11 POSITIONING THE NSPP IN AUSTRALIA'S SUICIDE PREVENTION EFFORTS

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

11.1 Introduction

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

11.2 The spectrum of suicide prevention activities in Australia

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

11.2.1 National initiatives

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

Table 11-1: Selected key national initiatives

- NSPP and TATS-funded projects
- MindMatters and KidsMatter
- Aboriginal and Torres Strait Islander Suicide Prevention activity
- Development of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- Renewal of the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing (in development)
- Research bodies and related funding, including the Black Dog Institute, the Australian Institute for Suicide Research and Prevention, the Hunter Institute for Mental Health and *beyondblue*'s research program
- Acute, sub-acute and community mental health services
- ATAPS, the Better Access initiative, and other programs offered through Medicare Locals
- Initiatives under the National Drug Strategy
- Aged care programs
- Initiatives under A Stronger, Fairer Australia – Australia's social inclusion policy, including a range of strategies that address unemployment, homelessness, disability and other key forms of disadvantage, all of which are risk factors for suicide

- Initiatives run by headspace – Australia's National Youth Mental Health Foundation – including headspace centres, headspace school support and headspace online counselling
- *beyondblue* services
- Helplines, including Lifeline, Kids Helpline and MensLine Australia
- Initiatives that support GPs (and other primary care health professionals), including GP Psych Support, Primary Mental Health Care, the Royal Australian College of General Practitioners (RACGP) mental health page and Suicide Questions, Answers and Resources (SQUARE)
- Online counselling and self-help services, such as the MoodGYM program established by the Centre for Mental Health Research at Australian National University
- Programs delivered through the Department of Veterans Affairs, such as Operation Life
- Indigenous initiatives and mental health programs delivered through Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), such as Personal Helpers and Mentors Services (PHaMS).

11.2.2 State and territory initiatives

It is not feasible within this evaluation to conduct a mapping exercise of all suicide prevention activities occurring at state/territory level. This is a challenging task which has been taken on by researchers in some jurisdictions[90]; however, a key methodological issue with such mapping studies relates to the definition of what constitutes suicide prevention activity.

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

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

[90] Queensland Health, *A mapping exercise of existing suicide prevention programs and services in Queensland*, report prepared by Australian Institute for Suicide Research and Prevention, accessed 24 April 2013, <http://www.griffith.edu.au/health/australian-institute-suicide-research-prevention/research/past-projects>.

11.3 ATAPS Suicide Prevention service initiative

11.3.1 Background to ATAPS

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

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

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

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

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

[91] J Fletcher, K King, B Bassilios et al, *Evaluating the Access to Allied Psychological Services (ATAPS) Program: Nineteenth Interim Evaluation Report*, University of Melbourne Centre for Health Policy, Programs and Economics, Melbourne, 2012.
[92] Department of Health and Ageing, *Operational Guidelines for the Access to Allied Psychological Services Initiative*, DoHA, Canberra, 2012.

11.3.2 ATAPS evaluations

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

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

11.3.3 Summary of ATAPS Suicide Prevention service initiative evaluation findings

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

Level of uptake by consumers

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

Level of participation by professionals

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

Socio-demographic and clinical profiles of consumers

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

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

[93] Fletcher et al, *Evaluating the Access to Allied Psychological Services (ATAPS) Program*.

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

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

Nature of the treatment received by consumers

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

Outcomes for consumers

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

11.3.4 Implications of the ATAPS Suicide Prevention service initiative evaluation findings

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

Appropriateness

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

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

[94] Mann et al, 'Suicide Prevention Strategies'.

outcomes may be produced if GPs and other health professionals with specialised health care skills work together in the delivery of care.

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

Effectiveness

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

Efficiency

It has not been possible to establish the extent to which the ATAPS Suicide Prevention service initiative represents value for money. No economic analysis has been undertaken to date because the national expansion of the program is still in its infancy and there is limited data on outcomes at this stage.[95]

Key findings

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

11.4 MindMatters

11.4.1 Background to MindMatters

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

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

[95] Officer from DoHA Mental Health Services Branch, personal communication, 23 April 2013.

- Help school communities create a climate of positive mental health and wellbeing
- Develop strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing
- Enable schools to better collaborate with families and the health sector.[96]

The MindMatters initiative is currently being redeveloped and a new program will be available in 2014.

