



The Implementation and Initial Outcomes of the Suicide Prevention Strategy





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WESTERN AUSTRALIAN AUDITOR GENERAL'S REPORT

The Implementation and Initial Outcomes of the Suicide Prevention Strategy

Report 7
May 2014



**THE PRESIDENT
LEGISLATIVE COUNCIL**

**THE SPEAKER
LEGISLATIVE ASSEMBLY**

THE IMPLEMENTATION AND INITIAL OUTCOMES OF THE SUICIDE PREVENTION STRATEGY

This report has been prepared for submission to Parliament under the provisions of section 25 of the *Auditor General Act 2006*.

Performance audits are an integral part of the overall audit program. They seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities, and identify opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance parliamentary decision-making to the benefit of all Western Australians.

A handwritten signature in black ink, appearing to read 'C. Murphy'.

COLIN MURPHY
AUDITOR GENERAL
7 May 2014

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Auditor General's Overview

Suicide is the leading cause of death for both men and women between the ages of 15 and 44. It takes more lives than road trauma or skin cancer. It takes an enormous toll on the families, friends and communities left behind. That toll is rising. Western Australia's suicide rate has increased over the last decade to 36 per cent above the national rate, and some of our communities experience suicide rates up to 20 times the State average.



The causes of suicide are numerous and complex which makes preventing it one of the most difficult challenges that we face as a society. It is also one of the most important.

Western Australia's Suicide Prevention Strategy 2009-2013 introduced a new approach to prevention. It sought to engage communities in designing and implementing their own prevention activities on the basis that broad engagement multiplied the chances of building resilience and preventing suicide. I commend the effort and commitment of all those across the State who got involved.

My audit shows that the Strategy succeeded in engaging communities in planning and participating in suicide prevention activities that they felt would work for them. This delivered benefits for individuals and communities.

But the benefits could have been greater. Delays resulted from a poor procurement process, the initial planning was inadequate and governance arrangements were unclear and inefficient. These issues cost time, effort and money that could have been spent on prevention activities. Changes were made in 2012 and 2013, increasing the number of community action plans, but other parts of the Strategy were not completed.

How long the impact of the Strategy will sustain is uncertain. Some of the initiatives that began under the Strategy are likely to last, but many communities do not have the capacity to carry on with prevention activities on their own.

Efforts to prevent suicide need to continue, and a community based approach can deliver benefits. Learning the lessons in this report will increase the likelihood that future prevention efforts deliver maximum and sustained benefits, and contribute to reducing the tragedy of suicide in our communities.

Executive Summary

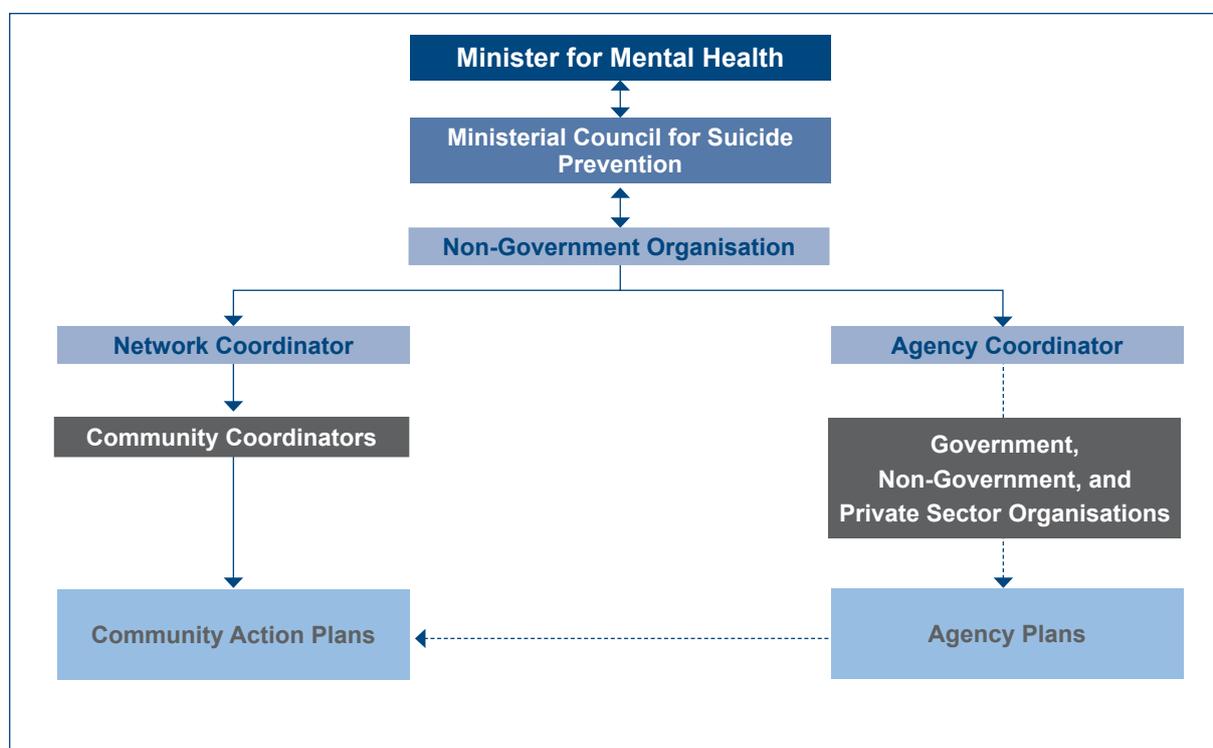
Background

The annual number of suicides in Western Australia (WA) has risen from a 15-year low of 194 in 2004 to 366 in 2012. Much of the rise is due to population growth, but in recent years the suicide rate – suicides per 100 000 of population – has also risen. WA's suicide rate has been higher than the national rate since 2006 and is now 36 per cent higher. Suicide is now the leading cause of death for both men and women between the ages of 15 and 44. Kimberley Aboriginal communities such as those in Balgo, Fitzroy Crossing, Mowanjum and Derby, have experienced suicide rates up to 20 times the State average.

The number of deaths by suicide is only part of the story. Suicide attempts are estimated at 20 to 30 times the number of confirmed suicides. Often attempted suicides leave people with permanent injuries requiring ongoing care. Based on national estimates, the economic cost to the State for suicides and attempted suicides could be more than \$1.8 billion per year.

The State Government has spent \$18 million implementing the *Western Australian Suicide Prevention Strategy 2009-2013* (the Strategy), also known as OneLife. It promoted a coordinated approach across all levels of government and the whole community, emphasising 'integrated policies, programs and responses' to suicide. The Strategy was a guide for policies and services to better meet the needs of people most at risk, and a call for open discussion about suicide and its causes.

The Ministerial Council for Suicide Prevention (the Council) led the Strategy. Its members, appointed by the Minister for Mental Health, include people with an interest and experience with suicide. Centrecare, a Non-Government Organisation (NGO) was contracted to work with communities to deliver the objectives of the Strategy. See Figure 1.



Source: Adapted from Mental Health Commission.

Figure 1: Governance structure for the Strategy as illustrated in the Strategy document

The Commissioner for Mental Health is an ex-officio member of the Council. Although not mentioned in the governance structure, the Mental Health Commission (the Commission) managed Centrecare's contract and was accountable for Strategy funds.

The Strategy is based on a community development model built around Community Action Plans (CAPs), which is a new approach to suicide prevention in Western Australia. CAPs comprise community engagement, consultation, training and suicide prevention activities. Specifically, these were intended to raise awareness of risk factors, promote mental health literacy, connectedness and resilience, improve collaboration of mental health resources, including access to services within a community, and be sustainable. Community Coordinators helped communities develop and deliver CAPs. Under the Strategy, communities are considered to be geographic, occupational, demographic or other groups with an interest in suicide prevention.

Of the \$18 million total funding, \$4 million was allocated after the Strategy's formal end in June 2013. By December 2013, 65 per cent of total funds had been spent on 55 CAPs. The balance of funds was spent on evaluation, other programs and administration. Funding is enough to enable existing CAP activities to continue until June 2014, providing nearly all CAPs with an additional six months to implement activities. Eight CAPs in the Kimberley and Wheatbelt received almost another year to implement their activities.

Another key component of the Strategy is the Agency Suicide Prevention Pledge Partner Program which aims to raise awareness in organisations about suicide and obtains their commitment to develop suicide prevention plans for their workplaces. By December 2013, 244 organisations had pledged to develop suicide prevention plans and to support community prevention activities.

This audit assessed if the Strategy was supported by good governance, implemented effectively and efficiently, and delivered sustainable action to reduce suicide.

Audit Conclusion

The *Western Australian Suicide Prevention Strategy 2009-2013* was the first to use a community development model to address suicide prevention in WA. It engaged communities and organisations in suicide prevention activities that coordinators and agency partners reported have benefited participants. However, the limited capacity in many communities to continue prevention activities without external support reduces the likelihood that the initial benefits will be sustained.

Inadequate planning led to delays in implementing the Strategy that reduced its impact. The roles, responsibilities and reporting requirements between the Council, the Commission and Centrecare were not adequately defined at the outset, contributing to delays and inefficiencies. Changes were made to address these issues mid-way through the Strategy, enabling an increase in activity and the number of community action plans. Other parts of the Strategy, such as a coordinated inter-agency approach to suicide prevention, were not fully implemented.

