Building capacity for life promotion

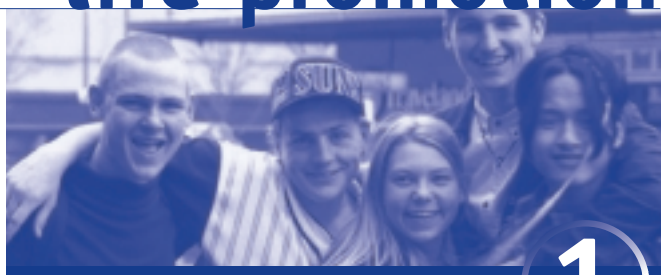
TECHNICAL REPORT VOLUME 1

Evaluation of the National Youth Suicide Prevention Strategy

Australian Institute of Family Studies

Building capacity for life promotion

Building capacity for life promotion



TECHNICAL REPORT VOLUME 1

Evaluation of the National Youth Suicide Prevention Strategy

Penny Mitchell

Australian Institute of Family Studies

Australian Institute of Family Studies
300 Queen Street, Melbourne, Victoria 3000 Australia
Phone (03) 9214 7888. Fax (03) 9214 7839. Internet www.aifs.org.au/

National Library of Australia
Cataloguing-in-Publication

Mitchell, Penny.
Building capacity for life promotion: Evaluation of the National Youth Suicide Prevention Strategy: Technical report volume 1

Bibliography.
Includes index.

ISBN 0 642 39476 8.

1. Youth - Suicidal behaviour - Australia - Prevention.
2. Suicide - Australia - Prevention. I. Australian Institute of Family Studies. II. Title. (Series: technical report (Australian Institute of Family Studies); 1).

362.287

Designed by Double Jay Graphic Design
Printed by Impact Printing

Contents

Acknowledgements

The evaluation of the National Youth Suicide Prevention Strategy was conducted independently and published by the Australian Institute of Family Studies.

This volume, and the other four volumes comprising the evaluation report, were 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 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 this Technical Report: Judy Adams, Peter Bitmead, Michael Dudley, John Howard, Deb Howe, Norm Kelk, Nick Kowalenko, Steve McKinney, Jonine Penrose-Wall, and Graham Vimpani.

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.

Evaluation format

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, with the aim of identifying lessons from the Strategy to carry forward for the future.

The Institute's evaluation results are presented in five separate reports – an overview volume entitled *Valuing Young Lives*, and four technical reports which present detailed information about what was achieved and learned by projects within each of the particular approaches adopted by the Strategy. The five volumes in the series are as follows.

- **Valuing Young Lives.** This volume 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.
- **Building Capacity for Life Promotion: Technical Report, Volume 1.** This report 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.
- **Primary Prevention and Early Intervention: Technical Report, Volume 2.** 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 from early intervention aspects of Strategy projects is collated and synthesised in this volume.

- **Crisis Intervention and Primary Care: Technical Report, Volume 3.** 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.

- **Treatment and Support: Technical Report, Volume 4.** 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.

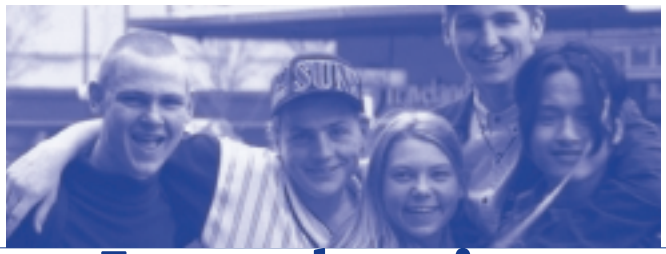
Note on the recommendations

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 put forward a total of 36 recommendations, and these are published in the Recommendations chapter (pp. 10–21) of the overview volume *Valuing Young Lives.*

These recommendations appear again at the end of chapters throughout the four technical reports – as they pertain to findings and discussion in each chapter.

As they appear throughout the technical reports, recommendations are numbered according to their position at the end of each chapter. (The corresponding original number that is attached to each recommendation in *Valuing Young Lives* is also shown, in brackets.)

In addition to the recommendations, the technical reports include "further suggestions" which complement and elaborate upon the basic recommendations.



Introduction

A major strength of the National Youth Suicide Prevention 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 new structures focused specifically on suicide. Such capacity building should continue to occupy a central place in future suicide prevention efforts.

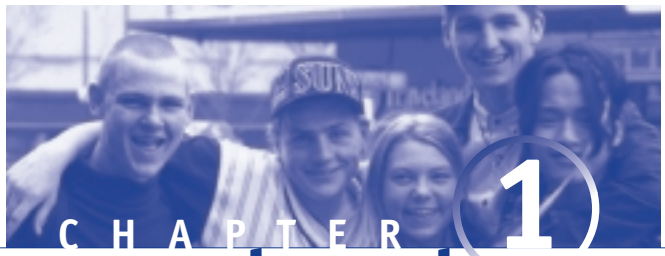
Much of this capacity building effort is similar to work that has been going on for several years in the area of mental health promotion. There has been an increasing focus on helping services reorient towards a population health approach that emphasises the promotion of positive emotional health and wellbeing – a holistic approach to enhancing the quality of life of individuals at risk, those who care for them, and whole communities. The title of this volume, *Building Capacity for Life Promotion,* is designed to recognise and reinforce this shift towards a positive, quality of life promoting approach to suicide prevention that has taken place during the course of the National Youth Suicide Prevention Strategy.

This volume, the first of the technical reports, presents the results of a meta-analysis (or meta-evaluation) of the evaluations of system-level capacity building projects and activities funded under the National Youth Suicide Prevention Strategy. These system-level activities aimed to build capacity or facilitate the adoption of evidence-based practice throughout service systems relevant to youth suicide prevention.

System-level capacity building activities used by the Strategy and which were subjected to evaluation included: research and evaluation; communications (identification and dissemination of good practice); education and training; networking and intersectoral collaboration; and community development.

The National Youth Suicide Prevention Strategy also included a variety of policy and planning activities, but these were not subjected to focused evaluation. However, information about these activities, and reflection upon their value, is used at various points in the discussion of other capacity building activities.

The sources of information used in the evaluation of the Strategy, and the methods used to analyse these data, are described in detail in the overview volume, *Valuing Young Lives.*



CHAPTER 1

Research and evaluation

This chapter presents and analyses information about the research and evaluation activities funded under the National Youth Suicide Prevention Strategy.

The aim of the Strategy's research and evaluation was to strengthen the evidence base for prevention of youth suicide in Australia and help ensure that programs and activities: are consistent with highest need; address the most significant risk and protective factors; use interventions that work; and are appropriate to the needs of target groups.

Details of the main research and evaluation projects and activities funded under the Strategy are shown below. Detailed discussion of the full range of research findings and other issues relevant to youth suicide prevention is beyond the scope of this Chapter (or of the evaluation of the Strategy), however many research issues are flagged in other parts of the evaluation report series.

Two recommendations (1.1 and 1.2) and two further suggestions (1.1a and 1.2a) are provided at the end of the chapter.

Research and evaluation activities

A variety of research and evaluation activities were conducted under the Strategy.

Evaluation of National Demonstration Projects

The 44 National Demonstration Projects funded under the National Youth Suicide Prevention 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. The process of developing evaluation plans and guiding the work was overseen by an Evaluation Working Group. Evaluation reports varied dramatically in their quality and comprehensiveness, and 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; only a minority used controlled designs.

The evaluation of the Strategy conducted by the Australian Institute of Family Studies is based primarily upon a qualitative meta-analysis of the information presented in the evaluation reports of the National Demonstration Projects. 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 an understanding of the factors that facilitated and inhibited achievement at these different levels.

Research and consultation with young people on mental health issues

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).

National Youth Suicide Research Strategy

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. These covered:

- the epidemiology of suicide and attempted suicide among young Australians including definitional and data collection issues (Cantor, Neulinger, Roth and Spinks 1999);
- risk factor identification, prevalence, incidence and attributable risk for suicide and attempted suicide among young people (Beautrais 1999); and
- the effectiveness and cost effectiveness of interventions that aim to reduce youth suicide (Patton and Burns 1999).

Based on the results of the literature reviews, four areas of research were identified as being of strategic importance at this time. 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.

National stocktakes of programs and activities

As part of a National Communications Project, the Australian Institute of Family Studies conducted two national stocktakes of programs and activities 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 (for example, Mitchell 1999a, 1999b).

National Coronial Information System

Coronial acts and procedures differ between states and territories, resulting in considerable variation in the reporting of suicide rates among young people.

In March 1997, as part of a whole-of-government approach to the development of a National Coronial Information System (NCIS), funding towards the development and implementation of a suicide module for NCIS was allocated to Monash University's National Centre for Coronial Information. Information from state and territory coronial jurisdictions was also collected by NCIS to support injury prevention activities related to suicide, violence and drug abuse. A committee has been established to review existing data items and to identify additional items that might routinely be collected.

Study of suicide in indigenous communities

A study of suicide in indigenous communities of North Queensland was undertaken (Hunter, Reser, Baird and Reser 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.

Results of the evaluation

This chapter does not seek to summarise the results of the research or evaluation work presented in any of the reports of the projects identified above, nor does it seek to evaluate the contribution that these projects have made to the evidence base for youth suicide prevention. This is not possible because there has been no

evaluation of the impacts of most of these projects, nor the effectiveness of the processes through which they were implemented.

The only source of evaluation data about research and evaluation activities of the Strategy is the evaluation reports of the National Demonstration Projects. These reports provide valuable insights into the issues facing evaluation in the field of youth suicide prevention. Based on a qualitative meta-analysis of all these project evaluations, this chapter seeks to describe some of the major lessons that have been learned from the evaluation of individual projects and offer suggestions for addressing some of the major issues that have been identified.

Information from this analysis falls into three major themes:

- enhancing the appropriateness and rigour of youth suicide program evaluation;
- engaging young people in research and evaluation; and
- engaging service providers and building capacity for evaluation and service development research.

What works to enhance the appropriateness and rigour of youth suicide program evaluation?

'Appropriateness' in the context of evaluation methodology is concerned with whether or not the evaluation design and methods are suitable for addressing the research questions that have been identified. Rigour is concerned with whether or not the design and methods are capable of generating data that can provide clear answers to the research questions.

In many cases the design and methods of project evaluations conducted under the National Youth Suicide Prevention Strategy were not appropriate to the research questions and were not sufficiently rigorous to be capable of answering the research questions.

➤ *An appropriate evaluation framework*

Evaluation theorists have developed a wide range of frameworks that can be used to guide the design of evaluations. Established frameworks help evaluators take a systematic approach to identifying and addressing the variables that need to be taken into account in evaluation design – the aims of the program, key research questions, the evaluability of the program, the types of data that need to be collected, and the resources that are available to conduct the evaluation.

Few project evaluations articulated a clear framework. The projects that did so tended to select more rigorous designs and had a more rational and systematic approach to data collection, analysis and reporting. Furthermore, discussion of the evaluation results in these projects tended to be more comprehensive and more clearly linked to the wider context in which the project was operating.

Examples of frameworks used by some Strategy projects include: clinical outcomes; action research; process, impact and outcome evaluation; and ethnographic research.

The Institute's evaluation of the Strategy is based on the following frameworks: the Public Health Approach; and Program Theory (Bickman 1996) /Program Logic (Department of Finance 1994).

➤ *Clear definition of goals and objectives*

Measurement of program achievement and effectiveness is greatly facilitated when the program being evaluated has clear goals and objectives expressed in terms of changes for the target population, or aims expressed in terms of changes in the way services operate.

Many of the Strategy projects did not have goals, objectives and aims expressed in terms of measurable outcomes, impacts or performance indicators. Rather, items listed in the goals and objectives sections of project reports tended to be strategies and activities. For example, some typical "goals" and "objectives" listed for projects included:

- "map existing procedures and protocols";
- "develop a profile of youth at risk of suicide"
- "develop new protocols";
- "develop a functioning network";
- "track a cohort of clients through the system";
- "provide training to staff;
- "identify and interview a comparison group"; and
- "evaluate response from both health service personnel and clients".

The intention or rationale behind these so-called "objectives" in terms of desired changes in clients, other target groups such as staff, or the qualities of the wider service system, was often poorly articulated.

By mistaking strategies and activities for objectives, evaluation may be able to determine whether a project "did what it said it would do" but it will be less able to determine whether the project actually made a difference for the target population, or whether any meaningful changes in service provision were accomplished.

Even when projects provided criteria for success or achievement of project aims these were often poorly defined or were not expressed in measurable terms. For example, several projects aimed to establish "functioning networks" of service providers. However, none of these projects provided any criteria to define "functioning networks". Similarly, few of the training projects provided clear definitions of the skills and knowledge they were seeking to instil in trainees.

➤ *An appropriate design*

Evaluation design is a technical exercise for ensuring that the evaluation will generate information capable of answering the questions that need to be addressed. Few evaluation reports included any critical reflection on the range of designs that could have been utilised or the reasons for choosing particular designs.

