SUBMISSION MADE TO THE

SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE

INQUIRY INTO SUICIDE IN AUSTRALIA

MADE BY KENTISH REGIONAL CLINIC INC

SHEFFIELD TASMANIA

November 2009

EXECUTIVE SUMMARY:

The Community Response to Eliminating Suicide (known as CORES) program was developed in the rural community of Kentish, in Tasmania and had been operating since 2003 within Tasmania and around Australia since 2007.

The CORES Program is operated by Kentish Regional Clinic (KRC) and has provided services to over 25 communities throughout Australia, with over 1,500 people having been trained in suicide intervention and over 70 team leaders trained to deliver the intervention course into their own communities. It is the recipient of a national and state award for its work on suicide prevention and has been featured on ABC Landline program twice (in November 2006 and again in October 2008).

In the middle of 2009 an external independent evaluation was undertaken and included is a summary from the report, which details the CORES program and how it works in the area of suicide prevention.

A full report of the evaluation is attached to this submission, which includes the most up to date research on suicide prevention within Australia.

This submission includes a set of overall recommendations, as well as specific recommendations on selected terms of reference.

However, the general view expressed by this submission is that; to date, suicide and suicide prevention has not been directly addressed within Australian society. There are many myths and misconceptions spread by well meaning people which has resulted in Australian society avoiding the use of the word suicide and therefore limiting the ability to fully address rates of suicide.

Until we (as a society) create the "space" for people to discuss, talk and relate their experiences of suicide, then no significant progress will be made to reduce the rate of suicide.

Our experience has shown us (working with people and communities) the more the issue of suicide is openly talked about and people can relate their experiences, the greater the positive outcomes.

While we can possibly never eliminate suicide, our approach (of talking openly about suicide and providing skills) has significantly reduced suicide rates within communities.

Therefore, in our opinion, for real progress to be made to reduce the rate of suicide, the issue of suicide requires an honest and open debate, with an education program about suicide conducted in the public arena, not dissimilar to other health related causes.

Summary from the Evaluation report

The Community Response to Eliminating Suicide

Background to CORES

CORES, the Community Response to Eliminating Suicide, began in Sheffield, Tasmania, with the impetus for the program was ten suicides in the space of three years, including five suicides in one year, in a region of 5000 people. These suicides involved a broad cross-section of individuals, and no underlying systemic cause for the rise in suicides could be identified. Some of the suicides were young people; others were farmers who were struggling with drought; still others were individuals who had recently suffered loss or grief (e.g. a long-term relationship breaking down).

The CORES philosophy

CORES is a holistic training and support package that builds a community's strength and capacity to prevent suicide. It empowers community members to recognise the signs of suicide and intervene before a crisis occurs to refer someone to appropriate services. The underlying philosophy of CORES can be summarised in the words of KRC:

The more people from within a community who complete the training, the less likelihood there is of someone at risk not receiving help. It empowers communities to watch out for each other.

Why CORES Was Established

There are several reasons why CORES was initially established and why those involved with KRC see it as imperative to expand the scope of the program:

- Other suicide intervention programs had been described by some participants as being too long (e.g. at least two days) and some individuals cannot afford to give up this much time. Consequently, KRC felt that there was benefit in promoting a program that was only required one full day's training. Also, the experience of KRC was that some other suicide prevention programs are too expensive for community-based people to access (i.e.around $200 or more), which is a disincentive to individuals who may want to undertake the program off their own initiative. Consequently, KRC designed the CORES program to be highly affordable (i.e. currently $50).

- Secondly, KRC felt that most other programs tended to not directly examine the specific needs facing rural communities. Consequently, KRC wanted to implement a program tailored to a regional and rural context.

- Thirdly, whilst some other suicide intervention programs may be targeted at the general community, they are not designed to be owned and driven by the general community. Consequently, KRC wanted to introduce a program which adopts a 'train-the-trainer' model and aim to empower a core group of community members to educate their own community about the risks of suicide and how to intervene if they feel that someone is suicidal. KRC felt that a community-owned suicide prevention program would have a number of benefits, including:

    - More effectively connecting individuals at risk of suicide with key health services;
    - Provide communities with a sense of empowerment that they are taking charge of an important social issue which effects them;
    - Ensuring that the program is sustainable into the long term.

The CORES Model

What Does CORES Do?

The CORES model is based around a comprehensive community package which delivers one-day suicide intervention training to members of different communities. 'Community' is understood to be cultural, geographical or situational. Local team leaders are encouraged to volunteer to be trained to deliver the program and 'champion' it locally through attending regular team meetings. Ultimately, communities are responsible for shaping the way the program is delivered, and consequently there is some flexibility in relation to what CORES 'looks like' in each community.

Why Does It Work?

A number of reasons are identified as to why CORES works so effectively, including:

- ***Fit With the Current Service System***. CORES is intended to be the first referral point for people who might be suicidal and have not yet accessed any supports. The role of a trained community member is to identify people in the course of their daily lives who might be at risk of suicide and link them in to professional support services. Research shows that people who are suicidal cannot be relied upon to seek help for themselves and that when they do, friends and family are the most likely first point of contact.
- ***Community Ownership***. Community ownership is at the heart of the CORES model. Consequently, KRC undertakes a SWOOP analysis of a community before deciding whether or not CORES can work in that community. SWOOP stands for:
    - Sense of community (history);
    - Want the program;
    - Originators of their own capacity;
    - Outcome focused;
    - Prepared to do the work

KRC has in the past decided against putting the program into some communities if they observe that strong and cohesive sense of community does not exist across at least part of the Local Government Area (LGA).

- ***Champions***. In order for the CORES program to become established, it generally requires individuals within the community to 'champion' the program. The key is to generate sufficient interest in the CORES program locally before KRC arrives to deliver the support package. Champions may also connect with local community-based organisations, which often provide the infrastructure to support the CORES program (e.g. a venue for local meetings).
- ***Accessibility***. CORES is designed to be delivered by non-professionals for nonprofessionals. This means that people do not have to have a background in mental health or any health-related field to understand and absorb the material. The training is designed to be simple, easy to understand and easy for team leaders to learn and then deliver. However, importantly, the CORES program also maintains strict professional boundaries.

- ***Theoretical underpinning*.** Although primarily based on the 'lived experiences' of KRC management, the CORES program has strong theoretical underpinnings in social capital (and social inclusion) theory, social networking theory and theories around what constitutes healthy communities.

Interestingly, CORES do not locate themselves within the 'mental health paradigm', but rather see themselves as belonging within the broader 'public health paradigm', with a specific mandate to prevent suicide. KRC feel that positioning CORES in this manner makes CORES more accessible to the regional and rural communities it is targeted towards.

Who does CORES benefit?

Due to the multilayered way in which CORES is introduced into a community and then operates, it has a number of benefits across an individual and community level and as such their 'target group' is much broader than just people at risk of suicide. The following discussion considers the issue of 'who CORES benefits' at three levels:

- Individual, community and system. Rather than simply discussing these benefits in the abstract, illustrative quotes which emerged during the course of the stakeholder interviews have been included under relevant points.
  - At an individual level, the program has a number of benefits, including:
    - **Resourcing people with knowledge about suicide that they can apply in their own lives;**
    - **Encouraging and creating a space for healing among those who have lost family or friends to suicide;**
    - **Introducing people to a network of like-minded individuals who are similarly resourced and committed to the goal of preventing suicide;**
    - **Up-skilling people in suicide prevention so that they can intervene successfully and save lives;**
    - **Reducing the need for people contemplating suicide to independently access support services, something which can be difficult for people in a suicidal frame of mind. Those people who might be experiencing 'psychache'2 or suicidal thoughts can benefit from talking with a trained CORES community member, and thus be lead to appropriate support services;**
    - **Generating social capital which has a flow on effect that can benefit individuals in many ways (e.g. assisting communities to be more resilient in the face of a different sort of crisis, such as a natural disaster). A healthy community is comprised of individuals who are well connected and resourced. Therefore the above list of individual benefits also has an impact at a community level. There are also specific benefits which are likely to manifest at the community level, including: · Greater community-wide awareness of the issue of suicide and its impact on communities;**
    - **Better knowledge of the range of supports available in the community for people who are experiencing stress;**
    - **Finally, at a systemic level, CORES encourages sector-wide and community-wide recognition of suicide as a social and health issue. CORES encourages the impact of suicide on communities (and the families of those who complete suicide) to be brought out into the open, in a way which facilitates open discussion of what is often a taboo issue. Also, from a systems perspective, CORES 'completes' the service system by strengthening local social networks and normalising health seeking behavior, which in turn connects those individuals at risk to the services they require. Presently, there are a variety of support services available to individuals at risk of suicide. However, an individual at risk who has not previously engaged in help-seeking behavior and does not regularly access health services will generally only attempt to access the necessary services if: (Success Works September 2009).**

In Summary the benefits of the CORES program to a community include:

- The development and empowerment of community members to form a team to train their own community.
- Individuals within each community that have the skills to deliver the training into their own community.
- The setting up of a local network where members of the community are aware of the professional resources available to them, to assist those at risk of suicide.
- An increase awareness of suicide and the signs that people show when contemplating suicide.
- An easy intervention method that is effective and one that refers the person at risk onto professional services, if required.
- The reduction of the suicide rate within each community, as a result of the increase awareness and skilling of community members to intervene.
- A sustainable program, where there is little or no ongoing cost to the community to continue the program within their community, after the initial 12 months mentoring period (all communities involved in the CORES program are continuing to train within their community).
- The program has also developed a culture of care and volunteering within each community.
- A linking with other communities around Australia, through the CORES web network.

Overall Recommendations:

1) **That suicide prevention policy, awareness and action programs become a cross department alliance and not left solely to the Department of Health and Ageing. Currently suicide is closely aligned to the health department through the area of mental health.**

   In our opinion, the issue of preventing suicide is more about social inclusion than mental health and we have found that models which promote social inclusion in communities are best placed (as a strategy) to reduce the incidents of suicide and self harm.

2) **That the National Suicide Prevention Strategy includes policy and action initiatives developed and driven by the community as well as Government and service providers.**

3) **These initiatives should be funded through community groups who wish to take action on reducing suicide and self harm in their communities, rather than the current system of Governments identifying "areas of need" and then funding service providers to "fix" the "problem". Our experience is that a community focused and driven approach is both successful and sustainable.**

Summary of Recommendations made in the detail submission:

Term of Reference: c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

Recommendation:

That Federal and State governments provide the necessary resources to the above agencies in order for appropriate training to take place and that a system for ongoing training is established in order to maintain skills in this area.

Term of Reference: d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging, help-seeking and enhancing public discussion of suicide;

Recommendation:

That a public awareness program is developed which directly addresses the issue of suicide and is not "hidden" under any other name and is treated as a stand alone issue.

Term of Reference: e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

Recommendation:

That Federal and State governments provide the necessary resources to health and community workers, in order for their skills to be developed appropriately and maintained so they can be effective when encountering people at risk of suicide.

Term of Reference: f) the role of targeted programs and services that address the particular circumstances of high-risk groups;

Recommendation:

That Federal and State governments provide the necessary resources to target programs to high risk groups.

Term of Reference:

h) the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

Recommendations:

1. ***That the NSPS provide for a national approach to funding programs to allow across boarders funding to occur, rather than being restricted to state by state funding allocations.***

2. ***That funding from the NSPS is made available to community groups for them to purchase services required for their community which will give them a sense of ownership and involvement.***

3. ***That the Federal Government provides initial seed funding for the establishment of a Suicide Prevention Foundation (representing interested parties) for the sole purpose of attracting donations and funds for communities to undertake suicide prevention and intervention related programs.***

Comments on Terms of Reference:

The following comments for each of the terms of reference are made from the perspective of operating an "on the ground" program and deals with the "Action" side of suicide prevention.

The comments under each term of reference have been kept brief and are supported by detail information in the evaluation report (Appendix One). Therefore, for more detail on any particular comment, please refer to the evaluation.

These comments and opinions are based upon our experience and are confirmed by an extensive continuous improvement system operated by CORES, which has captured comments from every one of the more than 1,500 participants who have completed the program.

Not all terms of reference are addressed, as some deal with areas outside of our knowledge and experience.

Attachments to this submission:

Appendix 1: Evaluation of the CORES program by SuccessWorks.

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POINTS IN REGARD TO TERMS OF REFERENCE:

c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

In general, we have found that training and skills development of staff from these agencies do not prepare the staff to properly address how to deal with somebody who has suicidal thoughts or tendencies.

This is due to staff who are not qualified to "treat" anybody who may be at risk, but, at times, may use their "professional" knowledge and role in an inappropriate manner.

One example of this was a training program undertaken by a health department with a scenario requiring health professionals (not qualified to "treat" people in this area, but a mixture of allied health professionals) to take action when confronted by somebody (in the scenario) with suicidal tendencies.

Their professional "sides" took over and they tried to "treat" the person in the scenario, and had no skills of how to refer the person onto the right areas or even what to say to the person.

We have found this to be typical of agency and health professionals who reside outside of the "professional" area of counselling.

Recommendation:

That Federal and State governments provide the necessary resources to the above agencies in order for appropriate training to take place and that a system for ongoing training is established in order to maintain skills in this area.

d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging, help-seeking and enhancing public discussion of suicide;

There seems considerable confusion between mental health issues and any connection to suicide or self harm.

While there has been extensive awareness programs in regard to mental health, there are very few that publicly address the issue of suicide, either prevention or post-vention.

In our experience, a majority of people who have suicidal thoughts or contemplate suicide do not have a mental illness and do not identify with those with a mental illness. It is, however, recognised that people who are suffering from a mental illness do have higher rates of contemplating suicide, and this needs to be dealt with appropriately.

However, from our experience, the majority of people who contemplate suicide or have suicidal thoughts do so after an event in their life that has left them thinking that they have little or no future. Events such as, the loss of a loved one, loss of work, home or property, or having been excluded socially from a situation (loss of position), leaves people concentrating on possible solutions and unfortunately one of these is suicide or self harm.

Therefore, any public awareness program needs to address the issue of suicide and suicidal thoughts in the context of this being a reaction to these events and anybody feeling this way should not be classified as having a mental illness and that support is available.

Current support systems depend too much on somebody seeking help because they have a mental illness, when clearly they do not.

Unfortunately, most current advertising or awareness programs avoid the use of the word suicide and tend to hide behind a mental illness "label" such as depression or other forms of mental illness, which is not an effective strategy for encouraging self help.

There are programs and organisations that deal with depression and other mental health issues, but these do not necessarily relate to suicide and people often do not make the connection between the two.

Recommendation:

That a public awareness program is developed which directly addresses the issue of suicide and is not "hidden" under any other name and is treated as a stand alone issue.

e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

Following on from the comments made in respect to point c) of the terms of reference, our experience is that further training and support should be offered to front-line health and community workers to deal with people they encounter who may be at risk of suicide.

However, the manner in which the term of reference has been framed suggests that front-line health and community workers can provide services to people at risk. We find this a common misconception and in most cases dangerous to both the health worker and the person at risk.

It is appropriate for health and community workers to have the skills and connections, but not to provide services as such.

Therefore we make the following recommendation:

Recommendation:

That Federal and State governments provide the necessary resources to health and community workers, in order for their skills to be developed appropriately and maintained so they can be effective when encountering people at risk of suicide.

f) the role of targeted programs and services that address the particular circumstances of high-risk groups;

There is currently a need to have programs provided to high risk groups. These groups include Gay, Lesbian, Bi-sexual, Trans-sexual, Inter-sexual (GLBTI), Ethnic or Indigenous groups who may be at high risk.

An example of the issue is that there are few, if any programs specifically targeted for the GLBTI community. There is an increasing body of literature detailing research into suicide in the GLBTI community, with a recent meta-analysis found that people who identify as lesbian, gay or bisexual are at higher risk of suicidal ideation and behaviour as well as mental disorder and substance use/misuse (King et al 2008). Most of the research to date has been conducted internationally. The result is consistently that people who are gay, lesbian or bisexual are more likely to have suicidal thoughts or engage in suicidal behaviour than the general population (Meads et al 2007; Warner et al 2004; Cochran and Mays 2000; Fergusson et al 1999).

Looking specifically at Australia, a survey of 5476 people found that 15.7% had thought within the previous two weeks that they would be better off dead within (Pitts et al 2006). This figure would more than certainly be larger if asking about the same thoughts over a longer period of time.

Even though these are the "facts" surrounding such a group, our experience is that funding for programs in this area is not available from Federal and State Governments.

There is a similar story for Indigenous groups who may require targeted programs, but again our experience is that these groups have been unable to gain access to funding.

Therefore, there is a role for targeted programs.

References:

Cochran S, Mays V. 2000. Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: Results from NHANES III. *American Journal of Public Health, 90(4),* 573-578.

Fergusson DM, Horwood LJ, Beautrais AL. 1999. Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry, 56,* 876-880.

King M, Semlyen J, See Tai, S, Killaspy H, Osborn D, Popelyuk D, Nazareth I. 2008. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8,* 70-

Meads C, Buckley E, Sanderson P. 2007. Ten years of lesbian health survey research in the UK West Midlands. *BMC Public Health, 7,* 251-

Warner J, McKeown E, Griffin M, Johnson K, Ramsay A, Cort C, King M. 2004. Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. *British Journal of Psychiatry, 185,* 479-485.

Recommendation:

That Federal and State governments provide the necessary resources to target programs to high risk groups.

h) the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

Overall, we find that the National Suicide Prevention Strategy (NSPS) provides a strong policy direction, with the Life Is For Everyone (LIFE) material containing important information, direction and presented in a professional manner.

However, we make the following comment in regard to its implementation of the strategy and actions 'on the ground":

> **We see the NSPS providing a policy framework that can be applied nationally, but there are several issues surrounding the implementation of this policy that prevents this from being a national strategy of action.**

We make this comment as the result of our experience in trying to provide targeted programs to communities throughout Australia with the following comments directly addressing what we see as the limitations of its application;

1 One reason why we feel the NSPS may not be effective in addressing suicide rates and prevention is that it develops its strategies from a paradigm which is often not applicable to dealing with issues surrounding suicide. The paradigm from which the strategy currently delivers programs is from a health or medical perspective, which diagnoses the "patient" with a "problem" and then provides "treatment" in order to fix the problem.

This is evident in the targeting of programs to areas where there are high levels of suicide, as these are seen as being "problems" which need "treatment".

Our experience is that for any program to work effectively it requires a strong commitment from the community itself. While "safety" programs can be introduced and service providers introduce "solutions" to address a high suicide rate, these often fail to address the issue unless the community is willing to work together and care for each other.

For example, KRC have been requested to help several communities, where individuals within the community have a sense of passion and wish to addressing the suicide rate, but once we talked to the community we found little or no interest from the whole community in addressing the issue. In these cases we have declined to introduce the program, as we knew the program would not work, nor would any other program work, as the community was unwilling to work together. In most cases it was a "head in the sand" attitude that prevailed (Kentish regional Clinic has had two "failures" in this area, before realising the program MUST be driven by the community).

Therefore, by simply identifying areas where rates of suicide may be high and promoting programs in those areas (without the full sign-on by the community), will, in our experience, do nothing to reduce the rate of suicide and are often counter productive.

Therefore the NSPS needs to take account of this in setting it policy and action direction. Understanding the environment is important for anybody trying to address the issue of suicide or self harm in the community and it has to be based on a community accepting suicide as an issuing and wanting to do something about it. The paradigm of identifying "problems' and simply applying "treatment" fails to address the real issue of suicide prevention, in that it is a community responsibility and can only be addressed as such.

An alternative paradigm to apply is the one of allowing communities to find and provide the solutions themselves, when they are ready to address the issue and providing the resources for them to prevent suicide and self harm. This is an empowerment paradigm instead of the health or treatment paradigm.

Our experience has shown that utilising this paradigm is effective and is sustainable well into the future.

2 The application of resources is administered on a state by state basis with very little cross boarder collaboration, with little or no direction at a national level.

Currently Kentish Regional Clinic has programs operating in each state of Australia except WA and NSW, but the community groups we deal with (outside of Tasmania) have not been able to access any suicide prevention funding, as there is no central or co-ordinated approach to funding projects. Each State office of the Department of Health and Ageing provides project plans for their "state", with no cross board discussions or awareness.

This has left Kentish Regional Clinic having to discuss programs with each state office of the Department of Health and Ageing, which is both time consuming and counter productive.

3 Communities find it extremely difficult or impossible to access funds from sources outside of the Federal Government. After many failed grant applications to foundations, trusts and philanthropy groups, the grant request is often declined on the basis that:- " This is an area where we do not provide funds, and consider that funding for this type of program is the sole domain of Governments".

