5 Profile of projects

5 PROFILE OF PROJECTS

This chapter provides a profile of all 49 specified NSPP/TATS funded projects across the life of the Evaluation. Projects characteristics examined include service approach, delivery mechanisms, target groups, LIFE Action Areas addressed and geographical reach.

A more detailed Snapshot of project activity, based on MDS data from October 2012 to March 2013, is provided in Chapter 6.

Assessment of the extent to which these 49 projects contribute to the appropriateness, effectiveness and efficiency of the NSPP is presented in subsequent chapters (7, 8, 9 and 10). For readability purposes, the term NSPP is used in this chapter to refer to both the NSPP and TATS funded projects included in this Evaluation.

5.1 Overview

A profile of each of the 49 projects is provided at *Appendix A*. The information presented in this chapter has been derived primarily from project representatives' responses to the online survey (*Section 4.4*). The funding information identified for each project is based on data provided by the Department in June 2013.
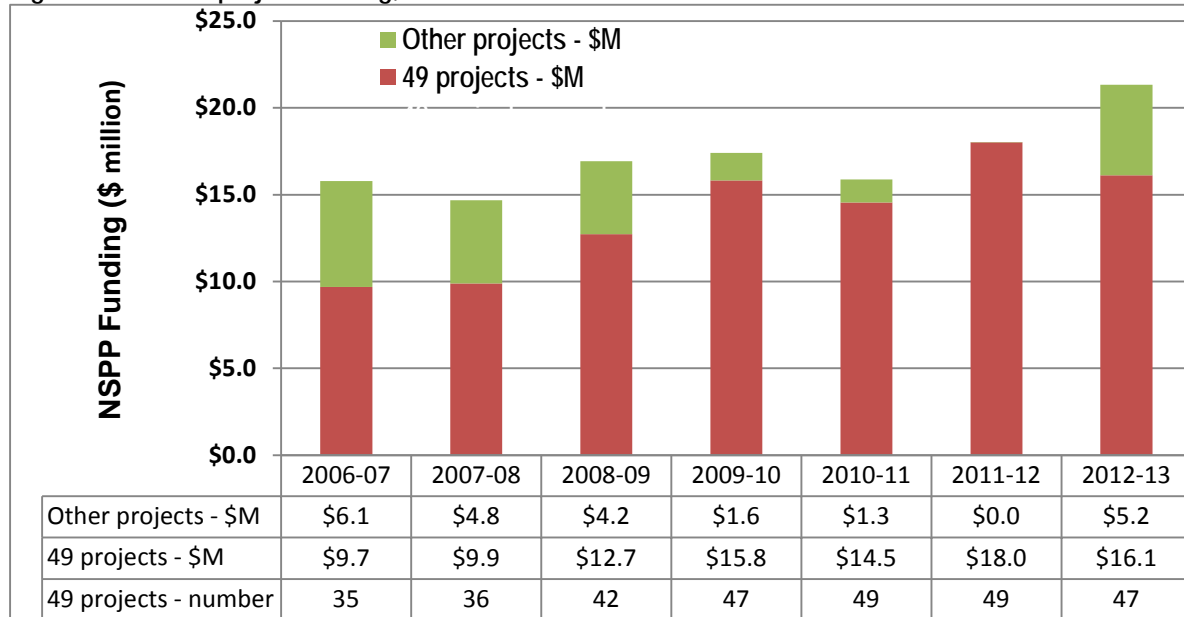
One project was funded for both a local and a national component and is therefore treated as two projects for the purposes of some of the following analysis, yielding a total of 50 projects. Throughout each section of this chapter, the total number of projects analysed (49 or 50) is clearly indicated.

From July 2006 to June 2013, a total of $120.1 million was allocated to fund NSPP projects. The 49 projects included in this Project Profile received a total of $96.8 million funding over this seven-year period. Other NSPP-funded projects, not included in the Evaluation, received $23.3 million over this period.

The following *Figure 5-1* shows the total NSPP funding for each year from July 2006 to June 2013. The figure identifies total funding allocated to the 49 projects each year, and total funding for other projects. Other projects (ie, projects outside the scope of this Evaluation) are those that were not funded in 2010-11, because they ceased receiving funding before then or did not commence receiving funding until after 2010-11.