A considerable number of the evaluations aimed to determine whether or not the program was effective in reducing suicidal behaviour among young people, or effective in reducing problems such as symptoms of mental health problems and other life stressors. However, few of the projects that identified these sorts of research questions used designs that were appropriate to answering these questions. Most Strategy projects used single group, cross sectional designs involving collection of data at a single point in time. Few projects used experimental or quasi-experimental designs involving use of a control group. This limited the extent to which any effects observed could be confidently attributed to the interventions being evaluated, rather than various uncontrolled factors. The few evaluators that reflected on this problem tended towards the view that insufficient resources were available to allow the use of a controlled design. Others argued that use of control groups in studies of the effectiveness of suicide prevention interventions is unethical.

➤ *Appropriate methods*

Choices about methodology centred on the relative benefits of quantitative versus qualitative methods. Two major factors emerged as exerting an influence on the choice of evaluation methods – namely, the research questions, and the needs and concerns of the target groups.

Strategy projects used qualitative methods and quantitative methods. The most comprehensive evaluations tended to use both. In most cases the nature of the research questions drove decisions about the use of quantitative versus qualitative methods.

Qualitative methods were generally felt to be most appropriate for the purpose of documenting the process of project implementation, exploring the experiences of stakeholders and clients, and gaining insight into the ways in which interventions may generate changes in young people's lives. Quantitative methods were considered more effective for addressing questions such as whether or not clients did actually improve, how much they improved and whether or not improvements were associated with particular kinds of interventions.

Several groups of evaluators argued that quantitative methods were not appropriate to the needs of their target group and that qualitative methods were more appropriate. For example, it was reported that Aboriginal clients at Benelong's Haven rejected questionnaires because "*they wanted to give information freely and not be coerced*". Similarly, the evaluators of the Connexions Project

expressed the view that young people who are highly marginalised and emotionally damaged are reluctant to engage in evaluation involving structured questionnaires.

However, a substantial number of projects did use quantitative instruments to collect data from young people, many of whom were judged to be at very high risk of suicide. No adverse reactions were observed. This suggests that when the needs and concerns of the target group are invoked as the reason for rejecting quantitative methods, these judgements are frequently based on the personal preferences and biases of individual clinicians or researchers rather than the real needs and concerns of young people.

It must be acknowledged that some people have limited literacy skills and feel uncomfortable when asked to complete questionnaires. However, sensitive means are available to assist people with low literacy complete self report instruments, and numerous evaluation studies have used these methods successfully.

➤ *Comprehensive reporting of interventions, methods and results*

An important aim of evaluation is to further general understanding about the nature of interventions that are effective so that they can be replicated and refined. To this end it is critical that evaluation reports include detailed description of the interventions being evaluated. A sizable minority of evaluation reports did not provide adequately clear description of the intervention or the activities undertaken.

Some evaluation reports claimed that aspects of projects were evaluated but no description of the methods or results was given. Claims of significant impacts were sometimes reported that were not based on any evidence, or were based on evidence that was not suitable to the questions being asked. “Reductions” in rates of risk factors or increases in positive behaviours among professionals were sometimes claimed but baseline or other comparative data were not reported. There was considerable confusion regarding the difference between outcomes, impacts, and process indicators.

These deficiencies were apparent in evaluations conducted internally and those conducted by external consultants.

➤ *Literature review*

Thorough and critical review of the literature is essential to the task of identifying and providing readers with a rationale for the framework, design and methods used in an evaluation. Projects that included such literature review tended to have a more systematic approach to their evaluations and more authoritative discussion of results, including the strengths and weaknesses of their findings. Literature review can be very valuable even in areas where little evaluation research has been previously conducted. The evaluation reports of the Lifeline

project (Rolfe and Turley 1999) and Kids Help Line project (King, Nurcombe and Bickman 1999) provide excellent examples of how a very small literature base can nevertheless provide valuable guidance in the design of valid methods and tools likely to be of value to researchers and practitioners in the wider field beyond the life of the current project.

➤ *Realistic timelines*

A major barrier to the measurement of outcomes for most of the Strategy projects was undoubtedly the limited timeframe available to the projects. A large proportion of projects were undertaken with a two-year timeframe. Two years, and even three years, is now widely acknowledged among experienced evaluators as an insufficient time for most new interventions, particularly primary prevention programs, to yield changes in the health status of the target population. Even in the case of projects that aim to generate changes in service systems, it is usually excessively optimistic to expect meaningful changes in the procedures and practices of service systems within two years.

If projects are funded for only two or three years it is unrealistic to expect evaluation to detect significant outcomes. Nevertheless, as the authors of the Mackay and Moranbah Hospital Protocols project state: "It is important for the evaluation to have an "eye" for this methodological difficulty and develop a means to collect base line data that would allow for a meaningful outcome evaluation at a suitable point in time" (Ward, Neville and Jones 1999).

➤ *Build the evaluation into the program design*

Several evaluators noted that a major barrier for the evaluation was the fact that the projects were well under way before the evaluation was initiated. In some cases this meant that evaluations were unable to collect baseline data about impact and outcome indicators and could only use data collected after the intervention was completed. This meant that the evaluations were unable to determine whether or not there had been changes in the indicators associated with the intervention.

In some cases projects and evaluations were designed simultaneously. This allowed proper consideration to be given to ensuring that the project was capable of generating information that could be used to better understand the factors that were most important in determining impacts and outcomes. Simultaneous planning of projects and evaluation meant that process evaluation data could be generated quickly and used by project staff to fine tune implementation of their projects.

Simultaneous design of projects and evaluations usually requires evaluators and project staff to work together as a team. This teamwork provides additional benefits (see below).

➤ *Appropriate tools and instruments*

Prior to the National Youth Suicide Prevention Strategy very little evaluation research had been conducted in several major areas targeted by the Strategy. Lack of prior research and evaluation activity meant that there was often a lack of instruments that were appropriate for use by the project evaluations. A number of projects have developed instruments and other tools. In several cases this work constitutes a substantial contribution to the task of building capacity for research and evaluation. In some cases development of appropriate instruments has required diversion of substantial proportions of the evaluation budget and this has sometimes limited the scope of other aspects of these evaluations. Evaluators have noted development of these tools as a major achievement of these projects.

One notable area of achievement was in the area of worker competency assessment. The general practice training projects and Kids Help Line developed and trialed tools for objectively and directly measuring the competency of general practitioners and telephone counsellors when working with young people. The GP Practice Audits provided a measure of the extent to which general practitioners were able to detect suicidal ideation and psychological morbidity among young people compared to young people's own self report. Kids Help Line developed a system for recording and objective rating of actual telephone counselling sessions (King et al. 1999).

The Lifeline project developed a set of tools for monitoring service use and performance that could be of value to future evaluation of telephone counselling services (Rolfe and Turley 1999).

➤ *Sufficient resources and dedicated staff*

Projects that had higher levels of resources allocated to evaluation tended to use more rigorous designs and collect more comprehensive data. Adequate resources allowed employment of staff who were dedicated to the task. The Lifeline project, for example, employed a full-time evaluation coordinator and two part-time project workers.

Evaluation is complex and time consuming work. The experience of the Strategy is that it is difficult to collect and analyse data of sufficient quality and quantity unless specific staff are dedicated to this work. If evaluation is added as another duty of staff with clinical or project responsibilities, evaluation almost always is allocated a low place in the list of competing priorities.

➤ *Management of evaluation resources*

Many of the projects experienced considerable difficulties conducting evaluation activities despite the fact that projects were granted substantial funding resources to conduct evaluation. In some cases it appears that project resources allocated for "demonstration projects" were simply used for ongoing service provision with

little priority given to evaluation. For example, one project manager states in his final report that there was insufficient time to conduct case study interviews with clients and to write up the report "in light of demands of . . . running a 24-hour service". However, $40,000 over two years was specifically allocated to this particular project to pay an external consultant to evaluate the project.

These problems may have occurred due to a lack of clarity about the meaning of terms such as "demonstration project". The purpose of a demonstration project is to test and demonstrate what can be achieved by a defined intervention. Evaluation is not an optional add-on but a central and intrinsic characteristic of a demonstration project.

In another case the project manager reported that "in all, the evaluation was funded for only 13 days across the nine months the evaluators were involved with the Project". In fact, the evaluators dedicated more time than this; however it appears the evaluation budget for this project was still inadequate. It is not clear whether this error of judgment about the management of the evaluation budget belonged to the project manager alone or whether it was a shared misjudgment by the project team and the Commonwealth who agreed to the amount allocated to the evaluation.

A number of project managers also reported strong dissatisfaction with the way that evaluations were managed by external evaluators. In some cases it appears likely that external evaluators were not delivering the quality of work that project managers had hoped for. Concerns were raised about the lack of opportunities for project managers to obtain redress from external evaluators for failing to deliver pieces of work that had been agreed to. Conversely, a number of external evaluators reported a lack of adequate cooperation on the part of some project and service staff.

➤ *An evaluation team*

A team approach tended to be associated with more comprehensive and critically reflective evaluation. Even if an evaluation project employs a dedicated researcher, it is rare for one person to have the range of skills and experience necessary to ensure adequate consideration and coverage of relevant issues. Specific skills and knowledge essential to any evaluation process include:

- technical design skills;
- technical data management skills;
- data analysis skills (usually quantitative and qualitative);
- subject matter knowledge;
- contextual knowledge specific to the project being evaluated;
- contextual knowledge of the broad policy, political and social environment in which the project is operating; and
- report writing skills.

While the establishment of an evaluation advisory group or similar was generally found to go part of the way towards a team approach to evaluation, members of advisory groups were observed as rarely allocating sufficient time to the work of such groups. Members of the 12-person Evaluation Working Group appointed by the Strategy gave an average of approximately four hours per week over a three-year period to the task of assisting in the design of Strategy project evaluations and review of evaluation reports. However, most members of the Group felt that this was not enough time to provide sufficient guidance to all projects requiring it.

A central feature of the overall approach to the evaluation of the Strategy was the combination of internal and external evaluation. A variety of different models evolved. Some projects were evaluated only internally, some only externally, while others included both internal and external evaluation. Sometimes external evaluators worked in total or relative isolation from the project staff and the agencies where projects were based. Other external evaluators worked closely with projects and agency staff. In general, evaluations that involved close collaboration between service providers and external evaluators were more successful. This partnership approach tended to generate more rigorous and comprehensive evaluations while at the same time providing opportunities for service providers to develop their evaluation skills.

What works to engage young people in research and evaluation?

The involvement of young people in the evaluations of Strategy projects varied substantially. A number of projects argued that it was extremely difficult to engage young people in research and evaluation and chose not to pursue this challenge. Others engaged young people very effectively. Just a sample of those projects that successfully engaged young people in evaluation are noted below.

- *The Keep Yourself Alive Project* (Beckinsale, Martin and Clark 1998) managed to survey 3144 young people who were attending general practitioners. According to the survey results, 5.9 per cent of these were at high risk of suicide. No adverse reactions to the research were identified.
- *The National General Practice Youth Suicide Prevention Project* (Pfaff, Acres and McKelvey 1998) managed to survey 3209 young people attending general practitioners. According to the survey results, 22 per cent were experiencing intense and uncontrollable suicidal ideation. No adverse reactions to the research were identified.
- *Program for Parents* (Toumbourou and Gregg 1999) did not experience undue difficulty in obtaining quantitative data from young people. This evaluation

used structured instruments of 120 items to measure depression, delinquency, substance use, family attachment, self-harm, social skills and emotional control. Questionnaires took 20 minutes to complete. Data were collected on two occasions from three groups of young people. Adolescent response rates were 58 per cent in control schools (n=272), 62 per cent in targeted schools (n=305) and 50 per cent in the community PACE group (n=181) for the first survey. Numbers of respondents in the second survey were 257, 262 and 161 respectively. Thus dropout rates were low. A reasonable proportion of these young people were experiencing quite serious problems. No adverse reactions to the research were identified.

- *Hospital protocol projects.* Central Sydney Area Health Service (Vajda and Steinbeck 1999), Blacktown (Fry et al. 1999), Maroondah (Brann and Sutherland 1999), and Mackay and Moranbah (Ward et al. 1999) hospital protocol projects conducted studies of young people who had presented to accident and emergency departments following a suicide attempt. In the Central Sydney Area Health Service study 23 young people were contacted by phone within three weeks. No refusals were reported. Young people were generally very pleased to be contacted, and several used the opportunity to ask questions and get further advice about ongoing care services. The Maroondah Project conducted in-depth interviews with 15 young people who had previously made suicide attempts.

- *The YPPI-IA Project* (Howe, Temple, Mackson and Teesson 1999) used a range of quantitative instruments to measure mental health outcomes including the HoNOS, CES-D, ASQ-R and ADAD. Measures were taken at baseline and six and 12 month follow-up. Around 60 per cent of the young people completed the self-report baseline measures. The main reason for young people not completing the baseline measures was that they were too unwell to attempt the questionnaires. Of those who completed baseline self report measures, around half completed follow-up measures. The main reasons why repeat measures were not taken were that the young person had not been on the Program long enough, or they were deemed "six-weekers" who only stayed for a six-week assessment period and were deemed not suitable for the Program.

