Community Response to Eliminate Suicide (CORES): a Rural, Suicide Awareness and Intervention Program.

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Background. Suicide is a prominent public health issue in Australia. Men and women in rural areas are over represented in suicide statistics while Tasmania has one of the highest suicide rates in the country.

Context. The CORES program was developed in the small Tasmanian rural community of Sheffield in response to a number of high profile suicides in this area over a short period of time.

Innovation. The CORES suicide intervention program, based upon a community development model, was developed for delivery in rural, community contexts and comprises a suite of activities. It aims to increase the individual community member’s awareness of suicide risk; develop individual interpersonal skills, and to build peer support and awareness of support services. Uniquely, CORES also aims to build and empower communities to take ownership of suicide prevention strategies. Reports from community members confirm increased competence in this area. CORES builds community capital through establishing training teams, creating new connections across communities and linking people with services.

Implications. This study provides support for CORES as a beneficial and feasible community-based suicide intervention program for rural communities. Since 2003, CORES has been adopted by communities around Australia. More than half of the leadership of these groups is still active after a decade in operation, which reflects positively on the quality, outcomes and perceived value of the program.

Introduction

Suicide – International and National Context

Suicide is a global public health problem. Internationally, there are marked differences between countries in terms of policy, trends in suicide rates and profiles of groups at risk of suicide. Against a background trend of increasing global suicide rates (Martin & Page, 2010), suicide rates in Australia have decreased over the last 40 years (ABS, 2012; Harrison, Pointer, & Elnour, 2009). This trend masks the grim reality of approximately 2000 deaths by suicide reported each year, with estimates of 65,000 attempts to complete suicide (ABS, 2012). There appears to be no decrease in suicidal intention, or in the rate of suicide attempts (Large & Nielssen, 2010). There is considerable complexity in trends when examined by state, age, gender and mechanism of harm (ABS, 2012). In New South Wales the suicide trend is decreasing, whereas that for Tasmania appears to be increasing. Men account for the majority of suicides, with those aged 24-49 and 75-85 at greater risk. Female suicide rates remain relatively constant. Suicide rates in Aboriginal and Torres Strait Islander communities and rural and remote communities are greater in number than in urban communities, and tend to be increasing.

Suicide in Rural Communities

Significant health disparities exist between rural and urban communities. In general, rural men have poorer health than rural women and their urban living counterparts (Phillips, 2009). Rates of male
suicide in rural areas of Australia have been increasing, whilst the rate for females has been relatively stable (ABS, 2012). In rural areas of the UK, New Zealand and Australia, the suicide rate for young males 25-40 is 2-3 fold higher than in urban areas, whilst there is no significant risk difference for females in rural and urban areas (Judd, Cooper, & Fraser, 2006; Middleton, Gunnell, & Frankel, 2003). Generally agricultural workers (including graziers, crop farmers, shearsers and farm workers) in rural areas are at greater risk of death due to injury (Phillips, 2009) and suicide (Hirsch, 2006). Overall, the trend for suicide rates in rural areas is increasing, particularly amongst youth and men.

At a national level, people living in rural and remote Australia have poorer health outcomes than their urban counterparts. Poorer health outcomes in rural areas have been partly attributed to fewer health practitioners in rural areas; the time and distance required to get medical attention; the general inaccessibility of services and low population thresholds (Rolley & Humphreys, 1993). Dudley et al (1998) and Judd et al (2006) reported that suicide is more common among men in rural areas and in inland communities with less than 4000 people. This suggests there may be a threshold community size inland from the eastern seaboard where the ability to attract and maintain services impacts upon health. In addition, the ongoing climactic and socioeconomic adversity and natural disasters in rural areas negatively impact upon the mental health of those communities (Tonna, Kelly, & Crockett, 2009). Clearly, however, rural Australia is not a series of identikit towns. The context of rural communities requires closer attention to better understand the health outcomes of each community.