Key Findings

Monitoring and reporting

- Communities and organisations reported benefits from prevention activities funded by the Strategy. Those activities that strengthened the sense of community and raised suicide awareness such as back-to-country camps, sporting activities and community barbecues were well received. Training that better equipped communities and organisations to recognise and respond to warning signs also received positive reports. These activities contributed to de-stigmatising suicide and better understanding of its causes. But small numbers, lack of reliable data and large number of influential factors make it hard to measure the direct impact of prevention activities on the suicide rate.

- Once the CAPs were underway, the Council tracked progress regularly. However, the reporting to the Council was inconsistent and focused on qualitative feedback. It lacked more quantifiable and objective measures which would have allowed the Council, the Commission and Centrecare to consistently measure CAP performance, assess the effectiveness of implementation, and inform future funding decisions.
- Under the Pledge Partner Program, 244 organisations made commitments to raise awareness about suicide and to develop prevention plans. While progress in securing pledges and promoting the initiative was tracked, the plans themselves were not monitored so the Council has limited evidence of what was done or how effective it was in promoting suicide prevention. Centrecare advised that potential partners resisted pledging until assured that there would be no reporting burden.

Planning

- There was no implementation plan that covered the life of the Strategy. The Council developed one-year business plans that focused resources annually, but these did not provide the basis to monitor overall progress and balance resources across all aspects of the Strategy over four years. This contributed to the areas of the Strategy addressing coordination and standards and quality not being fully implemented.
- The Commission did not adequately define the roles and responsibilities of the Council, the Commission and NGO in the Request for Expression of Interest (EOI). Negotiations with the first choice NGO broke down after five months because the parties could not agree on the roles and responsibilities. It took more than a year from the start of the Strategy in June 2009 to appoint Centrecare, delaying the start of and reducing the time available for prevention activities.
- A lack of CAP guidelines led to communities wasting time revising funding proposals to meet the Council's criteria, which themselves changed during the Strategy. This led to an iterative process between communities and the Council through Centrecare. In a few cases this back-and-forth process took months, adding to the cost of the process and delaying timely prevention activities.
- In the procurement process to engage Centrecare, the Commission was not clear or consistent about what Centrecare was meant to do or the autonomy it would have to deliver the Strategy. The number of CAPs to be delivered was not confirmed until mid-way through the Strategy. More money and resources were needed to address this.
- Reporting templates were repeatedly changed and the requirements of the Council remained unclear to those doing the reporting until guidelines were finalised in 2013. Reports frequently had to be revised and re-submitted, resulting in inefficiencies for communities and Centrecare.

Sustaining activity

- The Council did not define or make clear what was meant by the requirement that prevention activities under CAPs should be sustainable. The sustainability of activities was not consistently used by the Council in assessing and approving CAPs. We found that 30 per cent of approved CAP proposals did not mention sustainability, 35 per cent said that they would rely on the momentum in the community to be sustainable and the rest said they would need ongoing funding to be sustainable. On this basis it appears unlikely that widespread sustainability will be achieved.
- The Council and the Commission have recognised this by using unallocated money to fund activities to a maximum of \$10 000 through a grant program beyond the Strategy's end

date. Sixteen organisations have been funded for further suicide prevention activities, while another 13 have been funded to deliver mental health and suicide prevention training in local communities.

- The time in which CAP activities were carried out, one year or less, reduced the chances of making lasting change. Research shows that community development approaches need three to five years to be effective and brief interventions are unlikely to bring about lasting change.
- The suicide prevention activities that the Council approved in each CAP were not coordinated with existing activities to avoid duplication, increase efficiencies and last longer. The Commission only began to systematically map existing suicide prevention efforts in late 2013.

Recommendations

For any future suicide prevention strategy or activities the Commission and the Council should:

- develop quantifiable and objective measures to complement qualitative reporting and allow more consistent assessment of suicide prevention activities to inform strategy development
- develop an over-arching implementation plan
- review the governance structure and clearly define the roles and responsibilities of all parties
- identify, collaborate and coordinate with existing suicide prevention efforts to increase efficiencies and the likelihood that benefits will be sustained.

Agency Responses

Mental Health Commission

The Mental Health Commission (MHC) accepts the recommendations of this report and acknowledges the work undertaken by the Office of the Auditor General in the preparation of the report. The MHC will work with the Ministerial Council for Suicide Prevention to implement the recommendations outlined in the report, subject to appropriate funding and resources being made available.

The MHC is pleased that the Auditor General has acknowledged that communities and organisations have benefited from suicide prevention activities funded by the *Western Australian Suicide Prevention Strategy 2009-2013* (the Strategy). Following the Strategy evaluation, further planning will be undertaken to ensure the next phase of the Strategy and future suicide prevention initiatives are effective, sustainable and integrated with existing programs. Suicide affects the whole community and it is vital that communities, businesses and government agencies work together to find ways to prevent its devastating impacts.

The next multi-year suicide prevention strategy will include a comprehensive implementation plan, including enhanced coronial data analysis. While the inaugural Strategy is independently evaluated, interim funding is being sought through the State Budget process to continue suicide prevention activities for another year. Improved governance will be prioritised, with MHC overseeing the operational aspects of the Strategy's implementation with dedicated suicide prevention staff. Furthermore, the role of the Ministerial Council for Suicide Prevention as an overarching body providing expert advice, rather than a hands-on approach, will be clarified through an updated Terms of Reference.

The proposed merger with the Drug and Alcohol Office, together with the development of a 10-year plan for mental health and alcohol and other drug service delivery, will see a greater focus on coordination and collaboration between services.

Thank you again for the report on the Strategy's outcomes and implementation, and recommendations to strengthen future suicide prevention activities in Western Australia.

Centrecare

Centrecare acknowledges the work of the Office of the Auditor General in undertaking an audit and compiling a report which speaks to the audit's findings and recommendations of what was, and still remains an exceedingly complex, ambitious and innovative prevention strategy designed to tackle suicide in Western Australia. Whilst the brevity of the report can never truly reflect the extensive work undertaken within such a large project, or the challenges and achievements experienced, it does overall reflect the thrust of the *Western Australian Suicide Prevention Strategy*.

Further clarification and expansion of the scope of the work would have been beneficial, in particular in relation to the Community Action Plans (CAPs), as stating a mere number fails to describe the uniqueness of each CAP, the breadth of geographical coverage, the number of participating locations and the impact these variables had on the work and resources needed.

In addition, whilst the report speaks accurately to the lack of preparedness of all parties prior to the implementation of the Strategy, it would have been advantageous to provide a more detailed explanation of the reasons for this lack of preparedness, particularly given the delay in the work commencing, and the directive to engage with as many communities as possible, as quickly as possible. Whilst both of these issues were outside the control of Centrecare, the impact on implementation of the Strategy should not be underestimated, particularly in relation to capacity to plan and prepare accordingly.

If you or anyone you know needs help, you can call Helpline:

Mental Health Response line (24 Hours)	9224 8888 1300 555 788 (Perth metropolitan) 1800 676 822 (Peel region)
Crisis Care (24 Hours)	9223 1111 1800 199 008 (freecall STD) 9325 1232 (TTY)
Lifeline (24 Hours)	13 11 14
Suicide Callback Service (24 Hours)	1300 659 467
Samaritans Crisis Line (24 Hours)	13 52 47 (Crisis line) 1800 198 313 (Youth Line WA)
Kids Helpline	1800 551 800
Family Helpline	1800 643 000

Audit Focus and Scope

This audit focuses on implementation of the *Western Australian Suicide Prevention Strategy 2009-2013* by the Council, the Commission and Centrecare. We addressed the following questions:

- Has the Strategy been successful in delivering sustainable action to reduce suicide?
- Have governance and implementation supported the Strategy efficiently and effectively?

The audit does not attempt to assess the work of local agencies and Community Coordinators except as it reflects on governance of the Strategy as a whole. Centrecare contracted Edith Cowan University's Sellenger Centre to evaluate the impact of CAPs in communities.

We reviewed current research into suicide prevention, policies and strategies in other jurisdictions.

We examined the Commission, Council and Centrecare records including CAPs, annual business plans, minutes, funding applications, progress reports, grant acquittals and contracts.

We interviewed Council members and officers from the Commission and Centrecare responsible for implementing the Strategy and Edith Cowan University evaluators. We visited a sample of five locations implementing CAPs (Roleystone, Toodyay, Broome, Derby and Mowanjum) and interviewed Community Coordinators, Host Agencies and some participants. We also interviewed Community Coordinators and participants in Fitzroy Crossing and One Arm Point by phone. An account of our visit to the Kimberley is in Appendix 1.

We analysed statistics from the Australian Bureau of Statistics and data collated by the State Coroner.

The audit was conducted in accordance with Australian Auditing and Assurance Standards.

Background

Western Australia's suicide rate is rising and some communities are affected more than others

Western Australia's suicide rate is significantly higher than the national rate and has been climbing relatively steadily since 2004 when it reached a 30-year low. By contrast, the national suicide rate has been on a downward trend since the mid 90s. See Figure 2.