11.4.2 The MindMatters evaluations

The following discussion focuses on the MindMatters initiative from 2006 to 2013. It is informed primarily by two documents: the *MindMatters Evaluation Report September 2010*[97] and *The Impact of MindMatters by State*[98], which is based on data collected through the Principals School Leadership Survey in 2011. Whilst a more comprehensive suite of evaluation reports (including case studies of individual schools) was completed between 2000 and 2005, they have not been reviewed here as they are outside the timeframe for the current NSPP evaluation.

11.4.3 The MindMatters evaluation findings

The following section outlines the key MindMatters evaluation findings based on the available reports.

The MindMatters Evaluation Report September 2010

The *MindMatters Evaluation Report September 2010* assessed awareness and uptake of the MindMatters initiative, based on the administration of a brief questionnaire for school staff. The evaluators reported difficulties with engaging schools to complete the questionnaire: in total, 1,200 schools across Australia were contacted, with 166 participating in the survey. This low response rate has implications for the representativeness of the sample.

The key evaluation findings were:

- Of those responding:
  - 98% of secondary schools were aware of the MindMatters initiative
  - 66% of secondary schools were using at least some aspects of the MindMatters initiative, with government schools more likely to use MindMatters than non-government schools
  - 77% of schools had used at least some aspect of MindMatters in the past three years
- In 68% of those schools using MindMatters, the program was the responsibility of an implementation team (suggesting a higher level of engagement with the program)
- 65% of schools had used MindMatters as a curriculum resource
- 38% of schools reported using MindMatters as their key organising resource for mental health promotion
- 51% of schools reported using programs other than MindMatters for mental health promotion. In most cases, these schools were using the other program in addition to MindMatters. A wide range of programs were reported in the survey, but the only one listed in the evaluation report was *beyondblue*

[96] MindMatters, 'About MindMatters', accessed 2 April 2013, <http://www.mindmatters.edu.au/about/about_landing.html>.
[97] Australian Council for Educational Research, *MindMatters Evaluation Report*, ACER, Melbourne, 2010.
[98] Principals Australia Institute, *Impact of MindMatters by State, 2011*, PAI, Sydney, 2013. Provided to AHA by PAI via email, 2 April 2013. This document is expected to be available from the MindMatters website shortly <www.mindmatters.edu.au>.

- 64% of schools reported that staff members had attended recent MindMatters professional development sessions.

The authors noted that the findings from this evaluation were largely consistent with those from the previous (2006) evaluation.

Impact of MindMatters by State

A 2011 survey of school principals by PAI assessed levels of satisfaction with MindMatters.[99] Note that no information was provided regarding the sample size or response rate for this survey and, as such, the results should be interpreted with caution. The survey found that of the school leaders nationally:

- 79% were satisfied or very satisfied with MindMatters providing strategies for classroom teachers in supporting mental health and wellbeing for students
- 71% were satisfied or very satisfied with MindMatters contributing to providing knowledge, understanding and strategies specifically for high support needs students
- 73% were satisfied or very satisfied with MindMatters building their own personal understanding of mental health and wellbeing
- 79% were satisfied or very satisfied with MindMatters increasing knowledge and understanding of mental health and wellbeing of staff attending professional learning
- 78% were satisfied or very satisfied with MindMatters providing professional development ideas used in their schools
- 71% were satisfied or very satisfied with MindMatters assisting in dealing with staff issues in relation to their mental health and wellbeing
- 80% were satisfied or very satisfied with MindMatters with the overall benefits it provided for staff, students and the school community.

11.4.4 Implications of the MindMatters initiative evaluation findings

The following considers the MindMatters initiative evaluation findings in terms of appropriateness, effectiveness and efficiency.

Appropriateness

The widespread uptake of the MindMatters initiative by schools and the high levels of satisfaction of school leaders suggest that MindMatters was considered appropriate by its target audience. The delivery of mental health prevention, promotion and early intervention to secondary schools through the MindMatters initiative was based on the Health Promoting Schools Framework, and the WHO Comprehensive School Mental Health Model, and on sound evidence concerning the capacity of schools to enhance protective factors.[100]

The curriculum materials focused on issues such as resilience, loss and grief, bullying and harassment, understanding of mental illness and reduction of stigma. Notably, the issue of suicide was not dealt with directly in the program. This is a prudent approach given that there is currently a lack of evidence that