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Figure 5-1: NSPP project funding, 2006-07 to 2012-13

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Other projects - $M	$6.1	$4.8	$4.2	$1.6	$1.3	$0.0	$5.2
49 projects - $M	$9.7	$9.9	$12.7	$15.8	$14.5	$18.0	$16.1
49 projects - number	35	36	42	47	49	49	47

Total NSPP funding increased from $15.8 million in 2006-07 to $21.3 million for 2012-13. The amount allocated to the 49 projects was $9.7 million for 2006-07; increasing to $18.0 million for 2011-12 and $16.1 million for 2012-13.

As shown, only 35 of the 49 projects received funding in 2006-07, ie, 14 did not commence until later years. By 2009-10, all but two of the 49 projects were operating.

Further information about the funding allocated to these 49 projects is provided in *Section 5.11*.

5.2 Project approaches

The NSPP-funded activities spanned the three major suicide prevention approaches: universal, selective and indicated. Universal approaches can be applied to a whole population or community; selective approaches can be applied to a sub-group known to be at increased risk while indicated measures target individuals who are at high risk.[36]

As shown in the following *Table 5-1*, selective approaches were the most common approach reported, with 72% of projects identifying this approach.
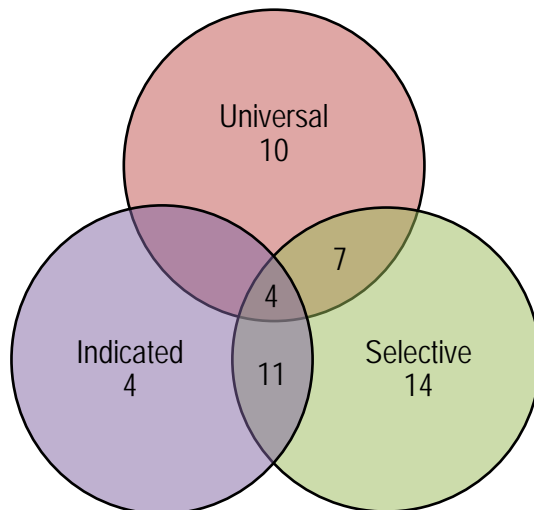
Table 5-1: Project approach (n=50)

Approach	Projects	%
Universal	21	42%
Selective	36	72%
Indicated	19	38%

Many projects adopted multiple approaches, as illustrated in the following *Figure 5-2.*

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[36] DoHA, *LIFE Framework*, p.18.

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5 Profile of projects

Figure 5-2: Overlap of project approaches (n=50)

As shown above:

- Four (8%) of the 50 projects adopted all three approaches
- Eighteen (7+11), ie, 36% adopted two approaches
- Twenty-eight (4+10+14), ie, 56% adopted a single approach.

5.3 Service delivery mechanisms

Multiple service delivery mechanisms were used by most projects. Approximately 20 projects reported that they conducted some one-on-one activities with clients as one element of their services. This ranged from counselling (phone, face-to-face), case management and practical support, to the identification and referral of people at risk (without specific counselling intervention).

The scale of individual and/or group activities could not be quantified from the pre-existing data/documentation. Accordingly, an analysis of the number of one-on-one clients or the proportion of time one-on-one interventions constituted of all projects was not available. Activity-based information for the period October 2012 to March 2013 obtained from the MDS is presented in *Chapter* 6.

At the August 2012 consultation workshops, project representatives indicated that group activities often resulted in one-on-one interaction/follow-up with individual participants at a later date. This additional service delivery was seldom reported as part of the individual level activity submitted by projects as part of their standard DoHA reports. Furthermore, other initiatives that are outside the scope of this project profile, such as the ATAPS service initiative, are also involved in individual service provision. These combined factors suggest that the scale of one-on-one activities supported by NSPP funding may be understated and that the 20 projects cited above is an underestimation.

5.4 Target groups

All 18 major acknowledged at risk groups were represented as target groups across the NSPP-funded projects, as detailed in the following *Table 5-2*.

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Table 5-2: Target group by approach

Target group	Universal	Selective	Indicated
Bereaved	5	17	8
Men	9	20	11
Children	0	5	3
Youth	7	17	9
Indigenous	2	17	7
Mental illness	2	8	5
Previous attempt	2	12	9
Self-harm	1	8	6
Rural and remote	8	21	9
LGBTI	2	5	2
CALD	3	7	1
Refugee	1	6	2
Older people	1	8	5
AOD problem	1	8	3
Whole community	11	18	8
Workforce settings	10	17	10
Redundancies	4	7	5
Natural disasters	0	3	2
Other	5	6	4

A small number of projects identified 'other' target groups in the survey, thus signifying that they target a group not specified in the list provided. However, in most cases the narrative description of these 'other' groups matched already selected target groups. Two newly identified target groups did emerge, namely:

- Domestic violence victims
- Families of specific at-risk groups.

Table 5-2 also summarises the range of approaches taken by projects to address the needs of these target groups. As previously identified, selective approaches were most commonly used.

5.5 LIFE Action Areas

Activities under the six LIFE Action Areas were explored from two perspectives. Project representatives were asked to:

- Identify which of the six LIFE Action Areas applied to their project
- Assess their progress toward achieving each of the individual LIFE Framework Action Area Outcomes.

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Sixteen (32%) of the 50 projects reported that they addressed all six LIFE Action Areas. As shown in *Table 5-3,* all LIFE Action Areas were well represented among the 50 projects.

Table 5-3: Project coverage of LIFE Action Areas

	LIFE Action Area	n = 50	%
1	Improving the evidence base and understanding of suicide prevention	29	58%
2	Building individual resilience and the capacity for self-help	41	82%
3	Improving community strength, resilience and capacity in suicide prevention	45	90%
4	Taking a coordinated approach to suicide prevention	35	70%
5	Providing targeted suicide prevention activities	39	78%
6	Implementing standards and quality in suicide prevention	26	52%

Four Action Areas were addressed by 70% or more of the projects, as follows:

3. Improving community strength, resilience and capacity in suicide prevention (90%)

2. Building individual resilience and the capacity for self-help (82%)

5. Providing targeted suicide prevention activities (78%)

4. Taking a coordinated approach to suicide prevention (70%).

Project representatives were also asked to assess their progress toward achieving each of the individual LIFE Framework Action Area Outcomes, thus facilitating a more refined assessment of achievements across each of the 19 outcome areas that make up the six LIFE Action Areas (see *Section 3.3.1*).

Assessment of progress was ranked using a five-point Likert style scale, with 1 indicating 'not achieved' and 5 indicating 'fully achieved'. A 'not applicable' option was also provided.

The results of this assessment are summarised in the following *Figure 5-3*.

As shown in *Figure 5-3* below, there was relatively little variation in average achievement score across the 19 LIFE Action Area Outcomes. The average outcome score per area ranged from 3.41 to 4.06, with the exception of one outlier. As a rating of five indicates fully achieved and a rating of one indicates not achieved, project representatives mostly self-reported their achievements at the top end of the scale.

One notable outlier was for outcome 5.2 (Systematic, long term, structural interventions), for which an average score of 3.06 was reported.

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Figure 5-3: Progress towards achieving LIFE Action Area Outcomes: average score per outcome
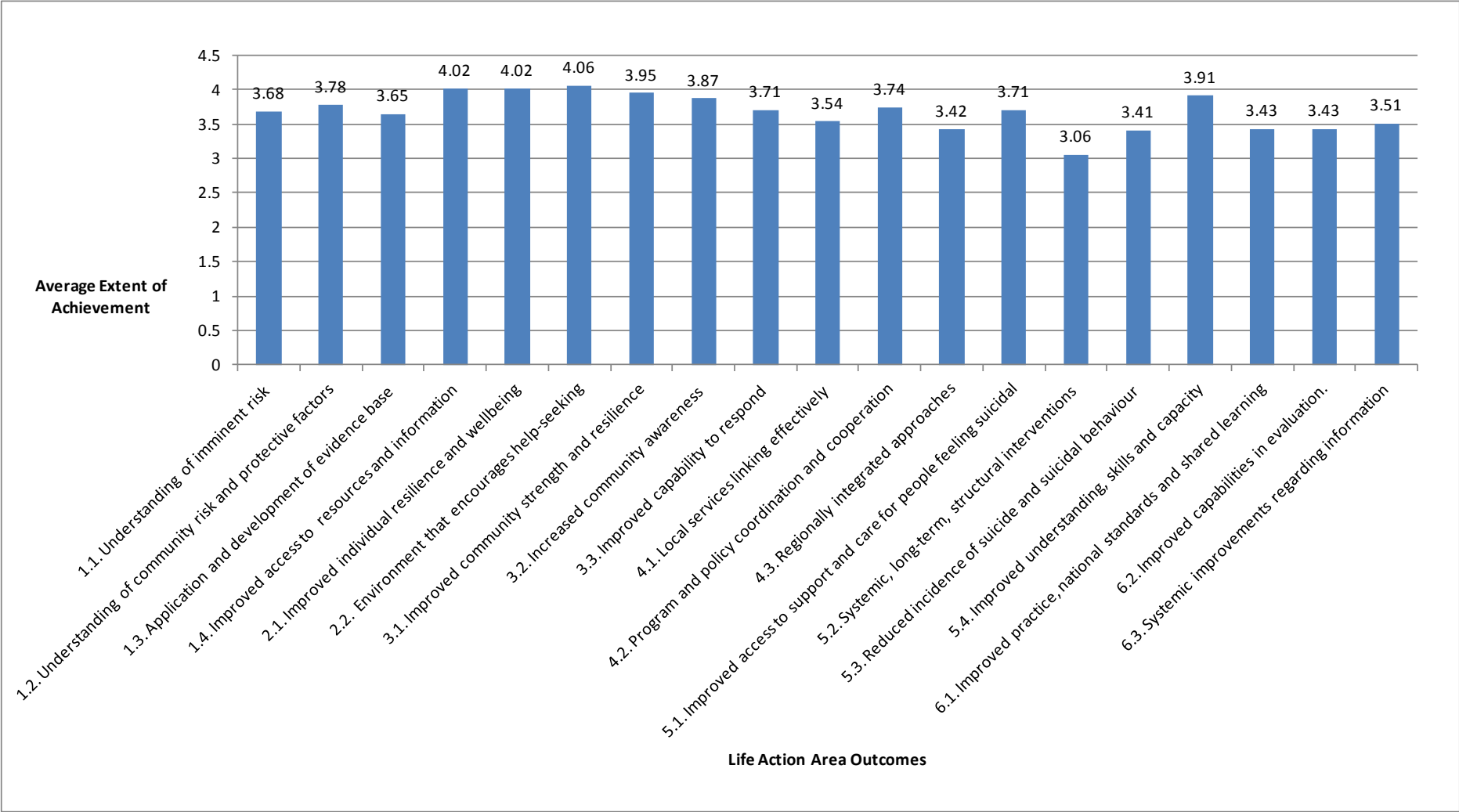
Note: The above wording for each Action Area Outcome is abbreviated – see *Table 3-2* for a complete description.

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5.6   Geographical reach of projects

As shown in the following *Table 5-4,* locally oriented projects accounted for the largest proportion (56%) of projects, state-wide projects made up 14%, and projects with a national reach made up the remaining 30% of projects.

Table 5-4: Geographical reach of projects

Region	Projects	%
Local	28	56%
State-wide	7	14%
National	15	30%
Total	**50**	**100%**

Analysis of the geographical descriptions provided by project representatives indicated a more complex reach than *Table 5-4* would suggest. For example:

- Four projects identified as local were found to operate in one or more other states. Their activities within these other states were, however, confined to small/local areas.

- One local project also had a national component.

- One local project contributed to international suicide prevention efforts.

The implications of this complex geographical reach within Australia are discussed in more detail in the subsequent chapters of this report.

The approach taken by projects differed according to geographical reach, as shown in *Table 5-5.*

Table 5-5: Geographical reach of project, by approach

Region	Universal	Selective	Indicated	Total
Local	8	23	15	**28**
State-wide	2	7	2	**7**
National	11	6	2	**15**
Total	**21**	**36**	**19**	**50**

As indicated, locally oriented projects (28) mainly used selective (23) and indicated (15) approaches, with selective being the most commonly cited of the two approaches.

Projects with state-wide reach (7) tended to use selective approaches (7). As would be expected, the national projects (15) were largely characterised by universal approaches (11).

5.7   Strategies and activities

Project activities varied widely across the body of NSPP-funded projects. As indicated in *Section 5.5* the majority of projects were multi-faceted and it was not uncommon for a single project to operate

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across a range of target groups and use a number of different interventions. The main activities applied by projects are described below.

5.7.1 Universal approaches

The key activities undertaken by projects engaged in universal approaches include:

- Public awareness campaigns designed to improve mental health literacy and encourage help-seeking (delivered via a range of channels including print, television, radio and online).
- Development of media guidelines and resources, and training for media personnel on appropriate reporting of suicide and mental illness.
- Advocacy and capacity-building approaches to strengthen the suicide prevention sector.
- Whole-of-school or whole-of-workplace activities such as resilience training or education for parents.
- Research and evaluation into suicide epidemiology and program effectiveness.

5.7.2 Selective approaches

The key activities undertaken by projects engaged in selective approaches include:

- Gatekeeper training for people who work (or live) with higher risk groups, to help these gatekeepers identify and respond to individuals at risk of suicide. This included support for health professionals working with people at risk of suicide, provision of educational resources (either print format or online) and face-to-face training.
- Training and support for personnel responding to suicide or suicide attempts (eg, police or ambulance officers).
- Postvention support for people and communities that have been bereaved by suicide. This included a range of activities such as support groups, counselling, assistance with funeral arrangements and ongoing follow-up.
- Community capacity-building or mental health promotion approaches aimed at reducing risk factors for suicide and improving resilience. This included activities to improve social connectedness (eg, community events, support groups, homework clubs), improve resilience (eg, education to improve mental health self-care), and culturally specific activities such as 'back to country' trips.
- Establishing peer support groups (this activity may be considered selective or indicated, depending on whether high-risk *groups* are involved, or if *individuals* identified as being at high risk of suicide are involved).

5.7.3 Indicated approaches

The key activities undertaken by projects engaged in indicated approaches include:

- Provision of clinical or counselling services (face-to-face, telephone-based or online).
- Activities to improve the care pathways and support for people at high risk of suicide moving through the health system. This included partnerships between organisations, strengthening discharge and referral protocols.

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- Practical assistance for people following suicide attempts upon discharge from hospital (such as support to manage activities of daily living, assistance to attend appointments, and referral to other services as required).

The formation and maintenance of partnerships or collaborative relationships to strengthen service delivery was an activity undertaken by almost all projects and has not been listed as a separate activity here. Collaboration by projects is examined in *Section 5.10.*

5.8 Stability or change over time

The extent of stability or change within projects was examined from three perspectives:

- Changes in aims/objectives
- Changes in activities
- Changes in scope.

5.8.1 Changes in aims/objectives

The majority of projects (77%) reported that their aims and objectives had remained unchanged over time (*Table 5-6*). Of the 11 projects that did report change, six were local, three were state-wide and two were national projects.

Table 5-6: Change in aims/objectives over time

Have the aims or objectives changed over time?	
	n (%)
No	37 (77%)
Yes	11 (23%)
Total	48 (100%)

Note: Information not available for two projects.

The main changes to aims/objectives cited were:

- Increase in scope of the project (ie, inclusion of new sites)
- Increasing public or community awareness of the services provided by the project
- More focussed targeting of particular high-risk groups.

In each case, the projects indicated that the change had occurred in response to identified need. Details of these changes are provided in the following sections.

5.8.2 Changes in activities

Less than half of all project representatives (45%) reported changes in their project strategies and activities over the life of the project.

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Table 5-7: Change in activities/strategies over time

Have activities/strategies changed over time?	
	n (%)
No	27 (55%)
Yes	22 (45%)
Total	49 (100%)

Note: Information not available for one project.

Of the 22 project representatives that did report changes in activities or strategies, feedback from staff and consumers emerged as the most frequently cited impetus for change. Learnings gleaned from project evaluations or reviews were also cited. The nature of the changes varied, but the majority were related to process refinements that aimed to improve efficiency or to better meet the needs of the target population.

Four projects referred to restrictive DoHA contractual obligations where short-term funding agreements reduced flexibility within projects or potentially created service delivery gaps.

5.8.3 Changes in scope

The majority of project representatives (81%) reported that their project had not grown in scope to national level (*Table 5-8*). Of the eight that did report such growth, the key mechanisms through which this growth was achieved was firstly by the project being recognised for the success of its activities and then being successful in securing additional funding to expand the scope of the project.

In one case, this expansion was from Australia to an international audience. Of the seven projects that grew to become national, four primarily used gatekeeper training approaches and three were community capacity-building projects. The project that expanded to an international audience was a research project.

Table 5-8: Grown in scope from local to national

Has your project grown in scope from a local project to a national project?	
	n (%)
No	39 (81%)
Yes	9 (19%)
Total	48 (100%)

Notes:

1. One of the 'yes' projects changed from national to international.

2. Information not available for two projects.

5.9 Community acceptance

Overall, high levels of community acceptance were reported by the project representatives, with the majority (89%) rating it as either four or five on the Likert scale provided (*Table 5-9*). Five projects reported lower scores of two or three. These latter projects were either based in the healthcare sector or in local community settings. Of these, one of the healthcare sector projects reported low levels of

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acceptance within the professional community. Conversely, the other reported high levels of acceptance within the professional community but noted that the project was not designed to target the general community. Projects directed at the general community that scored poorly reported lack of community acceptance of suicide as a reality in the community or a reticence to address suicide as an issue because of 'collective grief' as the main reason for poor community acceptance.

Projects that were well accepted by the community tended to be those that serviced areas or communities where there was strong awareness of suicide as a problem, and in which the projects were perceived to be providing a necessary and valued service. Evidence for strong community acceptance cited by project representatives included high levels of uptake of resources or training, referrals to services from a range of sources, and feedback from service users on the appropriateness and value of the services. Several organisations attributed the level of community acceptance they received to the length of time they had been operating in the community.

Table 5-9: Level of community acceptance

How would you rate the level of community acceptance of your project?	
	n (%)
1 (very low)	0 (0%)
2	2 (4%)
3	3 (6%)
4	12 (24%)
5 (very high)	32 (65%)
Total	49 (100%)

Note: Information not available for one project.

5.10   Collaboration

Project representatives reported high levels of collaborative working with other organisations that conducted suicide prevention activities in their area/region, with 92% indicating that they engaged in such collaborations.

Table 5-10: Level of collaboration with other organisations

Have you worked collaboratively with any organisations conducting suicide prevention activities in your area/region?	
	n (%)
No	4 (8%)
Yes	45 (92%)
Total	49 (100%)

Note: Information not available for one project.

Further details about the range and nature of these collaborations are provided below.

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5.10.1 Range of collaborating organisations

For those projects that worked collaboratively with other organisations, a diverse range of partner organisations were listed, including:

- Mental health and suicide prevention peak bodies (including consumer groups)
- Suicide prevention service providers (including crisis lines, counselling services, bereavement services
- Police and emergency services
- Healthcare organisations (including hospitals, mental health services, community health services, Medicare Locals, Divisions of General Practice (now Medicare Locals) and Aboriginal Community Controlled Health Organisations)
- Courts, prisons and other law/justice agencies
- Research organisations
- Schools
- Corporate industries
- Welfare services and job network agencies
- Local, state and federal governments.

A number of organisations indicated that they collaborated with other NSPP-funded projects.

5.10.2 Nature of collaboration

For those projects who reported collaborating with other organisations, collaboration was undertaken for the following purposes:

- Joint provision of training or other activities
- Increase referral or access to appropriate services
- Resource sharing, communication and capacity building
- Participation on working groups or advisory panels
- Community awareness-raising about service availability or about suicide prevention more generally
- Data collection, evaluation or research.

5.11 Project funding and workforce resources

This section provides a profile of the resources and funding available to the 50 NSPP-funded projects. It provides detail on:

- NSPP funding
- Project workforce.

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5.11.1 NSPP funding

The following identifies the NSPP funding allocated to the 50 projects, in terms of:

- Year and funding round
- Project funding range
- Suicide prevention approach
- Geographic reach.

Funding by year and funding round

The following *Table 5-11* identifies total NSPP funding for the 50 projects, by year and funding round, over the period 2006-07 to 2012-13.

Table 5-11: NSPP funding by year and round, 2006-07 to 2012-13

| Funding	Round 1			Round 2		Round 3	
	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Annual	$9,693,265	$9,899,222	$12,728,465	$15,822,454	$14,543,198	$18,020,48	$16,109,317
Round	$32,320,952			$30,365,652		$34,129,797	
Total	$96,816,401						

As shown above, NSPP funding for the seven-year period totalled $96.8 million. Round 1 funding ($32.3 million) was broadly similar to funding for Round 2 ($30.3 million) and Round 3 ($34.1 million). Annual funding generally rose over the period identified, with funding of $9.7 million in 2006-07 and $16.1 million in 2012-13; however peak funding was in 2011-12 with funding of $18.0 million for these 50 projects.

Funding by project

Over the seven-year period identified, projects were allocated average funding of $1.94 million per project. Funding ranged from $143,231 for the project which received the least funding to $10,109,980 for the project which received the most. The following *Figure 5-4* provides analysis of the range of project funding.

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Figure 5-4: Number of projects, by funding range, 2006-07 to 2012-13
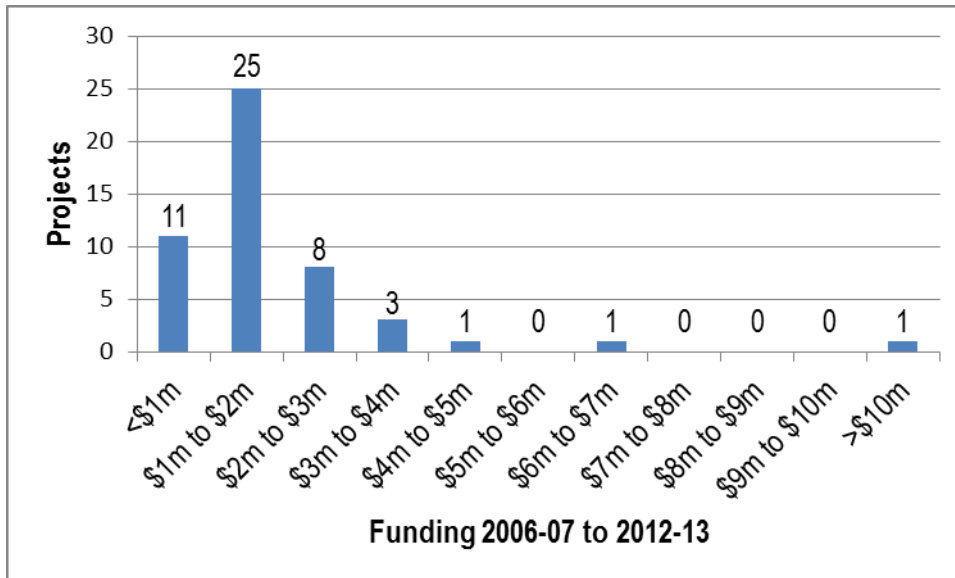
The most common funding range was between $1 million and $2 million, with half (25) of all projects receiving this level of funding. Few projects received $3 million or more, ie, only 12% (6 of 50), of which one project received funding of $10.1 million.

Funding by suicide prevention approach

As indicated previously, NSPP-funded activities spanned the three major suicide prevention approaches, namely:

- Universal
- Selective
- Indicated.

The following *Table 5-12* presents an analysis of the number of projects which adopted each suicide prevention approach and the funding associated with these projects.

Table 5-12: NSPP projects and funding by suicide prevention approach

Approach	Projects		Funding		Funding per project
	No.	%	$	%	
Universal	21	42%	$43,989,059	45%	$2,094,717
Selective	36	72%	$65,169,601	67%	$1,810,267
Indicated	19	38%	$38,217,224	39%	$2,011,433
All projects/funding	50		$96,816,401		$1,936,328

Note that the sum of number of projects and funding shown above for each approach is greater than the total NSPP projects (50) and funding ($96.8 million). This is because many projects adopted multiple approaches, and these projects have been included (ie, repeated) in the figures shown for each approach.

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As indicated in *Table 5-12*, selective approaches were the most common approach, representing 72% (36) of projects and 67% ($65.2 million) of funding. Universal approaches accounted for 45% ($44.0 million) of funding while indicated approaches represented 38% ($38.2 million) of total funding.

For the universal approach, the share of funding (45%) was greater than the share of projects (42%), indicating higher than average funding for these projects ($2.1 million versus $1.9 million). Projects adopting the selective approach received average funding of $1.8 million, slightly below the overall average; while projects adopting the indicated approach received average funding of $2.0 million, slightly above the overall average.

Funding by geographic reach

The allocation of NSPP funding by the geographic reach of projects (national, state-wide or local) is identified in *Table 5-13*. The reach of each project was determined based on its response to the NSPP project survey.

Table 5-13: NSPP projects and funding by geographic reach, 2006-07 to 2012-13

Reach	Projects		Funding		Funding per project
	No.	%	$	%	
National	15	30%	$37,091,816	38%	$2,472,788
State-wide	7	14%	$8,817,495	9%	$1,259,642
Local	28	56%	$50,907,090	53%	$1,818,810
Total	50	100%	$96,816,401	100%	$1,936,328

Locally oriented projects accounted for the largest proportion of projects (56%) and funding (53%). National projects represented the second largest group with 30% of projects and 38% of funding, while state-wide projects represented 14% of projects and received 9% of total funding.

State-wide projects had the lowest average funding ($1.3 million), considerably lower than the average funding for all projects ($1.9 million). National projects had the highest average funding ($2.5 million), significantly higher than the average for all projects, while local projects received average funding ($1.8 million) broadly in line with the average overall.

5.11.2 Project workforce

Project representatives were asked in the survey to identify the number of full time equivalent (FTE) staff and volunteers that worked with their project during each funding period. This information was used to identify the number of staff/volunteers that worked with each project over its duration to date, ie, the typical number of staff/volunteers that worked with the project at a given point in time. This information is summarised in the following *Table 5-14*.

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Table 5-14: NSPP projects staff and volunteers

Workforce	Total FTE workforce across all projects
Staff	176.9
Volunteers	221.7
Total	398.6

Note: Information is for 48 projects as two did not respond to this question.

As identified in *Table 5-14*, across all 48 projects that responded, there were a total of 176.9 FTE staff and 221.7 FTE volunteers, representing a total NSPP workforce of 398.6 FTE personnel. It should be noted, however, that the majority of volunteers work in a small number of projects, with more than half of all FTE volunteers (116.7) associated with a single project.

The following *Table 5-15* identifies the average number project staff by geographic reach.

Table 5-15: NSPP project staff, by project geographic reach

Reach	FTE Staff			Average project funding (2006-07 to 2012-13)
	NSPP-funded	Non-NSPP-funded	Total	
National	2.8	0.6	3.4	$2,472,788
State-wide	2.3	2.4	5.7	$1,259,642
Local	2.5	1.1	3.3	$1,818,810
Total	2.6	1.1	3.7	$1,936,328

As identified in *Table 5-15*, state-wide projects had notably more staff (5.7 FTE) than both national (3.4 FTE) and local (3.3 FTE) projects. Our investigation indicates that in part this may be due to some state-wide projects receiving additional non-NSPP funds, which allowed them to employ non-NSPP-funded staff. State-wide projects employed an average of 2.4 non-NSPP-funded staff, compared with local (1.1 FTE) and national (0.6 FTE) projects. By virtue of the type of work undertaken by national level projects, fewer staff may be required. This was found to be the case for national projects engaged in media work, web-based services and conference organisation, for example.

It would also appear that the average number of NSPP-funded staff employed was broadly similar across national (2.8 FTE), state-wide (2.3 FTE) and local (2.5 FTE) projects. This was despite state-wide projects receiving significantly less NSPP funding ($1.3 million) on average, than local ($1.8 million) and national ($2.5 million) projects.

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5.12 Summary profile

Overall, NSPP-funded activities can be summarised as follows.

Suicide prevention approach:

- Spanned all three major suicide prevention approaches

- Often used multiple approaches within projects

- Most commonly used selective approaches or combinations of selective and indicated approaches.

Life Framework Action Areas:

- Spanned all six LIFE Framework Action Areas

- Addressed multiple LIFE Framework Action Areas within individual projects.

Target groups:

- Included all major acknowledged 'at risk' target groups

- Were multi-faceted and it was not uncommon for a single project to operate across a range of target groups and use a number of different interventions.

Aims, objectives, strategies and scope

- Had aims and objectives that had remained unchanged over time during the review period

- Had remained largely unchanged in terms of project strategies and activities over the life of the project

- Had not grown in scope from local to national.

Community acceptance and collaborative work in area/region:

- Received high levels of community acceptance

- Involved very high levels of collaborative work with other organisations conducting suicide prevention activities in their area/region that were not NSPP-funded.

Funding:

- Over the seven-year period to June 2013, projects were allocated average funding of $1.93 million per project. Funding ranged from $143,231 for the project which received the least funding, to $10,109,980 for the project which received the most.

- Locally oriented projects accounted for the largest proportion of projects (56%) and funding (53%).

- On average each project had 8.3 full time equivalent (FTE) workforce at a given point in time, comprising 3.7 FTE paid staff and 4.6 FTE volunteers

- The average number of NSPP-funded staff employed was broadly similar across national (2.8 FTE), state-wide (2.3 FTE) and local (2.5 FTE) projects.

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