Therefore, communities are limited to being able to fund programs in which they have ownership. The NSPS does not provide for funding to community groups as the funding process is not an open one, but a private process between Government and service providers.

In our opinion, the provision of funding for programs to address suicide and self harm should be provided to communities and not solely to service providers. This method of providing funds ensures the community selects a program that best suits their needs, providing ownership of the program and driven by the community, rather than by the service provider.

Based on these comments we make the following recommendations:

Recommendations:

1 That the NSPS provide for a national approach to funding programs to allow across boarders funding to occur, rather than being restricted to state by state funding allocations.

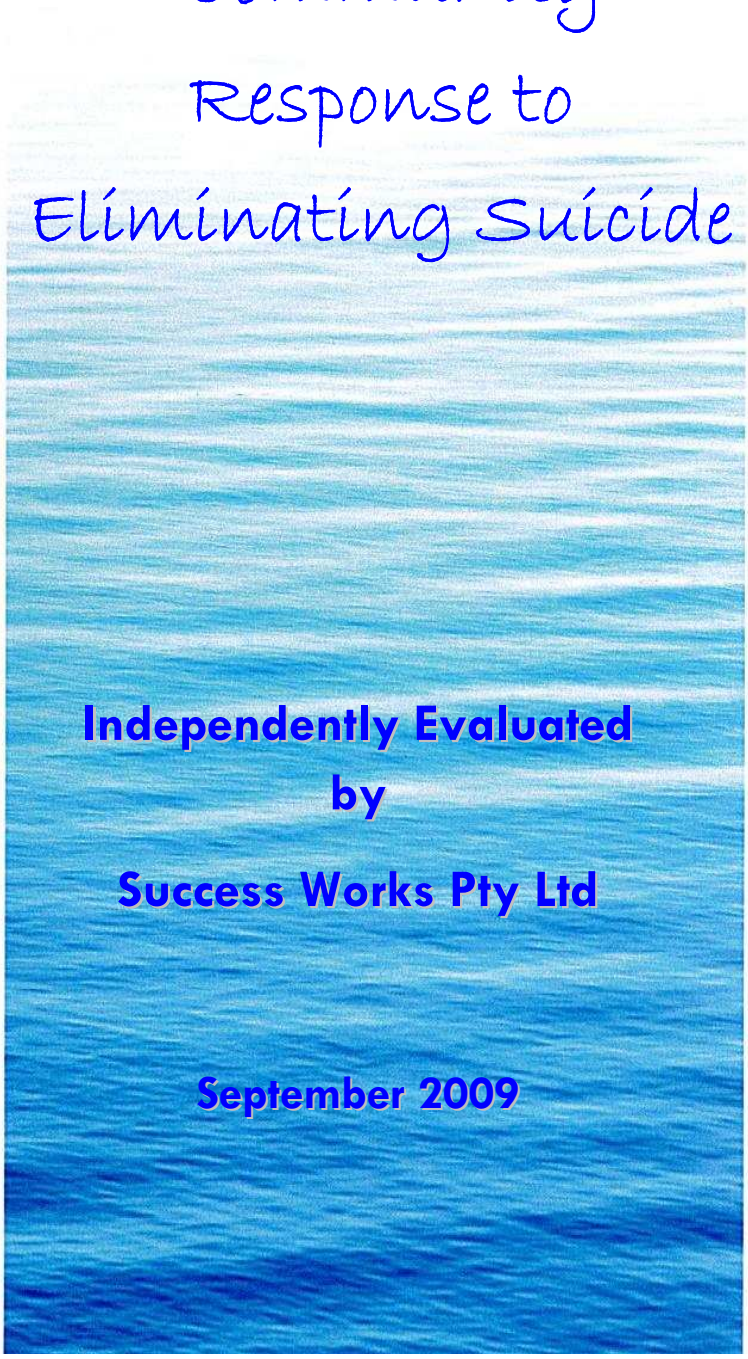
2 That funding from the NSPS is made available to community groups for them to purchase services required for their community which will give them a sense of ownership and involvement.

3 That the Federal Government provides initial seed funding for the establishment of a Suicide Prevention Foundation (representing interested parties) for the sole purpose of attracting donations and funds for communities to undertake suicide prevention and intervention related programs.

Appendix 1

CORES™

Community Response to Eliminating Suicide



Independently Evaluated by

Success Works Pty Ltd

September 2009

SuccessWorks

Contents

Evaluation Overview

Purpose

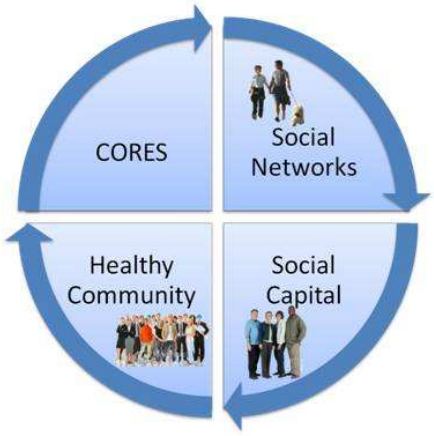
The purpose of this project was two-fold: to evaluate the CORES model with a particular emphasis on the five Tasmanian pilot sites, and to document the model to assist CORES with future promotion of the program.

SuccessWorks

Our Methodology

Our approach to this evaluation has been primarily qualitative. We have relied on interviews, focus groups and workshops as the major sources of data for examining the impact of CORES.

The CORES model



SuccessWorks

Evaluation Questions

- To what extent is there now greater awareness of the risks and social implications of suicide?
- Has social capital and networking among community members been strengthened?
- Has social isolation been decreased among community members?
- Has suicide been reduced in CORES communities?
- Is CORES sustainable?

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Activities

- Initial meetings with KRC staff
- Focus Group with CORES team in Kentish
- Interviews with KRC staff
- Phone interviews with people from all the CORES sites
- Online questionnaires completed
- Workshop in Sheffield with CORES representatives
- Document review and Literature review

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Why CORES works…

- Fit with the current service system
- Community ownership
- Champions
- Accessibility
- Theoretical Underpinnings

Individual benefits…

- Resources people with knowledge
- Encourages a space for healing
- Acts as a buffer against suicide
- Creates new social networks
- Up-skills people to intervene
- Reduces the need for help-seeking
- Generates social capital and inclusion

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Community benefits…

- Greater community-wide awareness of suicide
- Better knowledge about community resources
- Strengthens social networks
- Cross-over of social networks

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System benefits…

- Encourages recognition of suicide as a social issue
- Encourages dialogue about suicide
- 'Completes' the service system by linking people to services

Future Directions for CORES…

- CORES model is flexible and might be expanded to other forms of 'community'
- KRC will need to expand its organisational capacity
- Explore other avenues for funding
- KRC to continue to document and disseminate learnings
- KRC to get creative about lifting CORES' profile
- Work on the networking and 'linking' CORES teams together

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Is the CORES model effective?

Yes!

Provided KRC can maintain and improve its organisational capacity and hang in there with communities where CORES is slower to become established, the model works and works well.

Executive Summary

Overview

Success Works was commissioned by the Kentish Regional Clinic (KRC) to evaluate CORES, the Community Response to Eliminating Suicide. This evaluation has considered the experiences of all sites that have undertaken the CORES program to date, focussing in particular on the five pilot sites funded by the Commonwealth Department of Health and Aging. In addition, this evaluation report, at the request of KRC, has also documented the CORES model, to assist KRC with planning for the future of the program.

Structure of Report

This evaluation report is structured into three parts. Part A provides a brief summary of the literature relevant to CORES, before going on to examine the history and philosophy of the program. This section also unpacks the CORES model, exploring how the model operates on a number of different levels. Part B is focused specifically around the evaluation. It begins by outlining the approach to the evaluation and then goes on to outline the various components of the evaluation framework, including the project logic, the evaluation questions and key data sources. Part B then proceeds to address each of the five evaluation questions in turn, with a specific focus on the five pilot sites funded through DOHA. Part C examines future directions for the CORES program, including possible options for expanding (and consolidating) the CORES model.

The Community Response to Eliminating Suicide

Background to CORES

CORES, the Community Response to Eliminating Suicide, began in Sheffield, Tasmania, as a program run through Tandara Lodge, a local aged care facility. The impetus for the program was ten suicides in the space of three years, including five suicides in one year, in a region of 5000 people. These suicides involved a broad cross-section of individuals, and no underlying systemic cause for the rise in suicides could be identified. Some of the suicides were young people; others were farmers who were struggling with drought; still others were individuals who had recently suffered loss or grief (e.g. a long-term relationship breaking down).

The CORES philosophy

CORES is a holistic training and support package that builds a community's strength and capacity to prevent suicide. It empowers community members to recognise the signs of suicide and intervene before a crisis occurs to refer someone to appropriate services. The underlying philosophy of CORES can be summarised in the words of KRC:

> *The more people from within a community who complete the training, the less likelihood there is of someone at risk not receiving help. It empowers communities to watch out for each other.*

Why CORES Was Established

There are several reasons why CORES was initially established and why those involved with KRC see it as imperative to expand the scope of the program:

- First, other suicide intervention programs had been described by some participants as being too long (e.g. at least two days) and some individuals cannot afford to give up this much time. Consequently, KRC felt that there was benefit in promoting a program that was only required one full day's training. Also, the experience of KRC was that some other suicide prevention programs are too expensive for community-based people to access (i.e. around $200 or more), which is a disincentive to individuals who may want to undertake the program off their own initiative. Consequently, KRC designed the CORES program to be highly affordable (i.e. currently $50).
- Secondly, KRC felt that most other programs tended to not directly examine the specific needs facing rural communities. Consequently, KRC wanted to implement a program tailored to a regional and rural context.
- Thirdly, whilst some other suicide intervention programs may be targeted at the general community, they are not designed to be owned and driven by the general community.

Consequently, KRC wanted to introduce a program which adopts a 'train-the-trainer' model and aim to empower a core group of community members to educate their own community about the risks of suicide and how to intervene if they feel that someone is suicidal. KRC felt that a community-owned suicide prevention program would have a number of benefits, including:

- More effectively connecting individuals at risk of suicide with key health services;
- Provide communities with a sense of empowerment that they are taking charge of an important social issue which effects them;

- Ensure that the program is sustainable into the long term.

The CORES Model

What Does CORES Do?

The CORES model is based around a comprehensive community package which delivers one-day suicide intervention training to members of different communities. 'Community' is understood to be cultural, geographical or situational. Local team leaders are encouraged to volunteer to be trained to deliver the program and 'champion' it locally through attending regular team meetings. Ultimately, communities are responsible for shaping the way the program is delivered, and consequently there is some flexibility in relation to what CORES 'looks like' in each community.

Why Does It Work?

A number of reasons are identified as to why CORES works so effectively, including:

- *Fit With the Current Service System*. CORES is intended to be the first referral point for people who might be suicidal and have not yet accessed any supports. The role of a trained community member is to identify people in the course of their daily lives who might be at risk of suicide and link them in to professional support services. Research shows that people who are suicidal cannot be relied upon to seek help for themselves and that when they do, friends and family are the most likely first point of contact.
- *Community Ownership*. Community ownership is at the heart of the CORES model. Consequently, KRC undertakes a SWOOP analysis of a community before deciding whether or not CORES can work in that community. SWOOP stands for:
    - Sense of community (history);
    - Want the program;
    - Originators of their own capacity;
    - Outcome focused;
    - Prepared to do the work

    KRC has in the past decided against putting the program into some communities if they observe that strong and cohesive sense of community does not exist across at least part of the Local Government Area (LGA).

- *Champions*. In order for the CORES program to become established, it generally requires individuals within the community to 'champion' the program. The key is to generate sufficient interest in the CORES program locally before KRC arrives to deliver the support package. Champions may also connect with local community-based organisations, which often provide the infrastructure to support the CORES program (e.g. a venue for local meetings).
- *Accessibility*. CORES is designed to be delivered by non-professionals for non-professionals. This means that people do not have to have a background in mental health or any health-related field to understand and absorb the material. The training is designed to be simple, easy to understand and easy for team leaders to learn and then deliver. However, importantly, the CORES program also maintains strict professional boundaries.
- *Theoretical underpinning*. Although primarily based on the 'lived experiences' of KRC management, the CORES program has strong theoretical underpinnings in social capital (and social inclusion) theory, social networking theory and theories around what constitutes healthy communities. Interestingly, CORES do not locate themselves within the 'mental health paradigm', but rather see themselves as belonging within the broader 'public health paradigm', with a specific mandate to prevent suicide. KRC feel that positioning CORES in this manner makes CORES more accessible to the regional and rural communities it is targeted towards.

Who does CORES benefit?

Due to the multilayered way in which CORES is introduced into a community and then operates, it has a number of benefits across an individual and community level and as such their 'target group' is much broader than just people at risk of suicide. The following discussion considers the issue of 'who CORES benefits' at three levels: individual, community and system. Rather than simply discussing these benefits in the abstract, illustrative quotes which emerged during the course of the stakeholder interviews have been included under relevant points.[1]

[1] Note that in the actual body of the evaluation report, the discussion of the CORES model has been kept completely separate from the evaluation of the CORES program. However, given the space constraints in an Executive Summary, it was determined that including 'primarily evidence' within the discussion of the CORES model was the most concise means of combining both abstract concepts and concrete examples in relation to the benefit of CORES.

At an individual level, the program has a number of benefits, including:

- Resourcing people with knowledge about suicide that they can apply in their own lives;

  > *The Program is very competent in raising awareness of suicide and they encourage you to go to websites and do your own broader research which has really opened my mind up to the issue (Community member, Burdekin).*

- Encouraging and creating a space for healing among those who have lost family or friends to suicide;

  > *The 'black funnel' initiative was especially powerful and gave me more insight into how my son must have been feeling before he took his life. While the course was confronting and (for me) emotional, the information and understanding I gained has definitely helped me in dealing with my loss (CORES training participant, Personal Story).*

- Acting as a buffer for people at risk of suicide, in terms of giving them a 'positive' social outlet;

- Introducing people to a network of like-minded individuals who are similarly resourced and committed to the goal of preventing suicide;

  > *The social aspect is great in that I have formed so many new friendships. My co team leader and I had not worked together before, but knew each other through Local Government, but we just clicked as presenters and we always have comments about how well we work as a team (Team Leader, South Australia).*

- Up-skilling people in suicide prevention so that they can intervene successfully and save lives;

  > *The training assists you to recognise the signs of suicide and importantly it gives you the confidence to ask people directly – this is the most challenging thing and the area where most people struggle. Role playing it in the training makes it possible (Team Leader, Circular Head).*

- Reducing the need for people contemplating suicide to independently access support services, something which can be difficult for people in a suicidal frame of mind. Those people who might be experiencing

'psychache'[2] or suicidal thoughts can benefit from talking with a trained CORES community member, and thus be lead to appropriate support services;

> *My workmates know that I am involved with CORES as a team leader – if they needed help, my hope is that they would approach me. But people need to know a little bit about the program and what it is about for this to work – so promoting the program is really important. The more people you know and the more people who know you are involved, the more chance you have of helping someone (Team Leader, Circular Head).*

- Generating social capital which has a flow on effect that can benefit individuals in many ways (e.g. assisting communities to be more resilient in the face of a different sort of crisis, such as a natural disaster)

A healthy community is comprised of individuals who are well connected and resourced. Therefore the above list of individual benefits also has an impact at a community level. There are also specific benefits which are likely to manifest at the community level, including:

- Greater community-wide awareness of the issue of suicide and its impact on communities;

> *I think CORES is raising awareness slowly, and just having things like posters advertising events around the towns helps. Hopefully over the next couple of years the stigma of talking about suicide will abate and this will lead to more openness about mental health issues as well (Community Member, Meander Valley).*

- Better knowledge of the range of supports available in the community for people who are experiencing stress;

> *I used to think not (that there were not enough services in our community), but CORES has raised my awareness of options. We have adequate services locally for our needs I would think, and Launceston is not that far away if more extended or specialist help is required (Community member, Meander Valley).*

- Improved social networks for people in the community;
- CORES can facilitate 'cross-over' and intersection of social networks.

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[2] The term 'psychache' was coined by Edwin Shneidman to refer to the constant and ongoing psychological and emotional pain experienced by people in the lead-up to considering suicide.

Finally, at a systemic level, CORES encourages sector-wide and community-wide recognition of suicide as a social and health issue. CORES encourages the impact of suicide on communities (and the families of those who complete suicide) to be brought out into the open, in a way which facilitates open discussion of what is often a taboo issue.

Also, from a systems perspective, CORES 'completes' the service system by strengthening local social networks and normalising health seeking behavior, which in turn connects those individuals at risk to the services they require. Presently, there are a variety of support services available to individuals at risk of suicide. However, an individual at risk who has not previously engaged in help-seeking behavior and does not regularly access health services will generally only attempt to access the necessary services if:

- others within their broad social and professional networks have knowledge of appropriate services;

  > *Being a small rural community we really struggle. That's why the CORES training is so valuable because it is the conduit between the community and the service providers. People have to travel 80km to a Doctor, sometimes 150 and often to Adelaide 600km away for mental health services (Community Member, South Australia).*

- others within their broad social and professional networks feel that accessing such services is 'acceptable behavior'

  > *The CORES program is aimed at non-professionals – that's its main difference and critical success factor. Some people are loathe to ask professionals for help, whereas they'll ask a mate, or accept help from a mate (Team Leader, Central Coast).*

Consequently, a program such as CORES can assist the service system to more effectively reach its target group.

The Evaluation of CORES

The current evaluation of CORES undertaken by Success Works simultaneously encompasseed elements of a 'process' evaluation, a 'formative' evaluation and a 'summative' evaluation.

The primary focus of the current evaluation was qualitative. A variety of qualitative research methods were utilised throughout the evaluation, including a focus group, a workshop, an online questionnaire, interviews with a range of stakeholders and a document review. The only major quantitative component of the evaluation is the presentation of aggregate data around what CORES has delivered to date across the various communities. This data is presented below.

The Scale Of CORES

Across the seven years of operation, CORES has delivered 131 one-day courses to 1426 people. In addition, 16 team leader training courses have been undertaken, and 71 team leaders have been trained in total (59 who are currently active).

It is evident that the program ramped up considerably in 2008. This was due to a number of factors, including:

- the rollout of CORES in Burdekin (which resulted in 128 individuals from this community undertaking the one-day training in 2008);
- the continuation of the Buloke (Donald) program (which began in late 2007);
- the delivery of several 'ad hoc' packages in 2008, where communities paid for a discrete number of courses (rather than purchasing the full CORES community package).

It is apparent that momentum around the program has continued into 2009, with 55 courses and 597 individuals having been trained in the current calendar year to date, representing a 145% increase compared with numbers for the equivalent period in 2008 (i.e. January to mid-August).

Much of the increased activity in 2009 has been the result of the five 'pilot sites' rolling out CORES. These pilot sites, which have had their programs funded through the Department of Health and Ageing, include:

- Central Coast
- Meander Valley
- Dorset
- Kingborough/ Huonville
- West Tamar

Together, for the year to date, 218 individuals have undertaken the one-day training across these five pilot sites. Specifically, 73 individuals have undertaken the training in Central Coast, 51 in Meander Valley, 41 in West Tamar (additionally, 10 individuals were trained in West Tamar in late 2008), 35 in Kingborough/ Huonville, and 18 in Dorset.

Evaluation Outcomes

With reference to the Project Logic developed in conjunction with KRC, Success Works has outlined a series of evaluation questions. The overarching evaluation question was determined to be: Is the CORES model effective? From this overarching question, a number of sub-questions were developed. Responses to these sub-

questions form the structure of the evaluation, with each of these sub-questions considered in turn below.

To what extent is there now greater awareness of the risks and social implications of suicide?

The CORES program appears to have been successful in relation to raising awareness of the risks and social implications of suicide. This can be gleaned both from the number of individuals who have participated in the one-day training course (over 1400), as well as the very positive feedback which has been received in relation to the course. In particular, participants and team leaders have commended the highly accessible nature of the material presented and the simplicity of the program to administer, as well as the strength of using visual tools and 'hands-on' activities to facilitate learning.

As might be expected, there appears to be a correlation between the length of time CORES has been present in a community and the level of awareness around the issue of suicide.

There was some criticism levied at the structure and content of the training manuals used by team leaders by a small proportion of individuals interviewed. However, it appears that KRC are highly receptive to this criticism, and, in conjunction with a group of team leaders, are currently modifying the training manual to make it more 'user-friendly'.

