4 METHODS

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

4.1 Background and data sources

This Report was preceded by a *Mid-term Assessment Report* and *Interim Analysis Report*. In order to obtain the information required for the desktop review, DoHA requested that all 49 projects (see Appendix A) provide DoHA with copies of appropriate project documentation/data related to their NSPP-funded activities conducted during the period 2006-11. This was to include funding agreements, progress reports, final reports, internal evaluations and external evaluation reports, if applicable.[29] The documentation/data was then forwarded by DoHA to AHA for analysis. The information provided is summarised in *Table 4-1*.

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

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

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

4.2 Pre-existing project documentation/data

The project documentation supplied by DoHA comprised the following.

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

Table 4-1: Pre-existing project data

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

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

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

4.3 Documentation/data quality: implications

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

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

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

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

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

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

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

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

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

4.4 Project survey

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

- Changes to aims and objectives

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

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

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

4.5 Stage 2 literature review

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

Lessons learned from the literature helped to identify:

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

4.6 Stakeholder consultations

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

4 Methods

Table 4-2: Stakeholder consultations

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

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

4 Methods

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

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

4.7.1 ATAPS Suicide Prevention service initiative

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

4.7.2 MindMatters

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

4.8 Minimum Data Set

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

The MDS comprises three main types of data:

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

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

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

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

4.9 Data analysis protocols

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

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

A thematic analysis of narrative data derived from the project documentation/data and the free text responses provided in the survey and MDS, and consultation transcripts was conducted to identify key themes and issues. The thematic analysis was conducted using grounded theory, a technique that uses a constant comparative method of coding and recoding.[30] [31] In each case, this process involved a minimum of two consultants.

4.10 Evaluability issues

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

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

4.10.1 Internal data limitations

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

Among the key shortcomings identified were:

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

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

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

[30] J Saldana, *The coding manual for qualitative researchers*, Sage Publications, Los Angeles & London, 2009.
[31] E DePoy & L Gitlin, *Introduction to research: understanding and applying multiple strategies*, 2nd edn, Elsevier Mosby, St Louis, 1998.

4.10.2 Broader challenges in evaluating suicide prevention programs

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

- The actual number of people who take their own lives is a statistically rare event. This makes it difficult to achieve the statistical power that is necessary to identify patterns and causation, or to draw conclusions about reductions in the suicide rate.
- There is limited suicide data on specific target groups, data on protective and risk factors, pathways to suicide and mental health statistics. This creates difficulties in understanding the impact of programs on target groups.
- Issues of attribution: suicide prevention programs do not operate in isolation. They are provided in an environment where other contextual factors are present. For example, the presence of other programs or improvements in economic or social circumstances can also have an effect on the suicide rate. It is therefore difficult to separate out these effects from the program itself.
- Barriers exist to establishing longitudinal effects of programs on reductions in the suicide rate. Small program size and short program duration can diminish the statistical power of studies and thus limit the ability to establish causation and assess the effects of the program.
- While the quality of Australian deaths information is high by world standards, the ABS acknowledge that '[t]here remain considerable challenges in improving the quality of suicide data, particularly in relation to timeliness, consistency of process across jurisdictions and improving the identification of Aboriginal and Torres Strait Islander peoples at the time of death.'[32] Some have argued that ABS figures underestimate the total figures.[33]
- The issue of evidence. Much has been written on suicide prevention generally, yet the issue of what constitutes evidence of success remains contested. This is because:
  - While randomised control trials or quasi-experiments are often considered the gold standard in terms of evidence, the conduct of such trials is often unfeasible/inappropriate in the suicide prevention context because of the complexity of causality described above and for ethical and/or funding reasons.
  - Reliance on peer-reviewed publications as an evidence source is itself problematic because of publication biases and the lag that exists between innovation, established practice, research and publication.
  - Established practice is often considered to afford the best opportunities to collect evidence and as a consequence, this can make it hard to achieve a balance between innovation and established practice in the published studies.
  - Reliance on peer-reviewed publications as the primary source of information may fail to acknowledge valuable local insights that smaller projects have to offer.[34][35]

[32] DePoy & Gitlin, *Introduction to research*.
[33] RFG Williams, DP Doessel, S Jerneja & D de Leo, 'Accuracy of Official Suicide Mortality Data in Queensland', *Australian & New Zealand Journal of Psychiatry*, DOI: 10.3109/00048674.2010.483222, vol 44, no 9, 2010, pp.815-822.
[34] DoHA, *LIFE: Research and Evidence in Suicide Prevention*.
[35] M Nordentoft, 'Crucial Elements in Suicide Prevention Strategies', *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, vol 35, no 4, 2010, pp.848-53.