Valuing young lives

We cannot afford to be self absorbed. We cannot afford to pursue our work narrowly, unaligned or isolated from other disciplines and from citizens, too complacent or too busy to generate a poem, a vision, a multi-leveled and multidisciplinary strategy, for our complicated times. All our children need us to do this, and more.

Valuing young lives

Evaluation of the National Youth Suicide Prevention Strategy

Penny Mitchell
Foreword

The Australian Institute of Family Studies was commissioned by the Commonwealth Department of Health and Aged Care to evaluate the National Youth Suicide Prevention Strategy, which ran from 1995 to 1999. This report aims to identify lessons from the Strategy to carry forward for the future.

During the 1980s and 1990s, rates of suicide among Australia’s young people became a focus of both community and government concern. In response to these concerns, State and Territory governments began developing strategies aimed at identifying ‘at risk’ young people and locating programs and initiatives within frameworks appropriate to their needs. The National Youth Suicide Prevention Strategy represented the first attempt to provide a nationally-coordinated approach to youth suicide prevention throughout Australia.

In publishing a set of guidelines for the development of national suicide prevention programs, the United Nations (1996) recognised suicide as multi-factorial and multi-determined in origin, and recommended a multi-faceted response. In keeping with United Nations recommendations, the Strategy funded a range of projects within a public health framework guided by panels of experts and community representatives. Development and implementation of the Strategy included broad consultation and research.

In keeping with internationally accepted principles of best practice, evaluation was built into all aspects of the Strategy. Each project funded under the Strategy had an evaluation component, and the Australian Institute of Family Studies was charged with the responsibility for the overall evaluation of the Strategy.

The Australian Institute of Family Studies, through its research and information activities, seeks to enhance understanding of the factors that affect family wellbeing and stability in Australia. The suicide of a young person is a devastating experience for the surviving members of the families concerned. We hope and trust that our evaluation will contribute to enhanced public policy and practice to inhibit the tragic loss of young Australians in our society.

David I. Stanton
Director
Australian Institute of Family Studies
June 2000
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Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy was written by Penny Mitchell, Research Fellow attached to the Youth Suicide Prevention Project at the Australian Institute of Family Studies. The evaluation was carried out under the general direction of Judy Adams, Manager of the Youth Suicide Prevention Project at the Australian Institute of Family Studies. The evaluation was originally guided by the late Dr Harry McGurk, Director of the Australian Institute of Family Studies from 1994 to 1998. Harry was greatly concerned for the welfare of young people and their families, and deeply committed to tackling the problem of youth suicide.

The work was funded by the Mental Health Branch of the Commonwealth Department of Health and Aged Care. Preparation of the report was overseen by the Evaluation Steering Group of the National Advisory Council on Youth Suicide Prevention. This work would not have been possible without the dedication of the staff, managers, and evaluators of the National Youth Suicide Prevention Strategy projects; the contribution of clients who participated in evaluation activities; and the commitment of the Evaluation Working Group who provided advice and support to the evaluation of projects funded under the National Youth Suicide Prevention Strategy.

Thanks are also extended to those organisations that participated in oral consultations and completed the stakeholder survey.

The author would like to thank the following individuals for valuable support, input, and critical comments on draft sections of the report: Judy Adams, Pierre Baume, Peter Bitmead, Peter Brann, Jane Burns, Dermott Casey, Michael Dudley, Sara Glover, John Howard, Deb Howe, Norm Kelk, Nick Kowalenko, Christine McCarthy, Steve McKinney, Meredith Michie, Ross Millward, Lucio Naccarella, Jonine Penrose-Wall, Lesley Roxbee, Suzy Saw, Alison Stanford, John Toumbourou, Jacqueline Vajda, Graham Vimpani, and Meredith Williams.

About the author

Penny Mitchell (BSc, MPH) is a Research Fellow at the Australian Institute of Family Studies where she has worked on the National Communications Project and the Evaluation of the National Youth Suicide Prevention Strategy since March 1998. Penny has worked as a researcher in psychology, public health and mental health since 1987 with a focus on service development and evaluation research, transcultural mental health, and youth suicide prevention.
The Summative Evaluation of the National Youth Suicide Prevention Strategy, which was conducted independently by the Australian Institute of Family Studies, is published by the Institute in five separate reports.

**Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy** provides an overview of the Strategy, what the Strategy achieved and what was learned from the Strategy as a whole. The report includes administration, policy context, conceptual basis and a description of activities within each of the main approaches adopted by the Strategy. It presents the evaluation methodology and a summary of major achievements and good practice findings.

Detailed information about what was achieved and learned by projects within each of the particular approaches adopted by the Strategy is presented in a series of supplementary technical reports. These reports present the results of a comprehensive qualitative meta-analysis (or meta-evaluation) of the evaluation reports of the National Demonstration Projects funded under the Strategy.

**Supplementary Report: Volume One** is entitled *Building Capacity for Life Promotion*. It describes the Strategy’s system level activities which aimed to build capacity and assist the adoption of evidence-based practice in all service systems relevant to youth suicide prevention. Activities described in this volume include research and evaluation, communications, education and training, networking and intersectoral collaboration, and community development.

**Supplementary Report: Volume Two** is entitled *Primary Prevention and Early Intervention*. The goal of primary prevention is to prevent the development of problems (risk factors) that place people at risk of suicide. Primary prevention also includes mental health promotion, which aims to promote wellbeing, optimism, resilience and interconnectedness between people and communities. Primary prevention activities of the National Youth Suicide Prevention Strategy were concentrated in four areas: parenting education and support; school-based programs; media education; and access to means/injury prevention. The goal of early intervention activity is to reduce the prevalence of risk factors for suicide among young people who have begun to develop early signs of disturbance or who are exposed to environments known to be harmful. What has been learned about early intervention aspects of Strategy projects is collated and synthesised in this volume.
Supplementary Report: Volume Three is entitled Crisis Intervention and Primary Care. Crisis intervention activities are often short-term activities directed at young people who may be at immediate risk of suicidal behaviour. Crisis intervention aims to respond quickly to crises that could result in self-harm or suicide attempts. Crisis intervention activity of the National Youth Suicide Prevention Strategy focused in two areas: telephone counselling services; and hospital accident and emergency department protocols. This volume also describes projects set in general practice and other primary health care settings.

Supplementary Report: Volume Four is entitled Treatment and Support. In keeping with the guiding principle that attention should be paid to the needs of young people who are marginalised from mainstream society, a number of projects were based in organisations helping these young people. The term ‘marginalisation’ refers not only to the stigma and social rejection associated with the experiences or risk factors of conditions such as homelessness or drug misuse, but also to the fact that young people with multiple problems are generally poorly catered for by most services. This volume also describes projects aimed at young people with mental health problems.

Judy Adams
Youth Suicide Prevention Project Manager
Australian Institute of Family Studies
The National Youth Suicide Prevention Strategy was an initiative of the Commonwealth Government to provide a coordinated approach to youth suicide prevention throughout Australia.

The goals of the National Youth Suicide Prevention Strategy were to:

- prevent premature death from suicide among young people;
- reduce rates of injury and self-harm;
- reduce the incidence and prevalence of suicidal ideation and behaviour; and
- enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

The Strategy was administered and coordinated through the Mental Health Branch of the Commonwealth Department of Health and Aged Care (formerly Health and Family Services). The Summative Evaluation of the Strategy was conducted independently by the Australian Institute of Family Studies.

Advice from stakeholder representatives was provided by a number of bodies including the Youth Suicide Prevention Advisory Group (July 1995 to June 1998) and the National Advisory Council on Youth Suicide Prevention (from July 1998). Technical advice on the conduct of project evaluations was provided by the Evaluation Working Group.

A total of $31 million was allocated to the Strategy from July 1995 to June 1999. Funds were distributed across eighty-eight different projects and activities including forty-four National Demonstration Projects. Funds were allocated via a number of processes including competitive tendering and selective tendering.

**Approaches used by the Strategy**

The Strategy was based on the understanding that youth suicide is a complex phenomenon which is caused by a number of interacting factors including biological, psychological, social and cultural factors. This understanding is widely referred to as the *biopsychosocial model*. The Strategy has also been guided by, and has sought to promote, the principles of the *Public Health Approach* to enhancing population health and wellbeing.
Consistent with the biopsychosocial model of causality and the principles of the Public Health Approach, the Strategy employed a variety of interventions including those that modify individual risk factors and protective factors, as well those that modify the physical, social and cultural factors that shape environments:

- primary prevention and cultural change;
- early intervention;
- crisis intervention and primary care;
- treatment, support and postvention; and
- access to means/injury prevention.

A major emphasis of the Strategy was on building the capacity of existing services and programs to provide more effective responses to the needs of young people rather than creating new services and programs. System level activities aimed to facilitate the adoption of evidence-based practice throughout all the service systems relevant to youth suicide prevention and included:

- policy and planning;
- research and evaluation;
- communications (identification and dissemination of good practice);
- education and training;
- networking and intersectoral collaboration; and
- community development.

**Aims and methods of the AIFS evaluation**

The aims of the summative evaluation, conducted by the Australian Institute of family Studies, were to:

- determine the extent to which the National Youth Suicide Prevention Strategy has achieved impacts or outputs directly related to its stated goals;
- determine the extent to which the Strategy has initiated activities appropriate to the achievement of objectives directly associated with the stated goals;
- document the main lessons learned through the experience of implementing a nationally coordinated approach to prevention of youth suicide; and
- identify findings to inform the Commonwealth Government, particularly the Minister for Health and Aged Care, on future national youth suicide prevention policy development.

The evaluation has used two well established frameworks to guide its design and methodology – the Public Health Approach, and Program Theory or Program Logic.

The Public Health Approach to program evaluation emphasises the importance of examining program effects at three levels. *Outcomes* are the changes in the
health and wellbeing of the target population or program participants that are attributable to the intervention. Impacts are changes in modifiable risk and protective factors in individuals (behaviours, skills, attitudes and knowledge) and environments. Processes are changes in service and program delivery systems.

Program Theory (Bickman 1996) and Program Logic (Department of Finance 1994) provide hypothetical maps of the logical and causal relationships between program inputs, processes, impacts and outcomes. Program Theory therefore provides a framework for systematically determining whether program inputs or activities are appropriate to program goals and objectives.

Five main methods were used to collect and analyse data for the evaluation:

- a qualitative meta-analysis (meta-evaluation) of project evaluation reports;
- survey of key stakeholders;
- informal consultation with key stakeholders;
- review of research and practice literature; and
- review of policy and program context.

**Did the Strategy meet its aims?**

A major aim of the evaluation was to determine the extent to which the Strategy had initiated activities appropriate to the achievement of objectives directly associated with its stated goals. The results suggest that the Strategy did initiate many activities that are appropriate to the achievement of objectives associated with its stated goals. Furthermore, the range of activities initiated was fairly comprehensive in that it included activities from nearly all of the prevention approaches that have been identified as necessary in the research literature.

The Strategy also included most of the elements that have been identified as essential to coherent national strategies (United Nations 1996; WHO 1990; Taylor, Kingdom and Jenkins 1997). However, the Strategy cannot be considered to be a fully ‘comprehensive nationally coordinated approach’ to youth suicide prevention throughout Australia. Rather, it is more accurately understood as a phase of developmental research.

If the goal of reducing rates of suicide and suicidal behaviour among young people is to be realised, the Strategy will need to be followed by a phase in which promising interventions are widely implemented throughout all relevant service systems and in many communities throughout the nation. This will require ongoing leadership and coordination by the Commonwealth as well as state and territory governments.

There is evidence from the project evaluations and consensus among stakeholders that the Strategy has resulted in enhancements to the capacity of service systems to prevent suicide among young people. The knowledge base about the
complexity of causal factors and the effectiveness of various interventions has been expanded and information has been documented in forms that are accessible and user-friendly. Several promising primary prevention and early intervention programs have been developed or expanded, documented in manuals and capacity to deliver these programs more widely has been built. Training in suicide prevention and a range of interventions has been provided to large numbers of professionals and training resources have been expanded and made more accessible.

No data are available to indicate whether or not the Strategy has led to, or even been associated with, significant outcomes (improvements in the health and wellbeing of young people) at a population level. Similarly, no reliable data are available to indicate whether or not the Strategy has led to, or been associated with, positive changes in individual or environmental risk and protective factors at the population level (impacts). The Strategy represents only the earliest stage of a long-term reform process and changes in population health outcomes and impacts as a result of this process would not be expected to be observable for some considerable time.

Nevertheless, a number of projects demonstrated positive outcomes for young people and significant impacts on target groups participating in trial programs. There is evidence that there is a much higher level of awareness about the range of issues relevant to youth suicide prevention throughout service systems including the roles of professionals in different sectors and the challenges that organisations need to address if they are to make their services and programs more appropriate to the needs of young people and further develop their own capacity.

**Good practice findings**

Five major themes emerged concerning principles of good practice in prevention of suicide among young people.

**Multidimensional approach**

The value of the multidimensional approach used by the Strategy has been affirmed strongly by the evaluation. The multidimensional approach includes attention to the full spectrum of interventions; whole populations as well as high risk sub-populations and individuals; a range of different settings and sectors; and multiple levels of action including target populations, service agencies, service systems, local, state and Commonwealth government.

**Access**

The concept of access has emerged as central as the Strategy unfolded. One of the concerns underlying the Strategy was a recognition that young people generally under-use a range of services that have historically treated and supported individuals at high risk of harm and that there has been a shortage of primary
prevention and early intervention programs targeting young people. At the same time, the evidence is mounting that adolescence, in addition to early childhood, is a critical period for effective prevention and early intervention. An explicit and implicit assumption evident in the concerns of many project staff and evaluators is that population health gains can be improved by increasing the proportion of prevention and early intervention activity that is directed to young people.

The projects sought to explore ways in which current services can be adjusted to make them more accessible to young people and encouraged the gradual expansion and development of prevention programs targeting risk factors affecting young people, through capacity building. Much has been learned about the characteristics of services and programs that are likely to make them more accessible to young people. Critical elements of accessible services and programs include: universal and selective (aggregated) targeting; flexibility in terms of selection criteria and source of referrals; delivery in multiple community-based settings; and having multiple “soft” entry points.

Engagement

Problems of engagement go hand in hand with barriers to access as major reasons why service systems have failed to develop appropriate responses to young people’s needs. Services and prevention programs have particularly failed to adequately engage young males and young people with complex psychosocial problems. Communication is the key to engagement both in therapeutic situations as well as for the purposes of engaging young people as partners in service and community development. The evaluation found that service providers need to develop better knowledge of adolescent developmental health issues and skills in challenging negative assumptions about young people’s culture.

Providing a relaxed youth-friendly environment and a holistic range of services within one location is also very important for engaging young people who may lack the resources, skills and motivation to engage with service that are widely dispersed in different locations and administrative systems. Assertive follow-up is particularly critical for ensuring that young people at high risk are provided with the encouragement and practical assistance to return to services once initial contact has been made.

Effective intervention

Effective intervention was a particularly problematic issue among the good practice findings. Previous literature on the topic of evidence-based intervention has focused on the need to increase the extent to which interventions are based on epidemiological data about risk and protective factors and evidence about the efficacy of model interventions. The experience of the Strategy has also demonstrated the importance of service agencies actively engaging in an ongoing process
of generating, reflecting and acting on evidence about the effectiveness of their own daily practice.

The Strategy has underscored the importance of interventions that address protective factors as well as risk factors. This is important across the full spectrum of interventions, not just primary prevention. Protective factors operating within communities with low suicide rates clearly remain a poorly understood and untapped resource. Providing adequately holistic interventions that address all the systems impacting on young people’s health and wellbeing was a challenge that proved difficult for individual projects to meet. Nevertheless, the importance of striving to provide holistic, multisystemic intervention was underscored by a large number of project evaluations.

**Capacity building**

Important lessons have been learned about capacity building for youth suicide prevention. A major strength of the Strategy was its emphasis on building the capacity of existing services and programs rather than creating new structures focused on suicide prevention. The importance of fundamental structural reform in building the capacity of systems to respond to priorities like suicide prevention has been strongly affirmed.

Just as interventions directly targeting young people need to be multidimensional, so do capacity building efforts. One-dimensional activities aimed at increasing the knowledge and skills of service providers such as provision of information and education and training are insufficient, as is the mere generation of more evidence about risk factors or efficacious interventions. Capacity building interventions need to be designed with an awareness of all the forces that operate within systems to facilitate or inhibit the changes that are desired, and address as many of these as possible in a comprehensive fashion. Individual agencies can achieve little working in isolation. Genuine collaboration between organisations is necessary. This requires active engagement beyond the activities of individual project staff or service providers. Real collaboration or partnership involves developing and working towards shared goals and usually demands a willingness to modify organisational structures and processes. This requires the active support of senior management alongside other staff.

Evidence-based practice in the provision of human services and programs is not only about evidence of risk and protective factors and the efficacy of particular treatments and prevention programs. Evidence for the effectiveness of ways in which service systems are organised and managed and the decisions made by governments also need to be subject to critical scrutiny. “Practice based evidence” provides the tools that allow service systems to respond appropriately to the evidence provided by epidemiology and the other biological and social sciences.

The evaluations of the demonstration projects funded under the National Youth Suicide Prevention Strategy identified many barriers to the implementation of
suicide prevention programs and interventions. The service systems with greatest responsibility for suicide prevention are operating under conditions of severe resource limitations, and the changes required to implement good practice in suicide prevention are generally perceived as competing with many other service reform priorities.

Capacity building should continue to occupy a central place in future suicide prevention efforts. It is also important to note in this regard that many of the barriers to service reform that were identified by the Strategy evaluations have been identified in evaluations of similar national and state/territory-funded strategies and programs aimed at service reform, particularly in the area of health promotion.

Just as the barriers to service reform identified by suicide prevention and health promotion practitioners are similar, so are the key principles for reform. For example, both suicide prevention and health promotion require multidimensional interventions, the active involvement of multiple sectors of government, and community and consumer involvement. Another point of convergence between health promotion and suicide prevention is in the increasing recognition among researchers and practitioners in both these fields that many of the health outcomes of interest, be they mental, emotional or physical, are likely to have common determinants in fundamental social problems such as social inequality (Hawe et al. 1997; National Advisory Council on Suicide Prevention 2000; Vimpani 2000; Wilkinson and Marmot 1998).

These convergences suggest that a generic approach to capacity building aimed at enabling service agencies to be more responsive to the health and welfare problems identified and prioritised by local communities may be the best approach to building capacity for suicide prevention. Major challenges for governments will be to help identify appropriate models of generic capacity building and to create a policy environment that supports the development of agencies that are capable of building their own capacity and the capacity of the communities they serve.

**Future directions**

Two strategies are suggested that would progress these aims: first, the development of learning organisations; and second, the creation of systematic policy frameworks capable of supporting intersectoral partnerships and developing social capital.

**Development of learning organisations**

More attention needs to be directed to enhancing the accessibility and effective use of practice-based evidence. Documentation and dissemination of information is not enough. Many agencies lack the tools that are required to tap into existing
stores of knowledge and to ensure that their own experiences are subject to critical reflection and are fully used. All organisations should have structures and processes in place which facilitate ongoing learning as a basis for ongoing action.

Researchers and specialists in the area of organisational development have recommended the concept of learning organisations as the epitome of an organisation with capacity for learning and development. The concept of the learning organisation was developed within the business management sector (Senge 1990) but it has demonstrated substantial relevance and utility in the public sector as well (Birleson 1998; Hawe et al. 1997). The learning organisation model provides a comprehensive framework for ensuring that an organisation places quality improvement at the centre of its concern and is able to adapt quickly to new demands.

**Systematic policy frameworks**

Coordination of system reform efforts at a national or state/territory level provides unique opportunities to address structural barriers that cannot be addressed effectively by capacity building initiatives conducted by individual agencies or local interagency networks. A major barrier to the formation of genuine partnerships between agencies is the lack of clear direction at a policy level within the range of sectors that need to be involved. Although policy documents within sectors increasingly espouse a partnership approach these generally lack details of models that can be actively adopted or levers that can be utilised or built upon.

To be sustainable and effective, local partnerships must be complemented and supported by strategic partnerships between: Commonwealth Government departments; the Commonwealth and the states and territories; and state/territory governments and area/regional/district authorities.

The dominance of traditional funding categories for government programs based on problems (such as suicide, drug misuse) and service systems or functions (such as health services, education, community services) places limits on the formation of intersectoral partnerships and the ability of service agencies to respond to diverse local needs. New policy and funding frameworks incorporating a wider array of conceptual dimensions including structural social issues, populations and places or localities may be needed in order to provide adequate flexibility. There are positive signs of a move towards this flexibility with the emergence of several new national policies focused on social issues and incorporating key health promotion concepts.

**Valuing young lives**

The National Youth Suicide Prevention Strategy was not just about suicide prevention, it was also about young people and their place in Australian society. The concerns that prompted the initiation of the Strategy comprised not only
epidemiological evidence about suicide rates and their variation across populations, but evidence that young people suffer serious disadvantages in their access to health and social resources compared to other populations, particularly in the area of mental health.

The Strategy represents a major part of the effort that the Commonwealth Government has made over the past seven years to address the recommendations of the “Report of the National Inquiry into the Human Rights of People with Mental Illness” (Burdekin 1993).

The findings of the evaluation of the Strategy underscore the critical importance of reaffirming our commitment to social justice for young people. There is evidence that progress has been made against some of the deficits identified by Burdekin, particularly in the area of knowledge, research, training and commitment to the establishment of prevention programs.

However, the evaluation of the Strategy has also revealed evidence that many of the structural deficiencies in service systems remain as problematic as they have ever been. At the end of the National Youth Suicide Prevention Strategy, there is considerable readiness to begin the work of seriously tackling these problems. Long-term political commitment is vital.
As part of its evaluation of the National Youth Suicide Prevention Strategy, the Australian Institute of Family Studies was required to make recommendations to inform future efforts in suicide prevention. The Institute has put forward the following thirty-six recommendations.

**General recommendations**

The first four recommendations address general principles that should be followed in future suicide prevention initiatives.

*It is recommended that:*

1. Future suicide prevention initiatives should address the general population and all vulnerable groups, but include a major focus on special populations who have been identified as being particularly at risk for negative outcomes, or who experience additional barriers to service access, such as young people, Aboriginal and Torres Strait Islander people, and people living in rural and remote locations.

2. Future suicide prevention initiatives should be guided by the following five good practice principles:
   - use a comprehensive multidimensional approach involving indicated, selective and universal targeting, a spectrum of interventions, a range of settings, and sectors and multiple levels of action;
   - ensure accessibility of services and programs for marginalised and hard-to-reach populations;
   - enhance engagement of marginalised and hard-to-reach populations;
   - ensure effective intervention by basing programs on evidence about risk and protective factors, evaluation of program efficacy and practice-based evidence of program effectiveness; and
   - build capacity in all levels of service systems.

3. Future suicide prevention initiatives should be developed and implemented within the context of a comprehensive and systematic policy framework that supports partnerships between sectors of government and with communities.
4. The quality of suicide and mental health data in the indigenous population should be improved.

**Parenting programs**

An increasing number of sectors are recognising the importance of early childhood experience and the role of good parenting throughout childhood and adolescence in producing healthy, resilient and well-adjusted adults, and preventing a range of negative social outcomes. Many different service systems are providing parenting programs but there is great variability in the availability of effective programs across population groups and locations.

*It is recommended that:*

5. Development and expansion of parenting education and support programs should be recognised as the joint responsibility of a range of sectors of government, and future policy development should focus on identifying roles and responsibilities in relation to the development, planning, financing, coordination, administration, delivery, and evaluation of parenting programs.

6. Coordinating bodies should be identified or established to more effectively manage, support, evaluate and disseminate the array of available parenting programs to ensure their activities are comprehensive and complementary in meeting the needs of diverse populations.

7. Priorities for future program development and research should include:
   - identifying the forms of targeting, setting, and modes of delivery best suited to addressing the parenting education and support needs of particular population groups, especially indigenous people and people from non-English-speaking backgrounds;
   - the effectiveness of volunteer and paraprofessional home visiting programs; and
   - programs for children of parents with mental disorders.

**School-based programs**

As institutions that inevitably play a role in developing the psychological wellbeing of students, schools must be seen as providing an investment in the development of the mental health of young people, and need to be valued in this role. Programs such as *Mind Matters* and resources such as *Education for Life: A Guide* can make a contribution to the development of environments that can enhance protection and lessen risks to which young people are exposed.

*It is recommended that:*

8. Further development of mental health promotion programs and resources in schools should give particular consideration to:
   - professional development and support around the development of school ethos and organisational change;
• professional development and support around the development of community partnerships;

• ensuring curriculum, ethos and partnerships are sensitive to cultural and social diversity;

• incorporation of or linkage to primary prevention and early intervention programs targeting the development of protective factors and the prevention of specific risk factors for suicide; and

• development of structures and processes such as democratic decision-making, strategic planning, and participatory action research, that support the active involvement of teachers, students, parents and community members.

9. The Commonwealth and state and territory governments should work together to develop and regularly update policies, protocols and monitoring systems which ensure that every school and every child has access to an appropriate variety of mental health promotion, prevention, early intervention and support programs, and that programs are offered safely in the context of whole-school approach to mental health promotion.

**Early intervention**

Early intervention is an orientation to service delivery that emphasises enhancing access and engagement of young people at risk of negative outcomes, thereby maximising the chance that they will be exposed to interventions effective in reducing exposure to further risk, or enhancing protective factors.

It is recommended that:

10. Governments and regional authorities should continue to facilitate the development of networks of service providers and community members aimed at enhancing identification of young people at risk of suicide and mental health problems, providing support and facilitating their access to appropriate intervention. Networks should include the following characteristics:

• comprehensive membership including: youth workers, school personnel, general practitioners, welfare and other community workers, health workers, mental health services, telephone counselling services, clergy;

• formal referral protocols, computerised, regularly updated referral databases, regular joint training of network members, community education using a range of media including the internet; and

• support by policy development, joint planning and formal coordination between all relevant sectors at the level of regional authorities and state and territory governments.

11. Evaluation research should be directed towards identifying the factors that enhance and inhibit engagement of young people at risk for mental health
problems and suicide in community-based early intervention projects. Priority groups for research should include: males, indigenous young people, and young people involved in the juvenile and criminal justice systems.

**Hospital accident and emergency departments**

Health services have an obligation to provide an equivalent quality of care for all patients who present with life threatening conditions, whether these conditions be related to physical or mental health problems.

*It is recommended that:*

12. Accident and emergency departments should work in partnership with mental health services and other community agencies to develop protocols for the management of people who present with suicide attempts or deliberate self-harm. With respect to presentations by young people, these protocols should include the following minimum components of care:

- triage rating system that gives appropriate consideration to psychiatric criteria;
- prompt comprehensive (psychosocial) mental health assessment by an appropriately qualified, trained and experienced mental health professional;
- formal referral to an appropriate ongoing care agency; appointments should be arranged for within 24-48 hours following discharge;
- development of an ongoing care plan in collaboration with the young person and carers nominated by the young person;
- assertive follow-up of young person to encourage attendance at ongoing care; and
- provision of detailed information about the emergency department, suicide attempt, and support services available.

13. Governments should collaborate to:

- develop a National Minimum Data Set for emergency departments that includes a module on the management of suicide attempt and deliberate self-harm;
- provide resources to support continual quality improvement by emergency departments and mental health services; and
- develop a nationally agreed multidisciplinary set of clinical guidelines or standards pertaining to the management of people presenting with suicide attempt and deliberate self-harm to emergency departments: these guidelines/standards should include consideration of the special needs of young people.
**General practice and other primary health care settings**

Primary health care services have a critical role to play in enhancing the provision of primary prevention and early intervention programs as well as providing ongoing treatment and support for young people at risk of suicidal and self-harming behaviour.

*It is recommended that:*

14. Governments should work in partnership with Divisions of General Practice, Mental Health Services, and youth health services to identify strategies for expanding the range and quality of primary health care services available for young people at risk. General models could include: community-based youth health services; multipurpose youth services; and GP Mental Health Shared Care.

15. The new National Advisory Council on Suicide Prevention should work closely with the primary health care initiatives of the *Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan*, the Office of Aboriginal and Torres Strait Islander Health, the National Aboriginal Community Controlled Health Organisation, and other relevant agencies and strategies to identify and advance promising models of primary health care for indigenous youth.

**Telephone counselling**

Telephone counselling services have a part to play, alongside other services, in enhancing identification and engagement of young people at risk, directing them to appropriate services, helping them through suicidal crises, and enhancing the continuity of care provided to individuals at risk.

*It is recommended that:*

16. In any future expansion or development of telephone counselling services, priority should be given to the following:

- the place and role of telephone counselling services in relation to the other services in youth suicide prevention, and the linkages between these services;

- strategies for supporting an active and systematic approach to referral and follow-up of young callers at risk of suicide including the improvement and updating of electronic referral databases and skills in engaging young males; and

- ongoing professional development of telephone counselling staff including training, supervision, development of competency standards and performance monitoring.
Support for marginalised and disaffected young people

The transition from childhood to adulthood can be a difficult time for many young people. Some have multiple experiences which damage their connections to family, peers and community, making it particularly difficult to make transitions to adult life. These young people can be helped by services that are easily accessible, actively oriented towards engagement, and are capable of addressing the full range of problems in a holistic fashion.

It is recommended that:

17. Governments should work in partnership with Area/Regional Health Services, youth health services, and young people to identify strategies for expanding the capacity of youth health services to provide a comprehensive health service to young people affected by multiple risk factors for suicide.

18. Funding should be provided to support a program of service development research aimed at identifying strategies for engaging marginalised and alienated young people with services. Key topics for further exploration should include:

- models of service provision targeting young people with mental health problems including personality disorders and other complex problems;
- the involvement of families and care givers;
- staff turnover, the mental health and wellbeing of staff, and strategies for ensuring adequate professional support of staff;
- collaboration between primary health care services, specialist mental health services and other government and non-government agencies; and
- strategies for enhancing quality assurance and evaluation.

19. The National Advisory Council on Suicide Prevention and the Commonwealth Mental Health Branch should work closely with the Youth Homelessness Taskforce and the National Youth Pathways Action Plan Drafting Committee to ensure that appropriate attention is given to issues of relevance to suicide prevention and young people with mental health problems, and to identify opportunities for collaboration.

Mental health services

Mental health services that are accessible and appropriate to the needs of young people are critical to youth suicide prevention. “The root of the difficulty in applying research findings to improve services is that the services are mostly not conceived as a system of care. If mental health is the desired outcome, we can only hope to achieve it if services are planned and enabled to work together as a system with this common aim” (Kurtz 1996: 51).
It is recommended that:

20. Commonwealth and state and territory governments should develop policy frameworks and strategic plans to guide the development of mental health services for young people. These should give particular consideration to:

- ensuring that service models are available which address the specific needs of young people in addition to adults and children, as well as young people with complex mental health problems and those exposed to multiple risk factors for suicide;
- the engagement of young males with mental health services;
- methods of treatment of dual diagnosis (substance misuse and mental disorders) and models of collaboration between mental health services and drug and alcohol services;
- achieving an appropriate balance between generic mental health services and specialist units (such as those focusing on psychosis, depression, youth, dual diagnosis);
- building the capacity of mental health services in early intervention, primary prevention and mental health promotion; and
- building the capacity of mental health services to evaluate service provision.

21. Funding should be provided to support a research program focusing on:

- evaluation of the effectiveness of youth specific service models versus existing models of mental health service provision for adolescents and young adults;
- development of valid indicators of service accessibility and engagement that can be used with reasonable ease by service managers;
- efficacy and effectiveness of treatments for depression, anxiety and substance misuse in young people: evaluation research should monitor long-term outcomes;
- pathways to mental health care; and
- the attributes of a safe and effective termination process from the perspective of young consumers of mental health services as well as clinicians.

Access to means

“Both the physical availability and the social and cultural acceptability of particular means of suicide are important determinants of the methods used” (Cantor et al. 1996). “Discussion, supervision and restriction are necessary to ensure that typical instruments of suicide are not easily accessible, especially to those at risk” (United Nations 1996).
It is recommended that:

22. The following steps should be taken to reduce access to car exhaust gas as a means of suicide:
   • introducing legislation to enable implementation of a tailpipe system to prevent the effective attachment of the full range of commonly available hoses and pipes in new vehicles, and make the system a necessary condition of the sale of used vehicles;
   • introducing legislation to ensure that current Australian standards for catalytic converters comply with the most recent international standards for carbon monoxide emission across all car manufacturers;
   • ensuring that research continues into the development of motor vehicle exhaust gas sensors linked to engine cut-out switches in vehicles;

23. The following steps should be taken to reduce access to firearms as a means of suicide:
   • continuing efforts to reduce the availability of firearms; and
   • encouraging safe storage of firearms.

24. The following steps should be taken to reduce access to railways and jumping from heights as a means of suicide:
   • requiring that the National Injury Surveillance Unit work with railway representatives to implement a research and development strategy for safety technology;
   • requiring that appropriate authorities erect barriers wherever possible at high-risk jump sites; and
   • installing telephone help lines at high-risk sites where effective barriers do not exist or are impractical.

25. The following steps should be taken to reduce access to hanging as a means of suicide:
   • further research should be conducted to (i) determine factors contributing to the major rise in hanging as a means of suicide and (ii) develop interventions to counter this means of suicide; and
   • particular attention should be given to the development of culturally appropriate intervention strategies within Aboriginal and Torres Strait Islander communities.

Research and evaluation

Research should be planned to cover the working of “services as a system of care, as well as to increase what we know about treatment efficacy and effective clinical practice” (Kurtz 1996: 56).


**It is recommended that:**

26. Governments and authorities should work in partnership to identify strategies for ensuring that all services with roles and responsibilities in youth suicide prevention have access to the resources (infrastructure, funds, staff, expertise) needed for evaluation of program effectiveness. Strategies to consider should include:

- creation of dedicated Evaluation and Research Support Units that will work in partnership with local services to develop their evaluation capacity;
- provision of training to service managers and staff in the principles of learning organisations and participatory action research; and
- expansion of the National Survey of Mental Health Services to collect a more comprehensive range of data about the activities and resourcing of Child and Adolescent Mental Health Services, youth health services and other relevant primary health care services.

27. Each Area/Regional Health Service should develop a Mental Health Evaluation and Service Development Research Strategy that specifies how the Area/Region will:

- support the collection and analysis of data about service provision;
- support the analysis of data about the mental health of young people as well as risk and protective factors in the community;
- conduct and participate in local, statewide and national service development research and evaluation activities; and
- ensure that the results of evaluation are incorporated into ongoing strategic planning.

**Communications**

“Research findings related to the effectiveness of health promotion and . . . prevention activities have burgeoned in recent years. Difficulty applying this [information], coupled with a failure to use it, however, have the potential to stifle progress in achieving many public health goals” (Johnson et al. 1996).

**It is recommended that:**

28. Governments should invest further in the development of specialised communications strategies for the express purpose of enhancing intersectoral collaboration on issues relevant to suicide prevention. These strategies should:

- focus on the task of transforming “information” into “knowledge” that meets the practical needs of users; and
- include action research mechanisms that create two-way communication between information users and information generators.
Education and training

Education and training in youth suicide prevention needs to reflect the full range of interventions required, the diversity of professionals involved, and the complexity of the environments and organisational systems in which practitioners are working.

It is recommended that:

29. Developmental research and evaluation in training should give priority to:
   • distance learning strategies for primary health care and specialist mental health professionals in rural and remote areas;
   • the processes by which suicide prevention training leads to behaviour change and improved outcomes for clients: this requires more fine-grained measurement and testing of the effects of specific components of training including content, mode of delivery and ongoing support, as well as the interaction between these; and
   • the utility of practice audits in reinforcing learning and behaviour change and evaluating the long-term impacts and outcomes of training: this work could begin with a systematic long-term follow-up of the cohorts of professionals that have recently received training under the National Youth Suicide Prevention Strategy.

30. Training in youth suicide prevention should prioritise the following content issues:
   • mental health promotion, primary prevention, early intervention and community development; and
   • exploring and challenging professional attitudes and other barriers to working intersectorally.

31. Governments and authorities should plan to provide resources for mental health services and other services expected to provide training in suicide prevention and child and adolescent mental health, as well as for agencies and organisations that require training. Funding should cover temporary replacement (backfill) of staff attending training.

Networking and intersectoral collaboration

Genuine collaboration requires engagement beyond the activities of individual staff at the margins of organisations. Formal organisational structures and processes need to be involved and this may sometimes require their adjustment. To be sustainable and effective, local partnerships must be complemented and supported by strategic partnerships between organisations at higher levels in service systems including between Commonwealth government departments, the Commonwealth and the states and territories, and state/territory governments and area/regional/district authorities.
It is recommended that:

32. Funders of projects requiring intersectoral collaboration should give consideration to:
   
   • the potential benefits of basing such projects in consortiums of agencies;
   
   • the extent to which project applicants have identified existing state/territory government, local government and area/regional planning structures and processes and specified the ways in which the project will liaise with these; and
   
   • the level of authority possessed by project staff with respect to the processes and structures at which change is directed.

33. Governments should identify mechanisms for enhancing the consistency and complementarity of policies relevant to the wellbeing of young people across all relevant departments – particularly health, education, employment and training, community services, criminal and juvenile justice.

Community development

Community development in the context of suicide prevention is a systemic activity which involves, or aims to assist, communities to develop their own programs and activities in ways that will be self-sustaining in the long term. The basic capacities required for this work are similar across many other health and social issues. There is evidence that long-term engagement of community members and maintenance of programs is greater when community development activity focuses on the issues prioritised by local people and when formal social structures including community controlled organisations are strong.

