who could be contacted in a crisis (e.g., elders, a respected police sergeant). The project officer then trained these individuals in basic suicide prevention skills (i.e., assessment and referral skills) and provided them with necessary support (e.g., from professional mental health care providers if required).

Three projects involved research. One examined the attitudes of young Aboriginal people towards suicide and the other two used participant action research in the development of their interventions (a men's group and a personal development training course).

Prisons

The prison-based projects used a variety of strategies to target Aboriginal and Torres Strait Islander inmates, including training prison staff to better identify and manage those at risk of suicide (often via the ASIST program). Prisoners themselves were also trained to deliver an induction to prison life, provide an ongoing mentor service, and increase the mentor's awareness of suicide risk in prison.

Media channels were used by one prison-based project, which made use of a radio program accessible within the local prison to broadcast supportive messages from prisoners' families and friends.

One project involved improving partnerships between the prison system and Aboriginal organisations. This partnership resulted in the formulation of resources (e.g., culturally appropriate referral pathways for Aboriginal people with mental health issues in prison) to increase the resilience of young Aboriginal men in prisons.

Other health care or community service settings

Many of the projects set in health and community services involved training for staff working with Aboriginal and Torres Strait Islander people, via packages such as the ASIST program. Training workshops involved participants from a wide range of groups (e.g., health professionals, police, Centrelink staff). Aboriginal health workers also received this training. One project involved cultural awareness training for mainstream mental health workers about meeting the needs of Aboriginal clients.

Projects targeting people from culturally and linguistically diverse backgrounds (n=12)

Community-based settings

Community-based projects targeting people from culturally and linguistically diverse backgrounds most commonly addressed issues of social isolation faced by these individuals (particularly those who had arrived in Australia relatively recently) by offering peer support groups and/or public health interventions such as 'adventure camps'. These approaches focused on self-awareness, problem-solving and assertiveness. For example, one project ran a group for male refugees that focused on providing education on the potential after effects of torture and trauma, as well as linking group members to a range of services (e.g., counselling, other social support groups).

A single community-based research project explored the needs of young migrants via interviews with this group, their carers and a range of service providers. The project identified several problem areas for young migrants from non-English speaking backgrounds including

social isolation, lack of peer support, a need for counselling and other mental health and support services (particularly in the aftermath of torture and trauma), language difficulties and sub-optimal education.

Schools

A single school-based project focused on enhancing the capacity of schools to provide a responsive and supportive environment for newly-arrived refugees. The project provided: training and secondary consultation to teachers of young refugees to assist them to deal with newly-arrived refugees; counselling to young people whom teachers deemed to be in need of additional intervention; peer support groups which focused on assisting refugees in the 'early settlement period'; and mental health curriculum material, designed to have a sustained impact on schools.

Other health care or community service settings

Several projects offered training to health and other professionals (e.g., people in the community with pastoral care roles) that focused specifically on issues that might be related to the migration experience or its aftermath (including trauma, depression and suicide risk). The training took various forms. For example, one project translated the existing Mental Health First Aid course (Kitchener & Jorm, 2002) into Vietnamese, Croatian and Italian, and trained instructors who spoke each of these languages to deliver the course.

Projects targeting people in rural/remote areas (n=36)

Community-based settings

Projects conducted in rural/remote community-based settings most commonly involved the provision of training to health/community professionals (e.g., local area health workers, teachers, police etc) or carers of people at risk of suicide (e.g., parents). The training often took the form of workshops and used standard approaches, such as ASIST workshops or the 'Gatekeeper' program. These focus on teaching people how to identify and respond to people at risk of suicide.

Also popular were projects that adopted public health interventions in rural/remote areas, particularly those that involved providing health

and mental health information via a variety of channels (e.g., seminars, pamphlets and other resources). For example, in one project, Lifeline was responsible for distributing a mental health information kit to around 5,000 services, agencies and community groups. Often these projects used existing community events (e.g., a rodeo or an ANZAC Day parade) as a vehicle for disseminating mental health information.

A number of community-based projects also offered direct clinical or counselling services, often dealing with tangible problems such as managing anger or coping with particular stressors (e.g., redundancy or relationship separation), and doing so in innovative ways. For example, in one project Relationships Australia conducted free individual 'Relationship Tune Up' sessions for rural men and marketed the counselling centre as 'a pub with no beer'. Once men were engaged in the service, it was possible to assess them for depression or suicidal ideation and to provide ongoing treatment or referral as required.