Less successful in engaging young people in research was the *High Street Youth Health Service* project (Kelk 1999a). A follow-up study of a small sample of clients attending this agency was conducted to monitor clinical outcomes. It was originally intended to study up to 50 clients but it was not possible to obtain these numbers and eventually only 12 young people were given a baseline assessment. Six young people received an assessment an average of 5.6 months later. Eight young people refused to participate in the study. This is a refusal rate of 40 per cent, which the evaluator considers is not particularly high. Recruitment relied upon clinicians approaching their clients. It appears that only 20 young people were approached to participate in the High Street Youth Health Service study.

➤ *Commitment of evaluators, project staff, agency staff and stakeholders*

The main factor determining the ability to engage young people in research and evaluation appeared to be the evaluators' and project staff members' level of commitment to the task. Some evaluators and project staff made considerable efforts to collect data from young people while others did not see this as a priority.

The attitudes of agency staff towards evaluation and the commitment of other project stakeholders to the issue of research into young people's experience also had a strong influence.

The evaluator of the High Street and Cellblock Youth Health Service projects (Kelk 1999a,b,c) notes that the main factor determining young people's involvement in the research was the willingness of clinicians to invite their clients to participate. Kelk reports that staff experienced difficulties approaching their clients and that they expressed concerns that the assessment would have a negative effect on clients. A high turnover of staff during the project also worked to reduce staff engagement with the project. Similarly, the evaluators of the Lifeline Project (Rolfe and Turley 1999) reported that some counsellors participated in the evaluation by inviting young people to be involved in the followup and some did not.

The evaluators of the Centacare Project (Martin, Roeger, Marks and Allison 1999) noted that it is particularly difficult to collect "hard" data from clinical staff and "at risk" young people when services are provided in informal settings and involve carrying out assessments rather than providing ongoing treatment (that is, providing consultations to providers in other agencies). It is argued that unless evaluators can be very confident that the integrity of data systems can be maintained, different approaches should be developed. This observation, and that below, underscores the importance of gaining the commitment of project stakeholders.

The evaluators of Program for Parents (Toumbourou and Gregg 1999) report that it is hard work to obtain adequate response rates, but it is not impossible:

> "Don't let the defeated evaluators get away with 'not trying'. Our experience has been that it isn't easy getting adequate response rates. The approach we have taken has been to try to work closely with the schools. We think we would have done better with more time. Schools varied considerably with respect to response rates. In some cases we had almost 90 per cent returns where the school was very on-side with what we were trying to do. Relationships with the school are everything."

This suggests that the enthusiasm and commitment of the organisation with the closest contact with young people is a key factor in engaging them in research.

➤ *Prospective follow-up with minimal delay*

The Mackay and Moranbah Hospital Protocol project found it easier to engage young people when research was conducted prospectively rather than

retrospectively (Ward, Neville and Jones 1999). During the life of the project, 30 young people were initially identified as presenting with self harm. Consent to be interviewed was sought, and 18 (60 per cent) gave consent to be followed up. Interviews were conducted about three months after presentation. One hundred and thirteen (113) young people presented in the 18 months prior to the project. Of those who were able to be contacted and asked whether they agreed to be interviewed, only 19 young people consented. The evaluators of the Mackay Project felt that the long delay between discharge and contact from the researcher experienced by the retrospective group is likely to have acted as a disincentive for young people to engage with and assist in the research.

In the Central Sydney Area Health Service study, 23 young people were contacted by phone within three weeks. No refusals were reported (Vajda and Steinbeck 1999).

The lesson from these results is that engagement of young people in research can be highly effective when follow-up is initiated promptly after the patient has presented to services.

Staff of the WA Youth Sexuality Project (Goldflam, Chadwick and Brown 1999) note that many young people who are at high risk of suicide live very transient lifestyles. This underscores the importance of conducting follow-up promptly with such young people.

➤ *Qualitative or quantitative methods*

The evaluators of the Connexions program (Ridge, Hee and Aroni 1999) reported that it was extraordinarily difficult to obtain useful data from marginalised young people using standardised questionnaires or focus groups. Individual interviews were also reported to be problematic due to the same reasons that make it difficult to engage this population in services. For these reasons ethnographic methods were used and found to be highly effective.

However, other projects did not report difficulties engaging young people in standard research approaches that included in-depth interviews and standardised instruments.

The evaluator of the High Street Youth Health Service Project (Kelk 1999b) reported that the structured questionnaire was generally well accepted by the young people but that there were several negative reactions to the clinical interview, which were handled competently by the clinicians. There were also at least three young people (out of a sample of 12) who did not return to the agency after the first assessment. It is possible that they were put off by the assessment but no further information is available that could confirm or refute this explanation. The evaluator believes that this level of negative reaction to the interview is acceptable, especially considering the extreme nature of the disorder experienced by some of the young people in this group. However he also suggests that the issue of negative responses to assessment should be a focus of study in any future research of this kind.

➤ *Instruments that help young people see improvement*

YPPI-IA Project staff were generally supportive of using quantitative measures, although they did perceive a variety of problems (Howe, Temple, Mackson and Teesson 1999). For example, some staff felt that the instruments were irrelevant to the clients, some felt that clients would have under-reported things like drug use, some felt that having to complete the instruments may have compromised the therapeutic relationship with the client.

Interestingly, young people themselves reported quite positive attitudes to the research component of the program. They indicated that it was a good way to monitor their own changes in alcohol and drug use and suicidality over time. It was also considered as an impetus to stop or decrease use of drugs and alcohol. According to young people in the YPPI-IA Project:

> "When I filled the form out it really blew me out. Then I thought, well, this is what I'm doing, this is how much I'm doing it, and this is how much I'm thinking stuff and things like this. And after that it was like just put me in hospital so I can stop this. I don't smoke pot any more."
>
> *Interviewer:* "So are you saying that it was helpful to fill it out?"
>
> "Yeah definitely."
>
> "Yeah, and how much I was doing drugs and alcohol, and how many times I actually thought about suicide, and all what my friends around me were like, and what they were doing."
>
> "Yeah I think it's cool. 'Cause each time with the drugs and that, now I've cut down."
>
> "Six months is a lot of time – you can see how much you change."

➤ *Realistic ethics committees*

Based on his experience evaluating a number of projects targeting "alienated and marginalised" young people attending youth health services, Kelk (1999c) notes that it is generally very difficult to secure approval from research ethics committees to conduct research and evaluation on "marginalised" young people but that many of the activities that would take place in such research projects proceed without question when the activity is initiated by clinical workers. By simply adding on the requirement of evaluation, such activities become subject to research ethics committee approval and are often blocked. Kelk suggests that few people on research ethics committees have an intimate knowledge of alienated, marginalised and homeless youth and as a consequence committees tend to overestimate the extent to which researchers or clinicians can exploit such young people for research purposes.

Kelk (1999c) recommends that in the interests of enhancing evidence-based practice within youth health services (and mental health services) it

may be appropriate for service managers and staff as well as research ethics committees to clarify the distinction between clinical innovation, evaluation and research.

For example, it is important for ethics committees to understand the extent to which many evaluation activities are (or should be) integrally bound up with high quality care and the need to minimise bureaucratic barriers. An important bureaucratic barrier that is frequently erected in front of activities labelled "evaluation" instead of "high quality care" is the need to gain written consent from clients. The Cental Sydney Area Health Service Research Ethics Committee deemed that consent to follow-up young people who had presented with a suicide attempt was not required because follow-up was judged to be within the duty of care of the hospital and part of routine quality assurance (Vadja and Steinbeck 1999).

What works to engage service providers in research and evaluation and build capacity?

When the evaluation activities of the National Youth Suicide Prevention Strategy were being planned many potential barriers were anticipated and considerable effort was directed towards the aim of developing the capacity of service agencies to conduct appropriate evaluation. This was the remit of the Evaluation Working Group. The Group provided assistance to projects in developing evaluation plans, were available to provide guidance and advice during the process of conducting the evaluation research, and reviewed evaluation reports during the drafting process.

Members of the Evaluation Working Group feel that the fostering of a culture of evaluation has been a major achievement of the Strategy. Many of the staff working on projects funded under the Strategy had little experience of evaluation before the Strategy and have learned much from the experience.

However, it is clear that major barriers remain to be addressed if rigorous evaluation is to become a more regular component of the service development process.

Evaluation was a key topic of discussion at the Second National Project Workers Workshop held in March 1999 at the Suicide Prevention Australia Conference in Melbourne. The point was made that convincing workers about the value and importance of evaluation was difficult. There is also considerable evidence in the Strategy project reports that one of the major barriers to research and evaluation of services and programs targeting young people is the attitude of service providers who work with young people and who govern the access of researchers and evaluators to young people using services.

Another major barrier to evaluation is the lack of infrastructure and resources for the collection, management and analysis of data.

➤ *Close collaboration between dedicated evaluators and agency staff*

It was noted earlier in this chapter that an ability to employ a dedicated evaluator who is not also burdened with clinical responsibilities was an important facilitator of rigorous evaluation.

There appear to be some attitudinal barriers to the use of dedicated evaluation staff that may be overcome if sufficient emphasis is put on close collaboration with agency staff, especially clinicians. There is also evidence that such collaboration helps build capacity of agency staff.

The evaluator of the *High Street Youth Health Service* project (Kelk 1999a) reports that staff considered and rejected an earlier proposal that a research officer be involved in collecting data from young people. Staff felt quite strongly that clients should only be assessed by clinical staff because research staff would not have sufficient rapport with the clients and would be unable to assist any clients who became distressed. Consequently no attempt was made to appoint a research officer for the *High Street Youth Health Service* project or for a connected project based at *Cellblock Youth Health Service*.

However, Kelk (1999c) argues that it would be possible for a research officer to carry out an important role in such projects. Specifically, it is suggested that a research officer would help to ensure that a sufficient focus on the research project is maintained throughout the recruitment and data collection phases. Kelk also notes that a research officer with clinical qualifications could carry out assessments, perhaps in conjunction with agency clinicians if necessary. A dedicated research officer would also be in a better position to collect data from young people not actively involved in counselling but who may be using other services of the agency. Alternatively, a research officer could play a primary role in supporting the clinical staff in their research roles, rather than conducting assessments directly. Such a worker would also have the role of collating and analysing data and providing regular feedback.

The YPPI-IA project team recommend that thorough discussion take place with staff about what it means for them to be involved in a research or evaluation project: “By discussing the obstacles, real or perceived, that prevent workers from making the mind-shift to being part of a research project, it is possible to overcome these problems” (YPPI-IA Project Team).

Some of the difficulties experienced by the Evaluation Working Group demonstrate the importance of close collaboration at all stages of the evaluation process. A major problem reported by the Group was that the evaluations were often not built in to the projects during their initial design but were developed later. This may have occurred because the importance of evaluation was not stressed sufficiently early in the course of the Strategy, and because insufficient resources were provided to proactively coordinate the design of evaluation. Although the Evaluation Working Group was convened close to the outset of the Strategy, it did

not have any input into decisions about projects that would be funded. This meant that the Group had to liaise with projects in the development of evaluation methods after projects had been designed and funding had already been allocated.

All members of the Evaluation Working Group also had full-time commitments elsewhere, and Mental Health Branch was only able to provide very limited secretarial support. More active assistance could have been provided to projects if some members of the Group could have been in a position to allocate more time, or if a dedicated worker with evaluation skills had been available to work for the Evaluation Working Group.

➤ *Infrastructure for evaluation and research*

Projects that were successful in collecting and reporting on large quantitative datasets tended to be based in organisations that have an established infrastructure capable of managing the complex technical tasks involved in this work. For example, evaluation of the *Keep Yourself Alive* Training Program required the use of SPSS software and staff with the expertise to manage and analyse the data (Beckinsale, Martin and Clark 1998). Ensuring an adequate quality of data required staff time to follow up respondents who failed to return data collection forms. This assistance was provided by the Royal Australian College of General Practitioners Quality Assurance Unit in South Australia, and the Child and Adolescent Mental Health Service.

A substantial number of evaluators and project staff pointed out that the services in which projects were based lacked appropriate computerised data systems. This included some hospital accident and emergency departments, particularly those in rural areas, as well as some mental health services. Where computerised data systems are available it was noted that these are often designed purely for financial accountability purposes and are not designed to provide information that is useful for clinical decision making, for quality assurance or for evaluation of service provision.

At the Second National Project Workers Workshop held in March 1999 it was suggested that resources for evaluation need to be specifically allocated, not just through project grants, and that evaluation methodologies need to be refined. This first point was also made by several project managers in their final reports. It is unclear why project managers did not perceive that such funds were allocated separately as they were meant to be.

➤ *A critically reflective organisational culture*

Projects where evaluations proceeded most successfully tended to be based in services that were characterised by a high level of critical reflectiveness. Project managers and evaluators in these projects often mentioned the importance of structures and processes that supported open communication between staff members about a wide range of issues and encouraged staff to contribute actively to

ongoing service development. Key structures and processes included clinical supervision and regular team meetings in which staff are encouraged to continually review their practice and discuss problems in a supportive environment. The role of management was noted as particularly critical. Managers need to be willing to acknowledge the fact that emotional and interpersonal problems do arise for professional staff working in human service agencies, and they need to create structures for addressing these problems openly.