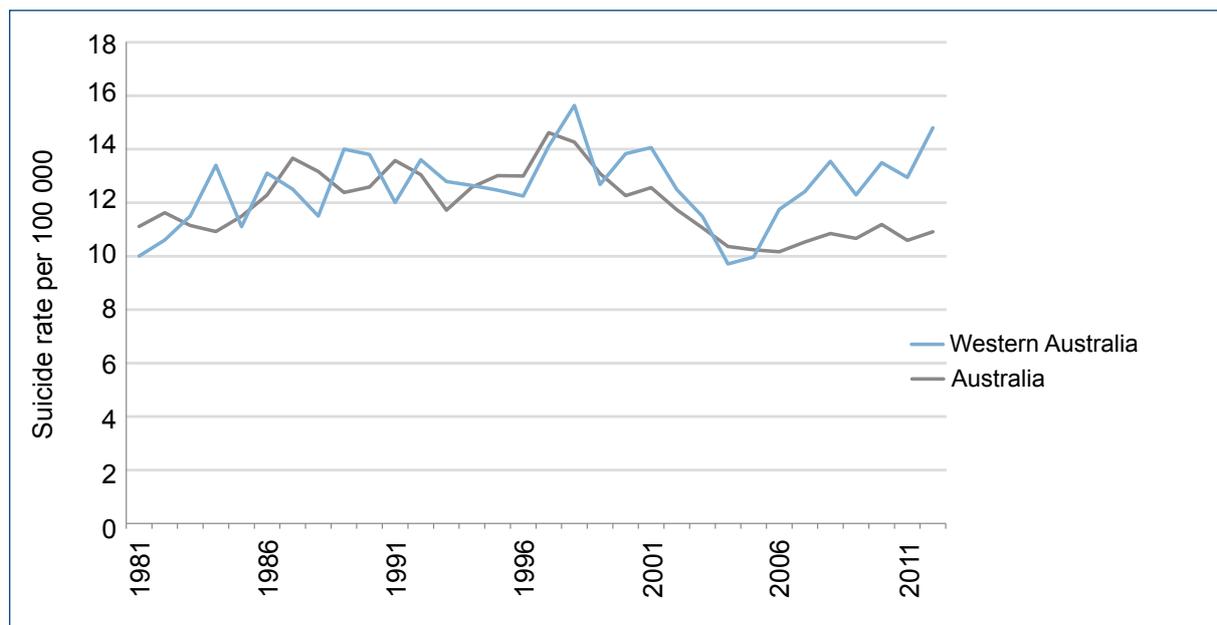


Figure 2: Suicide deaths per 100 000 of population in WA and Australia 1981 to 2012

The most recent data available is for 2012, when the suicide rate in WA was 14.8 per 100 000, or 366 deaths from suicide. The WA data for the last decade shows that some population groups are affected more than others. For example, in 2011 for the first time suicide was the leading cause of death for women aged 35 to 44 years. Suicide is now the leading cause of death for both men and women between the ages of 15 and 44. More people suicided in 2012 than were killed by skin cancer or road trauma.

While most suicides are in the Perth metropolitan area, the rural and remote areas of WA have a higher rate at 18.5 suicides per 100 000 people between 2006 and 2010. The region of highest risk is the Kimberley (Figure 3). Because of the small numbers involved in regional and remote areas, patterns and trends in suicide rates are not obvious.

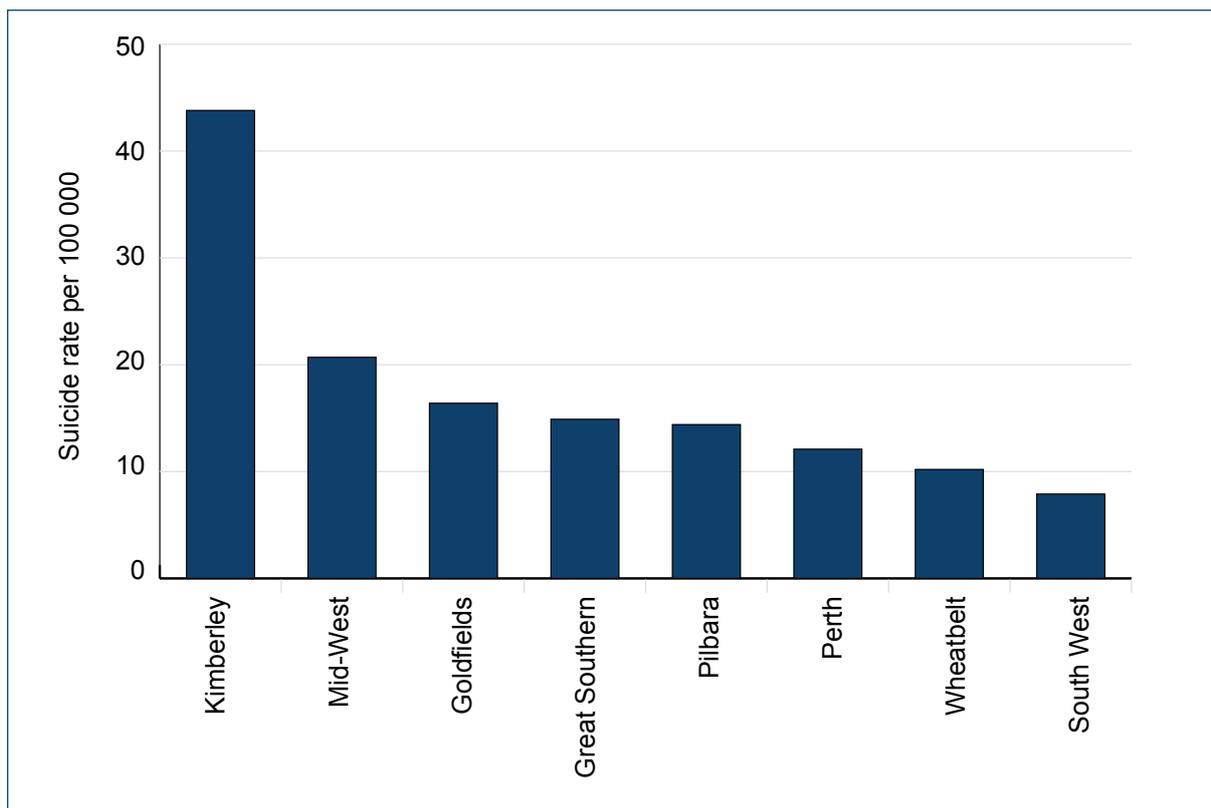


Figure 3: Average suicide rates per 100 000 in WA regions 2008-2012

Note: Assumes all cases under investigation by the State Coroner as possible suicides are found to be suicides.

A 2010 report *Breaking The Silence: Suicide and Suicide Prevention in Australia* notes that for every suicide there are between 20 and 30 attempts, many of which leave permanent injuries requiring ongoing management. Suicide and attempted suicide have been estimated to cost the nation over \$17.5 billion every year. Pro rata, the economic cost to WA could be more than \$1.8 billion per year.

Western Australia's Suicide Prevention Strategy sought to improve the State's understanding of and capacity to prevent suicide

The Minister for Mental Health launched the *Western Australian Suicide Prevention Strategy 2009-2013* in September 2009 to complement the *National Suicide Prevention Strategy: Living is for Everyone* (LIFE) launched in 2008. The State Government committed \$13 million over four years. The Commission allocated a further \$5 million during the life of the Strategy, bringing total expenditure to \$18 million. By the end of 2013, 65 per cent of total funds had been allocated to CAPs with the balance to evaluation, other programs and administration. There was no commitment to extend funding beyond 2013, although some activities have been funded in 2014.

The Ministerial Council for Suicide Prevention (the Council), an advisory council made up of appointees of the Minister for Mental Health, led the Strategy. Responsibility for carrying out the day-to-day work of the Council was assigned to a NGO. The Strategy did not assign a role to the Commission.

Suicide is the result of many factors, making it difficult to identify causes or to target with a specific response. The Strategy states that 'effective suicide prevention in Western Australia requires a coordinated approach across all levels of government and the whole of the community. It is important for all government agencies to deliver integrated policies, programs and responses to improve suicide prevention.'

While the Strategy does not talk of outcomes, it talks of achieving six action areas, making it clear they serve the same purpose. The action areas are:

1. Improve the evidence base and better understand suicide prevention
2. Build individual resilience and capacity for self-help
3. Improve community strength and resilience in suicide prevention
4. Coordinate approaches to suicide prevention
5. Target suicide prevention activities to those that are most at risk
6. Implement standards and quality in suicide prevention initiatives.

The Strategy focused on early prevention rather than clinical services – see a description of these in Appendix 2. Central to implementing it was a community development approach not used before in suicide prevention in WA. This approach empowers communities to address suicide prevention themselves by providing them with the necessary skills and resources.

Under the Strategy, community development in the form of CAPs was used to engage communities in grass roots prevention activities across the State – see a description of these in Appendix 3.

Specifically, CAPs were intended to raise awareness of risk factors, promote mental health literacy, connectedness and resilience, improve collaboration of mental health resources, including access to services within a community, and be sustainable. CAP activities could include, for example, hosting sporting and social events to bring communities together, information forums, and suicide prevention training programs. CAP funding allocations ranged from \$62 570 for the WA Jockeys CAP to \$893 473 for the Wheatbelt Aboriginal CAP.

The Council defined communities by geography, such as the Kimberley, by demography, such as youth, by occupations, such as farmers and by 'other groupings', such as Aboriginal and Lesbian Gay Bisexual Transgender Intersex Questioning.