It is recommended that:

34. Community development activities and programs should:

   • empower communities to address issues that they themselves have prioritised and identify their own solutions to these problems;

   • build community organisations or other formal structures (such as coalitions) that represent a wide cross section of the population, and which are controlled by the community in a democratic fashion;

   • develop organisational structures capable of supporting the participation of young people;

   • build formal links between local communities and existing local, regional, state/territory and national planning and governance structures; and

   • provide professionals and community members with training in skills relevant to community development.
35. Policy research should be conducted to identify frameworks and mechanisms best suited to supporting structural community development and local control over resource allocation. Key components of a comprehensive policy approach should include:

- development of “place management” policy approaches;
- trial of a block grant funding approach to community development on a demonstration project basis within a number of communities; and
- development of intersectoral collaborative planning structures and processes at the Commonwealth, state/territory and local government levels, and between levels of government.

36. Community development and other public health initiatives aimed at improving indigenous health and wellbeing should work with or through the State and Territory Agreements on Aboriginal and Torres Strait Islander Health.
The three chapters in Section One of this Evaluation Report provide background information critical to an understanding of the National Youth Suicide Prevention Strategy and the evaluation of the Strategy.

Chapter 1 provides a brief outline of the scope of the problem of youth suicide in Australia; Chapter 2 is a discussion of the recognition of the need to develop a national prevention strategy; and Chapter 3 describes the policy and program context pertinent to the development and implementation of the Strategy.
The increase in youth suicide since the 1950s is a major public health trend throughout the world. According to Bertolote (cited in De Leo et al. 1999): “Today suicide provokes almost as many deaths as road accidents and more than double the number of all the armed conflicts around the world. In almost every country, suicide is now one of the three leading causes of death among people aged 15–34 years . . . A global increase in suicide rates, from 10.1 (per 100,000) to 16 has been registered from 1950 to 1995.”

Caution should be exercised in comparing suicide rates among countries because of variations in data collection procedures. However, Australian suicide rates appear consistent with those in similar nations (Cantor et al. 1998), particularly predominantly English-speaking countries with pioneering histories, indigenous peoples, and multicultural populations, such as Canada, New Zealand and the United States (Cantor et al. 1998; La Vecchia et al. 1994).

**Rise of youth suicide in Australia**

In Australia in 1998, there were 446 deaths from suicide in the 15–24 year age group. Young males comprised 364 of these deaths. The age-specific rate of suicide for young males aged 15–19 was 17.2 per 100,000. For those aged 20–24, the rate was 35.9 per 100,000. The age-specific rate of suicide for young females aged 15–19 was 5.5 per 100,000, and for those aged 20–24 it was 7.1 per 100,000 (ABS 2000).

In 1998, the highest age-specific rate of suicide was recorded for males in the age range 25–29 years (42.6 per 100,000), followed by a rate of 39.4 per 100,000 for the age range 30–34, then 36.6 per 100,000 for those aged 35–39 (ABS 2000).

**Changes over time and variations between sub-populations**

Figure 1 shows the age-specific suicide rates for males and females aged 15–19 and 20–24 years from 1979 to 1998, including the Strategy years of 1995–1998.
While female rates have been relatively stable, Australia’s male suicide rate has increased disturbingly over the past twenty years. In 1998 deaths for young males outnumbered those for young females by a ratio of more than four to one (ABS 2000). Figure 1 demonstrates that rates for young females have been consistently lower than those for young males over the last twenty years.

One reason for the differences may be attributed to the methods of suicide used. Hassan and Tan (1989) found when comparing methods of suicide between 1961–1981, that males more commonly used violent methods such as firearms, with higher levels of lethality, than females. While rates have increased much more dramatically for young males than young females over the past twenty years there is a trend toward a slow but steady increase in the rate for females aged 15–19 over the period 1995–1998.

Figure 2 compares the age-specific suicide rates for males aged 15–19, 20–24 and 25–29 years between the years 1979–1998.

The suicide rate for males aged 15–19 appears to have stabilised over the period 1988–1998. The rate for males aged 20–24 also appeared to stabilise in the second half of the 1990s, but this trend was disturbed by a peak in 1997. The 1997 figures may represent an aberration from a plateau to which 1998 rates return. In contrast, the rate for males aged 25–29 has continued to rise steadily, particularly in the second part of the 1990s.

Figure 3 compares the age-specific suicide rates for males aged 25–29 years, 30–34 years, 35–39 years and 40–44 years during the period 1979–1998. The rates for these age groups are similar over this period. All have increased gradually, but the rate of increase appears to have climbed higher in the latter part of the 1990s.

A recent comparison of metropolitan and rural trends in youth suicide (Dudley et al. 1998) revealed that while suicide rates for 15–24-year-old Australian men have doubled since the 1960s, they have increased as much as twelve-fold in some towns with fewer than 4000 people. However, this is not the case for all and Kerr (1999) found that the higher rate of rural youth suicide was largely accounted for by suicide among immigrants to Australia, and that there was no significant difference in the suicide rate between rural and urban Australian-born males.

Suicide data on Aboriginal and Torres Strait Islander communities are unreliable, but it is estimated that the overall suicide rate may be 40 per cent higher than in the non-indigenous population (Harrison and Moller 1994, cited in Commonwealth Department of Health and Aged Care 2000).
Overall rates for immigrants are similar to those of Australian-born youth. However, males born in a country other than Australia have a lower suicide rate than Australian-born males, whereas the reverse applies for young women born in a country other than Australia (Morrell et al. 1999).

**Attempted suicide and deliberate self-harm**

The extent of attempted suicide is hard to determine. The term implies that the self-harming behaviour is intended to cause death. However, the true motive behind self-harming behaviour, and many apparent suicide attempts, is generally very difficult to determine.

The extent of self-harming behaviour is also difficult to determine because of a lack of generally accepted reporting procedures or definitions. Hospital presentations or admissions are most commonly used. However, use of hospital presentations grossly underestimates numbers of attempts because most attempters do not present to hospital, and there is considerable variability in the coding used by hospitals with those who do present. In the consultation among young people on mental health issues conducted as part of the National Youth Suicide Prevention Strategy (Keys Young 1997), 7 per cent of the young people studied said that they had attempted suicide, while 40 per cent said that they knew someone who had attempted suicide. Cantor et al. (1998) estimate that there are possibly up to 50 male and 300 female attempted suicides for each completed suicide.

However, in spite of difficulties in collecting data, certain differences have been identified between those attempting and those completing suicide. Whereas the completed suicide rate is far higher among young males than young females, the reverse is true for attempted suicide. However the female predominance of attempted suicides, as judged by hospital admissions, has declined in recent years with the female: male gender ratio now being about 1:2.1 (Cantor et al. 1998).

Suicide attempts are more likely to result in death among older adults than in the young (De Leo et al. 1999). In one study (Tiller et al. 1997), it was found that
the presence of a suicide note was an important discriminator between those who complete suicide and those who make attempts. Less than 5 per cent of attempters wrote a note. The same researchers found that disturbed family relationships, and physical and sexual abuse, were reported more often among suicide attempters than suicide completers.

Suicidal ideation is even more difficult to measure than suicide attempts because figures rely on self-reports from data obtained from research studies, surveys or interviews (Baume et al. 1998).

**Focus for government action**

These briefly described statistics give some idea of the extent of youth suicide and suicidal behaviour in Australia. They can only hint at the tragedy for the individuals concerned and the anguish of families and friends. Communities are affected (Roadknight 1999), the whole country suffers from the loss of so many young lives.

Suicide rates on such a scale indicate a public health problem and the Australian government has rightly become involved in efforts to address it. The particularly dramatic rates of youth suicide over time justify the focus to date on the age group 15–24, but the statistics demonstrate that this is not the only group at risk, and suggest that future efforts should include all vulnerable age groups.
The National Youth Suicide Prevention Strategy emerged out of a series of national and international events that drew attention to the need for a concerted and coordinated approach to prevention of suicide among young people as well as a series of policy developments that have shaped recent thinking in the areas of mental health and the health and welfare of young people.

International recognition


The United Nations (1996) meeting drew a number of conclusions and made a number of recommendations which emphasised the importance of a nationally coordinated approach and highlighted key characteristics of national strategies. These conclusions and recommendations include include that:

• the principle causes of this phenomenon are multifaceted and originate throughout the entire fabric of society;

• suicides, attempted suicides and their impact upon affected persons constitute a socioeconomic cost of increasing significance, and more effective prevention will reduce the magnitude of these costs;

• suicide is preventable;

• a holistic approach to prevention is required which includes bio-psycho-social elements and is systematic, goal-oriented and targeted at individuals, families and communities;
• national governments should establish or designate a governmental or non-
governmental coordinating body to be responsible for the prevention of sui-
cidal behaviour;

• national governments should provide the coordinating body with executive,
financial and technical resources to ensure effective and efficient formulation
and subsequent achievement of national strategy objectives; and

• each national strategy will be formulated in harmony with the cultural, social
and economic characteristics of each country and with the broad involvement
of different sectors and segments of society, and should be implemented
through appropriate programs in all areas of prevention.

Australia is one of the few countries to have answered the call of the United
Nations (1996) and the World Health Organisation (1990) for member states to
develop national strategies targeting suicide and other severe dysfunctional con-
ditions. According to Ramsay (1996: 12): “The majority of countries have no
national strategies, relying primarily on the uncoordinated efforts of government
agencies or non-governmental organisations, which usually have limited
resources.”

Other countries that have initiated comprehensive national strategies are Finland,
New Zealand, Norway and Sweden. Certain countries – Netherlands, England,
the United States, France and Estonia – have national prevention programs but
not a comprehensive strategy. Japan, Denmark, Austria, Canada and Germany
have carried out some initiatives but not national action.

**Finland’s suicide prevention initiative**

The Finnish Suicide Prevention Project was the first research-based, compre-
hensive national suicide prevention strategy to be implemented throughout a
whole country, and evaluated systematically both internally and externally.

The goal of the Project was to reduce the incidence of suicide by 20 per cent by
the end of the implementation period. The framework for the Project was a nation-
wide Target and Action Strategy which identified ways of preventing suicide which
suit local conditions. Implemented over a ten-year period from 1986–1996, the
Project consisted of a research phase from 1986–1988 (but still continuing),

An evaluation of the Finnish Suicide Prevention Project (Beskow et al. 1999) iden-
tified some particularly effective features. The Project used a clearly defined
model of suicide prevention, had measurable objectives, and a combination of
national planning and policy with extensive local implementation. Evaluation
was used throughout as a means of gaining a deeper understanding of effective
practices for suicide prevention.
Developments in Australia

The concerns that prompted the initiation of the Strategy comprised not only epidemiological evidence about suicide rates and their variation across populations, but evidence that young people suffer serious disadvantages in their access to health and social resources compared to other populations, particularly in the area of mental health.

*Mason report*

In 1988 the Youth Bureau within the Commonwealth Department of Employment, Education and Training commissioned the Australian Institute of Criminology to undertake a study of youth suicide prevention strategies both in Australia and internationally. The aim was to identify effective strategies and offer guidance for future initiatives by governments.

That study represents the first attempt to examine the issue at a national level. The resulting report (Mason 1990) made a total of thirty-five wide-ranging recommendations. Several of these included activities requiring coordination at a national level. The preface to the report also indicated that the structural causes of suicide needed to be addressed by the then Federal Government’s Social Justice Strategy for Young People which was also suggested as an appropriate setting within which to pilot several specific prevention programs targeting the most socially disadvantaged young people.

This was the first suggestion of a need for the Australian government to address the issue of youth suicide within a comprehensive policy framework. Many of the broad and specific recommendations of the Mason Report have been progressively adopted in the two national strategic initiatives over the past eight years.

*State initiatives*

Several state and territory governments initiated coordinated responses to suicide prevention before the first formal national strategy. These generally took the form of multisectoral working parties or advisory committees which aimed to collect evidence about the epidemiology of suicide in their jurisdictions and begin the process of identifying appropriate programs and activities. Several of these state and territory working parties conducted community consultations in the process of developing recommendations for action.

*NH&MRC working party*

In 1992 the National Health and Medical Research Council established a Working Party on preventing suicide comprising some prominent researchers in the field. The roles of the Working Party were to: review existing data systems and methods for collecting statistics on suicide in Australia; develop practical
guidelines for recognising at-risk behaviours and ways to prevent suicide; and develop a policy statement on suicide.

The report of the Working Party was intended to form the basis for developing a comprehensive suicide prevention strategy across all age groups (Lawrence 1995).

**Human rights and people with mental illness**

The Report of the National Inquiry into the Human Rights of People with Mental Illness, conducted by the Human Rights and Equal Opportunity Commission (Burdekin 1993), otherwise known as the Burdekin Report, found that children and adolescents are particularly poorly served by mental health services in Australia.

Specifically, Burdekin (1993: 647) reported that in relation to children and adolescents: “The overwhelming picture is one of inadequate funding, inadequate provision of facilities, inadequate staffing, inadequate training of health and other workers, inadequate inpatient care, inadequate community and home-based care, inadequate coordination between agencies, inadequate knowledge, inadequate research, inadequate data collection, and inadequate commitment to the establishment of prevention and intervention services.”

Burdekin (1993) also reported that these inadequacies in access and service provision are compounded for Aboriginal and Torres Strait Islander young people, those living in rural and remote areas, young people from non-English-speaking backgrounds, and for young people with dual or multiple disabilities.

In summary the report concluded that: “The human rights of disturbed and at-risk young Australians are being seriously denied by such glaring omissions, with often tragic consequences for the individuals and families involved, and for our entire community” (Burdekin 1993: 647).

**National health goals and targets for children and young people**

A project to develop a set of National Health Goals and Targets for Australian Children and Youth was funded by the Department of Health, Housing and Community Services in 1992. The project was based at the Child, Adolescent and Family Health Service in South Australia and was overseen by a Management Committee with expert representatives working in child and adolescent health, child and adolescent psychiatry in several states and territories, and the Australian Institute of Family Studies. An extensive consultation was conducted with individuals perceived to have specialised expertise in relevant areas and a report was released in September 1992 (unpublished).

Five major categories of goals were established: reduce the frequency of preventable premature mortality; reduce the impact of disability; reduce the incidence of vaccine preventable disease; reduce the impact of conditions occurring in adulthood but which have their origins or early manifestations in childhood or adolescence; and enhance family and social functioning.
Adolescent suicide was included as one of four causes of mortality targeted under the goal of reducing preventable mortality. The latter two goal categories listed above also represent directions in thinking about child and adolescent health more broadly that have shaped later initiatives such as the National Youth Suicide Prevention Strategy.

Specific strategies recommended for reducing suicide rates included: enhancing interpersonal and communication skills of adolescents and parents; reducing the availability of agents of harm; enhancing awareness of pre-suicidal behaviour and appropriate ways of dealing with this in the community “catchment system”, for example, school staff, family doctors, youth workers; and appropriate management and follow-up of youth who attempt suicide.

The National Health Goals and Targets for Australian Children and Youth also draws attention to the need for services for youth affected by the suicide and attempted suicide of a peer; improvements to mental health services for young people; improvements in services in the juvenile justice system, especially for Aboriginal youth; and strategies that address the use of drugs and alcohol.

Under the goal of enhancing family and social functioning, the report highlights the importance to young people’s health of social factors such as adequate housing and financial resources for families, access to educational opportunities, especially for Aboriginal and other socioeconomically disadvantaged groups, and improved employment opportunities for young people.

**National health goals and targets for mental health**

In 1994, the Australian Health Ministers agreed that one of the key goals for the improvement of mental health up to the year 2000 was to reduce the rate of suicide (National Health Goals and Targets Implementation Working Group on Mental Health 1994). Suicide reduction targets specific to young people were to: reduce by 20 per cent the incidence of suicide among adolescents aged 12–19 years; reduce by 15 per cent the incidence of injurious suicide attempts among adolescents aged 12–19 years; and to reduce by 20 per cent the incidence of suicide among men aged 20–24 years.

Among the strategies identified for reducing rates of suicide across all age groups was that governments should support the development of a national strategy on suicide prevention. In summary, other strategies recommended were:
• development of resilience and coping skills among young people both in and outside the education system;
• development of community-based self-help networks in rural areas, among those bereaved by suicide and other high risk communities;
• development of age-appropriate counselling services for people who have attempted suicide;
• development of protocols for management of suicide attempt and self-harm by all health facilities;
• education for primary care providers, teachers and guidance officers to improve identification of those at risk;
• education of the media;
• improvement of data collection systems;
• legislation to restrict access to firearms for all but essential purposes and to ensure safe storage; and
• establishment of a national clearing house and research centre for suicide research and prevention.

Activities consistent with all these recommendations have subsequently been supported through the National Youth Suicide Prevention Strategy, or addressed by other government actions in recent years.

**Public health significance of suicide prevention strategies**

In 1994 the Public Health Association of Australia hosted a National Conference on the Public Health Significance of Suicide Prevention Strategies which brought together professionals and academics from a range of disciplines, as well as consumers and advocacy organisations, with the aim of identifying common ground for developing a cooperative public health approach to suicide prevention in Australia. This conference provided a forum for the exchange of information about the growing number of prevention activities taking place throughout the states and territories and across a variety of sectors. The critical importance of a multidisciplinary approach was emphasised and the call for attention to suicide prevention in health policy and planning at a national level was reinforced (Public Health Association 1995).

**Here for Life: a national plan for youth in distress**

The first nationally coordinated response to the issue of youth suicide in Australia was entitled *Here for Life: A National Plan for Youth in Distress*, initiated in 1995 with the goal of reducing youth suicide rates in Australia.

The *Here for Life Plan* aimed to: develop, trial and evaluate best practice approaches to suicide prevention for groups of young people at the highest risk
of committing suicide; and integrate best practice in youth suicide prevention into standard approaches to youth health and to young people in crisis or at risk of suicide.

Consistent with these aims, the target groups of the *Here for Life Plan* were young people at highest risk – young people who had previously attempted suicide, young people who had a mental illness, young people living in rural and remote areas, young people from Aboriginal and Torres Strait Islander communities, and marginalised or seriously disaffected young people who engage in self-harming behaviour.

**National Youth Suicide Prevention Strategy**

The National Youth Suicide Prevention Strategy, introduced in 1995, involved a considerable broadening of scope compared to the *Here for Life Plan*. This expansion reflected recognition of a growing body of evidence concerning the process of risk development for suicidal behaviour across the life span.

The goals of the Strategy encompassed not just reduction of suicide rates but reduction of suicide attempt, suicidal behaviour and suicidal ideation, as well as promotion of social wellbeing and community connectedness.

Furthermore, the Strategy was concerned not just with those young people at highest risk (treatment, support and postvention) but also with young people affected by risk factors that may place them at risk in the future (early intervention) and the general population (primary prevention and promotion of health and wellbeing).

As noted at the beginning of this chapter, the United Nations (1996) highlighted important characteristics of national strategies, most of which have been taken up by the Australian Strategy:

- development, publication and implementation support for a national plan and conceptual framework;
- data collection and research;
- suicide prevention information and education;
- early identification, assessment, treatment and referral for professional care of individuals at risk;
- increased public awareness of mental wellbeing, suicidal behaviour, the consequences of stress and effective crisis management;
- provision of comprehensive specialist supportive and rehabilitation services;
- reduction in access to lethal methods of suicide;
- development of national and regional structures and supports for program implementation; and
- review and evaluation.
Based on the World Health Organisation (WHO 1990) and the United Nations (1996) recommendations Taylor, Kingdom and Jenkins (1997) extracted elements which they believed likely to be key factors in the coherence of national strategies. Specifically they argued that national strategies should be:

- supported by government policy;
- have clearly articulated general aims and goals;
- measurable objectives;
- have a strategic model for suicide prevention, and
- a focus on monitoring and evaluation.

The National Youth Suicide Prevention Strategy had three of the five elements regarded as necessary for coherence of national strategies – government policy support, clearly articulated general aims and goals, and an emphasis on monitoring and evaluation. An important limitation of the Strategy that it lacked measurable objectives, unlike the Finnish National Suicide Project where these were clearly defined. The Australian Strategy could have benefited from having a more coherent model of suicide prevention to guide policy development and planning.

A strength of the Project developed in Finland (National Research and Development Centre for Welfare and Health 1993) was that programs could be matched against this model during the period of the Strategy, and consequently modified and refined as necessary.

However, the Australian Strategy included the majority of elements recommended by the World Health Organisation and the United Nations. In this regard, Australia’s response may be compared most favourably with that of other countries.
This section provides a brief overview of a range of national policies and programs in the areas of mental health and the health and welfare of children and adolescents that can be seen as complementary to the National Youth Suicide Prevention Strategy.

**Developments in Australia**

Information on policies and programs gives an indication of the extent to which different arms of the Commonwealth government have been working to address the range of factors identified as being related to high suicide rates among young people. These policies and programs also signal infrastructure and levers that are available to support intersectoral collaboration at national, state and local levels.

**Mental health**

Extensive reform has taken place in mental health services in Australia over the past eight years. The National Mental Health Strategy was initiated in 1992 in response to a widely acknowledged need for major reform in the way mental health services are provided to people affected by mental illness. This strategy was endorsed by all Australian Health Ministers and has provided a comprehensive and detailed policy framework guiding reform in a number of areas.

The Commonwealth provided in excess of $250 million over the period 1 January 1993 to 30 June 1998 to assist implementation of the National Mental Health Strategy. Of this, $190 million was made available to states and territories for service reform.

Some of the major areas of reform addressed under the National Mental Health Strategy that are relevant to the National Youth Suicide Prevention Strategy include: changes in service mix; linking mental health services to other sectors; consumer and carer rights and participation; prevention; and mental health promotion.
Improved linkages between mental health services and other sectors could be anticipated to provide a basis on which to facilitate early intervention in mental health problems for young people.

Children and adolescents are identified as one of six special at risk groups whose needs must be dealt with. Other special groups include: older people; people from non-English-speaking backgrounds; Aboriginal and Torres Strait Islander people; people living in remote and rural areas; and offenders with a mental disorder. The National Mental Health Strategy identified the need for ensuring that the needs of special groups are addressed by consumer and community participation in the planning of services, specifically at the local service level. Apart from this, no specific strategies for ensuring that mental health services address the needs of children and young people are identified.

The Second National Mental Health Plan was endorsed by all Health Ministers on 30 July 1998 and seeks to expand the agenda of mental health reform by focusing on prevention, promotion and early intervention; the development of partnerships other health services, other sectors, non-government organisations and consumers; further reform in the private sector (including general practitioners); and improved quality and effectiveness of mental health services.

A Mental Health Promotion and Prevention National Action Plan was released in 1999 (Commonwealth Department of Health and Aged Care 1999) and a National Depression Initiative is currently being developed.

**Child and youth health**

A philosophical framework to guide the development of health services for young people during the late 1990s was provided by *The Health of Young Australians: A National Health Policy for Children and Young People* which was endorsed by the Australian Health Ministers Conference in June 1995. Its associated Action Plan, The National Health Plan for Young Australians, was endorsed by the Australian Health Ministers Conference in July 1996.

*The Health of Young Australians* articulates a number of key understandings regarding the health needs of children and young people that find further expression in the philosophy and principles underlying the National Youth Suicide Prevention Strategy. Specifically, the policy recognises that the health and health service issues affecting children and young people are special and sometimes unique, and that ongoing, positive investments are needed for an infant to grow into a competent, participating member of society.

**Aboriginal and Torres Strait Islander wellbeing**

A national initiative to improve the emotional and social wellbeing (mental health) status of Aboriginal people and Torres Strait Islanders has been underway since 1996–1997. The *Aboriginal and Torres Strait Islander Emotional and Social*
WellBeing (Mental Health) Action Plan has been administered by the Office for Aboriginal and Torres Strait Islander Health. Funding of $20.5 million was allocated over a period of four years, until 1999–2000.

The aim was to provide a coordinated approach to the development of a wide range of mental health services and activities that are accessible and culturally appropriate to the needs of Aboriginal people and Torres Strait Islanders.

The Action Plan incorporated three interlinked approaches: first, enhancing the appropriateness of mainstream mental health services to the needs of Aboriginal people; second, enhancing the mental health capacity of Aboriginal and Torres Strait Islander specific primary health care services; and third, developing specialist Aboriginal and Torres Strait Islander mental health services and programs.

More generally, Aboriginal and Torres Strait Islander health policy is based strongly on the principle of primary health care delivered by Aboriginal community controlled organisations. Implementation of this policy is facilitated by the work of peak bodies representing Aboriginal community controlled health organisations in each state and territory as well as the National Aboriginal Community Controlled Organisation.

An important mechanism for planning is the Agreements on Aboriginal and Torres Strait Islander Health. These are signed agreements between all state and territory Health Ministers, the Commonwealth Minister for Health and Aged Care, the Aboriginal and Torres Strait Islander Commission, and the various state and territory peak bodies representing Aboriginal community controlled health organisations.

The aims of the Agreements are to improve health outcomes. First, by improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health-related programs. Second, by increasing the level of resources allocated to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples, including within mainstream services. Third, by ensuring transparent and regular reporting for all services and programs. Fourth, by joint planning processes which allow for: full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities; improved cooperation and coordination of current service delivery by all spheres of government; and increased clarity with respect to the roles and responsibilities of the key stakeholders.

Planning at state, territory and regional levels is coordinated through state and territory Forums that include representation from all signatories to the Agreements. At a Commonwealth level, planning is coordinated through the Aboriginal and Torres Strait Islander Health Council which includes representation from the National Aboriginal Community Controlled Organisation, the Commonwealth Department of Health and Aged Care, the Australian Health Ministers Advisory Council, Aboriginal and Torres Strait Islander Commission, the Torres Strait Regional Authority, and the National Health and Medical Research Council.
The Agreements explicitly recognise that involving Aboriginal and Torres Strait Islander peoples in planning requires the maintenance of “a viable and independent Commonwealth funded National Aboriginal Community Controlled Health Organisation” and a viable and independent state/territory body representing the community controlled sector.

The Agreements and Forums are important mechanisms through which other national, state and local initiatives can coordinate with activities and programs of Aboriginal community controlled health organisations.

**Family and community**

The Commonwealth government has provided support to family services through its *Family Relationships Services Program* for the past four decades. The purpose of the Program is to promote and maintain quality family relationships. It is administered by the Family Services Branch within the Legal Aid and Family Services Division of the Attorney-General’s Department pursuant to provisions in the *Marriage Act 1961* and the *Family Law Act 1975*, and other administrative arrangements. Grants have been provided to both secular and church-based organisations. There are currently around sixty non-government agencies in receipt of grants through this Program.

In April 2000 the Commonwealth Department of Family and Community Services launched its new *Stronger Families and Communities Strategy*. The Strategy represents the Government’s primary response to the recommendations of an inquiry into aspects of family services initiated by the Attorney-General and referred to the House of Representatives Standing Committee on Legal and Constitutional Affairs. The results of this inquiry are documented in a report entitled *To Have and To Hold* which was released in 1998.

The *Stronger Families and Communities Strategy* aims to shift the focus of family and community services towards prevention and early intervention while maintaining support for families and communities at greatest risk. The underlying philosophy is that by helping to build stronger family and community relationships, much can be done to prevent difficult and expensive problems that arise if those relationships break down or do not work as well as they should. Another key principle is an emphasis on helping local communities to develop their own
solutions to local problems. Thus families and community members will be encouraged to be involved in developing projects funded under the Strategy.

The Federal government has committed $240 million to the *Stranger Families and Communities Strategy* over a period of four years, to be allocated across nine different initiatives:

- Stronger Families Fund;
- Early intervention, parenting and family relationship support;
- Greater flexibility and choice in child care;
- Local solutions to local problems;
- Can Do Community;
- Potential leadership in local communities;
- National skills development program for volunteers and international year of the volunteer;
- Longitudinal Study of Australian Children; and
- Communications strategy.

*Substance misuse*

Substance misuse has been the focus of concerted strategic action at the Commonwealth level since 1985 with the initiation of the National Campaign Against Drug Abuse.

The *National Drug Strategy* launched in 1993 was a cooperative venture between the Commonwealth and state/territory governments which aimed “to minimise the harmful effects of drugs and drug use in Australian society” (Ministerial Council on Drug Strategy 1997). Over $266 million was allocated by the Commonwealth to the National Drug Strategy between 1993 and 1997, comprising $199.7 million through a cost-sharing arrangement with matching contributions from state/territory governments, and $66.4 million on national initiatives such as research centres and other drug programs. The National Drug Strategy is based in the philosophy of harm minimisation and has supported a balanced range of interventions targeting the misuse of both licit and illicit substances.

Following the recommendations of Single and Rohl’s (1997) evaluation of the Strategy, a National Drug Strategy Unit was established within the Health and Aged Care to provide improved coordination of the ongoing Strategy, and a new National Drug Strategic Framework was developed for 1998-99 to 2002–03.

In addition to the development of partnerships and links with other strategies, the new National Drug Strategic Framework maintains a continuing commitment to the principle of harm minimisation. Other priority areas are increasing the community’s understanding of drug-related harm, reducing supply, preventing use, improving access to treatment, and enhancing professional education, training and research, and data development.
Violence and crime

The National Campaign Against Violence and Crime was a three-year strategic approach to the prevention of violence and crime in Australian communities. Administered through the Commonwealth Attorney-General’s Department, $13 million was allocated to the Campaign.

A new Commonwealth initiative entitled National Crime Prevention has recently replaced the Campaign. National Crime Prevention aims to find and promote ways of preventing crime, and fear of crime, in Australian communities. Linked to this is the National Anti-Crime Strategy which is a shared initiative of the state and territory governments in partnership with the Commonwealth which aims to harness Australia’s crime prevention talent and ensure that all agencies and officials cooperate to develop and promote best practice in crime prevention.

Young people and crime prevention is an area of high priority. Initiatives under National Crime Prevention and the National Anti-Crime Strategy focusing on young people include projects on the use of public space, public events, domestic violence, early intervention and homeless youth. Reports on domestic violence, public space and early intervention have recently been released.

The recent gun buy-back scheme which was implemented by the Attorney-General’s Department under The National Firearms Program Implementation Act 1996 and 1997 is another initiative from within the criminal justice sector that has important implications for youth suicide prevention. Following a national public education campaign, the gun buy-back scheme secured the surrender of 640,000 self-loading rifles and self-loading and pump-action shotguns, as well as other prohibited firearms nationwide. The effectiveness of the gun buy-back scheme is currently being evaluated by the Australian Institute of Criminology.

Homelessness

The Supported Accommodation Assistance Program (SAAP) is currently the primary service delivery response to homelessness in Australia. This is a cost-shared program between the Commonwealth and state and territory governments which are also jointly responsible for setting national priorities, monitoring and evaluation. The states and territories are responsible for the management and administration of the Program at the state/territory level.

The Program provides transitional supported accommodation and support services to people who are homeless, and people who are in crisis and are at imminent risk of becoming homeless, including those who are escaping domestic violence. Its goals are to resolve crises, break the cycle of homelessness, and re-establish independent living or other long-term housing arrangements as quickly as possible.

The Program provides funding to approximately 1200 community agencies across Australia. Besides providing supported accommodation, the agencies provide
meals, counselling, referral, mediation and advocacy support. The main reason young people use the services is family or relationship breakdown. Thirty-eight per cent of clients are aged 15–24 years.

The Youth Homelessness Pilot Program and the Prime Ministerial Youth Homelessness Taskforce were established by the Prime Minister in 1996 in response to concerns raised by some parents and community groups that existing programs placed too little emphasis on assisting young homeless people and their families to achieve reconciliation.

The Taskforce established twenty-six pilot projects which focused on identifying young people at risk of homelessness or who had recently become homeless, and supporting young people and their families in the reconciliation process. The pilot projects emphasised the principle of working with the young person, their family and, if possible, both together.

**Employment and training**

The Department of Education, Training and Youth Affairs provides special assistance with training and employment to young people through its Job Placement, Employment and Training (JPET) Program. This is an Australia-wide Commonwealth government program which assists young people aged 15–21 years affected by a variety of disadvantages to overcome barriers preventing them from maintaining stable accommodation and entering into full-time education, training or employment.

The JPET Program provides a holistic approach which offers ongoing support and referral services to overcome barriers such as housing difficulties, family problems, substance abuse, sexual or other abuse, lack of self-esteem and income support difficulties.

Community organisations are funded to provide JPET services to assist young people in the target groups listed above. These organisations must have good links with other community organisations and previous experience in assisting disadvantaged young people. There are 102 JPET services around Australia and these provide support to around 10,500 young people each year.

Funding for the JPET Program was due to cease at the end of June 2000, but has been extended for another four years with a total funding of $58.4 million.

**Income support**

Income support to people of all ages requiring assistance is provided by Centrelink. Centrelink has recently been restructured to operate as a “one-stop-shop” for Commonwealth services. A new approach to customer service is also being designed to improve access to services. The needs of young people have been an important consideration.
Centrelink’s new customer service delivery model is a combination of a One Main Contact Model and a Life Events Model whereby one customer service officer takes responsibility for all of the customer’s business, and service focuses on the life events currently being experienced by the customer.

Centrelink managers believe this model will be particularly beneficial in identifying young people at risk of a range of negative outcomes, including self-harming behaviour and suicide, and directing them to appropriate early intervention services. For example, Centrelink has been an important partner in a number of the Youth Homelessness Pilot Program projects (see above).

Another key aspect of Centrelink’s approach to service delivery is outreach and out-servicing. Community education is provided to ensure people are informed about Centrelink services and customers are provided with a wide range of access points including the internet, kiosk, over the phone, and in person. Customer service officers can also deliver services in a wide range of locations where customers are located including homes, prisons, refuges and any other location in the community. There is no need for customers to come into a Centrelink office.

One of the major assets of Centrelink in relation to early intervention is the sheer size and breadth of its service delivery infrastructure. Centrelink has a network of 20,000 customer service officers located in 296 Customer Service Centres throughout metropolitan, regional and rural Australia. Its capacity for outreach beyond these centres will further facilitate a role in early intervention with high risk young people who have historically been difficult to reach using centre-based interventions.

Implementation of the One Main Contact Model in existing Customer Service Centres is expected by June 1999. Centrelink is also currently conducting an evaluation of the Youth Allowance Scheme.

**Public health**

The National Health Priority Areas initiative builds on previous activity that took place under the banner of National Health Goals and Targets. The initiative seeks to focus public and health policy attention on those areas that contribute most to the burden of illness in the population and on areas of activity that can lead to significant reductions in the burden of illness. Mental Health is one of the five National Health Priority Areas.
Beginning with the National Health Goals and Targets, this initiative has insti-
tuted an increased commitment to the systematic monitoring of health outcomes. It has stimulated considerable activity related to the development and improve-
ment of information systems capable of providing information on health status
and needs at a population level, as well as monitoring activity and outcomes in
the areas of prevention, early intervention, treatment, and ongoing management
of chronic conditions.

The Australian Institute of Health and Welfare has the responsibility for moni-
toring and reporting national progress in the priority areas and is also playing a
major role in data development.

The National Public Health Partnership, endorsed by the Australian Health Min-
isters on 4 July 1996, is a working arrangement between the Commonwealth
and the states and territories to plan and coordinate national public health activ-
ities. It provides a more systematic and strategic approach for addressing public
health priorities and a vehicle through which major initiatives, new directions,
and best practice can be assessed and implemented.

In late 1998 the Commonwealth Department of Health and Family Services (now
Health and Aged Care) initiated the National Research and Development Col-
laboration on Health and Socioeconomic Status for Australia. The Collaboration
aims to increase understanding of, and the capacity to act on, social inequalities
in health. It will enable health system policy development to be informed by rel-
evant research, and policy makers and practitioners engaging with health and
socioeconomic status issues to have timely evidence to support their efforts. Inter-
sectoral collaboration will receive high priority among the policy and structural
issues to be explored.

**Rural health and infrastructure**

The Regional Australia Strategy contains a wide range of initiatives designed to
help enhance the economic, environmental and social infrastructure of rural and
regional Australia. A number of these initiatives contribute directly to the devel-
opment of infrastructure relevant to suicide prevention in rural areas.

At the level of service delivery the Regional Australia Strategy is contributing
funds to extend the coverage of the Multipurpose Services model which has shown considerable success in overcoming the difficulties involved in providing
a comprehensive range of services to small populations in rural and remote areas.
More than $24 million was provided over four years from 1998–1999. The Mul-
tipurpose Service model emphasises tailoring the service mix to the needs of the
community through community involvement in service development.

The Regional Australia Strategy also includes a new initiative entitled Improv-
ing services for families through enhancement of family and community service
networks which aims to improve links between family services in rural areas. It
also enhances support for a *Best Practice Parenting Grants Program* which aims to support parents and disseminate information about the outcomes of projects.

In collaboration with the states and territories, the Commonwealth is also developing a new plan of action for rural health for the period 1998–2002. The focus is on delivering more effective primary health care services and programs. The *Regional Australia Strategy* identifies the intention to increase the core funding of existing Aboriginal and Torres Strait Islander primary health care services by more than $42 million over four years in order to use best practice in tackling local health issues. The Strategy is also contributing approximately $8 million over four years to upgrade health infrastructure and staff housing in remote indigenous communities.

**Youth affairs**

The Youth Bureau in the Department of Education, Training and Youth Affairs has been given responsibility for overall coordination of youth affairs at the Commonwealth level. This remit includes development of policy with respect to the roles of a wide range of youth services. This group of services is highly varied and includes those fully and partially funded under, or administering projects in, most of the program areas outlined above. These services and programs are funded and administered by a wide variety of Commonwealth and state/territory government departments and units. Local government is also responsible for provision of generalist youth services in some states. Non-government agencies continue to play an increasingly prominent role in provision of services to young people.

Given the complexity of structures and programs in the “youth sector”, the importance of improving collaboration between the various initiatives concerned with the social and emotional wellbeing of young people is recognised by the Youth Bureau. Specifically, the importance of developing policy coordination has been identified. The Youth Bureau is currently exploring ways to position itself to do this effectively.