A number of evaluators noted that an unintended benefit of conducting the evaluations of the Strategy projects has been to stimulate organisations to become more reflective and self-critical.

General discussion

The National Youth Suicide Prevention Strategy represents a significant step forward in efforts by government to ensure that evaluation and research are built in to the management of strategic national initiatives. The Strategy was built around the recognition of the lack of sufficient knowledge about the effectiveness of the many and various interventions that have been proposed to prevent suicide among young people, and the belief that it should not be necessary to wait until such knowledge is available before taking action.

The evaluation activities conducted under the Strategy have demonstrated that valuable knowledge can be gained by trying new strategies and evaluating effectiveness while these strategies are being implemented in the settings that will ultimately be asked to adopt and institutionalise those that prove most valuable. This approach, usually referred to as "effectiveness evaluation", has the important advantage of allowing evaluators to observe and document the difficulties that inevitably arise when new interventions are trialed in real world settings, and the strategies that are useful for overcoming barriers to implementation. Building the knowledge base in this area has been a major contribution of the Strategy evaluation effort.

The Australian Institute of Family Studies summative evaluation of the Strategy has also provided an opportunity to reflect critically upon the evaluation efforts of the Strategy, alongside all the other groups of activities. Evaluation should not be seen simply as a higher order activity that should 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, it can be recognised that evaluation varies in its effectiveness and usefulness just as other activities do. The evaluation activities of the Strategy are a good example of this.

A major challenge in designing and conducting the evaluation of the Strategy has been the great diversity of the projects undertaken. Projects have used an extremely

diverse variety of approaches and interventions, addressed a diverse range of risk factors and target groups, and have been implemented within a diverse range of settings. The sheer diversity of the projects funded under the Strategy is perhaps unprecedented in the history of national strategies of this nature.

This diversity posed enormous challenges to the development of a unifying evaluation framework that would be equally appropriate for all the funded projects. As a result, projects have been evaluated using a wide variety of designs and methods. While this creates major difficulties in comparing outcomes and impacts across different projects and approaches, it has had the advantage of providing insight into some of the factors that appear to be important for ensuring that evaluation itself is appropriate and useful. The process of identifying the factors that have contributed to appropriate and useful evaluation of Strategy projects has revealed a number of problem areas that need to be given further consideration in efforts to promote effective evaluation of youth suicide prevention activities, and other related government activities.

Key areas of concern include:

- using appropriate frameworks;
- the problem of control;
- matching evaluation design to agency functions and levels of logistical capability;
- resources for evaluation;
- evaluation and the clinical relationship;
- standardised instruments;
- making evaluation useful for clinicians; and
- involving young people in evaluation.

Frameworks: evaluation and the planning cycle

Few of the Strategy project evaluation reports articulated any kind of clear evaluation framework as guiding the design of their evaluation research.

The Strategy was intended to be a Public Health Approach (CDHFS 1995). It is therefore surprising and concerning that so few evaluations incorporated key concepts of the Public Health Approach into their evaluation frameworks. The Public Health Approach to evaluation is particularly relevant when the programs being evaluated are part of a broader strategy that has significance beyond the usually limited concerns of project managers and other local stakeholders. This is certainly the case when projects are funded as part of a national strategy.

A strength of the Public Health Approach is that evaluation is seen as forming part of a strategic planning cycle, as shown in Figure 1.1.

FIGURE 1.1 The public health strategic planning cycle

Situating evaluation clearly within a strategic planning framework highlights the importance of distinguishing between the different types of information that evaluation is capable of providing to assist strategic planning. Public health theorists and practitioners have embraced the distinction between process, impact and outcome evaluation and have linked these levels of evaluation or effect directly to different levels of goal setting within the planning process (see Table 1.1).

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). Goals and objectives are ideally determined through a process of systematic population-based needs assessment. This should include comprehensive literature review, collection or collation of epidemiological data about the health and wellbeing of the local population, and consultation with relevant stakeholders including service users, service providers and the general public (for example, Kurtz 1996).

The Public Health Approach identifies the critical importance of distinguishing between *goals and outcomes* and *objectives and impacts* on the one hand, 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.

Whether an evaluation focuses on outcomes, impacts or processes (performance indicators), it is critical that they are measurable. Measurable goals and objectives

TABLE 1.1 Levels of strategic planning and effect

Levels of strategic planning	Levels of effect
Goals	Outcomes
Objectives	Impacts
Aims	Processes (or Performance Indicators)

provide a framework for determining the effectiveness of the interventions being evaluated. Measurable aims and performance indicators allow us to determine whether or not the program has been implemented as planned or whether the service is operating as intended. Together, measurable goals, objectives and performance indicators provide a vision of where we want to be and how far we have moved towards making the vision a reality.

Many of the Strategy projects did not have goals, objectives and aims expressed in terms of measurable outcomes, impacts or performance indicators. Rather, the items listed in goals and objectives sections of the project reports tended to be strategies and activities. The intention or rationale behind these so called "objectives" in terms of desired changes in clients, other target groups such as staff or the qualities of the wider service system were rarely articulated.

By mistaking strategies for objectives, evaluation may be able to determine whether a program "did what it said it would do" but it will be less able to determine whether it actually made a difference for the target population or whether any meaningful changes in service provision were accomplished.

These considerations also point to the distinction between "client focused" and "population focused" services versus "provider focused" services, two other widely misunderstood terms. Objectives phrased in terms of service strategies rather than outcomes and impacts for clients and populations tend to arise from and maintain a provider or service-centred perspective and inhibit the development of a client centred and population focused perspective.

The problem of control

Much of the evaluation work conducted by the Strategy has demonstrated improvements in the wellbeing of young people who have been clients of services and programs under evaluation, or have observed some positive changes in the way that services operate. However, only a few projects have used evaluation designs that allowed investigators to confidently attribute changes in the target groups to the particular interventions being evaluated.

A number of fairly strong hypotheses have been generated about the kinds of strategies that are likely to be effective in reducing risk factors for suicide among young people, and the kinds of strategies that might help build capacity for suicide prevention. In general, however, it has not been possible to rule out the possibility that positive changes have resulted merely from the fact that the projects increased general levels of awareness about suicide prevention and young people, in the service environments in which they were operating.

In other words, the designs of the project evaluations have generally not been of the kind necessary to rule out the possibility that merely focusing on the issue of suicide for an extended period of time led to the positive changes observed. If this is true then it is difficult to justify continued investment in the development of

sophisticated, comprehensive, highly tailored interventions that are relatively expensive to implement. We cannot afford to assume that programs and interventions that "look good" and cost more will actually improve outcomes for consumers above and beyond the outcomes that can be achieved by existing practice or cheaper options. Responsible managers who are under pressure to balance budgets are unlikely to be convinced and will be reluctant to take up such new programs and practices.

Justification of continued investment in new interventions requires stronger evidence that they are superior to cheaper options. Generation of this evidence will require the use of evaluation designs capable of testing the relative superiority of one intervention over another, and identifying the range of factors in service environments which enhance or inhibit the effectiveness of particular interventions. In other words we need to find ways of increasing the extent to which control group designs are used in effectiveness evaluation.

The issue of control in service and program evaluation continues to be a highly vexing question in the evaluation debate. The experience of the National Youth Suicide Prevention Strategy has added to the existing body of evidence that individual service agencies are, for the most part, unable and unwilling to conduct evaluation using control group designs. Resource limitations are usually the major factor inhibiting such evaluation. However, this was not a major problem for Strategy projects which were provided with relatively generous funding sufficient to allow the use of controlled designs. A number of Strategy evaluation teams that reflected critically upon the design options available to them argued that the use of a control group in the evaluation of their project would have been unethical because it would mean denying certain young people access to an intervention that may be of assistance to them.

While the use of controlled evaluation designs is generally not feasible or acceptable within the context of program evaluation activity taking place in individual service agencies, this does not mean that efforts to conduct evaluation of this nature should be abandoned. Alternative approaches to well controlled effectiveness evaluation need to be found that overcome logistical problems and ethical concerns. This will require cooperation between the various agencies or professionals who are working on the development of particular interventions or programs.

Some of the ethical objections to controlled research that have been raised are open to challenge. Resource limitations that affect all services mean that decisions are regularly made to *exclude* certain potential clients from access to certain services. Often such decisions are made on the basis of age – for example, Child and Adolescent Mental Health Services often restrict their services to children and adolescents 18 years and under. Sometimes mental health services are denied to young people who are not currently living with their family or are involved in the juvenile justice system. Moreover, similar services can vary among themselves as to the particular exclusion criteria that they apply.

Many referring service providers and potential consumers experience these exclusion criteria as quite arbitrary, and a case can be made that in many situations they are not much more rational than an essentially random allocation process. If we tolerate the fact that services will continue to apply such restrictive criteria, then it is not a major ethical leap to condone research that uses control group designs. Controlled research can in fact be seen as more ethical than certain forms of exclusionary clinical practice because research is at least part of a concerted effort to develop a rational, evidence-based approach to resource distribution in the future.

An argument against the use of randomised controlled trials put forward by clinicians is that clients will be unwilling to consent to randomisation if they know that one of the treatment conditions is considered to be possibly superior to the other. This is a valid concern. However, it is only valid when randomisation takes place at the level of individual clients. This ethical problem can be circumvented if randomisation (or another form of allocation to conditions) takes place at a higher level, such as at the level of service agencies.

While certain confounding factors will be operating and there will be natural variation in certain components of interventions within the control and study groups (for example, the training and experience of staff), such factors might be able to be controlled statistically if they can be accurately quantified. Such a study design would have certain important benefits over experimental efficacy evaluation because it would allow examination of how outcomes vary according to the presence of particular service characteristics. The results of such naturalistic effectiveness research would also be much more relevant and generalisable across the real world of service provision.

Matching evaluation design to logistical capacity

Such naturalistic effectiveness research involving multiple sites will require a more strategic approach to the planning of evaluation activities. It will require the formation of partnerships between governments, universities and service agencies. However, it is important to realise the value of the evaluation research that can be conducted by individual service agencies and the ways in which this work can contribute to the wider evidence base.

Evaluation needs to be appropriate to the information needs of the service collecting the data. In general, individual services adopt and further develop interventions that have been developed elsewhere. Presently the main type of evidence available to guide these choices comes from efficacy research conducted using experimentally controlled trials. A major limitation of this evidence is that it does not take account of the fact that real services operate in complex environments. They are subject to many environmental factors that could render interventions that have been proven in efficacy research, ineffective in the real service environment. Many services also choose to modify interventions in an effort to make them more appropriate to the specific characteristics of their service. These facts

are increasingly recognised as demonstrating a need for effectiveness evaluation (Wells 1999).

The questions that need to be addressed by effectiveness evaluation are different from those addressed by efficacy evaluation. Some evaluation questions appropriate to individual service agencies are listed in Table 1.2. Effectiveness evaluation, as conducted by individual service agencies, is mainly concerned with

TABLE 1.2 Levels of effectiveness evaluation

Setting	Evaluation questions	Evaluation designs	Rationale and issues
Local agencies	Are we implementing the program as intended? Are our clients getting better or worse? What are the factors that help our clients get better?	Routine monitoring of quality and clinical outcomes. Single group designs. Cross sectional and pre- and post-repeated measures. Routine measurement of costs.	Local agencies are in a position to provide documentation of the process of service delivery and program implementation and to collect data about the impacts and outcomes for clients of their particular service or program. In general single agencies do not have the resources to conduct longitudinal follow-up or control group studies.
National and state/territory collaboration	What types of interventions and modes of service delivery are associated with the best outcomes? What types of interventions and modes of service delivery are most cost effective? What factors in the service environment facilitate and inhibit effectiveness?	Control group designs. Longitudinal follow-up. Multi-site trials. Cost effectiveness analysis. Cost-benefit analysis.	Trials involving the comparison of outcomes and costs across different types of interventions and testing for the effects of different service environments require multi-site trials. This requires collaboration between a number of agencies, the technical assistance of highly skilled evaluators and the coordination of Commonwealth and state/territory governments. Longitudinal follow-up will also require injection of funds from national funding bodies.

determining whether or not the clients being subjected to the interventions of this service are getting better.

Another important issue for effectiveness evaluation at the individual service level is to identify the factors that are associated with clients getting better or worse. Efficacy research tends to relegate many of these factors to the status of "confounders", but effectiveness evaluation recognises that real services need to develop a better understanding of these mediating factors if we are to develop a constructive response to them. The evidence base for service development requires that we study mediating variables as they are manifest in the real world rather than trying to control them out of the picture artificially.

Because real services modify interventions, it is important to find out whether the modifications have been successful or not. Because clients of real services are highly diverse, it is necessary to discover whether the intervention is effective for all clients or only some. Because real services use a range of interventions, it is also important to find out which combinations work best under what circumstances. These questions are often not addressed in experimentally controlled efficacy research, but they are crucial to building the evidence base for service development. Further, individual service agencies are in a position to address these vital questions in the evaluation work they conduct, and controlled designs are not necessarily the most appropriate for addressing these issues.