Communities reported benefits from activities under the Strategy

The reports on Community Action Plans show that communities saw benefits from suicide prevention activities and training

Community Coordinators provided at least some progress reports for all but one of the 36 Stage Two CAPs. These reports included narrative accounts of:

- reducing the stigma of mental health issues and suicide
- training to deal with mental health problems
- community members having a better understanding of suicide
- more knowledge of warning signs and how to respond
- people in need being more likely to seek help.

Community Coordinators also reported occasions when they have been able to directly help a person at risk of suicide who approached them as a result of the activities.

Consistent with a community development approach to building community resilience, events such as football matches, music recordings, and coffee mornings were hosted in the Kimberley. Participants reported that these succeeded in engaging people and strengthening a sense of community. One of the highlights for many people we spoke with was the back-to-country camps. Further accounts of positive impacts of CAPs in the Kimberley are included in Appendix 1.

Pledge Partners also provided positive feedback from participants in workshops such as Working Minds Training. The program was developed mid-way through the Strategy to engage organisations in suicide prevention. The Agency Coordinator conducted suicide prevention awareness raising forums and training workshops. By December 2013, 244 organisations had pledged to develop suicide prevention plans for their workplaces and support community prevention activities. But Centrecare did not monitor or report on the implementation of the agency plans. While there was positive feedback from participants in workshops the Council does not know if the agency plans were actioned and if the program has been effective.

The reporting lacked the rigour for assessing Community Action Plans' performance

The Council tracked progress of CAPs through monthly reporting by Community Coordinators. However, the reporting was inconsistent and focused on qualitative anecdotal feedback. While informative, it lacked more quantifiable and objective measures which would have allowed the Council, the Commission and Centrecare to more consistently measure CAP performance.

We found the CAPs' monthly reports provided mainly qualitative anecdotal feedback that was overwhelmingly positive and varied in detail. Additional objective quantifiable reporting criteria, such as number of participants that gave positive and negative feedback about an activity, or the number of participants seeking more information or help could have assisted the Council to assess CAPs performance and inform future funding.

The Agency Coordinator regularly reported the progress of securing pledges and promoting organisation-wide suicide prevention initiatives. Part of becoming a Pledge Partner meant that organisations developed action plans specific to them.

Centrecare advised that it never intended to monitor the performance of organisations against these plans. It reported that potential partners resisted pledging until they were assured that there would be no reporting burden. Pledge Partners did not receive any direct funding from the Strategy that might have provided a requirement to report. Centrecare received a further \$100 000 to enable the Agency Coordinator to continue promoting the program until June 2014. The MHC advised that it intends to continue the role of the Agency Coordinator until December 2014.

Centrecare contracted Edith Cowan University (ECU) to evaluate the CAPs. It is expected to report in mid-2014 on the process of developing and implementing the plans, and whether activities achieved their objectives. This post-strategy evaluation was not meant to measure the Strategy's impact on the suicide rate, but will try to measure the changes to community protective or risk factors before and after the Strategy. The ECU report will not be evaluating the Pledge Partner Program. Not monitoring the program missed an opportunity to contribute to the evidence base and to better understand suicide prevention, one of the Strategy's action areas.

Inadequate planning held back the Strategy's implementation and reduced its potential impact

The lack of an implementation plan covering the life of the Strategy reduced the Council's capacity to ensure progress across all action areas

The Council did not develop an implementation plan for the life of the whole Strategy. The Council developed one-year business plans that focused resources annually, but these did not provide the basis to monitor overall progress and balance resources across all areas of the Strategy over four years. This contributed to the action areas of the Strategy addressing coordination and standards and quality not being fully implemented.

For instance, 65 per cent of the funds went to CAPs, but there is no way to show if this was what the Council intended or if it achieved what the Strategy set out to do. We found no documented reason for the Council prioritising CAPs over other action areas, such as taking a coordinated approach to suicide prevention between communities, agencies and all levels of government.

An implementation plan would have identified clear outcomes and outlined how each action area would be resourced and managed. This would have allowed the Council to ensure effort and resources were adequately distributed across all areas over the four years. The Council developed a series of annual business plans that allocated resources for one year. The short-term focus of these business plans did not provide a basis to ensure that effort was appropriately balanced overall.

An implementation plan could also have helped ease the difficulties faced when significant organisational changes occurred during the Strategy. These changes included the creation of the Mental Health Commission and appointment of a Commissioner in 2010, large-scale change of Council members including the Chair in 2011, and changes in key personnel at Centrecare.

Developing and implementing CAPs has been the main means of delivering the Strategy. By the end of 2013 allocations to CAPs, excluding the costs of administration by Centrecare and ECU's evaluation, accounted for 65 per cent of total Strategy funds. CAPs absorbed the vast majority of time and effort.

A consequence of focusing on CAPs was that parts of the Strategy relating to coordination between communities, agencies and levels of government and implementing standards and quality, were not implemented. There is, however, no documented evidence that this was a deliberate decision based on achieving the objectives of the Strategy.

Communities benefited less because time was lost appointing a Non-Government Organisation

The Commission did not adequately manage the procurement of the NGO that would work with communities to deliver the objectives of the Strategy. As a result, the eventual appointment of Centrecare occurred eight months later than expected. This delay not only reduced momentum in communities created by announcements and consultations, but towards the end of the Strategy also reduced the duration of CAPs. Despite the time lost, the Strategy's end date was not revised until June 2013 when the option was taken up to extend the contract with Centrecare for another year.

The request for EOIs was advertised in September 2009 and closed in October 2009. The request did not specify the scope of the work required to implement the Strategy or who would have what role in delivering, managing and governing the Strategy. Instead it invited NGOs to propose their implementation ideas and planned to negotiate with the preferred provider to clarify these. This meant respondents were not clear about the risks they faced, particularly relating to governance and scope. Consequently, negotiations with the first choice provider broke down in April 2010 after five months trying to reach agreement. The selection panel then negotiated with Centrecare and it took a further three months to appoint them. See Figure 4.

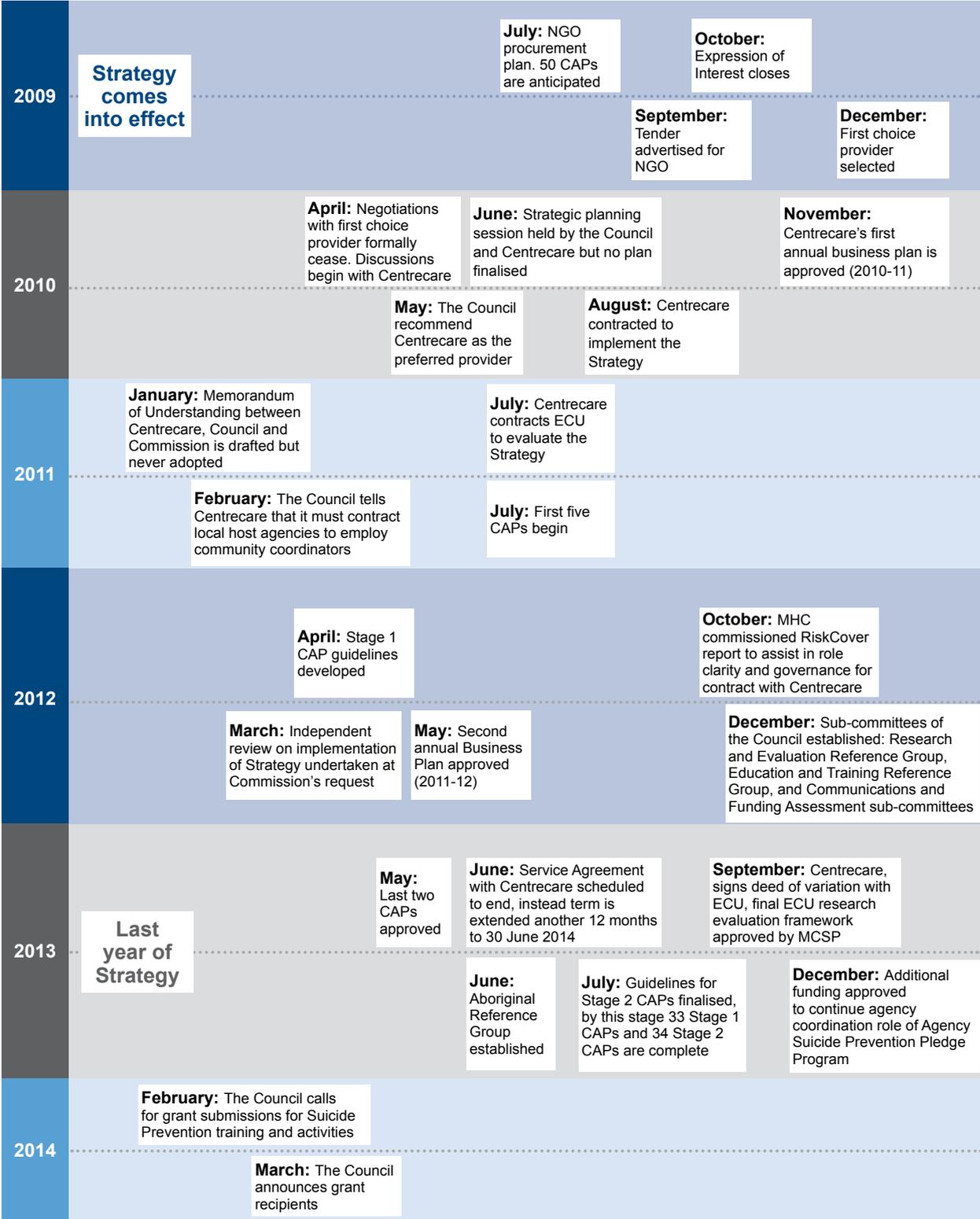


Figure 4: Strategy implementation timeline July 2009 to December 2013, including activity beyond the Strategy in 2014

One of the communities we spoke to began to develop its plans when the Strategy was announced, but it was two years before the plan was approved and funds provided. The loss of momentum meant that Community Coordinators had to work hard to re-engage those communities that had become sceptical. It also meant that funding itself took longer than necessary to reach communities, and the shorter time of some CAPs reduced their chance of delivering sustained benefits.