Finally, it needs to be stated that the scope of our findings in relation to this question are limited, due to the fact that we only collected data from individuals who participated directly in the CORES program (either in a team leader or participant capacity). Consequently, the broader impact of the CORES program on building awareness of the risks of suicide at the community level cannot be accurately accessed in the current evaluation.

Has social capital and networking among community members been strengthened?

It is apparent that the CORES initiative has substantially strengthened social capital on a number of different levels. The initial efforts to get CORES off the ground in a community require a 'base' of social capital (often in the form of a community champion and his or her immediate network), however CORES is then able to grow social capital exponentially through:

- Bringing people together to undertake the one-day training;
- Developing a network of local CORES team members, that attend team meetings and promote CORES;

- Connecting and strengthening links between individuals, and between community organisations, through providing them with a common purpose through which to work together.

One suggestion arising from this evaluation is that further efforts be made to strengthen inter-community social capital, through supporting team leaders from different parts of Tasmania to develop strong relationships. This would appear to be critical to the long-term sustainability of the CORES model. It should be noted that KRC are planning on bringing together all the team leaders from the various sites together for a conference in September 2010. This will clearly be an extremely valuable opportunity to strengthen inter-community networks.

Has social isolation been decreased among community members?

It is apparent that CORES has decreased social isolation amongst community members. Most obviously, this occurs when an individual who has been trained in the CORES program intervenes with someone at risk of suicide. However, social isolation is also reduced through other processes which occur around CORES (such as being part of a CORES team).

Additionally, it was discussed how CORES also reduces social isolation through normalising help-seeking behaviours, which allow individuals who may have 'fallen out of' the service system to be 'brought back into it'. A description offered during the workshop was that CORES 'captures' people in the community who might have 'fallen through the cracks' between all the other services available in the CORES communities.

Finally, it was considered how undertaking the CORES program can reduce the psychological isolation experience by individuals who have lost a close friend or family member to suicide.

> *I found coping with my neighbour's suicide very hard. It had a massive impact on me. I felt extremely guilty. Doing the course increased my awareness and helped me to open up and to talk about the situation and my feelings (Community member, Kentish).*

Has suicide been reduced in CORES communities?

Sufficient responses were received to demonstrate that CORES had in fact averted possible suicides, with a number of people identifying others at significant risk and able to divert them into appropriate services. It is apparent then that individuals are able to utilise the basic skills that they acquired through their one-day training in 'real-life' situations. This is critical and in many ways can be considered the most important outcome of CORES.

Is CORES sustainable?

As has been reiterated through this current evaluation report, the CORES model is designed to be sustainable. Consequently, one would expect that once CORES is established within a given site, the program could continue to operate relatively autonomously at the local level into the future. Indeed, there was some evidence of the program's sustainability during the evaluation, particularly within communities where the program was well established (such as Sheffield/Kentish, Burdekin and Circular Head). It is clearly premature to draw any conclusions around the sustainability of the pilot sites, however one would expect CORES to continue in these sites *provided that the respective communities take full ownership of the programs and that KRC has capacity to continue to work with them*.

Future Directions for CORES

Many ideas were 'floated' throughout the consultations considering future directions for CORES. While it was not specifically within the evaluation mandate to present KRC with options for its future, it is worth reiterating a number of points raised throughout the consultations that have been discussed:

- The CORES model is flexible enough to be expanded to consider other forms of 'community' such as schools, workplaces, cultural or ethnic communities or clubs and community associations. Furthermore, the option has also been canvassed of applying the CORES model to other social issues beyond suicide.
- KRC, provided it can continue to strengthen its organisational capacity, is well placed to look at ways to expand its staffing pool, which might involve taking on additional project officers.
- KRC needs to continue to explore options for secure funding. This funding may come from organisations and government agencies not just specifically concerned with suicide prevention programs, given the variety of other benefits CORES brings to a community that the evaluation has identified.
- Given that each community is different in terms of the exact manner in which CORES operates, KRC should endeavour to continue to document and disseminate learnings in relation to 'what works for whom' (for example, different strategies for generating community-wide enthusiasm for the program).
- KRC also needs to look at ways to lift the profile of CORES, in part to secure funding to improve its' own organisational capacity and in part to assist the communities CORES goes into to advertise the program.

- Finally the networking and 'linking' role of KRC is presently underdeveloped, due mainly to resource constraints and the rapid growth the CORES program has recently experienced. It has been recognised that there are very dedicated and committed team leaders and community members working in the different CORES communities who would benefit from greater networking with each other. In this regard, it is worth noting that KRC has planned a conference for CORES team leaders in September 2010.

Conclusion: Is the CORES Model Effective?

> *The best thing about CORES is that it is not a government service; it is community based and run; and has a simple but powerful message of hope that anybody can be readily equipped to save a life (Community Member, Meander Valley).*

The above quote aptly describes what is simultaneously most unique and most effective about the CORES model: that it is community 'based and run'. Although many programs describe the importance of community capacity building and community ownership, very few programs base their entire model and philosophy on these principles.

It is evident from the evaluation that the advantages of CORES being community driven are many and varied. The current evaluation has demonstrated that being community driven has made the one-day training program more accessible to lay-people than would otherwise be the case, made the actual experience of being involved with CORES highly positive and facilitated the actual process of undertaking interventions with people at risk. However, perhaps most crucially, being community driven has ensured the sustainability of local programs.

To date, the five pilot sites funded by the Department of Health and Ageing have experienced the same positive benefits of social networking and raising awareness of suicide, as well as training people to respond to suicidal intent in others, as the more established sites. However, it has become very apparent across the course of the evaluation that CORES takes longer than 6-12 months to fully establish itself in a community, particularly when the funding comes from an external body (rather than being raised internally within a community).

It is fitting to conclude by considering the comprehensive review of suicide prevention programs by Headey and Pirkis et al. (2006), discussed in the literature review. Headey and Pirkis et al. (2006) note that ensuring that the outcomes associated with various suicide prevention strategies were sustainable beyond the life of direct funding was the major issue for many programs. In examining the programs that were most successful in this regard, the authors suggest that there appear to be two paths towards sustainability:

- Embedding the project's activities or resources into an existing service or system in such a way that they continued beyond the funded life of the project;
- Equipping participants with skills and knowledge that they would retain after the project activities had ceased, which commonly occurred in projects employing train-the-trainer approaches (Headey and Pirkis et al 2006).

CORES would appear to be the consummate program with regards to being sustainable, given that it is fundamentally community owned and driven (and needs to be in order to be effective) and employs a train-the-trainer model. Indeed, it is unfortunate that the CORES program was not well established enough at the time for it to be considered for Headey and Pirkis et al.'s (2006) review; because there is a strong possibility the authors would have considered CORES to be a 'best practice' example of a sustainable community suicide prevention program.

Introduction

Success Works has been commissioned by the Kentish Regional Clinic (KRC) to evaluate CORES, the Community Response to Eliminating Suicide. This evaluation is part of the funding requirements for the funding the Department of Health and Aging (DOHA) provided for the five pilot sites in Tasmania, and therefore this evaluation has particularly considered the experiences of the pilot sites. At the same time, Success Works was also requested to document the CORES model, to assist KRC with planning for the future of the program.

This evaluation report is structured into three parts. Part A will provide a brief summary of the literature relevant to CORES, before going on to examine the history and philosophy of the program. This section will also unpack the CORES model, exploring how the model operates on a number of different levels. Specifically, the capacity of the CORES model to simultaneously enrich and strengthen community networks and provide community members with a set of tools which they can utilise to intervene if they feel someone is at risk of suicide is discussed.

Part B is focused specifically around the evaluation. It begins by outlining the approach to the evaluation and then goes on to outline the various components of the evaluation framework, including the project logic, the evaluation questions and key data sources. Part B then proceeds to address each of the five evaluation questions in turn, with a specific focus on the five pilot sites funded through DOHA. This part of the report concludes by outlining a detailed case study of the CORES program in the Queensland community of Burdekin. The purpose of introducing a case study is to both reinforce and integrate the responses put forward to the evaluation questions, as well as to gain a deeper understanding of how the CORES program operates 'on the ground'.

Part C examines future directions for the CORES program, including possible options for expanding (and consolidating) the CORES model. This part concludes by outlining overall evaluation findings.

Definitions

People become involved in CORES in a number of capacities and the language used to describe each of these roles can be confusing to someone not intimately familiar with the program. Consequently, for clarity, it is important to be upfront regarding what is meant by specific terms used in this report. Throughout this report:

- interviewees will be used to describe people who were directly interviewed as part of the consultations;

- community members is the generic term for people who have been consulted as part of this project or who have participated in a workshop or focus group or who have completed a one-day training course;
- team leaders are people who have completed the team leader training that enables them to deliver the one-day training, and generally (although not always) are members of the local CORES team;
- Kentish Regional Clinic (KRC) refers to the organisation and team of people who deliver the CORES program.

PART A: About CORES

1. The Community Response to Eliminating Suicide

1.1 Background to CORES

CORES, the Community Response to Eliminating Suicide, began in Sheffield, Tasmania, as a program run through Tandara Lodge, a local aged care facility. The impetus for the program was ten suicides in the space of three years, including five suicides in one year, in a region of 5000 people. These suicides involved a broad cross-section of individuals, and no underlying systemic cause for the rise in suicides could be identified. Some of the suicides were young people; others were farmers who were struggling with drought; still others were individuals who had recently suffered loss or grief (e.g. a long-term relationship breaking down).

The program was originally delivered through Tandara Lodge to local people from the Kentish Shire. After leaving Tandara Lodge, Coralanne Walker was given permission to take the program and all its material and trademarks with her. The Kentish Regional Clinic (KRC) was then created as a community based organisation, with a Board of local representatives, to manage CORES. Coralanne is now the Manager of KRC. Mark Sheldon-Stemm is the current Chair of KRC.

Training the community appeared to Coralanne and Mark as the most sensible way to tackle their local suicide problem.

> *'We're local people, the people we train should be local people too – within their own communities' (Mark Sheldon-Stemm, KRC).*

The first funding KRC received was community grant funding of $41,000 from the Tasmanian Community Fund. This provided funds for team leader and community training throughout Tasmania.

In 2006, a *Landline* program aired on ABC TV showcasing the program's success in Sheffield, and this generated enormous amounts of interesting around the country, including Donald and the Burdekin region in Queensland. Each of these communities was rural and agricultural and had a local problem with suicide. In 2008 *Landline* did a follow-up program and further funding was received from DOHA for five pilot sites in Tasmania. KRC has also provided some one-day training in South Australia and

Western Australia and a package at Eyre Peninsula, and has strong support in both states from Members of Parliament.

In addition, CORES received a Tasmanian LIFE Award, in recognition of the contribution of individuals and organisations in promoting life and preventing suicide in Tasmania, from the Tasmanian Department of Health and Human Services and an Honorable Mention in the category of promoting healthy communities.

In total, CORES is now active in nine communities within Tasmania, two in Victoria and one in Queensland, one in South Australia and training has also been given in South Australia and Western Australia.

Why CORES Was Established

There are several reasons why CORES was initially established and why those involved with KRC see it as imperative to expand the scope of the program. It was KRC's experience that other programs tended to be designed for caregivers or health professionals, and not suited to 'ordinary' community members. First, other suicide intervention programs had been described by some participants as being too long (e.g. at least two days) and some individuals cannot afford to give up this much time. Consequently, KRC felt that there was benefit in promoting a program that was only required one full day's training. Second, the experience of KRC was that some other suicide prevention programs are too expensive for ordinary people to access (i.e. around $200 or more), which is a disincentive to individuals who may want to undertake the program off their own initiative. Consequently, KRC designed the CORES program to be highly affordable (i.e. currently $50). Third, KRC felt that most other programs tended to not directly examine the specific needs facing rural communities. Consequently, KRC wanted to implement a program tailored to a regional and rural context.

Finally, and related to this issue of a program being targeted to meet the needs of rural and regional communities and community members, is perhaps the major motivation for developing CORES in the first instance. Whilst some other suicide intervention programs may be targeted at the general community, they are not designed to be owned and driven by the general community. Consequently, KRC wanted to introduce a program which adopts a 'train-the-trainer' model and aim to empower a core group of community members to educate their own community about the risks of suicide and how to intervene if they feel that someone is suicidal. KRC felt that a community-owned suicide prevention program would have a number of benefits, including:

- More effectively connecting individuals at risk of suicide with key health services;

- Provide communities with a sense of empowerment that they are taking charge of an important social issue which effects them;
- Ensure that the program is sustainable into the long term.

For all of the above reasons, KRC developed, and have since endeavoured to promulgate, the CORES program.

Having considered the background to the development of CORES, the remainder of this chapter will concern itself with a discussion of the philosophy which underpins it, as well as outlining the CORES model in more detail.

1.2 The CORES Philosophy

Dealing with the issue of suicide is both challenging and complex. Given that the nature of the topic in itself is distressing, trying to understand the complex circumstances and psychological variables of people in crisis only make it more difficult. What is most disturbing about suicide is that survivors are left asking the unanswerable question 'why', and wondering what they could or should have done to prevent it. It is impossible to identify any single cause of suicide but the study of suicidal behavior allows people to identify a whole range of risk factors, and to coordinate their efforts for their alleviation.

Suicide affects hundreds of thousands of Australians every year. Whilst the incidence of suicide is relatively rare, they are all nonetheless premature, needless deaths which have a devastating impact on extended family relationships, workplaces, schools and ultimately, the community as a whole. In rural communities that are like "big families" (Landline DVD), this impact is more pronounced.

CORES is a holistic training and support package that builds a community's strength and capacity to prevent suicide. It empowers community members to recognise the signs of suicide and intervene before a crisis occurs to refer someone to appropriate services.

> *"The more people from within a community who complete the training, the less likelihood there is of someone at risk not receiving help. It empowers communities to watch out for each other.*
>
> *One of the greatest things we can do as humans is to be somehow responsible for saving another human life. But something greater than this is to be somehow responsible for saving the life of someone we don't know and we are never likely to meet. This is something great. This is what the CORES program is all about.*

It doesn't matter if Kentish Regional Clinic no longer exists, what has been passed on can, and will, live on into the future, championed by people in the community" (Source: Kentish Regional Clinic).

The above mission statement highlights CORES' philosophy. The essence of CORES is the team based in the community who take responsibility for managing and delivering the one day training. CORES offers comprehensive mentoring and support to communities and flexible training through a simple yet effective intervention model. It engages people in the community no matter what their backgrounds may be and presents material in a simple to understand format. The training was developed by reflecting on other suicide-intervention programs that the CORES managers had experience with, and has aimed to distinguish itself from these by being more accessible, inexpensive, and better suited to rural communities. As discussed in the previous section, CORES is not only targeted at the local community, but embedded within, owned by and sustained by respective local communities. To date 'community' has been mostly understood to mean a geographic location, however it has been designed to adapt to any understanding of 'community', providing that the essential elements are in place.

The following chapter explores the CORES model in terms of what they do and why and how they do it.

2. The CORES model

2.1 What Does CORES Do?

The CORES model is based around a comprehensive community package which delivers one-day suicide intervention training to members of different communities. 'Community' is understood to be cultural, geographical or situational. Local team leaders are encouraged to volunteer to be trained to deliver the program and 'champion' it locally through attending regular team meetings. While the ideal scenario is for the program to be delivered as a complete package, elements of it can be extracted if that is the community's preference. Ultimately, communities will be responsible for shaping the way the program is delivered into their community and for organising their own funding base.

The complete community package costs $35,000 and this includes 12 months of support from KRC team to train six team leaders within that community, so that they form part of the 'team' and can go on to deliver the one-day training. Twelve months is believed to be an effective period of time for the local community to both understand the program and take full advantage of regular visits from KRC team. This package also includes training 200 people in the one-day course over the first 12 months of the program. The cost includes KRC supplying all the CORES material and visiting the community a number of times throughout the first 12 months.

The package is designed to be flexible and 'fit' the community it is being developed for, however the usual and preferred process of activities is as follows:

- Preliminary relationship building with key stakeholders in the community and link in with a local community-based group.
- Conduct a preliminary one day workshop (if possible).
- Launch of CORES through a large public event.
- Conduct some one day courses. As a result of this, people who want to become trained team leaders nominate themselves. If numbers are initially low, team leaders from different areas may get trained together. This allows individuals to receive team leader training quickly rather than have to wait for sufficient numbers in their local area. The other advantage of this approach is that it allows team leaders to build supportive networks which span multiple areas. The team leader training is 4 consecutive days.
- Team Leaders conduct one day workshops, initially with direct support from CORES management. CORES supply the training materials for up to 200

program participants. The $35,000 package means that these participants can attend the course for free.

- CORES provide ongoing support to the community (mainly in the form of additional training for team leaders) throughout the 12 month period.

Where the full package outlined above is not possible, the CORES team can and frequently do provide one-day training at a one-off cost of $50 per person. Alternatively if people want to be trained as team leaders without being part of community package, it costs $1100 per person if they travel to Sheffield for the training or $1500 if the CORES trainers are required to travel. A minimum of six team leaders are required to be trained in any one location to justify the CORES trainers traveling to that region. Where this can't happen, the training can be co-organised with other nearby sites, or held over until sufficient numbers are reached.

Elements of the model that are flexible include the way in which it is introduced into communities, i.e. the details around when and where to run the 'preliminary' one-day training sessions, how and when to market and then host the public launch, and how to then train the volunteer team leaders. KRC are also open to suggestions about the groups that participate in the one-day training, and has run individual sessions with workplaces.

Elements of CORES that are 'not negotiable' relate to the content of the one-day training and the four-day team leader training, discussions of which are below. The reason for this is that based on experience – the KRC team know what works, and are also careful to ensure that the format and content of the training is consistently applied through the train-the-trainer process to minimise the risk of it being incorrectly applied. Having said that, KRC is open to suggestions about ways to modify the materials and the training and has continually updated it over the past several years.

The content of the one-day training has been adapted from strategies that are known to work for educating people about the risk factors for suicide. The program for the one-day training is as follows:

1. Community myths about suicide are debunked
2. Suicide statistics are presented and discussed
3. The 'river of risk' and 'funnel vision' analogies are explained
4. Signs and indicators for suicide, including feelings, words and behaviours to be aware of, are explained
5. The Wallet Card containing instructions for intervening are presented to the group
6. Participants are taught about the ABCD method of assessing risk

7. The types of interventions – direct, cooperative and non-direct, are discussed
8. Agreements, or 'contracts' are explained and a range of scenarios are presented to allow the participants to practice.
9. Lastly, community resources are identified.

The one-day training is comprehensive, and includes a range of activities to keep the group engaged. Ideally, the one day course has between 8 and 15 people. Normally, two team leaders are involved in delivery the course.

The ABCD Risk Assessment involves the following steps:

1. A = Ask the question. The question is 'are you considering suicide'? Community members are taught how to ask the question after creating an atmosphere that will generate honesty.
2. B = Assess prior behavior. If the answer to the previous question is yes, then community members are taught to assess prior behavior by asking whether the person has contemplated/attempted suicide before, and if anyone they know has completed suicide. If the answer to either of these questions is yes, then the '40x' rule applies[3].
3. C = Current plan. Community members are next taught to ask the person if they have a plan for when, where and how they plan to take their own life. This question helps the person doing the intervention to decide how immediate the risk is, and how serious the person is about completing suicide. Community members are taught to err on the side of caution, so even if a plan is not well-defined, there may still be enough 'flags' to warrant immediate, direct intervention.
4. D= Dam wall. This means that the community members ask the person they are intervening with what things in their lives have stopped them completing suicide. These 'things' are the coping mechanisms that make up the dam wall that stops them from floating down the river of risk. People who can identify few things in their lives worth living for are at a higher risk.

Absent from the above list is the question of 'why' someone might want to complete suicide, which is not asked during a suicide intervention. It is not the place of the person doing the intervention to ask this question because they are not qualified to address any of the responses that they might get. The professionals who treat the suicidal person can ask this question and respond appropriately. The only questions

[3] Research has found that a person who has either attempted suicide previously or have a 'significant other' who has completed suicide is 40-100 times more likely to attempt again (Source: Ettlinger, 1964, Usden, 1996, Tanny and Motto 1990).

the community members ask are the ABCD questions defined above, to assist them in deciding which of three courses of action to take:

1. Direct

   If someone is believed to be at high risk the person intervening might decide to call 000 as a form of immediate direct intervention that does not require the suicidal person's cooperation.

2. Cooperative

   If the risk is significant but may not be immediate, the person doing the intervention might suggest options to the person for them to explore together. This might be taking the person to see their GP, taking them to the hospital, telling their friends and families about their issues, and/or signing a contract that they will avoid risky behaviours like using drugs or alcohol and will take particular action if they begin to feel suicidal again.

3. Non-direct

   If the immediate risk appears low, non-direct action could be the suicidal person agreeing (signing contracts is encouraged) to contact their doctor or some other support service independently.

KRC is also careful not to overstate CORES' capacity to prevent suicide, and the one-day training includes a disclaimer that approximately one in ten suicides is considered 'unpreventable', and the focus is on those that can be prevented.

2.2 Why Does It Work?

Fit With the Current Service System

CORES is intended to be the first referral point for people who might be suicidal and have not yet accessed any supports. The role of a trained community member is to identify people in the course of their daily lives who might be at risk of suicide and link them in to professional support services. Research shows that people who are suicidal can not be relied upon to seek help for themselves and that when they do, friends and family are the most likely first point of contact (Kentish Regional Clinic).

The CORES trainers are not counselors and the community members they train are given very specific guidelines around their role. The ABCD risk assessment used as part of their interventions is deliberately basic, and is only intended to provide guidance for how to respond. It is not intended to determine treatment options for the individual – that is up to the professionals to decide.

KRC see their role as one small part of the broader mosaic. They connect individuals at risk of suicide to relevant services, with the specific service identified depending upon a number of factors including:

- what actual services are available locally,
- the history of service usage of the individual they are assisting (e.g. the individual may have a pre-existing relationship with a psychologist or other counselor);
- the apparent immediacy for which the service is required

Therefore the program serves as a link between a social problem and specialised services available within and beyond a community. The program does not seek to impinge upon the practices of specialised services but rather leads individuals to them.

Community Ownership

As stated, community ownership of CORES is essential for its success. KRC undertakes a SWOOP analysis of a community before deciding whether or not CORES can work in that community.

SWOOP stands for:

- Sense of community (history);
- Want the program;
- Originators of their own capacity;
- Outcome focused;
- Prepared to do the work

KRC has in the past decided against putting the program into some communities if they observe that strong and cohesive sense of community does not exist across at least part of the Local Government Area (LGA). Without a strong and cohesive sense of community, community ownership is difficult to establish; and community ownership is, in turn, critical to the long-term sustainability (and therefore ultimately the success) of the program.

Champions

To this end, it is desirable for the community to raise its own funds to run the program (as has been the case in Victoria, Queensland and some of the Tasmanian sites). Through raising its own money, the community takes ownership of the program (or, alternatively, the community has already expressed an enthusiasm and willingness to embrace the program and hence raises its own money). CORES can only succeed if

the community owns the program. Furthermore, it is critical that the program have community 'champions' in the form of individuals or a community based organisation with a solid infrastructure.

These champions can then generate interest locally about the program before the KRC team comes in. This interest is important to ensure that a team of people is ready to assume the responsibility of being trained team leaders. To reiterate, the 'core' of the CORES philosophy is that community ownership is vital to the sustainability and success of the model.

Accessibility

CORES is designed to be delivered by non-professionals for non-professionals. This means that people do not have to have a background in mental health or any health-related field to understand and absorb the material.

The training is designed to be simple, easy to understand and easy for team leaders to learn and then deliver. However, importantly, the CORES program also maintains strict professional boundaries. Consequently, a key element of both the team leader training and the actual one-day suicide prevention training is to emphasise that individuals who complete CORES training are not professional counselors (unless they actually have a professional qualification in counseling alongside their CORES training). Again, the emphasis is on the responsibility of the individual who has received the training to connect people at risk to the help they require.

The analogy often drawn upon by KRC when describing the role of CORES team members is that of a first-aid officer. The role of a first-aid officer at the scene of an accident is to make some preliminary assessment of the scene and then, depending on the situation, provide some form of basic intervention (e.g. ascertain whether the individual is conscious, administer CPR etc). The first aid officer will then contact the relevant emergency service, who may require some additional information from the first-aid officer and/or require them to undertake some additional minor intervention.

A first-aid officer is not attempting to replace a professional medic; on the contrary, an appropriately trained first-aid officer would see it as paramount in their role to connect the individual in need of immediate assistance to an appropriate service. Further, an appropriately trained first-aid officer understands his or her role and its inherent limitations. He or she will be careful not to overstep the boundaries of this role, knowing that even well-meaning intentions can produce more harm than good.

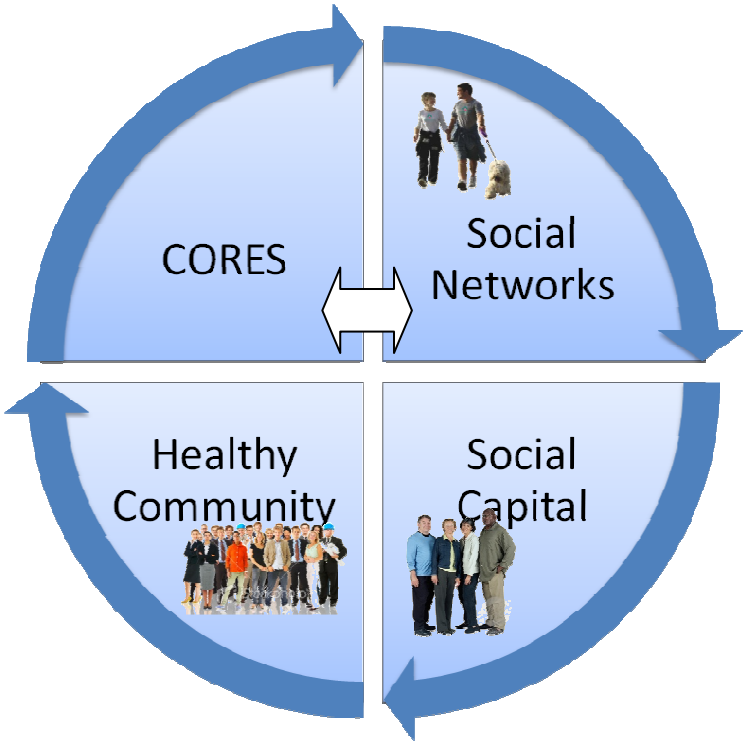
To suggest that a first-aid officer should not intervene in an accident because he or she is not a trained medic would be seen by most people as a problematic and ultimately self-defeating proposition, provided that the first-aid officer only operated within the limits of their training. Similarly, it is proposed that opposition to the CORES

model on the basis that CORES team members (and others who have completed the one-day training) are not trained professionals is seen as an equally problematic and self-defeating proposition, again provided that CORES team members operate within the limits of their training.

Theoretical Underpinnings

Although more intuitive than theoretical, being primarily based on the 'lived experiences' of the CORES founders, CORES reflects an understanding of the theories of social capital, social networking and healthy communities (discussed further in Chapter 3). This has been diagrammatically conceptualised as follows to show that CORES both leverages off and builds social networks, which in turn contribute to social capital, which is one element of a healthy community.

Figure 1: CORES Model



Interestingly, CORES do not locate themselves within the 'mental health paradigm', but rather see themselves as belonging within the broader 'public health paradigm', with a specific mandate to prevent suicide. KRC feel that positioning CORES in this manner makes CORES more accessible to the regional and rural communities it is targeted towards.

It is really important for CORES to maintain its focus and to not be associated with mental health – to maintain its broader community perspective. Mental health issues have a particular stigma around them within the community that may make CORES less accessible to community members (KRC Employee).

2.3 Who Does It Benefit?

Due to the multilayered way in which CORES is introduced into a community and then operates, it has a number of benefits across an individual and community level and as such their 'target group' is much broader than just people at risk of suicide.

At an individual level, the program has a number of benefits, including:

- Resourcing people with knowledge about suicide that they can apply in their own lives;
- Encouraging and creating a space for healing among those who have lost family or friends to suicide;
- Acting as a buffer for people at risk of suicide, in terms of giving them a 'positive' social outlet;
- Introducing people to a network of like-minded individuals who are similarly resourced and committed to the goal of preventing suicide;
- Up-skilling people in suicide prevention so that they can intervene successfully and save lives;
- Reducing the need for people contemplating suicide to independently access support services, something which can be difficult for people in a suicidal frame of mind. Those people who might be experiencing 'psychache'[4] or suicidal thoughts can benefit from talking with a trained CORES community member, and thus be lead to appropriate support services;
- Generating social capital which has a flow on effect that can benefit individuals in many ways (including social inclusion and assisting communities to be more resilient in the face of a different sort of crisis, such as a natural disaster)

A healthy community is comprised of individuals who are well connected and resourced. Therefore the above list of individual benefits also has an impact at a

[4] The term 'psychache' was coined by Edwin Shneidman to refer to the constant and ongoing psychological and emotional pain experienced by people in the lead-up to considering suicide.

community level. There are also specific benefits which are likely to manifest at the community level, including:

- Greater community-wide awareness of the issue of suicide and its impact on communities;
- Better knowledge of the range of supports available in the community for people who are experiencing stress;
- Improved social networks for people in the community;
- CORES can facilitate 'cross-over' and intersection of social networks.

Finally, at a systemic level, CORES encourages sector-wide and community-wide recognition of suicide as a social and health issue. CORES encourages the impact of suicide on communities (and the families of those who complete suicide) to be brought out into the open, in a way which facilitates open discussion of what is often a taboo issue.

Also, from a systems perspective, CORES 'completes' the service system by strengthening local social networks and normalising health seeking behavior, which in turn connects those individuals at risk to the services they require. Presently, there are a variety of support services available to individuals at risk of suicide. However, an individual at risk who has not previously engaged in help-seeking behavior and does not regularly access health services will generally only attempt to access the necessary services if:

- others within their broad social and professional networks have knowledge of appropriate services;
- others within their broad social and professional networks feel that accessing such services is 'acceptable behavior'

Consequently, a program such as CORES can assist the service system to more effectively reach its target group.

3. Literature

This chapter presents a summary of the literature underpinning CORES, mainly relating to the political context in which CORES operates, the challenges that exist in trying to measure suicide prevention and the risk and protective factors for suicide, and presents some of the theory around social capital and social networking as a means of addressing suicide risk in communities.

3.1 Suicide and Suicide Behaviours

Suicide can be defined as the deliberate taking of one's life (Buttersworths 1997). However suicide behaviour tends to present on a continuum of behaviours including suicide attempts and suicide ideation can be linked to a common set of causes. Estimates are that for every completed suicide there are ten attempts (Baum 2007). The spectrum of suicidal behaviours is influenced by a common set of risk factors, with the extent of the individual's risk factor exposure influencing the extent of their suicidal behaviour.

Suicide in Australia

Across Australia, the suicide rate has declined over the past decade. Specifically, the number of deaths recorded as intentional self harm (suicide) has decreased over the last 10 years, from 2683 in 1998 to 1,881 in 2007. Throughout this period, the crude death rate from suicide per 100,000 declined from 23.1 to 13.9 for all males and 5.7 to 4.0 for all females (ABS 2009).

However, some caution needs to be taken when interpreting year-to-year changes in suicide statistics. This is due to the fact that in order for a death to be classified as suicide, the interpretation used by the ABS requires that specific documentation from a medical or legal authority be available regarding both the self-inflicted nature and suicidal intent of the incident. If this information is not available then the death must be classified as accidental. Importantly, the interpretation of what constitutes a "medical or legal authority" has been inconsistently applied by the ABS over a number of years. This has resulted in a review of ABS coding practices in relation to suicide in January 2007, in an attempt to be both more comprehensive and accurate in recording suicides (ABS 2009). Consequently, whilst future suicide data is likely to be both more accurate and highly comparable (due to the systematic rules now applied to the coding of a suicide), historical trends should be interpreted as indicative rather than definitive.

Interestingly, when considering the number of suicides in Tasmania across the same ten year period, the same decline is not evident. Specifically, there were 59 recorded

suicides in 1998, increasing somewhat to 67 in 2007. However, the ABS emphasises that suicide rates in states and territories may fluctuate over time, particularly in small jurisdictions, and therefore 'year-to-year' variations should be interpreted with caution. Given this proviso, additional analysis was undertaken of the Tasmanian suicide data. This analysis involved calculating the average number of suicides across the first five years of the period under consideration (i.e. 1998-2002) and comparing this with the average number of suicides across the second five years of the period under consideration (i.e. 2003-2007). This analysis revealed an increase in the number of suicides of a similar magnitude to that observed between 1998 and 2007. Specifically, the average number of suicides between 1998 and 2002 in Tasmania was 64, whereas the average number of suicides between 2003 and 2007 in Tasmania was 74. By contrast, all other Australian jurisdictions, except for the Northern Territory, experienced a decline in the number of suicides across these two periods. Across the period 2003-2007, the age-standardised death rate from suicide in Tasmania was higher than for all other jurisdictions except for the Northern Territory, and approximately 57% higher than the equivalent rate for the whole of Australia (ABS 2009).

The above indicates that suicide continues to be a significant issue in Australia, particularly in Tasmania. The official suicide rate, which, as stated above, can be unreliable, partly because it does not account for a number of drownings, drug overdoses and single vehicle, single driver car accidents that may, in fact, be suicides (SPA 2008).

Suicide is more common among men in rural areas and in communities with less than 4000 people (Hoogland 2000; SPA 2008), which partly accounts for the situation in Tasmania. Rural communities tend to be more isolated, have fewer services, be more culturally homogenous, offer less privacy and anonymity and have more pronounced social problems. In addition they are likely to have more conservative social values that can make people experiencing personal challenges reluctant to seek help. There are many reasons why this is the case. Economic and social change in Australia, particularly in the last 30 years has had a dramatic impact on farming and rural areas (Hoogland and Pieterse 2000). People in farming communities may be experiencing a high sense of alienation and isolation is exacerbated by financial insecurity and family breakdown (Hoogland and Pieterse 2000).

Irrespective of the method, rate of suicide, or in fact who suicides, "The suffering of a suicidal person is much more significant than an analysis of statistics can reveal" (Hoogland and Pieterse 2000: 5). The form this suffering takes, and the impact it has on the person's life before they attempt or complete suicide will vary, and the outcome of it in terms of lost productivity and 'drain' on the health system,

demonstrates that there is merit in any program that can alleviate this suffering – whether the person ultimately suicides or not.

3.2 The Politics of Suicide

In Australia, suicide has traditionally been considered a mental health issue and has been Commonwealth funded as such. Because of its medical status, this funding has tended to be geared towards the health system generally and mental health practitioners in particular. The seriousness of the issue has meant that governments and experts in the field are very careful about making sure suicide is dealt with professionally, and that interventions and /or treatment are strictly monitored, contained, accountable and remain professionalised. Suicide is considered to be at the high risk, crisis, tertiary end of the spectrum. Because of the high degree of risk, it is appropriate that treatment for suicidal intent remains within the medical profession, however it is entirely appropriate that suicide *prevention*, i.e. by building strong communities whilst linking people at risk to professional services, occurs at the community level.

Australia has adopted a national suicide prevention strategy in various forms since the mid-1990s funded through DOHA. In September 2008 the Australian Government announced the formation of a new National Suicide Prevention Strategy to be monitored by a Suicide Prevention Advisory Council, which among other things will signal a shift towards priorities including:

> "strengthening the capacity of communities to prevent suicide in specific geographic areas. The government will work with states and territories to identify local areas most affected by suicide, and will develop appropriate locally tailored projects to support local populations affected by or at risk of suicide" (Roxon 2008).

As revealed in the previous chapter, the CORES model would appear to be consistent with the above direction put forward by the Suicide Prevention Advisory Council and the Federal Minister for Health. There is scope to tailor the CORES model to the specific needs of individual communities, and CORES focuses specifically on strengthening the capacity of communities to enable them to take responsibility for addressing the issue of suicide.

Measuring Suicide Prevention

As the following excerpt from DOHA acknowledges, measuring the success of suicide prevention initiatives presents a challenge.

"It is obviously desirable to use reduced suicide rates as a measure of effectiveness but this can be difficult to track, particularly within a local region, and should not be

the only measure used. Assessing the effectiveness of suicide prevention activities can use measures such as:

- reductions in suicide attempts and/or suicidal thinking;
- reductions in risk factors and vulnerabilities to suicidal behaviours (eg mental illness, feelings of hopelessness);
- increase in individual and/or community awareness of appropriate suicide prevention;
- changes in behaviours and response to suicide prevention strategies; and/or
- improvements in individual protective or resiliency factors (eg improved coping skills, more help-seeking behaviours, better social connectedness, better understanding of mental illness)" (DOHA Life Brochure)

Measuring the effectiveness of suicide prevention activities is inherently difficult because it is measuring the *absence* of something, and then endeavoring to determine whether its absence is due to the activity itself or to other factors. Having to be comfortable with the ambiguity of suicide prevention, (i.e. never really being sure as to how many lives might be saved due to a particular program) is a familiar reality to those working in the field, however it also presents a challenge for those interested in evaluating the efficacy of such programs (such as funding bodies).

However, it must be said that evaluators of social policy programs confront the issue of how to assess the success of a particular program against objectives which are both long-term in nature and impacted upon by a myriad of factors beyond the control of program providers in almost every program they evaluate. The tool which has been developed by evaluators for circumventing this issue is a project (or program) logic (described in more detail in chapter 4). A project (or program) logic aims to identify the causal mechanisms which underpin a particular program (Owen and Rogers 1999). It attempts to explicitly identify the medium term outcomes which can be expected to lead to the desired long-term outcomes, and in turn identifies those short-term outcomes which are requisite for achieving medium-term outcomes (Baehler 2003). Consideration is then given to whether the outputs of a program (i.e. what the program directly 'produces') are likely to lead to the identified short-term outcomes. Having 'reverse engineered' the logic underpinning the program, evaluators can then set about measuring the outputs and short-term outcomes associated with a program, and, if possible, the extent to which the outputs can be empirically demonstrated to lead to the generation of the short-term outcomes. It is important to note that short and medium term outcomes may also be critical ends in themselves.

As the above discussion illustrates, project logics can begin with the desired long-term outcomes and 'work backwards' (for example, in instances where there is interest in identifying any gaps that may exist within a particular program, given its long-term objectives). Alternatively, project logics can begin with the program itself and project outwards (for instance, in instances where the long-term outcomes of the program have not been clearly articulated). In some instances, developing a project logic can be an iterative process and evaluators will endeavour to work both 'forwards' and 'backwards' until they feel that they have comprehensively 'unpacked' a program.

The measures suggested by DOHA above are indicative of the kinds of evidence that can be potentially considered for determining the success of a particular program, with an understanding that these increases in protective factors and reductions in risk factors (both of which may be articulated as short or medium term outcomes) are likely to lead to lower rates of suicide within a community (which is clearly a long-term outcome, and the ultimate goal of any suicide prevention program).[5]

3.3 The Cost Of Suicide

Given the above mentioned difficulties of measurement, assessing the cost of suicide to society, and the 'gain' of suicide prevention in economic terms, can be difficult. While a human life has infinite value, it is useful for funding bodies to be able to quantify their work in terms of costs and benefits. In Australia, "overall, suicide prevention has struggled to gain a foothold in the public health realm, largely because of the perception that it is an outcome with a low base rate" (Knox and Caine 2005). Fluctuations in suicide rates, particularly on an LGA level, are difficult to quantify or 'tie' to a cause.

While the cost of suicide is difficult to measure, the cost of the "psychache" that leads to suicide in terms of lost productivity and drain on the broader health and welfare system is considerable. Social capital can be mobilised to counter this at comparably little cost.

To continue within this paradigm of considering suicide as a health issue, people who are socially isolated (a key risk factor for suicide) are known to have poorer health in general and higher mortality rates (House, Landis and Umberson 1998)[6]. Indeed, there are many compelling correlations between health and social issues; so many, in fact, that the World Health Organisation draw on a 'social determinants of health'

[5] A project logic which unpacks the CORES program is included in Part B of the current evaluation report.

[6] Durkheim was among the first to identify a link between social connection and health status (Cullen and Whitford 2001).

perspective to describe the vastly different health outcomes evident across various social groups, both within and between particular communities. A brief overview of the social determinant of health is provided in the next section.

3.4 Suicide Risk Factors

The Social Determinants Of Health

The World Health Organisation (WHO) has conceptualised adverse health outcomes, including suicide and suicide risk, in terms of a number of social determinants of health. In this context, social determinants of health can be considered elements of a person's life and social setting that can contribute to suicide risk and adverse health outcomes more generally.

The social determinants of health (WHO 2003) approach recognises that illness is related to the social, economic, political and environmental circumstances in which people live. Factors such as income and social status, social support networks, education and literacy (including health literacy), employment, gender, culture and physical ability are seen as the underlying causes of overall health and wellbeing. The workplace is acknowledged as one of the key arenas whereby establishing good social relations can have a beneficial impact on wellbeing.

A few key social determinants of health which have implications for suicide risk are discussed briefly below.

Stress

The WHO report presents both a logical rationale and supportive data demonstrating how sustained high levels of stress[7] are associated with a wide range of health conditions, including 'infections, diabetes, high blood pressure, heart attack, stroke, [and] depression' (WHO 2003: 13).

Social Exclusion

The WHO (2003) present evidence that social exclusion is likely to result from a number of different factors, including absolute and relative poverty, discrimination, stigmatisation, hostility and unemployment. Moreover, social exclusion has in turn been linked to a range of health problems, in particular, cardiovascular disease and other chronic illness. Individuals who do not have good social networks die at two to three times the rate of those who do (Eckersley 2007).

[7] Stress is defined as physical, mental, or emotional strain or tension.

Work

The WHO report presents data which establishes a strong link between low levels of job autonomy and chronic illness, which can lead to depression and hence suicide risk. The correlation between having low levels of control over one's job and higher rates of heart disease escalates substantially if the job also places high demands on the individual and/or if the individual is inadequately rewarded for effort (rewards may take the form of money, status or self-esteem).

Unemployment

Job insecurity and unemployment is associated with a range of illnesses and premature death. Indeed, the WHO data (2003) demonstrates that individuals who are unemployed are more likely to suffer from long-standing illnesses than their employed counterparts. Individuals who are insecurely employed are far more likely to suffer from poor mental health than those who are securely employed.

Social Support

The WHO report also notes that, in a similar manner to social exclusion, individuals who receive less social and emotional support from others are more likely to experience adverse wellbeing outcomes, including depression, pregnancy complications and higher levels of disability from chronic diseases (WHO 2003). Conversely, good social relations have been causally associated with a healthier physiological response to stress, as well as improved patient recovery rates from several different conditions.

Addiction

'Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health' (WHO 2003: 24). Indeed, this notion of a spiraling 'vicious circle' between 'harsh economic, environmental and social conditions' and 'alcohol and drug dependence' is a reoccurring theme in the WHO material. The WHO conclude that therefore, rather than attempting to tackle the issue of substance dependency in isolation, it is vital to endeavour to simultaneously improve the social and economic circumstances of vulnerable individuals, in order to reduce the likelihood that individuals attempt to 'escape' their problems by turning to drugs and alcohol. It is now accepted that comorbidity of a substance abuse issue and mental illness is prevalent.

Risk Factors Associated With Suicide

Having considered those social determinants of health which appear to be related to suicide risk, it is now necessary to undertake a more specific discussion around risk factors associated with suicide. Beautrais (2000) groups risk factors into a number of different categories including:

- Social and family risk factors;
- Individual and personality risk factors;
- Mental health factors;
- Stressful life events and adverse life circumstances;
- Environmental and contextual factors

These risk factors will now be considered in turn.

Social And Family Risk Factors

Low socio-economic status, limited educational achievement, low income and poverty have all been linked to increased risk of suicidal behaviour ((Bucca and Ceppi et al. 1994; Gould, Fisher et al. 1996; Beautrais and Joyce et al. 1998). For example, Bucca and Ceppi et al. (1994) found that the odds of suicide were twice as high among individuals classified as having a low socio-economic status compared with individuals from more advantaged backgrounds. In Australia, research has revealed that there is a strong correlation between poverty and suicide rates (Morrell and Page et al. 2007).

Impaired parent child relationships, poor family communication styles, and extremes of low and high parental expectations and control are all also associated with increased risk of suicide and suicide attempts (Beautrais 2000) and many of these relationship issues are socially determined or shaped.

Individual And Personality Risk Factors

Beautrais (2000) notes that genetic factors may contribute to suicide risk through genetic predisposition to psychiatric disorders associated with suicide. There have been a number of studies involving twins which offer evidence in support of this proposition (e.g. Roy and Segal et al. 1991).

Personality factors that have been linked with suicide and suicide attempt amongst young people include low self-esteem, external locus of control, helplessness, introversion, neuroticism and impulsivity. Beautrais (2000) does however state that, amongst young people, it is often difficult to differentiate between emerging personality factors and behaviours which represent mental disorders, and therefore to determine the extent of co-morbidity between these two sets of risk factors.

Mental Health Factors And Drug And Alcohol Abuse

In her seminal literature review documenting the suicide risk factors in young people, Beautrais (2000) presents compelling evidence from a variety of different sources which suggests that mental health factors are the most important determinant of suicide. Specifically, she notes that there is substantial evidence from both psychological autopsy reports and case control studies which reveal that individuals with affective mood disorders (such as depression), substance use disorders and individuals who demonstrate antisocial behaviour patterns are associated with a substantial majority of suicides. In fact, most evidence suggests that at least one of the above mental health disorders was present in 90% of all suicides.

Stressful Life Events And Adverse Life Circumstances

It is apparent from examining the literature that the majority of people who die by suicide experience an identifiable stressful life event preceding death. Indeed, in a meta-analysis of the literature from studies using psychological autopsy reports, Beautrais (2000) found that approximately nine out of ten suicides were preceded by a stressful life event. The most common events identified included interpersonal losses and conflicts, and disciplinary or legal crises.

Environmental And Contextual Factors

A growing body of literature suggests that media publicity may encourage suicide behaviour. Although Beautrais (2000) suggests that the cause and effect linkage remains somewhat controversial, many studies have suggested that media reporting of suicide may have a normalizing effect of suicide behaviour, particularly amongst young people. This may result in young people developing the perception that suicide is an acceptable means of dealing with life's problems. However, in a separate study by the same author, it was revealed that the vast majority of young people strongly reject the notion that suicide is acceptable. In particular, young men tend to be more disapproving of suicide than young women (Beautrais and Horwood et al. 2004). This is a particularly important finding given that suicide is more common among young men. It is possible that young men's negative attitude towards the idea of suicide serves as a barrier to young men encountering stressful life events to seek the necessary help.

The content of the CORES one-day training educates participants about the wide variety of risk factors that may present in different forms in people at risk of suicide.

3.5 Suicide Protective Factors

Beautrais (2000) noted that there is relatively little research into the types of factors which may assist in insulating individuals from the risk of suicide. Given the risk factors

associated with suicide (e.g. poor coping skills, inability to problem solve, low self-esteem), we can hypothesise that a number of their antitheses (e.g. good coping skills and problem solving behaviours, high self-esteem) may function as protective factors, however Beautrais acknowledges that further research is required into this area.

There is some evidence that various social supports, such as belonging to a social peer group, lessen the risk of suicide (Rubenstein and Heeren et al. 1989) and strong family ties have been linked with a reduction in the risk of suicide-related behaviours. At the individual level, having children is generally associated with a decreased risk of suicide. However the relationship between birth rates and suicide is more ambivalent, perhaps due to other socio-demographic factors (Maskill and Hodges et al. 2005). For example, in countries like Australia, low socio-economic status tends to be associated with both high fertility rates and increased risk of suicide.

Just as social disconnection and isolation is believed to be a risk factor for suicide, strong social networks and being integrated into the community are protective factors (Ministerial Council for Suicide Prevention 2007). Social networks, the social capital they generate and the communities they exist within, as well as being protective factors in themselves, are the space where suicide prevention activities can be most effective. Given its importance as a protective factor, the issue of social capital, is considered in the next section.

What Is Social Capital?

Definitions of social capital are many and varied, from Kawachi's definition of the "features of social organisation, such as civic participation, norms of reciprocity, and trust in others, that facilitate cooperation for mutual benefit" (Kawachi et al 1997: 1491) to the Victorian Government's definition of "the mutual trust and social behaviours that allow and define civic engagement" (reference Melbourne 3030 document). Notions of trust, engagement, networks, shared or social norms, cooperation and social cohesion come up repeatedly among the definitions. The Organisation for Economic Cooperation and Development (OECD) defines Social Capital as the "networks, together with shared norms, values and understandings which facilitate cooperation within or among groups" (ABS 2004 cited in Humpage 2005).

Social capital "is not just the sum of the institutions which underpin a society – it is the glue that holds them together" (quoted in Cullen and Whiteford 2001: 4). Robert Putnam states that "Whereas physical capital refers to physical objects and human capital refers to the properties of individuals, social capital refers to connections among individuals – social networks and the norms of reciprocity and trustworthiness

that arise from them" (Putnam 1993 quoted in Humpage 2005). This creates an energy that can be put to productive use in tackling social problems as they arise.

Social capital then is the combination of intangible social linkages and networks and skills that members of a community offer, which contribute to an overall community resourcefulness and capacity to strengthen from within and meet its own needs. The concept also includes an element of self-sufficiency and sustainability.

Social capital can also be considered to be horizontal or vertical. Horizontal means that it bonds across communities and peers, and vertical means that it links communities to organisations, funding bodies and governments across the usual power divides (Cullen and Whiteford 2001).

High social capital can correlate with lower levels of suicide (Cullen and Whiteford quoted in Stewart-Withers and O'Brien 2006), and in light of this many policy documents now feature as least a perfunctory acknowledgement of its benefit in suicide prevention (Stewart-Withers and O'Brien).

Stewart-Withers and O'Brien (2006) maintain that any approach to suicide prevention needs to reflect the values and beliefs of the culture and community and occur in partnership. 'Grass-roots' support is needed to make it successful. The CORES experience shows that this has been critical to its success and is also the component which distinguishes it most from other suicide prevention programs. This will be discussed further in 6.2.

3.6 Approaches to Suicide Prevention

Mann and Apter et al. (2005), provide the most comprehensive systematic review to date outlining the characteristics, and relative success of, various suicide prevention strategies. The authors categorise suicide prevention strategies under seven main types of prevention strategies, including:

- Education and Awareness Programs (primary care physicians, general public, community or organisational gatekeepers);
- Screening for individuals at high risk;
- Pharmacotherapy treatment (antidepressants, including selective serotonin reuptake inhibitors, and antipsychotics);
- Psychotherapy (alcohol programs, cognitive behavioural therapy);
- Follow-up care for suicide attempts;
- Restriction of access to lethal means;
- Media reporting guidelines for suicide

The authors emphasise that further systematic research is required in order to establish the relative effectiveness of particular interventions. However, they also note that, considering the availability of existing evidence, the interventions with the most compelling empirical support appear to be: physician education, means restriction and organisational gatekeepers. A summary of some of these approaches appears below.

Access To Means

Although somewhat dated now, several studies have found that suicides by particular methods have decreased after the introduction of policies to restrict access to these means. For example, one study which investigated the impact of firearm control legislation in Queensland found that suicides by firearm decreased after the introduction of the legislation (Cantor and Slater 1995). Similar findings were revealed in a Canadian study (Lester and Leenaars 1993). Mann and Apter et al. (2005) note that in jurisdictions where the method of suicide is relatively common, means restriction has often led to a reduction in the overall suicide rate. For example, restricting access to barbiturates in the 1960's in Australia was linked to a decline in the total number of deaths by suicide during this period (Oliver and Hertzel 1972).

Primary Care Physicians

There is evidence from a variety of different settings that mental health education programs targeted at primary care physicians have improved the detection, treatment and management of depression (Mann and Apter et al. 2005). For example, an Australian program which endeavoured to train primary care physicians to recognise symptoms of psychological distress and suicide ideation in young people was found to substantially increase the number of patients recognised as being suicidal (Pfaff and Acres et al. 2001). It is anticipated that responding to depression more effectively, particularly amongst young people, will lead to a reduction in suicide behaviours. The rationale is that a primary care physician is the logical person to screen potentially suicidal individuals, given that the majority of individuals who commit suicide have come into contact with a primary care physician in the month before death (Mann and Apter et al. 2005). Indeed, there is direct evidence from a number of countries (including Sweden, Japan, Hungary and Slovenia) which suggests that efforts to educate primary care physicians have resulted in an increase in the number of anti-depressant subscriptions and declines in suicide rates (Mann and Apter et al. 2005).

Gatekeeper Interventions

Interventions focused around organisational gatekeepers, whose role is to identify at risk individuals and direct them to appropriate sources of treatment, have been

posited as an effective means of reducing suicidal behaviours. For example, a multi-layered gatekeeper intervention strategy in the US Air Force lowered the incidence of suicide in the target population by 33% (Knox and Litts et al. 2003).

In considering the success to date of gatekeeper interventions, Mann, Apter et al. (2005) concluded that 'where the roles of gatekeepers are formalised and pathways to treatment are readily available, such as in the military, educating gatekeepers helps reduce suicidal behaviour' (p. 2071). However, the authors note that more investigation is required into the efficacy of gatekeeper education in non-institutional settings.

In a review of the 156 local projects funded under the Australian National Suicide Prevention Strategy, the major impacts achieved by the more successful projects included one or more of the following:

- Improvements in participants' knowledge about risk and protective factors for suicide;
- Increases in social connectedness;
- Improvements in mental health literacy;
- Reductions in depressive symptomatology (Headey and Pirkis et al. 2006)

All four of these outcomes would certainly appear to be within the scope of CORES, although measuring some of them (in particular, reductions in depressive symptomatology), is problematic, given the 'low-key', 'unintrusive' nature of this particular intervention.

The comprehensive review by Headey and Pirkis et al. (2006) also noted that ensuring that the outcomes associated with the prevention strategy were sustainable beyond the life of direct funding was an issue for many projects. In examining the projects that were most successful in this regard, the authors suggest that there appear to be two paths towards sustainability:

- Embedding the project's activities or resources into an existing service or system in such a way that they continued beyond the funded life of the project;
- Equipping participants with skills and knowledge that they would retain after the project activities had ceased, which commonly occurred in projects employing train-the-trainer approaches (Headey and Pirkis et al 2006)

Interestingly, the discussion of the CORES model outlined in the previous section suggests that CORES appears to meet both these criteria for sustainability. This will be discussed further in Part B of this report.

Community Based Initiatives

The Mann and Apter et al. (2005) review did not explicitly consider community based initiatives, which, in a sense, can be seen as an extension of a gatekeeper intervention to laypeople within the community. A brief discussion of some of the literature which has considered the efficacy of community based interventions is provided below.

South Australian research has found that community based partnerships are vital to the success of suicide prevention initiatives because they:

- ensure community and cultural accountability;
- promote the initiative;
- provide expertise and/or resources that the initiative's lead organisation did not have;
- offer positive role models;
- enable a holistic approach;
- support the involvement of young people;
- support sustainability (Social Inclusion Unit 2007)

The Social Inclusion Unit in SA suggests that "the role and contribution of community partners was vital in strengthening the reach, capacity and success of each initiative in addressing suicide prevention in their local areas, and collectively made a significant contribution to suicide prevention across South Australia" (Social Inclusion Unit 2007: 5).

Community based programs have been described as particularly important for Indigenous communities. Guidelines out of Canada advise that "programs should be locally initiated, owned and accountable, embodying the norms and values of the local/regional First Nations culture…Suicide prevention should be the responsibility of the entire community, requiring community support and solidarity among family, religious, political or other groups. There should be close collaboration between health, social and education services" (Health Canada 2007).

'Community spirit' and the communal nature of many agricultural and rural areas may function as a potential protective factor to individuals at risk of self-harm or suicide, according to Suicide Prevention Australia (SPA) (SPA 2008: 7). The SPA report that according to organisations such as Aussie Helpers and the Country Women's Association of Australia, one of the greatest challenges in attracting people to mental health information sessions and community functions is the fear of social stigma; resulting in a reluctance to attend among those most at-risk and those best

resourced to help (SPA 2008: 7). As discussed in chapter 3, this is one of the reasons why CORES does not view suicide from a mental health platform, and this philosophy carries through from the way the program is designed and run, to how it is marketed and the community response it generates.

Suicide Prevention Australia put forwards a strong argument for a suicide prevention model which is community based. It states that "individuals, such as Rural Financial Counselors, support workers, teachers, sports coaches, and small businesspeople in remote, rural and regional areas, should be provided with the requisite training to independently refer clients in crisis to the most appropriate and available mental health and health care services and resources (while also acknowledging their own stresses and emotive responses to such crises)" (SPA 2008: 9). There would appear to be an extremely strong congruence between this statement by SPA and the suicide prevention service provided through the CORES model.

3.7 Summary

The above literature summary raises a number of issues that are relevant to CORES, particularly the notion of social capital and social isolation as both protective and risk factors (respectively) for suicide and a means by which community based interventions can best operate.

Part B: The Evaluation of CORES

4. Methodology

4.1 Overview Of Approach To The Evaluation

Before outlining the specific methodology that was adopted for evaluating CORES, it is necessary to first contextualise the current evaluation within the 'evaluative methods' paradigm. This 'contextualisation' provides a further means of establishing how the current evaluation has a multitude of purposes, which reflect both the requirements of the current evaluation as outlined by KRC, as well as the nature of the CORES program itself.

There are many different approaches to evaluating a program. Such approaches include, but are not limited to: process evaluations, formative evaluations, outcome evaluations, summative evaluations, utilisation-focussed evaluations and meta-evaluations. The exact approach (or approaches) adopted for any particular program are dependent on a number of factors including:

- the needs and requirements of the organisation commissioning the evaluation;
- the 'status' of the program (i.e. pre-rollout, rollout, established, extinguished);
- the scale and scope of the program (e.g. a single discrete program with a defined target group versus a complex multitude of programs with a varied and only loosely defined target group)

The current evaluation of CORES undertaken by Success Works will simultaneously encompasses elements of a 'process' evaluation, a 'formative' evaluation and a 'summative' evaluation. A brief overview of each of these approaches, and their applicability to the current evaluation of CORES, is provided below.

Formative Evaluations

Formative evaluations are usually undertaken during the implementation of the program to gain further insight and contribute to a learning process. The purpose is to support and improve the management, implementation and development of the program. The evaluators as well as clients are often internal to the organisation. However, increasingly external evaluators are being used to assist key learnings to emerge. The objectivity of findings is often not the main concern, and more emphasis

is put on the direct applicability of results. Operational questions, monitoring of events and to some extent impacts are addressed.

There is clearly a strong formative component with regards to the CORES evaluation. KRC have demonstrated a genuine commitment to refining and improving CORES, and have asked the evaluators to focus particularly on the learnings that have presented during the implementation of CORES across the five DOHA-funded pilot sites. The KRC are very much interested in 'examining the reality on-the-ground' of the CORES model as it is rolled-out in particular communities, with a view of gaining knowledge around how CORES can be customised so that it operates most effectively in a given community.

Process Evaluations

Process evaluations are similar to Formative Evaluations, in that they document the process of establishment and monitor how a project and/or program is implemented. Process evaluation concentrates on what is done within a service or program. However, within a process evaluation, the emphasis is often on whether a particular program has been rolled out according to pre-determined specifications. Consequently, there is a strong emphasis on 'documenting program activities' in a process evaluation, as opposed to the evaluators facilitating learning through the evaluation process (which is more typical of a formative evaluation). Process evaluations measure the activities of a program, the quality of activities and services, and whom the program is reaching.

The 'process' component to the CORES evaluation is clearly around the documentation of the CORES model. Documenting the CORES model, including distinguishing between the components of the model that are 'essential' and even 'non-negotiable' and those components of the model that are 'flexible' and 'customisable', is a critical output associated with the current evaluation.

Summative Evaluations

These are usually carried out when the program has been in place for some time to study its effectiveness and judge its overall value. These evaluations are typically used to assist in allocating resources or enhancing public accountability. The clients are usually external, such as government, program managers and other decision-makers. The objectivity and overall reliability of findings is considered important, and external evaluators are therefore often commissioned to conduct the evaluation. Questions regarding the overall relevance of the program outcomes achieved are addressed in a Summative Evaluation.

Given that the current evaluation has a mandate to examine the impact of CORES across the range of communities in which it has been rolled out, and, more broadly,

to examine the efficacy of the CORES model in general, it is clear that the current evaluation has a strong summative component.

Summative evaluations can be further classified according to the evaluation methods that are utilised. Whilst process and formative evaluations tend to be fundamentally qualitative, a summative evaluation can be predominantly qualitative, predominantly quantitative or can adopt a mixed-methods approach. At its most effective, a mixed-methods approach endeavours to use qualitative and quantitative information in a complementary and integrated manner, with quantitative information typically used to 'summarise and distil' and qualitative information used to 'elaborate and explain'.

The current summative evaluation of CORES is primarily qualitative. Success Works has relied on interviews, focus groups and workshops as the major sources of data for examining the impact of CORES. Whilst some quantitative information is considered, particularly in relation to the scale of the program, the current evaluation falls short of being a true 'mixed methods' approach. The fact that the current evaluation is primarily qualitative in nature reflects a number of factors, including:

- The diffuse nature of the program (typically it is easier to quantify the impacts of centrally administered programs, whereas CORES is relatively decentralised in the short to medium term and almost completely decentralised in the long-term);
- That the benefits of the program are multi-faceted (again, it is typically easier to quantify the impacts of the program with a discrete outcome);
- The logistical and budgeting constraints around administering a large-scale survey to gain an accurate quantifiable picture of the CORES initiative

In summary, the current evaluation will encompass three approaches to evaluation: formative, process and summative. To reiterate, the evaluation is formative in that there is an emphasis on 'wanting to learn what works' and to 'readily apply these learnings'; process-driven in that there is a very definite requirement to 'document the CORES model'; and has a summative component in that there is a need to 'examine the impact of CORES' and to 'explore its overall value as a community-driven suicide intervention program'.

Project Logic

The Project Logic provides a summary of the logic underpinning the initiative. The Project Logic is a visual representation of the relationship between the various components of a program. The components include the program inputs, the program elements (i.e. what is being funded through the program), the outputs of the program and the outcomes expected in the short, medium and long term. The

Project Logic is a schematic representation highlighting the "logic" by which the program is expected to work. The outputs and outcomes identified in the logic model become the evaluation questions which in turn drive the data collection tools. It is worth noting that the Project Logic for the CORES evaluation has been endorsed by key internal stakeholders at the KRC. In summary, the project logic offers a mechanistic, post hoc description of what the logic appears to have been for initiating the CORES program in the first instance. The Project Logic for CORES is displayed on the next page.

Inputs	Activities	Outputs	Short Term Outcomes	Medium Term Outcomes	Long Term Outcomes
Local Community Sponsoring Organisation Local Champion CORES trainers CORES Program Model	Communities hear about CORES (through the media, word-of-mouth etc) ↓ Community Information Session Held ↓ CORES look for a lead organisation in the local community ↓ CORE team/ 'group of significant people' engaged ↓ Team Leaders trained ↓ One day course delivered to community members ↓ Ongoing support to CORE team provided by CORES	Increased awareness of suicide as a social issue amongst course participants - Debunking of myths around suicide - Risk factors and coping skills/ resources identified - Recognising signs and indicators of suicide risk Increased capacity to assess risk of suicide amongst course participants Increased understanding of and competence in carrying out interventions amongst course participants Increased awareness of referral options and support services amongst course participants Strengthened relationships between CORES and local community	Strengthened relationships within the local community Increased support to people in the community at risk of suicide The profile of existing supports for people at risk of suicide is raised Increased number of referrals to support services CORES is established and becomes known in the community	Social capital and networking among community members is strengthened Social isolation is decreased Increased community capacity to address issues of suicide and promote suicide prevention Reduced impact of suicide on local community CORES program is sustained within the community Community participates in a national network of communities focused on suicide prevention	Elimination of suicide in local community Highly engaged and socially connected individuals The community is strong and well-resourced The CORES program is established nation-wide

4.2 Evaluation Questions

In consultation with KRC, Success Works developed a series of evaluation questions. The overarching evaluation question was determined to be:

Is the CORES model effective?

In order to answer this question, there was a need to first comprehensively document the CORES model, a task which was undertaken in Part A of the current report. Having outlined the CORES model, the reader should be able to consider Part B of the current report having a clear idea of what exactly is being evaluated.

As the overarching question which has essentially directed the entire evaluation, this evaluation question will not be addressed explicitly until Part C of this report (which covers conclusions and future directions). However, from this overarching question, a number of sub-questions have been developed. Each of these sub-questions will be considered sequentially in the next chapter under the following headings:

- Raising Awareness of Suicide - *To what extent is there now greater awareness of the risks and social implications of suicide?*
- Strengthening Social Capital and Networking - *Has social capital and networking among community members been strengthened?*
- Reducing Social Isolation - *Has social isolation been decreased among community members?*
- Reducing Suicide - *Has suicide been reduced in CORES communities?*
- The Sustainability of CORES - *Is CORES sustainable?*

4.3 Evaluation Methods And Data Sources

As discussed under the first section in this chapter, the primary focus of the current evaluation will be qualitative. A variety of qualitative research methods have been utilised throughout this evaluation, including a focus group, a workshop, an online questionnaire, interviews with a range of stakeholders and a document review.

The only major quantitative component of the evaluation is the presentation of aggregate data around what CORES has delivered to date across the various communities. This information will be presented before consideration of the evaluation (sub) questions. The primary purpose of presenting the information relating to aggregate data 'up-front' is that it provides some context around the scale and scope of the CORES program.

Focus Group

A focus group was undertaken with members of the CORES team in Kentish. The focus group was organised by staff at KRC, however no staff actual staff employed by KRC attended the focus group. There were six participants in the focus group. The discussion undertaken during the focus group revolved around:

- the reasons why these individuals had become involved in CORES;
- how the program had been established in Kentish;
- the impacts of the program on the members of the focus group and the group's perspective of the impact of the program on the broader community.

Interviews

Face-to-face interviews were undertaken with a number of staff members from Kentish Regional Clinic, including the manager, the project officer and administrative officer. In addition, the Chairman of the Board of KRC was interviewed as part of the evaluation.

In addition, phone interviews were undertaken with 22 individuals across all sites at which CORES is currently operating. The sites included in the consultation are listed below:

- Burdekin
- Central Coast (Pilot site)
- Central Highlands
- Circular Head
- Donald
- Dorset (Pilot site)
- Kentish
- Kingston Huonville (Pilot site)
- Meander Valley (Pilot site)
- West Tamar (Pilot site)

In addition we spoke to a number of people who have had some interest or involvement with CORES but who are not attached to a CORES 'team' as such.

Participants in these phone interviews included both team leaders and other members of the community involved in CORES. All of these individuals who were

interviewed had completed the 1-day training. Phone interviews were also undertaken with the Landline reporter who reported CORES, as well as two state senators (one from South Australia and one from Western Australia) who are advocating for CORES to be expanded into their respective states. A copy of the phone interview schedule is included in Appendix B.

Workshop

A workshop was held in Kentish. The workshop involved three KRC staff, as well as representatives from state and local government, communities where CORES has been operating for some time and communities which were still considering rolling out CORES.

The workshop adopted a strengths-based approach in order to examine how the CORES model operates. During the workshop, the CORES program was discussed at three different levels: at the individual level, the community level and the program level. Specifically, through the sharing of positive personal stories in relation to the CORES program, the workshop participants were encouraged to examine what it was about the individuals and the communities involved, and the program itself that had allowed the positive story to happen. The workshop concluded by examining the sustainability of the CORES model and also discussed possible future directions for the CORES model.

Online Questionnaire

An online questionnaire was sent out to all participants who attended the one-day workshop who provided their email addresses on the program evaluation form. This resulted in approximately 150 individuals being emailed. The online questionnaire asked individuals a single question 'Please tell us a story about a time when you used your CORES training and what the outcome was. Feel free to include more than one story if you like'. Success Works received 20 responses to this email, 11 of which related to an individual relaying a story (or stories) where they had directly utilised their CORES training, 7 which involved individuals utilising the skills they have gained through CORES in some other way and 2 which simply indicated that these individuals had not used their training. In addition, stories were collected through emails passed on to the evaluators by team leaders from some of the CORES sites.

Document Review

The document review was primarily in relation to the qualitative feedback around the one-day training (i.e. program evaluation forms), as well as a brief review of the policies and procedure documents developed by KRC.

5. What CORES has achieved to date

5.1 The Scale Of CORES

	One-Day Courses Held	People Trained In The One-Day Course	Team Leader Training Courses Held	Team Leaders Trained
2009	55	597	9	40
2008	41	462	4	17
2007	10	98	2	9
2006	4	23	1	4
2005	3	50		
2004	6	57		
2003	12	139		1
TOTAL	**131**	**1426**	**16**	**71**

The above table presents information in relation to the number of individuals trained through the CORES program across its seven years of operation. It contains information relating to the number of one-day courses held, the number of people who have been trained in the one-day course, the number of team leader trained courses held, and the number of team leaders trained.

Upon viewing the table, it is evident that the program ramped up considerably in 2008. This was due to a number of factors, including:

- the rollout of CORES in Burdekin (which resulted in 128 individuals from this community undertaking the one-day training in 2008);
- the continuation of the Buloke (Donald) program (which began in late 2007);
- the delivery of several 'ad hoc' packages in 2008, where communities paid for a discrete number of courses (rather than purchasing the full CORES community package).

It is apparent that momentum around the program has continued into 2009, with 55 courses and 597 individuals having been trained in the current calendar year to date, representing a 145% increase compared with numbers for the equivalent period in 2008 (i.e. January to mid-August).

The table above also indicates that 71 team leaders have been trained across the six years the program has been running, with more than half (40) team leaders trained for the year to date in 2009. This suggests that CORES can be expected to expand further in 2010 in terms of the number of individuals who receive the one-day training, given the additional capacity that has been developed during 2009. Importantly, further data indicates that, of the 71 team leaders who have received training, 59 (83%) are still currently active.

Of the 59 team leaders currently active, 10 of these team leaders are based at the pilot sites: 4 in the Meander Valley, 3 in West Tamar, 2 in the Central Coast and 1 in Dorset. As yet, there are no team leaders trained in Kingborough/ Huon. Reasons why the Dorset and Kingborough/Huonville have been slower to 'take off' will be discussed in the following chapter.

5.2 Pilot Sites

Much of the increased activity in 2009 has been the result of the five 'pilot sites' rolling out CORES. These pilot sites, which have had their programs funded through DOHA, include:

- Central Coast
- Meander Valley
- Dorset
- Kingborough/ Huonville
- West Tamar

The process of establishing CORES in each of the pilot sites has been quite different in terms of the 'source' of community interest in the program and the way in which further interest has been mobilised. The funding for the pilot sites was received in October 2008 and CORES was established in each of those communities by March 2009.

Together, for the year to date, 218 individuals have undertaken the one-day training across these five pilot sites. Specifically, 73 individuals have undertaken the training in Central Coast, 51 in Meander Valley, 41 in West Tamar (additionally, 10 individuals were trained in West Tamar in late 2008), 35 in Kingborough/ Huonville, and 18 in Dorset.

This would indicate that Central Coast and Meander Valley have been the most 'successful' pilot sites to date as measured by attendance at one-day training courses. Given the emphasis on filtering the CORES message out through the community via trained community members this may have implications for the

sustainability of these sites. Correspondingly, the program has been less able to gain momentum in Kingborough/Huonville and Dorset.

The pilot sites will be discussed further in the following chapter, however preliminary observations are that the communities that have been responsive to the program are those that had a greater enthusiasm for it to begin with. Where the community is eager for CORES, 12 months is sufficient time to assess its progress, however for other programs that are slower to become embedded a more realistic timeframe for evaluation is 24 months.

The current situation reflects this in that Central Coast, Meander Valley and West Tamar are showing 'good' progress at this 6-month point, Kingsborough-Huonville is gaining momentum, and KRC will next turn its attention to bringing Dorset up to date. Even though some of the pilot sites have been slow to respond, KRC have indicated that these will be ongoing CORES sites and while funds for these sites have been spent, KRC will continue to work with the communities to complete all aspects of the funding agreement and have these as part of the on-going CORES locations into the future.

6. Evaluation Outcomes

As stated above, this evaluation considered a number of questions, the discussion of which now appears below.

6.1 Raising Awareness of Suicide

During the consultations, participants were asked to what extent they believe there is now greater awareness of the risks and social implications of suicide. In order to address this particular evaluation question around awareness of the risks and social implications of suicide, it is relevant to consider the most immediate and tangible output of CORES: the one-day suicide intervention training. Specifically, in order to address this question it is critical to consider both the scope and the perceived efficacy of the one day training delivered by team leaders through the 'train-the-trainer' model.

> *I think CORES is raising awareness slowly, and just having things like posters advertising events around the towns helps. Hopefully over the next couple of years the stigma of talking about suicide will abate and this will lead to more openness about mental health issues as well (Community Member, Meander Valley).*

Efficacy Of The One Day Training: Building Awareness

A question asked of the interview participants was whether the course had in fact improved their awareness of suicide and the response to this was definitely positive. It appears that the *way* in which this education is provided is key to its success.

> *The Program is very competent in raising awareness of suicide and they encourage you to go to websites and do your own broader research which has really opened my mind up to the issue (Community member, Burdekin).*

Learning By Doing

The one-day training course emphasises that adults 'learn-by-doing'; hence the training includes a series of role-plays, and is, more generally, highly interactive in its structure. Adult learning theory shows that adults most effectively 'learn by doing' and is based on the following principles:

- Adults need to be involved in the planning and evaluation of their instruction;
- Experience (including mistakes) provides the basis for learning activities;

- Adults are most interested in learning about subjects that have immediate relevance to their job or personal life;
- Adult learning is problem-centered rather than content-oriented (Conlan, Grabowski and Smith 2003).

This 'learning-by-doing' approach was particularly appreciated by what could generally be described as a highly pragmatic audience. 'Pragmatic' in this instance refers to the fact that program participants tend to be local business people, farmers or individuals employed in the government and community sector engaged in front-line service delivery.

One of the examples of the programmatic approach is a role-play which involves participants generating hypothetical scenarios which involve both 'asking' and 'being asked' the question 'Are you considering suicide?' In these hypothetical scenarios, participants are also required to consider a number of other factors including past suicidal behaviour and the 'when', 'where' and 'how' of the planned suicide (if it is planned).

This role play is effective on at least two levels. First, it cements some of the key learnings from the course in relation to suicidal behaviour (e.g. 'the 40-100 times more likely rule'); undertaking the role-play therefore assists more broadly with building awareness. Second, it allows people to practice 'asking the question', which, although highly artificial, instills participants with confidence to ask the question in a 'real-life' scenario, in part because it assists people in realising that it is not an easy question to ask. As aptly summed up by one particular team leader:

> *The training assists you to recognise the signs of suicide and importantly it gives you the confidence to ask people directly – this is the most challenging thing and the area where most people struggle. Role playing it in the training makes it possible (Team Leader, Circular Head).*

Group Size

Although the actual content of the course is highly suitable to facilitating adult learning, some participants who were trained in larger groups noted that this environment was less conducive to learning, because it is more difficult to ensure that all members of a larger group remain engaged in the material. One trainee interviewed, who participated in a session with 20 participants, suggested that the training groups be capped at a maximum of 15 participants (*Community Member, Burdekin)*. Two more individuals suggested that 10 should be the maximum size for the one-day training.

It should be noted that actual CORES policy is to include in the training between 8 and 15 participants. Consequently, criticism leveled at the size of groups can be seen as more of a policy implementation issue, rather than a policy issue per se. In fact, feedback around the preferred size of the training groups can be seen as an endorsement of the CORES policy of having relatively small groups participate in the one-day training.

Data provided by CORES indicates that the average size of a one day training course is 10.9 participants, which is almost at the mid-point of the desired range (from the perspective of CORES policy). Only 9 of the 131 courses undertaken (7%) had more than 15 participants, with the largest course comprising of 22 participants. According to the data provided to Success Works, there were only 2 sessions where 20 or more participants participated (including the aforementioned session in Burdekin, and a session in South Australia). Consequently, it would appear that 'contraventions' of CORES policy in terms of having larger than desired groups for the one-day training is relatively rare.

Overall Feedback

General feedback around the content of the one-day training was positive. Participants were impressed by the breadth of the material covered, and how much they actually learnt that they didn't know previously about suicide. The myths and facts around suicide, presented at the beginning of the day's program, were particularly well received.

> *The most beneficial part of doing the CORES course has been in receiving education about the myths around suicide – and knowing that talking to people can actually make a difference (Community Member, Central Coast).*

As summarised by one individual interviewed:

> *The CORES program is for any person from any walk of life and offers skills that can be used in a really practical way to undertake interventions with people at risk of suicide (Community Member, Central Coast).*

Team Leader Feedback

The interviews conducted for this evaluation also included team leaders who were trained to deliver the program through its train-the-trainer component.

Team Leaders were generally very positive around the experience of delivering the one day training. They emphasised that the training was very well structured and very simple to administer, and that this was important because it allowed them to effectively communicate with participants. Furthermore, they felt that the content of the training was highly appropriate:

It is a well-directed program directed to teach people to be able to recognise the signs of suicide – it does this very well. The program is not over your head in any sense and encourages involvement from participants during the training. It doesn't pretend to be the be all and end all. They refer to other agencies, like Beyond Blue if people want further information. They are not punching above their weight or pretending to be more qualified than they are (Team Leader, Burdekin).

I am a teacher and have participated in and run lots of different courses. I think the strength of the CORES material is that it is essentially based on one-diagram: The river of risk. This diagram describes the issue in a very simplistic and very accurate manner. I have found this diagram very useful when working with young people, as young people can understand it and identify where they are in relation to the river of risk (Team Leader, Burdekin).

Clear and concise language; recognition that most people learn most effectively when information is presented visually and communicating the importance of clearly-defined boundaries and responsibilities to give participants guidance in their role were all elements of the training material strongly appreciated by the team leaders, as reported in interviews with the evaluators.

Program Materials

In general, participants have been very positive about the material provided in the training course, in particular, the booklet received during the one-day training. Many of the comments made by individuals who had undertaken the one-day training course reinforced this:

I think that the fact that the manual is written from a layman's point of view is a good thing; that is not made up of high-falluting language. I feel that those who wrote it know and understand the issue of suicide (Community Member, Burdekin).

There has however been some mixed feedback around the CORES training manual which team leaders are expected to follow (almost verbatim in parts) when delivering the course. Whilst most individuals have been positive about the language used in terms of being easy for everyone, regardless of their level of education to understand, others have suggested that the team leader's manual is not well structured and therefore difficult to use.

The training manual needs rewriting. It has very poor sentence structure, the language needs revamping and there are still a number of errors and typos. Some of the sections are not explained very well and some of the direction for the trainer is not very well explained (Anonymous Team Leader).

The take-away point from the above quote is that having a clear and simple structure is critical for any program which is designed to be delivered by lay-people through a train-the-trainer model. Overall though, most team leaders highlighted that the training manuals were very well prepared and allowed them as trainers to present material in an organised and professional manner, even when delivering the course for the first time.

The accessibility of the course materials is critical to the CORES message being well received, because if the language were too complex, it would imply that the course had a professional focus, which would likely alienate some of the people who currently feel that they are able to participate. It would also have implications for the type of individual who would likely be willing to volunteer as a team leader.

There was also criticism by some team leaders in relation to particular components of the course. Specifically, two team leaders who participated in phone interviews made the comment that improvements could be made in relation to the way in which the scenarios are introduced and discussed, and specifically the way they are presented to participants.

It is worth mentioning at this point that KRC management are currently in the process of refining the training modules that Team Leaders use to deliver the program. There have been several iterations of refining the course materials which has taken place since the program was first developed. These refinements have resulted in moderate alterations to elements of the course material. Feedback during interviews with some of the long-standing team leaders indicated that the program materials and manuals have improved over time in relation to both their structure and content.

Raising Awareness Of Suicide And The Pilot Sites

In the pilot sites, given the relatively short duration of the program there, and the fact that it takes at least 12 months for a program to be sufficiently established, awareness of suicide was the most noted outcome to date observed by interview participants. The experience of the pilot sites in becoming established has been different to the experience of the other sites, in that the funding was able to be provided from a government source and did not have to be raised by the communities themselves. While some of the communities had already expressed an interest in CORES, others were approached by KRC once they had secured the funding, which has likely had an impact on the interest CORES has generated to date. What this means for this issue of awareness is that some of the community members from the pilot sites participated in the training as an extension of their professional community service roles and therefore were coming from a different 'knowledge base' about suicide than community members from the more established sites whose interest in CORES was more organic.

I was pretty aware of it anyway as a social issue because I'm a nurse but the training was very comprehensive and very understandable and you don't need a professional background to understand it (Community Member, Central Coast).

Nevertheless, all community members interviewed from the pilot sites affirmed that their awareness of suicide and its social implications had been "absolutely" increased, and were confidence that the knowledge would be transferred to their broader community as the sites became more embedded in the community.

To What Extent Is There Now Greater Awareness Of The Risks And Social Implications Of Suicide?

In summary, the CORES program appears to have been successful in relation to raising awareness of the risks and social implications of suicide. This can be gleaned both from the number of individuals who have participated in the one-day training course (over 1400), as well as the very positive feedback which has been received in relation to the course. In particular, participants and team leaders have commended the highly accessible nature of the material presented and the simplicity of the program to administer, as well as the strength of using visual tools and 'hands-on' activities to facilitate learning.

As might be expected, there appears to be a correlation between the length of time CORES has been present in a community and the level of awareness around the issue of suicide.

There was some criticism leveled at the structure and content of the training manuals used by team leaders by a small proportion of individuals interviewed. However, it appears that KRC are highly receptive to this criticism, and, in conjunction with a group of team leaders, are currently modifying the training manual to make it more 'user-friendly'.

Finally, it needs to be stated that the scope of our findings in relation to this question are limited, due to the fact that we only collected data from individuals who participated directly in the CORES program (either in a team leader or participant capacity). Consequently, the broader impact of the CORES program on building awareness of the risks of suicide at the community level cannot be accurately accessed in the current evaluation.

6.2 Strengthening Social Capital and Networking

A consistent finding throughout this evaluation was the importance of the way in which CORES leverages off existing social networks within communities and created new pools of social capital which is then in turn used to generate a variety of

outcomes including social inclusion. The social capital diagram presented in Chapter 2: The CORES Model demonstrates how CORES intersects with and supports social networking and social capital theories.

CORES and Social Capital

The evaluation found that CORES satisfies all the different understandings of social capital. The process via which CORES becomes embedded in a community and the way it is structured around a core team generates social capital. It also links parts of the community together around a common goal in a way in which they might not usually interact. These bonds and the organisational structure generates social capital which is used to make a vertical impact – i.e. to connect individuals in need of services to the services themselves, as well as to influence the decisions of funding bodies and those responsible for investing in communities.

Research has shown that social capital has been linked to numerous benefits for communities, including better health and educational outcomes, improved child welfare, lower crime rates and improved governmental responsiveness and efficiency (Productivity Commission 2003).

More importantly, research has provided evidence that suggests strong communities, or those that are rich in social capital, are able to collectively deal with their problems; identifying issues and taking preventative or early intervention measures before things become too difficult. CORES is one example of this, where the program is known to only work where there is sufficient community interest in driving and sustaining it. Strong communities also provide ways for every member to participate and contribute, thus enhancing democracy and social cohesion (Humpage 2005).

Other issues that arose in the consultations in relation to this issue of social networking and social capital are discussed below.

Regular Team Meetings

Within the CORES program, regular team meetings serve an important function in building social capital. They are a nexus point where the social networks belonging to each of the team members conjoin, and where information and ideas can be exchanged, about CORES and about other issues that matter to their community. The meetings are very important for maintaining momentum for the program and regular communication about how to keep CORES relevant to the community. Meetings can be challenging to organise because someone needs to volunteer to organise them, and most of the team members have a range of other commitments. Anecdotally it appears that most meetings occur after hours, and it can be difficult to get regular and sizeable attendance. Provided there is a 'core' group of regular attendees some fluctuations in numbers are acceptable.

It can also be a challenge to be keep meetings relevant and interesting, particularly where team members are involved in CORES primarily as an extension of their 'professional' lives and where there motivation is not primarily personal. This is not an issue per se, except that people who are already active in their community roles and who might have a number of after-hours commitments may find it harder to maintain their enthusiasm for CORES, particularly after it has been established for some time. If a site is slow to take off, then maintaining enthusiasm for the program in the face of what might appear to be community lethargy or disinterest presents a challenge. This may be the point where the meetings either take place bi-monthly or quarterly, or where the focus of the meetings shifts to primarily social gatherings, for debriefing, or where the group organise guest speakers or other ways of keeping them relevant and interesting.

> *Rather than trying to sustain a high level of involvement, it may be necessary to downscale after the initial package so that people don't get burned out or feel discouraged that they are no longer achieving a lot. It will be important for a core group in the community to assess, target and manage the longer term demand for our CORES product (Community member, Meander Valley).*

The Role of Champions

One of the strongest findings to emerge out of the evaluation workshop held in Sheffield was that community champions are critical for the establishment of CORES in any community. It was apparent from discussions with workshop participants that community champions require a number of characteristics including, energy, persistence and a passion for the issues of suicide prevention, as well as the broader challenges facing rural communities. However, importantly, community champions will generally also be very well 'socially' resourced within their communities, having strong networks which they can mobilize to promote interest in the CORES program. In this manner, community champions and their immediate network provide a 'pool' of social capital which the CORES program can leverage off. However, once the CORES program is established, it in itself generates social capital, through, for example, the regular team meetings described above.

Leveraging Off Community Organisations

Another way in which CORES has both contributed towards social capital and networking and simultaneously leveraged off existing 'reserves' is by connecting with community organisations already established and respected in the community, as has been the case in Burdekin (see case study on pages 57-58). In the beginning stages of getting a new program established, KRC and whoever the local champion for CORES happens to be networks with groups such as Rotary and Lions club (who tend to have strong reputations in rural communities) and also explore options for

networking with other groups or organisations, like sporting clubs, churches and schools. This networking is for the purpose of promoting the program and generating interest in it, and also for exploring different options for delivering the one-day training. CORES can therefore be a means of linking these different organisations and networks together.

Careful consideration is required to ensure that the lead agency/ association/ organisation (where one is identified) is one that has good standing in the community and one that will not restrict the number of people who might be interested in the program, as the following quote demonstrates.

> *We need to get things away from being associated with the church. In some ways the association is beneficial, but it also deters others from indicating interest, e.g. sport clubs, etc., because they are under the impression that it is a 'Christian' group.(Feedback from meeting at Circular Head).*

Word-Of-Mouth

Along similar lines, the evaluation found that most of the promotion for CORES in the various communities has come via word-of-mouth, indicating the strength and relevance of social networks to the CORES model. In many cases, people found out about a program through friends or other community groups they are involved with.

Word-of-mouth has recruited people to participate in the one-day training and to volunteer as Team Leaders or Team Members and once they have done the one-day training interviewees and community members have reported to us that they regularly endorse the program to family and friends.

Word-of-mouth is also a means of disseminating learnings in relation to the one-day training, and therefore in strengthening community awareness around the issue of suicide. People who have completed the training are able to pass on the information they have learnt, for example about the myths and facts of suicide to family and friends, outside the context of an intervention. Although there was neither the time nor the resources in the current evaluation to explore how many individuals' participants of the CORES one-day training had shared their knowledge with, anecdotally this sharing of learnings appeared to happen informally on a regular basis.

Word-of-mouth has also facilitated the intervention process. It appears to become 'common knowledge' around a particular community that someone within their broad social network has been trained either in the one-day training or as a Team Leader, and can therefore be considered a 'go to' person in a crisis situation. Community members reported to the evaluators that they are often regarded or referred to as someone who knows how to help on a range of issues much broader

than suicide, and that they are regularly approached for information about support services or to give advice on how to deal with a particular issue. Community members did state that they are always aware of the boundaries of their role and they are explicit about these boundaries when people approach them. Likewise, when they are approaching someone else they believe to be at risk, they are quick to emphasise 'up-front' that they are not trained counselors and their role is *only* to facilitate access to supports.

> *My workmates know that I am involved with CORES as a team leader – if they needed help, my hope is that they would approach me. But people need to know a little bit about the program and what it is about for this to work – so promoting the program is really important. The more people you know and the more people who know you are involved, the more chance you have of helping someone (Team Leader, Circular Head).*

Strengthening Inter-Community Social Capital

On the issue of social capital and networking, the evaluation identified an area for development in promoting the networking of team leaders from the different communities. Even the pilot sites within Tasmania, although they are quite close together geographically, very much view themselves as separate communities with quite distinct sets of needs. CORES aims to promote networking so that different teams can meet, share their experiences, leverage off and support each other, but to date, and it is still 'early days' for the pilot sites, the bulk of this networking has occurred only through the CORES team acting in a facilitating role.

> *Email networks are difficult to manage and because everyone is spread so far apart in terms of geography, I do not anticipate meeting other team leaders face-to-face. Although, ideally, it would be fantastic to meet, logistically it would be very difficult to get away (Team Leader, Circular Head).*

Strengthening Social Capital And Networking And The Pilot Sites

As stated during in Chapter 2: The CORES Model, KRC's preferred method is to undertake a SWOOP analysis of a community before they agree to launch CORES there. In the case of some of the pilot sites this was not able to happen, and as such two of the pilot sites in particular (Dorset and Kingborough-Huonville) may not have the necessary champions and social capital base to work from in sustaining CORES. Time will tell if this indeed the case, but generally there is a correlation between the amount of social capital and the success of CORES in becoming established and then sustained in a community. While CORES itself builds social capital, it is required to leverage off an established base in order for the enthusiasm CORES generates among participants to be contagious.

Ours is a very diverse spread out area, and I'm not really sure why CORES has struggled a bit to gain a foothold but it may have something to do with the fact that it's an external program coming into the area, and hasn't sprung from the local community (Community member, Kingborough/Huonville).

The degree to which social capital and networking were found to exist during this evaluation varied according to how long CORES had been established within the different communities, with the length of time correlating to the levels of friendship existing among the team members. This was most pronounced in Kentish where the 'team' has known and worked with each other for several years, with some of them founding members. During a focus group held with the Kentish team, the team members reported back how much they had gained from each other's support, and from knowing they could call on each for help or advice on any issue not just restricted to suicide or CORES, which indicates a range of 'side benefits' that CORES facilitates.

Finally, in regard to social capital and networking, it is important to recognise that people do not always define their participation in CORES 'socially', nor should this be an expected outcome of CORES. For the participants in the 'newer' sites, particularly the pilot sites, the social aspect did not appear to be as important. When participants are asked explicitly how important the social aspect of being part of CORES is to them, many CORES team members from the various communities tend to play down its importance.

This is quite likely due to the different ways in which these sites were established, with many of the community members spoken to involved in CORES because it relates directly to their professional working lives which may be in some other sort of human service or local government role.

We get together to train and have become friends as part of that, however it's not that important to me to be sociable because I see it as part of my work (Team Leader, Circular Head).

The social aspect is great in that I have formed so many new friendships. My co team leader and I had not worked together before, but knew each other through Local Government, but we just clicked as presenters and we always have comments about how well we work as a team (Team Leader, South Australia).

This can be contrasted to the situation in Kentish, where the social aspect appears to be more explicitly part of the appeal of the program. While it is not always the case that people are drawn to be part of a CORES team because of the social component, it is reasonable to expect that the combination of broadening their

social circle and drawing support from each other is a motivating factor for many of the participants.

> *I've met quite a few nice people, and with a few you feel that CORES is a bond that will initiate real friendships (Community Member, Meander Valley).*

The point to emphasise here is that over time, in the more established CORES communities, the core 'team' have built strong networks and in many cases friendships through their common interest in CORES and their belief in their community's efficacy. These networks combine to build resilience for those people, including their ability to use each other as supports, to sustain the program more effectively in the community, and to present the CORES message more strongly to the wider community.

Has Social Capital And Networking Among Community Members Been Strengthened?

In summary, it is apparent that the CORES initiative has substantially strengthened social capital on a number of different levels. The initial efforts to get CORES off the ground in a community require a 'base' of social capital (often in the form of a community champion and his or her immediate network), however CORES is then able to grow social capital exponentially through:

- Bringing people together to undertake the one-day training;
- Developing a network of local CORES team members, that attend team meetings and promote CORES;
- Connecting and strengthening links between individuals, and between community organisations, through providing them with a common purpose through which to work together.

One suggestion arising from this evaluation is that further efforts be made to strengthen inter-community social capital, through supporting team leaders from different parts of Tasmania to develop strong relationships. This would appear to be critical to the long-term sustainability of the CORES model. It should be noted that KRC are planning on bringing together all the team leaders from the various sites together for a conference in September 2010. This will clearly be an extremely valuable opportunity to strengthen inter-community networks.

6.3 Reducing Social Isolation

A key aim for the CORES program is decreasing social isolation, which is one of the key contributors to suicide and other forms of 'psychache' or chronic illness (see Part A), all of which create a heavy impost on communities and the service system. This

isolation can be physical in terms of people living in isolated communities or living alone (perhaps grieving the loss of a spouse or their independence) however it can also be metaphysical in terms of people feeling unable to independently seek professional help or reach out for support. The more vulnerable someone is, the least likely it is that they can independently exercise this choice.

The CORES Intervention And Reducing Social Isolation

The issue of social isolation was considered throughout the consultations for this evaluation, and is related to the above question of social networks. Clearly social isolation is likely to be reduced when an intervention with someone at risk of suicide is undertaken. This is meant in the simple sense that many individuals contemplating suicide may either be relatively social isolated and/ or feel that there are very few people who they are able to talk to about their suicidal feelings. Consequently, a sensitive intervention will reduce social isolation even if the individual was not intending to complete suicide. Although it is beyond the scope of the current evaluation to undertake a systematic estimate of the number of interventions carried out by individuals who have done the CORES training, many personal stories of interventions were disclosed to evaluators through the course of the current evaluation. These personal stories are presented in the next chapter.

Other Ways In Which CORES Reduces Social Isolation

In addition to the interventions themselves, it is apparent that CORES can reduce social isolation in other ways. As discussed in the previous section, being part of a CORES team reduces social isolation, as does participating in the one-day training and meeting people that they might not otherwise meet. One participant, for example, flew himself from interstate to Tasmania to participate in a one-day training course in Sheffield, because he realised that he was in fact in CORES' 'target group' as an older retired man living on his own and with no children.

> *When 'less likely' types volunteer to become Team Leaders, we encourage them to do so. They are encouraged to take small steps, depending on what they are comfortable doing (e.g. they may not deliver the one day training 'solo'). We think that it is good for both them and the community when these 'less likely' types volunteer (Manager, KRC).*

A variety of feedback was received around the issue of CORES addressing the 'false' expectations of help-seeking behavior, which is particularly an issue for men in rural communities.

> *The CORES program is aimed at non-professionals – that's its main difference and critical success factor. Some people are loathe to ask professionals for*

help, whereas they'll ask a mate, or accept help from a mate (Team Leader, Central Coast).

CORES normalises help-seeking and provides an avenue for people into health services. Connecting people to services is its primary goal and activity, and is a key factor in reducing social isolation. Consequently, the CORES program includes the identification of local services as a key component of the one-day training, and may suggest that one or more individuals in a group take responsibility for following-up and locating the contact details of all the services brainstormed during the session. The one-day training also identifies which groups of services are most appropriate for the type of intervention – direct, cooperative or non-direct – that is required. It is the general view of the Kentish Regional Clinic that most areas have sufficient local services available, although identifying such services may require individuals to 'think outside the square'.

Amongst local team leaders delivering the program, there are contrasting views in relation to whether there are sufficient local services available. Although these views tended to differ across areas, consideration should also be given to the fact that depending on an individual's personal network and profession, he/she may have more or less knowledge in relation to which services are available in a particular area. Some examples of comments in relation to the adequacy or otherwise of local services is provided below:

I definitely do not think there are enough services to refer people to. There are not many skills services available outside of business hours that could effectively respond in this area (Team Leader, Central Highlands).

Being a small rural community we really struggle. That's why the CORES training is so valuable because it is the conduit between the community and the service providers. People have to travel 80km to a Doctor, sometimes 150 and often to Adelaide 600km away for mental health services (Community Member, South Australia).

Accepting Loss

Finally, undertaking the CORES program often has the effect of reducing the 'psychological' isolation experienced by individuals who have lost a member of their families or close friend to suicide. Although this is not a stated aim of the CORES program, it can have a powerful impact nonetheless. For example:

The 'black funnel' initiative was especially powerful and gave me more insight into how my son must have been feeling before he took his life. While the course was confronting and (for me) emotional, the information and

understanding I gained has definitely helped me in dealing with my loss (CORES training participant, Personal Story).

Reducing Social Isolation And The Pilot Sites

Part of the one-day training course and the intent behind CORES is to educate community members about the services they do have available in their communities for people at risk of suicide. Interviews with community members at the pilot sites appear to indicate that they perceive they have fewer community resources available to them for if/when they need to intervene with someone at risk. Unfortunately we can definitively state whether this is due to the fact the pilot sites do in fact have fewer community services available (and stretching the hypothesis further a sense of doubt about their potential to impact the issue might be one reason for the programs struggling to gain ground in two of the pilot sites), or whether the length of time the program has been established and the numbers of people who have so far been trained corresponds with a lack of awareness of what services are available.

> *I used to think not, but CORES has raised my awareness of options. We have adequate services locally for our needs I would think, and Launceston is not that far away if more extended or specialist help is required (Community member, Meander Valley)*.

> *There are only a few I know about through my other work, but they're all part-time workers so I'm concerned they wouldn't be available when I need them (Community member, Dorset)*.

Has Social Isolation Been Decreased Among Community Members?

It is apparent that CORES has decreased social isolation amongst community members. Most obviously, this occurs when an individual who has been trained in the CORES program intervenes with someone at risk of suicide. However, social isolation is also reduced through other processes which occur around CORES (such as being part of a CORES team).

Additionally, it was discussed how CORES also reduces social isolation through normalising help-seeking behaviours, which allow individuals who may have 'fallen out of' the service system to be 'brought back into it'. A description offered during the workshop was that CORES 'captures' people in the community who might have 'fallen through the cracks' between all the other services available in the CORES communities.

Finally, it was considered how undertaking the CORES program can reduce the psychological isolation experience by individuals who have lost a close friend or family member to suicide.

> *I found coping with my neighbour's suicide very hard. It had a massive impact on me. I felt extremely guilty. Doing the course increased my awareness and helped me to open up and to talk about the situation and my feelings (Community member, Kentish).*

6.4 Reducing the Occurrence of Suicide

Suicide and attempted suicide are difficult to quantify or measure, as discussed in Part A of this report. In Sheffield, where CORES was first established, the occurrence of suicide dropped to only one suicide in the first two years of the program running there, down from ten over the previous three years. However given the intangible nature of prevention, when it is difficult to measure the 'absence' of something and hypothesise the reasons why it may or may not have occurred, this issue of the efficacy of CORES 'on the ground' was approached from the perspective of whether it resulted in successful interventions. As mentioned previously participants were asked to provide their 'stories' about successful interventions through face-to-face consultations, online surveys, phone interviews and the workshop in Sheffield, which provide possible evidence a suicide attempt or completion successfully averted.

While it is impossible to know whether a suicide would or would not have been attempted and/or successful, had the intervention not taken place, without the intervention it would have been up to the suicidal person to seek help themselves, or another 'untrained' friend or family member to intervene, leaving that person at greater risk.

> *What appealed about the program was that it was mainly about interacting with friends - to make a group of people look after their best mates - not about intervening with strangers and this relies on having a rapport with people. Being a man I know that males really don't talk much to each other, they'd rather talk about cars than what's happening in their lives (Community member, Circular Head).*

Whether or not a suicide is averted, having trained and resourced people in the community ready to respond to 'signals' creates an extra buffer of protection that would not exist otherwise.

Importantly, individuals who undertake an intervention and 'ask the question' still feel that this is worthwhile even if the individual responds in the negative. There does not seem to be a sense of regret associated with having asked the question; on the

contrary, having asked the question most individuals get a sense of 'having done the right thing'.

> *I have done one intervention. I have known this guy for a while, and knew he was going through some difficult times. My radar started to go off. So I had a chat with him and ask him the question directly of whether he was suicidal. I felt confident from his response that he wasn't about to go and kill himself. He responded really well to me asking him the question (Team Leader, Kentish).*

A sample of the collection of personal stories gathered throughout the evaluation, where individuals who have completed their CORES training have intervened with an individual at risk of suicide, are provided below. We would like to thank the individuals involved who have shared their stories for the purpose of inclusion in the evaluation report.

> *I completed training in 2008 and this year I had a situation with a student which arose out of the blue and I was able to use my knowledge to deal with this. I had only met the person once at an initial workshop and she disclosed to me that she had recently been admitted to hospital following a suicide attempt related to domestic violence. The following day she rang my workplace and asked to speak to me. The admin staff were alerted by her agitation and called me from class to speak with her. She was very agitated as her ex had located her and was menacing her and she indicated that she was contemplating suicide again. I was able to talk to her using the formula we had learned and worked out an intervention, setting time limits and a backup plan. I rang her again after 10 minutes to ensure that she had the help we agreed she should seek and again after she had time to put some strategies into place. I was amazed that someone that I had only just met had turned to me for help and was gratified that I had the confidence to step in and give the help needed* (CORES training participant, *Personal Story).*

> *My fourteen year old daughter came to me because she knew I had done the CORES course. She told me one of her school friends was suffering from depression and asked if I would talk to her. Upon doing so I learned she was suicidal. I told her I wasn't qualified to counsel her. I recommended she speak to the school guidance officer, which she and my daughter did together. They contacted her parents and she is now receiving counselling. Had I not done this course I would not have been confident to help out or know what to do in this situation* (CORES training participant, *Personal Story).*

> *On one occasion, I was contacted by a friend to visit a young woman from the area who had lost her brother several years ago to suicide and whose mother was very concerned that her daughter was in danger of going down the same path. This young woman has an ongoing mental illness and a recent*

*relationship hicupp had caused her to become very unstable mentally. I called a friend who is also a Team member and together we went out to see her. We were able to ascertain by means of the strategies we learnt in training that she was not suicidal but was in need of help. We transported her to the hospital where she was able to receive the help she needed and she is now back holding down a good job and functioning as well as possible with her mental illness (*CORES training participant, *Personal Story)*.

*Just recently, I was contacted by the Principal of our local High school who knew of my involvement with CORES. I was asked to go out into the country and check on one of the staff who he felt was suicidal. I took a team member with me. On arriving at the property, we found no-one at home and suspected that she may be hiding in the surrounding bush. We didn't feel that we on our own could mount a search of the area so I reported our findings back to the school Principal who contacted the police. She was found safe, but unwell mentally and consequently was followed up by her doctor. Although we didn't get to use our training, in this instance, it was good to know that CORES is recognised as being a valuable resource in our Municipality and members can be called on to assist in the event of people being concerned about a friend, colleague, etc (*CORES training participant, *Personal Story)*.

*I have used my training on two occasions. The first time was with a young bloke who had just been through a relationship breakup and he wasn't happy in his job. He seemed to be handling it quite well on the surface but with the knowledge I gained through my training I picked up that things were not as they seemed. We worked through the process together and when I asked him if he was thinking of killing himself he answered he had been thinking about it. Again sticking to my training we decided together that he needed to talk to a professional to help him sort out his issues. He did it and to his credit he's now going well. The second time was with a middle aged male friend who had just lost his father who he was very close to. Other family problems emerged after his father's passing that he found hard to deal with. After a few chats together my radar went off again and my training kicked in. When I asked him the question, I got a yes. This is not what you want to hear and it is confronting but I knew what to do. He to went to talk to a counsellor and they are working through the issues together. Without my training I wouldn't have picked up the signs as early as I did and, even if I did pick up the signs I wouldn't have known what to do. The training helped me (*CORES training participant, *Personal Story)*.

Reducing the Occurrence of Suicide and the Pilot Sites

Insufficient data was available to systematically examine whether a larger number of interventions have taken place in established sites, as compared with the pilot sites. However, anecdotally, from discussing the issue with KRC, it appears that the longer that the CORES program has been established within a community, the more likely that those community members at risk will approach individuals who are known to be associated with CORES for assistance.

Has Suicide Been Reduced In CORES Communities?

Sufficient responses were received to demonstrate that CORES had in fact averted possible suicides, with a number of people identifying others at significant risk and able to divert them into appropriate services. It is apparent then that individuals are able to utilise the basic skills that they acquired through their one-day training in 'real-life' situations. This is critical and in many ways can be considered the most important outcome of CORES.

6.5 Sustainability of CORES

The sustainability of CORES as a reflection of its effectiveness is integral to the CORES model. Sustainability was discussed during all the consultations, and was both canvassed directly with interviewees and considered by the evaluators overall. Sustainability was considered in two ways: the sustainability of CORES in KRC, and the sustainability of the program within the different sites it is currently operating in. They will be discussed in turn and this section will conclude by discussing the issue of funding and sustainability.

Organisational Capacity of Kentish Regional Clinic

> *The main issue is that they're (i.e. Kentish Regional Clinic) a bit stretched as far as staffing goes. Coralanne seems to spend the majority of her time on the road delivering courses and promoting the program and can be hard to get hold of (Team Leader, Central Coast).*

KRC's organisational capacity came up in the consultations in terms of the rapid growth of the program outstripping their ability to 'keep up' over the past 18 months. The growth of the program is excellent for its exposure and of significant benefit for the communities where CORES has now been established, however it raises issues for KRC management.

The relatively low cost of each CORES program is able to sufficiently cover KRC's day-to-day management costs, however it does not provide any 'fat' in their budget to employ extra staff to work on collecting and cataloguing information about the sites

for example, or working on the protocols and policies that underpin the model. CORES' ability to market itself effectively and gain traction with government support has been hampered by this limited capacity.

Currently, CORES employs Coralanne as its Manager, as well as a new Project Officer (who is currently being trained to visit the CORES sites and assist with training), a casual Team Leader (who assists in a variety of capacities as needed) and two part time administrative staff. The administrative staff primarily field enquiries, answer basic questions, send out information packs about CORES, book venues and arrange the one-day training, handles accounts and finance and all the record keeping. Enquiries from new communities are directed to Coralanne (and soon to the Project Officer) who responds to them in between visiting the CORES sites and conducting the one-day training. Mark has oversight of CORES' finances and management, and primarily liases with funding bodies and other stakeholders about the evaluation.

The functions that currently present the most challenge for KRC are the networking and linking function between the different sites, actively promoting and consolidating CORES, exploring new options for CORES' delivery, and bringing on new staff who can be trained to deliver the course and travel between the different sites. Coralanne is effectively working two full-time roles, as Office Manager and chief Project Officer. KRC might struggle to sustain its work in communities if Coralanne would retire. While KRC is aware of this problem and is actively trying to address it, this is limited by lack of a pool of funds to draw on, and avenues for funding to cover administrative costs is limited.

The sustainability of KRC will depend on it being able to secure funding to increase its staffing capacity to respond to the growth of the CORES program across Tasmania and the mainland.

Sustainability of CORES Sites

From consulting with all the sites at which CORES has been established, it is apparent that CORES is sustainable at the local level, provided that the program is sufficiently 'owned' by a particular community. Indeed, the sustainability of CORES due to community ownership is at the very heart of the CORES model. However, at some of the sites at which CORES has only recently been established, there are still some concerns around local ownership. This relates particularly to the five pilot sites funded through the Department of Health and Ageing. For example:

> *The only issue with the CORES program is that it is driven by Kentish Regional Clinic – and there are not always available on tap. They do their best, but at the end of the day, CORES needs to be locally driven within Dorset (Community Member, Dorset).*

The above quote demonstrates the fact that CORES fundamentally is not a 'hub-spoke' model. Although, in some newly establish sites, such as Dorset, it currently operates in this manner, with KRC serving as the hub, as was discussed throughout Part A.

CORES is better conceptualised as a 'pure' network model, owned and driven by intra-community networks and supported by inter-community networks. It is this latter element that needs to be developed more extensively in order to ensure the program's sustainability into the long-term.

As discussed in section 6.2, one of the components that require further development to strengthen inter-community networks is the network of team leaders. As discussed earlier, due to logistical difficulties team leaders from different communities may not be able to regularly meet in person. Because of these difficulties, efforts by KRC to facilitate a team leader meeting in September 2010 are greatly anticipated and appreciated by some team leaders *(Workshop discussion)*.

It is possible that some team leaders who are comfortable liaising by email may feel that this is a sufficient means of networking. However, it is clear from the interview responses that a significant number of team leaders do not feel that strong networks can be developed which primarily relying on email as their mode of communication.

> *Although people discuss using email, I personally find email networks difficult to manage (Team Leader, Circular Head)*.

Finally, it is apparent that individuals residing in what can be defined as more 'suburban' communities where CORES has been established are unclear as to whether the CORES model can effectively operate sustainably in their community. This was particularly the case in Central Coast:

> *I hope CORES will be sustainable in my community. I feel that CORES may go better in rural communities, because they are more intimately connected. Central Coast is more suburban (Team Leader, Central Coast)*.

Funding

The current cost of the complete CORES community package (see the CORES Model in Chapter 2), is $35,000 per year. Although this is inexpensive compared to the cost of establishing State or Commonwealth-run services in communities, it is still a considerable cost for small communities or organisations. Funding came up in most of the consultations when community members and interviewees were asked what was needed to make CORES sustainable in their communities.

In some communities, for example Burdekin in Queensland, and Sheffield, the funding source has been relatively secure and has given those communities a firm base from which to operate. Although the model is designed to be sustainable, some insecurity

still appears to be felt about whether CORES would continue without funding. Once the program is established in a community, the only ongoing cost required is for the materials for the one-day training, and these can be paid for either by an independent funding source within that community, or by asking course participants to pay a token fee for their one-day training. There was some discussion around the implications asking people to pay for the training might have.

> *I feel that what is needed to make CORES a successful program in our community is to offer the training to community members free of charge. As the years have gone by, the training has become more popular. I feel that making the training available for free has certainly helped (Team Leader, Circular Head).*
>
> *We have delivered training in our community but with some cost to the participant and without any cost. Although either way has not made a big difference to the level of participation, It is more appealing to not have to pay (Community Member, Dorset).*

On the one hand, paying for something gives it an air of legitimacy and seriousness that something that is 'free' does not have, but alternatively if all participants were required to pay then this might be a disincentive for participation. KRC's experience is that CORES works best in communities that have raised the funds themselves, both for the initial up-front cost and for the ongoing cost of materials. Fundraising both generates and reflects a broader community commitment, which has been found to be somewhat lacking in communities that have been passive recipients of government funding. As stated in Chapter 2, KRC only goes into communities where they believe there is a degree of commitment to the program already present, and a reasonable likelihood of it being sustained, however this commitment is harder to measure when funding is being externally supplied and the reality of this level of commitment may not always reflect their expectations.

The ideal situation is that a community will apply for its own funding from the government, and then 'purchase' the package from KRC. KRC has found that it has had to advocate for funding on behalf of communities, who can find 12 month funding-cycles a disincentive to apply for funding for a program like CORES, particularly when 'communities', whether it is community organisations or local governments, may lack the resources to complete funding applications on a yearly basis.

In Sheffield, the CORES team is supported by a fundraising body that is separately managed to KRC, and this has given them a degree of freedom to maintain the program. This may provide a model for other communities in how to continue to fund CORES from within; however sharing information about how to establish this fundraising arm will rely on the networking discussed above.

Sustainability And The Pilot Sites

As referred to elsewhere in this report, sustainability for the pilot sites is likely to be an issue where the sites themselves are lacking the community champions and/or social capital required to market and sustain the program. Also, because the pilot sites were given the funding as opposed to having to fund it themselves (or apply for the funding themselves), this may have an impact on the degree to which community members take up the opportunities presented by CORES.

Sustainability for the pilot sites may also depend on the ability of KRC to assist the sites with strategising how to build momentum and interest, and this relates directly to KRC's organisational capacity. KRC has made a commitment to do this, and foresee that the pilot sites will all ultimately be sustainable, with the main difference between them being a matter of how long it takes to establish this sustainability.

Is CORES Sustainable?

As has been reiterated through this current evaluation report, the CORES model is designed to be sustainable. Consequently, one would expect that once CORES is established within a given site, the program could continue to operate relatively autonomously at the local level into the future, as evidenced by Circular Head, Donald, Burdekin and Kentish. Indeed, there was some evidence of the program's sustainability during the evaluation, particularly within communities where the program was well established (such as Sheffield/Kentish, Burdekin and Circular Head). It is clearly premature to draw any conclusions around the sustainability of the pilot sites, however one would expect CORES to continue in these sites *provided that the respective communities take full ownership of the programs and that KRC has capacity to continue to work with them*.

6.6 Burdekin Case Study

Burdekin is a cane growing region in North Queensland and CORES has had a presence there, predominantly in the town of Ayr, for the last 2 years. CORES was invited to Burdekin after Bob Bermingham from the Burdekin Community Association (BCA) and Peter Shadforth, a businessman from the Sunshine Coast who owns property in Burdekin both independently saw the 2006 *Landline* program about CORES. Peter Shadforth then contacted the BCA to offer to pay for the program if they were prepared to manage it. The BCA then contacted KRC to enquire about running a pilot of the program in Burdekin. CORES was rolled out and has now been refunded 3 times, with Peter Shadforth prepared to fund the cost each time.

BCA has continued to manage the program, with Ross Romeo, a part-time BCA employee and trained local member, acting as a Project Manager for the Burdekin team, and his wage is partly subsidised by KRC. BCA sees its role in the community as

being to provide prevention and early intervention programs for the local community, and CORES fit well within this broader agenda. Like most rural communities, suicide had also been a significant issue in Burdekin, particularly with changes in the sugar cane industry.

The role of the BCA in CORES has been critical to its success. It has meant that CORES has been able to maintain a physical presence in Burdekin that might otherwise have been challenging. The BCA has been able to manage training, provide some of the necessary infrastructure and advertising, and also leverage off the learnings provided by CORES in doing their own work. For example, although not all BCA employees and volunteers have participated in a one-day training course, the knowledge has filtered out so that now BCA is regularly approached by people wanting information about suicide or seeking help with a friend or family member because they have heard about BCA's association with CORES. CORES has filtered out through the Burdekin area in the way KRC intended it to.

One of the team members interviewed for this evaluation said that he himself has used the training twice, and likens it to being "first on the scene at a car accident". The trained team leaders "do what they can" in that moment but there is no pressure or expectation on them to solve that person's problems for them. This indicates that in Burdekin there is a healthy understanding among team leaders of their precise role and how it 'fits' within the broader service system.

BCA are now finding that they are getting interest from professionals and community-members alike as far away as Townsville and have already arranged one one-day training program in Townsville. They average one training day a month and have a steady flow of enquiries. The BCA are assured that as long as they are involved with the program it will continue to run and will be sustainable. So far 209 people have been trained in CORES in the Burdekin region and there are 13 team leaders trained to deliver the program. For every person who completes the training the BCA estimate that there are another 200 people who are able to gain from it.

To summarise, the factors that have made Burdekin a success to date are:

- the patronage of a committed local businessman;
- that the initial interest in CORES came from the community;
- the ongoing auspicing of the program by the BCA;
- a committed team of team leaders and general interest and enthusiasm from the community.

PART C: Future Directions for CORES

7. Future Directions of CORES

Building on the previous discussions, many ideas have been 'floated' throughout the consultations for the future direction for CORES. While it was not specifically within the evaluation mandate to present KRC with options for its future, it is worth reiterating a number of points raised throughout the consultations that have been discussed in various forms above:

- The CORES model combines flexibility with a consistency of framework in such a way that gives it considerable scope for expanding into other forms of 'community' such as schools, workplaces, cultural or ethnic communities or clubs and community associations. The option has also been canvassed of applying the CORES model to other social issues beyond suicide.

  I think that the CORES program, with a little further simplification, would be very appropriately delivered to young people. I feel that the program includes many significant life skills that young people could learn and use (Community Member, Central Coast).

- KRC, provided it can continue to strengthen its organisational capacity, is well placed to look at ways to expand its staffing pool, which might involve taking on Project Officers located within some of its well established sites, such as has taken place in Burdekin, Queensland. Or, KRC might see that it is in its interests to maintain a solid base in Sheffield, with improved capacity for travelling to other sites when this is required.

- Similarly, KRC needs to continue to explore options for secure funding, which might come from non-traditionally 'suicide' funders, given the variety of other benefits CORES brings to a community that the evaluation has identified. Corporate sponsorship is one suggestion that has been made, particularly applicable if KRC looks at introducing the program into workplaces.

- The success of the CORES model largely hinges on solid investment in the program from the communities in which it is established through leveraging off existing social capital, social networks and 'champions' in the form of individuals or community associations with considerable standing in the community. Every community is different in terms of 'what works' in creating community-wide enthusiasm for the program, and KRC are continually reflecting on their learnings in this respect. Documenting these learnings

consistently might assist them in the work they do in the future with communities, particularly if the experience of some of the pilot sites struggling to gain momentum is repeated.

- KRC also needs to look at ways to lift its profile, largely to achieve the above-mentioned goals of securing funding to improve its organizational capacity and to assist the communities CORES goes into to advertise the program. The most successful 'profile raising' activity KRC has been involved with to date was the *Landline* stories in 2006 and 2008. *Landline* has been almost completely responsibility for the flurry of interest in CORES over the past 12 – 18 months. On speaking to the *Landline* reporter who covered the story, it emerged that the CORES story generated the second highest amount of enquiries to ABC following any story.

  Another suggestion for marketing CORES has been to get a high-profile or celebrity patron for the program.

  Jeff Kennett has done a fantastic job for Beyond Blue in Victoria – having a similar high profile figure for CORES would be very worthwhile. The more people that know that CORES exists, the more comfortable people will be approaching people they know are involved in the program for help (Team Leader, Circular Head).

- Finally the networking and 'linking' role of KRC is presently underdeveloped because of time limitations and the rapid growth they have experienced. It has been recognised that there are very dedicated and committed team leaders and community members working in the different CORES communities who would benefit from greater networking with others. KRC is challenged by its resources in this regard but also by the view in some of these communities, who despite what some might consider to be short distances between, view themselves as isolated from other communities with very distinct sets of needs.

  KRC, through its local origins and the breadth of the Manager's experiences, is well placed to think of innovative ways to network the CORES sites together to strengthen the program as a whole as well as benefiting the individual communities.

8. Conclusion: Is the CORES Model Effective?

> *The best thing about CORES is that it is not a government service; it is community based and run; and has a simple but powerful message of hope that anybody can be readily equipped to save a life (Community Member, Meander Valley).*

The above quote aptly describes what is simultaneously most unique and most effective about the CORES model: that it is community 'based and run'. Although many programs describe the importance of community capacity building and community ownership, very few programs base their entire model and philosophy on these principles.

It is evident from the evaluation that the advantages of CORES being community driven are many and varied. The current evaluation has demonstrated that being community driven has made the one-day training program more accessible to lay-people than would otherwise be the case, made the actual experience of being involved with CORES highly positive and facilitated the actual process of undertaking interventions with people at risk. However, perhaps most crucially, being community driven has ensured the sustainability of local programs.

The evaluation can conclude that the outcomes hypothesised in the project logic have been found to occur as a result of CORES. The factors which most legitimise the individual programs and contribute to their sustainability have been discussed, and this evaluation has found evidence to suggest that sustainability will take longer to establish for some of the pilot sites than for others. This is not a conclusive finding however because the pilot sites have not yet been running for 12 months, and as such have barely had time to be established. Despite the sustainability issue, the pilot sites have to date experienced the same positive benefits of social networking and raising awareness of suicide, as well as training people to respond to suicidal intent in others, as in the more established sites.

It is fitting to conclude by considering the comprehensive review of suicide prevention programs by Headey and Pirkis et al. (2006), discussed in the literature review. Headey and Pirkis et al. (2006) note that ensuring that the outcomes associated with various suicide prevention strategies were sustainable beyond the life of direct funding was the major issue for many programs. In examining the programs that were most successful in this regard, the authors suggest that there appear to be two paths towards sustainability:

- Embedding the project's activities or resources into an existing service or system in such a way that they continued beyond the funded life of the project;
- Equipping participants with skills and knowledge that they would retain after the project activities had ceased, which commonly occurred in projects employing train-the-trainer approaches (Headey and Pirkis et al 2006).

CORES would appear to be the consummate program with regards to being sustainable, given that it is fundamentally community owned and driven (and needs to be in order to be effective) and employs a train-the-trainer model. Indeed, it is unfortunate that the CORES program was not well established enough at the time for it to be considered for Headey and Pirkis et al.'s (2006) review; because there is a strong possibility the authors would have considered CORES to be a 'best practice' example of a sustainable community suicide prevention program.

APPENDIX A: BIBLIOGRAPHY

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APPENDIX B: PHONE INTERVIEW QUESTIONS

Team Leader/community member interview questions:

- How did you hear about CORES?
- What was it that appealed to you about the CORES program?
- Can you tell us what activities you've participated in so far?
- Has CORES assisted in building your awareness of suicide as a social issue?
- Do you feel you now understand the risk factors of suicide?
- Do you think you have the skills now to intervene with someone you believe to be at risk of suicide?
- Do you think there are enough services in your community to refer people to?
- Have you used your training? If you have, would you mind telling us about one of the times you have used your training?
- What's been of the most benefit to you from CORES?
- How important has the social aspect of being part of the CORES team been for you?
- What do you think the greatest strength of CORES is?
- Are there any improvements you can think of that could be made to the program?
- What do you think CORES has done for your community?
- What do you think is needed to make CORES a successful program in any community?
- Do you think CORES will be sustainable in your community?
- How is CORES different to other programs on offer?
- Are there any other issues you would like to raise or comment on to do with CORES, or any of the questions I have asked today?

Additional questions for trained team leaders:

- Have you delivered a one-day course?
- How did that go?

- Have you found the support from CORES helpful?
- Have you formed networks with other team leaders across other CORES sites?

Questions for the Misc. list*

- What attracted you to CORES?
- How is CORES different to other programs on offer?
- What do you feel the major benefits of CORES to your community have been/will be?
- Have you faced any obstacles getting CORES established in your community?
- What do you think the real strength of CORES is?

*These interviews will be largely conversational because each person on our interviewee list has quite a different story, however the questions above are a guide.