The information that has been generated by the evaluations of the Strategy projects provides a pointer for ways in which evaluation at the individual service level can be made more useful. A major aim of the qualitative meta-analysis of Strategy project evaluations was to identify the (mediating) factors associated with project effectiveness. This exercise identified a large number of factors that could be playing a role, but the quality of the evidence concerning the importance of these factors was generally inadequate to draw firm conclusions.

A major problem was that few evaluations collected data about mediating factors in a systematic way. The Strategy has generated a large number of hypotheses about the factors that help and hinder implementation of effective programs, but further evaluation is required to test these hypotheses. Future evaluation conducted at the individual service level needs to include more systematic measurement of "processes", performance indicators and other mediating factors, in addition to data about outcomes and impacts. At present, most of the information about these factors is purely qualitative. Quantitative measurement in addition to qualitative description would allow more rigorous testing of the hypotheses that the qualitative research has generated.

Resources for evaluation

Strategy project evaluations that did attempt to collect or analyse data relevant to these indicators very frequently found that the necessary data were not available because they were not collected routinely by services, or staff of services

were poorly engaged in the exercise of collecting data specifically for the project. Projects that did manage to collect some useful data tended to have special staff dedicated to this task, but most of these projects nevertheless encountered high levels of resistance or disinterest from clinical staff whose cooperation they depended upon. Electronic and paper data systems in many services were found to be inadequate to the task of accurately and systemically documenting information relevant to the process of service delivery.

Any kind of evaluation is complex and time consuming work. The experience of the Strategy is that it is difficult to collect and analyse data of sufficient quality and quantity unless specific staff are dedicated to this work. If evaluation is added as another duty of staff with clinical or project responsibilities, evaluation almost always is allocated a low place in the list of competing priorities. If service systems such as mental health services are committed to enhancing quality and effectiveness, and increasing the level of evaluation activity within services, then additional dedicated resources will need to be provided to support this work. At the same time, greater awareness by government project fund providers of the very real limitations to the level of evaluation that can be conducted by individual agencies may also help stimulate a more rational use of the limited resources that are available for evaluation across the system as a whole.

Government has an important role to play in enhancing capacity for high quality evaluation and creating the conditions in which appropriately designed evaluations can be conducted. Governments and senior managers need to give greater consideration to the development of structures that can provide support for appropriately designed evaluation at all levels of the service system. While health services in most states have directed considerable resources towards the development of electronic data systems over the past decade it is apparent that this investment has yet to yield rewards in terms of capacity for process, impact and outcome evaluation. Services appear to lack the resources and skills to use these systems effectively. Greater attention may need to be directed to other types of evaluation resources as well as organisational barriers to evaluation. Resources and organisational issues need to be addressed at the level of local service agencies and at the level of collaborative activity within and between states and territories.

Local service agencies need greater assistance if they are to conduct routine monitoring of service quality and clinical outcomes, and if they are to participate as partners in collaborative efforts to develop the evidence base for program effectiveness. Provision of appropriate technical assistance will need to be accompanied by strategies for ensuring that service providers, especially clinicians, are involved and engaged in the data collection process. This will require ensuring that such activities are useful, and are seen to be useful, for service providers.

A central feature of the overall approach to the evaluation of the Strategy was the combination of internal and external evaluation. A variety of different

models evolved. Some projects were evaluated only internally, some only externally, while others included both internal and external evaluation. Sometimes external evaluators worked in total or relative isolation from the project staff and the agencies where projects were based. Other external evaluators worked closely with projects and agency staff.

In general, evaluations that involved close collaboration between project staff or service providers and external evaluators were more successful. This partnership approach tended to generate more rigorous and comprehensive evaluations while at the same time providing opportunities for service providers to develop their evaluation skills. Close collaboration with agency staff ensured that the evaluation methods were more relevant to the day to day work and concerns of agency staff. This in turn inspired greater cooperation and active involvement in data collection. In brief, the evaluations had greater meaning for agency staff.

Formation of partnerships between evaluators and clinicians suffers from many of the same barriers confronting development of partnerships between sectors. Evaluators and clinicians often speak different languages. In some projects there was evidence of considerable tension between evaluators and project staff that was related to different understandings of the role and place of evaluation in service development and delivery. Two of the major sources of contention are: a widespread perception that evaluation necessarily involves an intrusion into and a threat to the clinical relationship; and a perception among many clinicians that standardised instruments are not useful and that they inhibit engagement with young people.

Evaluation and the clinical relationship

While a strong case can be made that some methods of data collection may be experienced negatively by some clients, this danger does not extend to evaluation of the process of service provision. Despite this, the belief that "evaluation is intrusive" appears to have contributed to a generalised reluctance on the part of evaluators, as well as clinicians, to collect data about any aspect of clinical service provision, whether or not it necessitates collecting data from clients directly.

There are various ways of collecting valuable information about clinical outcomes and the process of service provision that pose no threat to the clinical relationship. If monitoring of clinical outcomes from the clients' point of view is not possible or appropriate, then standardised clinician ratings could be considered instead. Documentation of whether or not critical aspects of service provision have taken place also need not pose a threat to the confidentiality or safety of the clinical relationship.

Standardised instruments

The question of the value and appropriateness of standardised instruments was a major issue, especially for projects that were focusing on young people at high

risk of suicide. Evaluators expressed divergent opinions concerning the appropriateness and usefulness of formal questionnaires and standardised instruments.

Some argued passionately that it is inappropriate to ask young people experiencing complex problems to complete formal questionnaires. In these cases qualitative evaluation methods were preferred. Other evaluators found that, when they are asked, young people are willing and able to complete such questionnaires, that they are well received, and that few young people experience any negative reactions. Moreover, the standardised instruments that were used generally demonstrated sensitivity to change and convergent validity with other clinical information.

A number of project managers and evaluators argued that it is inappropriate to measure outcomes for the young people in their service using standardised instruments because of the fact that the outcomes of interest are so varied.

This concern, while true to some extent, is open to challenge. There is a set of outcomes, risk factors and protective factors that have very broad applicability across a wide range and a large proportion of young people at risk of suicide. The importance of this understanding is fundamental when a public health or population-based approach is adopted to address the underlying issues. While each individual experiences these risk factors and outcomes to varying degrees and in a unique pattern, we cannot plan service systems or understand and address underlying causes such as social factors if we only look at the individual level. Some understanding of the aggregate experience is necessary for this. This is perhaps where the major value of standardised instruments lies and this may be beyond the interest and experience of most clinicians or youth workers.

However, also at the individual level, standardised instruments that measure the most common risk factors, protective factors and outcomes, will in most cases be highly relevant in planning the care and treatment of individual clients, and can help clinicians see the problems of their clients from the broader perspective of how they compare with others who have experienced similar problems. It is possible that many clinicians have not been exposed to much discussion of the uses and value of standardised instruments. Formal education about the uses of standardised instruments is provided routinely to some professional groups, namely psychologists and public health professionals, but not others.

Nevertheless, it needs to be acknowledged that many standardised instruments fail to provide a clear picture of the concerns and goals of individual clients, and that these factors are not yet given adequate consideration in systems of outcome measurement. One such tool that might be worthy of exploration or further development in future evaluation research with this population is Goal Attainment Scaling, a tool that is also a useful clinical case planning tool (Kiresuk and Sherman 1968).

On balance, it is clear that the difficulties of collecting quantitative data from young people at risk of suicide are very real. The major barrier appears to be the

reluctance of clinicians to approach their clients to act as participants in evaluation, rather than widespread rejection of structured questionnaires by young people themselves. Further work is required to clarify and address the concerns of clinicians regarding the use of structured instruments in the evaluation of services.

Making evaluation useful for clinicians

A major limitation affecting the evaluation of clinical programs appears to lie in the negotiation of appropriate definitions of the desired impacts or performance indicators by clinical staff and evaluators. A close correspondence between clinical and evaluation information needs is desirable, and is likely to enhance clinicians' engagement in the evaluation process. If clinicians do not see the information as relevant to their needs, it is not surprising that they will be reluctant to dedicate time to this work. To provide just one example, an important aspect of good referral practice in suicide prevention, especially when greater interagency collaboration is a concurrent aim, is follow-up by the referrer to determine whether or not the client presented, whether or not the referral was appropriate to the provider referred to, and whether or not the client has engaged with the new agency. Collection of this basic information is intrinsic to good clinical practice as well as being useful for continuous quality enhancement and other evaluation purposes.

While the requirements of evaluation should not be allowed to distort interventions in such a way as to reduce their effectiveness, often very minor adjustments to project design can provide avenues for rigorous testing of effectiveness, and exploration of the mechanisms by which an intervention exerts its effects. Furthermore, data collection need not always be considered an extra duty for project staff. If evaluation and project are designed simultaneously, the evaluation can also be tailored in such a way as to make it compatible with the aims of the project. If process evaluation data can be made available early it can be used by project staff to fine tune implementation of projects. Collection of baseline data on risk and protective factors can be used as a project planning tool or an engagement exercise for young people or other target groups. If collection of such information is considered irrelevant by project planners or target groups, then it probably is!

Involving young people in evaluation

Involvement of young people in research and evaluation should extend beyond their use as subjects of study. Young people should be involved as participants in critical reflection upon the planning, implementation and evaluation of services and programs which aim to address their needs. Very few projects included this sort of involvement of young people. At present most agencies involved in providing services to young people appear to lack a forum or mechanism through which to involve young people. Kurtz (1996) has identified systematic population-based needs assessment as a process which provides a forum or basis for seeking the input of consumers.

TABLE 1.3 Challenges for evaluation of youth suicide prevention activities

Setting questions	Evaluation	Challenges	Strategies
Local agencies	Are we implementing the program as intended? Are our clients getting better or worse? What are the factors that help our clients get better?	Many clinicians doubt the value of evaluation. Poor understanding of the value of standardised instruments. Inadequate data systems. Insufficient technical support. Involving young people.	Close collaboration between dedicated evaluators and clinicians. Creation of structures to provide education and technical support to local services and liaison with state/territory and national initiatives. Integration of evaluation into comprehensive strategic planning cycles. More comprehensive and regular collection of national data.
National and state/ territory collaboration	What types of interventions are associated with the best outcomes? What factors in the service environment facilitate and inhibit effectiveness?	Lack of structures to support comparative service and program evaluation. Inadequate access to national and local data about the emotional wellbeing of young people.	

As noted earlier, systematic needs assessment forms an integral part of the planning cycle within which evaluation is also embedded under the Public Health Approach. Unless evaluation is connected to needs assessment and planning in an ongoing process the input of young people, either at the evaluation or the needs assessment stage has little relevance and cannot be used effectively.

Only a minority of National Youth Suicide Prevention Strategy projects appear to have included – or been grounded within – a systematic planning process taking place within the services in which they were based. Or if they were, the relevance of this wider planning process was not discussed at any length in the evaluation reports. The few projects that did discuss this ongoing service development process (for example, YPPI-IA, Kids Help Line and Lifeline) tended to have a stronger vision of the ways in which the input of young people could be

used and a stronger commitment to ensuring their active participation in the future. Some projects had this vision and commitment but were not embedded in a wider strategic planning process (for example, Out of the Blues). Such projects tend not to have continued beyond the Strategy funding and the input that was gained from young people may have been lost to those particular service systems.

A failure to provide mechanisms which are viewed by agency staff as capable of ensuring that evaluation data will be acted upon could also be expected to engender cynicism about the value of evaluation activity and a reluctance to engage in this work.

Building capacity for research and evaluation

It is not possible to expect most small service agencies to conduct evaluation of their services or special projects using experimental or even quasi-experimental control group designs. Such designs are beyond the resource and skill base available to individual services. However, it would be desirable for individual agencies to increase the level of evaluation activity and to achieve greater rigour in the evaluation work they do.

While it is not possible for individual agencies to conduct rigorous outcome evaluations using proper controls, numerous critical questions about the effectiveness of services remain unanswered. The scarcity of resources available for the provision of services that address suicide-related behaviours, and the risk and protective factors associated with it, demands that these resources are not wasted on interventions that are not effective. Mechanisms need to be found to support the kind of evaluation activity that is necessary to answer these questions.

It would be particularly desirable for such mechanisms to serve the dual functions of building the capacity of individual service agencies to conduct their own evaluation while at the same time supporting evaluation research that addresses major questions for service systems. A partnership involving local service agencies in various sectors as well as state and territory governments appears to be essential.

A Public Health Approach that situates evaluation as an integral component of a strategic planning cycle along with systematic needs assessment could provide a useful framework for guiding the design of rigorous and appropriate evaluation. It is also essential to develop structures and mechanisms for building the capacity of service systems to evaluate their activities more comprehensively.

One possible approach to addressing the current deficits in the infrastructure and support available for service evaluation is for major service systems (such as Mental Health Services, Divisions of General Practice and Community Health Services) to work in partnership to establish dedicated Evaluation and Research Support Units *(Recommendation 1.1, first dot point)*. These would need to be staffed by highly skilled, multidisciplinary teams of three to five staff and be closely linked to Area and Regional planning structures *(Suggestion 1.1a)*.