The journey that leads to the contemplation of suicide arises from many factors. It is variable, unpredictable and may not inevitably lead to suicide. “The contemplation of suicide arises from complex interactions of adverse life events, social and geographical isolation, cultural and family background, socio economic disadvantage, genetic makeup, mental and physical health, the extent of support of family and friends, and the ability of a person to manage life events and bounce back from adversity.” (Department of Health & Aging, 2007, p. 10). Risk factors for suicide at the population level include social and educational disadvantage, access to means, and social and cultural isolation (Crawford, Kuforiji, & Ghosh, 2010; Hirsch, 2006). There is a well-developed understanding of the circumstances that influence decision making such as living alone, unemployment and divorce (Kolves, Milner, McKay, & De Leo, 2012). There is also a deepening understanding of factors which protect against suicide – access to GP services, social networks and personal self-esteem and coping strategies (Beautrais, 2000). Holistic suicide prevention strategies act at the levels of individuals, families and communities and aim to decrease the numbers of people at high risk of suicide. They also decrease the mean risk of suicide across the whole population.

**Suicide Prevention Strategies**

The Australian National Suicide Prevention strategy has been evolving since the early 1990s. The first strategies reflected the dominance of the biomedical model and focused on youth (Department of Human Services and Health, 1995) and strengthening the health system and mental health workforce capacity. The most recent framework (Department of Health & Aging, 2007) draws upon an increasingly stronger and richer evidence base, using a population health approach that focuses on strengthening communities as a strategy to prevent suicide. The latest strategy promotes working with communities where suicide risk is greatest. Indigenous, rural and some cultural
community groups were targeted for specific support to link people at risk to community and professional services. The development of the CORES program exemplifies this change in strategy.

Suicide prevention strategies are categorised on the basis of their target and response levels. The Australian framework recognises universal strategies that target the whole population regardless of risk, selective strategies that address populations at risk of suicide, and indicated strategies that target populations at high risk or where suicidal behaviour is present. The two most successful prevention strategies are those that decrease access to the means of suicide (the gatekeeper models) and those that educate health care practitioners (WHO, 2010). Gatekeeper models involve providing suicide awareness and intervention training to people in key roles in communities (e.g. teacher, pharmacists etc) who are able to refer people at risk to appropriate services. Little is known about the effectiveness of gatekeeper models in community settings but more evidence of their effectiveness is emerging (Beautrais, Fergusson, & Coggan, 2007; M.S. Gould & Kramer, 2011; Headey, Pirkis, & et al, 2006; Isaac et al., 2009). Gatekeeper models work best where the gatekeeper role is clear and treatment pathways are well known and accessible (Mann et al., 2005). Universal programs are those which improve the knowledge, skills and attitudes of medical trainees towards suicide prevention (Isaac et al., 2009; Mann et al., 2005). The CORES program aims to achieve both of these strategies through use of community members (who may include champions in gatekeeper type roles - for example, pharmacists or teachers) with a high community profile and knowledge about access to informed community health services.

In this paper we report the history, philosophy and development of the CORES community development/gatekeeper suicide awareness and intervention program, a description of the program and its implementation, and provide evidence for the effectiveness of the program in Australian rural communities.

The History of CORES

CORES began in the rural township of Sheffield in the Kentish local government area in the shadow of Mount Roland, in North West Tasmania. The Kentish region covers some 1200 sq. km with an overall population of approximately 5500, focused mainly in two towns of Sheffield (pop 1000) and Railton (pop 900). The region is supported primarily by farming, tourism and a cement factory. Council performance showed a low rates base with low expenditure per capita on social and community services and community health. The Kentish area suffers significant social disadvantage (SEIFA 945 compared with the Australian mean of 1000) with high unemployment; high youth unemployment; a high incidence of diabetes, obesity, smoking and the lowest life expectancy in the state (Snashell & Reusanna, 2005). In the period 1996-2000 there were 90 suicides in North West Tasmania, including 5 local suicides in Sheffield over a short period of time (Snashell & Reusanna, 2005)(Table 1). This raised concerns and piqued a desire to address health needs within the community in a positive manner. A community action group was formed in 2000 and funds were sought from the Commonwealth Department of Health to conduct a Health Needs Analysis (in 2001, repeated in 2005) which provided an evidence base for finance from the Tasmania Community Fund (2002) to establish the CORES program, and later the Tandara Lodge Kentish Health Centre (in 2007).
CORES: Community Response to Eliminate Suicide

<table>
<thead>
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<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
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<td>20.1</td>
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<td>15.3</td>
<td>14.1</td>
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<td>14.7</td>
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<td>14.1</td>
<td>15.5</td>
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</tr>
</tbody>
</table>


CORES Program Philosophy and Design

CORES is underpinned by a community development philosophy that reflects its history, origins and goals which emerged from cohesive action by a rural community under stress. The community had a strong sense of belief that they could, through local leadership and participation, reflect on problems and build social networks, learn new skills and make a difference to improve the health, wellbeing and strength of the whole community. Consistent with this philosophy (Shaffer, 1989), the aims of this approach were to (i) gather local people in the community to examine and understand their community and suicide myths and realities, and develop solutions; (ii) develop the skills of local people to identify and respond to suicide at an early stage; (iii) engage local people in the delivery of the program; (iv) identify and link people to community and professional support services, and (v) empower the local community to own and manage the program. The explicit adoption of a community development approach for CORES infuses the rationale, development and delivery of the overall program.

Implementing CORES with a Community

The CORES program, based at Kentish Regional Clinic Inc. (KRC), has been implemented with 24 other local governments/communities around Australia. It comprises a comprehensive package to facilitate building community engagement. The goals of the project are to establish and train a local team to lead the program and deliver Suicide Awareness and Intervention Program (SAIP) training for local residents (Figure 1). New communities implementing CORES receive ongoing support from the KRC through structured meetings, training and mentoring for six team leaders, and the delivery of the SAIP training program for 200 residents. Through discussion with the local team leaders, the SAIP training is tailored to local community issues and available health and community service networks. The KRC also facilitates communication with the public through social media and supports networking amongst team leaders from communities around Australia.

Community engagement and ownership of CORES is critical for its long term success when adopted by new communities. Internal evaluation and a review of Australian suicide prevention strategies (Headey et al., 2006) has informed the ongoing development of community engagement processes. The KRC visits the community to conduct an analysis to assess five key components (i) a sense of community; (ii) a desire for the program; (iii) a capacity to manage and develop the program; (iv) a clear focus on goals and outcomes, and (v) the dedication to undertake the work to achieve those goals. A strong and well-established community based organisation with sufficient financial, management and organisational capacity is an ideal sponsor.

Community consultations are held in the early phases of establishing a new CORES program. This aims to uncover local health issues and concerns, factors associated with suicide, barriers to accessing help and knowledge of help seeking behaviours, and available resources and support.
CORES Suicide Awareness & Intervention Program

services ("service mapping") within the community. The community is encouraged to review available statistical data and health service reports as part of a needs analysis and review. This information is used to inform the local intervention training program. During this process the CORES team continues to evaluate the potential organisational and community support for the program, and individuals with leadership potential for managing the program and training. Even when communities are not in a position to support the program, CORES endeavours to maintain a loose relationship to support their access to other relevant services.

![Diagram](Figure 1. An overview of the CORES program inputs, outputs and outcomes (SuccessWorks, 2011).

**Description of the One-Day Suicide Awareness & Intervention Program (SAIP)**

The aim of the training program is to increase the ability of local community members to identify people at risk of suicide, assess immediate risk through structured conversation and facilitate help-seeking behaviour through the identification of support services. The outcomes and content of the 1-Day SAIP (Figure 1) are consistent with best practice guidelines (Kelly, Jorm, Kitchener, & Langlands, 2008) and national guidelines espoused in the LIFE Framework (Department of Health & Aging, 2007) tempered by the KRC community philosophy and supported by a manual and resources. The SAIP is delivered by two trainers to a small group of 10-15 participants in a manner that draws upon lived experience and promotes active participation. This also allows for one trainer to support any individual who may have an emotional response to the training because of prior exposure to suicide or other issues, thus maintaining a supportive and safe environment.

The SAIP commences with a welcome and brief introductions, followed by a small group discussion about ground rules and the importance of personal safety and confidentiality. A significant amount of time is spent discussing suicide myths and statistics and answering questions. This Q&A period provides a neutral zone for conversation before an open invitation for participants to introduce themselves, and any in-depth introductions. This is followed by morning tea, thus promoting a positive and friendly dynamic within the group.
The body of the SAIP focuses on four elements – (i) understanding a suicide journey through the use of a river and dam analogy as an illustration; (ii) the experience of “funnel vision”, (iii) the tools and resources for interventions including the ABCD Assessment and (iv) role play of an intervention. The ABCD Assessment acronym stands for Ask, Behaviour, Current Plan and Dam. The training regularly emphasises the limits and possible outcomes of any intervention, but it also emphasises that if the person contemplating suicide is sitting there talking to you, they do not want to die, they just feel that there is no other option.

<table>
<thead>
<tr>
<th>Key learning outcomes of the 1 Day Training program</th>
<th>Key topic areas of the 1-Day Training program</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Raise awareness and knowledge of suicide: risk factors, signs and indicators, diversity of pathways, protective factors.</td>
<td>• Debunking and addressing myths about suicide</td>
</tr>
<tr>
<td>• Develop skills and confidence in communicating with individuals who may be at risk of suicide</td>
<td>• Presenting and discussing facts about suicide and analogies that illustrate risk.</td>
</tr>
<tr>
<td>• Apply a framework to assess an individual’s risk of suicide</td>
<td>• Signs and indicators of suicide</td>
</tr>
<tr>
<td>• Increase awareness and knowledge of local resources and support services to facilitate help-seeking behaviour</td>
<td>• Risk assessment</td>
</tr>
<tr>
<td>• Establish a network of individuals for personal and professional support</td>
<td>• Interventions and limitations of your role</td>
</tr>
<tr>
<td>• Reflect on personal motivation for involvement in the SAIP program and limitations of role.</td>
<td>• Community resources and support services</td>
</tr>
<tr>
<td></td>
<td>• Scenarios and role plays for application of knowledge and development of skills.</td>
</tr>
</tbody>
</table>

Table 2. Key learning outcomes and topic areas of the SAIP program.

The concept of a journey towards suicide is grounded through use of a visual image of many tributaries flowing into a river which then reaches a dam wall. The tributaries represent the stresses and struggles experienced by most people. The “dam wall” represents those positive aspects of life (personal strengths and skills) that prevent people from committing suicide (Rapp & Goscha, 2012). This image is a central element of the program – it is used by trainers to illustrate the processes that may lead an individual to contemplate suicide and a more complete understanding of this is gained as community participants practice and learn experientially during an intervention role play. This concept also enables the caregiver to demonstrate to the person at risk what has been happening in their life. This scaffolding of understanding is always well represented in positive feedback and participants report grasping the concepts more fully through the reiteration of the model.

Understanding of the journey is developed further through the use of the experience of “Funnel Vision”. Participants look through a funnel to experience the narrowed perspective of someone who can only focus on ending their life, and see how this view of hopelessness and inevitability (Davidson, Wingate, Rasmussen, & Slish, 2009) prevents someone from seeing the positive things they have in their life. The participants are asked to look again through the funnel from the narrow end as an illustration of how the course will enable them to help “turn the funnel around” and show the person at risk that there are other options than suicide. This is the most powerful part of the
program as it assists greatly in the understanding of what it is like for an individual contemplating suicide. To reverse the vision from a narrow focus on suicide to broader one focusing on life is the goal of the ABCD intervention.

The third element is the ABCD intervention followed by scenarios that bring all parts of the training together. Participants learn how to A – ask the person at risk if they are considering suicide; B – assess for past behaviours, experiences, thereby gauging the level of risk but also identifying personal strengths and skills that will help the person move forward (Rapp & Goscha, 2012); C – understand if the person at risk has a current plan for suicide and D – (the “dam”) try to ascertain what it is that is keeping those at risk alive and how they managed to cope with their stresses and struggles before the present instance. Participants apply their learning and new skills through the use of examples, scenarios and role plays. They explain and demonstrate how to recognise a person at risk, how to assess risk, and how to assist the person by referral. The final part of the role play is where the person at risk and the support person work to identify strengths and coping skills that may have once been in place, but have been forgotten about. Identifying these help the support person (a participant) “turn the funnel around” for the person at risk. Community members work in pairs through the role play, supported by the trainers. The small group environment ensures that there is sufficient quality interaction between participants to build professional relationships amongst the team.

The day concludes with a circle activity. The final activity involves having the participants stand in a circle whilst a ball of wool is passed from person to person. The Team Leader holds the end of the wool, saying a few words about the day and inviting the participants to do the same once the wool has reached their hands. By holding onto the wool and having it traverse across from person to person, a web of wool is produced. The Team Leader explains that this is a network that joins all participants and leaders altogether and that all in the circle are able to help one another if a situation arose that required it. This activity helps participants to understand that they are not alone and anyone that they have met through the day can assist them if needs be.

The SAIP places an emphasis on knowledge about suicide and safety for community members. In the absence of other risk factors for suicide, current evidence suggests that such thinking by itself is not a risk factor (Beautrais, 2000). However, for a small group of individuals, suicidal thinking can become uncontrollable and persistent, and when associated with other mental health problems, may indicate a serious risk of suicide or suicide attempt (Beautrais et al., 2007). CORES acknowledges that not all suicides are preventable (Walter & Pridmore, 2012). It strongly suggests counselling and support for those cases where participants have used their SAIP training, but the suicide was completed regardless of this.

**Team Leader Training Program (TLTP)**

The success of CORES depends significantly on the team that manages the program, delivers the SAIP training to community members and works to ensure its ongoing presence in the community. Team Leaders must have leadership potential with significant time, motivation and profile within the community to support the governance and management of the program. They must understand the community in which they are working, and have an informed understanding of the health and support services in their community. In addition, they require a capacity to learn about suicide and
to develop interpersonal communication skills for the successful delivery of the 1-day SAIP. CORES works with the local community to select the best group of Team Leaders with a balance of skills suited to the successful embedding of the program within the new community. Team Leaders are selected on the basis of responses to an Expression of Interest letter.

The TLTP is a 4-day experiential program (the Train the Trainer Course) for a maximum of 6 people, based upon adult learning principles of reflection, application and role play. This program consists of the completion of the one day program as a participant prior to training, followed by three days of learning how to deliver that program and delivery of a 1-day program under supervision. The TLTP unpacks the program philosophy and rationale, includes specific content about mental health and suicide, and develops the micro teaching and communication skills necessary to deliver the program in a safe and supportive environment. During this time all participants are required to take turns delivering the course, in parts, to their fellow trainees. The final requirement of this program is for the trainees to deliver two one day courses under the supervision of the Team Leader Trainer. Team Leaders are supported as a community within CORES. Quarterly face to face team leader meetings are held around Tasmania, usually centred on a guest speaker (e.g. Standby, Men’s Health) or professional development activity. Networking, information sharing and updating of resources by Team Leaders is facilitated by these meetings and the use of the secure zone of the CORES website.

**Program Evaluation**

Over the last decade CORES has been evaluated through ongoing informal feedback and internal review, and external evaluations directed against the project logic. Informal feedback has been gathered after training sessions and team leader meetings have focused on quality assurance and monitoring implementation. Routine training evaluations were done by pre- and post- training surveys and follow-up questionnaires. These related to previous knowledge and training in regard to suicide awareness and intervention; to the level of comfort in talking about suicide to people who may be at risk; and to confidence in the ability to provide appropriate assistance to people who might be family members, friends, colleagues or strangers. Follow-up email questionnaires, interviews and focus groups and the CORES website have sought feedback from participants on their use of knowledge and skills developed through CORES. Two external reviews have used quantitative and qualitative data gained through surveys, interviews and focus groups to address the key program outcomes.

**Benefits of the CORES program**

**Reaching Rural Communities and Decreasing Social Isolation**

Since its inception in 2003, the CORES program has been adopted by Tasmanian and interstate rural communities. In Tasmania, fourteen regional councils (Kentish, Central Coast, Meander Valley, Dorset, Kingborough and West Tamar) have taken up CORES delivering 247 SAIP training courses to 2803 individuals in Tasmania, and 43 Train the Trainer courses which have trained 157 team leaders. Nationally, the program has been rolled out in ten other regional communities e.g. Innisfail, Townsville, Ingham and Burdekin (Qld); Donald and Hay (Vic), Riverland and the Eyre Peninsula (SA). Over the last five years, CORES has delivered 408 one-day SAIP courses to over 5000 individuals (2014 data), with 43 Train the Trainer programs for 157 team leaders of whom 87 remain active in their community (see Table 3).
Table 3. Scale of CORES program operations in communities across Australia

<table>
<thead>
<tr>
<th>Year</th>
<th>Community Sites</th>
<th>1-Day Courses</th>
<th>People trained</th>
<th>Team Leader Courses</th>
<th>Team Leaders Trained</th>
<th>Total 2012 Active Team Leaders</th>
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<td>43</td>
<td>157</td>
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The intervention element of CORES also aims to decrease social isolation through dialogue, consideration of suicide risk and referral for assistance i.e. normalising help seeking behaviour. A sensitive intervention can decrease social isolation as individuals share their circumstances. Six months after completing 1-day SAIP training in 2011, 10 trainees across two sites reported that they had applied their skills in their community. Since 2010, there have been over 900 recorded interventions where a trained individual engaged with another person at risk of suicide, specifically using their CORES based skills. Focus groups and interviews with trainees revealed that many of them believe that their conversations about CORES were creating change within their community.

**Increasing Community Engagement and Development**

The effect of CORES on local communities can be evaluated through the ways in which CORES has built social capital. CORES has been continually operating for nearly a decade in Sheffield, supported by local government funding, regular fund raising events in the town and external grants. Monthly meetings and annual meetings have been held since its inception, with strong attendances at annual meetings. The program has a high profile in the township, supported by a committed executive team of people with new blood refreshing the executive every few years. By supporting health and social needs analyses, CORES has advocated for social and infrastructure development and improvements in health care in the region. CORES has trained five team leaders in Sheffield, all of whom are still active, and over 300 people have attended 1-day SAIPs. The CORES program has a high profile through the relationships it has built between service organisations, businesses and schools, religious and sporting groups, resulting in links between individuals and families across social and geographical boundaries. Feedback gained from the community through surveys and focus groups (Snashell & Reusanna, 2005) show consistent strong support for the program through perceived benefits.

There is a similar pattern of community engagement in Townsville, North Queensland, where CORES began in September 2010. CORES was sponsored by local businesses who provided funding, office
space and vehicles, and local media outlets and service organisations (particularly Rotary) across the region continue to support fundraising initiatives. It is wholly supported through community based funding. Through its education activities, CORES has trained 39 team leaders (aged 16-80) and provided SAIP courses to more than 1400 people. There are 350 reports of trainees using their SAIP skills with individuals in their community. The program has created new relationships between councils, businesses, the university, private and public schools, sporting clubs, employment agencies, disability services and neighbourhood centres through the nearby regions of Burdekin, Hinchinbrook, Innisfail and McKinlay/Cloncurry. Many of these organisations now provide material support for CORES through advertising and access to training rooms. A key element of CORES in the region is delivery of the SAIP and linking people with mental health support services. This same pattern of community engagement is seen with CORES’ presence in other regions across Australia.

Discussion

In this report, the value and success of the CORES program is discussed here against two broad domains - evidence-based design and development, and success in terms of its uptake and impact.

SAIP Design, Development and Outcomes

Philosophy

The community development approach adopted by CORES in 2003 was somewhat ahead of its time. There is increasing evidence that community development is an essential pre-requisite step in the development of new health services in communities (Seebohm & Gilchrist, 2008; Taylor, Wilkinson, & Cheers, 2008). The approach used by CORES - linking with existing health and service organisations and developing ownership and skills within the community to maintain the program (e.g. through the TLTP) have since been identified (Headey et al., 2006) as key practices for successful and sustainable community health programs. The LIFE Framework (Department of Health & Aging, 2007) emphasises an evidence-based approach to the design of suicide prevention programs. The implementation of CORES aligns with the LIFE Strategy by delivering on the five key areas identified by LIFE - building individual resilience; improving community strength, using a co-ordinated approach, providing targeted activities, and implementing proven remedial standards. Gould & Kramer (2001) suggests that the purpose of training is “to develop knowledge, skills and attributes to identify people at risk, assess levels of risk and manage the situation and refer when necessary”.

The outcomes of CORES are similar to the goals of the most effective gatekeeper suicide programs (Isaac et al., 2009) and recent Australian mental health training initiatives (Headey et al., 2006), including those utilised in drought and disaster affected rural areas (Hart, Berry, & Tonna, 2011; Wade et al., 2013). Comparisons between trainees pre- and post-SAIP surveys show significant improvements in awareness and knowledge of suicide, confidence in raising suicide discussion and when and how to refer someone.

SAIP Content and Activities

The structure and key activities used within the 1-day SAIP developed by CORES reflect present public guidelines and research on effective gatekeeper suicide prevention programs. These programs (Isaac et al., 2009) are also organised on a five-part structure: Preparing, Connecting, Understanding,
Assisting and Networking. Guidelines for the public on assisting individuals contemplating suicide were developed through consensus with health professionals and people who have been suicidal (Kelly et al., 2008). The SAIP specifically addresses key issues for assisting individuals contemplating suicide: recognising the signs of distress, interpreting those signs and taking action by including them in role play scenarios. The ABCD intervention used by CORES is lay focused, and analogous to that of ALGEE (Approach/Assess/Assist, Listen, Give, Encourage help seeking, Encourage self-help) used in Mental Health First Aid (Kitchener & Jorm, 2007) and the LINK framework (Look for possible concerns, Inquire about concerns, Note level of risk, and Know referral resources) used by the US Airforce program (Isaac et al., 2009).

Participants responded positively to the repeated use of the river analogy in teaching, explaining and intervening through role plays. The novel use of the funnel vision experience illustrates for participants the sense of entrapment, impaired perspective and inability to see a positive future reported by rural farmers in the UK (Ni Laoire, 2005). The active learning strategies utilised in CORES are also consistent with those reported from the most effective suicide awareness and intervention programs (Pisani, Cross, & Gould, 2011). The program materials were rated highly, with particular comments made about their accessibility for a lay audience. This reflects CORES efforts to write materials in a straight-forward manner to accommodate the range of health literacy levels in rural areas.

**CORES Uptake and Sustainability**

The key to success with CORES is community engagement. CORES aims to strengthen communities through activities that link both individuals and groups across service organisations, schools and sporting teams. CORES has also promoted inter-community networking across the country and amongst training teams so that communities can learn and support each other, and free capacity within CORES to continue work with new communities. CORES has been specifically engaged in some communities after drought or natural disasters because it strengthens community leadership and it has a focus on community development rather than service delivery. The presence of active community leaders and community organisations is key to CORES’ ability to work with communities. Not all communities are able to engage and sustain CORES. In several communities suffering a combination of drought, industry restructuring and/or downturn, business closures and increasing unemployment, service organisations and key community leaders have been overwhelmed and unable to take on further work to embed CORES. Today, CORES remains active in 15 Australian rural communities.

Another reflection of CORES success is its longevity and continuing interaction with community members. CORES has provided SAIP training to over 5000 people in 24 communities around Australia since 2003, making it one of the largest and long running programs of its type in Australia\(^1\). Other rural mental health initiatives launched in response to drought and natural disasters in Australia have been service-focused and short term (Hart et al., 2011; Wade et al., 2013). The CORES program builds upon existing community networks and organisations to form new relationships between them to achieve its broader goals e.g. linking service clubs with sporting clubs and school groups. In addition to creating new networks, it also connects individuals together in pursuit of a

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\(^1\) Figures updated: 5200 in December, 2013.
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common goal (e.g. via the 1-day SAIP), and also links people with services. This level of networking takes years to build. In 2012 more than half of CORES trained team leaders over the last decade were still active in their communities providing support and further SAIP training even though CORES has moved from active community development to a support phase in many of those regions. Their longevity is a reflection of CORES’ community development philosophy.

Researching Community-based Approaches to Mental Health

The next challenge for Kentish Regional Clinic, is establishing the value of CORES and its impact on rural mental. The use of community based approaches for mental health promotion challenges program managers to select carefully between measures that are valued by health professionals, but also reflect community engagement and concerns, and individual clinical and social outcomes. Evaluative models need to align with program goals, but also to address community outcomes as well as those of individuals and the broader society. (Sainsbury, 1976). Furthermore the complexity of the suicide phenomenon and nature of community gatekeeper suicide prevention programs challenges effective evaluation and research (Mann et al., 2005). Major gaps in our knowledge of community based gatekeeper programmes are identified in the literature. CORES has a significant base of engaged communities, trainees and team leaders from which evidence gain be gained to address these shortfalls.

Conclusion

This study provides support for CORES as a beneficial and feasible community-based suicide intervention program for rural communities. Reports from community members confirm increased competence to recognise individuals at risk and respond appropriately with dialogue and referral. CORES builds community capital through establishing training teams, creating new connections across communities and linking people with health services. Since 2003, CORES has been adopted by 24 communities around Australia, reflecting the quality and perceived community benefits of the program.

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