[99] PAI, *Impact of MindMatters by State*.
[100] T Hazell, K Vincent, T Waring et al, 'The Challenges of Evaluating National Mental Health Promotion Programs in Schools: A case study using the Evaluation of MindMatters', *International Journal of Mental Health Promotion*, vol 4, no 4, 2002, pp21-27.

school-based programs that focus on raising awareness about suicide are beneficial and not harmful.[101] There is also some evidence that MindMatters can be successfully adapted and implemented in schools with high numbers of students from Aboriginal and Torres Strait Islander backgrounds, as it provides sufficient flexibility to enable schools to take ownership of the program.[102]

Effectiveness

Based on the evaluation reports available, it is not possible to comment on the extent to which the MindMatters initiative has influenced help-seeking behaviour or measures of mental health (or suicide rates) within the student population during the period 200613. However, the level of uptake of the initiative suggests that MindMatters may have assisted schools in creating an environment that is supportive of mental health. It should also be noted that as a population health intervention (as compared with mental health clinical interventions), a program such as MindMatters has the capacity to achieve large collective benefits, although the benefits to the individual may be small and difficult to measure.[103]

Efficiency

Based on the evaluation reports available to inform this report, it is not possible to comment on the extent to which the MindMatters initiative has been delivered efficiently, or if it represents value for money.

Key findings

- MindMatters was a national mental health promotion initiative for secondary schools that addressed some of the risk and protective factors for suicide. It had high levels of uptake and acceptance across Australian schools and appears to be an appropriate intervention. The evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of MindMatters.

11.5 Integration and synergies between the NSPP and other suicide prevention activities

Through consultations with stakeholders, a rich range of perspectives were offered on the extent to which the NSPP is integrated or works synergistically with other suicide prevention efforts. The key themes that emerged from these interviews are described below.

11.5.1 Understanding of the NSPP

The stakeholders consulted held a variety of views about what the NSPP was, and, consequently, these differing interpretations influenced their views of how the NSPP is integrated with other activities. A number of stakeholders did not understand the difference between the NSPS and the NSPP, and the two terms were often used synonymously. While some people referred to the NSPP as the program of funding for suicide prevention activities, others considered it to be the overarching strategy for suicide

[101] Beautrais et al, 'Effective Strategies for Suicide Prevention in New Zealand'.
[102] Closing the Gap Clearinghouse, *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people*, Resource Sheet 19, Australian Institute of Health and Welfare and Australian Institute of Family Studies, Canberra, 2013.
[103] L Rowling, 'School mental health promotion: MindMatters as an example of mental health reform', *Health Promotion Journal of Australia*, vol 18, no 3, 2007, pp229-235.

prevention in Australia, and still others considered that the NSPP was encapsulated within the LIFE Framework. One suicide prevention expert was not certain whether '*the NSPS is operationalised within the LIFE Framework, or is it the other way round?*' The relationship between the NSPP and the TATS package was also not well understood.

This confusion made it difficult to unpack stakeholders' views about the contribution of the NSPP to overall suicide prevention efforts in Australia and the way that it integrates with other programs. For example, one respondent remarked that a key success of the NSPP has been in shining a light on the need for better data and monitoring in suicide prevention. However, it is possible that in making this comment the respondent was referring to the LIFE Framework or the broader NSPS, rather than the NSPP specifically.

Those who were aware of the body of NSPP-funded projects were generally uncertain about the rationale for funding the existing mix of projects (this included representatives from the DoHA STOs). Some suggested that while the projects did reflect the LIFE Framework, the LIFE Framework was so broad that any and all suicide prevention activities could conceivably be considered to align with the framework.

Other stakeholders felt that Australia's approach to suicide prevention was too narrowly focused on mental illness and this criticism was levelled at both the NSPP and the LIFE Framework. Arguably, this view points to a limited understanding of the NSPP and the LIFE Framework, because the LIFE Framework and the NSPP funding guidelines do in fact include a strong focus on the 'upstream' risk factors for suicide and the role of universal interventions (see *Section 3.3.1*). At the same time, this view also suggests that when considering Australian Government strategy around suicide prevention, people do not easily differentiate between the NSPS, the NSPP, the LIFE Framework and other Australian Government mental health initiatives such as the *Report Card* and the *Roadmap*.

Key findings

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

11.5.2 Integration between the NSPP and other suicide prevention efforts

Discussions with DoHA STO representatives showed that there were variations in their level of understanding of NSPP-funded projects underway in their jurisdiction. This variability may be a function of the staff turnover and the diversity of programs included in the STO portfolios.

Communication and leadership were consistently reported as areas in which improvements could be made to enhance integration. These are described below.

Communication

STO representatives listed intra- and inter-departmental communication as an area for possible improvement. Examples cited included:

- Jurisdictions would benefit from more information about developments at federal level regarding departmental restructures, strategy development and funding announcements. This would assist

jurisdictions to plan their activities, have input into decisions about where funds may be needed and avoid duplication of services or competition for funding between NGOs. The national expansion of two NSPP-funded projects under the TATS package was identified as an example where such information was not made available

- Some jurisdictions found it difficult to adjust their service provision models to align with Australian Government projects
- STO representatives reported having good working relationships with jurisdictional staff responsible for developing and implementing state/territory level suicide prevention strategies; however, jurisdictional staff tended to approach DoHA CO directly with questions or concerns, thereby excluding STO staff.

Leadership

While the jurisdictional representatives were consistently of the view that communication regarding the NSPP could be improved, they also suggested that the Australian Government should take a stronger leadership role in shaping the direction of suicide prevention in Australia. This view was echoed by the peak body representatives and other experts interviewed. They suggested that the leadership role of the Australian Government could be strengthened in the following areas:

- Providing a more detailed vision for suicide prevention in Australia. While the LIFE Framework was seen in general as a useful document, it was considered by some to lack specificity regarding priorities and concrete actions
- Better promotion of the evidence for what works, and promotion of a stronger commitment to evidence-based practice
- Playing a stronger role in the collection, management and dissemination of data
- Playing a coordinating role between national and jurisdictional suicide prevention efforts to ensure that gaps in the delivery of services are taken into account in a more systematic manner (this included a stronger role in coordinating 'rapid responses' to suicide 'clusters' in particular areas)
- Strengthening the terms of reference of ASPAC to enable the Council to take a more strategic role
- Setting targets for the reduction in suicide rates and related outcomes
- Supporting improved sector coordination mechanisms to promote a shared vision of suicide prevention in Australia.

Key findings

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

11.6 Gaps and opportunities in national suicide prevention efforts

Stakeholders provided a range of responses in relation to perceived gaps in suicide prevention activities. These included a stronger focus on emerging or under-recognised target groups, including:

- Youth (particularly Aboriginal and Torres Strait Islander youth)
- People recently released from prison
- Men who have been involved with Family Court matters
- People who have recently separated or divorced
- Refugees
- Elderly people
- People who have previously attempted suicide or self-harmed (to better understand and respond to their needs beyond the immediate crisis period).

Stakeholders also stressed that while Australia's approach to suicide prevention needs an overarching structure, it must also be flexible enough to respond to societal changes. Examples included addressing the role of the social media in influencing suicide and self-harm risk, the needs of the veteran community and the impact of socio-demographic changes on the distribution of risk across society. Examples of the latter include reportedly higher rates of suicide amongst 'fly-in fly-out' workers, and amongst men in the rock lobster fishing industry in Western Australia as a result of job losses.

Although the Australian Government has taken a leadership role in suicide prevention through the Living is For Everyone (LIFE) website, many stakeholders called for greater Australian Government leadership and coordination across the spectrum of suicide prevention activities as outlined in *Section 11.5*.

In response to questions about where the Australian Government should focus its suicide prevention funding, two distinct opinions were voiced. A number of experts argued that it was appropriate to fund a broad range of suicide prevention initiatives covering a range of target groups, settings, intervention points and activities. The rationale for this was that since the aetiology of suicide is complex and multifactorial, the response should reflect this. The alternate view was that the government should concentrate its efforts on a narrower range of interventions that have been proven to be effective, and to roll these out consistently. Several stakeholders commented that the NSPP should look to 'scale up' effective initiatives. Within both camps there was unanimous agreement that research and evaluation needs a stronger commitment and better resourcing – a view reflected in the recommendations and conclusions made within the previous evaluations of the NSPS/NSPP (see *Section 3.11*) and the Senate Inquiry into Suicide (as outlined in *Section 3.4*).

11.7 Consistency with the Australian Government Mental Health Reform agenda

As outlined in *Section 3.6*, the Mental Health Reform package, released in 2011, signalled the then-incumbent Labor Government's commitment to ongoing mental health reform.[104] The reform package aimed to:

- Improve access not only to mental health services, but also to social support, housing, education and employment services for people with a mental illness
- View mental illness not just as a health issue, but also take steps to improve economic and social participation by people with mental illness
- Take a whole-of-life approach to the prevention and treatment of mental illness.

[104] This refers to the government at the time that the evaluation commenced. In September 2013 a change of government occurred.

11 Positioning the NSPP in Australia's suicide prevention efforts

As described in *Section 3.6*, initiatives under the Mental Health Reform package that are particularly relevant to the NSPP are the formation of the *Roadmap for Mental Health Reform* (the Roadmap), the National Mental Health Commission and delivery of its first *Report Card*, the TATS package, and the expansion of the ATAPS Suicide Prevention service initiative.[105]

The NSPP was considered by stakeholders to be broadly aligned with the Mental Health Reform agenda. However a number of stakeholders expressed the view that the cause of suicide prevention has suffered due to too narrow a focus on mental health and mental illness (the one exception to this was a submission by the Royal Australian and New Zealand College of Psychiatrists (RANZCP)). This was considered in part to be a consequence of the responsibility for suicide prevention being 'pigeon holed' within the mental health units of governments. While the link between mental illness and suicide was acknowledged (including the increased risk of mental ill-health amongst those bereaved by suicide), there was general agreement that suicide prevention needs to broaden its focus beyond the biomedical paradigm to a broader 'social determinants' approach. There was strong agreement that suicide prevention should be leveraged out of all human service programs and receive attention and commitment from all areas of government. A number of respondents commented on the need for a 'joined up' approach to suicide prevention.

By extension, articulating the Australian Government's direction regarding suicide prevention in documents whose primary focus is on mental health and treatment of mental illness may potentially be seen to represent a similar narrowing of perspective in relation to suicide prevention. This is despite the fact that, under closer scrutiny, the Mental Health Reform agenda (as articulated through the Report Card and the Roadmap in particular) clearly addresses the issue of mental illness from a social determinants approach and advocates collective, multi-sectoral action to improve outcomes.

Key findings

- While the NSPP is broadly aligned with the National Mental Health Reform agenda, some stakeholders believed that suicide prevention is too strongly linked to a mental health agenda, at the expense of a broader 'social determinants' approach.

11.8 Potential consequences of not continuing the NSPP

At the local level, cessation of the projects would be likely to be strongly felt by those who used the services (for example, those using counselling or support services). Several stakeholders felt that a key strength of the NSPP was the opportunity it provided to trial innovative responses for emerging risk groups and did not want this opportunity to be lost. Notable exceptions are those projects with a strong capacity building focus that developed community links and networks. For these projects, the NSPP funding was used as 'seed funding' with the expectation that, once established, the networks would be sustainable.

From a national perspective, it is difficult to comment on the potential consequences of not continuing the NSPP funding. The stakeholders interviewed were unanimously of the view that the Australian Government needs to retain a strong commitment and vision in relation to suicide prevention (including funding for suicide prevention activities). However, they did not see that the NSPP in its current form was integral to this vision. Those interviewed also reiterated the view that, given the multiplicity of

[105] Note: The Coalition Government, elected in 2013, has given a commitment to review existing mental health programs.

activities and initiatives that exist within the suicide prevention space *(see Section 11.2*) and the lack of outcome data for the individual programs, it is unlikely that the cessation of the NSPP in its current form would lead to a measurable increase in rates of suicide or self-harm.

11.9 Summary of key findings

- The ATAPS Suicide Prevention service initiative is an appropriate and effective suicide prevention intervention. It is not possible to establish the efficiency of the program because the national expansion of the program is still in its infancy and there is limited data on outcomes at this stage.
- MindMatters was a national mental health promotion initiative for secondary schools that addressed some of the risk and protective factors for suicide. It had high levels of uptake and acceptance across Australian schools and appears to be an appropriate intervention. The evaluation reports produced to date (from 2006 to 2012) do not address the effectiveness or efficiency of MindMatters.
- People working in the suicide prevention sector held mixed and sometimes confused views of what the NSPP is. Many did not see the NSPP as a distinct component of the Australian Government's activity around suicide prevention, and several confused the NSPP with the NSPS or the LIFE Framework.
- Communication and leadership between DoHA, the jurisdictions and the sector was seen as an area for improvement, to ensure the NSPP is integrated with other suicide prevention activities in Australia.
- Some stakeholders believe that suicide prevention is currently too strongly linked to a mental health agenda at the expense of a broader 'social determinants' approach.