A significant development in youth affairs generally is the recommendation of the Prime Minister’s Youth Homelessness Taskforce to develop a *National Youth Pathways Action Plan*. The aim of the Plan would be to build and strengthen pathways for young people at risk in making the transition from dependence to active social and economic participation in the community. One major strategic objective is coordinating the efforts of the range of programs currently targeting young people including youth homelessness, youth suicide prevention, drug and alcohol and employment programs. The Taskforce also recommended that: “the Prime Minister ensure a concerted whole-of-government approach to the development of Commonwealth youth policy, including a clear point of accountability and ongoing processes for community participation in the provision of advice to government” (p.30).
An Interdepartmental Committee was established under the Department of Prime Minister and Cabinet to consider the establishment of a National Youth Pathways Action Plan and work on developing the plan began in late 1999.

**Coordinated care trials**

The February 1994 meeting of the Council of Australian Governments endorsed the need for reform of health and community services. Following this meeting, The Council recognised that profound structural change was needed in the health and community services system. A model consisting of three streams was proposed: general care; acute care; and coordinated care.

The *Coordinated Care* stream was identified as the priority for development. It was envisaged that the Coordinated Care stream would allow freer flow of resources to follow the patient rather than being locked up in individual providers and programs (Marcus 1999). In mid-1995 the Commonwealth developed proposals for a set of Coordinated Care Trials to test whether wider reforms were possible. Thirteen trials are currently being run in fifteen locations across Australia.

Each trial consists of: first, a trial sponsor (such as an area health service or a division of general practice) which is contracted to Commonwealth and state governments to manage the trial; second, a funding “pool” which combines funds drawn from a range of Commonwealth and state health care programs such as the Medicare Benefits Scheme, Pharmaceutical Benefits Scheme, and hospital funding, which is used to purchase any service for individual patients thought appropriate; third, a care coordination process which can be undertaken by a person (say, a local GP or designated case manager) or a service; and fourth, a defined client group – usually people with high care needs with a particular diagnosis or condition, or those with a range of chronic illnesses.

Four of the thirteen trials target indigenous peoples. Of the nine mainstream trials, five have targeted the aged population with complex care needs, and four have targeted various groups with no age restrictions. No trial has a special focus on young people or people whose complex health problems include mental disorders or suicidal behaviour. However, the four trials targeting various groups may include young people with these problems.

**Significance of the context**

Current policy developments in these fields continue to stimulate thinking about good practice in youth suicide prevention. They also shape the realities of the environment in which programs and activities take place.

The previous chapter outlined some of the major developments that have contributed to the formation of the National Youth Suicide Prevention Strategy. This
chapter has described current policies and programs in the areas of mental health and adolescent health and welfare that may have impacted upon the implementation of the Strategy.

This context is critical to assessing the appropriateness of the scope or breadth of actions taken by the National Youth Suicide Prevention Strategy and for identifying opportunities for intrasectoral and intersectoral collaboration. Consideration of this context is also necessary in judging the extent to which any outcomes or impacts are likely to be due to the Strategy compared to other initiatives.
Section 2
The strategy and its evaluation

The three chapters in Section Two of this Evaluation Report describe the National Youth Suicide Prevention Strategy and its evaluation by the Australian Institute of Family Studies.

Chapter 4 presents an examination of the conceptual underpinnings of the Strategy; Chapter 5 provides a detailed description of the Strategy’s approaches and activities; and Chapter 6 gives a detailed description of the methodology of the evaluation.
This chapter provides a description of the National Youth Suicide Prevention Strategy including its goals and administration, and the philosophy and principles underlying its development.

**Goals and administration**

The National Youth Suicide Prevention Strategy is an initiative of the Commonwealth Government to provide a coordinated approach to youth suicide prevention throughout Australia.

The thinking behind the development of the Strategy, its goals, principles and major approaches, are described in two publications of the Commonwealth Department of Health and Family Services: *Youth suicide in Australia: a background monograph*, and *Youth suicide in Australia: the national youth suicide prevention strategy*.

The original stated goals of the Strategy were:

- to prevent premature death from suicide among young people;
- to reduce rates of injury and self-harm;
- to reduce the incidence and prevalence of suicidal ideation and behaviour; and
- to enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

The Strategy was funded, administered and coordinated by the Mental Health Branch of the Commonwealth Department of Health and Aged Care (formerly Health and Family Services). Advice from stakeholder representatives was provided by a number of bodies including the Youth Suicide Prevention Advisory Group (July 1995 to June 1998) (see Appendix 4) and the National Advisory Council on Youth Suicide Prevention (from July 1998) (Appendix 5). Technical advice on the conduct of project evaluations was provided by the Evaluation Working Group (Appendix 6).
The Youth Suicide Prevention Advisory Group comprised representatives from government, the community, consumers, young people, service providers and researchers. The Terms of Reference of the Advisory Group were to advise the Commonwealth Department of Health and Family Services on youth suicide prevention issues including:

- the development and implementation of national policy and direction in youth suicide prevention;
- current and emerging knowledge and clinical practice in suicide prevention;
- the development of priority activities to be undertaken, including additional priorities beyond those specified in the existing youth suicide prevention programs;
- the views of other expert and consumer groups; and
- specific issues related to implementation of the youth suicide prevention program.

The National Advisory Council on Youth Suicide Prevention was formed in July 1998 and comprised seventeen members representing government, the community, consumers, young people, service providers and researchers. The Council reported to the Minister for Health and Aged Care, whereas the Youth Suicide Prevention Advisory Group advised and reported to the Department. Each state and territory government was represented in the composition of the Council. The general role of the Council was similar to that of the Advisory Group in terms of providing general advice on the National Youth Suicide Prevention Strategy. The initial focus of the Council was on developing coordination between the Commonwealth and the states and territories, and on developing a new framework for suicide prevention in Australia.

Consultation about activities across relevant Commonwealth agencies was facilitated by an inter-agency working group. Regular (three-monthly) reports on the Strategy were provided to the Ministerial Council on Employment, Education, Training and Youth Affairs Youth Taskforce through the Youth Bureau. Three-monthly reports on the Strategy were also provided to the AHMAC National Mental Health Working Group which oversees the National Mental Health Strategy.

A total of $31 million was allocated to the Strategy from July 1995 to June 1999. Funds were distributed across over eighty-eight different projects and activities including forty-four National Demonstration Projects. Funds were allocated via a number of processes including competitive tendering and selective tendering.

**Philosophy and principles**

Clarification of the theoretical assumptions and principles underlying programs is an important exercise in guiding reporting and evaluation. Theoretical assumptions and principles guide the selection and design of strategic actions. In
combination with stated goals they provide a framework for critically assessing the appropriateness of activities actually undertaken.

The two main philosophical or conceptual systems underlying the National Youth Suicide Prevention Strategy are the biopsychosocial model and the Public Health Approach.

**Biopsychosocial model**

There is widespread agreement among researchers and others that there is no single cause of suicide. The dominant perspective as to the cause of suicide among young people is that it is a highly complex phenomenon arising from a range of causes including biological and psychological factors operating within individuals as well as social and cultural factors.

This perspective, which is known as the biopsychosocial model is widely shared by a variety of professional groups in Australia and internationally, including those trained in both the medical and social sciences. It forms the basis of the approach adopted by the National Youth Suicide Prevention Strategy and is reflected, for example, in the literature review of risk factors for suicide among young people (Beautrais 2000) and interventions (Patton and Burns 2000) commissioned by the National Health and Medical Research Council.

The implication of the biopsychosocial model of causality to approaches to prevention is that comprehensive intervention strategies are required which address the range of biological, psychological and social causes. This understanding also calls for the involvement of a wide range of professionals, service sectors and government departments. Accordingly, the Strategy adopted a Public Health Approach to the planning of activities.

**A Public Health Approach**

“Public Health is a combination of science, practical skills, and beliefs that is directed to the maintenance and improvement of the health of all people. It is one of the efforts organised by society to protect, promote and restore the people’s health through collective or social actions” (Public Health Association 1998).

The principles on which the National Youth Suicide Prevention Strategy was based, as outlined in the *Youth Suicide in Australia: The National Youth Suicide Prevention Strategy* (CDHFS 1997), are those of a Public Health Approach. As indicated in the definition above, Public Health is a science, a practical method and a philosophy; it is an organised, planned and collective effort involving society as a whole; it is concerned with protecting and enhancing the health of the whole population as well as restoring the health of those whose health is poor; its methods include social action.
In this section, some of the key principles of the Public Health Approach as operationalised in the Strategy are elaborated.

**Evidence-based practice**

The Public Health Approach is science and practice. It emphasises the importance of ongoing study or research in order to inform the development of practice. Evidence-based practice in the Public Health Approach is based in the science of epidemiology – the study of the distribution and determinants of health problems in human populations – and the evaluation of actions taken to improve health (Irwig 1989).

The intention of evidence-based practice is to ensure that actions taken to improve health are based on the best available evidence about what the determinants of health problems are and what interventions are effective. It is widely acknowledged that in relation to youth suicide there is currently limited understanding of determinants and even less knowledge of what works to prevent suicide. This lack of knowledge does not justify inaction. The Strategy sought to build on the evidence base by supporting research directly, as well as embarking on a variety of interventions that seem sensible within the limits of current knowledge, and evaluating the effectiveness of these interventions within the limits of current resources and skills.

**Population-based and individual approaches**

The Public Health Approach seeks an improvement in the health of all people. It also seeks to protect, promote and restore the people’s health. Thus, in addition to interventions aimed at restoring the health of individuals and groups affected by health problems, the Public Health Approach involves interventions that aim to improve the health of whole populations.

Furthermore, the Public Health Approach involves collective or social actions. Collective or social actions are generally required in order to improve the health and wellbeing of whole populations. Public Health professionals argue that collective or social actions are also necessary to restore the wellbeing of groups whose health is poor.

The debate between those who advocate a focus on high-risk individuals and those who advocate population-based approaches is one of the most important tensions in suicide prevention research and practice in Australia today. The National Youth Suicide Prevention Strategy endorsed both individual and population-based approaches.

Historically, the focus on the individual is associated with the biomedical or the disease model which views abnormal or disturbed behaviour (such as suicide) as arising from disturbances or disorder within the individual displaying that behaviour. Interventions consistent with this view of causality include treatment...
of the underlying illness (such as depression) affecting the individual. Most psychological treatments are also based on the notion of individualistic disease.

The biopsychosocial model described above moves beyond the biomedical or disease model to recognise the importance of social factors in determining disturbed behaviour in addition to biological and psychological factors. Moreover, social factors are generally understood as interacting with biological and psychological factors in complex ways.

Proponents of the biopsychosocial model do not necessarily endorse a population-based approach. Rather, recognition of the importance of social factors is usually manifest in an extension of individualised treatment or support plans to include interventions aimed at social factors in the individual client’s immediate environment (for example, their living situation or employment status) or research that examines the impact of social factors on individuals.

Individualistic approaches are concerned with reducing the risk of suicide for individuals. They rely on strategies for identifying individuals likely to be at risk and targeting interventions at those individuals.

Population-based approaches aim to reduce the level of risk within populations or sub-populations through interventions designed to be relevant in some way for all members of those populations. These may include interventions that address individual risk and protective factors affecting large numbers of people in a population (for example, attitudes and behaviours such as pessimism and problem solving styles), or interventions that aim to alter environmental, systemic or structural determinants of social problems (such as social and economic policy and the quality of environments). As such, the population-based approach also provides a conceptual framework for intervention that is capable of addressing the cultural and moral factors that have been argued as being responsible for high suicide rates in certain types of societies (Durkheim 1897, cited in Giddens 1978; Eckersley 1995, 1997).

Some advocates of a population-based approach have argued that a focus on high risk individuals is not going to be effective in reducing suicide rates because current knowledge does not allow us to identify high risk individuals with sufficient sensitivity and specificity. Individualistic approaches will miss most of the suicides because we cannot predict them. Interventions that aim to reduce
risk for the whole population are advocated as necessary if significant impacts are to be made on rates of suicide in the population (Rosenman 1998).

Difficulty in accurately identifying people who would suicide without intervention is not an adequate reason to reject approaches that focus on individuals. A variety of clinical interventions and other support services focus on individuals belonging to high risk groups that contain a much larger number of people than those who exhibit suicide-related behaviour. Interventions providing treatment and support to individuals in groups at high risk for suicide (for example, people with a mental illness or homeless young people) are considered to have benefits reaching far beyond the prevention of suicide. Advocates of a population-based approach to suicide prevention would agree but may argue that these services should be seen as primarily addressing different health outcomes.

The issue of the role of services in preventing suicide may be more important in relation to youth suicide than adult suicide. Inappropriateness of services to young people’s needs is widely regarded as a factor contributing to high suicide rates among young people with mental health problems.

**A planned approach: national, state and local interventions**

Public Health is an organised effort. Effective organisation of effort to address significant public health problems requires the involvement of structures usually only present in large organisations such as government.

There is strong and widespread consensus that a centrally coordinated approach is required to the problem of suicide prevention among young people. At the same time there is recognition of the importance of interventions that are designed and implemented at a local level. Local community control and ownership is critical to the long-term sustainability of prevention projects. It should also be recognised that developing opportunity structures for community involvement is, in itself, a valid approach to suicide prevention.

Positions emphasising the importance of centrally coordinated and localised responses are not necessarily contradictory. The aim of centrally coordinated approaches should not be to direct or control the initiation of interventions. Rather, the aim should be to develop resources and infrastructure that provide support for the development and sustenance of a wide variety of locally-based initiatives, and to provide information and guidance that will assist in developing interventions that are likely to be most effective. Centrally coordinated strategies should not seek to replace local initiatives, rather they should complement and facilitate them.

Coordination at a central level also provides a more cost effective approach to management of certain activities. Some types of program development activity are very costly and cannot be managed effectively by local services or community groups acting on their own. Examples include research, information systems, staff training programs, development of good practice guidelines and standards,
and large scale population-based mental health promotion programs. Effective central coordination and monitoring also provides information about strengths and gaps in activity levels across different localities and sectors, and helps avoid inefficient duplication of costly program development effort that does take place in local programs.

The distinction between national and state/territory level approaches is also important. While both can often provide coordination and development of resources, infrastructure and information more cost effectively than local services, certain activities are better managed at the national than the state/territory level. These include the development of resources and programs that have wide generalisability across a range of geographic settings both within and across sectors. Because the states/territories are largely responsible for the administration of key services such as mental health services, they are often in a better position to manage the development of service infrastructure.

**Involvement of community, consumers and young people**

Public Health is an organised effort by society. It involves collective actions. The critical importance of involving communities in efforts to improve and promote health is acknowledged in key documents underpinning the development of public health practice in recent decades such as the *Ottawa Charter for Health Promotion* (WHO 1986).

The importance of ensuring the participation of consumers and community members in service development has received unprecedented recognition and support within the mental health field in Australia over recent years. Increasing consumer and community involvement has been a major priority and principle of the National Mental Health Strategy.

Consumer and community participation is recognised as essential for improving the quality and effectiveness of services and ensuring they are appropriate to the needs of diverse populations. Involving members of special needs groups in the planning and operation of services is the major strategy identified in the National Mental Health Strategy for improving responsiveness to the needs of these groups (Australian Health Ministers 1992: 14).

The National Youth Suicide Prevention Strategy recognised that program planning and evaluation should include the input of “those who have gained expertise through life experience” as well as those who have studied the issues. It is also acknowledged that communities and those most affected by programs should be given opportunities for input. The Strategy sought to involve members of the community, users of programs, and other young people in all levels of activity, from planning at the Commonwealth government level through to implementation of projects at the local level.

There are barriers that stand in the way of involving young people in program development and implementation. The aim of enhancing the involvement of
young people in program development and implementation has received consider- able attention from the Youth Suicide Prevention Advisory Group, the Eval- uation Working Group, and the National Advisory Council on Youth Suicide Prevention in their oversight of the Strategy.

Key measures that have involved young people include:

• representation of young people on advisory groups and working parties appointed under the Strategy;
• a large scale consultation with more than 1200 young people;
• funding support to forums and conferences on youth mental health issues and youth participation in these meetings;
• consultation with peak bodies; and
• encouragement for projects to involve young people in project management, implementation and evaluation.

**Intersectoral collaboration**

Understanding that youth suicide is a highly complex problem resulting from the interaction of a wide variety individual and social factors has led to the recogni- tion that a comprehensive approach to intervention is required. A sufficiently comprehensive approach cannot be achieved by any one sector acting alone. At the same time, the need for administrative and policy leadership and coordination in the implementation of new initiatives often requires that particular sectors of government assume primary responsibility.

As outlined in Chapter 3, a variety of national policies and programs in areas related to suicide prevention among young people are currently in place. Effective intersectoral collaboration requires awareness of the scope of such programs in the interests of avoiding duplication as well as identifying areas of common interest where cooperation is necessary for the achievement of maximal outcomes.

Operationalisation of intersectoral collaboration can take various forms:

• **Whole-of-government.** The most elaborate form involves the active engagement of all relevant government departments in the process of policy development, implementation and administration, and the creation of structures at all levels of government through which these departments work in partnership towards common goals.

• **Accommodation.** At the other end of the spectrum, intersectoral collaboration could involve a recognition of the complementarity between the activities of various arms of government and an accommodation to these complementary activities in the design of new initiatives. This accommodation could be passive, such as attempts to avoid duplication, or active, such as consulting with workers in other sectors to gain their input into program development.
Participation. Intersectoral collaboration falling between a whole-of-government approach and accommodation could involve the creation of project management, or steering committees with intersectoral representation, or allocation of funds to initiate or complement initiatives managed within other sectors.

Administrative and policy leadership in youth suicide prevention in Australia currently rests with the mental health sector. Other sectors with significant involvement in youth suicide prevention strategies, both national and state/territory, include: education; welfare; youth affairs; the wider health sector, particularly primary health care; employment; the justice system; primary industry; sport and recreation; and arts and culture. The National Youth Suicide Prevention Strategy involved the accommodation and participation forms of intersectoral collaboration.

The need for leadership responsibility as well as intersectoral involvement creates difficulties for many government programs. Policy development relies heavily on the use of language and conceptual frameworks that have meaning for practitioners and others within particular sectors. Language and conceptual frameworks guiding policy development within a particular sector can create conceptual barriers to practitioners from other sectors engaging in intersectoral partnerships.

The conceptual framework defining approaches to suicide prevention outlined in the original National Youth Suicide Prevention Strategy policy document (CDHFS 1997) and the Second National Stocktake of Youth Suicide Prevention Programs and Activities (AIFS 1999) used terminology that has no clear association with any particular sector with interests in youth suicide prevention. For instance, terms such as universal, selective and indicated prevention, as well as rehabilitation and case-identification, familiar in the mental health sector (Mrazek and Haggerty 1994) but unfamiliar in other sectors, were avoided. More generic terms such as primary prevention, early intervention, crisis intervention, primary care, support and postvention were used instead.

Sensitivity to cultural diversity

The National Youth Suicide Prevention Strategy is based on the principle that programs directed to young people should take into account youth culture, current social issues affecting young people, and the particular needs of diverse groups of young people. Much of the effort of the Strategy has been oriented towards service development activity which seeks to enhance the sensitivity of services to the special needs of young people and particular groups of young people who are marginalised from mainstream society.

Sensitivity to cultural diversity is acknowledged by all Australian governments as critical to service and program development in a country such as Australia where 16.9 per cent of the population speak languages other than English at home.
and where the indigenous population suffers from significantly higher mortality and morbidity than other Australians.

The notions of culture and cultural diversity are also useful when talking about sensitivity to the special needs of young people and other diverse groups. The concept of culture is an inclusive concept that recognises and affirms difference in its many forms and dimensions. It refers not only to differences based on ethnicity or language, but also embraces differences of lifestyle, world view and social experience that characterise socially defined sub-populations such as young people, same-sex attracted and transgender people, people who use drugs, and people who are homeless. Culture can also capture the common experiences of exclusion and discrimination that are widely recognised as affecting sub-populations such as those listed above that have minority status in society and have a high risk of suicide.

Insensitivity to special needs is frequently a failure to recognise the role of culture and cultural difference, particularly a failure to recognise that services and service providers have their own culture (Fitzgerald 1992), one that is generally oriented towards the norm, the average or the mainstream.

Similarly, the failure to develop services appropriate to the needs of young people in general, in many ways stems from a failure to recognise that there is a culture around adolescence that is different from mainstream adult culture. The physiological facts of being at a particular developmental stage interact with social forces to create a dynamic culture of youth that shapes patterns of behaviour, expectations, beliefs and thoughts in the same way as any other culture shapes (or embodies) these variables.

Development of services and programs appropriate to the needs of people from diverse groups, including young people, requires a commitment to the valuing and understanding of cultural diversity. It also requires a commitment to recognising and challenging the forces that contribute to the marginalisation and oppression of certain culturally defined groups. Actively involving members of diverse groups in service and program planning and implementation is increasingly acknowledged as the most important strategy for demonstrating such valuing of diversity, developing the necessary understanding and counteracting the forces of exclusion.
This chapter provides a description of the activities undertaken by the National Youth Suicide Prevention Strategy. Activities are grouped according to direct and system level approaches. Maps of Program Logic demonstrate how specific Strategy activities (inputs) are logically related to overall Strategy goals (outcomes) via system level processes and intermediate impacts for target populations. The chapter ends with a brief comparison with the approach taken by Finland’s National Strategy.

Approaches

The Strategy adopted approaches involving two levels of activity – direct level and system level.

Direct prevention approaches were aimed directly at young people or other target groups such as parents, families, peers and community members directly connected to young people. Direct level activities also worked directly with environments to modify risk and protective factors present in these environments.

Direct prevention approaches of the Strategy included:

- primary prevention and cultural change;
- early intervention;
- crisis intervention and primary care;
- treatment, support and postvention; and
- access to means/injury prevention.

System level activities aimed to build capacity or facilitate the adoption of evidence-based practice throughout all the service systems relevant to youth suicide prevention. System level activities worked across a number of direct approaches.

System level activities of the Strategy included:

- policy and planning;
• research and evaluation;
• communications (identification and dissemination of good practice);
• education and training;
• networking and intersectoral collaboration; and
• community development.

In practice, at the level of individual funded projects, there was considerable overlap between direct and system level activities. For instance, much of the Strategy activity under direct prevention approaches actually involved system level activity aimed at building capacity to conduct appropriate evidence-based interventions within each of the direct prevention approaches.

Because the focus of the various projects has evolved during implementation, the grouping of activities used here for the purposes of reporting and evaluation is slightly different from the grouping originally used for the purposes of funding and administration.

The information presented below provides a brief outline of the activities within each prevention approach. Details of all the National Demonstration Projects funded under the Strategy are provided in Appendix 3 and in the four published *Valuing young lives* supplementary technical reports.

**Direct prevention approaches**

The Strategy adopted five direct prevention approaches: primary prevention and cultural change; early intervention; crisis intervention and primary care; treatment, support and postvention; and restricting access to means.

**Primary prevention and cultural change**

The goal of primary prevention is to prevent the development of problems (risk factors) that place people at risk of suicide – for example, to prevent mental health problems, and to promote the development of resilience and protective factors such as optimism and interconnectedness between people and communities.

The purpose or nature of “cultural change” was not clearly defined in the Strategy documentation. However, there has been an understanding among many of those involved in the Strategy that promotion of values such as compassion and building social capital by increasing trust and social connectedness are fundamentally important to preventing suicide.

Primary prevention can be selectively or universally targeted. Selectively targeted primary prevention strategies target sub-groups in the population that have a higher than average chance of developing risk factors for suicide. Universal strategies target whole populations and include interventions targeting all individuals in a population, as well as interventions targeting environments and social and cultural factors.
Primary prevention activity funded under the Strategy was concentrated in four areas:

- parenting education and support;
- school-based programs;
- media education; and
- community development.

Seven parenting education and support programs were funded under the Strategy. The goal of these was to prevent the development of emotional and behavioural problems in children and adolescents such as conduct disorder and depression which have been linked to self-harm and suicide in later life. The projects addressed different aspects of service and program development activity. In order to ensure complementarity in the range of parenting activities, the parenting projects were provided with additional coordination and support at a national level.

The Strategy also funded a comprehensive school-based mental health promotion program entitled *Mind Matters* which developed and trialed structured resources to support a whole-school approach to mental health promotion in secondary schools. The program, which was piloted in twenty-four schools throughout Australia, focused on curriculum, ethos and organisation, and building partnerships between schools and community agencies.

Also consistent with the environmental settings approach to health promotion, the Strategy directed attention towards educating the media in safe ways to report on and talk about youth suicide issues. A media resource kit was developed and about 1400 copies distributed.

A number of community development projects included a focus on primary prevention. For example, by emphasising community-wide responsibility for the nurture of children and young people and changes to the quality of the community environment, *Project X* based at Kyogle Youth Action mainly supported a primary prevention approach. Projects based at *Cellblock Youth Health Service* and *High Street Youth Health Service* in Sydney involved recruiting and training young people to develop artistic resources for mental health promotion among young people.

**Early intervention**

The goal of early intervention in suicide prevention is to reduce the prevalence of emerging and recently developed risk factors for suicide among young people. Early intervention occurs after risk factors have begun to emerge but before suicide-related behaviours appear. The rationale behind early intervention is that it is more effective than late intervention in reversing the course of illness or problem progression, or reducing severity. If effective in this objective, early intervention should reduce the severity or period of exposure of individuals to these
risk factors and thereby prevent the development of negative concomitants such as suicide.

Early intervention for the purpose of suicide prevention targets individuals or groups who are developing problems which could place them at high risk of developing self-harm and suicide-related behaviours. This includes young people with early and emerging mental health problems, young people exposed to abuse/neglect/violence/sexual assault, or young people who are beginning to become involved in antisocial and offending behaviour.

Early intervention includes strategies to facilitate early identification of young people at risk in order to assist them gain access to appropriate help as soon as possible, as well as intervention to prevent the further development – or reduce the intensity, severity and duration – of the predisposing problems.

The main early intervention project of the Strategy was the Australian Early Intervention Network for Mental Health in Young People (AusEinet) which was funded in partnership with the National Mental Health Strategy. AusEinet focused on early intervention into mental health problems.

Three projects based in mental health services, and funded under the treatment, support and postvention approach, all included elements of early intervention such as seeking to enhance access of young people to services, and strengthening their engagement with services. Several of the parenting projects can be more correctly categorised as early intervention than primary prevention because they targeted parents who were already experiencing problems parenting their children.

A number of other projects also included strategies aimed at enhancing the identification of young people developing risk factors for suicide and enhancing their access to appropriate care. Three projects provided training to general practitioners and other community health workers in identifying risk factors for suicide in young people and linking them into appropriate services. Several projects sought to develop networks of service providers aimed at smoothing referral pathways for young people. These should have an impact on enhancing early detection and intervention for young people with emerging and early onset mental health problems. Based on consultation with stakeholders and a review of the literature, a report was produced which provides recommendations on ways of improving the quality of gatekeeper training.

Two projects focused on providing young people with information about a range of problems they are likely to encounter which could place them at risk, and ways
of seeking help. These were Reach Out! which provided information over the internet and the Here For Life Youth Sexuality Project which targeted same-sex attracted young people, peers and family members.

The National Youth Suicide Prevention Strategy and the Department of Employment, Education, Training and Youth Affairs jointly funded an early intervention project called As Soon As Possible at Bowden Brompton Community School in South Australia. A comprehensive set of measures was employed to facilitate: the detection of students with drug and alcohol problems, and/or feelings of anxiety, hopelessness, low self-esteem and depression; and the prompt development of an action plan.

**Crisis intervention and primary care**

Crisis intervention and primary care are short-term activities designed for young people who may be at immediate risk of suicidal behaviour. Crisis intervention aims to quickly ameliorate crises that could result in self-harm or suicide attempt. Primary care services act as a first point of call for people who may require assistance in tackling problems. Primary care providers such as general practitioners and community health services are in a position to identify young people who may be at risk, provide immediate support through crises, and link people into specialist services if required.

In this regard, activity of the Strategy was focused in hospital accident and emergency departments, general practice, and telephone counselling services.

Eight Strategy projects involved research and consultation to develop and trial protocols for the identification and management of deliberate self-harm and suicide attempt among young people presenting to hospital accident and emergency departments.

Three projects focused on developing the skills of general practitioners and other primary care providers to identify young people at risk and intervene effectively. Training focused on improving the ability of GPs to recognise risk signs such as depression and provide appropriate support and referral. One project also provided training to community health workers. Another project focused on the development of networks including GPs and other service providers. Networks aim to facilitate the sharing of information, smooth referral pathways for young people through the health system, and enhance cooperation between service providers in pursuit of professional development.

Resources were provided to Lifeline and Kids Help Line to expand their capacity to provide telephone counselling services to young people. These services have been extended and training provided to staff to increase their skills in counselling young people in crisis. Both these counselling services also implemented community education programs to increase general awareness about the availability of telephone counselling services.
Ongoing treatment, support and postvention activities are aimed at individual young people with long-term problems which place them at sustained risk of suicide. This group includes young people who have made suicide attempts or harmed themselves, as well as young people experiencing mental health problems and other sustained risk factors such as exposure to neglect and abuse, homelessness, and substance misuse which can lead to their being marginalised from the wider community. Postvention refers to interventions directed to family, friends, peers and other relevant contacts of young people who have completed suicide.

The Strategy funded three demonstration projects based in specialist child and adolescent mental health services. These aimed to improve the quality of treatment and the appropriateness of ongoing care provided to young people with mental disorders. One project focused on depression, one focused on early psychosis and substance misuse, and one developed interventions to identify young people at high risk of suicide and provide therapy specifically tailored to reduce identified suicide risk factors among young people with mental disorders.

Seven projects were based in agencies (including youth health services as well as a range of non-government agencies) that provide services to young people identified as marginalised and disaffected. These young people are generally affected by one or more risk factors for suicide including homelessness, substance misuse, contact with the juvenile justice system, or sexual identity issues. Many also have mental health problems and have made suicide attempts or developed suicide-related behaviours.

A major focus of the projects was exploration of strategies for engaging marginalised young people with helping services. The term “marginalisation” refers not only to the stigma and social rejection associated with the experiences or risk factors listed above, but also to the fact that young people with multiple problems are generally poorly catered for by most services. They are widely considered extremely challenging to work with. The specialist nature of most services means that their problems tend to be dealt with in isolation from each other. These young people tend to be shunted between services, with less than adequate follow-up, and they frequently fall through the gaps. As a result of their negative experiences in the service system many of these young people are highly suspicious of professional service providers.

Two of these projects focused specifically on providing intensive support to young people who have attempted suicide. A project based at The Bridge Youth Service conducted a drama group which provided a therapeutic experience for young people who had attempted or considered suicide. A project based at Centacare Catholic Family Services provided a clinical mobile suicide risk assessment service as well as consultancy and training to workers in other services.
**Restricting access to means: injury prevention**

Projects in this group explored issues around reducing access to the more lethal and injurious means of suicide and self-harm. There is a presumption that reducing access to means gives people a chance to reconsider their decision to end their life. The goal is to reduce the rate of completed suicides and injuries resulting from suicide attempt. Measures that restrict access to means of suicide may be included as primary prevention since they are basically concerned with the quality of environments, and are universally targeted.

Activity in the area of access to means was mostly limited to research into the issues surrounding the development of strategies. Initially a background report was prepared which examined trends in methods of suicide over the past twenty years up to 1994. This report made recommendations for further action.

Subsequent research was conducted by the Australian Institute for Suicide Research and Prevention to investigate the dramatic increase in the use of hanging with a view to designing effective methods of prevention. A separate study of indigenous suicide issues in North Queensland included consideration of the significance of hanging as a method of suicide among young Aboriginal people. The Australian Coroners Society was funded to conduct further research into railway deaths and jumping from heights behaviour. Research and development activity was conducted by two different groups to examine various aspects of the feasibility of modifying car exhaust systems to reduce prospects of carbon monoxide poisoning. The Coastal and Wheatbelt Public Health Unit in Western Australia piloted community-based approaches to reducing access to firearms and other means in rural areas.

An Access to Methods Working Group, comprised of six people representing researchers, government and services from various states and territories, oversaw the development and implementation of the Strategy’s Access to Means projects.

In order to progress the recommendations that emerge from the research into motor vehicle exhaust systems, the Australian Medical Association provided secretariat support to an ongoing Working Party of key stakeholders. The issue is also being considered within the National Injury Prevention Strategic Framework.

**System level approaches**

System level activities of the Strategy aimed to build capacity or facilitate the adoption of evidence-based practice throughout the service systems relevant to youth suicide prevention. Much of the activity described above under direct prevention approaches involves system level interventions that aim to build capacity. However, this activity was oriented towards particular types of direct prevention approaches. The Strategy also supported a number of projects that focused entirely on building capacity across a range of different approaches.
Policy and planning activities

It is important to recognise the importance of, and critically examine, policy and planning activities along with other system level activities because the quality of policy and planning can be the critical factor in the success or failure of government strategies.

Administration and management of the Strategy is outlined in Chapter 4. As indicated there, policy and planning activity for the Strategy has included input from a variety of stakeholders including professional groups, states and territories, researchers, young people and mental health service consumers, through representation on various advisory bodies.

The roles of the Youth Suicide Prevention Advisory Group (prior to 1998) (Appendix 4) and the National Advisory Council on Youth Suicide Prevention (from July 1998) (Appendix 5) were described earlier. Sub-groups of these bodies include an Education and Training Working Group, an Indigenous Issues Education and Training Sub-group, and an Access to Means Working Group.

The Evaluation Working Group (described earlier; see also Appendix 7) provided assistance in the planning and implementation of project evaluations. This group met thirty-two times during the course of the Strategy, six of which were two-day meetings.

Intersectoral communication at a Commonwealth level has been facilitated by the Commonwealth Agencies Working Group on Suicide Prevention and Mental Health Prevention and Promotion. This group originated from a Youth Suicide Prevention Working Group formed in 1995 as a sub-committee of an existing mental health Inter-Departmental Committee. This sub-committee met for a second time in 1997, and in November 1998 re-formed (as the present group) in order to discuss directions for youth suicide prevention under the new draft National Action Plan for Suicide Prevention, and to present the draft Mental Health Promotion and Prevention Action Plan.

Communication at a Commonwealth level has also been assisted by reporting mechanisms between the Strategy and the Australian Health Ministers Advisory Committee National Mental Health Working Group, and the Ministerial Council on Employment, Education, Training and Youth Affairs Youth Taskforce.

The policy framework of the Strategy is articulated in the Department of Health and Aged Care publication entitled Youth suicide in Australia: the National Youth Suicide Prevention Strategy. Information that informed this policy document is summarised in Youth suicide in Australia: a background monograph.

Funding was provided for approximately four full-time staff within Mental Health Branch to oversee the development and implementation of the Strategy. However, workloads of the National Mental Health Strategy and the National Youth Suicide Prevention Strategy have been shared and have fluctuated as necessary. There has been continuity of some key staff.


Research and evaluation

Research and evaluation activities of the Strategy included a range of information gathering activities which sought to increase the extent to which policy and program development are based on evidence. The aim is to ensure that programs are consistent with highest need, are addressing the most significant risk factors, are using interventions that work, and are appropriate to the needs of target groups.

In collaboration with the National Mental Health Strategy, the National Youth Suicide Prevention Strategy provided part of the funding for a structured consultation with young people on mental health and suicide issues. The report of this consultation, entitled Research and consultation with young people on mental health issues, was published in December 1997 (Keys Young 1997).

A National Youth Suicide Research Strategy was initiated in a collaboration between Mental Health Branch and the Strategic Research Development Committee of the National Health and Medical Research Council. A draft research agenda was initially developed in a national workshop held in Canberra in June 1997. Following the workshop three detailed literature reviews were commissioned to provide an up-to-date analysis of the research evidence in three areas.

The literature reviews examined:

- the epidemiology of suicide and attempted suicide among young Australians including definitional and data collection issues (Cantor et al. 2000);
- risk factor identification, prevalence, incidence and attributable risk for suicide and attempted suicide among young people (Beautrais 2000); and
- the effectiveness and cost effectiveness of interventions that aim to reduce youth suicide (Patton and Burns 2000).

Based on the results of the literature reviews, four areas of research were identified as being of strategic importance. A process of commissioning four research projects costing a total of $1,000,000 was set in train:

- a large scale randomised controlled trial of a universal intervention aimed at increasing resilience and reducing risk factors for adolescents and young adults;
- a large scale case-control study that includes suicides and medically serious attempts across several target populations;
- a study to explore the attitudes and responses of young men to intervention services, including strategies of engagement and service provision; and
- a scoping study which overviews a prospective longitudinal study of youth health and social and mental wellbeing including issues associated with resourcing and administering the study.

As part of a National Communications Project the Australian Institute of Family Studies conducted two national stocktakes of activity in youth suicide prevention
(AIFS 1998, 1999). In addition to facilitating communication between practitioners, analysis of these data provided information about areas of strength and weakness in current prevention activity that throws light on the appropriateness of other Strategy activities and can help guide planning into the future (Mitchell 1999a, 1999b).

In March 1997, funding was provided to support State Coroners in developing a suicide module for the National Coronial Information System. A draft report was submitted to Mental Health Branch. The issue of youth suicide data collection has now been subsumed into a whole-of-government approach to the development of the National Coronial Information System. A study of suicide in indigenous communities of North Queensland was also undertaken (Hunter et al. 1999). This included an analysis of official suicide statistics and comparison with data collected from three specific communities; a review of research literature on indigenous suicide; and an historical study of a community development process in one community.

Evaluation of each individual project funded under the Strategy and this Evaluation Report constitute a major research and evaluation initiative of the Strategy. In addition, many of the projects focusing on particular direct prevention approaches have had a major or minor research component.

**Communications**

Communications – the identification and dissemination of good practice – is closely related to research and evaluation but goes some steps further to enhance wide access to information.

A National Communications Project based at the Australian Institute of Family Studies has had primary responsibility for regularly disseminating information about Strategy activities and other suicide prevention activities to stakeholders. This has occurred via regular mailouts, publication of three issues of a *Youth Suicide Prevention Bulletin*, an Internet site, and an email discussion list. Other major components of this project included: the development of a substantial library collection and library service on youth suicide prevention; two national stocktakes of youth suicide prevention programs and activities; and the organisation of seminars and workshops at various professional conferences throughout Australia.
AusEinet, funded jointly by the Strategy and the National Mental Health Strategy, is a network which aims to promote the development of early intervention into mental health problems. In addition to a variety of other program development activities, it had a communications role in relation to early intervention as one approach to prevention of youth suicide. AusEinet has published regular newsletters, developed an Internet site, runs an email discussion list, and has published a series of guides on clinical approaches to early intervention in child and adolescent mental health.

Specific projects under other direct and system level approaches also used a variety of communications strategies to promote awareness of their projects and influence the opinions of stakeholders. Major communications strategies included presentations at conferences and seminars, publication of newsletters and reports, and the development of good practice guides.

Information relevant to good practice in education and training activities related to youth suicide prevention has been compiled and distributed by the Faculty of Health and Behavioural Sciences at Wollongong University (see below). A good practice guide has also been developed for suicide prevention in schools. The development of protocols for the management of self-harm and attempted suicide in hospital accident and emergency departments is another example of identification and dissemination of good practice.

**Education and training**

While education and training includes dissemination of information about good practice, it also includes active and structured reflection upon this information in ways designed to promote its impact on behaviour. Education and training in suicide prevention is an area where a significant amount of activity had been occurring for a number of years outside of the National Strategy, and there was considerable variability in the quality of the training programs on offer. The Strategy sought to improve the quality of education and training materials available and help users gain access to the best quality programs.

A project based at the Faculty of Health and Behavioural Sciences at the University of Wollongong produced a resource guide which reviews a large number of existing training programs against a set of educational criteria which were developed with broad consultation. This guide has been made widely available on the internet and in updateable printed form to assist organisations wishing to purchase suitable training for their staff. This group also developed good practice guidelines for the development of suicide prevention training.

Two projects (also described under the Crisis intervention and primary care approach) focused on developing and providing training to general practitioners. Large numbers of GPs received this training, as well as some community health workers. A project based at Victoria University of Technology developed a training program for youth workers, Aboriginal health workers, and juvenile
justice workers; and a project based at the Hunter Institute for Mental Health explored ways of ensuring that university curriculum for relevant disciplines allocates sufficient attention to issues relevant to youth suicide prevention.

A reasonable number of other Strategy projects belonging to a range of other approaches also provided training relevant to suicide prevention, mostly for their own staff, or for staff of agencies with which they were working.

In order to facilitate the wide usage of education and training products arising from the Strategy, a Working Group on Education and Training Issues was established. Membership included representation from the National Advisory Council on Youth Suicide Prevention, as well as the education sector, youth sector, general practice, and Industry Training Advisory Boards of Community Services and Health, Administration/Corrections, and Emergency services.

The terms of reference of the Working Group were to:

• provide advice to the Department of Health and Aged Care and the National Advisory Council on Youth Suicide Prevention on the quality and implementation of products arising from the Strategy, including proposed guidelines and resource guide;

• link youth suicide prevention education and training initiatives across sectors and levels of government; and

• provide advice to the Department and the National Advisory Council on priority education and training activities which may be considered under any future national suicide prevention plan.

An Indigenous Sub-group of the Working Group on Education and Training was also formed. The original role of this sub-group was to assist in the development of competency-based training in youth suicide prevention for Indigenous Community Health Workers.

The Indigenous Sub-group is continuing in order to:

• provide advice on possible education and training initiatives for indigenous communities;

• link indigenous suicide prevention education and training initiatives across sectors and levels of government; and

• provide broader advice on issues of suicide prevention within indigenous communities.

**Networking and intersectoral collaboration**

Networking of services has emerged as a popular approach to suicide prevention in its own right. This strategy has been particularly popular in rural and regional areas, mainly as a way of smoothing referral pathways, sealing gaps in the system, and sharing skills and knowledge.
Networking and intersectoral collaboration is built into several Strategy projects described under other approaches. AusEinet (also mentioned above under early intervention and communications) is intended to be, first and foremost, a network involving clinicians, consumers, carers, researchers and policy makers. The Logan Area of General Practice and Southern Rural Queensland Area of General Practice established a number of networks that aim to link general practitioners in with a variety of other service providers in order to facilitate the identification, management and referral of young people at risk.

A number of projects funded under other approaches also put considerable effort into networking and enhancing cooperation and collaboration between service agencies. Youth health services and community agencies working with young people who are marginalised and disaffected were particularly proactive in this regard. Networking and intersectoral collaboration is a central component of community development programs.

**Community development**

Strategy funding for community development activity was intended to assist communities develop their own programs in ways that would be self-sustaining in the long term. A key ingredient of community development is the integral involvement of community members in the planning, decision-making and implementation of programs and activities. A broad-based community development strategy may support a number of different interventions belonging to different direct prevention approaches described above (especially primary prevention, and early intervention).

Community development could be seen as spanning direct and system level approaches. It aims to effect change in social and service systems. However, involving members of target groups and communities in program development has also been observed as having direct positive impacts on the mental health and wellbeing of participants and the wider community.

Genuine community development needs to be distinguished from community support programs that develop community services or provide community education about suicide but are not oriented towards community ownership and empowerment.

The Strategy supported several projects that attempted to use a genuine community development approach.

The **Support to Rural Communities Project** was administered by the Gilmore Centre (formerly the Australian Rural Health Research Institute) at Charles Sturt University. The aim of the project was to trial and evaluate the effectiveness of state, territory and regional networks representing a substantial geographic area in supporting a number of rural or remote communities to prevent and respond to suicide or suicide attempts by young people. The major strategies actually used
were to: employ a person at each trial site and provide training; identify and strengthen existing networks; provide support and training to network members; develop a resource and training manual on suicide prevention; and provide clinical support. The project was implemented at five sites: Tiwi Islands in the Northern Territory, Atherton in Queensland, Bourke in New South Wales, Oatlands in Tasmania, and Millicent in South Australia.

Project X, based at Kyogle Youth Action, aimed to foster the belief that nurturing children and young people is a broad community responsibility. It sought to engage all major community organisations and as many community members as possible in managing, advising on, designing and participating in a variety of suicide prevention projects. The project was entirely managed and driven by young people.

Projects based at Cellblock Youth Health Service and High Street Youth Health Service in Sydney recruited and trained young people to develop artistic resources for mental health promotion among young people.

Community development, or community participation, has been identified as a critical element of programs that seek to address sub-populations with special needs. Certain Strategy projects targeting particular sub-populations may be considered community development to the extent that they were based in community organisations belonging to the particular communities concerned.

Many such community organisations tend to adopt a community development approach in their work generally. As well as providing support services directly to members of their community these organisations often aim to engage community members as voluntary contributors to the work of their organisation. They provide support such as training and community network development to facilitate this involvement. One such project that actually involved young people as participants was the Here For Life Youth Sexuality Project based at the Western Australian Aids Council, and the Gay and Lesbian Counselling Service (Western Australia).

The Strategy contributed $1 million towards the establishment of the Lumbu Foundation for indigenous families and children as part of the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan. The Lumbu Foundation aims to distribute small grants to support a wide range of community development projects in indigenous communities.

The research project that examined indigenous suicide issues in North Queensland (Hunter et al. 1999) included a detailed historical study of a community development process that took place in the community of Yarrabah in Far North Queensland during the 1980s and 1990s. This study provided valuable insights into the factors that facilitated community empowerment in addressing youth suicide issues as well as wider social problems in the community.
This chapter describes the purpose, aims, scope, framework and design of the evaluation of the National Youth Suicide Prevention Strategy conducted by the Australian Institute of Family Studies, as well as the methods used to collect and analyse the data. The ways in which particular types of information have been used to inform the evaluation are explained.

**Purpose of the evaluation**

The Australian Institute of Family Studies was commissioned by the Commonwealth Department of Health and Aged Care to evaluate the National Youth Suicide Prevention Strategy 1995–1999. This evaluation constitutes a “summative evaluation”, a term used to refer to evaluation activity occurring at the ends of cycles of development activity, for the purpose of providing input to management decisions concerning the future of the program being evaluated.

With the increasing scarcity of resources available for government programs, it is critical to ensure that those funds that are available are used appropriately. Program evaluation is essential for ensuring accountability to government and the public concerning the use of tax payers’ money.

Social problems such as suicide among young people demand effective action. Serious concerns have been raised in a number of recent reports about the quality of services and programs available to address problems relevant to suicide such as the state of mental health services (Burdekin 1993), the wellbeing and human rights of Aboriginal people and Torres Strait Islanders (Johnston 1991; Wilson 1997) and the legal rights of children (ALRC/HREOC 1997).

It is incumbent upon governments to ensure that actions funded by them are achieving the outcomes they are designed to achieve or, at the very least, that such actions are not causing harm. In the area of suicide there is evidence that some interventions can indeed cause harm, and vigilant monitoring is necessary to
ensure detection of such negative outcomes if and when they occur, and to ensure that action is taken to avoid continuation of harmful practices.

In addition to providing accountability and avoiding harm, evaluation of past and current activity aims to provide policy makers and planners with information they can use to make the best possible decisions about the allocation of resources at their disposal. The evaluation reported on here has also sought to provide practitioners and researchers with detailed information that may be of use in guiding practice and the design of future research.

**Aims of the evaluation**

The original Terms of Reference of the evaluation were:

- to determine the extent to which the National Youth Suicide Prevention Strategy has achieved its goals or developed and initiated activities which achieve objectives directly related to those goals; and

- to develop recommendations to inform the Government, particularly the Minister for Health and Aged Care, on future national youth suicide prevention policy development.

During early discussions around the development of the evaluation plan, stakeholders expressed the view that most of the stated goals of the Strategy were highly ambitious and somewhat unrealistic given the limited four-year time frame in which it was operating. For example, there was a clear consensus among stakeholders that the Strategy was not going to be able to meet the goals of reducing rates of suicide, suicidal behaviour and injury among young people.

This realisation indicated the need to expand the aims of the evaluation beyond the task of ascertaining whether or not the Strategy had met its goals. The majority of stakeholders expressed a strong preference for the evaluation to identify interventions that are effective in reducing risk factors for suicide and enhancing protective factors, and to generate detailed practical information about the factors that facilitate and inhibit the process of implementing effective interventions.

Based on the original Terms of Reference and the input of stakeholders, the following aims were developed for the evaluation:

- determine the extent to which the Strategy has achieved impacts or outputs directly related to its stated goals;

- determine the extent to which the Strategy has initiated activities appropriate to the achievement of objectives directly associated with the stated goals;

- document the main lessons learned through the experience of implementing a nationally coordinated approach to prevention of youth suicide; and
• develop recommendations to inform the Government, particularly the Minister for Health and Aged Care, on future national youth suicide prevention policy development.

The focus of the evaluation is on assessing appropriateness and, where possible, effectiveness (Department of Finance 1994). Appropriateness refers to whether or not program inputs and processes are appropriate to the achievement of program objectives. Effectiveness is concerned with whether or not the program has achieved its objectives, documenting unanticipated outcomes (both positive and negative), and identifying the factors responsible for outcomes (factors both internal and external to the program).

Evaluation of effectiveness requires the existence of clear objectives that are measurable and realistic. As explained below, such objectives were not articulated for the National Youth Suicide Prevention Strategy prior to the evaluation, and no systems for collecting relevant data were put in place. Analysis of program logic (Department of Finance 1994) has been used to derive objectives (impacts) and aims (processes) that are amenable to valid measurement (see Appendix One). Wherever possible the evaluation has sought to address the question of whether these post-hoc aims and objectives have been met.

Irrespective of the extent to which aims and objectives were met, many people involved in the Strategy have gained experience and knowledge invaluable to progressing prevention of suicide among young people in Australia in the future. It is critical that these learning experiences – both positive and negative – are documented so that others may gain insight from them.

Scope of the evaluation

The evaluation includes the following components.

• A description of the National Youth Suicide Prevention Strategy including: administration and management; principles and philosophy; and goals (outcomes), objectives (impacts), processes, and inputs (activities). Articulation of principles and concepts is important for defining the parameters or scope of program evaluation. This information is also critical for assessing the extent to which a program has been implemented as originally intended, or has strayed from its principles (evaluating program integrity).

• Consideration of the context of the Strategy including the history of the development of the Strategy, the broader policy context, the scope of the problem of youth suicide in Australia, evidence concerning risk factors for suicide, evidence concerning effective interventions, literature describing other national youth suicide prevention strategies.

• Identification of the Strategy’s actual outcomes and impacts as well as other achievements, using a number of sources of information.
• An examination of the extent to which the Strategy processes and inputs were appropriate to achievement of its stated goals and implied objectives, including consideration of the evidence base, the broader policy context, barriers and facilitators, and sustainability and generalisability.

• Identification of gaps and issues remaining to be addressed.

• Documentation of what has been learned about good practice in youth suicide prevention.

• Recommendations for future directions.

Design issues

Summative evaluation acknowledges that program goals may not be achievable in the short term and that the work of achieving these goals is a long-term process.

Short time since initiation of Strategy

In considering the achievements of the Strategy it is important to recognise that many of the activities of the Strategy were designed to stimulate change within complex organisational and social systems. In most cases the projects were operating at the level of change initiation. The process of change is yet to move on to wider adoption, generalised implementation and institutionalisation (Nutbeam and Harris 1998; Goodman, Steckler and Kegler 1997) in the relevant systems. It would be expected that considerable time would be required to translate these system level effects or processes into impacts on risk and protective factors, and outcomes in terms of health status and suicide rates within populations. The direct level Strategy activities were also mainly small scale projects in local communities and consequently had very limited potential to affect suicide rates nationally.

The short time frame of the Strategy is the main reason why the evaluation cannot rely on suicide statistics as an indicator of effectiveness. The earliest activities of the Strategy began only in 1996, and many started later than this. It is unlikely that these activities would have had time to affect suicide rates.

Suicide rates and the Strategy

In addition to the short time available since the initiation of the Strategy and the problem of confounding factors (see below), there are a number of problems with suicide statistics which make them unreliable as indicators of achievement for the Strategy.

While suicide rates are undesirably high, suicides are nonetheless infrequent as statistical events. The relatively low frequency of suicide means that there are considerable problems in using suicide rates as an outcome criterion in the evaluation of interventions (Eisenberg 1980). Worldwide, the reliability of
suicide reporting is questionable. Reliability of suicide data is adversely affected by factors such as under-reporting (Cantor et al. 2000).

Historical underreporting and variation in reporting of a genuinely low frequency event makes official suicide statistics extremely vulnerable to artificial variations that are unrelated to the influence of preventative interventions. In Australia for example, varying data collection procedures among states and territories provide considerable scope for suicide rates to be influenced by those procedures (Cantor et al. 2000), and to impact negatively on the reliability of the data collected. It is to be expected that attempted suicide rates and suicidal ideation would be affected still more.

**Absence of measurable intermediate objectives**

A set of measurable objectives and or performance indicators is essential to rigorous evaluation (Department of Finance 1994). The issues raised above in relation to the early status of the change process initiated by the Strategy, and other problems with suicide statistics, underscore the importance of having a set of intermediate objectives and indicators that can be used to monitor progress towards goal achievement over time.

In the case of suicide prevention, intermediate impacts and performance indicators include the incidence and prevalence of risk and protective factors for suicide among young people and in community environments, and system level policies, structures, standards, skills and knowledge.

No such set of intermediate objectives or indicators was developed for the Strategy. These have been developed retrospectively using analysis of program logic (Department of Finance 1994).

**Lack of baseline data for intermediate indicators**

Since the initiation of the Strategy, several national surveys have produced data on the prevalence and incidence of key risk factors for suicide (ABS 1997; Sawyer et al. 2000). Several other projects are currently generating information that may be relevant to system level indicators.

Unfortunately, little or no data are available on the status of these key indicators in the period prior to the initiation of the Strategy, and this precludes an ability to assess reliably whether progress has been made on these indicators over the course of the Strategy.
Confounding factors

A major design issue for the evaluation is the difficulty in attributing any observed outcomes or impacts to the Strategy specifically. Many other factors, including related national and state/territory programs, could be exerting an influence on suicide rates and other indicators. Inferences about cause and effect are only possible with the use of experimental designs that compare outcomes and impacts for subjects (or settings) exposed to the program and subjects (or settings) not exposed to the program, while controlling or adjusting for the effects of confounding factors.

The nature of a national strategy like the National Youth Suicide Prevention Strategy is such that it is not possible to secure a control group or setting that will allow comparison of outcomes for individuals or communities exposed and not exposed to the Strategy. Many of the programs funded under the Strategy had national coverage.

In the absence of a control group, the next best evidence for causality comes from longitudinal studies that examine changes in outcomes and impacts over time, before and after the introduction of an intervention. However, such data would still be of limited value in the evaluation of the Strategy because the Strategy represents only the earliest stage of a long-term process. Changes in health outcomes as a result of this process would not be expected to be observable for some considerable time.

However, depending on the nature of research designs used to evaluate specific components or individual projects of the Strategy, it may be possible to make inferences about the causes of changes associated with these components/projects.

Framework for the evaluation

Two well established frameworks were used to guide the design of the evaluation, analysis of data and reporting of results: the Public Health Approach, and Program Theory or Program Logic.

Public Health Approach

The Public Health Approach to evaluation situates evaluation within a strategic planning approach to improvement of population health outcomes. Public Health strategic planning is based on the formulation of goals that are phrased in terms of desired health outcomes (measurable changes in the health status of target groups) and objectives which are phrased in terms of desired impacts (such as prevalence of risk and protective factors including attitudes, knowledge, skills, and behaviours of members of the target group).

The Public Health Approach identifies the importance of distinguishing between, on the one hand, goals and outcomes and objectives and impacts that are phrased
in terms of changes in the population being targeted by the program, and aims and processes on the other. Aims and processes are commonly phrased in terms of performance indicators, or the qualities of services and programs that are desired. Aims and processes also frequently refer to the strategies and activities that are put in place by a program.

**Public Health Approach to program evaluation**

- **Outcomes** – changes in the health and wellbeing of the target population or program participants
- **Impacts** – changes in modifiable risk and protective factors in individuals (behaviours, skills, attitudes and knowledge) and environments
- **Processes** – changes in service and program delivery systems

The focus on population health outcomes within the Public Health Approach provides a means of addressing several of the evaluation design issues discussed above. Population health outcomes monitoring acknowledges that significant gains in the health of whole populations requires a long-term commitment to planned action and sustained monitoring of progress.

By emphasising changes in population health status and the prevalence of risk and protective factors as the key focus, a population health outcomes approach places less emphasis on the necessity of attributing changes to particular programs. It is understood and acknowledged that many programs and other factors could be contributing to changes in health status. The focus is on ensuring that society as a whole is moving towards achievement of the desired outcomes. Any contribution of particular programs such as the Strategy to changes in health status is seen in the context of other relevant programs and factors.

**Program Theory / Program Logic**

Program Theory (Bickman 1996) and Program Logic (Department of Finance 1994) were used as a tool for exploring the contribution of the Strategy to any progress toward population health gain.

A Map of Program Logic is a diagrammatic representation of four major groups of elements: inputs (or activities); processes/aims; impacts/objectives; and outcomes/goals. Bickman (1996: 112) has described Program Theory as “a plausible and sensible model of how a program is supposed to work”. Program Theory and Program Logic provide hypothetical maps of the logical and causal relationships between program inputs (activities), processes, impacts and outcomes. They are a powerful tool for assessing the appropriateness of activities, identifying gaps, and formulating evaluation questions to address these issues.
Analysis of program logic can be used during program design or as a tool for understanding a program that has already been initiated.

The Program Theory approach differentiates between program theory failure and program implementation failure. Program implementation is assessed by identifying whether program inputs are in fact put in place as planned. If this does not occur then the program theory cannot be tested. Program theory is tested by determining whether implementation is followed by the processes hypothesised to flow from the inputs, and whether these processes are followed by the hypothesised impacts and outcomes.

Maps of Program Logic were developed for the Strategy as a whole and for each of the five direct prevention approaches – primary prevention and cultural change, early intervention, crisis intervention and primary care, treatment, support and postvention, and access to means (see Appendix 1). These frameworks have helped guide the analysis and reporting of results.

Each map of Program Logic was developed in two main steps:

- **Recording outcomes/goals and inputs**
  These two groups of elements were largely given. Inputs were framed in terms of the activities that were actually undertaken by the Strategy projects. Information about these activities was obtained from program documentation and individual project reports. The outcomes/goals were obtained directly from the original stated goals of the Strategy and by modifying the original stated goals slightly according to the rationale of particular direct prevention approaches articulated in Strategy policy documents and the wider literature.

- **Deriving or deducing processes and impacts/objectives**
  Processes/aims and impacts/objectives were derived by analysing the logical relationships between inputs and goals/outcomes or the theoretical pathways by which inputs are expected to be translated into outcomes. More specifically, processes were derived by considering the nature of inputs and the aims of specific activities articulated in project reports. Projects with similar aims and activities were grouped and common processes abstracted.

  Impacts/objectives were derived by analysing the logical relationship between the goals/outcomes and processes. This involved a consideration of theory and empirical evidence regarding the full range of conditions necessary for the achievement of the stated goals/outcomes as well as a consideration of the limitations imposed by the actual processes set in train by the Strategy. The aim was to develop a set of objectives/impacts that struck a balance between providing a means of identifying and describing actual achievements and ensuring an ability to detect gaps in practice. This is a difficult task if expected impacts are modest as is the case here.

In combination, the Public Health (population-health outcomes) Approach and analysis of Program Logic provide a framework for organising data in a manner
that can indicate whether the Strategy has been effective in initiating processes or has achieved impacts that are logically consistent with progress towards population health goals.

**Methods of data collection and analysis**

The Australian Institute of Family Studies evaluation of the Strategy uses naturalistic or phenomenological methods of data collection and analysis (Patton 1989). Naturalistic inquiry methods seek to describe and understand the program and the factors affecting its outcomes and processes in natural settings. In contrast to experimental methods, naturalistic methods minimise the extent to which the evaluator manipulates program variables for the purpose of controlled study.

Naturalistic inquiry is often more appropriate than experimental methods when the program is being studied under real world conditions that may render the program subject to change and redirection (Patton 1989). In other words, a naturalistic approach may be preferred to an experimental approach when the focus of the evaluation is on effectiveness and appropriateness rather than efficacy (see Irwig 1989 for a discussion of efficacy versus effectiveness).

Another important feature of naturalistic evaluation is minimisation of constraints to outcome and impact measures (Guba 1978, cited in Patton 1989). Naturalistic inquiry maintains an openness that facilitates discovery of unanticipated impacts, both positive and negative. Unanticipated impacts may be missed in experimental designs that rely on measurement of a fixed set of variables determined in advance according to deductive hypotheses. The naturalistic approach is also better suited to the exploration and understanding of process issues in program implementation. Such understanding is vital to the development of strategies for enhancing uptake of effective programs in the complex and often messy real world of service systems.

Naturalistic inquiry often relies most heavily on qualitative data, however, there is no necessary constraint on the types of data that can be used. Both qualitative and quantitative data are used in this evaluation. While the overall evaluation of the Strategy uses a naturalistic approach, there is not an exclusive reliance on data obtained from naturalistic research. This evaluation incorporates data from a number of different sources. The main source of data is the evaluations of individual programs funded under the Strategy. These individual program evaluations have used a wide variety of approaches and methods.

Five main methods were used to collect and analyse data for the evaluation:

- a qualitative meta-analysis (meta-evaluation) of project evaluation reports;
- survey of key stakeholders;
- informal consultation with key stakeholders;
- review of research and practice literature; and
- review of policy and program context.
Information from two other studies conducted as part of the Strategy was also used:

- a national stocktake of youth suicide prevention programs and activities (AIFS 1998); and
- a report on research and consultation with young people (Keys Young 1997).

**Qualitative meta-analysis of project evaluation reports**

The forty-four National Demonstration Projects funded under the Strategy were evaluated individually. Some of these evaluations were conducted by external evaluators who were independent of the agencies conducting the projects while some projects were evaluated internally by project managers and staff.

Evaluation reports varied dramatically in their quality and comprehensiveness. Two projects failed to provide either an evaluation or a final report. A wide range of evaluation designs and methods were used depending on the skills, capacities and resources available to evaluators. Most used descriptive qualitative methods, with only a minority using controlled designs.

Information from the individual project evaluation reports was content analysed to identify common themes. Separate qualitative meta-analyses were conducted for each of the main direct and system level approaches used by the Strategy. Analysis of Program Logic provided the framework for content analysis. First, the project evaluation reports were searched for evidence pertaining to outcomes, impacts, processes and inputs. Second, information relevant to the relationships between inputs, processes, impacts and outcomes was identified in order to develop understanding the factors that facilitated and inhibited achievement at these different levels.

**Survey of key stakeholders**

A survey of key stakeholders of the Strategy was conducted in October 1999. Specific stakeholders were targeted including: Area Directors of Mental Health in all states and territories of Australia; Divisions of General Practice; non-government peak bodies in a variety of sectors; indigenous organisations; and professional associations.

A major rationale in such targeting was to capture the viewpoint of stakeholders who have not necessarily been involved in the Strategy but whose active involvement will be important if the work of the Strategy is to be extended. Respondents were assured of confidentiality, so names are not included here.

The survey explored stakeholders’ perceptions regarding progress towards population health outcomes and impacts and changes in service systems relevant to the goals, objectives and aims of the Strategy. Respondents were asked to rate each indicator on a scale of one to five according to how much they believed the
situation had improved or worsened between 1995 and 1999. For each group of indicators (relating to the major prevention approaches) respondents were asked to indicate the extent to which they believed the Strategy had contributed to the changes they perceived as having taken place.

Three hundred questionnaires were mailed out and 151 were returned yielding a return rate of just over 50 per cent. Four of the 151 were not completed at all and four were not used because of other problems. Thus a total of 143 survey forms were entered onto computer and analysed.

**Informal consultation with key stakeholders**

Consultation with key stakeholders was informal and took place in a variety of ways. The evaluator met with officers of the Commonwealth government and several national peak bodies across a number of sectors with interests in youth suicide prevention (Appendix 9). Discussion at these meetings focused on identifying the information needs of stakeholders as well as their views about the extent to which their departments or branches or organisations had been involved in the Strategy and their views about future involvement.

The evaluator consulted in an informal manner with a wide range of other stakeholders over the two years of the National Communications Project during conferences and workshops, via the YSP-L email discussion list, and in numerous discussions with practitioners working in the field.

The qualitative meta-analysis of each group of projects was reviewed by a number of individuals including people with relevant expertise in the field who have not been involved with the Strategy, and comments were incorporated into the discussion.

**Review of research and practice literature**

The evaluation has drawn on a wide range of literature to enrich discussion of the findings. This literature includes research into youth suicide as well as literature from many related fields including child and adolescent mental health, early intervention, youth health, health promotion, sociology, public policy, professional development, and organisational development.

**Review of policy and program context**

A review of national and international policy and other significant events leading up to the initiation of the Strategy was conducted to ensure that the evaluation of the Strategy gave adequate consideration of the context in which it was developed (see Chapters 2 and 3).

Current policies and programs related to mental health and youth affairs have been described. Information about related policies and programs provides an
indication of broader factors that may be impacting on implementation of the Strategy. The nature of such policies and programs is relevant to judging the appropriateness of the scope or breadth of Strategy activities and indicates some of the opportunities that are available for intersectoral collaboration.

An analysis of national strategies undertaken by other countries is provided. This information sheds light on a variety of alternative approaches that might have been adopted, providing a vital context for understanding the directions taken in Australia.

**National stocktake of programs and activities**

The first *National Stocktake of Programs and Activities in Youth Suicide Prevention* was conducted by the Australian Institute of Family Studies as part of the National Communications Project funded under the Strategy. The Stocktake collected information from all states and territories of Australia over a period extending from October 1997 to September 1998. The database contains a total of 919 projects including: projects funded under the National Youth Suicide Prevention Strategy (64 projects); those funded by state and territory strategies (158 projects); and those funded from a wide range of other sources (697 projects). Coverage is inclusive of a very broad range of activity and is not restricted to projects focused exclusively and directly on youth suicide prevention.

The Stocktake questionnaire was distributed through a number of channels: a national mailing list developed by the Australian Institute of Family Studies; mailing lists and other contacts of liaison officers based in state and territory Mental Health Branches; and the Youth Suicide Prevention Website at the Australian Institute of Family Studies. Data were collected by the Institute, entered into a database, and analysed for the purposes of the Communications Project and the Institute’s evaluation.

The Stocktake did not aim to provide a comprehensive audit of all the programs and activities in Australia that are relevant to youth suicide prevention. Rather, the objective was to identify the diverse range of activities that respondents consider relevant. Thus it is the qualitative nature of activities rather than the quantity of activities that is the main concern. Having said this, the amount of activity in particular areas relative to others does suggest possible areas of strength and weakness in practice and may raise questions worthy of further investigation.

Information from the first Stocktake is used in the evaluation to provide a context that sheds light on the appropriateness of Strategy activities. The Stocktake provides a picture of the nature of activities that were taking place prior to and during implementation of the Strategy. This context provides indications as to the strengths and weaknesses of current activity and the kinds of interventions that are necessary or appropriate at a national level.

Data from the analysis of the Stocktake database are reported elsewhere and are not repeated in detail in this Evaluation Report. Insights from the analysis of
the Stocktake are referred to at appropriate points throughout the discussion in Sections Three and Four of the report.

Research and consultation with young people

The Research and consultation with young people on mental health issues (Keys Young 1997) was commissioned by the Commonwealth Department of Health and Family Services and funded by the National Youth Suicide Prevention Strategy and the National Mental Health Strategy. The research aimed to provide information about young people’s knowledge, attitudes and experiences with mental health issues and mental health services that could be used to inform development of mental health promotion, mental health literacy and early intervention initiatives.

Specifically, the research examined young people’s: knowledge of and attitudes towards mental health and mental illness; their behaviours in dealing with their own and other people’s mental health problems; and their experiences when seeking help from either professionals, family, friends or informal networks.

The research and consultation were carried out by Keys Young between mid 1996 and early 1997. There were several main methods used in the research. Focus group discussions with young people from the general community, were held in nine country and city locations in five states. There were also one-to-one or small group discussions (held in five states and the Northern Territory) with approximately 100 young people considered to be ‘at-risk’ or marginalised in some way (including young people with a diagnosed mental illness, young people who had attempted suicide, young people living in isolated areas, young indigenous Australians, young offenders, homeless young people, and gay and lesbian young people. A sample survey using face-to-face interviews with 1200 young people aged 14–24 across Australia was also conducted.

The information from this research is used to provide insight into the appropriateness of initiatives taken under the Strategy in relation to the felt and expressed needs of young people.

Summary

The following chapters identify the Strategy’s actual outcomes and impacts as well as other achievements. The extent to which the Strategy processes and inputs were appropriate to the achievement of its stated goals and implied objectives is examined, including consideration of the evidence base, the broader policy context, barriers and facilitators, sustainability, and generalisability. Gaps and issues remaining to be addressed are identified, and what has been learned about good practice in youth suicide prevention is documented. Finally, recommendations are made for future directions.
Section 3

Results

The two chapters in Section Three of this Evaluation Report provide a summary of the results of the evaluation of the National Youth Suicide Prevention Strategy, conducted by the Australian Institute of Family Studies.

Chapter 7 outlines the major achievements of the Strategy, and identifies major gaps; and in Chapter 8 good practice findings are discussed. The material presented here focuses on general findings that were common across most or all of the approaches used by the Strategy. Detailed description and analysis of information specific to each of the main direct and system-level approaches used by the Strategy is provided in four separate Technical Supplement Reports.
This chapter outlines the major areas of achievement of the National Youth Suicide Prevention Strategy. Consistent with the frameworks of the Public Health Approach and Program Theory, achievements are considered at three levels:

- **processes** – evidence of substantial and lasting changes in service systems such as infrastructure development, accessibility of appropriate ongoing services and programs, and skills, knowledge and behaviours of service providers;
- **impacts** – evidence of changes in individual and environmental risk factors and protective factors such as behaviours, skills, attitudes and knowledge of young people, families, and communities; and
- **outcomes** – evidence of improvements in the health and wellbeing of young people as a result of the Strategy’s activities.

The Public Health Approach to program evaluation emphasises the importance of considering outcomes, impacts and processes at the level of whole populations and whole systems, as well as individuals and particular agencies. Details of outcomes, impacts and processes within each of the major direct approaches to suicide prevention are shown in table form in Appendix 2.

In considering the achievements of the Strategy it is important to recognise that many of its activities were designed to stimulate change within complex organisational and social systems. In most cases the projects were operating at the level of change initiation. Furthermore, this change initiation process was only small scale, in the form of a limited number of demonstration projects. The process of change is yet to move on to wider adoption, generalised implementation and institutionalisation in the relevant systems (Nutbeam and Harris 1998; Goodman, Steckler and Kegler 1997).

Translating these system level effects or processes into impacts on risk and protective factors, and outcomes in terms of health status and suicide rates within populations, would be expected to require considerable time. Nevertheless, some data relevant to population and wider system level effects were collected.
Processes

A substantial majority of Strategy projects resulted in enhancements in the capacity of the agencies in which they were based to provide improved quality of service for young people. A smaller number of projects also increased the capacity of other agencies with which they worked. Substantial progress has been made in the areas of primary prevention and early intervention, while moderate progress has been made in crisis intervention, primary care, and treatment and support.

Key stakeholders of the Strategy identified considerable progress at a wider system level in the areas of primary prevention (particularly parenting), early intervention and treatment and support, but considerably less progress in the areas of crisis intervention and primary care.

While the evaluation results are most comprehensive in the area of processes or systems change, they are still quite limited. No project evaluations used quantitative methods to measure systems change. At the time the Strategy projects were being evaluated, few if any widely accepted indicators of capacity building and systems change were available. Significant progress in this area has been made only very recently (Hawe et al. 2000).

Program level processes

The Strategy’s parenting projects provided training to nearly 1000 professionals to equip them to deliver parenting programs. Most of the parenting projects improved the documentation of parenting programs by preparing comprehensive manuals. In some cases program coordination and support structures have been strengthened. This has come about largely through the cementing of partnerships between professionals based in community agencies and academic centres. These partnerships have led to a rigorous approach to ongoing program development and evaluation as well as ensuring that staff in community agencies are adequately supported to manage program delivery. However, the stability of these structures is uncertain. Their future is dependent upon the injection of ongoing resources.

A number of the parenting projects worked with Aboriginal communities and demonstrated considerable progress in developing and adapting programs to the needs of these particular communities. One parenting program developed and distributed parenting resources for culturally and linguistically diverse communities. Several others had also been successfully trialled with non-English-speaking background communities in the past.

Curricula and a Guide for suicide prevention in schools have been developed, as have resource materials for supporting whole-school approaches to mental health promotion. These resources are in the process of being widely distributed. A model for supporting schools to develop a whole-school approach has been trialled and
found to be effective in certain respects, but lacking in others. The curriculum component was found to be generally successful and relatively straightforward to implement due to teachers and other school staff being provided with adequate training and support. Efforts to change school ethos and organisational structures and develop partnerships with community agencies were less successful.

A Media Resource Kit was produced and more than 1400 copies have been distributed. No support structures have been put in place to promote use of the Media Resource Kit. The ultimate usefulness of the school and media resource materials that are being distributed will depend upon the extent to which proper support structures are developed and resourced to promote, educate and support professionals to use the materials effectively.

A substantial proportion of the Strategy’s early intervention programs were found to be effective in engaging young people at risk in early interventions. Model support structures for enhancing the capacity of mental health services and community agencies to conduct early intervention have been trialled. While these projects have not yet been fully evaluated, there were encouraging signs that positive changes were occurring in the trial agencies including organisational commitment to ongoing service development. Gatekeeper training designed to enhance the capacity of community members and other service providers to identify young people at risk was provided to over 3500 people during the course of the Strategy. Results of the evaluation of much of this work are not yet available.

The Strategy directed a relatively large proportion of inputs to the area of crisis intervention and primary care. Projects were funded in hospital accident and emergency departments, telephone counselling services, and the primary health care sector.

The seven Strategy projects targeting hospital accident and emergency departments made reasonable progress in the development of protocols that may enhance the quality of care provided to young people presenting to emergency departments in the future. However, substantial structural and organisational barriers were encountered and remain in place. While some model protocols have been developed these may be of limited wider usefulness because the “process” of engaging managers and staff in developing the protocol may be essential for meaningful organisational change.

Training provided to staff of telephone counselling services was assessed as being of high quality, has been well received, and has led to increased knowledge and confidence. However, the data do not demonstrate increases in competency, and training was not attended by all relevant staff. Telephone counselling services have developed useful tools for performance monitoring, quality enhancement and evaluation that will be of value to a wider number of services.

Suicide prevention training was provided to a large number of primary health care professionals, and training resources have been developed and made widely available. This training was generally perceived as useful by general practitioners
but limited with respect to the full range of training needs that they perceived. Only one of the projects demonstrated significant increases in the ability of GPs to identify young people at risk of suicide. Substantial barriers to ongoing professional development and making necessary changes in work practice remain in place. Efforts to develop networks and enhance collaboration between primary health care professionals, especially general practitioners and other professionals, met with very limited success.

Knowledge of the issues and barriers that need to be addressed to progress service development in the area of Crisis Intervention and Primary Care has been substantially enhanced.

The Strategy has generated considerable information about strategies that are likely to enhance the accessibility of treatment and support services and the engagement of young people with mental health problems and other complex problems.

Community development projects funded by the Strategy demonstrated variable achievements in empowering communities to develop and sustain their own youth suicide prevention programs. The project that was implemented most fully concentrated primarily on community education aimed at developing the skills of professionals and community members to recognise and respond to young people at risk (gatekeeper training).

Some communities exhibited engagement with the aims of community development projects while others did not. Sustainable community-based committees have been established in a number of locations and these vary in their strength and level of activity. Young people were generally poorly engaged in the community development projects that submitted evaluation reports. One project that was actually managed and conducted by young people did not manage to submit an evaluation report. On the other hand, the historical study of the Yarrabah community in Far North Queensland yielded valuable information about factors that enhance the ability of Aboriginal communities to initiate and sustain their own suicide prevention initiatives.

During the process of overseeing the development of evaluation plans and implementation of project evaluations, the Evaluation Working Group observed an increase in the commitment to, and capacity for, program evaluation within many of the agencies involved in the Strategy. Several project managers and evaluators also observed this among the staff of the agencies hosting the projects.
**Wider system level processes**

There is evidence from the project evaluations and consensus among stakeholders that the Strategy has resulted in enhancements to the capacity of service systems to prevent suicide among young people. The knowledge base about the complexity of causal factors and the effectiveness of various interventions has been expanded and information has been documented in forms that are accessible and user-friendly.

Information presented in project reports suggests that there is a much higher level of awareness about the issues relevant to youth suicide prevention throughout service systems, including the roles of professionals in different sectors and the challenges that organisations need to meet if they are to make their services and programs more appropriate to the needs of young people and further develop their own capacity.

The survey of key stakeholders of the Strategy (Appendix 10) examined opinions about the extent to which changes had occurred on several indicators of systems capacity between 1995 and 1999. Survey stakeholders identified considerable progress in the areas of primary prevention (particularly parenting), early intervention, and treatment and support, but considerably less progress in the areas of crisis intervention and primary care.

- **Primary prevention**

The survey examined four different types of processes or changes in capacity for primary prevention: the availability of parenting education and support programs; school’s skills and resources for mental health promotion; the skills and resources of communities to implement mental health promotion; and primary prevention programs and the availability of resources to help the media report safely on youth suicide issues. Between 55 per cent and 38 per cent of stakeholders in the survey believed that the situation was “a little better” in 1999 compared to 1995 on these indicators of capacity for primary prevention. Between 36 and 29 per cent believed that there had been no change.

A large majority (90 per cent) of stakeholders believed that the Strategy had played a strong (11 per cent), moderate (31 per cent), or some (48 per cent) role in the progress made in primary prevention over the past five years.

- **Early intervention**

Fifty-nine per cent of stakeholders in the survey believed that the extent to which young people who are developing risk factors for suicide are gaining access to appropriate services with minimal delay had become a little better between 1995–1999. The majority believed that the skills and knowledge of specialist service providers (58 per cent) and primary care providers (62 per cent) with respect to early intervention had become a little better since 1995, while 21 per cent and 25 per cent respectively believed there had been no change.
A large majority of stakeholders (84 per cent) believed that the Strategy had played a strong (11 per cent), moderate (36 per cent), or some (37 per cent) role in the progress that has been made in early intervention (including access to services) over the past five years;

**Crisis intervention and primary care**

In the area of crisis intervention the survey examined opinions about: the extent to which telephone counselling services have the capacity to respond adequately to young people; the extent to which young people who present to emergency departments with suicide attempt and deliberate self-harm are accurately identified and assessed; and the extent to which these young people receive appropriate treatment and care. Between 44 per cent and 47 per cent of stakeholders believed that the situation was “a little better” in 1999 compared to 1995 on these indicators of capacity for crisis intervention. Between 20 per cent and 30 per cent believed there had been no change.

Forty-one per cent of stakeholders believed that the extent to which primary health care services are accessible and appropriate for young people had become a little better between 1995–1999, while 39 per cent believed there had been no change.

Twenty-two per cent of stakeholders believed that the availability of counselling for young people in rural and remote areas had become a little better between 1995–1999, while 44 per cent believed there had been no change.

**Treatment and support**

The survey examined stakeholders’ views about the availability of skills, information and resources needed to work towards good practice in two areas of practice: management of mental disorders in young people; and management of young people with other complex problems.

Respectively, 52 per cent and 48 per cent of stakeholders believed that the situation was “a little better” in 1999 compared to 1995 on this indicator of capacity for treatment and support. However, it is noteworthy that 13 per cent compared to 6 per cent respectively believed that the situation was “a lot better”, while 23 per cent and 27 per cent respectively believed there had been no change.

**Impacts**

A substantial minority of Strategy projects demonstrated some evidence of impact upon individual and environmental risk factors and protective factors, especially in the areas of primary prevention, early intervention and treatment and support. Key stakeholders of the Strategy identified some progress at a wider (population) level in the areas of primary prevention, early intervention and crisis intervention, but minimal progress in the area of treatment and support.
Clinical/program impacts

Evaluation of several parenting programs suggested parents exposed to those programs experienced increased confidence and satisfaction and decreased depression. Several early intervention projects reported improvements in the social adjustment of children, and several reported improvements in the school and/or family environments of children and young people.

Follow-up of a sample of young people using telephone counselling services found that young people were generally satisfied with the service. Most callers used one or more of the services to which they were referred, and problems were found to get better gradually over time.

Projects based in mental health services demonstrated significant reductions in psychiatric disability among the young people attending these services. Some of the projects targeting marginalised and disaffected young people provided evidence that life skills were enhanced after young people had been involved with programs for some length of time. The projects based in mental health services did not examine life skills. Strategy projects based in mental health services and other services targeting marginalised young people demonstrated that they were accessible and had the capacity to engage the young people attending those services.

Population level impacts

No reliable data are available to indicate whether or not the Strategy has led to, or even been associated with, positive changes in individual or environmental risk and protective factors at the population level.

The survey of key stakeholders of the Strategy examined opinions about the extent to which changes had occurred on several indicators of program impact between 1995–1999.

Four questions examined impacts in the area of primary prevention including skills and knowledge of parents, quality of school and community environments, and media reporting of youth suicide issues.

Between 59 per cent and 42 per cent of respondents believed there had been a little improvement on these indicators, while 21 per cent to 34 per cent believed there had been no change. Ninety per cent of stakeholders believed that the Strategy has played at least some role in the positive changes that were reported as having taken place in the area of primary prevention since 1995, with 11 per cent believing the Strategy had played a strong role and 31 per cent believing it had played a moderate role.

A set of three questions in the survey of key Strategy stakeholders explored impacts of crisis intervention activities between 1995–1999 including the extent to which young people who experience acute crises are enabled to resolve these...
crises promptly, the extent to which young people who experience acute crises are able to access appropriate support with minimal delay, and that the extent to which young people are being provided with the support, care, knowledge and skills to develop positive solutions and avoid crises in the future.

Between 41 per cent and 48 per cent of stakeholders believed there had been a little improvement in these areas, while between 37 per cent and 29 per cent believed there had been no change. Seventy-six per cent believed that the Strategy played at least some role in the positive changes that were identified as having occurred since 1995, with 13 per cent believing the Strategy has played a strong role and 28 per cent believing it has played a moderate role.

Fifty-seven per cent of stakeholders believed that the harm, distress and disadvantage suffered by young people living with problems that could place them at risk of suicide had “not changed” between 1995–1999, while 17 per cent believed it had got a little better and 13 per cent believed it had got a little worse. Fifty-two per cent of stakeholders believed that the life skills of young people living with problems that could place them at risk of suicide had “not changed” between 1995–1999, while 18 per cent believed they had got a little better and 15 per cent believed they had got a little worse.

Outcomes

Only a very small number of Strategy projects demonstrated any reliable evidence of positive outcomes for young people.

Clinical/program outcomes

Only a few Strategy projects were able to demonstrate statistically significant reductions in suicidality or improvements in the health and wellbeing of young people exposed to their programs. These include the three projects targeting young
people with mental disorders and one of the projects targeting young people presenting to accident and emergency departments.

These four projects were based in mental health services. Although outcomes for these young people improved after they were exposed to these interventions, none of these studies used a control group so it is not possible to conclude that the outcomes are superior to those that might have been achieved under “usual care”, or even whether the outcomes were a result of the intervention.

One parenting program conducted an outcome evaluation during the Strategy and evidence of preventative effects for the intervention compared to a control condition was found. Several of the parenting programs funded under the Strategy had been evaluated previously and project managers reported that positive outcomes had been observed for children and young people compared to control groups.

Evaluation of the telephone counselling projects found that telephone counselling was associated with observable reductions in suicidal ideation immediately after the initial telephone call, but these changes were not large. High levels of suicidal ideation were found to persist in young callers who were followed up.

Some of the Strategy projects targeting marginalised and disaffected young people found evidence that quality of life was enhanced after young people had been involved with programs for some length of time. The projects based in mental health services did not examine quality of life.

**Population level outcomes**

As expected, no data are available to indicate whether or not the Strategy has led to, or even been associated with, improvements in the health and wellbeing of young people at a population level.

**Gaps in the Strategy**

The process of identifying gaps was guided by the Terms of Reference of the evaluation, which include the statement that the evaluation should determine the extent to which the National Youth Suicide Prevention Strategy has achieved impacts or outputs directly related to its stated goals, and by the framework of Program Theory/Program Logic (Department of Finance 1994), which asks the evaluator to consider the extent to which inputs or activities were appropriate to the task of achieving stated goals.

Determining appropriateness requires attention to the question of whether program activities are logically related to goals and whether they are sufficient for reaching these goals. Identification of aims/processes and objectives/impacts through the analysis of Program Logic provides a systematic framework for identifying gaps.
In determining gaps it is also important to consider the stage of development of the program being evaluated. As noted elsewhere, the Strategy constitutes the earliest stage of what will need to be a long-term commitment to widespread dissemination, generalised implementation, and institutionalisation in the relevant systems.

There were some significant gaps in the efforts of the Strategy. Two main types of gaps were identified. These include:

- a failure to address some major risk factors for suicide that have been identified in the literature; and
- a failure to address adequately the organisational and structural barriers to the implementation of good practice.

**Risk factors not addressed**

Children of parents with mental illness have been identified as being at high risk for the development of mental illness, but this risk group was not addressed in any of the parenting programs or mental health service based projects funded by the Strategy. Projects in the area of early intervention and treatment and support did not adequately explore issues of access and engagement for young people from high risk sub-populations such as males, Aboriginal and Torres Strait Islander young people, young people involved in the criminal and juvenile justice systems, and young people living in rural and remote areas.

The Strategy did not direct any significant attention to postvention. Postvention approaches have been identified by stakeholders and various Australian writers as particularly important for Aboriginal and Torres Strait Islander communities, some of which experience the premature deaths of young people so frequently that an unstoppable spiral of mourning and self-harm (including substance misuse, violence, criminal activity and suicide) is sometimes perceived as occurring.

Community and political responses to these issues have been identified by human rights professionals as increasingly punitive and based on emotive responses rather than evidence about what works to reduce crime, violence and self-harm. It is an important task of suicide prevention to assess these developments from the perspective of the evidence base which is now very substantial and includes several major reports from the Human Rights and Equal Opportunity Commission (Johnston 1991; Wilson 1997), the Attorney General’s Department (National Crime Prevention 1999), as well as a large international research literature.

The biopsychosocial model and the Public Health Approach adopted by the Strategy presuppose the importance of addressing causal factors deriving from social conditions, and doing so using population level interventions. The use of the term “Primary prevention and cultural change” as one of the main direct prevention approaches outlined in the original Strategy document (CDH&FS 1997b) also
suggests a commitment to addressing cultural factors that may play a role in determining patterns of suicide in Australia.

The original intention to address social and cultural factors at a population level was not translated into practice during implementation of the Strategy. In practice, primary prevention activities focused on building the skills and knowledge of parents and on mental health promotion in schools, using curriculum. Intentions to focus on environmental and organisational factors in schools were not fully implemented. Furthermore, the community development project that was most fully implemented focused on community education aimed at developing the skills of community members to identify and support individual young people at risk.

There is a lack of common understanding among stakeholders concerned with suicide prevention regarding the meaning of “addressing social risk factors”. In practice, most Strategy projects only addressed social factors as they applied to the lives of individual young people or parents and the micro-environments or settings in which they live their lives. However, health promotion practitioners tend to understand “addressing social risk factors” in terms of tackling the fundamental social causes of health problems.

Hawe et al. (1997) draw the distinction between “risk factor” programs that operate at the level of individual behaviours or exposures, and programs that target “risk conditions” which can only be addressed at the level of whole populations or the whole of society. There is increasing evidence and consensus among public health professionals and others that programs that operate only at the level of individuals and setting environments (for example, schools) cannot make much of a difference to the serious social problems affecting children and families unless these programs are supported and reinforced by changes in whole communities and the whole of society (Buchanan 2000; Maton 1999).

The Strategy did not explore issues related to social and cultural factors in the wider society identified by some writers as playing a major role in increased rates of health and mental health problems, including suicide, throughout the world. Structural causes of social disadvantage and inequality that have been identified as undermining social connectedness and social capital (Wilkinson and Marmot 1998; Winter 2000) were left unchallenged. Cultural factors identified in the literature as requiring critical attention include the continuing rise of values such as materialism, consumerism and individualism, which are argued by some as undermining the ethical and spiritual values of collectivism and compassion which appear to undergird the community connectedness necessary for promoting resilience and wellbeing (Buchanan 2000; Eckersley 1993, 1995, 1997; Tacey 1997-98; Tacey 2000).

Strategies aimed at social and cultural change would include encouraging and promoting widespread critical discussion of the social values that underpin
Australian society and the impacts these values have on the wellbeing of all members of the community, particularly those who do not achieve “success” in the terms dictated by dominant values. It is possible that cultural change strategies may be particularly important for addressing the high risk of suicide experienced by young males, young Aboriginal people, and young people involved in the justice system (see Patience 1992).

**Organisational and structural barriers**

The Australian Institute of Family Studies evaluation of the Strategy identified the need for a comprehensive range of capacity building activities if efforts to change the behaviour of organisations are to be successful (see Chapter 8). However, the capacity building efforts of the Strategy were limited to only a few of the strategies identified as necessary.

The Strategy focused strongly upon training. While much of this training was carried out effectively, it was narrow in its scope. For example, training for general practitioners and other primary health care professionals focused strongly on suicide risk assessment and referral, and neglected other important roles such as ongoing management and involvement in primary prevention and early intervention programs.

Networking was the second major focus of the Strategy in the area of capacity building. Projects that addressed collaboration between specialist and primary care providers reported minimal achievement, with substantial structural and organisational barriers remaining in place.

Only a narrow range of collaborative capacity building strategies were trialled in the primary health care sector. For example, the potential of Mental Health Shared Care and Multi Purpose Services in enhancing primary mental health care options for young people was not examined. The Strategy did not adequately explore the issues surrounding the development of partnerships between mental health services and services targeting marginalised and disaffected young people such as youth health services. Major structural and organisational barriers to collaboration remain to be addressed.

Insufficient attention was also directed to the full range of sectors that need to be involved in preventing youth suicide. The Strategy focused strongly on the health sector (emergency departments, mental health, and primary health care) and the
education sector. Little attention was directed to the role of other key sectors such as the youth sector and the criminal and juvenile justice sector. Projects that did address intersectoral collaboration generally reported minimal progress. It was found to be extremely difficult to develop stable structures capable of supporting sustained collaboration.

While there was an intention to build the capacity of communities to develop their own suicide prevention programs, the community development projects that provided evaluation reports did not demonstrate evidence of significant gains in this area. Only four Strategy projects involved young people as partners in the planning and delivery of mental health promotion and primary prevention activities.

A major area of concern for capacity building is program evaluation. Resources and skills in this area are generally poor throughout all the service systems involved in youth suicide prevention. The Strategy directed substantial resources to evaluation, and it made considerable efforts to ensure that projects had access to expert advice and support in conducting evaluation. Every project was provided with a budget for evaluation. The Evaluation Working Group, comprising sixteen people with considerable expertise in youth suicide prevention, met a total of thirty-two times throughout the course of the Strategy, and every member allocated a considerable number of hours to reading and commenting on evaluation plans, interim reports and draft evaluation reports. Members of the Evaluation Working Group also attended two national workshops for project managers and evaluators, and provided special advice and assistance on request.

However, the amount of support provided by the Strategy proved insufficient to the task of overcoming the very substantial barriers that service agencies face in this area. Projects generally lacked the infrastructure support and expertise to design rigorous evaluations and collect, analyse and report data of adequate quality for evaluation purposes. This seriously limited the ability of the Strategy to rigorously test the effectiveness of many of the interventions trialled.
Content analysis of the evaluation reports of the National Demonstration Projects yielded very detailed information about the experience of implementing the projects, including evidence and insights regarding the types of interventions associated with positive outcomes and impacts, and the practices that facilitate successful implementation of interventions. Much of this detailed information is specific to particular approaches to suicide prevention.

This chapter presents the key findings arising from the detailed meta-analyses that were common across most or all of the approaches used by the National Youth Suicide Prevention Strategy. Detailed information and argument supporting the findings presented here is available in the four Technical Supplement Reports.

It should be noted that very few of the Strategy projects achieved highly rigorous evaluations. Much of the evidence on which these “good practice findings” are based is qualitative, or reflects a consensus of expert opinion across project managers and evaluators. Some conclusions are also derived from overarching analysis based on findings from project evaluations combined with previous research literature and therefore reflect the opinion of the summative evaluator. Further research is clearly needed to substantiate most of the findings of this summative evaluation.

Although the Strategy used a diversity of approaches, there was a strong consistency in the central themes that emerged from the different approaches regarding the essential elements of good practice. Summation of results of project evaluations from approaches as divergent as primary prevention, and treatment and support, yielded similar conclusions about the key issues that practitioners and policy makers need to consider when designing interventions for young people.

There are five major themes: multidimensional approach; access; engagement; effective intervention; and capacity building.
**Multidimensional approach**

The value of the multidimensional approach used by the Strategy has been affirmed strongly by the evaluation. Evidence for this includes the relative success of projects that managed to use a multidimensional approach within themselves compared to projects that were narrowly focused. For example, evaluators of projects that focused on one particular type of intervention or setting observed greater limitations in the ability of such projects to meet the diverse and complex needs of members of their target group.

The premise that the causes of suicide among young people are complex in their origins and need to be addressed on multiple levels remains the basic starting point. The Strategy experience has also enhanced our understanding of what is needed in a truly multidimensional approach. Themes that have emerged strongly from the evaluation are summarised in the table below.

<table>
<thead>
<tr>
<th>A multidimensional approach to youth suicide prevention</th>
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<tr>
<td><strong>Multiple populations</strong></td>
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<tr>
<td>Whole populations</td>
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<tr>
<td>High risk sub-populations</td>
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<tr>
<td>Individuals</td>
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<tr>
<td><strong>Spectrum of interventions</strong></td>
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<tr>
<td>Promotion of wellbeing and resilience</td>
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<tr>
<td>Prevention of risk conditions</td>
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<tr>
<td>Early intervention</td>
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<td>Crisis intervention</td>
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<td>Treatment and support</td>
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<tr>
<td>Postvention</td>
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<tr>
<td>Restricting access to means</td>
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<td><strong>Range of settings</strong></td>
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<td>Service agencies</td>
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<td>Schools</td>
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<tr>
<td>Families</td>
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<tr>
<td>Communities</td>
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<tr>
<td>Society</td>
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<tr>
<td><strong>Range of sectors</strong></td>
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<tr>
<td>Mental health, primary health care, social welfare, education, criminal and juvenile justice</td>
</tr>
<tr>
<td><strong>Levels of action</strong></td>
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<tr>
<td>Target populations, service agencies, regional service systems, local, state and Commonwealth government</td>
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</table>

**Multiple populations**

The Strategy experience has affirmed the importance of including interventions that target whole populations, high-risk sub-populations as well as individuals at high risk. The balance of opinion among stakeholders, project managers and
evaluators is that strategies that only target high risk individuals (such as treatment of mental disorders) are limited in their ability to make an impression on rates of suicide in the population. There is a strong consensus of opinion that interventions targeting whole populations and high risk sub-populations are also required.

Evaluation of the projects has illustrated the complex ways in which strategies targeting different populations interact with each other. For example, strategies targeting high risk sub-populations such as community education and community outreach can be important for enhancing access to treatment services for individuals at highest risk. Similarly “whole population” approaches are not necessarily accessible to all parts of the population unless they are supplemented by or include strategies that address barriers to access and engagement for sub-populations that are marginalised. This highlights the importance of interventions that use one kind of targeting strategy being closely linked with interventions that use other, complementary targeting strategies.

**Spectrum of interventions**

The Strategy trialled interventions from all but one part of the spectrum – promotion of resilience, prevention of risk conditions, early intervention, crisis intervention, treatment and support, and prevention of access to means.

The experience of many projects has been that it is rarely sufficient for any one program to focus exclusively on just one type of intervention. Even the needs of relatively homogeneous groups of young people are too complex for one type of intervention to address satisfactorily. For example, primary prevention and early intervention programs frequently detected young people or parents who were experiencing complex and escalating problems that required more intensive interventions. Thus primary prevention and early intervention programs need to be closely linked with specialist service providers.

![Spectrum of interventions in suicide prevention](source: Australian Institute of Family Studies 2000, adapted from Mrazek & Haggerty 1994.)
Conversely, there is evidence that treatment services need to incorporate early intervention strategies if they are to be adequately accessible to young people and engage them effectively, especially young people with complex problems who currently under use specialist mental health services. In other words, suicide prevention programs need to take place within the context of a comprehensive and integrated approach.

**Settings**

Targeting multiple populations and ensuring that the full spectrum of interventions are made available requires that suicide prevention activities are delivered through a variety of settings. It is not sufficient for clinical service agencies to be the sole or even the primary setting for suicide prevention. It is not possible to implement primary prevention and early intervention strategies or target high risk sub-populations solely through clinical agency-based activities.

Primary prevention and early intervention activities require professionals to deliver programs in community settings, preferably where members of the target population live their daily lives. Schools are an ideal setting in this regard. Strategy projects that worked with young people exposed to multiple risk factors for suicide found that these young people are often marginalised from mainstream society and are reluctant to use many mainstream organisations and health services. Even greater flexibility is needed to conceptualise and create “settings” where services can be delivered effectively to these young people. Youth friendly “multipurpose service” settings and physical outreach appear to be particularly important.

Projects that did attempt to deliver programs across a range of settings tended to experience substantial barriers which appeared to be due to a lack of attention to issues of intersectoral collaboration by higher level authorities.

**Sectors**

It is well established in the research literature that suicide and self-harm share many individual and environmental risk factors in common with other serious negative outcomes affecting young people, including homelessness, substance misuse, criminal activity and mental disorders. Indeed, these outcomes are frequently observed together in the same individuals. It is likely that these outcomes share some of the same causes as suicide and self-harm, as well as constituting intermediate risk conditions on the developmental pathway to suicide.

Whether or not one or both of these epidemiological hypotheses is correct, it is clear that effective suicide prevention requires the involvement of all the sectors that deal with these related outcomes. Interventions will not be sufficiently comprehensive unless all relevant risk factors are addressed. Further, interventions directed at all these outcomes may be delivered in a more cost effective fashion if there is collaboration in their design, delivery and evaluation.
While the Strategy did not achieve satisfactory levels of collaboration across all relevant sectors considerable information has been generated about the barriers that exist and strategies that may be required to overcome these.

**Levels of action**

One of the most important barriers faced by the Strategy projects that tried to work collaboratively with agencies from other sectors was a lack of collaborative planning structures and processes that they could attach their work to. For example, several projects experienced difficulties engaging with schools and reported that principals were reluctant because they were unaware of any state government policies directing them to work with community agencies on suicide prevention or mental health issues. In some cases such structures were in place but Strategy projects failed to identify these. For example, projects targeting rural areas failed to make use of the state and territory Agreements on Aboriginal and Torres Strait Islander Health or the New South Wales Regional Coordination Program.

These experiences highlight the importance of collaboration taking place at multiple levels in all relevant sectors. Collaborative planning structures and processes need to be developed at all levels including Commonwealth government, state and territory governments, regional service systems, as well as local service agencies. Further, information about the existence and operation of these planning mechanisms needs to be communicated in a proactive fashion to all relevant service agencies. Open communication was found to be critical to effective collaboration between service agencies. It is likely that open communication will also be critical for effective collaboration between government departments and between levels of government.

**Access**

The concept of access emerged as a central concept as the Strategy unfolded. There was some awareness of the importance of this concept when the Strategy was initiated but this understanding has evolved strongly to the point where it can be seen as an organising principle for much of the activity and learning that has taken place during the Strategy.

One of the concerns underlying the Strategy was a recognition that young people generally under-use a range of services that have historically treated and supported individuals at high risk of harm and that there has been a shortage of mental health promotion, primary prevention and early intervention programs targeting young people. At the same time, the evidence is mounting that adolescence, in addition to early childhood, is a critical period for effective prevention and early intervention. This recognition is growing not only with respect to preventing suicide but a range of adverse health and wellbeing outcomes such as criminal activity (National Crime Prevention 1999).
An explicit and implicit assumption evident in the concerns of many project staff and evaluators is that population health gains can be improved by increasing the proportion of prevention and early intervention activity directed to young people. The projects sought to explore ways in which current services can be adjusted to make them more accessible to young people and encouraged the gradual expansion and development of prevention programs targeting risk factors affecting young people, through capacity building.

Content analysis of Strategy project evaluations identified four major principles or characteristics that services and programs need to possess if they are to be accessible for young people, including the full range of young people who are at high risk of suicide (see table below).

<table>
<thead>
<tr>
<th>Access to services and programs for young people</th>
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<tbody>
<tr>
<td><strong>Universal and selective targeting</strong> (aggregated targeting)</td>
</tr>
<tr>
<td>whole populations; sub-populations; individuals</td>
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<tr>
<td><strong>Flexible services</strong></td>
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<tr>
<td>flexible selection criteria; primary, secondary and tertiary referrals; multiple “soft” entry points; multiple settings</td>
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<tr>
<td><strong>Outreach</strong></td>
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<tr>
<td>offering interventions where young people live their normal lives</td>
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<tr>
<td><strong>Promotion</strong></td>
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<tr>
<td>publicity and community education targeting young people</td>
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</table>

**Universal and selective targeting**

Analysis of the strengths and weaknesses of Strategy projects in reaching different populations of concern suggests that a combination of universal and selective targeting strategies is beneficial. Young people in greatest need can be excluded from universal programs if these fail to consider the diversity of barriers that affect particular groups of young people.

Conversely, selective programs often use eligibility criteria that appear somewhat arbitrary, such as restrictive age and geographic criteria, which contribute to a sense of exclusion for young people and families who do not meet the criteria. While selective programs may sometimes risk stigmatising certain population groups, some universal programs may also fail to provide sufficient confidentiality for these same groups. This appears to be particularly problematic for school-based programs.

The concept of “aggregated targeting” (Guterman 1999) emerged as particularly useful for enhancing access. Aggregated targeting involves applying a universal approach to a specific sub-population. Thus a program might be promoted as universally appropriate for all young people, or all parents, or all members of a community, but this promotional activity is directed or targeted to particular
sub-populations. This approach avoids the danger of stigmatising individuals and families by labelling them as “high risk” which has been identified as a negative effect of selective targeting approaches, while at the same time actively seeking to minimise barriers and facilitate access by those most in need. Sub-populations in need may be defined in various ways including geographically, demographically or culturally.

Such aggregated targeting strategies were used with considerable success by Strategy projects in addressing the social and cultural issues affecting Aboriginal communities and same sex attracted young people, and in reaching families experiencing socioeconomic disadvantage. Participants in these programs expressed positive feedback about the programs. The opportunity to meet and learn from others who had experienced similar problems was noted as particularly attractive.

Flexible services

Many of the characteristics that were identified as enhancing the accessibility of services for young people can be grouped under the general heading of “flexibility”. Evaluation of Strategy projects based in mental health services and youth health services that targeted young people (adolescents and young adults), and which had flexible eligibility criteria, demonstrated strong benefits in terms of access and engagement.

Project staff and evaluators in several projects observed that mental health services generally operate under highly restricted conditions that were experienced as limiting access for many young people in need. Age criteria were found to be problematic barriers for young people at risk of suicide. Child and Adolescent Mental Health Services generally restrict services to an upper age limit of seventeen or eighteen. Adult Mental Health Services target adults aged eighteen years and over. Many special programs focusing on young people have age limits and these vary substantially across different programs. Another highly problematic type of restriction criterion applied by most mental health services is geographic.

The purpose of these age and geographic limits is largely for the rationing of limited resources. However, the contribution of these restrictions to the goal of delivering more effective and efficient services has never been subject to rigorous evaluation. There is a complete absence of evidence that the imposition of strict age limits or geographic restrictions contributes to better mental health outcomes for populations.

In contrast, there is considerable anecdotal evidence in the Strategy project reports, supported by other literature (for example, Hearn 1993), of negative effects of such restrictive eligibility criteria. Staff of community welfare agencies in particular complain that young people of certain ages, or living in particular locations, are denied access to mental health services or programs in what is often perceived as an arbitrary fashion by young people, carers and referring
agencies. In many cases similar alternative programs are not available for young people outside of a given age bracket, or those living outside of catchment areas. There are a number of services and programs that use discretion in the application of age-related criteria and these do not report being more overwhelmed by excessive demand than other services do.

Imposition of strict age criteria by Child and Adolescent Mental Health Services and Adult Mental Health Services is a particular problem for young people in late adolescence who are at a vulnerable stage in the development of mental health problems, and in the development of their relationship with service providers. Clinical progress may be threatened by premature referral to adult services. Similarly, many young people under the age of eighteen do not see themselves as children and do not feel comfortable using Child and Adolescent Mental Health Services. There is also a substantial number of adolescents and young adults whose needs are not being met by either Child and Adolescent Mental Health Services or Adult Mental Health Services. Many of these young people have complex problems related to adolescence, including movement towards independent living, education, employment and sexuality, which are poorly understood by professionals trained only in adult or child mental health.

Another important area of flexibility concerns where services will accept referrals from. Specialist mental health services are generally positioned as secondary and tertiary referral services and do not actively encourage primary or direct referrals from individuals or carers. In contrast, two of the three Strategy projects based in mental health services encouraged direct referrals from young people and parents, and felt that this was important for enhancing access. Several states and territories have policies explicitly advocating the development of “single points of entry” for mental health services. In contrast Strategy projects reported that having multiple entry points is important for increasing access for young people.

There is evidence that when young people experience crises it is critical that they gain access to an appropriate treatment or service as promptly as possible. Delays in access reduce the likelihood that young people who have deliberately self-harmed or attempted suicide will present for appointments following self-harm or suicide attempts. Eliminating barriers to service access may also play a role in preventing episodes of self-harm.

The tiered framework for mental health services (primary, secondary and tertiary) is helpful as a conceptual tool for ensuring that a comprehensive array of services is available to meet different levels of need. However, there is no evidence that it is necessary or conducive to improved outcomes for each and every service unit to identify itself as belonging to one tier or another and use this as a basis for determining the access of clients.

The tiered structure of mental health services can be used to promote access or restrict it depending on how the roles of the tiers are perceived and managed. The different tiers can work to increase the number of available “entry” points
in the system, or they can be used as filters and barriers. Increasing the number of different professionals that young people can tell their story to will enhance access, but increasing the number that they have to tell their story to is likely to deter young people from the helpseeking path.

It is important that specialist mental health services are not viewed and presented as the last and most desperate step on a downward spiral staircase. Breaking down stigma and enhancing access to services requires that specialist mental health services are physically and functionally integrated with mainstream health and community services. The move under the National Mental Health Strategy to shift inpatient psychiatric beds as much as possible into general hospital settings is just one example of the range of strategies required.

There is much room for parallel forms of integration with respect to community mental health services and generalist primary health care services. Specialist community mental health services need to be made available in general practice settings, community health services and youth health services in addition to stand alone mental health centres. In the case of young people with complex problems and at high risk of suicide, there are indications that co-locating mental health services with a comprehensive range of other services will be of major benefit in terms of access and engagement.

Young people, especially those with complex problems, do not necessarily use services for discrete periods of time in the way that is commonly expected of adults. Young people tend to drift into and away from services only to return to ask for assistance again at a later stage. Sometimes this process is benign but sometimes it is indicative of difficulties with access and engagement. Administrative procedures in most services are not appropriate for accommodating this pattern of service use or detecting and addressing problems when they arise. The practice of closing cases when clients fail to present for specified periods of time, with the requirement that they join the end of long waiting lists when they eventually re-present, is a major barrier to service access for transient young people who are particularly vulnerable to neglect by helping authorities because of their lack of connectedness with community.
**Promotion**

Providing multiple entry points for services and making prevention and early intervention programs available in multiple settings needs to be supplemented by provision of information about the nature of services and programs that are available and how they can be accessed. This information needs to be presented in forms that are appropriate and attractive for target groups, particularly those such as young people who experience greater barriers to access than others. Services and programs targeting young people need to advertise themselves via the media, and in venues that young people (including those who do not fit conventional norms) use, such as popular magazines, counter culture magazines, gay and lesbian media, the internet, schools, universities, local community organisations, and Centrelink.

Networking and collaboration between specialist treatment and support services, primary health care services, community welfare and other “gatekeeper” agencies was identified as an effective way of maintaining awareness of services and programs among relevant providers. Participation of mental health service providers in community education, mental health promotion, primary prevention and early intervention programs was considered to be particularly important for promoting awareness of mental health services.

**Outreach**

Many youth health services use outreach approaches to enhance access for young people at risk, but most Child and Adolescent Mental Health Services favour an appointment based case work mode of clinical service delivery.

The expectation of services that clients will present for all scheduled appointments means that clients who do not meet this expectation generally receive fewer services than others. However, clients who fail to present for appointments are often those whose need for assistance is greatest, and their failure to attend is a symptom of their difficulties in coping with serious life problems.

Young people with mental health problems who are homeless, who are misusing substances, or who are involved in the juvenile justice system, generally experience great difficulty attending appointments at treatment and support services including primary health care services. Similarly, young people who are at high risk of developing these problems due to abuse, neglect and chaotic family situations generally experience great difficulty attending structured early intervention programs.

Ensuring that young people who are experiencing disruption to their lives have access to appropriate early intervention and treatment and support services requires that these interventions and services are provided in a highly flexible manner. Interventions need to be offered in locations convenient to young people and in a range of different settings.
Even at the level of primary prevention, when, theoretically, individuals should not be experiencing problems as a result of risk exposure, it is nevertheless important to realise that predisposing risk conditions, often environmental, may make it difficult for some people to participate in preventive programs. An orientation of outreach that brings programs to the places where members of the target group spend significant amounts of time, or delivers them through the media that they frequently use, was found to be productive by Strategy primary prevention projects.

Unfortunately, only a few Strategy projects systematically evaluated accessibility of programs for different sub-populations that have historically been identified as experiencing poor access such as Aboriginal and Torres Strait Islander people, people from non-English-speaking backgrounds, and people experiencing socioeconomic disadvantage.

**Engagement**

Along with access, engagement emerged as a central concept in youth suicide prevention that has grown in importance as the Strategy has unfolded. Problems of engagement go hand in hand with barriers to access as major reasons why service systems have failed to develop appropriate responses to young people’s needs.

Content analysis of Strategy project evaluations identified five major principles or characteristics that services and programs need to possess if they are to engage young people effectively, including the full range of young people who are at high risk of suicide.

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### Engaging young people with services and programs

- **Communication with young people**
- **Knowledge and attitudes**
  - knowledge of adolescent development and culture; non-judgemental attitude
- **Environment**
  - a relaxed, informal, youth-friendly “space”
- **Holistic approach**
  - addressing a range of practical needs
- **Assertive follow-up**

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### Communication with young people

Communication with young people needs to be developed on multiple levels and in all areas of intervention in the spectrum:

- communication about emotional wellbeing, resilience and mental illness;
- clinical, engagement in therapeutic alliance; and
- communication to foster partnership in service development.
Several Strategy projects developed specialised communications strategies targeting young people employing media that young people use heavily, such as the internet. Evaluation found that young peoples’ preferences for communication styles vary across different age groups and that the content, language and presentation of communications needs to be carefully tailored to the preferences and needs of particular age groups. It is clear that young people themselves need to be consulted in the development of communications materials. A range of communication media is also necessary. Communication strategies that rely totally on the internet are much less likely to reach young people who do not have internet access through home or school due to socioeconomic barriers or poor connection with social institutions.

Projects based in mental health services and targeting marginalised young people exposed to multiple risk factors found that open and clear communication is essential for engaging young people and families with treatment and support services, for developing a “therapeutic alliance”. Communication in therapeutic settings needs to convey the message that the young person’s perspective is understood and respected and that their goals are being given priority by service providers. Thus communication by the provider should include high levels of “active listening”.

The traditional approach to mental health assessment is often viewed as alienating by young people. Frequently considerable time is needed to develop a trusting relationship before they will communicate openly with professionals about their problems. Thus assessment takes place over an extended period of getting to know one another. This is very difficult for many service providers such as GPs and busy mental health professionals who have high caseloads. There is evidence that communicating with young people is viewed as very difficult by many practitioners. Many feel they have inadequate skills and need training to develop these. Training programs trialled under the Strategy did not include an adequately strong focus on communicating with young people.

Service agencies need to develop structures and processes for communicating with young people if they are to be effectively engaged as partners in the process of service development and evaluation. As in the clinical relationship, there needs to be clear demonstration that young people are being listened to and that their input is understood and is being responded to. Services still lack structures and processes for supporting dialogue with young people. This reflects a general lack of mechanisms for communicating with service users, community members and other agencies. These communication mechanisms need to be developed in parallel, and built in to ongoing planning processes if services are going to be able to use the input of young people and other stakeholders effectively.
Knowledge, attitudes and skills

A number of project managers and evaluators reported a widespread perception among professional service providers that adolescence is an alien culture that they have no understanding of. Many service providers appear to feel disempowered in regard to their capacity to work with adolescents and so they shy away from it in the same way that they shy away from working with, for example, clients from non-English-speaking backgrounds.

A number of Strategy projects were designed to directly address perceived knowledge deficits and negative attitudes among professionals regarding working with young people. Training programs were generally quite successful in improving knowledge and attitudes, but trainees reported a need for further training aimed at skill development. Formation of collaborative working relationships involving provision of training, supervision, consultation and shared care between specialist adolescent mental health workers, general practitioners, youth workers and providers in other community agencies, appears necessary.

Environment

A major factor in the ability of youth health services to engage young people who are marginalised and alienated from mainstream society is the manner in which they provide a relaxed, youth-friendly space in which young people are free to spend time and develop a relationship with service providers at their own pace.

A physical youth-friendly space also provides a venue for running a range of primary prevention and health promotion programs and for allowing young people to participate actively in the development of such programs.

Holistic approach

Providing a holistic range of services from a single location was found to be very important for engaging young people with complex problems at high risk of suicide. Many of these young people have practical needs that they have difficulty meeting on a daily basis. Providing for as many needs as possible in one location is extremely helpful for young people whose skills and capacity for daily living are stretched to the limit.

Young people with complex problems have almost always had negative experiences with services and have fallen through gaps while being repeatedly referred. It is very difficult to establish a trusting therapeutic relationship with these young people, and this relationship is easily damaged by premature or disorganised referral to additional services.

Assertive follow-up

When young people fail to present for appointments or comply with treatment plans, service providers need to take the initiative to provide active follow-up in
order to identify barriers and help young people overcome these. This is not usual practice for services that deal primarily with adults or families with children and its importance is not adequately appreciated. Lack of resources and the pressure of providing a service to those clients who do actually attend and comply mean that it is extremely difficult for service providers to provide assertive follow-up for young people who fail to cooperate. It needs to be borne in mind that the needs of these young people may be even greater than the needs of clients that do comply with treatment.

Effective intervention

The Strategy has yielded less knowledge about effective intervention than it has about access and engagement. Nevertheless there are some clear messages that may be of value in guiding decisions about the alternative paths forward.

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<thead>
<tr>
<th>Effective intervention with young people</th>
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<tr>
<td>• Evidence-based intervention</td>
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<tr>
<td>• Focus on risk and protective factors</td>
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<tr>
<td>practical ways of building on strengths</td>
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<tr>
<td>community-based protective factors</td>
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<td>• Holistic, multisystemic approach</td>
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<tr>
<td>address all relevant problems</td>
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<td>address problems in environments as well as individuals</td>
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Evidence-based intervention

There is a dearth of research that has examined either the efficacy or the effectiveness of interventions targeting risk factors for suicide among young people (Patton and Burns 2000). However, we do have increasing clarity about the nature of risk and protective factors, and we have programs that have demonstrated positive impacts on certain risk factors for suicide in controlled trials. We also have increasing understanding of the kinds of interventions that particular kinds of services are willing and able to implement.

Ongoing research into the efficacy of interventions is required, however there is an equally urgent need for evidence about the effectiveness of interventions as they are applied in real settings. There are now a number of promising primary prevention and early intervention programs documented in manuals which are suitable for wider dissemination. There are, however, practical barriers to the uptake of the programs that are available. Many agencies, including governments, will make modifications to documented programs in order to adjust for resource limitations, lack of appropriately trained staff, and diversity in the populations targeted by those agencies. While some of these modifications
will be appropriate, there is a danger that some will reduce the effectiveness of programs.

It is critical that ongoing effectiveness evaluation be conducted to monitor the impacts and outcomes of interventions that are adopted, especially when modifications are attempted. Production of such evidence about the real world effectiveness of interventions will require service agencies to engage actively in a continuing process of generating, reflecting and acting on evidence about the effectiveness of their own daily practice. Most service agencies lack the skills and resources needed to conduct this effectiveness evaluation in a rigorous manner.

**Focus on risk and protective factors**

Policy documents of the National Youth Suicide Prevention Strategy emphasised the importance of attending to protective factors as well as risk factors, and this philosophy was widely supported by project staff and evaluators.

However, some types of interventions managed to adhere to this principle better than others and the Strategy as a whole did not generate as much learning about building protective factors as it did about reducing risk factors. Numerous project managers and evaluators identified a focus on protective factors as well as risk factors as a strength of programs that they considered to be effective. For example, building on the strengths of parents or young people was identified as effective in building up self-esteem and self-efficacy and empowering individuals in their general problem solving capacity. Awareness of the importance of helping young people identify and build on strengths was also present in the projects targeting young people with mental disorders and who are marginalised and at high risk of suicide, but the ways in which “strength building” can be built into clinical practice need to be articulated and described more clearly.

Protective factors operating within communities with low suicide rates remain a poorly understood and an untapped resource. There is clearly much more that can be learned about community resilience by studying the characteristics of communities with low suicide rates, and the impacts of suicide prevention activities upon indicators of community wellbeing. Community resilience also needs to be studied at the level of sub-populations with low suicide rates. Why is it that some Aboriginal and non-English-speaking background communities have very low suicide rates?

**Holistic, multisystemic approach**

As indicated in the section on engagement, young people at high risk of suicide tend to have a complex array of problems. It follows that young people at risk need to be understood in the full context of their lives, including problems in their social environment.
Staff and evaluators of projects that worked with this population believed that one of the most important characteristics of effective intervention with this population is the provision of a holistic service that addresses most or all of the problems presented, simultaneously or in an integrated fashion.

However, projects generally experienced considerable difficulties in achieving this ideal. For example, some mental health services did not manage to provide or organise treatment of drug and alcohol problems for all clients with this need. Another did not manage to provide family therapy for depressed clients from severely dysfunctional families. Significantly lower levels of clinical improvement were observed in this latter group of young people with depression and severely dysfunctional families.

**Capacity building**

Capacity building is the area of practice in which the Strategy has generated the most substantial knowledge gains. Much has been learned about the strengths and weaknesses of the service systems that have been asked to take on the work of suicide prevention and the kinds of interventions that are needed to overcome these weaknesses and build on strengths.

It has frequently been observed that a fundamental problem with many service delivery systems is their fractured and disjointed nature (Melaville, Blank and Asayesh 1993). Most service systems are developed around particular problems, and as new priority problems emerge new structures are created to deal with these. This haphazard approach to service development does nothing to address the fundamental problem – rather, it compounds it.

Recognition of the discontinuities and gaps in service provision that result from this flawed service system was strong in the minds of those who designed the National Youth Suicide Prevention Strategy and it is a major strength of the Strategy that it has focused attention on addressing deficits in existing services and improving and expanding existing programs rather than developing new services and programs focused on suicide prevention.

The experience of capacity building generated by the Strategy has reaffirmed the fundamental importance of this approach and has generated new insights about the nature of the problems in service systems and the strategies that may prove most effective in overcoming these. However, it is also necessary to point out that many of the barriers to service reform identified by the Strategy evaluations have been identified in evaluations of similar national and state/territory funded strategies and programs aimed at service reform. Many of the oversights and limitations of Strategy projects and activities have been encountered and articulated previously.

An advantage of the method of meta-evaluation as used in this summative evaluation, especially when used to evaluate national initiatives, is that it provides a relatively unusual opportunity for viewing particular programs from the
Meta-evaluation of the projects funded under the Strategy identified seven core capacity building strategies, each of which appear necessary if substantial and lasting changes are to be made in the systems responsible for suicide prevention. The Strategy projects tended to effectively implement only the first three of these. Greater attention to the other four by new and refunded programs appears necessary if the gains made under the Strategy are to be advanced into the future.

### Policy and plans

A substantial number of Strategy projects included the development of policies and plans aimed at guiding changes in practice among staff of their services. Development of these policies and plans on their own rarely resulted in any noticeable changes in behaviour or service processes. One of the limitations of most policies and plans identified by stakeholders is that they lack sufficient information about the practices being advocated. There is often a lack of common understanding of terms.

Policies and plans are often expressed in very general language that does not spell out the precise roles and responsibilities of particular agencies or staff members. This leaves a lot of room for flexibility in responding to plans but it also leaves a lot of uncertainty about exactly what sorts of activities might be required of particular groups of stakeholders.

### Information and knowledge

Policies and plans need to be supplemented by detailed information, based on research and evaluation data, that clearly defines practices and processes being advocated and articulates the range of possible roles and responsibilities different stakeholders might consider adopting.
Clients of communications projects expressed a strong desire for the communication of “knowledge” rather than communication of “information”. Knowledge refers to a form of communication that involves “adding value” to information. In other words, users are asking for more than basic descriptions of model programs, or data about risk and protective factors, or data about the efficacy of particular interventions. Rather, they are asking for communications that interpret information and give them more guidance about how they can make use of information in their practice. Over attention to the generation of information at the expense of the dissemination of knowledge that can be used by practitioners has been identified as a major barrier to the achievement of many public health goals (Johnson et al. 1996).

However, a very clear finding from the evaluation of capacity building efforts of the Strategy is that provision of information about good practice is rarely sufficient to change behaviour. For example, the dissemination of practice guidelines and program manuals is insufficient to stimulate significant uptake of the practices and activities articulated in these documents. This finding is consistent with previous evaluation research (Davis and Taylor-Vaisey 1997).

**Education and training**

Provision of education and training is the next step in the service reform process. Education and training that incorporate adult learning principles that give recognition to building on experience and conveying information seen to be relevant to dealing with clinical and other problems in the workplace is essential.

Training that is structured around the content of policies, plans, practice guidelines and program manuals, and their immediate relevance, was found to be effective in increasing the knowledge of trainees about the information contained in these documents as well as boosting confidence in their ability to implement the practices being proposed. However, there was little evidence that education and training, even in combination with the provision of guidelines and manuals, resulted in behaviour change for a satisfactory proportion of trainees.

**Ongoing supervision and monitoring**

Trainees involved in several projects reported a need for ongoing support and supervision to help them build skills in the practices taught in training programs. Several projects used practice audits to evaluate the impacts of training on the behaviours and skills of trainees. The practice audits appeared to be a useful adjunct that helped reinforce the learning acquired during initial training. Monitoring of behaviour change and providing systematic feedback about impacts has been identified in the health professional training literature as important to the ability of health professionals to implement new skills (Davis et al. 1992).
Collaboration, partnerships and community development

Many services do not have the resources to provide professional supervision to their staff or to implement sophisticated monitoring and feedback systems suitable for continuing professional development purposes. In addition, trainees involved in several projects identified substantial barriers in the practice environment that they believed would seriously limit their ability to implement the practices advocated in training programs.

Evaluation of other programs and strategies shows that collaboration with professionals who possess specialist knowledge and expertise in the practices being promoted is an effective way of providing (1) ongoing supervision; and (2) addressing barriers in the practice environment (Mitchell, Malak and Small 1998). Mental Health-General Practice Shared Care has been observed to help develop the mental health assessment and management skills of GPs while at the same time increasing GPs access to professionals to which they are willing and able to refer clients when their skills are inadequate to the task of providing adequate care (O’Regan and Wilton 1997).

Strategy Projects generally experienced substantial difficulties in implementing collaborative activities with other agencies and with communities. Community development activities of the Strategy tended to be focused on community education about suicide rather than building the capacity of communities to initiate and sustain their own prevention programs. Viewing community development as a systemic capacity building activity to be pursued in parallel with other types of partnerships, rather than as a “direct” prevention activity that is “applied to” or “targeted at” communities as settings or environments, may provide a more appropriate framework for the conceptualisation and planning of community development strategies.

Involvement of organisational structures and processes

The major barriers to the development of collaboration experienced by Strategy projects were related to organisational structures. Collaboration was generally initiated by workers positioned on the margins of their own organisation – for example, workers employed on short-term projects. This problem has been observed in previous investigations of intersectoral collaboration (Harris et al. 1995).
Genuine collaboration requires engagement beyond the activities of individual staff at the margins of organisations. Formal organisational structures and processes need to be involved and this may sometimes require their adjustment. The structure of large hierarchical bureaucracies was encountered as particularly problematic when these failed to provide local teams with sufficient autonomy or sufficient direction, depending on which of these is required at particular points in time.

One of the most disquieting aspects of the efforts of Strategy projects in the area of networking and intersectoral collaboration was a widespread failure of projects to build on mechanisms for collaboration that are already in place, such as the Agreements on Aboriginal and Torres Strait Islander Health which were developed in 1996 and involve a commitment to collaboration between the Commonwealth Minister for Health, the Aboriginal and Torres Strait Islander Commission, all state and territory Health Ministers, and the various state and territory peak bodies representing Aboriginal community-controlled health organisations.

**Management support**

When asked to identify the factors most important to the success of projects, project staff most frequently identified having the support of management. While it is to be expected that management support would be essential, the fact that this was identified as an important issue by project staff is noteworthy.

It might be expected that projects such as those funded under the Strategy would have the support of management of the organisations in which they are based, as a matter of course. But this was clearly not the case. Some project staff had to fight hard to win the support of senior managers for the work that they were doing, and winning this support was perceived as a major milestone in the service reform process by project staff and external evaluators.

The importance of management support can be seen particularly clearly in the projects that sought to work collaboratively with other agencies, and where changes to service processes and structures were required to achieve this collaboration.
Section 4

Future directions

Under the guidance of the National Advisory Council on Suicide Prevention a new national suicide prevention framework entitled *LIFE: A National Framework for Prevention of Suicide and Self Harm* has been in the process of development since July 1998. The new framework has drawn on the findings of the evaluations of National Youth Suicide Prevention Strategy projects, and the findings of the Australian Institute of Family Studies evaluation, as they gradually emerged over the past two years, as well as epidemiological and other research data relevant to suicide in all age groups.

The *LIFE* framework adopts of whole-of-lifespan approach to suicide prevention and strongly emphasises positive life promotion. As a result, many of the future directions for suicide prevention in general, as well as youth suicide prevention, in terms of Commonwealth government activities over the next four years, have already been determined.

This concluding section of the report of the Australian Institute of Family Studies evaluation of the National Youth Suicide Prevention Strategy seeks to complement this planning work by highlighting some of the key lessons of the Strategy that might need to be given special consideration if the initiatives identified in the new national framework are to be implemented successfully, and if the specific commitments to young people’s health and well-being articulated under the Strategy are to be realised.
A major aim of the evaluation of the National Youth Suicide Prevention Strategy was to determine the extent to which the Strategy had initiated activities appropriate to the achievement of objectives directly associated with the Strategy’s stated goals.

In order to answer this question a Program Theory/Program Logic framework was used to organise and assist analysis of the available evidence concerning inputs, processes, impacts and outcomes (Appendix 1). The results of this analysis suggest that the Strategy did initiate many activities that are appropriate to the achievement of objectives associated with its stated goals. Furthermore, the range of activities initiated was reasonably comprehensive in that activities from nearly all of the prevention approaches identified as being necessary in the research literature were included. The Strategy also included most, but not all, of the elements that have been identified as essential to coherent national strategies (United Nations 1996; WHO 1990; Taylor, Kingdom and Jenkins 1997; see Chapter 2).

The stated goals of the Strategy are phrased in terms of reducing suicide and suicidal behaviour and enhancing protective factors among young people throughout Australia. The United Nations (1996) and the World Health Organisation (WHO 1990) argue that a comprehensive, nationally coordinated approach is needed if nations are to meet these sorts of goals.

In assessing the achievements of the Strategy in comparison to its stated goals it is important to consider the developmental context. Clearly the Strategy cannot be considered to be a fully “comprehensive, nationally coordinated approach” to youth suicide prevention throughout Australia. Rather, the Strategy can be considered to be a phase of developmental research rather than a comprehensive nationally coordinated approach. If the goal of reducing rates of suicide and suicidal behaviour among young people is to be realised, the Strategy will need to be followed by a phase in which promising interventions are widely implemented throughout all relevant service systems and in many communities throughout the nation. This will require ongoing leadership and coordination by
the Commonwealth as well as state and territory governments. The Commonwealth and the states and territories are addressing their responsibility for this leadership and coordination through the new suicide prevention framework, *LIFE: A National Framework for Prevention of Suicide and Self Harm.*

**Building on strengths, learning from the past**

The evaluations of the demonstration projects funded under the National Youth Suicide Prevention Strategy identified many barriers to the implementation of suicide prevention programs and interventions. The service systems with greatest responsibility for suicide prevention are operating under conditions of severe resource limitations, and the changes required to implement good practice in suicide prevention are generally perceived as competing with many other service reform priorities. There is a strong possibility that the strategies for suicide prevention recommended in the LIFE framework will not be adopted as widely as they need to be unless considerable effort is directed towards actively encouraging and facilitating implementation.

A major strength of the Strategy was its focus on building the capacity of health and welfare services and programs to respond appropriately to the needs of young people, rather than creating structures and processes focused specifically on suicide. Such capacity building should continue to occupy a central place in future suicide prevention efforts.

It is also important to note in this regard that many of the barriers to service reform identified by the Strategy evaluations have been identified in evaluations of similar national and state/territory funded strategies and programs aimed at service reform. Many of the oversights and limitations of Strategy projects and activities have been encountered and articulated previously. Yet in many cases project staff and managers involved in the Strategy either failed to adequately acknowledge or explicate these problems, or were unable to effectively address anticipated barriers.

This problem of failing to effectively use information gained from past experience has also been observed previously by Johnson et al. (1996: S9): “Lessard has characterised the development and application of knowledge in health promotion and disease prevention as a ‘bottleneck’ . . . He found it remarkable that many of the new directions being discussed were not new. Indeed, some of the directions outlined were first suggested years ago. Lessard asks, if we know what we have to do, if we know that the current system does not work, then why is this knowledge not put into practice? . . . Lessard suggests that rather than needing new knowledge to improve our health system, we need the will to apply what is known.”

Johnson et al. (1996) identify more effective methods of knowledge dissemination as critical to the solution of the bottleneck identified by Lessard. In the case
of the Strategy there appears to have been a failure of knowledge dissemination across the barriers that divide the field of suicide prevention from the wider field of public health and health promotion.

Just as the barriers to service reform identified by suicide prevention and health promotion practitioners are similar, so are the key principles for reform. For example, both suicide prevention and health promotion require multidimensional interventions, the active involvement of multiple sectors of government, and community and consumer involvement. This suggests that the structural barriers to progress in these fields are also likely to be the same. Another point of convergence between health promotion and suicide prevention is in the increasing recognition among researchers and practitioners in both these fields that many of the health outcomes of interest, be they mental, emotional or physical, are likely to have common determinants in fundamental social problems such as social inequality (Hawe et al. 1997; National Advisory Council on Suicide Prevention 2000; Vimpani 2000; Wilkinson and Marmot 1998).

The convergences in the key issues facing the fields of suicide prevention and health promotion suggest that health promotion professionals should be viewed as central partners in future suicide prevention efforts. They should perhaps be considered as even more central than other previously identified partners such as general practitioners, schools, community agencies, youth workers, and other specific service providers.

Hawe et al. (1997) have argued that capacity building efforts for health promotion will be most fruitful when they enhance capacity to respond to a wide variety of health promotion goals. This principle can be expanded to apply to service development and systems change across an even wider range of issues, especially suicide prevention. In other words, a generic approach to capacity building aimed at enabling service agencies to be more responsive to the health and welfare problems identified and prioritised by local communities may be the best approach to building capacity for suicide prevention.

This generic approach to capacity building may prove to be the only approach capable of gaining acceptance by the majority of service managers and staff who have many priorities other than suicide prevention competing for their attention. As Tobin (2000) suggests: “We can’t keep adding a new priority to the list of priorities every time there is a new issue . . . We need to look at more comprehensive systemic responses.”

Major challenges for governments will be to help identify appropriate models of generic capacity building and to create a policy environment that supports the
development of agencies capable of building their own capacity and the capacity of the communities they serve. Two strategies are suggested for progressing these aims: a learning organisation model; and policy, planning and coordination.

**Learning organisations**

All organisations need to have structures and processes in place which facilitate ongoing learning as a basis for ongoing action.

Evidence-based practice in the provision of human services and programs is not only about evidence of the efficacy of particular treatments and prevention programs in achieving particular outcomes for targeted populations. We also need to generate and respond to evidence regarding: the effectiveness of programs as they are implemented by real agencies in real settings; the ways in which agencies and service systems are organised and managed; and the effects of government policies and administrative processes.

This “practice-based evidence” tends to be neglected in favour of evidence grounded in the quantitative sciences such as epidemiology and conducted by university based academics. However, these two types of evidence are not competitive, they are complementary. Epidemiological evidence is useful for prioritising among different health issues and identifying the risk and protective factors to be targeted. Epidemiological advances often drive calls for changes in the priorities of service systems. Practice-based evidence provides the tools that allow service systems to respond appropriately to the evidence provided by epidemiology and the other biological and social sciences.

More attention needs to be directed to enhancing the accessibility and effective use of practice-based evidence. Documentation and dissemination of information is not enough. Many agencies lack the tools required to tap into existing stores of knowledge and to ensure that their own experiences are subject to critical reflection and are fully used.

The Australian Institute of Family Studies summative evaluation of the Strategy has provided an opportunity to reflect critically upon the evaluation effort along with all the other groups of activities. Evaluation should not be seen simply as a higher order activity that can be excluded from critical examination. Rather, evaluation should be seen as a tool for service and program development that has equal standing to others such as training, management, communications, and development of intersectoral partnerships. Seen in this light, we can recognise that evaluation varies in its effectiveness and usefulness just as other activities do.

Many of the Strategy projects struggled to achieve rigorous and useful evaluation regardless of whether they examined outcomes, impacts or processes. One of the major factors that facilitated effective evaluation was the use of an approach whereby external evaluators worked in partnership with internal evaluators, preferably service managers. Use of external evaluators helped ensure that
adequate amounts of time and resources were allocated to evaluation tasks and not subsumed by the pressures of daily service provision.

However, evaluations conducted purely by external consultants tended to experience serious difficulties in engaging service and program staff in the collection of necessary data. External evaluations were also vulnerable to the criticism of failing to adequately reflect the wider policy and service system context in which agencies and programs were embedded.

Partnerships between external and internal evaluators tended to lead to more comprehensively reflective evaluation and avoided problems of conflict of interest associated with internal evaluation. But perhaps the most important benefit of the internal–external partnership approach was the way in which this collaboration worked to enhance the technical evaluation knowledge, skills and reflective capacity of teams of service providers and, indeed, whole organisations. Evaluation reports produced by such partnerships tended to reflect high levels of confidence that the experience of the Strategy project evaluation would lead to stronger organisational commitment to evaluation and evidence based practice in the future and strong enthusiasm about developing mechanisms to support ongoing critical reflection and participative learning.

One process that has been used with considerable success in health and human services and in community development programs is Participatory Action Research (Maton 1999). Action research emphasises the importance of embedding evaluation and monitoring into an ongoing cycle of action and reflection. Action is intentionally researched (evaluated) and modified, leading to the next stage of action, which is again intentionally examined in order to inform further modification (Wadsworth 1991). Many different types of evidence are used. Participatory Action Research emphasises the participation of all relevant stakeholders in the evaluation-action cycle. Participatory Action Research has proven particularly useful as a mechanism for ensuring that the input of consumers is systematically collected and actually acted upon alongside other evidence. Participatory Action Research also appears to be particularly effective in ensuring that agency staff are engaged in the planning and evaluation process, something that is often difficult using other evaluation frameworks. By emphasising the value of all viewpoints and a range of different types of evidence, Participatory Action Research may be viewed as a less threatening and more relevant approach to evaluation and planning that demonstrates a genuine commitment to listening and building on strengths. Participatory Action Research has been employed effectively by mental health services (Tobin Dakos and Urbanc 1997), and there is considerable room to expand its use.

The learning organisation model provides a comprehensive framework for ensuring that an organisation places quality improvement at the centre of its concern and is able to adapt quickly to new demands. The concept of the learning organisation was developed within the business management sector (Senge 1990) but
it has demonstrated substantial relevance and utility in the public sector as well (Birleson 1998; Hawe et al. 1997).

**Policy, planning and coordination**

Coordination of system reform efforts at a national or state/territory level provides unique opportunities to address structural barriers that cannot be addressed effectively by capacity building initiatives conducted by individual agencies or local interagency networks.

Many of the barriers encountered by Strategy project staff in pursuing project aims can be attributed to their relative lack of knowledge, power and authority within the service systems they were seeking to change. There is evidence that relevant power brokers such as local service managers and state and territory government departments were frequently not sufficiently engaged in the Strategy.

The support of senior managers of area/regional service systems might have been secured more easily by projects if the Commonwealth had ensured that senior managers were involved in consultations and negotiations that took place leading up to the allocation of funding to projects. This would also help ensure that projects are located at the most appropriate level in bureaucratic structures.

More proactive planning and coordination between Commonwealth government departments could have helped projects develop links with the substantial array of Commonwealth strategies and programs addressing issues closely related to youth suicide prevention, thereby enhancing opportunities for intersectoral collaboration. Collaborative planning mechanisms that already exist at state/territory levels could also have been used more effectively by Strategy projects if the Commonwealth had been more proactive in consulting with relevant state and territory government departments.

There are some major inconsistencies across policy domains and jurisdictions in terms of the objectives and aims of particular policies. For example, political responses to social problems closely related to suicide and self harm such as violence and crime have been identified by human rights professionals as increasingly punitive in some states and territories and based on emotive responses rather than evidence about causes and what works to reduce these problems. These punitive responses have been noted as impacting on indigenous people particularly unfairly. It is an important task of suicide prevention to assess these developments from the perspective of the evidence base which is now very substantial and includes major reports from the Human Rights and Equal Opportunity Commission (1991, 1997) and the Attorney General’s Department (National Crime Prevention 1999), as well as a large international research literature.

A partnership approach to policy development and planning across sectors and between the Commonwealth government and the states and territories could be of benefit. Commonwealth–state relations have long been identified as a serious
problem for human service development (for example, Australian Council of Social Services 1991). Existing mechanisms for improving relations tend to rely on consultation, accommodation and cooperation rather than on genuine collaboration and partnership.

A major barrier to the formation of genuine partnerships between agencies is the lack of clear direction at a policy level within the range of sectors that need to be involved. Although policy documents within sectors increasingly espouse a partnership approach, these generally lack details of models that can be actively adopted, or levers that can be used or built upon.

To be sustainable and effective, local partnerships must be complemented and supported by strategic partnerships between: Commonwealth government departments; the Commonwealth and the states and territories; and state/territory governments and area/regional/district authorities.

Policy research is required to further understanding of the barriers that continue to block the formation of genuine intersectoral partnerships at the government level and to identify solutions. This research should be guided by the objective of identifying the ways in which government policy and program administration can be adjusted to facilitate intersectoral partnerships at the level of local service systems, and greater responsiveness to the range of health and social welfare issues identified by local communities. Commentators in the field of social capital research have argued that radical systemic change is required in systems of government – change that places social capital development at the centre of the policy making and administrative process (Stewart-Weeks 2000).

**Funding models**

One problem that is gaining increased recognition is the “silo” or “categorical” approach to the funding and administration of different government programs. Categorical funding has also been identified as a major barrier to expansion of local community control over the allocation of resources (Buchanan 2000) because funds are allocated for particular categories of activity, and diversion to other priorities is considered unethical. Even diversion to general capacity building has been observed as problematic in this funding system (Hawe et al. 1997). At present these silos tend to be organised along the lines of particular health and social problems such as suicide, mental disorders, substance use, crime, child abuse, domestic violence, to name just a few. As has been observed previously in this report and by other commentators, many of these problems have common causes and could be addressed more effectively in a coordinated approach.

Up to now efforts to improve coordination of government activities have often involved reorganisation of the silos or categories. Thus if it is observed that many different departments are addressing a particular issue or population group, then these programs may all be brought together in a single unit or branch of one department. Such reshuffling may improve coordination within this particular
area for a short time but eventually, as the need for new and expanded linkages emerge, new coordination problems develop. For example, while the reshuffle may improve coordination within a particular field of endeavour, the act of removing formal administrative responsibility for a particular issue from the range of other departments that previously had an interest actually severs or disrupts a key basis for the development of better links between departments.

The increasing popularity of the concept of intersectoral partnerships confirms increasing recognition that such categorical reshuffling is no longer a viable solution to the problem of collaboration across fields of endeavour. However, the question remains of whether or not particular types of silo arrangements are more fundamentally useful than others. At the moment there appears to be considerable confusion about this question.

There is currently a trend towards organising funding streams along functional lines that appear more consistent with positive health promotion concepts and concepts that reflect the social factors thought to underpin related health and well-being outcomes, in addition to the traditional problem-focused categories. This trend is manifest at both intersectoral and intrasectoral levels. For example, the Commonwealth Mental Health and Special Programs Branch is currently in the process of developing or renewing a national suicide prevention strategy, a national depression initiative, and a mental health promotion, prevention and early intervention national action plan. At the same time, the Commonwealth Department of Family and Community Services has recently released a Stronger Families and Communities Strategy, while the Commonwealth Department of Education and Training and Youth Affairs is in the process of developing a National Youth Pathways Action Plan. Over recent years criminal justice policy at the Commonwealth level has increasingly moved towards a prevention orientation (National Crime Prevention 1999).

The appearance of health promotion and sociological terms in funding category names alongside problem-focused terms appears to reflect a situation of increasing understanding of, and commitment to addressing, the social determinants of health and social problems that have traditionally been tackled in isolation. The convergence of terminology evident in various new national initiatives identified above could reflect and further exacerbate territorial confusion and competition between government departments and lead to further duplication and wastage of resources. Or it could reflect the evolution of a valuable basis for the development of true partnership in the pursuit of shared goals.

**A systematic policy framework**

If these emerging opportunities for partnership are to be realised, further work needs to be directed towards developing a systematic framework for policy development and collaborative planning that is positively oriented towards creating and sustaining partnerships.
One important first step will be to develop a common conceptual framework for understanding and communicating about different types of policy functions. Consideration of the policy issues surrounding youth suicide prevention and the barriers faced in implementing the Strategy suggests at least five different conceptual dimensions that need to be addressed in a systematic, whole-of-government approach to suicide prevention policy development: structural social policy; population-based policy; problem-centred policy; service system management policy; and place-centred policy.

- **Structural social policy** should cut across departments and address structural social issues common to the concerns of many or all sectors of government. Structural social policy needs to be developed in a manner that involves all relevant departments and should articulate roles and responsibilities across these departments.

- **Population-based policy** addresses the needs of particular demographically defined sub-groups in the population such as children, young people and older people, as well as issues of cultural and social diversity in populations. Population-based policy can be applied within particular departments or can address issues common across many departments.

- **Problem-centred policy** focuses on negative outcomes such as suicide, homelessness, and drug misuse. Many national strategic initiatives tend to be problem-centred. At present such problem-centred policy tends to be developed and implemented primarily within specific departments.

- **Service system (or functional) management policy** is concerned with the administration and development of service infrastructure systems such as health services, community services or the education or legal systems. This is currently the dominant form of policy shaping the spending and activities of Commonwealth and state and territory governments.

- **Place-centred policy** is a new concept in the realm of national policy. Place-centred policy has been identified as an approach with strong potential for supporting the development of social capital and enhancing local participation and control over community development (Buchanan 2000; Stewart-Weeks 2000).

In order to enhance the comprehensiveness and coherence of the policy development process for the purpose of improved coordination and collaboration across sectors of government, each new policy initiative should be positioned within a systematic framework such as the one described above, and articulate clearly with each dimension of the framework.

The National Youth Suicide Prevention Strategy was an example of a combination of problem-centred policy (suicide) and population-based policy (youth). A benefit of this dual policy focus was in building awareness of the ways in which suicide and suicide prevention activities are intricately bound up with
other health and social issues, and the ways in which these factors interact with developmental factors to exert their unique influence upon young people’s wellbeing. The population-based approach to suicide prevention provided a conceptual framework for understanding and acting upon diversity among young people.

In its implementation, the Strategy articulated with service system management policy (for example, mental health service development, community service development, schools). This articulation was sometimes rather haphazard, however, and implementation of strategies might have been more effective if Strategy policy development had identified other relevant service system management policies as well as the specific policy issues that needed to be addressed in these other policies. The Strategy did not articulate with structural social policy – however, this can be attributed to a relative lack of structural social policies compared to other forms such as service system management and problem-centred policy.

An example of the way in which a structural social policy approach can provide a framework for intersectoral collaboration is the Sure Start Program recently initiated in the United Kingdom (Glass 1999). Sure Start is a highly innovative cross-departmental strategy which aims to work in partnership with parents, communities, statutory agencies, voluntary groups and existing services and programs, to promote the physical, intellectual, social and emotional development of children – particularly those who are disadvantaged. The design of the program was initially informed by a series of comprehensive spending reviews that cut across the responsibilities of different departments. The review and development process, as well as implementation of the Sure Start Program itself, have been managed by groups of officials from all relevant departments. Sure Start is also using a place-focused policy approach. The program asks service agencies and community groups in particular localities to work together to develop an action plan for program implementation in their community.

**Valuing young lives**

While generic capacity building and policy development are fundamentally important for the future, it is also important not to lose sight of the historical factors that led to the development of the Strategy.

The National Youth Suicide Prevention Strategy was not just about suicide prevention, it was also about young people and their place in Australian society.
The concerns that prompted the initiation of the Strategy comprised not only epidemiological evidence about suicide rates and their variation across populations, but also evidence that young people suffer serious disadvantages in their access to health and social resources compared to other populations, particularly in the area of mental health.

In 1993 the Report of the National Inquiry into the Human Rights of People with Mental Illness (Burdekin 1993: 647) found that in relation to children and adolescents:

“The overwhelming picture is one of inadequate funding, inadequate provision of facilities, inadequate staffing, inadequate training of health and other workers, inadequate inpatient care, inadequate community and home-based care, inadequate coordination between agencies, inadequate knowledge, inadequate research, inadequate data collection, and inadequate commitment to the establishment of prevention and intervention services.”

The Strategy represents a major part of the effort that the Commonwealth government has made over the past seven years to address the recommendations of the Burdekin Report. However, recent developments in suicide prevention in Australia towards a whole of lifespan approach, while completely justified from a purely epidemiological view of suicide, nevertheless represent a movement away from the social justice component of the original youth suicide prevention agenda.

The findings of the Australian Institute of Family Studies evaluation of the National Youth Suicide Prevention Strategy underscore the critical importance of reaffirming an ongoing commitment to social justice for young people. There is evidence that progress has been made against some of the deficits identified by Burdekin, particularly in the area of knowledge, research, training and commitment to the establishment of prevention programs. However, the evaluation of the Strategy has also revealed evidence that many of the structural deficiencies in service systems remain as problematic as they have ever been.

The central concern of future youth suicide prevention efforts must be fundamental structural reform aimed at building the capacity of health and welfare systems to be consistently responsive to the growing and shifting evidence regarding the needs of young people. At the end of the Strategy there is considerable readiness to begin the work of seriously tackling these problems. Long-term political commitment is vital.
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Appendices
Appendix 1: Six Maps of Program Logic

1 Primary prevention and cultural change

Outcomes/Goals

• Reduce the incidence of known risk factors for suicide and suicide related behaviour among young people.

• Increase wellbeing, resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

Outputs/Impacts

• Parents have the skills, knowledge and support necessary to provide emotionally and mentally healthy parenting to their children.

• Schools provide a mental health promoting environment for children and adolescents.

• Media reports on and portrays suicide, mental illness and youth issues in a manner that is safe and which promotes positive mental health for young people.

• Communities provide environments and programs that are supportive of young people.

Processes

• Increase the capacity of services to provide parenting education, training and support programs.

• Provide materials, programs and support to schools to enable them to develop a whole-school approach to mental health promotion.

• Educate the media in safe ways to report on and portray suicide, mental illness and youth issues.

• Provide communities with the skills and knowledge to develop their capacity for program development.

• Young people are supported to be involved in the planning and delivery of mental health promotion projects targeting young people.

Inputs

• Fund seven demonstration projects in the area of parenting education and support.

• Fund a comprehensive mental health promotion program to develop and trial structured resources for secondary schools.

• Develop a media resource kit for reporting on and portraying suicide, mental illness and youth issues.

• Fund community development projects that aim to create environments that are supportive of young people.

• Fund a project which involves young people developing resources to promote mental health among young people.

• Evaluate funded projects.
2 Early intervention

Outcomes/Goals

- Reduce the prevalence of emerging and recently developed risk factors for suicide among young people.

Outputs/Impacts

- Reduce the average length of exposure to individual and environmental risk factors for suicide.
- Reduce the average number of risk factors to which children and young people are exposed.
- Minimise the negative consequences or impacts following exposure to risk factors.
- Increase exposure to protective factors.

Processes

- Inform young people about risk and protective factors and how to seek help.
- Identify young people at risk.
- Increase the accessibility of appropriate help including services.
- Engage young people at risk in interventions.
- Increase the skills and knowledge of specialists, primary care providers and other community members in identifying and supporting young people with emerging problems.
- Increase collaboration and communication between specialist service providers and primary health care providers.
- Increase collaboration between health care sector, professionals in other sectors and community members with regular contact with young people at risk.
- Provide resources and information to support good practice in early intervention.
- Increase levels of early intervention activity across the range of relevant sectors.

Inputs

- Contribute funding to the development of a national network for early intervention into mental health problems.
- Fund a variety of projects that include the development of service networks aimed at smoothing referral pathways for young people with emerging and early onset mental health problems.
- Provide training to general practitioners, community health workers and general community members in identifying and supporting young people with emerging problems and linking them into appropriate services.
- Provide assistance to schools in developing early intervention programs for students beginning to be affected by risk factors for suicide.
- Evaluate programs.
3 Crisis intervention and primary care

Outcomes/Goals

• Reduce the incidence of suicide and suicide related behaviour among young people resulting from acute crises.
• Prevent the development of acute crises.

Outputs/Impacts

• Distress suffered by young people experiencing acute crises is minimised.
• Young people experiencing acute crises are enabled to resolve crisis situations as promptly as possible.
• Young people experiencing problems are provided with the support, care, knowledge and skills that enable them to develop positive solutions and avoid the emergence of crises.

Processes

• Expand the capacity and enhance the quality of telephone counselling services for young people.
• Enhance the quality of care provided to young people presenting to hospital accident and emergency departments following self-harm and suicide attempts.
• Enhance the accessibility and appropriateness of primary health care services for young people.
• Enhance the capacity of counselling services in rural and remote areas.
• Develop the skills and awareness of young people and other community members in crisis intervention and how to access appropriate services.

Inputs

• Provide funds to two major telephone counselling services in order to: expand their capacity to serve young people; provide training to staff; provide community education about suicide prevention and the availability of services.
• Fund seven projects to research, develop and trial protocols for the identification and management of deliberate self-harm and suicide attempts among young people presenting to hospital accident and emergency departments.
• Fund three projects that provide training to general practitioners and community health workers to identify and support young people who are experiencing mental health problems and other risk factors and link them into appropriate services.
• Develop networks of general practitioners and other service providers.
• Provide funds to the states and territories to enhance counselling services in rural and remote areas.
• Provide community education on crisis intervention.
4 Treatment, support and postvention

Outcomes/Goals

- Reduce the incidence of suicide and suicide related behaviour among young people with established problems that place them at high and ongoing risk of suicide.
- Reduce the incidence of suicide and suicide related behaviour among people affected by the death of young people due to suicide.

Outputs/Impacts

- The harm, distress and disadvantage suffered by young people living with problems that could place them at risk of suicide is minimised.
- Maximise the life skills and quality of life of young people living with problems that could place them at risk of suicide.
- Increase engagement of young people with services and other support structures.

Processes

- Develop skills, knowledge and information pertinent to good practice in the treatment and management of mental disorders, particularly depression, psychosis and dual diagnosis involving substance misuse.
- Develop skills, knowledge and information pertinent to good practice in service provision to marginalised young people affected by problems such as homelessness, contact with the justice and juvenile justice system, sexual identity issues, self-harming behaviour, and previous suicide attempts.
- Increase the accessibility of services.

Relevant services systems include:

- mental health services;
- drug and alcohol services (including treatment and prevention services);
- youth services;
- community organisations;
- justice, including juvenile justice system;
- all other health and welfare services required by young people living with risk factors for suicide

Inputs

- Fund demonstration projects based in specialist child and adolescent mental health services to improve management of mental disorders particularly depression, psychosis, and dual diagnosis involving substance misuse.
- Fund demonstration projects based in community organisations, youth and other services specialising in service provision to marginalised young people affected by multiple problems such as homelessness, contact with the justice system, sexual identity issues, self-harming behaviour and previous suicide attempts.
- Evaluate funded projects.
5 Access to means/injury prevention

Outcomes/Goals

• Reduce the rate of death resulting from suicide attempts among young people.
• Reduce the rate and severity of injury resulting from suicide attempts and suicide related behaviour among people.

Outputs/Impacts

• Firearms are not accessible to young people unless supervised by a person experienced in the safe use of firearms.
• Community education materials relating to firearms and suicide are available.
• Information and resources are available to inform the design and implementation of strategies that restrict access to and injury from hanging as a means of suicide.
• Information and resources are available to inform the design and implementation of strategies that restrict access to and injury from jumping from heights as a means of suicide.
• Information and resources are available to inform the design and implementation of strategies that restrict access to and injury from car exhaust systems as a means of suicide.

Processes

• Strengthen the evidence base concerning access to means of suicide among young people in Australia.
• Enhance availability of information that can support the development of good practice in restriction of access to means.
• Enhance availability of information about good practice in the prevention of injury from use of firearms.

Inputs

• Conduct research into the general issues surrounding access to means of suicide by young people.
• Conduct research into the issues surrounding the use of hanging, car exhaust systems, jumping from heights and railways.
• Develop and trial a community education approach to prevention of injury and suicide by firearms.
6 System level activities

Outcomes/Goals

- Prevent premature death from suicide among young people.
- Reduce rates of injury and self-harm arising from suicidal behaviour.
- Reduce the incidence and prevalence of suicidal ideation and behaviour.
- Enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

Outputs/Impacts

Youth suicide prevention activities will:
- be informed by evidence concerning: epidemiology; risk factors; effectiveness of interventions; the needs and attitudes of young people and others most affected by programs;
- include a balance of individual-focused (indicated/Selective) and population-based (universal) interventions;
- involve young people and others most affected in the design, implementation and evaluation of programs;
- be responsive to the needs of culturally diverse populations (including Aboriginal and Torres Strait Islander and non-English-speaking background communities) as well as other marginalised young people;
- be responsive to the varied needs of different geographic areas including rural and remote communities;
- involve collaboration with other stakeholders;
- take place in a range of sectors responsible for the health and welfare of young people.

Sectors responsible include:
- mental health;
- primary health care;
- education;
- justice system;
- employment;
- youth sector;
- arts/recreation;
- public health;

Processes

- Strengthen the evidence base.
- Enhance the availability of information and resources that support good practice.
- Enhance the availability of education and training programs that support good practice.
- Develop structures and systems that facilitate uptake of good practice.
- Provide policies, protocols and service development/program plans that support good practice.

Inputs

- Research and evaluation:
  - conduct literature reviews on: epidemiology, risk factors, and effectiveness of interventions;
  - conduct research on the needs of young people regarding mental health issues;
  - evaluate each project and the Strategy as a whole.
• Communication (or Identification and dissemination of good practice):
  - establish structures and mechanisms for the distribution and exchange of information about youth; suicide prevention activities between professionals and other stakeholders
  - conduct two national stocktakes of programs and activities;
  - develop and distribute good practice guidelines in the areas of: school-based suicide prevention; education and training; management of self-harm and suicide attempts in accident and emergency departments.

• Education and training:
  - develop a resource guide and good practice guidelines in education and training;
  - develop and trial accredited programs and material resources for education and training of professionals and paraprofessionals in issues relating to youth suicide prevention;
  - provide input to the development of industrial competency standards.

• Networking and intersectoral collaboration:
  - conduct demonstration projects to develop and trial intersectoral networks.

• Community development:
  - implement demonstration projects in community development focusing on rural and remote, and Aboriginal and Torres Strait Islander communities.

• Policy and planning:
  - provide policy, planning, coordination, advice and support.
# Appendix 2: Four Maps of Achievements

## 1 Primary prevention and cultural change

### Outcomes/Goals

- Reduce the incidence of known risk factors for suicide among young people.
- Increase wellbeing, resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

### Minimal progress

- No data are available to indicate whether or not the Strategy has led to reductions in risk factors or increases in wellbeing and resilience at the population level.
- Evaluation of one parenting program demonstrated preventative effects for the group exposed to the intervention compared to a control group.

### Impacts/Objectives

- Parents have the skills, knowledge and support necessary to provide emotionally and mentally healthy parenting to their children.
- Schools provide a mental health promoting environment for children and adolescents.
- Media reports on and portrays suicide, mental illness and youth issues in a manner that is safe and which promotes positive mental health for young people.
- Communities provide environments and programs that are supportive of young people.

### Moderate progress

- Evaluation of several parenting programs suggested parents exposed to those programs experienced increased confidence and satisfaction and decreased depression.
- 53 per cent of respondents in the survey of stakeholders believe there has been no change in parents’ levels of skills, knowledge and support while 34 per cent believe these are a little better.
- 59 per cent of respondents in the survey of stakeholders believe there has been a little improvement in the extent to which schools provide a mental health promoting environment. 21 per cent believe there has been no change.
- 42 per cent of respondents in the survey of stakeholders believe there has been a little improvement in media reporting. 34 per cent believe there has been no change.
- 45 per cent of respondents in the survey of stakeholders believe there has been a little improvement in the extent to which communities provide mental health promoting environments for young people. 29 per cent believe there has been no change.

### Processes/Aims

- Increase the capacity of services to provide parenting education, training and support programs.

### Substantial progress

- 55 per cent of respondents in the survey of stakeholders believe that the availability of parenting education and support programs is a little better. 29 per cent believe there has been no change.
• Provide materials, programs and support to schools to enable them to develop a whole-school approach to mental health promotion.
• Educate the media in safe ways to report on and portray suicide, mental illness and youth issues.
• Provide communities with the skills and knowledge to develop their capacity for program development.
• Young people are supported to be involved in the planning and delivery of mental health promotion projects targeting young people.

• The Strategy parenting projects provided training to nearly 1000 professionals to equip them to deliver parenting programs.
• Several parenting projects improved the documentation of parenting programs by preparing comprehensive manuals.
• Program coordination and support structures have been strengthened
• 38 per cent of respondents in the survey of stakeholders believe that schools’ skills and resources have got a little better. 36 per cent believe there has been no change.
• Curriculum and a Guide for suicide prevention have been developed but not yet widely distributed. Resources for supporting whole-school approaches are under development.
• 42 per cent of respondents in the survey of stakeholders believe that availability of resources to help the media report safely has got a little better.
• A Media Resource Kit has been widely distributed.

Gaps

• Certain high risk groups such as parents with mental illness were not addressed.
• The Strategy did not direct attention to skilling or resourcing communities to develop their own primary prevention and mental health promotion programs.
• Only two Strategy projects involved young people in the planning and delivery of mental health promotion and primary prevention programs.
• The Strategy did not address cultural factors in the wider society that have been identified by some writers as playing a role in increased rates of youth suicide in countries such as Australia.
## 2 Early intervention

<table>
<thead>
<tr>
<th>Outcomes/Goals</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce the prevalence of emerging and recently developed risk factors for suicide among young people.</td>
<td>• No data are available to indicate whether or not the Strategy has led to reductions in the prevalence of emerging and recently developed risk factors among young people at the population level.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impacts/Objectives</th>
<th>Minor progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce the average length of exposure to individual and environmental risk factors for suicide.</td>
<td>• No data are available to indicate whether or not the Strategy has led to reductions in the average time that young people are exposed to risk factors for suicide or the average number of risk factors to which they are exposed at the population level.</td>
</tr>
<tr>
<td>• Reduce the average number of risk factors to which children and young people are exposed.</td>
<td>• Two projects focusing on early intervention demonstrated reductions in the severity of mental disorders experienced by young people including symptoms of psychosis and depression.</td>
</tr>
<tr>
<td>• Minimise the negative consequences or impacts following exposure to risk factors.</td>
<td>• Several projects reported improvements in the social adjustment of children as a result of early intervention programs.</td>
</tr>
<tr>
<td>• Increase exposure to protective factors.</td>
<td>• Several projects reported improvements in the school and/or family environments of children and young people as a result of early intervention programs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Processes/Aims</th>
<th>Substantial progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inform young people about risk and protective factors and how to seek help.</td>
<td>• A substantial proportion of Strategy early intervention programs were found to be effective in engaging young people at risk in early interventions.</td>
</tr>
<tr>
<td>• Identify young people at risk.</td>
<td>• Strategy projects provided training to a large number of primary care providers. One of these demonstrated significant increases in the ability of GPs to identify young people at risk of suicide.</td>
</tr>
<tr>
<td>• Increase the accessibility of appropriate help including services.</td>
<td>• Model support structures for enhancing capacity in early intervention have been trialed.</td>
</tr>
<tr>
<td>• Engage young people at risk in interventions.</td>
<td>• 59 per cent of respondents in the survey of Strategy key stakeholders believe that the extent to which young people who are developing risk factors for suicide are gaining access to appropriate services with minimal delay got ‘a little better’ between 1995 and 1999. A large majority of respondents (84 per cent) in this survey...</td>
</tr>
</tbody>
</table>
specialist service providers and primary health care providers.

- Increase collaboration between health care sector, professionals in other sectors and community members with regular contact with young people at risk.
- Provide resources and information to support good practice in early intervention.
- Increase levels of early intervention activity across the range of relevant sectors.

believed that the Strategy had played a strong (11 per cent), moderate (36 per cent) or some (37 per cent) role in the progress that has been made in early intervention (including access to services) over the past five years.

- The majority of respondents in the survey of Strategy key stakeholders believe that the skills and knowledge of specialist service providers (58 per cent) and primary care providers (62 per cent) with respect to early intervention have got ‘a little better’ since 1995. 21 per cent and 25 per cent respectively believe there has been no change.

Gaps

- A report on community gatekeeper training was produced but its recommendations re expanding the availability of gatekeeper training are yet to be implemented.
- Strategy Projects that addressed collaboration between specialist and primary care providers reported minimal achievement. Substantial structural and organisational barriers remain in place.
- Strategy projects that addressed intersectoral collaboration generally reported minimal progress. It was found to be extremely difficult to develop sustainable structures capable of supporting sustained collaboration.

The Strategy focused strongly on the health sector (emergency departments, mental health and primary health care), and the education sector. Little attention was directed to the role of other sectors.
## 3 Crisis intervention and primary care

### Outcomes/Goals

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the incidence of suicide and suicide related behaviour among young people resulting from acute crises.</td>
<td></td>
</tr>
</tbody>
</table>

### Impacts/Objectives

- Distress suffered by young people experiencing acute crises is minimised.
- Young people experiencing acute crises are enabled to resolve crisis situations as promptly as possible.
- Young people experiencing problems are provided with the support, care, knowledge and skills that enable them to develop positive solutions and avoid the emergence of crises.

### Not known/Minimal progress

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No data are available to indicate whether or not the Strategy has led to reductions in the incidence of suicide and suicide related behaviour among young people at the population level.</td>
</tr>
<tr>
<td>No data are available to indicate whether the incidence of acute suicidal crises experienced by young people has declined.</td>
</tr>
<tr>
<td>One emergency department project demonstrated reductions suicidality and the severity of psychiatric symptoms in young people provided with intensive followup after a suicide attempt.</td>
</tr>
</tbody>
</table>

### Outcomes/Goals

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the incidence of suicide and suicide related behaviour among young people resulting from acute crises.</td>
<td></td>
</tr>
</tbody>
</table>

### Impacts/Objectives

- 43 per cent of respondents in the survey of Strategy key stakeholders believed that the extent to which young people who experience acute crises are enabled to resolve these crises promptly got ‘a little better’ between 1995 and 1999. 37 per cent believed there had been no change.
- Telephone counselling was found to be effective in reducing immediate levels of psychological distress and suicidal ideation experienced by callers. Young people were generally satisfied with the service, most callers used one or more of the services to which they were referred, and problems get better gradually over time.
- 41 per cent of respondents in the survey of Strategy key stakeholders believed that the extent to which young people who experience acute crises are able to access appropriate support with minimal delay got ‘a little better’ between 1995 and 1999. 29 per cent believe there had been no change.
- 48 per cent of respondents believed that the extent to which young people are being provided with the support, care, knowledge and skills to develop positive solutions and avoid crises in the future has got ‘a little better’ since 1995. 30 per cent believed there had been no change.
<table>
<thead>
<tr>
<th>Processes/Aims</th>
<th>Moderate progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expand the capacity and enhance the quality of telephone counselling services for young people.</td>
<td>• Telephone counselling services have developed useful tools for performance monitoring, quality enhancement and evaluation.</td>
</tr>
<tr>
<td>• Enhance the quality of care provided to young people presenting to hospital accident and emergency departments following self-harm and suicide attempts.</td>
<td>• Training provided to staff of telephone counselling services was assessed as being of high quality, has been well received and has led to increased knowledge and confidence but the data do not demonstrate increases in competency and training has not been attended by all relevant staff.</td>
</tr>
<tr>
<td>• Enhance the accessibility and appropriateness of primary health care services for young people.</td>
<td>• 44 per cent of respondents in the survey of Strategy key stakeholders believed that the extent to which telephone counselling services have the capacity to respond adequately to calls from young people got ‘a little better’ between 1995 and 1999. 20 per cent believed there had been no change.</td>
</tr>
<tr>
<td>• Enhance the capacity of counselling services in rural and remote areas.</td>
<td>• Seven Strategy projects have made reasonable progress in the development of protocols that may enhance the quality of care provided to young people presenting to emergency departments in the future. Substantial structural and organisational barriers remain in place.</td>
</tr>
<tr>
<td>• Develop the skills and awareness of young people and other community members in crisis intervention and how to access appropriate services.</td>
<td>• 47 per cent of respondents in the survey of Strategy key stakeholders believe that the extent to which young people who present to emergency departments with suicide attempt and DSH are accurately identified and assessed got ‘a little better’ between 1995 and 1999. 30 per cent believe there has been no change. 46 per cent believe that the extent to which appropriate treatment and care is provided has got ‘a little better’. 23 per cent believe there has been no change.</td>
</tr>
<tr>
<td>• Telephone counselling services have developed useful tools for performance monitoring, quality enhancement and evaluation.</td>
<td>• Suicide prevention training has been provided to a large number of primary health care professionals and training resources have been developed and made widely available. Substantial barriers ongoing professional development and making necessary changes in work practice remain in place.</td>
</tr>
<tr>
<td>• Training provided to staff of telephone counselling services was assessed as being of high quality, has been well received and has led to increased knowledge and confidence but the data do not demonstrate increases in competency and training has not been attended by all relevant staff.</td>
<td>• 41 per cent of respondents in the survey of Strategy key stakeholders believe that the extent to which primary health care services are accessible and appropriate for young people got ‘a little better’ between 1995 and 1999. 39 per cent believe there has been no change.</td>
</tr>
<tr>
<td>• 44 per cent of respondents in the survey of Strategy key stakeholders believe that there has been no change in the availability of counselling for young people in rural and remote areas between 1995 and 1999. 22 per cent</td>
<td>• States and territories used funding provided under the Strategy to enhancing counselling services in rural and remote areas.</td>
</tr>
<tr>
<td>• 44 per cent of respondents in the survey of Strategy key stakeholders believe that there has been no change in the availability of counselling for young people in rural and remote areas between 1995 and 1999. 22 per cent</td>
<td>• 44 per cent of respondents in the survey of Strategy key stakeholders believe that there has been no change in the availability of counselling for young people in rural and remote areas between 1995 and 1999. 22 per cent</td>
</tr>
</tbody>
</table>
believe that availability has got ‘a little better’.

- Lifeline provided gatekeeper training to over 3500 people during the course of the Strategy. Results of the evaluation are not yet available.

- Knowledge of the issues and barriers that need to be addressed to progress service development in the area of Crisis Intervention and Primary Care has been substantially enhanced.

Gaps

- The Strategy addressed only a very small number of the roles that general practitioners and other primary health care services could play in youth suicide prevention.

- Only a narrow range of capacity building strategies targeting primary health care were trialed.

- Models of Shared Care and a number of promising alternative models of service provision were not examined.
## Outcomes/Goals

- Reduce the incidence of suicide and suicide related behaviour among young people with established problems that place them at high and ongoing risk of suicide.

## Minor progress

- No data are available to indicate whether or not the Strategy has led to reductions in the incidence of suicide and suicide related behaviour among young people with established problems at the population level.
- Strategy projects based in mental health services demonstrated significant reductions in suicidality among the young people attending these services.
- No data are available to indicate whether the incidence of suicide and suicide related behaviour among people affected by the death of young people due to suicide has declined.

## Impacts/Objectives

- The harm, distress and disadvantage suffered by young people living with problems that could place them at risk of suicide is minimised.
- Maximise the life skills and quality of life of young people living with problems that could place them at risk of suicide.
- Increase engagement of young people with services and other support structures.

## Minor progress

- No reliable data are available to indicate whether the Strategy has led to reductions in the harm, distress and disadvantage suffered by young people living with problems that could place them at risk of suicide at a population level.
- 57 per cent of respondents in the survey of Strategy key stakeholders believe that the harm, distress and disadvantage suffered by young people living with problems that could place them at risk of suicide has not changed between 1995 and 1999. 17 per cent believe it has got a little better. 12.6 per cent believe it has got a little worse.
- 52 per cent of respondents in the survey of Strategy key stakeholders believe that the life skills and quality of life of young people living with problems that could place them at risk of suicide has not changed between 1995 and 1999. 18 per cent believe it has got a little better and 15 per cent believe it has got a little worse.
- Strategy projects based in mental health services demonstrated significant reductions in psychiatric disability among the young people attending these services. Project evaluations did not examine quality of life or life skills.
- Some of the Strategy projects targeting marginalised and disaffected young people provided evidence that life skills and quality of life were enhanced after young people had been involved with programs for some length of time.
Processes/Aims

- Develop skills, knowledge and information pertinent to good practice.
- Increase the accessibility of services.

Moderate progress

- The Strategy has generated considerable information about strategies that are likely to enhance the accessibility of services and the engagement of young people.
- 52 per cent of respondents in the survey of Strategy key stakeholders believe that the availability of the skills, information and resources needed to work towards good practice in the treatment and management of mental disorders in young people has got ‘a little better’ since 1995. 13 per cent believe it is a lot better and 23 per cent believe there has been no change.

Gaps

- The project evaluations were not able to indicate whether these services were effective than other services in terms of accessibility, engagement or treatment outcomes.
- Projects in this group did not explore issues of access and engagement for young people from high risk subpopulations such as males, Aboriginal and Torres Strait Islander young people, or young people living in rural and remote areas.
- The Strategy did not adequately explore the issues surrounding the development of partnerships between mental health services, services targeting marginalised and disaffected young people and other sectors. Major structural and organisational barriers to collaboration remain to be addressed.
- The Strategy did not direct any significant attention to postvention.
Appendix 3: Projects funded under the National Youth Suicide Prevention Strategy

Access to Means of Suicide by Young Australians
Australian Institute for Suicide Research and Prevention
Griffith University
Nathan QLD 4111
Phone: 07 3875 3816
Fax: 07 3875 3840
C.Cantor@mailbox.gu.edu.au
Contact person: Dr Chris Cantor

Access to Means of Suicide with Firearms
Coastal and Wheatbelt Public Health Unit
McIver House
PO Box 337
Northam WA 6401
Phone: 08 9622 0120
Fax: 08 9622 5752
denise.laughlin@health.wa.gov.au
Contact person: Ms Denise Laughlin

Alternative to Gaol Program for Young Aboriginal People
Benelong’s Haven Ltd
Aboriginal Drug and Alcohol Family Rehabilitation Centre
2054 South West Rocks Road
Kinchela Creek NSW 2440
Phone: 02 6567 4856
Fax: 02 6567 4932
benelong@midcoast.com.au
Contact person: Mr John Nolan

As Soon As Possible (ASAP)
Bowden Brompton Community School
85 A Torrens Road
Brompton SA 5007
Phone: 08 8346 4041
Fax: 08 8340 3240
Contact person: Mr Chris Brandwood

AUSEINET: National Mental Health Early Intervention Network
Child and Adolescent Mental Health Services
Flinders Medical Centre
Bedford Park SA 5042
Phone: 08 8357 5788
Fax: 08 8357 5484
graham.martin@flinders.edu.au
Contact person: Dr Graham Martin

Blacktown Youth Suicide Prevention Project
Blacktown Mental Health Services
University of Western Sydney
Embark House, Marcel Crescent
Blacktown NSW 2148
Phone: 02 9830 8888
Fax: 02 9881 8899
Contact person: Ms Denise Laughlin

Cellblock Youth Health Service – Suicide Prevention Project
Cellblock Youth Health Service
142 Carillon Avenue
Camperdown NSW 2050
Phone: 02 9515 3822
Fax: 02 9515 4821
kss@diab.rpa.cs.nsw.gov.au
Contact person: Ms Jacqueline Vajda

Centrecare Catholic Family Services
33 Wakefield Street
Adelaide SA 5000
Phone: 08 8252 2311
Fax: 08 8255 6625
Contact person: Ms Dorothy Belperio

Communications Project
Australian Institute of Family Studies
300 Queen Street
Melbourne VIC 3000
Phone: 03 9214 7888
Fax: 03 9214 7839
fic@aifs.org.au
Contact person: Ms Judy Adams
Community Volunteers Supporting Families Project
The Family Action Centre
The University of Newcastle
Callaghan NSW 2308
Phone: 02 4921 7076
Fax: 02 4921 6934
mbarnes@mail.newcastle.edu.au
Contact person: Ms Marilyn Barnes

ConneXions
Jesuit Social Services
Policy and Planning
PO Box 271
Richmond VIC 3121
Phone: 03 9415 8700
Contact person: Mr David Murray

Coober Pedy Youth Support Project
Multicultural Community Forum: Coober Pedy
PO Box 172
Hutchison Street
Coober Pedy SA 5723
Phone: 08 8672 3299
Fax: 08 8672 3242
Contact person: Ms Marija Podnieks

Evaluation of the National Youth Suicide Prevention Strategy
Australian Institute of Family Studies
300 Queen Street
Melbourne VIC 3000
Phone: 03 9214 7888
Fax: 03 9214 7839
fic@afis.org.au
Contact person: Ms Judy Adams

Exploring Together Program
Victorian Parenting Centre
24 Drummond Street
Carlton VIC 3053
Phone: 03 9639 4111
Fax: 03 9639 4133
vpc@vicparenting.com.au
Contact person: Dr Lyn Littlefield

Family Wellbeing Training Course
Tangentyere Council
PO Box 8070
4 Elder Street
Alice Springs NT 0871
Phone: 08 8952 5855
Contact person: Ms Christine Palmer

Far North Queensland Competency-Based Education and Training
FNQ Indigenous Consortium for Social and Emotional Health and Wellbeing Ltd
PO Box 153 B
Suite 2/32 Loeven Street
Bungalow Cairns QLD 4870
Phone: 07 4051 8355
Fax: 07 4051 8311
consortium@internetnorth.com.au
Contact person: Mrs Thea Buthmann

Gatekeeper Education and Training Consultancy
Australian Catholic University
Signadou Campus
PO Box 256
223 Antill Street, Watson
Dickson ACT 2602
Phone: 03 9479 2407
Fax: 03 9479 3590
m.frederico@latrobe.edu.au
Contact person: Ms Margarita Frederico

Good Practice Guidelines for Education and Training in Youth Suicide
University of Wollongong
Department of Public Health and Nutrition
Northfields Avenue
Wollongong NSW 2500
Phone: 02 4221 4332
Fax: 02 4221 3486
Mary_Medley@uow.edu.au
Contact person: Ms Mary Medley

Grants to States and Territories for rural and regional counselling services
Mental Health Branch.
Department Health and Aged Care
GPO Box 9848
Canberra ACT 2601
Phone: 02 6289 7080
Fax: 02 6289 8777
carmel.bates@health.gov.au
Contact person: Ms Carmel Bates

Guidelines for Schools
Taylor Made Training
PO Box 519
Richmond VIC 3121
Phone: 03 9416 9856
Fax: 03 9416 9856
barryt@mira.net
Contact person: Mr Barry Taylor
Hanging as a Means of Suicide by Young Australians
Australian Institute for Suicide Research and Prevention
Griffith University
Nathan QLD 4111
Phone: 07 3875 3816
Fax: 07 3875 3840
Ddeleo@mailbox.gu.edu.au
Contact person: Prof. Diego De Leo

Here for Life Youth Sexuality Project
Western Australia AIDS Council
(in conjunction with Gay and Lesbian Counselling Service)
664 Murray Street
West Perth WA 6872
Phone: 08 9429 9900
Contact person: Mr Joe Bontempo

Joint Colleges Project
Department of Educational Medicine
Royal Brisbane Hospital
Herston Road
Brisbane QLD 4029
Contact person: Dr Richard Ashby

Keep Yourself Alive Project
Southern Child and Adolescent Mental Health Service
Flinders Medical Centre
Bedford Park SA 5042
Phone: 08 8204 4212
Fax: 08 8204 5465
graham.martin@flinders.edu.au
Contact person: Ms Jill Knappstein

Kids Help Line – Telephone Counselling Service
Kids Help Line
PO Box 376
Red Hill QLD 4059
Phone: 07 3369 1588
Fax: 07 3367 1266
Kidshelp@squirrel.com.au
Contact person: Ms Wendy Reid

Korobra International Youth Health Symposium
New Children’s Hospital – International Association for Adolescent Health
PO Box 3515
Parramatta NSW 2124
Phone: 02 9845 3077
Fax: 02 9845 0663
Contact person: Mr Michael Booth

Lifeline Australian Youth Suicide Prevention Initiative
Lifeline Australia
148 Lonsdale Street
Melbourne VIC 3000
Phone: 03 9662 1677
Fax: 03 9662 2352
mailbruce@compuserve.com
Contact person: Dr Bruce Turley

LifeSPAN
Mental Health Services for Kids and Youth (MS-SKY)
Locked bag 10
35 Poplar Road
Parkville Victoria 3052
Phone: 03 9342 2806
Fax: 03 9387 3003
Contact person: Ms Tanya Hermann

Limelight
The Bridge Youth Service
11B Edward Street
Shepparton VIC 3630
Phone: 03 5831 2390
Fax: 03 5831 4502
Contact person: Ms Helen Keighery

Logan Here for Life Youth Suicide Prevention Project
Southern Queensland Rural Division of General Practice
PO Box 814
Toowoomba QLD 4350
Phone: 07 4632 5800
Fax: 07 4632 1932
sqrdgp@medeserv.com.au.

Lumbu Foundation
Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS)
Reichstein Foundation
2nd Floor, 172 Flinders Street
Melbourne VIC 3000
Phone: 03 9639 6272
Fax: 03 9650 7501
Contact person: Ms Daphne Milward

Mackay and Moranbah
Child and Youth Mental Health Service
Staff Development Unit
PO Box 5580

164 Valuing young lives
Mackay QLD 4740
Phone: 07 4968 6599
Fax: 07 4968 6577
Contact person: Ms Trish Ward

Media Resource Kits
Department of Health and Family Services
Mental Health Branch
2nd Floor Alexander Building
Furzer Street
Woden ACT 2601
Phone: 02 6289 8596
Fax: 02 6289 7703
Contact person: Ms Lesley Roxbee

Media Resource Kits – Consultations
Keys Young
PO Box 252
Level 5, 20 Alfred Street
Milsom Point NSW 2061
Phone: 02 9956 7515
Fax: 02 9956 7514
research@keys-young.com.au
Contact person: Ms Rohan Pigott

Meerindoo Integrated Life Skills Program
Meerindoo Youth Accommodation Services
Auspiced by the Gippsland and East Gippsland Aboriginal Cooperative
PO Box 521
104 Day Street
Bairnsdale VIC 3875
Phone: 03 5152 2188
Fax: 03 5152 3196
Contact person: Mr Colin Hood

Mind Matters Evaluation
Hunter Institute for Mental Health
72 Watt Street
Newcastle NSW 2300
Phone: 02 4924 6721
Fax: 02 4924 6724
Contact person: Mr Trevor Hazell

Mind Matters – The National Mental Health Project in Schools
Consortium – Melbourne, Sydney and Deakin Universities with ACHPER
Youth Research Centre
Faculty of Education
University of Melbourne
Parkville VIC 3052
Phone: 03 9344 9633
Fax: 03 9344 9632
mindmat@edfac.unimelb.edu.au
Contact person: Ms Helen Cahill

Motor Vehicle Exhaust Gas Suicide Prevention Development
New Directions in Health and Safety
PO Box 38
Mt Compass SA 5210
Phone: 08 8556 8007
jmoller@dove.net.au
Contact person: Mr Jerry Moller

National General Practice Youth Suicide Prevention Project
Perth Central Coastal Division of General Practice
PO Box 809
Subiaco WA 6008
Phone: 08 9389 9121
Fax: 08 9386 4093
suicide@iinet.net.au
Contact person: Mr Jon Pfaff

National Training Project for the Prevention of Youth Suicide
Victoria University of Technology
Social & Community Studies
Department
PO Box 197
Nicholson Street
Footscray East VIC 3011
Phone: 03 9284 8674
Fax: 03 9284 8542
Andrew.Patching@vu.edu.au
Contact person: Mr Andrew Patching

National University Curriculum Project
Hunter Institute of Mental Health
PO Box 833
Newcastle NSW 2300
Phone: 02 4924 6273
Fax: 02 4924 6274
yspnucp@hunterlink.net.au
Contact person: Mr Trevor Hazell

National Youth Suicide Prevention Research Strategy
Mental Health Branch
Department of Health and Family Services
GPO Box 9848
Mail drop point 37
Canberra ACT 2601
Phone: 02 6289 6918
Fax: 02 6289 7703

Appendices 165
Contact person: Ms Gabriela Taloni

Out of the Blues
Southern Child and Adolescent Mental Health Service
Flinders Medical Centre
Flinders Drive
Bedford Park SA 5042
Phone: 08 8204 5412
Fax: 08 8204 5465

Peninsula Youth Suicide Prevention Project
Peninsula Health Care Network
PO Box 52
Frankston VIC 3199
Phone: 03 9784 7777

Reach Out
Inspire Foundation
PO Box 43
Westgate NSW 2048
Phone: 02 9568 4288
Fax: 02 9568 4354

Post-IASP Seminars
LifeLine – International Experts Seminars
148 Lonsdale Street
Melbourne VIC 3000
Phone: 03 9662 2355
Fax: 03 9663 1135

Program for Parents (PfP)
Parenting Australia (A Programme of Jesuit Social Services)
ConneXions
PO Box 1411
4 Derby Street
Collingwood VIC 3066
Phone: 03 9415 7186
Fax: 03 9416 5357
parents@infoxchange.net.au

Project Officer and Evaluator Workshop
Department of Health and Family Services Mental Health Branch
2nd Floor Alexander Building
Furzer Street
Woden ACT 2601
Phone: 02 6289 8596
Fax: 02 6289 7703

Project X: Youth Suicide Prevention Initiative
Kyogle Youth Action
PO Box 298

Reducing Access to Motor Vehicle Exhaust Gas
Prince of Wales Hospital
Department of Liaison Psychiatry
High Street
Randwick NSW 2031
Phone: 02 9382 2796
Fax: 02 9382 2177

Reducing Repeated Deliberate Self-harm Among Youth
South Eastern Sydney Area Health Service and Northern Rivers Area Health Service
1st Level, 2 Short Street
St George Hospital
Kogarah NSW 2217
Phone: 02 9350 2461

Research and Consultation Among Young People
Keys Young
PO Box 252
Level 5, 20 Alfred Street
Milsons Point NSW 2061
Phone: 02 9956 7515
Fax: 02 9956 7514
research@keys-young.com.au

Research Study on Suicides by Jumping from Heights and Railways
Jumping and railways suicides research – Australian Coroner’s Society Behavioral Research Practice, Melbourne
Business Group
10th Level 60 City Road IBM Tower
Southgate VIC 3006
Phone: 03 9684 7718
Fax: 03 9699 5477
Contact person: James Charisiou

Resourceful Adolescent and Family Project
School of Applied Psychology
Griffith University
Nathan QLD 4111
Phone: 07 3875 3514
Fax: 07 3875 6637
C.Dyer@mailbox.gu.edu.au
Contact person: Ms Carmel Dyer

Roundtable Seminar on the Reporting of Suicide
Australian Press Council
Suite 303, 149 Castlereagh Street
Sydney NSW 2000
Phone: 02 9261 1930
Fax: 02 9267 6826
info@presscouncil.org.au
Contact person: Mr Jack Herman

Satellite Broadcast
Rural Health Education Foundation
Canberra
PO Box 219
Mawson ACT 2607
Phone: 02 6232 5480
Fax: 02 6232 5484
rhef@hcn.net.au
Contact person: Ms Sarah Vandenbroek

Seasons for Growth
MacKillop Foundation
PO Box 1023
North Sydney NSW 2059
Phone: 02 9929 7001
Fax: 02 9929 7070
info@goodgrief.aust.com
Contact person: Ms Clare Koch

Shoalhaven Youth Suicide Initiative
PO Box 70
Culburra Beach NSW 2540
Phone: 018 226 207
Fax: 02 4447 4611
oasis@shoal.net.au
Contact person: Ms Wendy Preston

Social Change Media
Social Change Media
6A Nelson Street
Annandale NSW 2038
Phone: 02 9519 3299
Fax: 02 9519 8940
sean@socialchange.net.au
Contact person: Mr Sean Kidney

Staying Alive Project
Maroondah Hospital Area Mental Health Service
PO Box 135
21 Ware Crescent
Ringwood East VIC 3135
Phone: 03 9870 9788
Fax: 03 9870 7973
Contact person: Mr Peter Brann

Suicide in Indigenous Communities
University of Queensland
Department of Social and Preventive Medicine
PO Box 1103
Cairns QLD 4870
Contact person: Ernest Hunter

Suicide Prevention Australia Conference
PO Box K998
Haymarket NSW 2000
Phone: 02 9211 1788
Fax: 02 9211 0392
Contact person: Mr Alan Staines

Support for Coronial Information System
Mental Health Branch
MDP 37, PO Box 9848
Canberra ACT 2601
Phone: 02 6289 6883
Fax: 02 6289 7703
Contact person: Ms Gabriela Taloni

Support to Rural Communities Project
The Gilmore Centre
Locked Bag 588
Wagga Wagga NSW 2678
Phone: 02 6933 2530
Fax: 02 6933 2986
Contact person: Mr Peter Dunn

Workshops for Reviewing Criteria for Education and Training
Keys Young
PO Box 252
Level 5, 20 Alfred Street
Milsons Point NSW 1565
Phone: 02 9956 7515
Fax: 02 9956 7514
research@keys-young.com.au  
Contact person: Ms Rohan Pigott

**Young People and Psychiatric Illness – Intervention and Assessment (YPPI - IA)**  
Youth Mental Health Service  
YPPI Centre  
Central Coast Area Health Service  
GPO Box 361  
Gosford NSW 2250  
Phone: 02 4320 2578  
dhowe@doh.health.nsw.gov.au  
Contact person: Ms Deborah Howe

**Young Women’s Project**  
Young Women’s Project  
PO Box 2098  
Oakleigh VIC 3166  
Phone: 03 9563 2022  
Fax: 03 9563 1472  
*Contact person: Ms Karen Conlan*

**Youth At Risk of Deliberate Self-Harm Project (YARDS)**  
Northern Rivers Area Health Service  
South Eastern Sydney Area Health Service  
Rockdale Community Mental Health Centre  
21-25 King Street  
Rockdale NSW 2216  
Phone: 02 9597 2644  
Fax: 02 9597 4756  
*Contact persons: Mr Garry Stevens 02 9350 2501 and Mr Blake Hamilton*

**YouthLink Parenting Project**  
Inner City Mental Health Service  
Royal Perth Hospital  
70–74 Murray Street  
Perth WA  
Phone: 08 9224 1700 1800 066 247  
Fax: 08 9224 1711  
*Contact person: Mr Steven Edwards*
Appendix 4: Youth Suicide Prevention Advisory Group

Terms of reference
To advise the Commonwealth Department of Health and Family Services on youth suicide prevention issues including:

• the development and implementation of national policy and direction in youth suicide prevention;

• current and emerging knowledge and clinical practice in suicide prevention;

• the development of priority activities to be undertaken, including additional priorities beyond those specified in the existing youth suicide prevention programs;

• the views of other expert and consumer groups; and

• specific issues related to implementation of the youth suicide prevention programs.

Membership
Dr Meg Smith OAM: Chairperson
Dr Smith is a community psychologist and senior lecturer in the Department of Social Policy and Human Services at the University of Western Sydney.

Miss Jayne Badcock
Miss Badcock is studying for a Diploma in Disability Services Management and has an Advanced Certificate in Developmental Disability. She is currently employed as an Extended Care Assistant for the St Giles Society - Adult Services.

Mr Kenneth Bedford
Mr Bedford has completed an Associate Diploma in Youth Welfare through the Commonwealth Youth Program and has recently graduated with an Applied Health Science degree in Indigenous Primary Health Care.

Ms Mary Blackwood
Ms Blackwood works for the Department of Community and Health Services in Tasmania as the State Program Coordinator for Mental Health.

Dr Christopher Cantor
Dr Cantor has headed the Queensland Suicide Research and Prevention Program for seven years prior to its transition to the Australian Institute for Suicide Research and Prevention. He is now Senior Research Psychiatrist with that organisation.

Mr Steven Drew
Mr Drew is a Senior Policy Officer and statewide coordinator of the Young People at Risk: Access, Prevention and Action program for Mental Health Branch of Queensland Health.

Mr Darren Garvey
Mr Garvey is Associate Coordinator of the Centre for Aboriginal Studies at the Curtin University of Technology.

Dr Graham Martin
Dr Martin works as a Child and Adolescent Psychiatrist at Flinders Medical Centre, and is Director of Southern Child and Adolescent Mental Health Service.
Mr David Matthews
David Matthews is the Coordinator of PATHWAYS - Information Service for Young People in the Australian Capital Territory. This community-based service provides information and support to young people between 12 and 25 years.

Mr Sven Silburn
Mr Silburn is a consultant clinical psychologist employed by the TVW Telethon Institute for Child Health Research in Western Australia.

Mr Barry Taylor
Mr Taylor is a sociologist, has been a youth worker, and has been involved in youth suicide research in Australia, New Zealand, and the United States.

Mr Bruce Turley
Mr Turley is manager of Lifeline Melbourne and a member of the national board of Lifeline Australia.

Dr Ian Wilson
Dr Wilson has experience in city and rural general practice and as a medical educator in the Family Medicine Program and in community medicine.

Dr Harvey Whiteford
Dr Whiteford was Director of Mental Health for the Department of Health and Family Services, and as such is responsible for the National Mental Health Strategy and the national youth suicide prevention programs.
Appendix 5: National Advisory Council on Youth Suicide Prevention

Terms of reference

1. To advise the Commonwealth Minister for Family Services, and State and Territory Ministers on the development and implementation of national policy and direction on youth suicide prevention in accordance with the goals outlined above.

2. To develop national plans and policies which increase coordination and consistency at all levels of Government in relation to youth suicide prevention and which are consistent with international best practice.

3. To review and provide advice on the work of the Commonwealth and State and Territory Governments with regard to their role in youth suicide prevention, and to advise the Government on recommended improved practices and future directions and priorities.

4. To ensure that the interests of key groups affected by youth suicide, such as a range of young people, families, rural residents, indigenous people, non-government and community organisations, and consumers of mental health services, are represented in the development of national policy regarding youth suicide.

Membership

Chair
Professor Ian Webster AO: Professor of Public Health, University of New South Wales. Professor Webster has research interests in mental health, drug and alcohol problems and homelessness. He is well respected in the field of youth suicide prevention.

Government Representatives
Mr Dermot Casey (Commonwealth), Acting Assistant Secretary, Mental Health Branch, Department of Health and Aged Care.

Mr Andrew Stripp (VIC), Assistant Director, Mental Health Branch, Department of Human Services.

Mr Ross Pitt (QLD), Deputy Director-General, Queensland Health Department.

Mr Sven Silburn (WA), Research Psychologist, Division of Psychosocial Research, TVW Telethon Institute for Child Health Research.

Mr Kym Davey (SA), Executive Director, Youth Affairs Council of South Australia.

Ms Mary Blackwood (TAS), State Program Coordinator, Mental Health Program, Department of Community and Health Services.

Mr Harry Krebs (NT), Director Mental Health, Territory Health Service.

Mr Des Graham (ACT), Manager, Mental Health and Drug Strategy Unit, ACT Department of Health and Community Care.

Other Members
Ms Jayne Badcock (TAS), Rural Youth representative. Committee member of Australian Rural Youth.

Ms Merilyn Briggs (TAS), Local Government Councillor - Dorset Council. Director of the North East Community House, State Advisory Committee on the National Women's Health Program.
Professor Robert Goldney (SA), President of the International Association for Suicide Prevention; Professor of Psychiatry at Adelaide University; and practising private psychiatrist.

Ms Phil Iker (QLD), Past member of the National Community Advisory Group on mental health issues, Chair of the Social Health Working Party advising the Office of Aboriginal and Torres Strait Islander Health on mental health and youth suicide issues.

Associate Professor Graham Martin (SA), President of Suicide Prevention Australia, and practising child and adolescent psychiatrist.

Mrs Margaret Smith (NSW), National President of the Country Women's Association of Australia and member of the Council of the National Rural Health Alliance

Mr Bruce Turley (VIC), National manager of Lifeline's suicide prevention programs, and Board member of Lifeline Australia.

Appendix 6: National Advisory Council for Youth Suicide Prevention – Evaluation Steering Group

Responsibility

The Steering Committee’s role is to oversight the Australian Institute of Family Studies’ evaluation of the National Youth Suicide Prevention Strategy. This includes:

• monitoring progress and reviewing outputs for quality and appropriateness;
• providing guidance;
• ensuring stakeholder views are adequately captured; and
• presenting the findings and recommendations to the National Advisory Council for Youth Suicide Prevention.

Membership

Professor Ian Webster (Chair)        Ms Penny Carr
Professor Robert Goldney            Ms Maria Cotter
Dr John Howard                       Ms Rita Gill
Ms Jonine Penrose-Wall               Mr Dermot Casey
Appendix 7: Evaluation Working Group

Terms of reference

The Evaluation Working Group was established in December 1995 at the outset of the National Youth Suicide Prevention Strategy. The focus of advice was on the formative evaluation designs of $13M national demonstration projects. It was a sub-committee of the National Youth Suicide Prevention Advisory Group which has since been devolved and replaced by the Ministerial National Advisory Council on Youth Suicide Prevention. The terms of reference for the Evaluation Working Group remained the same despite the volume of projects funded increasing the $34M Strategy underway by 1999. The terms of reference are:

- Advise the Department of Health and Aged Care Services Mental Health Branch on the evaluation of National Youth Suicide Prevention Strategy projects.
- Advise the National Advisory Council on the project evaluation of the National Youth Suicide Prevention Strategy and other evaluation issues which may arise on a routine and ad hoc basis.
- Assist external evaluators and other key people working on the National Youth Suicide Prevention Strategy projects.
- Advise the Department and the National Advisory Council on data issues relevant to your suicide prevention.
- Provide technical advice and or other relevant input to the Department at strategic points of the overall evaluation of the National Youth Suicide Prevention Strategy.

Membership

Jonine Penrose-Wall (Chair) is National Mental Health Coordinator, Integration Support and Evaluation Resource Unit at the Centre for GP Integration Studies, The University of New South Wales.

Leone Coolahan (Deputy Chair) is a Health Information Analyst/Epidemiologist with the Southern Area Health Service.

Chris Cantor is a research psychiatrist and a co-founder of the Australian Institute for Suicide Research and Prevention based at Griffith University.

John Howard is a Senior Lecturer in Psychology and Director of the Social Health Programs, Department of Psychology, Macquarie University, and a visiting Clinical Psychologist in the Department of Adolescent Psychiatry, Prince of Wales Hospital, Sydney.

Darren Garvey is the Associate Coordinator of the Aboriginal Health Unit, Curtin University of Technology.

Nick Kowalenko teaches in the Department of Psychological Medicine, University of Sydney and is a child and adolescent psychiatrist and acting head, Department of Child, Adolescent and Family Psychiatry at Royal North Shore Hospital in Sydney.

Carmel Martin works in research at Health Services Branch, Health Care & Services Division, Department of Veterans’ Affairs, ACT, trained in general practice and public health medicine in the United Kingdom.

Graham Martin is Associate Professor and Director of the Southern Child Adolescent Mental Health Services, Flinders Medical Centre.
David Matthews is the former executive officer and youth spokesperson for the Australian Youth Policy and Action Coalition.

Stephen Morrell has been with the Department of Public Health and Community Medicine, University of Sydney since 1990.

Jonathan Nicholas has been working with the Inspire Foundation establishing the Reach Out! Online service. He now works as Content Coordinator for Reach Out!

Ian Perdrisat and Anne Poelina work at Cultural Education, Research and Training in Lismore, New South Wales.

Barry Taylor is a health sociologist in Melbourne who has been working on youth suicide prevention for over ten years in New Zealand and Australia.

Peter Bitmead was the National Youth Suicide Prevention Strategy Manager in Mental Health Branch and he coordinated the Strategy from 1995 to January 1998.

Meredith Williams worked in the Mental Health Branch from June 1995 to March 1999 on projects conducted under the National Mental Health Strategy and the National Youth Suicide Prevention Strategy.

Katherine McHugh is the current Mental Health Branch Secretariat (from April 1999) and provides support functions to the National Youth Suicide Prevention Strategy Evaluation Working Group.

Ian Thompson was Commonwealth Mental Health Branch delegate to the Evaluation Working Group from March to May 1999.
### Appendix 8: Suicide Prevention Products Developed by Projects

#### Hospital and health service protocols

| Central Sydney Area Health Service (CSAHS) Royal Prince Alfred Hospital | • Resource Manual ‘Youth Suicide Education and Training Resource Manual for Nurses’
| | • Area Directory of Support Services ‘Support Services for Young People and their Families’
| | • Resource Manual ‘Youth Suicide Education and Training Resource Manual for Nurses’
| | • Area Directory of Support Services ‘Support Services for Young People and their Families’
| Blacktown City Mental Health Services and Mt. Druitt Hospital | • ‘Inservice Education Program for Emergency Department Personnel’ - comprised of 3, 30 minute sessions
| | • Hospital Assessment of Risk and Mental Status (HARMS) Checklist
| | • Triage Checklist and questions for suspected suicidal patients
| | • Symptom Checklist ‘Youth Suicide Prevention Projects Symptom Checklist’
| | • Computer Programs: Blacktown Youth Suicide Prevention Project (BYSPP): Software to facilitate data entry and storage
| Mackay and Moranbah District Child and Youth Mental Health Services | • Protocols and Clinical Pathways
| | • Youth Suicide Prevention Project Questionnaire for General Practitioners
| | • Youth Suicide Prevention Project Questionnaire for School Guidance Officers
| | • Emergency Department Staff Pre-Training Questionnaire
| | • Child and Youth Deliberate Self Harm Risk Assessment and Referral Sheet
| | • Psychosocial Assessment of Youth at Risk of Deliberate Self Harm
| | • Satisfaction Questionnaire of the Services Provided to Youth at Risk of Deliberate Self Harm and their Parents or Carers
| | • Poster directed at staff advertising Mackay Based National Demonstration Project to maintain high profile of new protocols and clinical pathways
| | • Staff Evaluation Questionnaire of the Mackay and Moranbah Youth Suicide Prevention Project
### General practice and community health training projects

| Southern Child and Adolescent Mental Health Service | • Postvention Videotape ‘Picking up the Pieces’  
• Audiotape: 16 Programs (personnel interviews to compliment videotape)  
• Manual: Chapter 3 ‘After Suicide - Picking up the Pieces’ |
| Logan Area Division of General Practice & the Southern Queensland Rural Division of General Practice | • Four training modules for the Southern Queensland Rural component of the project Module 1: Raising the Issue (Satellite broadcast and 2 hour video), Module 2: Intervention, Module 3: Postvention Module 4: Prevention |

### Intervention services for youth attempting suicide

| Maroondah Hospital Area Mental Health Service | • The Staying Alive Project ‘Youth Suicide Information Kit’ targeting secondary schools, youth agencies, emergency department, and GPs |
### Intervention services for youth with mental illness

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Street Youth Health Service</strong></td>
<td>'High Street Youth Participation Project'</td>
</tr>
<tr>
<td><strong>Centacare Youth Suicide Intervention Program, Catholic Family Services</strong></td>
<td>'Pilot and Evaluate Strategies for Young People who have Attempted Suicide or Have Suicidal Tendencies'</td>
</tr>
<tr>
<td><strong>The Bridge Youth Health Service</strong></td>
<td>'Report on Limelight Productions of 1997'</td>
</tr>
<tr>
<td><strong>Central Coast Area Health Service, Area Mental Health Service</strong></td>
<td>'Catch Us If You Can!: Young People and Psychiatric Illness - Intervention and Assessment (YPPI-IA)'</td>
</tr>
<tr>
<td><strong>Southern Child and Adolescent Mental Health Service, Flinders Medical Centre</strong></td>
<td>'Out of the Blues - The South Australian Mood Disorders Unit for Young People'</td>
</tr>
</tbody>
</table>

### Appendices

- Resource booklet 'Air Your Laundry: What You Need to Know about Where to Go - A Young Person's Guide'
- Supported Accommodation Assistance Program (SAAP) Suicide Intervention Guidelines
- Principles Underpinning the Development of Interagency Protocols: A Coordinated Response to Young People at Risk of Suicide
- Peer Support Program
- Suicide Risk Assessment Training Handouts
- Suicide Risk Assessment Handbook
- Free Articles

- YPPI-IA Package’ incorporating: Executive Summary of the Project Final Report, ‘Catch Us If You Can’ Video, factsheets, client information pamphlets, stickers, postcards, posters, Link-Up Card, E.A.S.Y. Assessment Form, YPPI-IA Protocols, measures, guidelines and checklists. This package targets other services regarding ‘good practice’ and provides educational material for young people and for services working with young people.

- Pamphlet of information on research colloquium held in Nov 1998
### Support for rural communities

<table>
<thead>
<tr>
<th>Gilmore Centre</th>
<th>Rural Youth Suicide Prevention Resource Training Manual ‘Lives Worth Living’</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Support to Rural Communities Project’</td>
<td></td>
</tr>
</tbody>
</table>

### Support to young people who are marginalised

<table>
<thead>
<tr>
<th>Jesuit Social Services</th>
<th>METTA (Sanskrit for ‘compassion’) - pilot program established to rebate private therapists to provide long-term care for marginalised young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Connexions’</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Western Australia WA AIDS Council in Conjunction with Gay &amp; Lesbian Counselling Services</th>
<th>You’re Not Alone Booklet’ aimed at young people with same sex attractions ‘Someone You Love Booklet’ aimed at parents, family and friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Here for Life Youth Sexuality Project’</td>
<td></td>
</tr>
</tbody>
</table>

### Telephone counselling and intersectoral networking programs

<table>
<thead>
<tr>
<th>Lifeline Australia Inc.</th>
<th>• Nationwide telephone service • Enhanced Referral Database for access to all Lifeline Centres in Australia • Brochure on information for parents and guardians following a suicide attempt by a young person</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Lifelines Youth Suicide Prevention Program’</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Flinders University of South Australia and University of Adelaide</th>
<th>• Development of an internet site providing information to professionals - <a href="http://AUSEINET.FLINDERS.EDU.AU/">http://AUSEINET.FLINDERS.EDU.AU/</a> • AusEinetter - quarterly newsletter</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘AusEinet’</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inspire Foundation</th>
<th>• Reach Out! website: <a href="http://www.reachout.asn.au">http://www.reachout.asn.au</a> - targeting young people, their families and professionals • Promotional postcards, stickers and posters</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Reach Out!’</td>
<td></td>
</tr>
</tbody>
</table>

### Education and training projects

<table>
<thead>
<tr>
<th>Hunter Institute of Mental Health</th>
<th>• University curriculum materials ‘Response … Ability’ - new modules developed include Rural Youth Suicide, Substance Abuse and Youth Suicide and Social Issues Associated with Youth Suicide. • Video resources to accompany secondary education and nursing disciplines curriculum materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘National University Curriculum Project’</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Victoria University of Technology</th>
<th>• Training Program and Resource Guides • Video Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘National Training Program for the Prevention of Youth Suicide’</td>
<td></td>
</tr>
<tr>
<td>Organisation</td>
<td>Resource/Program</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Wollongong University</td>
<td>'Good Practice Guidelines and Resource Guide for Education and Training'</td>
</tr>
<tr>
<td>Jesuit Social Services - Parenting Adolescents</td>
<td>'Program for Parents (PfP)'</td>
</tr>
<tr>
<td>Victorian Parenting Centre</td>
<td>'Exploring Together Program'</td>
</tr>
<tr>
<td>Youthlink</td>
<td>'Family and Friends of Young People'</td>
</tr>
<tr>
<td>Social Change Media</td>
<td>'Promotion and Support of other Parenting Projects'</td>
</tr>
<tr>
<td>Griffith University, School of Applied Psychology</td>
<td>'Resourceful Family Project'</td>
</tr>
<tr>
<td>Family Action Centre, University of Newcastle</td>
<td>'Community Volunteers Supporting Families - Home-Start and Homelink'</td>
</tr>
</tbody>
</table>

- Wollongong University:
  - Good Practice Guidelines in Education and Training in Youth Suicide Prevention
  - Resource Guide on Education and Training

- Jesuit Social Services - Parenting Adolescents:
  - PfP Handouts for Training
  - A Resilience Booklet for Parents

- Victorian Parenting Centre:
  - Exploring Together Program information booklets for professionals
  - Exploring Together Program information booklets for parents
  - Summaries of previous evaluation results

- Youthlink:
  - A booklet for parents 'Growing up with Young People' (This booklet is available in adapted form for Indigenous communities and has been translated for the Chinese and Vietnamese Communities)

- Social Change Media:
  - Parenting information brochure 'Tips for Parents'

- Griffith University, School of Applied Psychology:
  - RAP-P Video (Urban, Rural-remote)
  - RAP-P Group Leader’s Manual (Urban)
  - RAP-P Group Leader’s Manual (Rural-remote)
  - RAP-P Group Leader’s Manual (Indigenous)
  - RAP-P Parent Workbook (Urban)
  - RAP-P Parent Workbook (Rural-remote)
  - RAP-P Indigenous Parent Program Video
  - RAP-P Implementation and Evaluation Manual
  - Brochure/Information Booklet

- Family Action Centre, University of Newcastle:
  - Newsletter - targeted to key stakeholders
Appendix 9: Commonwealth government and other national stakeholders involved in informal consultations

Steve Larkin, Executive Officer, National Aboriginal Community Controlled Health Organisation

Helen Monton, Office of Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

Lynne Jenkins, Rebecca Murdoch, Peter Bennett, Centrelink

Lorraine Cormack, Youth Bureau, Department of Employment Training and Youth Affairs

Kelly Corner, Prime Ministers Youth Homelessness Taskforce, Department of Family and Community Services

David Matthews, Australian Youth Policy and Action Coalition

Abd Malak, Maria Cassaniti, Australian Transcultural Mental Health Network

David Allen, Human Rights and Equal Opportunity Commission

Suzy Saw, Child and Youth Health, Population Health Strategies, Department of Health and Aged Care

Roger Hughes, Manager, National Drug Strategy, Department of Health and Aged Care

Ian Thompson, Kerry Webber, Conrad Gershevitch, Mental Health Branch, Department of Health and Aged Care

Mary Sexton, Injury Prevention Unit, Department of Health and Aged Care

Alan Thorpe, HIV/AIDS/HepC Strategy, National Centre for Disease Control, Department of Health and Aged Care

Angela Reddy, Ros Walker, National Health Priority Areas, Department of Health and Aged Care
Appendix 10: Evaluation of the National Youth Suicide Prevention Strategy

Survey of key stakeholders

Introduction and instructions

This survey is being conducted as part of the evaluation of the National Youth Suicide Prevention Strategy. The survey involves a small number of organisations and individuals who are considered to be key stakeholders but who have not necessarily been directly involved with the NYSPS or its activities. You do not need to know anything about specific NYSPS activities to take part in this survey. We simply want to know whether or not you think there has been progress towards key objectives of the NYSPS over the past five years.

The first part of the survey focuses on your general impressions of the appropriateness of youth suicide prevention activities that have taken place over the past five years.

Part A

1. Name of respondent ________________________________

2. Name of organisation ________________________________

(Please note that the information from Q1 and Q2 will be used only to facilitate follow-up of people who do not return their questionnaire on the due date. No identifying information will be used for analysis purposes).

3. What sector do you currently work in? (Tick one box only)

- Mental Health □ 1 Primary Health Care/General Practice □ 2
- Education □ 3 Youth Affairs □ 4
- Drug and alcohol □ 5 Justice (including Juvenile Justice) System □ 6
- Employment and training □ 7 Arts/Sport/Recreation □ 8
- Community/Welfare □ 9 Public Health/Health Promotion □ 10
- Other (Please specify) □ 11 (__________________________________________)

4. What type of work do you do? (Tick one box to indicate the main role only)

- Management □ 1 Policy/Planning □ 2
- Research/Evaluation □ 3 Advocacy □ 4
- Service provision □ 5 Education/Training □ 6
- Project Officer □ 7
- Other (Please specify) □ 7 (__________________________________________)

Appendices 181
5. How much awareness do you have of specific youth suicide prevention activities that have taken place over the past 5 years?
   - Strong awareness □ 1
   - Moderate awareness □ 2
   - A little □ 3
   - None □ 4

6. How appropriate do you think these activities have been generally?
   - Mostly appropriate □ 1
   - Mostly inappropriate □ 2
   - Unsure □ 9

7. How much knowledge do you have of the National Youth Suicide Prevention Strategy?
   - Strong knowledge □ 1
   - Moderate knowledge □ 2
   - A little □ 3
   - None □ 4

8. How appropriate do you think the NYSPS activities have been generally?
   - Mostly appropriate □ 1
   - Mostly inappropriate □ 2
   - Unsure □ 9

**Part B: Strategy approaches**

The second part of the survey asks you to make judgements about sets of statements that describe activities and practice in key areas targeted by the National Youth Suicide Prevention Strategy. You can elect to answer certain questions and not others, but please answer as many as possible.

The response format requires you to rate the extent to which the situation has changed for the better or worse between 1995 and 1999 using a five point scale.

The levels of the five point scale are:

1. A lot better
2. A little better
3. No change
4. A little worse
5. A lot worse

9. Don’t know/Unsure

It is acknowledged that each statement may cover a number of different dimensions. Try to base your response on your global impression about changes across these dimensions. Don’t think too long about your answer, rather respond on the basis of your first impression.
1. Primary Prevention

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1 A lot better  2 A little better  3 No change  4 A little worse  5 A lot worse  9 Don’t know/unsure

Parents have the skills and support necessary to provide mentally healthy parenting to their children.  1  2  3  4  5  9

PPB Parenting education and support programs are readily available.  1  2  3  4  5  9

PPC Schools provide a mental health promoting environment for children and adolescents.  1  2  3  4  5  9

PPD Schools have the skills and resources necessary to develop whole-school approaches to mental health promotion.  1  2  3  4  5  9

PPE The media portrays suicide and mental health issues in a way that promotes mental health for young people.  1  2  3  4  5  9

PPF Resources are available to help the media portray suicide and mental health issues in a safe and positive way.  1  2  3  4  5  9

PPG Communities provide environments and programs that are supportive of young people.  1  2  3  4  5  9

PPH Communities have the skills and resources to implement mental health promotion and primary prevention programs.  1  2  3  4  5  9

PPI Young people are involved in the planning and delivery of programs targeting young people.  1  2  3  4  5  9

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role □ 1  Moderate role □ 2  Some role □ 3  No role □ 4  Not Applic □ 9

(Note: Question is not applicable if no changes are perceived)

Additional comments ________________________________
2. Early intervention

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1 A lot better  2 A little better  3 No change  4 A little worse  5 A lot worse  9 Don’t know/unsure

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| EIA | Young people developing problems such as depression are gaining access to **appropriate specialist services** with minimum possible delay.  
  
  Appropriate specialist services include:  
  - specialist mental health services  
  - specialist youth services and youth focused programs | 1 | 2 | 3 | 4 | 5 | 9 |
| EIB | When young people become exposed to environmental risk factors for suicide, interventions to modify this exposure are initiated with minimal delay. | 1 | 2 | 3 | 4 | 5 | 9 |
| EIC | Levels of early intervention activity are adequate across the range of **relevant sectors**.  
  
  Relevant sectors include: mental health; primary health care; education; juvenile justice; youth sector; employment; arts/sport/recreation; public health, community | 1 | 2 | 3 | 4 | 5 | 9 |
| EID | Specialist providers have the skills and knowledge to identify young people with emerging problems and intervene appropriately. | 1 | 2 | 3 | 4 | 5 | 9 |
| EIE | Primary care providers have the skills and knowledge to identify and support young people with emerging problems. | 1 | 2 | 3 | 4 | 5 | 9 |
| EIF | There is collaboration between specialist service providers identify and primary health care providers who care for young people. | 1 | 2 | 3 | 4 | 5 | 9 |
| EIG | Community gatekeepers (eg teachers) have the skills and knowledge to identify young people with emerging problems and assist them access appropriate services. | 1 | 2 | 3 | 4 | 5 | 9 |
| EIH | Structures, systems and work practices facilitate early intervention. | 1 | 2 | 3 | 4 | 5 | 9 |
| EII | Resources and information to support good practice in early intervention are readily available. | 1 | 2 | 3 | 4 | 5 | 9 |

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role □ 1  Moderate role □ 2  Some role □ 3  No role □ 4  Not Applic □ 9

Additional comments ________________________________
### 3. Crisis intervention and primary care

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1 A lot better    2 A little better    3 No change    4 A little worse    5 A lot worse
9 Don’t know/unsure

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people who experience acute crises are enabled to resolve crises as promptly as possible.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Young people who experience acute crises are able to access appropriate support with minimum delay.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Young people experiencing problems are provided with the care, skills and resources that enable them to develop positive solutions and avoid crises.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Telephone counselling services have the capacity to respond adequately to calls from young people.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Young people presenting to hospital emergency departments following deliberate self-harm and suicide attempts are accurately identified and properly assessed.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Young people presenting to hospital emergency departments following deliberate self-harm and suicide attempts are provided with appropriate treatment and care.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Young people presenting to hospital accident and emergency departments following self-harm and suicide attempts are provided with appropriate followup care.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Primary health care services are accessible and appropriate to the needs of young people.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>A variety of forms of counselling appropriate to the needs of young people are available in rural and remote areas.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>Young people and community members have the skills and knowledge to support young people in crisis and help them access appropriate services.</td>
<td>1 2 3 4 5 9</td>
</tr>
</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

- Strong role [ ] 1
- Moderate role [ ] 2
- Some role [ ] 3
- No role [ ] 4
- Not Applic [ ] 9

Additional comments ________________________________________________________________
## 4. Treatment, support and postvention

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1 A lot better 2 A little better 3 No change 4 A little worse 5 A lot worse 9 Don’t know/unsure

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 2 3 4 5 9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TSA</strong>&lt;br&gt;The harm and disadvantage suffered by young people living with chronic problems that could place them at risk of suicide is minimised as far as possible.</td>
<td></td>
</tr>
<tr>
<td><strong>TSB</strong>&lt;br&gt;Young people living with chronic problems have the maximum possible quality of life given the limits of their problems.</td>
<td></td>
</tr>
<tr>
<td><strong>TSC</strong>&lt;br&gt;Young people experiencing chronic problems have access to effective treatment and support services.</td>
<td></td>
</tr>
<tr>
<td><strong>TSD</strong>&lt;br&gt;People affected by the death of a young person due to suicide have access to effective support.</td>
<td></td>
</tr>
<tr>
<td><strong>TSE</strong>&lt;br&gt;Services have access to the skills, information and resources needed to work towards good practice in the treatment and management of mental disorders in young people.</td>
<td></td>
</tr>
<tr>
<td><strong>TSF</strong>&lt;br&gt;Services have access to the skills, information and resources needed to work towards good practice in service provision to marginalised young people affected by problems such as homelessness, contact with the justice system, sexual identity issues, and self harming behaviour.</td>
<td></td>
</tr>
</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role □ 1 Moderate role □ 2 Some role □ 3 No role □ 4 Not Applicable □ 9

Additional comments ____________________________________________________________
## 5. Injury prevention/access to means

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>1 A lot better</th>
<th>2 A little better</th>
<th>3 No change</th>
<th>4 A little worse</th>
<th>5 A lot worse</th>
<th>9 Don’t know/unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA</td>
<td>Firearms are not accessible to young people unless supervised by a person experienced in the safe use of firearms.</td>
<td>1 2 3 4 5 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPB</td>
<td>Community education materials relating to firearms and suicide are available.</td>
<td>1 2 3 4 5 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPC</td>
<td>Resources are available to inform strategies that restrict access to hanging as a means of suicide.</td>
<td>1 2 3 4 5 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPD</td>
<td>Resources are available to inform strategies that restrict access to jumping from heights as a means of suicide.</td>
<td>1 2 3 4 5 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPE</td>
<td>Resources are available to inform strategies that restrict access to car exhaust systems as a means of suicide.</td>
<td>1 2 3 4 5 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPF</td>
<td>There is sufficient evidence available to inform the development of injury prevention measures to prevent suicide among young people in Australia.</td>
<td>1 2 3 4 5 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

<table>
<thead>
<tr>
<th></th>
<th>1 Strong role</th>
<th>2 Moderate role</th>
<th>3 Some role</th>
<th>4 No role</th>
<th>5 Not Applicable</th>
</tr>
</thead>
</table>

Additional comments
6. This set of statements explores the extent to which youth suicide prevention activities are becoming better informed by evidence concerning: epidemiology; risk factors; effectiveness of interventions; the needs and attitudes of young people and others most affected by programs.

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Evocative service systems are conducting activities based on the best available evidence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies and plans in place to support evidence-based practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structures, systems and work processes support evidence based practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Relevant service systems have sufficient skilled personnel to conduct evidence-based practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Education and training programs to support evidence-based practice are readily available.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical resources to support evidence-based practice are readily available.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVG</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information to support evidence-based practice is readily available.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>EVH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The evidence-base is sufficient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

<table>
<thead>
<tr>
<th>Role</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Strong role</td>
<td>Moderate role</td>
<td>Some role</td>
<td>No role</td>
<td>Not Applicable</td>
<td>9</td>
</tr>
</tbody>
</table>

Additional comments ________________________________
7. This set of statements explores whether youth suicide prevention activities are moving toward a balance of individual/group-focused (indicated/selective) as well as population-based (universal) interventions. (Across the spectrum of programs).

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1 A lot better  2 A little better  3 No change  4 A little worse  5 A lot worse
9 Don’t know/unsure

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAA There is currently an adequate balance between individual/group focused and population-based interventions.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAB The balance is overly in favour of individual/group focused activities.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAC The balance is overly in favour of population-based activities.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAD Policies and plans are in place to support a balance of activities.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAE Structures, systems and work practices facilitate a balance of activities.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAF Service systems and programs have sufficient skilled personnel to conduct a balance of activities.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAG Education and training programs to support a balance of activities are readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAH Practical resources to support a balance of activities are readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAI Information to support a balance of activities is readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>BAJ The evidence-base to inform a balance of activities is sufficient.</td>
<td>1 2 3 4 5 9</td>
</tr>
</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role □ 1 Moderate role □ 2 Some role □ 3 No role □ 4 Not Applic □ 9

Additional comments ___________________________
8. This set of statements looks at whether youth suicide prevention activities are getting better at involving young people and others most affected in the design, implementation and evaluation of programs.

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>INA Services and programs are involving young people in the design, implementation and evaluation of programs.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>INB Services and programs are involving others most affected in the design, implementation and evaluation of programs.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>INC Policies and plans are in place to support the involvement of young people and others most affected.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>IND Structures, systems and work practices facilitate this involvement.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>INE Service systems have sufficient skilled personnel to involve young people and others most affected.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>INF Education and training programs to support this involvement are readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>ING Practical resources to support the involvement of young people and others most affected are readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td>INH Information to support involvement is readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role 1  Moderate role 2  Some role 3  No role 4  Not Applicable 9

Additional comments

---

190 Valuing young lives
9. This set of statements explores the extent to which youth suicide prevention activities are becoming responsive to the needs of culturally diverse populations and marginalised young people.

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1 A lot better  2 A little better  3 No change  4 A little worse  5 A lot worse  9 Don’t know/unsure

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CSA</strong> Programs and activities are responsive to the needs of Aboriginal and Torres Strait Islander populations.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSB</strong> Programs and activities are responsive to the needs of non-English speaking background populations.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSC</strong> Programs and activities are responsive to the needs of marginalised groups of young people.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>Marginalised groups</strong> include: young people with mental health problems, young people who are homeless, misusing drugs, involved with the justice system, young people with sexual identity issues, among others.</td>
<td></td>
</tr>
<tr>
<td><strong>CSD</strong> Local communities have structures and resources that enable members of culturally diverse populations and marginalised groups to play a role in suicide prevention.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSE</strong> Policies and plans are in place to support responsivity to the needs of culturally diverse populations and marginalised young people.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSF</strong> Structures, systems and work practices facilitate this sensitivity.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSG</strong> Services and programs have sufficient skilled personnel to support responsivity to the needs of culturally diverse populations and marginalised young people.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSH</strong> Education and training programs are readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSI</strong> Practical resources are readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSJ</strong> Information to support this work is readily available.</td>
<td>1 2 3 4 5 9</td>
</tr>
<tr>
<td><strong>CSK</strong> The evidence-base is sufficient.</td>
<td>1 2 3 4 5 9</td>
</tr>
</tbody>
</table>

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role  1  Moderate role  2  Some role  3  No role  4  Not Applic  9

Additional comments
10. This set of statements examines whether youth suicide prevention activities are responsive to the varied needs of different geographic areas including rural and remote.

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRA</td>
<td>Programs and activities are responsive to the needs of rural and remote communities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRB</td>
<td>Programs and activities are responsive to the needs of regional communities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRC</td>
<td>Programs and activities are responsive to the needs of urban communities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRD</td>
<td>Local communities in different geographic areas have structures and resources that enable community members to play a role in suicide prevention.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRE</td>
<td>Policies and plans are in place to support responsivity to the varied needs of different geographic areas.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRF</td>
<td>Structures, systems and work practices facilitate this responsivity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRG</td>
<td>Services and programs have sufficient skilled personnel to support responsivity to the needs of different geographic regions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRH</td>
<td>Education and training programs are readily available.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRI</td>
<td>Practical resources to support responsivity to the needs of different geographic areas are readily available.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRJ</td>
<td>Information to support this work is readily available.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>RRK</td>
<td>The evidence-base is sufficient.</td>
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<td>2</td>
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To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

- [ ] Strong role
- [ ] Moderate role
- [ ] Some role
- [ ] No role
- [ ] Not Applicable

Additional comments
11. This set of statements looks at whether youth suicide prevention activities are involving better collaboration with relevant stakeholders both intrasectorally and intersectorally.

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

<table>
<thead>
<tr>
<th>1. A lot better</th>
<th>2. A little better</th>
<th>3. No change</th>
<th>4. A little worse</th>
<th>5. A lot worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Don’t know/unsure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICA</th>
<th>Programs and activities are being conducted in collaboration with all relevant stakeholders intrasectorally.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICB</th>
<th>Programs and activities are being conducted in collaboration with all relevant stakeholders intersectorally.</th>
</tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ICC</th>
<th>Policies and plans are in place to support collaborative activity.</th>
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<th>ICD</th>
<th>Structures, systems and work practices facilitate collaborative work.</th>
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<th>ICF</th>
<th>Practical resources to support collaborative work are readily available.</th>
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To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

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<td></td>
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Additional comments ____________________________
12. Finally, this last set of statements explores whether youth suicide prevention activities are taking place across the range of sectors responsible for the health and welfare of young people at levels adequate to effect reductions in rates of suicide.

Please rate each of the following statements according to how much the situation has improved or worsened between 1995 and 1999. Please circle the appropriate number.

1  A lot better  2  A little better  3  No change  4  A little worse  5  A lot worse  9  Don’t know/unsure

There is an adequate level of appropriate activity in the area of:

ISA  Mental Health  
ISB  Primary Health Care/General Practice  
ISC  Education  
ISDJ Justice system (including Juvenile Justice system)  
ISE  Employment and training  
ISF  Youth services  
ISG  Arts/Sport/Recreation  
ISH  Community/Welfare  
ISI  Public Health/Health Promotion  
ISJ  Other (please specify)  

To what extent has the National Youth Suicide Prevention Strategy played a role in changes you perceive as taking place since 1995?

Strong role ☐ 1  Moderate role ☐ 2  Some role ☐ 3  No role ☐ 4  Not Applicable ☐ 9

Additional comments ____________________________

Please return completed questionnaire by Friday 15th October
c/o Christine McCarthy, AIFS, 300 Queen St, Melbourne, 3000
or Fax it to 03 9214 7839