Communities wasted time revising proposals because there were no guidelines

The Council and Centrecare took a long time to develop guidelines for communities about what kinds of activities would be considered for funding. Clearly communicating the intention of the Strategy, the expectations of the Council and guidelines for operational activities, would have given communities a better chance of getting it right the first time and sped up CAP approvals.

Formal Stage One guidelines were only developed in April 2012, more than two years after the Strategy started. Stage One related to community engagement and training. The Stage Two guidelines were completed and approved in July 2013 when most of the CAPs were either complete or underway. Stage Two related to suicide prevention activities in communities.

Without documented guidelines, communities relied on Centrecare for guidance in developing their CAPs. Centrecare saw its role, at least in part, as advocating for communities rather than acting solely as the Council's administrator. This meant that, in the absence of guidelines, Centrecare supported CAPs that were not acceptable to Council. This led to an iterative process between communities and the Council through Centrecare until they were acceptable. The process was not helped by changes made by the Council to their CAP criteria during the Strategy. In a few cases this back-and-forth process took months. Aside from increasing efficiency, clear guidance could have also ensured that CAPs more comprehensively addressed the Strategy.

Poorly defined roles and responsibilities diverted attention from prevention activities and increased costs

Roles and responsibilities were not agreed when the Strategy started causing ongoing management problems

The Council, the Commission and Centrecare had significant roles in the governance of the Strategy but these were not adequately defined when the Strategy started (Figure 5). This meant that communications between the Council, the Commission and Centrecare were unnecessarily complex. It was not always clear to Centrecare from whom it should be taking direction in day-to-day operations and what were the limits of its own role. Dealing with this required ongoing effort by all parties that could have been directed to implementing the Strategy.

A Memorandum of Understanding, required under the service agreement with Centrecare, should have clarified the roles but it was never finalised. The Council made some changes to the governance structure in 2012-2013, but this did not resolve all the issues. As leader of the Strategy, the Council should have ensured that all parties were clear about their roles and agreed to them from the start. Some effort to clarify these roles was made by the Council and the Commission towards the end of the Strategy.

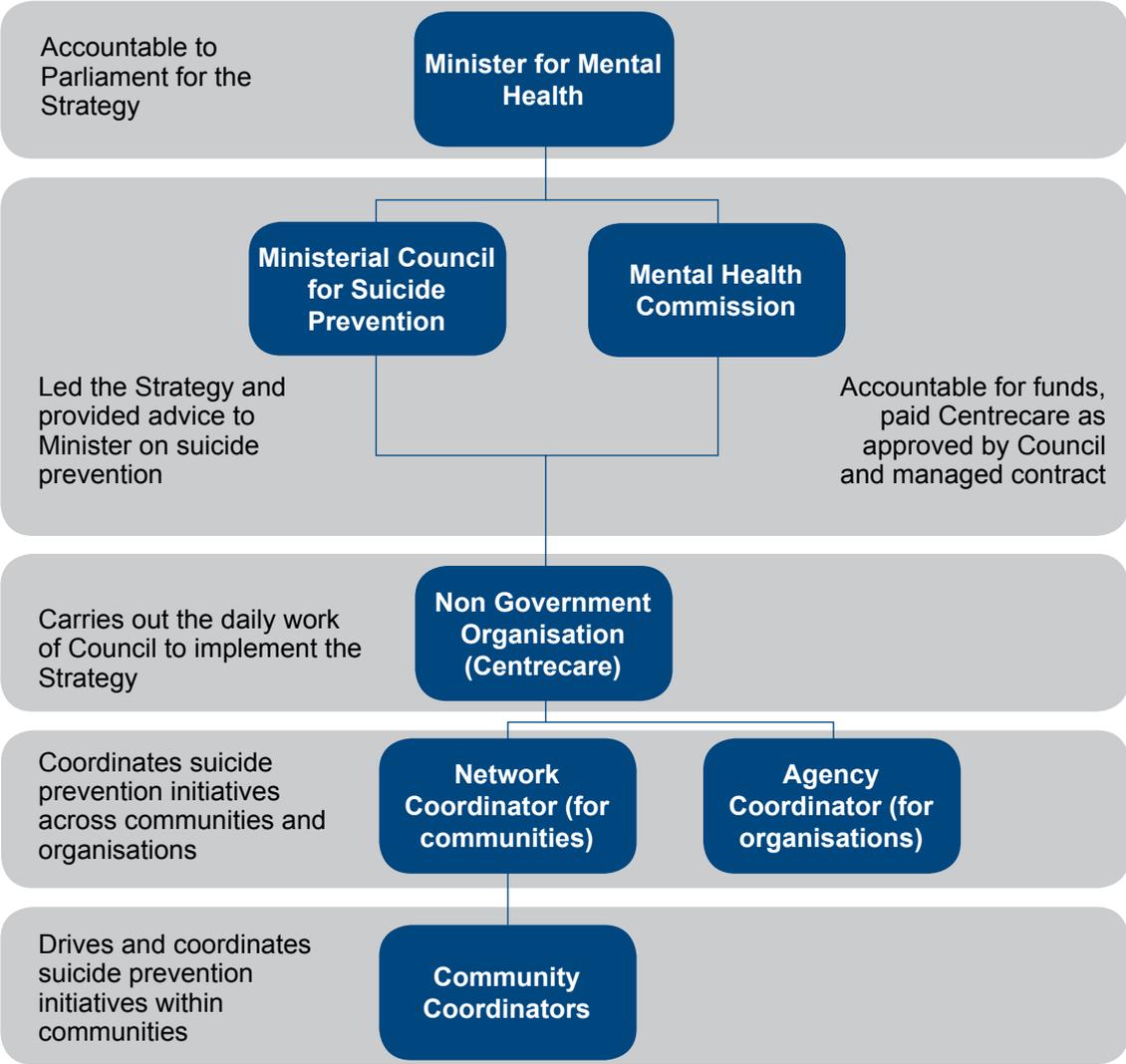


Figure 5: Governance structure for the Strategy including key responsibilities

The Commission is legally accountable for the Strategy funds and managing the contract with Centrecare, but this is not mentioned in the Strategy. The Council is charged with leading the Strategy but has no legislative foundation, is not an accountable authority and, despite directing Centrecare day-to-day, does not manage the contract. The Commission's role was not clearly documented until August 2012, some three years after the Strategy came into effect. This made it difficult for the Commission to assert its role as contract manager, and had day-to-day management consequences for Centrecare.

Problems with the governance framework first became obvious when the initially chosen tenderer for the NGO role withdrew. The Commission advised that the reason for its withdrawal was differing expectations of the Council's role: exercising day-to-day control of activities versus confining itself to setting direction.

Problems with the governance framework were also identified in March 2012 by an independent reviewer engaged by the Commission and again by RiskCover in late 2012. RiskCover, formerly a business unit of the Western Australian Insurance Commission, concluded that there was a high risk resulting from the 'Failure to clearly define an appropriate and workable governance framework'. The Council responded to this by becoming more operational and creating four sub-committees to focus on specific aspects of its activities. These were communications, funding, the ECU evaluation and Aboriginal interests.

Although its new operational focus ensured that funding was allocated more speedily, the Council's engagement in operational matters caused other problems. In practice, Centrecare was answering operationally to both the Council and the Commission, its contract manager. Council members communicated directly with Centrecare operational staff, causing management problems for Centrecare. There was no framework for Centrecare to resolve conflicting demands as would be expected in good governance practice.

Templates used by the communities in reporting on their activities were repeatedly changed by the Council leading to uncertainty about its requirements until reporting guidelines were finalised in 2013. The reporting uncertainty meant that reports frequently had to be revised and re-submitted, resulting in inefficiencies for communities and Centrecare.

The Council and the Commission were not clear or consistent about what Centrecare was meant to do, costing time and money

The lack of clear objectives, roles and responsibilities for effective delivery of the strategy first became evident in government's invitation to NGOs to submit an EOI to act as coordinator of the Strategy. The documentary material supporting the invitation was at odds with the Strategy and the Council's expectations. The resulting misunderstandings in some cases took years to correct and contributed to disputes, delays, lost opportunities and higher costs.

The different expectations and understandings between the Council, the Commission and Centrecare that remained for much of the Strategy included:

- the degree of autonomy that Centrecare would have to run the Strategy. Centrecare's EOI described a relatively autonomous role in which it would prepare the implementation plan, submit CAPs for approval and hire Community Coordinators directly. This was at odds with the Strategy which said locally based organisations would hire Community Coordinators as a way of encouraging local involvement and sustaining activities. The evaluation panel that assessed the EOI was aware of this difference but no one brought it up with Centrecare. The misunderstanding led to the Commission needing to devote more resources to manage contracts of locally-based host agencies.

- the number of CAPs to be completed. Centrecare's successful EOI proposed 'at least 12' CAPs be rolled out in the first year. This number was approved by the Council as part of the 2010-2011 Business Plan. But a target of 50 CAPs, originally mentioned in the NGO procurement plan but not in the request for EOIs, was confirmed in August 2011. Council minutes show that it was still discussing the number in July 2012. It commented that 'the changes and growth have been significant with very unclear processes, procedures and consideration given to cater for this expansion'. This led to the Commission providing an extra \$377 500 to Centrecare for the additional work.

Many suicide prevention activities are unlikely to be sustained, reducing the Strategy's long term impact

In reviewing the proposals for Community Action Plans, the Council did not consistently address how activities and benefits would be sustained

A key principle of the Strategy was the ability to sustain local suicide prevention efforts. The Council did not define or make clear how it expected sustainability to be addressed within CAPs. As a result the concept of sustainability was not consistently applied by the Council when it reviewed CAP proposals or in the Council's records of funding decisions.

Communities demonstrated in their proposals that they were not sure how they would achieve activities or impact that would sustain. All CAP proposals were required to describe how their suicide prevention activities would be sustained. Thirty-five per cent of the CAPs we looked at said they would need additional funding to keep going. Another 30 per cent relied on the goodwill and the natural momentum of the community to sustain, with the remaining CAPs not addressing it at all.

The only guidance covering sustainable prevention activities is contained in the Commonwealth Government's guide *A Framework for Effective Community-Based Suicide Prevention* (LIFE 2005) (the Framework). It recommends a variety of strategies for increasing sustainability, including:

- linking with concurrent community prevention efforts
- utilising existing community structures
- building and maintaining strong and stable committees
- fundraising
- development of in-kind donations
- building towards long term and sustainable levels of funding

CAPs used existing community structures through the local organisations that employed Community Coordinators. With a few exceptions where distances made it impractical, CAPs established committees. But other ways of achieving sustainability suggested by the Framework were not evident in the CAPs we reviewed. Community Coordinators explained that communities often lack the skills for fundraising.

Community Action Plans were too brief to make lasting change and communities do not have the capacity to support them

Under their contracts with Centrecare, most CAPs were funded for one year of activities. Some CAPs approved towards the end of the Strategy were funded for shorter periods, while a few were extended.

The Framework prepared for the Australian Government and based on academic research, reported that 'a one-year time frame is usually not enough ... Brief interventions are unlikely to bring about change. Multi-component and multi-year activities (3-5) are more likely to foster enduring benefits.'

Community Coordinators and community representatives we spoke to thought it unrealistic that a one-year CAP including a range of prevention activities would have an enduring impact. Some activities, such as community gatherings, were one-off events, while others, such as training programs ran for longer and could be repeated. Refer to Appendix 3 for more detail.

Community Coordinators also said they did not have the capacity, in resources or money, to support their suicide prevention activities beyond the end of the Strategy. The Council and the Commission have recognised this by using unallocated money to fund activities through a grant program beyond the Strategy's end date. Sixteen organisations have been funded for further suicide prevention activities, while another 13 have been funded to deliver mental health and suicide prevention training in local communities.

Not coordinating activities with existing efforts was inefficient and reduced the potential for them to last longer

A lack of focus on coordinating approaches to suicide prevention (Strategy Action Area 4) meant that opportunities to sustain and improve the effectiveness of suicide prevention measures has been missed. Aligning new and existing activities could have extended the life of the new activities and reduced the money, time and effort needed to set up new services.

To do this, an understanding of existing initiatives was needed. While some Community Coordinators 'mapped' services in their communities for their Stage One CAPs, others we spoke to showed little understanding of the suicide prevention landscape.

Besides the Strategy's \$18 million expenditure, the Commission also funded \$7.8 million worth of other suicide prevention activities in 2013. The Commonwealth's *Living is for Everyone Suicide Prevention Framework* committed \$123 million nationally to expand suicide prevention programs targeting high risk groups. But the Council and the Commission have not integrated these into their implementation planning.

While the Commission is represented at both a State and Federal level on key suicide prevention bodies, it advised that it lacked the capacity to systematically identify all existing suicide prevention efforts occurring in WA. During the course of the audit, when the Strategy was almost finished, the Commission began to address this. Not identifying existing services has increased the risk of investing money in activities that are already provided by another State or Federal Government agency, NGO or private sector supplier.

Appendix 1: Case Study of Suicide Prevention Activities in Kimberley Aboriginal Communities

In December 2013, the audit team visited three communities in the Kimberley that were participating in the Strategy. We also talked by phone to two others. Talking with the communities was important given that suicide rates in the Kimberley region are 2.5 times the state average and more than 3.5 times the national average. Aboriginal youth suicides are even higher. A number of communities have been especially hard hit, with 'spikes' or 'clusters' of suicides in a relatively short period of time. These include two of the communities we visited: Derby and Mowanjum.

In Broome we visited the organisation that ran the community consultations to develop suicide prevention action plans, the Kimberley Aboriginal Medical Services Council (KAMSC). We also talked to a number of the developers, trainers and participants of the Kimberley Empowerment, Healing and Leadership Program that was delivered as part of a number of the CAPs.

The second project we visited was in Derby where we met with Anglicare, which ran the local CAP. We also met members of the local committee who helped to set up the CAP and people who had participated in the suicide prevention activities it delivered.

We were told what it was like at the community level to set up and run suicide prevention action plans in a complex social environment. This gave deeper meaning to the higher-level audit findings in our report. We heard from people about both the process and the impacts of the Strategy.

The process

One of the first things people told us was that the process to develop and implement CAPs in the Kimberley took much longer than they expected. At first, they expected that a CAP would take 12 months from start to finish. This evolved to the expectation that consultations would take up to 12 months and carrying out the plan would take a further 12 months. But in the Kimberley, while funding was announced in March 2011, some of the CAP proposals were not approved until May 2013, and a few CAPs will not be completed until mid-2014.

We heard that the length of the process made it hard for people to maintain energy and engagement, and fed cynicism about the State Government's commitment. Once the plans went into action, local agencies found the reporting requirements onerous and Centrecare found it challenging to get them to acquit their contracts. But they largely kept to their time frame and delivered a wide range of suicide prevention activities. People told us about the positive impacts the activities had on them, their families and communities.

Contract delays

The first period of delay was related to the contract process. The Kimberley was one of the first six proposals Centrecare submitted to the Council in March 2011. The Council approved it, and soon afterward, the Minister announced that the Strategy would provide \$800 000 for the Kimberley CAPs. But Centrecare still needed to develop the service agreement it would sign with the local host agencies. There was a back-and-forth process between Centrecare and the Commission to develop these contracts, with a final review by the State Solicitor's Office. Centrecare's contract with the KAMSC was not signed until August 2011.

Community consultation challenges

The second process that took longer than expected was the community consultation process. Community consultation took approximately 18 months but was important in order to identify those activities that would likely be the most effective.

There were a number of reasons for the time taken. One was that Centrecare and the Council were figuring out the process as they went along. This meant there was some trial and error for the first communities to start the process.

A second reason was that the Kimberley region is a complex environment for both the grassroots and the service provider groups. Because of the way people from different tribes, cultures and language groups have been moved in the past from their lands and brought to live in settlements together, it can be hard to get consensus about what is needed and how to go about doing things. We heard about community meetings during times of crisis where people were scared, frustrated, and looking for someone to blame – a very difficult situation in which to try to work together towards solutions.

On the service provider side, in some communities there are many organisations whose mandates overlap. These agencies sometimes compete with each other for funding and clients. They do not always communicate or collaborate, and may have different visions of how to approach suicide prevention. Also, communities may find it harder to trust service providers they see as not being 'from' the community – whether that be someone from Perth who comes to work in Broome, someone from Broome who works in Derby, or someone from Derby who works in Mowanjum. These complexities contributed to slowing down the process of developing CAPs and made it hard for some communities to agree on who would be the host agency for implementing their CAP.

A third factor that slowed the community consultation process was staffing. KAMSC had planned to hire four people to hold community consultations. They hired one community coordinator as soon as they signed the contract but despite advertising the positions were unsuccessful in recruiting others. This meant that one person had to cover the entire region. The coordinator held consultations with one community at a time – a process that took almost a year, in part because of the distances and difficult travel conditions.

Derby was the first community to start consultations, in September through November 2011. Next were the Dampier Peninsula communities, then Halls Creek from May to July 2012, and Kununurra in late 2012. In Broome, the Hear Our Voices project held consultations in 2011 which formed the basis for the Kimberley Empowerment, Healing and Leadership Program. For the Fitzroy Crossing community, the KAMSC used a consultation document produced by Anglicare, also in 2011, rather than hold additional meetings.

Lengthy approval process

Another reason it took so long to get the CAPs off the ground in the Kimberley was the approval process once the CAPs were developed. KAMSC submitted the CAP for Derby and Dampier in May 2012 and Centrecare took it to the Council in June. During this time, the Council formalised its Policy and Funding Framework which set benchmark amounts for the funding as well as criteria for the scope of prevention activities. The proposed budgets for Derby and Dampier went beyond the new benchmark amounts and some of the activities were outside the funding scope. The Council asked Centrecare to rework the plans to fit within the criteria. The KAMSC project supervisor resigned at that time.

The resubmitted proposals were endorsed by Council in September 2012, four months after their original submission, with Dampier's approval only conditional. Council asked Centrecare to identify a host agency for Dampier and document its community consultations. Centrecare held meetings in the Dampier communities in October 2012 and then concluded that the best way forward was to have separate contracts for each of the three main Dampier communities (Ardyaloon, Beagle Bay and Djarindjin). Service agreements were eventually signed in June 2013, a full year after the first proposal was submitted to the Council.

Fitzroy Crossing, Halls Creek and Kununurra also went through a long process to gain approval. Centrecare first submitted the proposals to the Council's Funding and Assessment Sub-Committee (FASC) in January 2013. The Committee ran out of time to discuss them at that meeting, so it was put back to the following month. The FASC was concerned that there was no Host Agency or Community Coordinator for any of the three proposals. Centrecare explained the communities would rather have more funds for activities, so a host agency was excluded. The groups running the activities would give their time as in-kind support.

The FASC also asked why the budgets were higher than the benchmark amount. Centrecare explained that the communities were going to submit the plans to both the Commonwealth and the Council, but had missed the Commonwealth grant deadline. As a result, the Committee asked Centrecare to go back to the communities and ask them to prioritise the activities in the plan so they could fit within the budget benchmark.

In April, Centrecare and community representatives resubmitted the three proposals to the FASC. One of the plans had more than halved its budget, while the other two kept their original budgets. The Committee reviewed the proposed activities, particularly risk management and how much of the focus was within the scope of suicide prevention. The three proposals were approved but, to keep final budgets within the benchmark amount, not all activities within them were funded. Budget cuts were mainly to remove repetition of activities and exclude activities the FASC felt was not specifically suicide prevention.

The Council and the Minister signed off on the revised proposals in May 2013, while service agreements with Centrecare were not signed until late July and early August 2013. Because these CAPs were approved so late in the Strategy, these three communities (along with a few others) had to wait for finalised service agreements before they could carry out their activities. The delay was caused by the Commission and Centrecare negotiating who would be managing the Strategy once Centrecare's contract ran out in December 2013. In the end, host agencies were asked to sign two service agreements, one with Centrecare until the end of December 2013, and a second with the Commission from January to June 2014.

The approval process for the Kimberley Empowerment, Healing and Leadership Program (the Empowerment Program) followed a different path. Community consultations took place outside of the Suicide Prevention Strategy in 2011, around the same time. The Hear Our Voices team met with the Commission, the Minister and the Centrecare in early 2012. They proposed to trial the program in Broome before expanding to communities across the region. Since KAMSC had not been able to hire all four coordinators, some funds allocated from the community consultations remained. Those remaining funds, together with additional funds from the Council, were enough to run the Empowerment Program. KAMSC submitted a proposal in July 2012, and the Council and Minister signed their approval in August 2012.

Centrecare could not release the funding for the Empowerment Program until it received the final financial reports for the consultation phase from KAMSC. Centrecare's process was to allow the host agencies to roll over funding from the consultation phase to the implementation phase once they had acquitted the funds and confirmed how much of the unspent funds could be carried forward to the next phase. KAMSC staff turnover and a new Network Coordinator at Centrecare disrupted communication between Centrecare and KAMSC. Eventually, an external

accountant was contracted to review the accounts. In July 2013, the accountant provided an acquittal report that resulted in KAMSC not receiving further funding for the Empowerment Program until October 2013. However, they used internal funds to support it and delivered even more than they had proposed originally.

Delivering the CAPs

Communities were very enthusiastic about the activities. Community engagement and attendance was generally high but it was hard to sustain attendance for longer programs because of peoples' mobility and some of the people who were in need of support did not get involved because they did not have the confidence or literacy skills to be able to do so.

Communities still felt there were areas of real need for suicide prevention that were not addressed by the CAPs because they were outside the Strategy's scope. For example, several communities identified the need for a safe haven for youth in crisis, similar to a women's shelter or sobering up centre. Currently, youth feel they have nowhere to go after hours if they are in a bad situation at home or feeling suicidal. Halls Creek has long been working towards a healing centre, which they see as crucial to dealing with the underlying causes of suicide and mental health problems.

On the agency side, host agencies found the reporting requirements somewhat onerous, with monthly and quarterly reports, an extensive final report, and financial statements plus a formal acquittal and audit. They also expressed concern that on some occasions Centrecare was contacting communities directly without talking to them first. Host agencies felt this had caused confusion and made their work more difficult in keeping a trusting relationship with communities.

The impacts

CAP event participants and organisers told us about a wide range of impacts, for individuals, families and communities. We have highlighted some of the challenges above, so here we focus on largely positive impacts people reported experiencing.

The community-based approach was worthwhile

We heard high praise for the community-based approach to suicide prevention. People felt that communities should be the ones to come up with solutions to their problems, and also to increase their capacity to deliver the solutions. Although the community-based approach had challenges, people felt that it was worth the effort and time. It was seen as more likely to be culturally appropriate and sustainable if the community had ownership.

Community Coordinators were highly valued

People saw the Community Coordinators as playing a key role in suicide prevention. While communities had many people who work on suicide prevention in their professional or volunteer roles, having a person with this as their main focus made a big difference. In some areas, Community Coordinators also ended up being the first point of contact for people who were in crisis. While this could be a heavy burden, communities felt it filled a key gap.

People looked forward to the community events and ‘back-to-country’ camps

Community events such as football matches, music recordings, and coffee mornings succeeded in engaging people and strengthening a sense of community. In some places, there are very few organised activities and youth in particular feel they have little to look forward to in communities where funerals are the most common event bringing people together. People also liked the way some of the CAPs gave them a place where they could drop in casually if they were in need of support.

One of the highlights for many people we spoke with was the ‘back-to-country’ camps. Many of the Kimberley plans included these, with a range of target groups including young people, elders, parents, families, men’s or women’s groups. The camps aimed to reconnect people to culture and tradition, as well as providing a safe space for people to talk about mental health and suicide issues. Some of the camps focused on ‘healing’, both personal and cultural.

The feedback we heard about the camps was that they helped people feel comfortable to talk about difficult issues; they got you away from the ‘humbug’ of normal life (humbug refers generally to interpersonal challenges such as jealousy); they took people out of their drinking and dope smoking habits. As one person put it, ‘When you go on a trip back to your country, it helps you to connect with yourself. You feel at peace. Young boys in town, you don’t feel too well. When you take young blokes, you take notice they have much better fitness when they’re out in country than in town’. Another person talked with passion about the satisfaction of learning to catch fish and collect crabs, and to cook and eat them.

Training was put to use

Many of the CAPs included training in suicide prevention skills, such as the ASIST, Gatekeeper, and Mental Health First Aid programs. Participants in those trainings told us they found the courses very useful, and we were told of situations where people had intervened successfully to support someone who was suicidal. In one community, the training seemed to have helped to bring out leadership skills among a group of young men who had started to be seen in the community as a key resource in times of crisis. One participant said, ‘a young guy, my friend, wanted to hang himself, and I remembered the first aid, telling us how to approach a person, talk to him, keep him calm. I tried it and it worked. I sat him down, we had a beer and I settled him down. He’s more comfortable to talk with me now.’ Another said, ‘you got to take notice of people, let them know you care about them’.

Programs changed peoples' lives

The most striking stories people told us were about how participating in the programs and activities had transformed their lives. People who did the Empowerment Program told of significant life changes they felt were due to it. It helped them learn to overcome shyness and 'find their voice'. They learned the power of positive thinking, and looking after oneself. People found their communication with their children and other family and community members improved. They got the message that it's not wrong to look for help, or to talk to people about mental health. They learned not to judge each other, and how to overcome the 'tall poppy' syndrome of jealousy within communities. People felt they had better understanding of their own communities' history and how colonisation had affected people. Other concrete impacts people reported were:

- leaving an abusive relationship
- healing from a family suicide experience
- making a significant change in life course
- getting a promotion at work
- taking 'me' time
- taking more of a leadership role at work
- setting a goal and achieving it. For example quitting smoking, getting a driver's license
- cherishing their children.

Appendix 2: Suicide Intervention Model

Prevention strategies can be targeted universally at the general population, they can focus on selective at-risk groups or they can be directed to those at risk as required.

WA's Strategy is focused on the prevention aspects of the model in Figure 6.

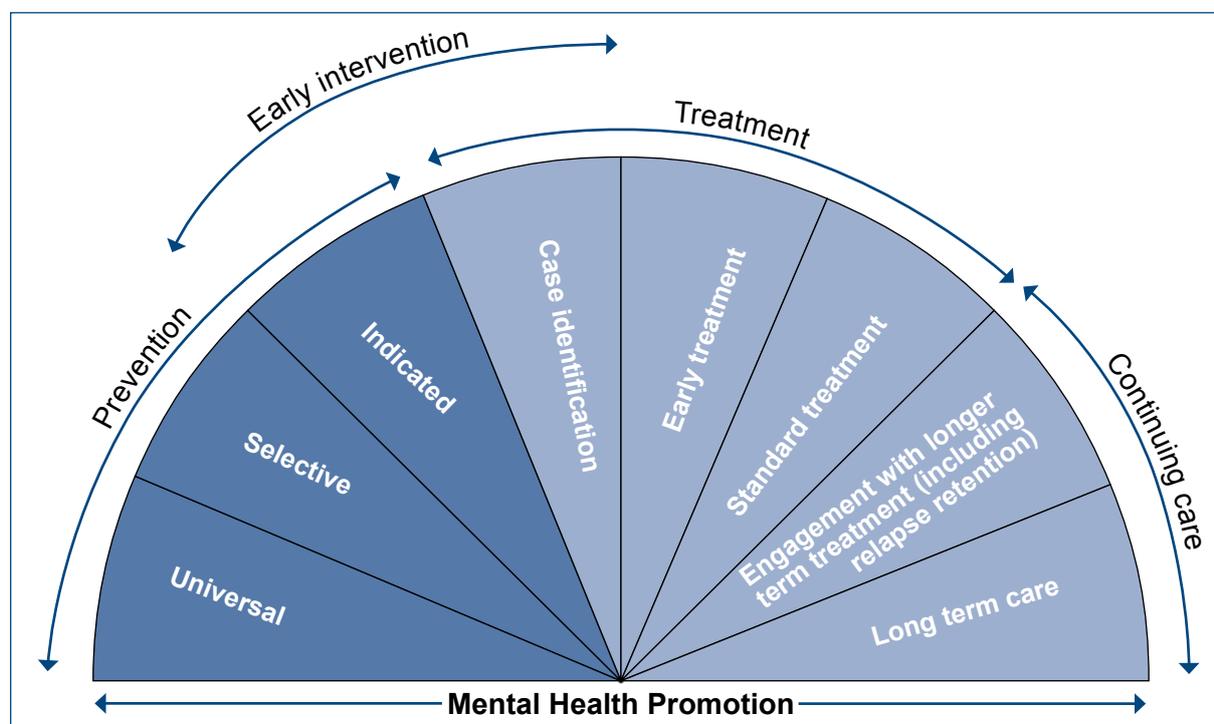


Figure 6: Mrazek and Haggerty's model of the spectrum of interventions for mental health problems and mental disorders

Source: Mrazek P and Haggerty R (1994). Reducing risks for mental disorders: Frontiers for preventative intervention research, Committee on Prevention of Mental Disorders, Division of Biobehavioural Sciences and Mental Disorders, Institute of Medicine, Washington, National Academy Press

Universal prevention strategies promote strong, resilient communities and focus on improving the mental health of the population. These strategies may include primary preventative activities that affect the whole population such as reducing access to the means of suicide.

Selective prevention strategies target at-risk groups such as Aboriginal youth, children of parents who have suicided or had a substance abuse problem and/or children growing up with domestic violence.

Indicated prevention strategies target individuals who have symptoms of or are at the highest risk of suicide, such as young people experiencing depression or people who have attempted suicide.

Case identification/early treatment strategies involve the early recognition and response to people who are currently at risk of suicide.

Standard treatment strategies provide access to services for people exhibiting suicidal behaviour or who have attempted suicide, including those who are hospitalised.

Relapse prevention and longer term treatment strategies aim to prevent recurring suicidal behaviour and hospitalisation by engaging with people who are at chronic risk of suicide or who repetitively self-harm.

Source: Western Australian Suicide Prevention Strategy 2009-13

Appendix 3: Community Action Plans

There were 55 CAPs funded by the Council during the term of the Strategy. CAPs included activities developed from the community consultations such as:

- 'back-to-country' camps to reconnect people to culture and provide a safe space for people to talk about mental health and suicide (the Kimberley)
- a CD containing information on mental health and wellbeing developed and distributed to farmers and the general community (Albany)
- a Suicide Prevention Forum attended by 83 community members (Town of Vincent)
- a Mental Health Professionals Morning Tea attended by around 40 community members (Lesbian Gay Bisexual Transgender Intersex Questioning Community)
- training programs such as Applied Suicide Intervention Skills Training (ASIST).

The first five CAPs were approved in July 2011 and began community consultation and planning along with some training. Suicide prevention activities in communities began in 2012.

By the end of 2013, 65 per cent (\$11.63 million) of total Suicide Prevention Strategy funds had been approved for developing and carrying out the CAPs. Of this, 38 per cent went to community engagement and training (Stage One CAPs) and 62 per cent to suicide prevention activities in communities (Stage Two CAPs). This is about 40 per cent of total funds for the Strategy.

After the first five CAPs were funded, the Council decided that CAPs could be usefully divided into separately funded stages. Stage One CAPs consisted of community consultation, some training and the development of plans. Thirty Stage One CAPs were fully implemented (four did not proceed and funding was returned). Budgets ranged from \$2 570 (WA Jockeys) to \$795 000 (the Kimberley), though not all budgets were fully spent. The Kimberley, for example, underspent its budget and was allowed to carry forward \$200 000 to Stage Two.

These were followed by 36 Stage Two CAPs focusing on suicide prevention activities according to plans developed in Stage One. These had budgets ranging from \$10 500 (Wheatbelt Youth) to \$778 706 (Wheatbelt Aboriginal). Six CAPs started directly with a proposal for Stage Two, as they had already identified their needs and had structures in place to develop a plan.

Actual CAP expenditure – Stages One and Two combined – ranged from \$62 570 for the WA Jockeys CAP to \$893 473 for the Wheatbelt Aboriginal CAP.

The Wheatbelt regions, from Jurien Bay down to Katanning and out to Hyden in the east, received the largest allocation of funds. This was followed by the Kimberley and non-geographical CAPs collectively (Figure 7).

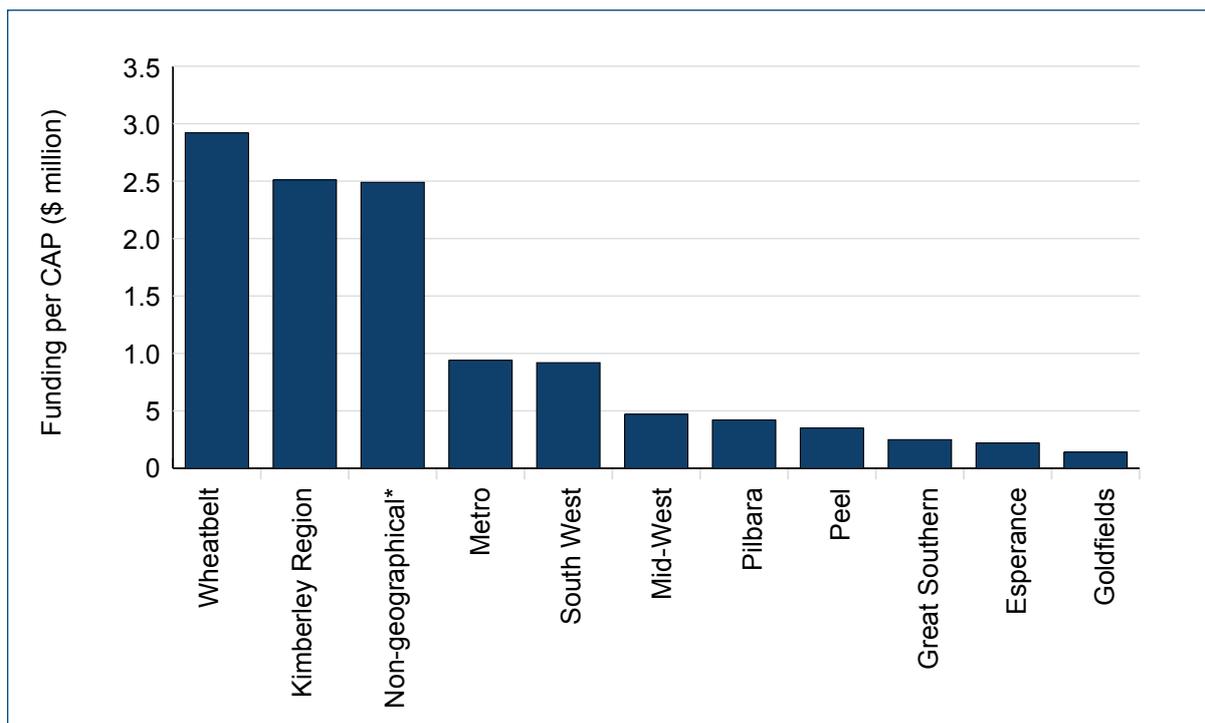


Figure 7: Total CAP expenditure by region.

* Non-geographical – CAPs that related to demography, occupations or other interest groups.

Some Stage 1 CAPs did not proceed to Stage 2 and others were split or amalgamated. Nineteen of the Stage 1 CAPs contained prevention activities, mainly training, as well as consultation and planning. This means there were 55 CAPs overall containing prevention activities.

Around 40 per cent of Stage 2 CAPs were completed by July 2013, the formal end of the Strategy. The rest were expected to be completed by December 2013, with a few exceptions to continue into 2014.

Auditor General's Reports

REPORT NUMBER	2014 REPORTS	DATE TABLED
6	Audit Results Report – Annual 2013 Assurance Audits (Universities and state training providers – Other audits completed since 1 November 2013)	7 May 2014
5	Across Government Benchmarking Audits – Controls Over Purchasing Cards – Debtor Management – Timely Payment of Invoices	1 April 2014
4	Behaviour Management in Schools	19 March 2014
3	Opinion on ministerial decision not to provide information to Parliament about funding for some tourism events	18 March 2014
2	Charging Card Administration Fees	12 March 2014
1	Water Corporation: Management of Water Pipes	19 February 2014



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