The mandate of Evaluation and Research Support Units should be to:

- provide evaluation support to services in their jurisdiction and to partners of these services (that is, non-government organisations and individual GP practices); and
- conduct, coordinate and participate in large scale (statewide and national) evaluations (for example, multisite trials in partnerships with services, universities and community agencies).

It is vitally important that such Evaluation and Research Support Units be highly accessible and responsive to the needs of service providers *as their major priority* and do not simply become semi-independent academic research centres or institutes that are oriented to creating and driving their own research agenda. Many such academic research centres focusing on specific issues already exist, but these have not addressed themselves systemically to the needs of service development research and evaluation.

During the 1990s the Commonwealth established a number of Support and Evaluation Research Units which worked with Divisions of General Practice to support the integration of general practice with the activities of the wider public health system and to facilitate research and evaluation in general practice. There is a perception that the Units have played a valuable role in this regard but that they generally lacked the resources required to play an adequately 'hands on' role in supporting rigorous service evaluation. The Units have recently been defunded even though they have not been evaluated. Evaluation of this model could provide some important insights.

Governments and Area/Regional authorities would need to direct careful attention to ensuring that the structure and management of Evaluation and Research Support Units ensures ongoing commitment to their role in building the evaluation and research capacity of local service agencies. Within these essential defining parameters, the precise structure and roles of the Units in each area should be determined according to the specific needs of local areas including the existing capacity of service systems and the health and social issues that have been identified as priorities for local populations. In some areas Public Health Units may already be providing useful epidemiological data relevant to population health needs, but in others the Evaluation and Research Support Units could play a major or primary role in the needs assessment phase of the planning-evaluation cycle.

To ensure that Evaluation and Research Support Units remain focused on their responsibilities to local services and communities, it is important that they be designed and managed as part of a broader intersectoral strategic planning process driven by government and local areas/regions. However, this process would need to be led by one particular sector, such as Mental Health.

To this end, it is recommended *(Recommendation 1.2)* that each Area/Regional Health Service 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.

In order to facilitate the development and implementation of Mental Health Evaluation and Service Development Research Strategies by Areas/Regions, the states and territories could consider developing a complementary strategy that provides guidance to Areas/Regions and identifies supportive functions that need to be conducted at a state/territory level *(Suggestion 2a)*.

These Mental Health Evaluation and Service Development Research Strategies should be developed in partnership with local area managers, all relevant sectors, as well as community agencies, service users and young people. They should also include ongoing communications activities such as workshops, events, publications and newsletters aimed at enhancing awareness of service providers and others of the existence of the strategy and the range of resources and supports that are being made available to assist them in conducting evaluation and service development research.

Another important type of data relevant to service evaluation and planning at a state and national level is data that allows comparisons to be made between different communities. Working independently, neither individual agencies nor area-wide Evaluation and Research Units would be capable of generating such data. The Commonwealth and state/territory governments need to collaborate to enhance monitoring and surveillance of child and adolescent mental health problems as well as risk and protective factors for suicide at a national level.

Better data are also needed about service systems and the implementation and outcomes of programs that are implemented on a wide scale. Data systems need to be able to regularly generate comparative data about activities, resources, and staffing of a range of services including: child and adolescent mental health services; primary health care services (GPs, community health, youth health services); local government services including generalist youth services and programs for young people; and government and non-government social welfare services.

One immediate possibility is for 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 *(Recommendation 1.1, third dot point)*. This has been recommended in the New South Wales Child and

Adolescent Mental Health Policy *Making Mental Health Better for Children and Young People* (NSW Health 1999).

Once data are collected they need to be analysed and reported in a form that is useful for policy makers and service providers. This is a task for Evaluation and Research Support Units.

The need for information that provides a picture of progress across states and territories highlights the importance of states and territories taking a lead on policy development and strategic planning in building capacity for evaluation.

Recommendations and suggestions

"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:

1.1 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.

(This is Recommendation 26 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

1.1a Dedicated Evaluation and Research Support Units should be developed in partnership between major service systems such as Mental Health Services, Divisions of General Practice and Community Health Services, and be staffed by highly skilled multidisciplinary teams of three to five staff. These Units should be closely linked to Area and Regional planning structures and their mandate should be to:

- provide evaluation support to services in their jurisdiction and to partners of these services (that is, non-government organisations and individual GP practices);

- conduct, coordinate and participate in large scale (statewide and national) evaluations (for example, multisite trials in partnerships with services, universities and community agencies).

It is recommended that:

1.2 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.

(This is Recommendation 27 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

1.2a In order to facilitate the development and implementation of Mental Health Evaluation and Service Development Research Strategies by Areas/Regions, the states and territories should develop a complementary strategy that provides guidance to Areas/Regions and identifies functions that need to be conducted at a state/territory level.

Project reports

AIFS (1998), *Youth Suicide Prevention Programs and Activities: National Stocktake April 1998*, Australian Institute of Family Studies, Melbourne.

AIFS (1999), *Youth Suicide Prevention Programs and Activities: National Stocktake October 1999*, Australian Institute of Family Studies, Melbourne.

Beautrais, A. (1999), "Risk factors for suicide and attempted suicide amongst young people", in Commonwealth Department of Health and Aged Care, *Youth Suicide Literature Review: Setting the Evidence-based Research Agenda for Australia*, AGPS, Canberra.

Beckinsale, P., Martin, G. & Clark, S. (1998), *Keep Yourself Alive Evaluation Report: General Practitioners*, Southern CAMHS, Bedford Park, SA.

Brann, P. & Sutherland, S. (1999), The Staying Alive Project: Draft Final Report (May), Maroondah Hospital Area Mental Health Service. (Unpublished)

Cantor, C.H., Neulinger, K., Roth, J. & Spinks, D. (1999), "The epidemiology of suicide and attempted suicide among young Australians", in Commonwealth Department of Health and Aged Care, *Youth Suicide Literature Review: Setting the Evidence-based Research Agenda for Australia.* AGPS, Canberra.

Fry, A., Teesson, M., Moloney, B., Roseby, S., O'Riordan, D. & Zurynski, Y. (1999), *Blacktown Youth Suicide Prevention Project: Final Report*, University of Western Sydney Nepean, Kingswood.

Goldflam, A, Chadwick, R. & Brown, G. (1999), *"Here for Life" Youth Sexuality Project: Eval.uation and Final Report*, WA Aids Council, Perth.

Howe, D., Temple, L., Mackson, C. & Teesson, M. (1999), *Catch Us if U Can: Young People and Psychiatric Illness: Intervention and Assessment*, Central Coast Area Health Service, Gosford.

Hunter, E., Reser, J., Baird, M. & Reser, P. (1999), "An analysis of suicide in indigenous communities of North Queensland: the historical, cultural and symbolic landscape", Department of Social and Preventive Medicine, University of Queensland. (Unpublished)

Kelk, N. (1999a), "Report on a group of clients attending High Street Youth Health Service," School of Community Medicine, University of NSW, Sydney. (Unpublished).

Kelk, N. (1999b), "Report on a group of clients attending Cellblock Youth Health Service", School of Community Medicine, University of NSW, Sydney. (Unpublished).

Kelk, N. (1999c), "Some general comments on eight Here for Life projects conducted at three youth health services", School of Community Medicine, University of NSW, Sydney. (Unpublished).

Keys Young (1997), *Research and Consultation Among Young People on Mental Health Issues*, Commonwealth Department of Health and Family Services, AGPS, Canberra.

King, R., Nurcombe, B. & Bickman, L. (1999), *Kids Help Line Suicide Intervention Strategy Evaluation: Report 2 – The Implementation, Impact and Outcome of Suicide Prevention Training for Telephone Counsellors*, Department of Psychiatry, University of Queensland, Brisbane.

Martin, G., Roeger, L., Marks, L. & Allison, S. (1999), "Final evaluation report for the Centacare Youth Suicide Intervention Program", Southern Child and Adolescent Mental Health Service, Adelaide. (Unpublished).

Patton, G. & Burns, J. (1999), "Preventive interventions for youth suicide: a risk factor based approach", in *Setting the Evidence-based Research Agenda for Australia: A Literature Review*, National Youth Suicide Prevention Strategy, Commonwealth Department of Health and Aged Care, Commonwealth of Australia, Canberra.

Pfaff, J.J., Acres, J.G. & McKelvey, R.S. (1998), *National General Practice Youth Suicide Prevention Project: Final Report*, Perth Central Coast Division of General Practice, Subiaco.

Ridge, D., Hee, A. & Aroni, R. (1999), "Evaluation of the Connexions Youth Suicide Prevention Initiative", School of Public Health, La Trobe University, Melbourne. (Unpublished).

Rolfe, A. & Turley, B. (1999), "Lifeline Australia youth suicide prevention project: interim evaluation report volume 1", Lifeline. (Unpublished).

Toumbourou, J. & Gregg, E. (1999), *Program for Parents: External Evaluation Report*, Centre for Adolescent Health, University of Melbourne.

Vajda, J. & Steinbeck, K. (1999), "The acute care responses to prevent youth suicide in the CSAHS: final report", Central Sydney Area Health Service. (Unpublished).

Ward, T., Neville, M. & Jones, R. (1999), "Listen as if life depended on it: draft final report (February), Mackay Integrated Mental Health Service. (Unpublished).

Other references

Bickman, L. (1996), "The application of Program Theory to the evaluation of a managed mental health care system", *Evaluation and Program Planning*, vol. 19, no. 2, pp. 111-119.

Department of Finance (1994), *Doing Evaluations: A Practical Guide*, AGPS, Canberra.

Kiresuk, T.J. & Sherman, R.E. (1968), "Goal Attainment Scaling: a general method for evaluating comprehensive community mental health programs", *Community Mental Health Journal*, vol. 4, no. 6, pp. 443-453.

Kurtz, Z. (1996), *Treating children Well: A Guide to Using the Evidence Base in Commissioning and Managing Services for the Mental Health of Children and Young People*, The Mental Health Foundation, London.

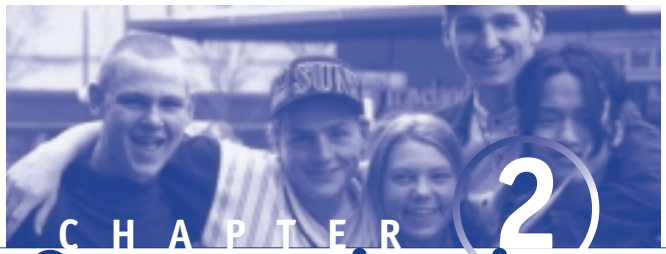
Mitchell, P. (1999a), "First national stocktake of youth suicide prevention activities: a content analysis, *Youth Suicide Prevention Bulletin*, no. 2, January, pp. 2-7.

Mitchell, P. (1999b), "Primary prevention of youth suicide in Australia", *Youth Suicide Prevention Bulletin*, no. 2. January, pp. 12-19.

Mitchell, P. (2000), *Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy*, Australian Institute of Family Studies, Melbourne.

NSW Health (1999), *Making Mental Health Better for Children and Young People*., NSW Health Department, Better Health Centre, Gladesville.

Wells, K.B. (1999), "Treatment research at the crossroads: the scientific interface of clinical trials and effectiveness research", *American Journal of Psychiatry*, vol. 156, no. 1, pp. 5-10.



CHAPTER 2

Communications

This chapter presents and analyses information about the communications activities funded under the National Youth Suicide Prevention Strategy.

The aim of communications activity was to ensure that professionals have access to the information they need to develop good practice in youth suicide prevention. The specific aims were to maximise the "reach" of information dissemination, and to meet the communications needs of those who are reached.

Details of the main communications projects and activities funded under the Strategy are shown below. One recommendation (2.1) is provided at the end of the chapter.

Communications activities

This chapter reports the results of the formal evaluation of the communications activities of two projects (Table 2.1): the *National Communications Project*, based at the Australian Institute of Family Studies, which was the major communications vehicle for the Strategy as a whole; and *AusEinet,* based at Flinders University and the University of Adelaide, which also included a substantial communications component focused around early intervention into mental health problems affecting young people.

Many of the projects funded under the Strategy included communications activities. Unfortunately much of this activity was not evaluated. Information about other communications activities specific to particular direct prevention approaches is reported in other volumes of the Technical Report series, as appropriate.

National Communications Project

The National Communications Project based at the Australian Institute of Family Studies had primary responsibility for regularly disseminating information about Strategy activities and other suicide prevention activities to stakeholders

TABLE 2.1 Communications projects of the Strategy

Project name	Organisation	Main strategies	Evaluation design and/or methods (networking component)
National Communications Project	Australian Institute of Family Studies	Bulletin, website, email discussion list, conference seminars, library, personal assistance, stocktakes	Random sample telephone survey of central mailing list, Convenience sample survey of Bulletin readers and electronic mailing list
AusEinet	Flinders University and the University of Adelaide	Newsletter, website, workshops, email discussion list, stocktakes	Survey of network members

working in the area of youth suicide prevention. The design of the project was based primarily on the results of a needs analysis of potential users. A total of 897 replies were received to the survey, from a very wide variety of stakeholders. Users expressed a need for a variety of forms of communication including printed, electronic and face-to-face.

In response to strong support for newsletters and discussion papers, the National Communications Project published a series of Youth Suicide Prevention Bulletins which contained a mix of articles including at least one substantial feature plus shorter newsletter-style items including descriptions of projects, book and article reviews, forthcoming events, information about state and territory activities, and discussion of theoretical and practice issues.

An Internet site was established which contains information on state and territory prevention strategies; updates on the Commonwealth Strategy; statistics and bibliographies; links to Australian and overseas websites and electronic publications; links to telephone counselling services; news of forthcoming conferences and events; and access to the databases of the National Stocktakes of Youth Suicide Prevention Activities. An email discussion list was also established to promote the exchange of information and ideas between professionals working in the field of youth suicide prevention.

In collaboration with state and territory health and community services departments, the Institute undertook two stocktakes of youth suicide prevention activities throughout Australia. These resulted in the collection of data relating to approximately 1500 projects or activities. Results were consolidated for distribution via print and electronic media. Analysis of data from the first stocktake provided

information about areas of strength and weakness in current prevention activity and was published in the Youth Suicide Prevention Bulletin and on the website.

In its capacity as an information service and clearinghouse, the Institute's Family Information Centre acted as a referral point for individuals and organisations seeking information about suicide prevention programs and activities. In a two-way involvement with the community concerned with youth suicide prevention, interested people were invited to contribute articles, news items, notices about conferences and so forth to publications, workshops and the Internet site. The Institute also: ran seminars, symposia and workshops focusing on good practice in youth suicide prevention on 12 occasions in different locations throughout Australia; distributed materials and publications emanating from the National Youth Suicide Prevention Strategy; and published and distributed Youth Suicide Prevention Bulletins to a mailing list of nearly 7000 individuals and organisations. The Communications website is located at: http://www.aifs.org.au/ysp/.

AusEinet

AusEinet (Australian Early Intervention Network for Mental Health in Young People) was funded jointly by the National Youth Suicide Prevention Strategy and the National Mental Health Strategy. Its aim is to promote the development of early intervention services and programs.

During the course of the National Youth Suicide Prevention Strategy, the AusEinet project had three interrelated streams. Stream I involved the development and maintenance of a national network involving clinicians, researchers, policy makers, consumers and carers; communications were a major component of Stream I activities. AusEinet has published regular newsletters; developed an Internet site (http://AusEinet.flinders.edu.au); runs an email discussion list; undertaken two national stocktakes of early intervention programs; hosted a major conference on early intervention (in June 1999); and published an international literature review. Based on work conducted in Streams II and III of the project, AusEinet has also published a book describing model projects which aimed to reorient services towards early intervention in the mental health of young people and a series of guides on clinical approaches to early intervention in child and adolescent mental health.

Results of the evaluation

This chapter reports the findings of a meta-analysis of the evaluations of the National Communications Project and the communications activities of Stream I of AusEinet. Information is organised around the two main strategic aims of communications activities – namely, maximising the total reach of information dissemination, and meeting the communications needs of those who are reached.

Within these two overarching aims the results are organised around the different types of communications media or strategies used by the two projects.

Discussion focuses on the strengths and weaknesses of the different strategies in regard to the two main strategic aims.

What works to maximise the total reach of information dissemination?

Various methods were used to collect information about the reach of the various communications strategies used by the National Communications Project. Each of these methods involve sampling biases because they rely on samples drawn from groups using particular forms of communication.

One of the more reliable sources of information about the relative effectiveness of the various communications strategies used by the National Communications Project was a survey of a random sample of project stakeholders using a computer assisted telephone interview (CATI). This involved a sample of 211 respondnets drawn randomly from the National Communications Project mailing list of approximately 7000 people (3 per cent sample).

The National Communications Project CATI sample included professionals from a variety of different sectors including: mental health (26 per cent); other health (18 per cent); social welfare (21 per cent); youth services (15 per cent); education (13 per cent); justice system (3 per cent) and other government (5 per cent). The sample comprised a broad cross-section of different types of professionals including: researchers (6 per cent); other information providers (14 per cent); education and training professionals (18 per cent); and service users and providers (59 per cent). In order to assess the relative reach, or penetration, of different types of communications into different types of audience, comparisons were made between two main types of audience: service providers (n=104), and researchers/information generators (n=40).

An important negative indicator of the effectiveness of targeting is “mistargeting”. Only a very small percentage of respondents in the National Communications Project CATI survey (less than 5 per cent) indicated that they might have been misidentified as interested users. The external evaluator of the National Communications Project noted that the project exceeded the expectations or success criteria set by the funders in regard to audience reach or penetration (Tanney 2000).

The main method used to evaluate communications activities of AusEinet was a General Evaluation Survey which examined knowledge of and attitudes towards AusEinet in a random sample of AusEinet members (Burgess, Fleming and Browne 1999). Ten per cent of people on the AusEinet mailing list (structured as 10 per cent from each state) were sent a questionnaire in the mail. A total of 277 questionnaires were distributed and 154 completed replies were returned, a response rate of 56 per cent. Respondents to the survey came from a variety of sectors including: health (38 per cent); education (7 per cent); family and youth services (7 per cent); as well as different types of organisations.

➤ *Printed publications*

Printed publications appeared to be one of the most effective communications strategies in terms of total audience reach.

Of the 211 respondents in the National Communications Project CATI random sample survey, 89 per cent were aware of the Youth Suicide Prevention Bulletin. Of these, 97 per cent had used the Bulletin. The data suggest that penetration of the Bulletin into the two main types of audience (service providers and researchers/information generators) was equivalent (Tanney 2000).

The National Communications Project produced three Youth Suicide Prevention Bulletins over the course of the initial two-year project. The funding body initially hoped that 2500 copies of three issues of a bulletin would be distributed. In fact, 5000 copies of the first and second were distributed and 8000 copies of the third. This reflected an increase in demand for information about youth suicide prevention as indicated by the size of the mailing list, which increased from approximately 2000 at the start of the project to 7000 by mid 1999.

AusEinet produced the AusEinetter Newsletter on a quarterly basis and a total of eight were published over the three years to June 1999. The AusEinetter was distributed to all names on the mailing list. Of the 154 respondents to the AusEinet General Evaluation Survey, 87 per cent reported receiving the newsletter.

➤ *Internet site*

There are indications that internet sites are highly effective in maximising the reach of information dissemination. Since the initiation of the National Communications Project website in July 1997 the average number of visits (or "hits" increased from 2726 per month in the last six months of 1997 to 12,300 per month in the first four months of 2000. Use of the site tends to be higher at the beginning (February to April) and the end (October to November) of the year, however the average monthly number of visits for 1998 (4773) and 1999 (7231) confirm that use of the website has increased steadily over the past three years.

A major difficulty in using number of visits as an indicator of reach is that a substantial proportion are likely to be repeat visits by the same users. Nevertheless, the large number of visits to the Australian Institute oif Family Studies Youth Suicide Prevention website suggests that this means of communication may have been the most effective of the various strategies in terms of total audience reach, alongside the Youth Suicide Prevention Bulletin.

Of the 211 respondents to the National Communications Project CATI survey, 71 per cent were aware of the Internet site, and of these, 38 per cent had accessed the site. These data suggest that the Internet site is likely to be reaching an audience that extends beyond the group captured on the mailing list (n=7000) from which the CATI sample was drawn. The data suggest that the two main types

of audience (service providers and researchers/information generators) were equally successful in accessing the Internet site (Tanney 2000).

In a question about access to electronic media, 44 per cent of CATI survey respondents indicated experiencing a lack of access to the Internet. In their free form comments, respondents in the survey of Internet site users expressed positive comments about ease of use of the site six times as often as negative comments about site operation.

AusEinet also established an Internet site. Of the 211 respondents in the AusEinet General Evaluation Survey, 22 per cent reported having accessed the website. The AusEinet website was designed to "establish a network presence and provide mechanisms for key stakeholders to influence the field" (Martin and Kosky 1997; cited in Burgess et al. 1999: 27). The external evaluators found that it is difficult at this point to assess the contribution the website has made to the Network as a whole. The evaluation found that the website was not yet being widely accessed by the child and adolescent health community. However, the evaluators argue that if it is expanded to include information currently being prepared, regularly updated to reflect current practice and promoted through a variety of sources, the website would become more widely used. They also suggest that it could become more integral as access to the internet expands (Burgess, Fleming and Browne 1999).

➤ *National stocktakes of programs and activities*

Participation in the two National Communications Project national stocktakes of youth suicide prevention programs and activities exceeded the expectations of the funding body. It was hoped that 200–500 responses would be received; in fact, the first stocktake generated 912 responses and the second generated 709.

AusEinet also conducted two stocktakes of early intervention activities targeting mental health problems of young people. Stocktake forms were distributed to the 2550 people on the mailing list in 1998 and 119 completed forms were returned. The second stocktake form was distributed to 2710 people in 1999 and 182 completed forms were returned.

The levels of awareness of the stocktakes among stakeholders was relatively low compared with other communications products in the case of both the National Communications Project and AusEinet. Of the 211 respondents to the National Communications Project CATI survey, 66 per cent were aware of the stocktakes, and of these, 57 per cent had used or accessed information about the stocktakes. Of the 154 respondents to the AusEinet General Evaluation Survey, only 57 per cent were aware of receiving the first stocktake publication, while 8 per cent were unsure.

Tanney (2000) concludes that audience awareness of the two National Communications stocktakes was disappointingly low compared with other communications

products, especially considering the fact that stocktake data were available in printed and electronic format. One likely explanation of this low awareness is that printed publications were not distributed to all stakeholders in the pool from which CATI respondents were drawn. They were only distributed to organisations that had participated in the stocktakes. More comprehensive distribution would likely have boosted awareness, as well as participation in the case of the second of the stocktakes. However, with a mailing list of 7000, the cost of this was beyond the financial capacity of the project. The decision to distribute the printed stocktake publications only to respondent organisations appears unfortunate because it might be expected that agencies that did not currently have any suicide prevention activities in place would be in greater need of information and ideas such as those contained in the stocktakes than agencies that did already have programs in place.

It is notable that levels of awareness of the two AusEinet stocktakes was also relatively low. It is possible that specific awareness of each stocktake may have been reduced or diluted because of confusion about the relationship between the two projects. However, such confusion may also be expected to be associated with general awareness of the fact that stocktakes of some sort were occurring.

➤ *Email discussion list*

Of the 211 respondents to the CATI survey, 26 per cent were aware of the National Communications Project email discussion list and, of these, 26 per cent had subscribed to the discussion list. In mid 1999 the total number of subscribers to the list was 207 and this number continues to increase gradually and steadily over time. The list has experienced very few de-subscriptions.

Compared with their representation in the broader CATI survey sample, researchers/information generators are over-represented compared to service providers among users of the email list. However, the body of email list users includes good numbers of service providers. In a question about access to electronic media, 20 per cent of CATI respondents indicated experiencing a lack of access to email. Tanney (2000) finds that while the email discussion list format is not a medium of communication that is preferred by a majority of stakeholders, the significant minority who do use it find it to be a convenient form of communication.

The email list was found to be particularly useful for generating and facilitating new subscriptions to the National Communications Project more broadly. The Research Fellow received many requests (via email) for subscription to the traditional mailing list, as well as the email list, from individuals after they had been forwarded information by colleagues who were members of the email list.

The AusEinet project also included an email discussion list but the evaluation report does not include an evaluation of this component of the project.

➤ *Conference seminars and workshops*

The National Communications Project conducted 15 conference seminars/presentations/workshops over the course of the project. Nine of these involved seminars/workshops which showcased a variety of youth suicide prevention projects including but not exclusively funded under the National Youth Suicide Prevention Strategy. Other presentations involved the Research Fellow speaking about the Strategy in general or the results of research conducted by the Communications Project. Seminars/workshops and other presentations were conducted in a number of capital cities and regional centres. They were generally delivered as part of other larger conferences in order to enhance attendance and minimise costs.

Of the 211 respondents to the National Communications Project CATI survey, 74 per cent were aware of the series of conference seminars and workshops, of whom 19 per cent had attended one or more of these. It is likely that the conference seminars reached an audience that extended beyond those people on the project mailing list, but no data are available as to the extent of this. Numbers of people attending events ranged from a high of approximately 300 at the 1998 Child and Adolescent Mental Health Services conference in Sydney to a low of 20 at a National General Practice conference in Melbourne. Average attendance was approximately 50 participants.

Workshops/seminars were a key early strategy of the AusEinet Project designed to rapidly increase awareness of the project and recruit network members. Eleven workshops were organised around Australia between October 1997 and July 1998, with a total of over 1000 participants attending.

The evaluators found that this strategy was largely successful in establishing a profile for the project. Where possible, workshops were scheduled to precede other related conferences (for example, the CAMHS Conferences in Adelaide and Sydney) and this helped to attract greater numbers of participants to AusEinet workshops.

➤ *Mailing list*

The mailing lists developed and maintained by both the National Communications Project and AusEinet were found to be highly valuable in facilitating the reach of communications activities.

By mid 1999, the National Communications Project had a mailing list of more than 7000 people, well surpassing expectations. Specific opportunities to subscribe to this mailing list were provided in brochures, the Youth Suicide Prevention Bulletin, and the Internet site. Tanney (2000) observes that there is evidence that much interest and subscription was generated through word of mouth. He also notes that growth through word of mouth is usually a reflection of a valued and useful product and is accomplished inexpensively.

The subscription process was successful in generating and maintaining a body of users that was focused and highly aware of their status as stakeholders in the

Strategy. Only a very small number of evaluation responses (less than 5 per cent) indicated that the materials sent were inappropriate for the people who had received them.

The external evaluation of AusEinet found that the AusEinet database of members was the core of the network. The database formed the distribution system for most of the communications generated by AusEinet and was found to be an effective tool for this purpose. The external evaluators recommend that the AusEinet network database be maintained.

At the time of the evaluation the AusEinet database included 2710 individuals/agencies and it has continued to grow. However, the evaluators were somewhat concerned about evidence that a significant minority of database members (8 per cent) had not heard of AusEinet. This may have been due to an initial recruitment strategy which involved procurement and amalgamation of mailing lists from a number of other sources. At this stage individuals were not required to make an active decision to subscribe or join AusEinet, they were just included automatically. This "passive" recruitment strategy may have led to a number of people being included in the network who did not have an active interest in the issues being addressed by AusEinet. Burgess, Fleming and Browne (1999) also recommend that mailing list members be contacted regularly to confirm their involvement and nominate further participants.

What works to meet the communication needs of those who are reached?

The external evaluator of the National Communications Project concluded that the project "generated very significant accomplishments" in meeting the communications needs of stakeholders (Tanney 2000). Respondents who were aware of particular program operations almost universally endorsed their usefulness and continuation. More of every product was a regular request from users.

In the National Communications Project CATI survey, 84 per cent of respondents verified the contribution of the National Youth Suicide Prevention Strategy to the sharing of information within their sector, and 70 per cent verified its contribution to sharing across different sectors. All program operations of the National Communications Project were observed as contributing to networking within and across sectors, except the Internet site. Researchers and professionals whose work involved the generation and dissemination of information had a stronger tendency to verify the information sharing role of the Strategy than service providers, especially with respect to cross sectoral sharing.

➤ *Printed publications*

The effectiveness of the Youth Suicide Prevention Bulletin in meeting the information needs of users was evaluated using the CATI survey described above

and a survey of subscribers recruited by distributing an evaluation questionnaire with the third issue of the Youth Suicide Prevention Bulletin.

Of the 182 CATI respondents who had used the Bulletin, 98 per cent said it was useful and 99 per cent endorsed its continued availability. The proportions of service providers compared with researchers who found the Bulletin useful was comparable.

More detailed information about the value of the Bulletin to users was obtained from the survey which was distributed to readers with the third issue of the Bulletin. Of the 7000 subscribers, 374 returned the completed questionnaire. An additional 347 replies expressed interest in learning more about the entire National Youth Suicide Prevention Strategy by requesting to be included in future correspondence and communication. Between 75 and 87 per cent of respondents endorsed the various major content areas included in the Bulletin as interesting or useful. Even when particular content issues were not generally endorsed, those respondents who did value them tended to describe them as especially informative. This suggests that the content of the Bulletin was meeting the needs of a diverse general readership as well as particular specialist interest groups.

Respondents were asked to provide general free form comments, and 83 per cent did so. The vast majority of comments were positive. The most frequent descriptors used were: informative (27 per cent), valuable (17 per cent), current (13 per cent), value material about intervention activities (13 per cent), valuable enough to share (10 per cent), good networking resources (9 per cent). Layout and style were mentioned in positive terms. The most consistent criticism (n=4) was the "density" and overwhelming nature of the information. While some found the content too broad and diverse (n=10), others valued the breadth (n=15).

Respondents were also asked to make suggestions for changes. There were no consistent suggestions for improvement. Seven per cent requested a more "basic and grassroots" approach while an equal proportion asked for more "focused and expert" content. This suggests that a balance between these two types of content is appropriate and that this was generally achieved.

Of the 154 respondents to the AusEinet General Evaluation Survey, 87 per cent reported receiving the newsletter and 72 per cent of these found it either relevant or extremely relevant. Respondents consistently ranked the AusEinetter newsletter as the most useful of all AusEinet strategies. This was attributed to its broad dissemination to all network members, its broad range of information, resources and contacts, and its regularity (quarterly). Thirty-four free form comments were received about the newsletter and the great majority were very positive. Suggestions for changes to the newsletter revolved around a stronger focus on the practical application of early intervention and more detail about specific subjects. The external evaluators concluded that the AusEinetter was the most useful and accessible of all AusEinet Stream I activities and "a major contributor and an

effective strategy in developing and sustaining the national network" (Burgess, Fleming and Browne 1999: 20).

➤ *Internet site*

Of the 150 CATI survey respondents who were aware of the National Communications Project internet site, only 57 (38 per cent) had accessed the site but only 5 per cent indicated an explicit lack of interest in the site. Of those that had used it, 94 per cent indicated the site was useful and 100 per cent endorsed its continued availability. The proportions of service providers compared with researchers who found the site useful were comparable.

Evaluation of the AusEinet website included several questions in the General Evaluation Survey and in-depth interviews with five users. Of the 22 per cent of respondents in this survey who had accessed the site, 77 per cent found it useful or very useful and 65 per cent said they would recommend it to others. In-depth interviews with five users provided some useful information about the general characteristics of websites that enhance their useability. The five users were identified by the Evaluation Team in consultation with AusEinet staff. These people included a primary school teacher, a mental health worker, a general practitioner, a young person (18-year-old male), and a Community Health Manager in a rural area. Each participant was asked to navigate around the website and was given a series of tasks and questions to complete. Interviews went for about 45 minutes.

Four major themes emerged regarding "good practice" on Internet sites:

- Authorship of the site must be clear. This is important in relation to the credibility of information presented.
- Updating and maintenance of the site and contents was identified as critical for credibility. Users expressed a desire for inclusion of a notice as to when information was last updated and the processes used to update.
- Finding the site should be as easy as possible. It is important that an internet site can be readily found by users who do not know the exact address. This is facilitated if the name of the site includes the key words it is concerned with.
- Navigability, or finding ones way around a website, was observed to be easier when material is organised in a logical fashion and presented using consistent or standardised visual aids including fonts, colours and backgrounds. Clear indexing of material is also helpful. For example, as more complex information is added to a website it is useful if larger documents are flagged by summary or index boxes for quick reference at the beginning.

At the time of the evaluation the AusEinet website had some problems in all these areas but most of these have now been addressed.

The AusEinet website was designed to "establish a network presence and provide mechanisms for key stakeholders to influence the field" (Martin and Kosky 1997;

cited in Burgess et al. 1999: 27). The external evaluators found that it is difficult at this point to assess the contribution the website has made to the network as a whole. Evaluation of the National Communications Project found that, compared with other communications strategies, the Internet site was not perceived as contributing significantly to networking.

➤ *National stocktakes of programs and activities*

Of the National Communications Project CATI survey respondents who were aware of the national stocktakes, 93 per cent said they were useful and 97 per cent endorsed their continued availability. A higher proportion of researchers than service providers found the stocktakes to be useful. Content analyses were conducted on data from the stocktakes and published in the Youth Suicide Prevention Bulletins and on the website. While the usefulness of this work was not evaluated specifically, the National Communications Project Research Fellow has received numerous requests for further information by stakeholders who had read these reports and found them useful.

Of the 154 respondents to the AusEinet General Evaluation Survey, only 57 per cent were aware of receiving the first stocktake publication, while 8 per cent were unsure. Of those who received it, 92 per cent reported using it and 41 per cent of found it "definitely helpful". Evaluation forms were also distributed with the AusEinet stocktake publications. Forty-seven forms were returned from the first stocktake report. Overall, the responses were positive with respect to both quality and quantity of information. The report was welcomed as a useful resource for information on early intervention programs around Australia. Mental Health Workers in Stream II of AusEinet working to reorient services to early intervention reported the stocktakes to be useful in their practice.

Following distribution of the stocktake publications, both AusEinet and the National Communications Project were contacted by a variety of agencies whose activities had not been included, indicating that the stocktakes were contributing to increasing awareness and expansion of networks.

➤ *Email discussion list*

Of the CATI survey respondents who were aware of the Youth Suicide Prevention email discussion list, 90 per cent said it was useful and 98 per cent endorsed its continued availability. A somewhat higher proportion of service providers than researchers/information generators found the email discussion list to be useful.

Twenty-three people responded to the survey of email list users. Most used the list as a source of current and broadly based information, not only to learn about issues within their own sector (74 per cent) but also to read beyond their interest area (90 per cent). Sixty per cent reported some increased breadth of appreciation of the entire subject but a similar number noted little change in the

depth of understanding about their own subject area. Respondents commented that the list contributed to networking within and beyond their sector of interest of involvement. Activity and interaction on the list was not high, with only 41 per cent ever posting an original item and two-thirds replying to a message but only rarely. However, 92 per cent felt that their involvement was "worth the time spent". Technical aspects of the email format which were observed as enhancing its usefulness include its speed (hence its currency) and the low level of investment needed to benefit from the service. The interactive capacity also observed as "allow[ing] a wide diversity of people to participate and contribute".

➤ *Conference seminars and workshops*

Of the National Communications Project CATI survey respondents who were aware of the conference seminar series, 93 per cent said it was useful and 98 per cent endorsed its continuation. Service providers and researchers/information generators found this form of communication to be equally useful.

In the CATI survey, conferences and workshops generated the greatest number of comments concerning their value as contributors to networking compared to other forms of communication. There was a very strong positive response by respondents to the educational seminars that were held in local areas (as opposed to national or state level meetings). They expressed a strong desire for more locally based seminar and workshop activity. Ten per cent of service providers asked for more networking and local resourcing when asked what other information would have been useful for them. There were also numerous requests for conferences or workshops to address special interest topics.

The aim of the AusEinet workshops/seminars was to stimulate interest and discussion on early intervention and to raise awareness, as well as collect information from stakeholders about their activities and the issues they were concerned about. Eleven workshops were held around Australia between October 1997 and July 1998 with over 1000 people attending. Of the 157 respondents in the AusEinet General Evaluation Survey 31 per cent had taken part in the AusEinet seminars and 68 per cent of these respondents found them to have been relevant or very relevant while 28 per cent found them not particularly relevant. Thirteen per cent of these respondents felt the seminar did not provide them with enough tools to begin including early intervention in their daily work; however 91 per cent of respondents said they would like to attend another seminar in the next 12 months.

Internal evaluation of the AusEinet seminars/workshops indicated that they were successful in: connecting people directly involved with or interested in the mental health of young people; expanding the AusEinet network membership; conveying information about the AusEinet project; and exchanging information about needs, theoretical approaches to early intervention, range of services available, opportunities, gaps, constraints to reorientation.

General discussion

From its inception, the National Youth Suicide Prevention Strategy has recognised the importance of effective communication and has placed considerable emphasis on ensuring that comprehensive communications systems were developed. The experience of developing these systems has reaffirmed the high levels of need for high quality information among a diversity of users, including researchers, practitioners and policy makers, and the need for a diversity of communications strategies in order to reach all relevant stakeholders.

The value of communications activities in helping to build capacity for activities such as suicide prevention has also been reaffirmed. For example, the external evaluators of AusEinet conclude that "sustainability and maintenance of Stream I (mostly communications) strategies are vital to the ongoing process of improving knowledge, commitment and reorientation of early intervention in mental health in young people in Australia" (Burgess et al. 1999: 35).

The National Communications Project and AusEinet can be seen as having paid attention to the infrastructure, vehicles and content required for effective communication (see Burgess et al. 1999 for further discussion of these issues). There is evidence that both the National Communications Project and AusEinet were successful in reaching large and broad audiences.

Evaluation of these two major communications projects also provided insight into the way that communications activities interact with other approaches to systems level capacity building, particularly networking and intersectoral collaboration.

Communications and networking

The role of communications activities in enhancing networking among professionals was a question of major importance in the evaluations of both the National Communications Project and AusEinet. The evaluations concentrated on the question of which types of communications activities were the most useful in this respect. The data suggest that conferences/workshops/seminars – in other words, face-to-face forms of communications – are the most effective forms of communication for enhancing networking.

However, the role of communications in networking needs to be considered in a broader context. It is not possible to determine the extent to which these projects have contributed to the development of networks. Part of the difficulty in making this assessment relates to the absence of clear definitions and indicators of effective networks and networking (see Chapter 4 for further discussion). At this stage it is probably fair to say that both projects have contributed to the proliferation of informal links between many organisations and individuals with an interest in youth suicide prevention and early intervention, but that no cohesive or integrated network "bodies" can yet be said to exist.

Even in the case of AusEinet, which labels itself as a "network", the body of the network is not much more than a list of organisations and individuals that receive printed materials that are sent out by the project team based in Adelaide, or who participate in the Email discussion group. