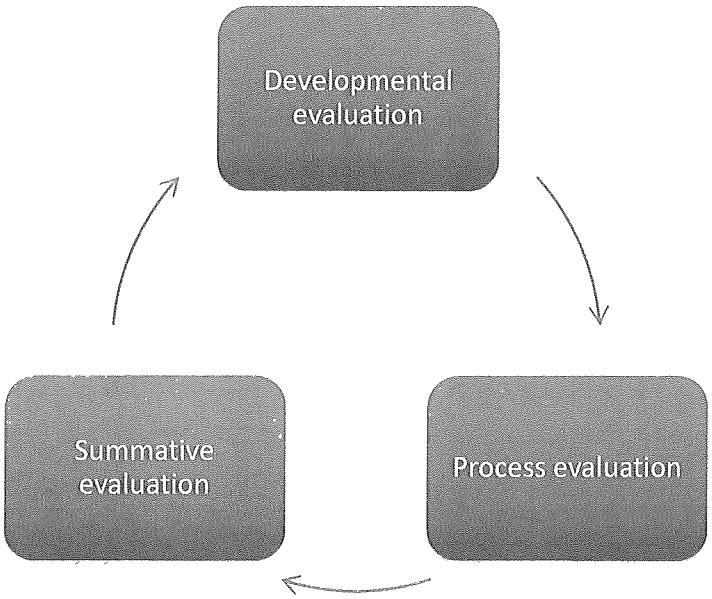
Executive Summary

Between the years of 2009-2013, 13 million dollars was allocated for the development and implementation of the WA Suicide Prevention Strategy, also branded as One Life. The Ministerial Council for Suicide Prevention (MCSP) was established in 2009 to lead and oversee the Strategy and initiatives implemented in WA communities, as well as to communicate recommendations to the Minister for Mental Health for issues relating to suicide. Centrecare was the appointed non-government organisation responsible for the coordination, development and implementation of Strategy initiatives within WA communities. Community Action Plans (CAP), embedded with suicide prevention initiatives, were developed in consultation with communities experiencing early signs of suicide crisis, and in partnership with government, non-government and private agencies. One Life was focused on primary prevention and funded events and activities within communities that were universal (e.g. whole of community well-being seminars) or selective (e.g. Empowerment Program, targeting a high risk group). Although events and activities implemented within communities did not have the 'look and feel' of traditional suicide prevention programs, they targeted issues associated with suicide. Edith Cowan University (ECU) was appointed to undertake research, development, and evaluation activities to inform the continued development of One Life. This report tells the story of the implementation of the One Life Strategy and the research, development, and evaluation activities conducted by Edith Cowan University. The research, development, and evaluation activities occurred in three phases as illustrated below.



As illustrated above, a developmental evaluation was conducted, followed by a process evaluation, and lastly a summative evaluation. This report details the outcomes of each phase, provides signposts to the contents of each chapter in the report, and includes recommendations to inform future implementation and research. Recommendations are presented at the end of the section for each of the three phases.

Phase 1: Developmental Evaluation

The Strategy was underpinned by Co-Production principles from within the MCSP and Community Development principles within Centrecare to facilitate implementation in communities. The principles associated with each of these approaches are compatible and supportive where the context is clear and understood by all parties. The MCSP and Centrecare acknowledged early that the development of an implementation framework and the process of implementation would out of necessity be developmental. Therefore, it was considered important to establish an approach according to principles of best practice, implement the approach, observe community abilities and engagement and then reflect and re-formulate or change the approach where risk was determined to be high. Given this approach, Centrecare tasked ECU to engage in research, development and evaluation activities that would inform the development of the implementation framework and the actual implementation of the strategy. As a developmental evaluation is most suited to initiatives requiring ongoing development, this approach was applied. The developmental evaluation outcomes assisted in the development of an implementation framework and are presented in Chapter Two through Ten of this report. Recommendations emanating from the first phase are:

- ***Recommendation 1***
  The appointed NGO responsible for implementation should be afforded a planning and development phase prior to implementation at the community level.
- ***Recommendation 2***
  During planning meetings, the role of co-production and CD and how they might be integrated to work together for the benefit of the Strategy should be considered.

- ***Recommendation 3***

  The Strategy framework and theoretical underpinnings should be documented and form a component within CC training regimes and Centrecare and MCSP staff induction programs.

- ***Recommendation 4***

  A developmental evaluation should be engaged in for the duration of the Strategy to inform continuous improvement. If the Strategy framework remains in its current form with three tiers (community and/or agencies, NGO and MCSP), attention should be afforded to where the evaluators contract lies. As final decision-making lies with the MCSP and the Mental Health Commissioner has a position on the MCSP, it is recommended the contract lie with the MHC. It is also recommended that an evaluation group be established consisting of Council members, NGO representatives, CC/agency and host agency representatives who collaborate to conceptualise, design and test strategies applied. This group would feed back to the MCSP for endorsement of recommendations and facilitate understanding across strategy players of the nature and purpose of evaluative activities. This would also foster greater support of evaluative initiatives amongst CCs responsible for data collection.

Phase 2: Process evaluation

By February 2012, Centrecare had developed a clear implementation framework that divided the process of implementing the Strategy into two distinct stages – Stage One CAPs (community consultation phase) and stage two CAPs (implementation of suicide prevention initiatives). It was at this time that Centrecare requested the research and evaluation team move to the process evaluation phase. The purpose of the process evaluation was to determine the fidelity of treatment and to examine (where appropriate) dose delivered, dose received, reach within the community, recruitment, and context. The process evaluation used a qualitative methodology and involved the conduct of semi-structured interviews with community coordinators, representatives from host agencies, Ministerial Council members and Centrecare staff. Interviews were conducted at two points during the Strategy and related specifically to experiences with Stage One community consultations and the process of developing a proposal for a Stage Two Community Action Plan (CAP) (interview one) and the implementation of Stage Two CAPs (interview two). This enabled consideration of the entire process of implementation and included both mainstream and Aboriginal CAPs.

Findings showed that all stakeholders interviewed during the conduct of the process evaluation were sensitive to the evolving nature of the Strategy and experienced similar frustrations revolving around lack of communication and/or understanding of the perspectives of various parties within the Strategy. Although it is arguable that those frustrations are typical 'Community Development trajectories' and also often occur in organisations that are undergoing rapid change, there is much to be learned from stakeholder perceptions of the process of developing and implementing CAPs. Results of the process evaluation are included in Chapter 11. Recommendations based on specific findings within the process evaluation are:

- ***Recommendation 5***

  At the outset of Strategy implementation, there is a need to develop a management system inclusive of documented policies, processes and procedures that facilitate the implementation of policies. Policies should address all core activities and clearly delineate the following:

  a. The role and requirements of the MCSP.
  b. The role and requirements of Centrecare.
  c. The role and requirements of Host Agencies.
  d. How community is defined and how communities are targeted.
  e. The process of applying for Stage 1 and Stage 2 CAPs.
  f. Role descriptions for CCs and all One Life Staff.
  g. CC capability framework to ensure the recruitment of suitably qualified CCs.
  h. The model of community consultation applied (e.g., How to conduct a safe community consultation).
  i. Guidelines for Stage 1 and Stage 2 suicide prevention activities.
  j. Risk management guidelines.
  k. Definition of sustainability.
  l. Criteria guiding CAP approval and means by which outcomes are communicated to CCs and Host Agencies.

- ***Recommendation 6***

  Form a MCSP reference group to facilitate the development and oversight of the management system.

- ***Recommendation 7***

  Make components of the management system available to the public. For example, decision-making processes should be transparent and therefore available and open to public scrutiny. These should form part of a package that is provided to CCs prior to developing their submission to aid the development of quality submissions that address core areas.

- ***Recommendation 8***

  Reconsider the number of layers within the strategy. The rationale behind appointing an NGO to implement the Strategy is sound and is understood. However, this structure complicates communications and approval processes and is a significant source of frustration to all parties. As final decision-making lies with the MCSP and the Mental Health Commissioner has a position on the MCSP, the Strategy is best facilitated by the Mental Health Commission.

- ***Recommendation 9***

  If the Strategy remains in its current form, reformulate the role of the appointed NGO to ensure decision-making is collaborative. Therefore, MCSP decision-making needs to accommodate the knowledge and experience the NGO brings to the table by affording an opportunity to vote.

- ***Recommendation 10***

  Have CCs host monthly MCSP meetings on a rotational basis to build a bridge between communities, CCs, the NGO and the MCSP. Meeting procedures can still provide an opportunity for closed discussion within this format.

- ***Recommendation 11***

  Develop ongoing training for CCs that carefully scaffolds the skills required to perform the role effectively and safely and build their knowledge of suicide and suicide prevention. This training should be linked directly to the capability framework. It should also focus on varied aspects of safety (practical and legal) relevant to the selection and implementation of suicide prevention activities. Training should also canvass self-protective behaviours and techniques in the event that community members turn against CCs should a suicide occur.

- ***Recommendation 12***

  Review the number of towns CCs are managing to maximise community engagement and minimise the requirement for extensive travel. Alternatively, consider increasing the capacity of CCs by reviewing current FTEs.

- ***Recommendation 13***

  Ensure community consultations during Stage One (and therefore Stage Two submissions) include an analysis of support services currently available to the community. Raising public discussion about suicide in areas that lack services represents a risk. Although this is a documented requirement in the Stage One process, it is not currently mandated.

- ***Recommendation 14***

  Develop and review on a quarterly basis, risk management guidelines.

- ***Recommendation 15***

  Ensure risk management guidelines incorporate a documented strategy for the management of vulnerable community members who approach CCs during consultations. Ensure guidelines include a clear process for managing, reporting and documenting instances, actions and outcomes.

- ***Recommendation 16***

  Ensure there is a requirement for CCs to submit a variation relating to any change in the nature of the activities implemented within Stage Two CAPs for endorsement by Council. This should be managed by a reference groups to ensure the timely approval of variations.

- ***Recommendation 17***

  Ensure CCs have the appropriate skills to manage situations where community members may be left vulnerable in the wake of increased awareness and discussion. This should form part of the capability framework. Although CCs were required to undertake Gatekeeper training, a significant number of CCs (without prior working experience in mental health or health) felt ill equipped to manage these situations despite being trained.

- ***Recommendation 18***

  Develop support mechanisms for those working on the ground to enable/require adequate and regular opportunities to debrief. Those operating on the ground are:

  - CCs.

- Centrecare staff.
- MCSP members.

- ***Recommendation 19***

  Develop an intranet site so CCs can communicate regularly and share ideas, experiences, information, knowledge and resources. This site should be monitored by the appointed NGO (or any other entity managing the Strategy) to ensure adequate oversight of activity.

- ***Recommendation 20***

  Reviewing the feasibility of appointed NGO resourcing.

- ***Recommendation 21***

  Conceptualise the meaning of the term 'sustainability' for Host Agencies and CCs and how to facilitate sustainability. Does the term denote: sustainable behaviour change within communities or sustainable community engagement and/or active involvement. Both are dependent on ongoing funding and/or commitment to the strategy.

- ***Recommendation 22***

  Ensure expected outcomes are documented and realistic to ensure the safe implementation of the strategy.

- ***Recommendation 23***

  Review the flow of funding to ensure operational imperatives are met in a timely manner.

- ***Recommendation 24***

  Add experience in suicide prevention, working within a community development framework, experience working in health/mental health to the CC capability framework.

Phase 3: Summative evaluation

The final phase of the evaluation was a summative evaluation that was designed to determine outcomes attained by the Strategy. The change to the summative evaluation required a different approach by the research and evaluation team, who developed a range of surveys and interview schedules to address the varying activities and populations who were participating in the CAPs. A balance between consistency for data collection and analysis, and flexibility to uncover local specific needs was addressed through these means (surveys and interviews). Additionally, a Western Australian population sample was recruited to

provide further information across a range of measures and to provide a cross-sectional comparative group. This meant that One Life participants could be compared to non One Life participants across a range of measures that would inform outcomes of the Strategy. Results revealed that only one CAP clearly met all its outcomes. This CAP was managed by a Local Government Authority and this success forms one of the recommendations shown below.

There were several key aspects of the Strategy that were analysed in this phase of the work. First, the effects of individual community action plans are presented in Chapters 12 (Statistical analyses of survey data) and 13 (Qualitative analysis of interview data). Second, the effects of accredited training conducted across a number of CAPs was evaluated through both survey and interview strategies. The results of this training are presented in Chapter 14. Another key area was the work of the Agency team in the recruitment of Pledge Partners and the delivery of suicide prevention within organisations. This work is presented in Chapter 15 of the report. A number of Aboriginal communities completed a Community Action Plan and the evaluation of the events held within these plans was undertaken within a structure of both cultural safety and security which resulted in the adoption of a different but appropriate methodology. The evaluation of Aboriginal CAPs is presented in Chapter 17. The final chapter in the report (Chapter 18) contains information in relation to the issue of Sustainability for Suicide Prevention.

Recommendations based on the results of phase three of the evaluation are split into those relating to CAP activities (Recommendation numbers 25 to 34); those in relation to training (Recommendation numbers 35 to 38); and those relating to the work of the Agency Team with Pledge Partners (Recommendation numbers (39 and 40). The recommendations developed from the evaluation of Aboriginal CAPs are included in Recommendations 42 to 52. Recommendations around sustainability are included from number 53 to 55.

- ***Recommendation 25***

  Host Agencies should be Local Government Authorities. This will ensure that suicide prevention initiatives become embedded within existing community wellness programs and that CCs have access to the resources, experience and knowledge required to perform their duties appropriately.
- ***Recommendation 26***

  Consider the possibility of CC stigma and address this issue in CC training programs.

- ***Recommendation 26***

  During Stage One CAPs embed a community readiness assessment to eliminate the possibility of CCs questioning community readiness to address the issue of suicide. This will also serve to mitigate potential risk by ensuring that events delivered during Stage Two are aligned with levels of community readiness.

- ***Recommendation 27***

  Consider reformulating the distinction between Stage One and Stage Two CAPs and develop a process that is aligned with stages outlined by a model of community readiness. For example, the CRM Model of Community Readiness provides clear recommendations relating to the type of activities that should be engaged in during each stage of readiness. This will ensure that events and activities take into consideration where the community is currently positioned on the issues of suicide.

- ***Recommendation 28***

  During Stage One CAPs, require CCs to demonstrate how they consulted with the 'whole' of community to ensure that all at risk groups have been targeted. Also require CCs to document the outcome of consultations with all at risk groups. CCs should be provided with a framework agreed upon by Council to facilitate this process.

- ***Recommendation 29***

  During Stage One CAPs, require CCs to form a Consulting Committee that consists of representatives from all at risk groups (e.g., young people and men). Although service providers should hold positions on the Consulting Committee, they should not be the only community representatives. It is acknowledged that this may not be possible in some remote areas where a select few community members are stretched across all community committees. Under these circumstances, the CC should seek to join a related committee and ensure the issue of suicide prevention is built into terms of reference.

- ***Recommendation 30***

  When preparing for Stage Two CAP submissions, ensure CCs are required to submit a plan in terms of how they intend to promote activities and thereby generate attendance rates. This plan should also target those who are less active in community initiatives, thereby minimising reliance on CCs existing social and professional networks.

- ***Recommendation 31***

  Draw on existing literature and suicide prevention training program materials to determine how the topic of suicide should be broached by CCs within communities. This will ensure that a candid, yet safe approach is adopted and will alleviate CC reticence to raise the issue of suicide and/or label events as suicide prevention events. This reticence may well reinforce stigma within the community. Ensure that this aspect is embedded within CC induction training and reinforced within refresher training.

- ***Recommendation 32***

  Given the different focus of events within each event category, identify outcomes that are expected for all categories of events.

- ***Recommendation 33***

  Consider the depth of information to be delivered during each category of event, the type of information to be delivered (e.g., risk factors and how to help someone in crisis), the source of the information (e.g., peer reviewed material, expertise of the person delivering the message) and how it is delivered (e.g., candidly according to accepted conventions). Draw on existing literature and suicide prevention training program materials to develop a set of resources to be provided to CCs to facilitate the delivery of this information in the most appropriate manner. If it is determined that the CC does not have the expertise to deliver this information safely, the event should not be approved.

- ***Recommendation 34***

  Ensure that Stage Two CAP submissions apply a more targeted approach to ensure that the unique needs of all at risk groups are addressed (e.g., men and young people).

- ***Recommendation 35***

  Ensure that suicide prevention training continues to form a component of all Stage Two CAP submissions.

- ***Recommendation 36***

  Ensure that those selected for training within Stage Two CAP submissions hold positions within the community (e.g., work, roles) where the likelihood of applying the skills derived from training is high.

- ***Recommendation 37***

  Consider allocating a proportion of funding to refresher training for those who have attended suicide prevention training within communities.

- ***Recommendation 38***

  Ensure that support services are in place, or that a mechanism is established to provide those who have been trained with an immediate opportunity to debrief and to facilitate self-care.

- ***Recommendation 39***

  Facilitate ongoing engagement with Pledge Partner organisations to maintain focus and commitment to the aims of the One Life pledge partnership.

- ***Recommendation 40***

  Ensure ongoing engagement with Pledge Partner organisations focuses on:

  - Engagement with workers across all levels within the organisation to determine the mental health and wellbeing needs of workers and what approach workers believe will best address those needs.
  - Facilitating the development of policy that is focused on employee mental health and wellbeing to ensure that wellness programs become a normal aspect of working life and are therefore a component of organisational culture.
  - Facilitating the development of an organisational wellness program that is prepared annually to ensure activities occur at regular intervals during the year. Although the theme should be consistent across activities, the nature of the activity should be varied and targeted in some instances (e.g., unskilled employees). Training should always form a component of this program and activities should reinforce messages delivered by training. A range of training options should also be provided.
  - Facilitating the development of a culture within organisations that directly indicates mental health issues and suicide prevention are important and that stigmatising attitudes and behaviours within the workplace will not be tolerated. Facilitate the dissemination of this message to staff at all levels within the organisation.

This approach would require reviewing the current FTE allocation to Pledge Partner work.

- ***Recommendation 41***

  Directly align Pledge Partner work with geographic CAPs to ensure workplaces combine workplace initiatives (e.g., training) with community based initiatives. Assigning CCs to organisations within particular geographic locations might facilitate this.

- ***Recommendation 42***

  To maximise the probability of community engagement with One Life activities, commit to a 5-year minimum implementation model – preferably longer.

- ***Recommendation 43***

  Consider allocating funding to *existing* programs and services that are already demonstrating impact, rather than develop and implement new short-term programs.

- ***Recommendation 44***

  Consider embedding activities in established services and forums (e.g., Aboriginal art and language programs) and as part of school curriculum.

- ***Recommendation 45***

  Any activity implemented in an Aboriginal community, for Aboriginal people that includes a training/education component should:

  - Contain Aboriginal-relevant course materials.
  - Ensure that the approach to training/education is consistent with the specific learning styles of Aboriginal people.
  - Ensure that the delivery of training/education accommodates literacy levels.
  - Ensure (where possible) that an Aboriginal facilitator delivers training/education programs.
  - Ensure the cultural appropriateness of course content and delivery.

- ***Recommendation 46***

  Where a non-Aboriginal delivers an activity with a training/education component, that individual must demonstrate cultural competence. Cultural competence should not be assumed because an individual has knowledge of, or has lived in a particular region for a period of time.

- ***Recommendation 47***

  Future Aboriginal suicide prevention activities should consider having public speaking exercises embedded, in recognition of the widespread desire for such skills and their potential to overcome shame and promote help seeking.

- ***Recommendation 48***

  Ensure that facilitation and active engagement in evaluation activities is a contractual requirement of CCs.

- ***Recommendation 49***

  Ensure local Aboriginal individuals and/or organisations partner with evaluators from the outset and coordinate evaluation activities in Aboriginal communities (possibly establish regional evaluation coordinators much like some CCs maintained overarching geographical coordinators).

- ***Recommendation 50***

  Ensure all project documents (e.g., monthly/quarterly reports/Stage One reports) are automatically sent to the evaluation team.

- ***Recommendation 51***

  Establish an Aboriginal evaluation group consisting of Council members, NGO representatives, CC/agency and host agency representatives who collaborate to conceptualise, design and test strategies applied. This group would feed back to the MCSP for endorsement of recommendations and facilitate understanding across strategy players of the nature and purpose of evaluative activities. This would also foster greater support of evaluative initiatives amongst CCs responsible for data collection.

- ***Recommendation 52***

  The MCSP should carefully consider the feasibility of reframing the current Suicide Prevention Strategy to accommodate a separate approach for Aboriginal people. Alternatively, and to align with national developments, a separate Aboriginal Suicide Prevention Strategy should be considered.

- ***Recommendation 53***

  A process whereby a suitably qualified person is appointed within communities to manage and organise suicide prevention activities (including potential fund raising events) should be considered. This may become part of an existing role possibly within the provision of health or mental health.

- ***Recommendation 54***

  On the basis of the co-production approach to the Strategy, businesses should be encouraged to support suicide prevention in their community through sponsorship arrangements.

- ***Recommendation 55***
  Branded resources should be available to facilitate recognition of the One Life message and to support local suicide prevention activities.

Summary

This Executive Summary has provided an overview of the content within this report. Given the breadth and scope of research, development and evaluation activities, signposts have been provided to the detailed information contained within each Chapter in the report. As the detailed contexts in which specific findings are presented are important for understanding, the reader should take account of these contexts when interpreting findings. Similarly, the recommendations are best reviewed within the contexts of the Chapters to which they relate.