Peer support groups and other activities aimed at improving the social connectedness of people in rural and remote areas (particularly older people and men) were also relatively common.

Schools

School-based projects aimed to build resilience among rural young people by providing education on physical and mental health, improving access to community services (e.g., by developing partnerships), and conducting 'leadership' training with adolescents.

Tertiary institutions and workplaces

The projects set in rural/remote tertiary institutions and workplaces aimed to improve the mental health literacy of people in these settings, with a view to, for example, encouraging them to seek help when necessary.

Emergency departments

Two rural/remote emergency department projects were conducted which involved training and system change interventions designed to improve assessment and care of suicidal individuals. One involved training emergency department staff and other crisis responders to better assess and manage people at risk of suicide. The other involved developing protocols

across emergency departments to standardise the triage and management of people who have deliberately self-harmed.

Primary care settings

Two rural/remote primary care projects were conducted, and these also involved training and system change interventions. Both aimed to improve GPs' identification and management of people at risk of suicide, one via resources and the other via training and support.

Health or community services

Two projects targeting people in rural/remote areas were set in health and community services, and both involved training for staff, via packages such as the ASIST program. Training workshops involved participants from a wide range of groups (e.g., health professionals, police, Centrelink staff).

Projects targeting people bereaved by suicide (n=5)

Community-based settings

Several community-based projects developed resource packs for people bereaved by suicide and health practitioners who provide care for them. These resource packs provided information on the grief process following a suicide (e.g., common emotional reactions, stages of grief) and practical information on what to expect after the loss of a loved one (e.g., dealing with the coroner, arranging and paying for the funeral, administering the estate). In recognition of the fact that people who have been bereaved by suicide are at heightened risk of suicide themselves, one bereavement pack also contained a checklist of 'key warning signs' for suicide and a list of counselling and crisis services.

One project developed a 24-hour co-ordinated bereavement response that enlisted the support of 'emergency responders' (e.g., police and ambulance services) and 'secondary responders' (e.g., the coroner, schools, religious groups). It also provided immediate support and links to additional services, such as suicide bereavement support groups.

Other projects provided direct counselling services for individuals or groups and/or conducted bereavement training for members of the public and community service providers.

Projects targeting people who are gay, lesbian, bisexual or transgender (n=7)

Community-based settings

Five projects targeting people who are gay, lesbian, bisexual or transgender were community-based. These projects most commonly involved community capacity-building via workshops, information provision (e.g., through resources such as brochures and internet sites), support groups and individual counselling. For example, some formed regional peer support groups for young gay and lesbian people. Others provided professionals with training on issues relating to young gay and lesbian people and better equipped them to deal with issues arising for this group.

Schools

Four projects targeting people who are gay, lesbian, bisexual or transgender involved schools. Typically, they incorporated teacher training, curriculum development and/or workshops and support groups for same-sex attracted young people.

Projects targeting people with mental health problems (n=23)

Community-based settings

Several projects targeting people with mental health problems took place in community-based settings. These projects tended to target people (primarily young people) with comorbid drug and alcohol problems, and involved provision of support to families and carers through approaches such as family counselling, training of mental health clinicians in family inclusive approaches, and family group programs.

Emergency departments and primary care settings

Three projects targeted people with mental health problems via GPs and community mental health providers in primary care settings, and one of these also involved emergency department personnel. This project attempted to improve links between GPs, community mental health providers and emergency department staff. All three projects provided some level of training to GPs, ranging from using psychologists to help GPs perform broad psychological assessments, to training GPs to use a specific suicide assessment instrument (e.g., the 'Mini Suicidality Test').

Other health care or community service settings

Eight projects targeted people with mental health problems via other health care or community service settings. Some aimed to improve continuity of care for people in these settings (e.g., by introducing an intensive case management model, by streamlining discharge from acute inpatient settings into community settings or by promoting partnerships between elements of the system). Others provided suicide prevention training to staff (and volunteers) working in these settings (either face-to-face or online).

Projects targeting people who have deliberately self-harmed (n=5)

Emergency departments

All five projects targeting people who had deliberately self-harmed involved providing training to emergency department staff. There were three aspects to training: training emergency department triage staff to improve the recognition of deliberate self-harm; training 'after care' staff to provide effective follow up (see below); and training emergency department staff in protocols regarding referral of people to 'after care' (see below).

Three projects involved the provision of 'after care', or assertive follow up of people who had presented to the emergency department following deliberate self-harm and were subsequently discharged. The choice of the form of 'after care' provided depended on the project's resources. The metropolitan projects tended to be better resourced and therefore they directed efforts towards improving the quality of care, either by training staff to deliver a new model of 'after care' or by providing the 'after care' directly. For example, one metropolitan project trained clinicians to provide assertive follow up within 24 to 48 hours of a person being discharged from the emergency department, while another employed clinicians to deliver brief counselling over four to six weeks post-discharge and occasional follow up for a further six months. In rural projects, 'after care' enhancement relied on linking people to existing 'after care' services and community supports such as GPs and community mental health services. For example, in one rural project a 'transition worker' ensured that people were referred to an 'after care' agent, usually a GP.

Two projects established common sets of protocols across emergency departments and community health services or general practice. Typically, these projects established single systems to identify, manage and follow up people who presented to emergency departments with suicidal thoughts or behaviours.

Projects targeting men (n=21)

Community-based settings

Community-based projects targeting men used a wide range of strategies. One frequently-used approach was to provide suicide prevention training to health or community professionals who worked with men or carers who looked after men (usually older men), often via the ASIST course.

Public health interventions aimed at enhancing well-being and building resilience were also popular among the community-based projects targeting men, as were media approaches to highlighting men's health issues. Some of these projects targeted men by their content and context. For example, one rural project used the male-oriented slogan 'Before it gets too much ... Talk to a mate'. Others targeted men through male-dominated events (such as rodeos) by providing information on mental health issues at these events.

Projects providing social support for men were also popular, and were often employed in rural areas where men face particular issues of social isolation. Some offered face-to-face group based programs that were often activity-focused rather than being explicitly centred on social support. Others offered 'virtual' programs (e.g., an internet-based farmer advice and support group).

Other approaches included providing counselling and promoting partnerships. For example, in one case Lifeline helped to upskill local service providers in suicide prevention and fostered ongoing collaborations in order to continue the work.

A single research project was also conducted. This involved a program of research consultation with young men, their families (and carers) and relevant support agencies and services, in order to build knowledge about what strategies might be most effective in reducing risk factors for suicide among men.

Prisons

A single prison-based project targeting men provided training in identification and management of suicide risk to staff of a juvenile detention centre who dealt predominantly with male detainees.

Workplaces

Two men's projects were conducted in workplace settings. One was conducted in a remote rural area, and provided brief sessions on men's health, including information on suicide and depression. The other involved a national apprenticeship scheme whose constituent members were predominantly young men, and combined health promotion activities (e.g., building mental health and suicide prevention messages into staff inductions) with one-to-one counselling for people experiencing mental health difficulties.

Other health care or community service settings

Three projects targeting men were located in health or community services, and these provided suicide prevention training to health providers or members of the public who worked with men. Two provided suicide prevention training to carers of older men; the third provided training to a wide range of community-based professionals, from local business owners to community nurses.

Projects targeting veterans (n=2)

Community-based settings

Two projects targeted veterans, both of which were community-based. Both provided training to health professionals, veterans or veterans' carers/children via the ASIST program. One also provided individual and group counselling to children of veterans.

II. Lessons learned

Project processes

According to evidence gleaned from the project reports, there were striking commonalities across target groups in terms of 'what worked well' regarding project processes. The processes that stood out are described here.

Recruiting, retaining and supporting project staff and other project personnel

Projects that were able to recruit appropriately qualified and experienced staff from the outset

tended to run smoothly, especially if these staff could be retained for the project's duration. The same was true of other personnel brought in to assist with particular aspects of the project (e.g., community members recruited to assist with running group sessions). Retention was often dependent upon providing adequate support to project staff and other personnel, particularly in instances where they were professionally or geographically isolated. Difficulties with recruiting, retaining and supporting project staff and other project personnel were the most commonly-identified problems across projects.

Planning the project and taking into account logistical factors

Careful planning was reportedly crucial to project success. Allowing sufficient time for project development and implementation, operationalising project objectives into clear strategies and planning the project in phases were all important. The short-term nature of funding for these projects (often only one year) sometimes militated against spending time on planning, but those projects that were able to plan within this funding context (e.g., developing realistic objectives, putting in place strategies for sustainability) managed to overcome this. Logistical factors (e.g., timetabling issues in school-based projects) were sometimes difficult to overcome, however, even with careful planning.

Understanding the local context

Projects that went to some effort to understand the context within which they were operating tended to do well. A number of projects conducted 'service mapping' exercises to establish the nature and level of current service provision, and complement this by addressing areas of unmet need. This had the benefit of filling service gaps, rather than creating duplication, and also often brought related organisations 'on board'.

Establishing a reference group with representation from key stakeholders

Many projects established reference groups to guide their development. These groups had representation from key stakeholders, including members of the target group. Establishing such groups had many advantages. It meant that projects received advice from people with relevant experience and expertise. It ensured

'buy-in' from these individuals and often the organisations they represented. In addition, the presence of respected individuals on these reference groups gave projects credibility in the community.

Gaining project acceptance

Many projects put considerable effort into getting the project accepted by relevant parties (e.g., the community, school staff, clinicians and managers in health care settings), and found this yielded rewards. Conversely, those that faced resistance typically experienced ongoing difficulties. Gaining project acceptance involved eliciting the trust of these parties, which was not always easy to achieve, particularly in circumstances where they had had negative experiences with short-term projects in the past. Some found it useful to target prominent individuals (and/or organisations) to gain their support and enthusiasm for the project; others found it helpful to draw on the skills and expertise of key individuals in running the projects (e.g., involving local community members as trainers or group leaders). The more successful community-based projects targeting Aboriginal communities, for example, developed relationships with key stakeholders and often enlisted the support of respected elders to promote the project and deliver services (e.g., provide education and support to other community members). Similarly, a number of the projects that provided direct clinical or counselling services developed strategies for bringing clinicians and other providers 'on board', which was important in ensuring referrals.

Forming collaborative partnerships

Related to some of the above processes was the strategy of forming collaborative partnerships. Many projects went to considerable lengths to develop formal and informal links with relevant organisations, in order to gain their support and streamline service delivery. When they worked well, these partnerships formed the backbone of the project.

Seeking input from key stakeholders

Projects that explicitly sought input from key stakeholders regarding the design and implementation of the interventions run by the project typically did well. In particular, many

projects found that involving the target group in planning, developing and delivering the given intervention improved its acceptability and uptake. This was true, for example, in the case of projects targeting young people. By seeking their feedback in an ongoing fashion throughout the development and implementation phases, many of these projects were able to ensure that project-related services and activities were 'youth friendly'.

Promoting the project

Projects that promoted themselves well tended to gain community acceptance and achieve high participation rates. Projects that took a strategic approach to promotion and factored it into their planning generally did well in this regard, as did projects that used a variety of promotional avenues ranging from opportunistic meetings to targeted media advertising.

Taking evidence into account

Recourse to the best available evidence during the planning and development phases ensured that project interventions were optimally designed. Sometimes this involved reviewing the relevant scientific literature; in other cases it involved seeking the opinion of experts.

Providing flexible, multi-faceted and/or innovative interventions

Projects that were prepared to modify their strategies to cater to broad needs tended to be successful, as did those that took novel approaches to service delivery. These projects were able to be responsive to needs that emerged during the course of the project, by offering complementary project components to meet these needs. A number of the projects that were funded to support same-sex attracted young people, for example, ultimately provided service supports to parents of these young people, in response to feedback from the parents.

Tailoring the intervention(s) to meet identified needs

In a similar vein, projects that tailored their intervention(s) to meet the specific needs of the target group were well-received. For example, the projects targeting men found that it was important to 'gear' the style of delivery towards this group. Men typically favoured brief, informal, chatty presentations over lengthier, didactic, clinical presentations. In addition, they were more readily engaged where they worked

and took part in leisure activities than in purpose-designed settings. They were reluctant to talk about sensitive issues, so the projects often offered them non-threatening activities.

Utilising appropriate resources

For many projects, the key to success was using appropriate resources. Conversely, a lack of appropriate resources could lead to projects stalling. Sometimes existing resources, such as the ASIST package, were available. On other occasions new resources needed to be developed or existing resources needed to be modified, because available materials were not entirely appropriate to the needs of the target group. For example, some of the projects targeting Aboriginal and Torres Strait Islander people modified the ASIST package to better meet the needs of their constituent communities, and some of the projects targeting people from culturally and linguistically diverse backgrounds found that new practical, content-based resources were required.

Recognising the sensitivities surrounding suicide and mental health problems

Projects that explicitly addressed the stigma associated with suicide and mental health problems sometimes had an advantage. Some projects took a 'softly softly' approach, and addressed issues to do with suicide indirectly (e.g., by providing activities aimed at increasing resilience), rather than, for example, providing education about suicide prevention. This often worked well for target groups for whom particular taboos operated, such as some Aboriginal and Torres Strait Islander communities and some cultural groups. Other projects used fairly general issues to encourage initial participation, and moved on to more specific suicide-related topics once trust had been established. For example, a number of the projects targeting men began with broad-based presentations on men's health and introduced discussions of suicide prevention as time progressed.

Project impacts

There was some evidence of project impacts, and, like the successful processes, these were similar across target groups.

Improvements in participants' knowledge about risk and protective factors for suicide

Evaluations of training projects that targeted health/community professionals and/or carers typically demonstrated gains in knowledge about risk and protective factors for suicide among participants. Such gains were viewed positively, since they were seen as underpinning appropriate assessment of suicide risk.

Increases in social connectedness

Evaluations of several projects employing peer support groups as a vehicle for improving the social connectedness of participants suggested that they achieved this aim. Social isolation and lack of support are regarded as risk factors for suicide, so the peer support approach could be regarded as providing a buffer against suicide risk.

Improvements in mental health literacy

Evaluations of community education projects tended to suggest that they led to improvements in the general public's mental health literacy. In other words, these projects appeared to increase the likelihood that community members would recognise signs of depression and suicidality in others, would know where to advise them to go for help, and would seek help themselves if they were experiencing difficulties.

Reductions in depressive symptomatology

Several projects providing direct counselling and/or clinical services led to reductions in depressive symptomatology (and sometimes suicidal ideation) among recipients of these services, according to their evaluations.

Project sustainability

There were also some findings with regard to project sustainability; again these were similar across target groups. In general, the sustainability of the projects themselves was limited by their finite funding periods. Many project reports noted that this impacted on community support for the project and made it difficult to plan and deliver services with any sort of long-term focus. Some projects attempted to address this by seeking funding from alternative sources. This tended to be most successful in circumstances where relationships had been built up over time with potential funding bodies, and when sound evaluations had

been conducted that demonstrated the given project's worth.

Some projects went to considerable lengths to maximise the chances of their activities being sustained over time. This generally happened in one of two ways. The first involved embedding the project's activities or resources into an existing service or system in such a way that they continued beyond the funded life of the project (e.g., developing common protocols for use across emergency departments and community health services). The second involved equipping participants with skills and knowledge that they would retain after the project activities had ceased, which commonly occurred in projects employing train-the-trainer approaches.

Discussion

The current study provides an overview of the projects that have been funded to date under Australia's NSPS. These projects have been delivered to a range of target groups, in a number of settings, via varying approaches. Certain types of projects have been particularly dominant – namely those adopting universal and selective approaches in community-based settings with groups with a generalised heightened risk of suicide (Robinson, McGorry, Harris et al., 2006).

As noted, the NSPS is moving into a new phase, and funding has been announced for 31 new large community-based projects (valued at \$100,000-\$500,000 per annum) and 15 new small community-based projects (valued at \$50,000 or under). The projects are summarised on the Department of Health and Ageing website (<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/coag-mental-suicideprevention.htm>). They address a similar mix of target groups to the 156 original projects, with a particular emphasis on young people, Aboriginal and Torres Strait Islander people, and people bereaved by suicide. It is opportune to consider whether there are lessons for these projects from the current study, in terms of the way in which they are delivered.

There certainly appear to be some development and implementation processes that should be fostered in the new projects. Understanding the

context within which the project is operating is important, as is investigating constituents' needs and using the best available evidence to develop strategies to meet these needs. Multi-faceted strategies may work best, particularly if they provide complementary approaches, and/or meet the needs of different sub-groups. Garnering the support of key stakeholders by developing partnerships and establishing reference groups early in the piece is crucial, as is employing capable, well qualified and experienced staff. An awareness of these processes may prove useful to organisations managing the new projects. These processes could be encouraged by various means, including the development of communication networks (e.g., forums where previous or existing project officers could provide advice to new project officers) and/or explicit contractual requirements.

There is also an argument that consideration should be given to ways of encouraging the new projects' sustainability, since there is evidence from the current study that this is likely to impact upon the enthusiasm with which they are taken up. It is worth noting here that funding for the original projects was, from the outset, designed to be short-term. Projects were instructed to take steps towards becoming sustainable within the funding period. If they were unable to do this, they could apply for further NSPS funding. A minority of projects managed to secure ongoing funding, particularly if they built up relationships with funding bodies and/or could present strong evidence of the projects' value. Some were able to ensure the maintenance of project activities by embedding them within existing systems or equipping participants with skills and knowledge that they could continue to pass on to others. Again, it might be worth explicitly fostering these approaches as the new phase of the NSPS unfolds.

Emphasis should be given to evaluation of the new NSPS projects. The current work provided indications that the projects achieved improvements in knowledge about risk and protective factors for suicide, social connectedness and mental health literacy, and led to reductions in depressive symptomatology. Future evaluation efforts could strengthen this by

examining the extent to which any similar changes can be attributed to project interventions, whether these changes are maintained over time, whether they translate into reductions in completed or attempted suicide rates, and whether some interventions are more effective than others.

Because we are still learning what works and what doesn't work in suicide prevention, sound evaluations are crucial. A recent systematic review of the international literature on suicide prevention strategies indicated that although there is good evidence for the effectiveness of a small number of interventions, insufficient is known about a much larger number to determine whether they work or not (Mann, Apter, Bertolote et al., 2005). Absence of evidence of effectiveness should not necessarily be regarded as evidence of absence of effectiveness, so it is reasonable that future NSPS efforts might include interventions with as-yet unproven effectiveness, but only if they are evaluated appropriately.

Appropriate evaluation will involve careful consideration of design and method issues. Perfectly-designed randomised controlled trials are often ethically and practically difficult to mount in suicide prevention, but other sound evaluation designs are available and should be explored (Goldney, 1998). Quasi-experimental designs may prove useful, for example, because their inclusion of a control group enables any impacts observed for the intervention group to be attributed to the intervention with greater certainty. Consideration of appropriate outcome measures will also be important, in order that more definitive statements can be made about projects' effectiveness. Evidence of reductions in completed or attempted suicide rates would be desirable, but the relatively low base rate of these suicidal behaviours means this is not always feasible. Proxy measures may therefore be necessary, but there is an onus on evaluators to demonstrate that these measures are reliable and are related to the higher-level outcomes. Clarification of program logic or program theory may also be helpful here, because this can explicate the way in which various program inputs would be expected to lead to intermediate impacts and longer-term outcomes in a manner

that lends itself to scientific testing. Unanticipated negative outcomes should also be monitored and reported.

Future evaluation efforts will require careful forethought. Ideally, an evaluation framework should be devised that can guide the evaluation of the next phase of the NSPS and its component parts against its stated aims, and evaluations of individual projects should be designed in a manner that is consistent with this framework. In addition, the evaluation capacity of those commissioning and undertaking projects should be strengthened, perhaps by employing experienced evaluators to work collaboratively with local parties on design and analysis issues.

Sound evaluation efforts will permit an examination of the effectiveness of different interventions 'rolled out' through the new projects of the NSPS. Indeed, if costs are considered as well as benefits, future evaluations will have the potential to provide information on the cost-effectiveness of different interventions aimed at the same target group, and of the same intervention aimed at different target groups. It will also provide a better understanding of the cost-effectiveness of different processes for implementing and sustaining (or building capacity for) interventions of known efficacy, and will offer insights into the system-level and community-level factors that influence sustainability. Clarifying these sorts of questions will enable funders and providers of future interventions (both in Australia and overseas) to select suites of interventions that are likely to provide the best value for money, in terms of reducing suicide risk across various population groups.

To conclude, the 156 projects funded under the NSPS reached a broad range of target groups in places where they lived, worked, studied, engaged in other daily activities and/or sought care, and employed a range of approaches. Certain processes augured well for their success, and they achieved positive results. Funding a broad range of projects gave many communities access to suicide prevention activities, and fostered local innovation. The projects' accomplishments have been impressive, and set the scene for the next phase of the NSPS. As the NSPS moves into its this new phase, particular

implementation processes will need to be encouraged and strong evaluation efforts will be paramount, in order that the relative effectiveness and cost-effectiveness of different approaches can be tested.

Notes

1. Universal interventions target whole populations, with the aim of favourably shifting proximal and distal risk and protective factors across the entire population.
2. Selective interventions target subgroups whose members are not yet manifesting suicidal behaviours, but exhibit proximal or distal risk factors that predispose them to do so in the future.
3. Indicated interventions are designed for people who are identified through screening programs or by clinical presentation as already beginning to exhibit suicidal thoughts or behaviours.

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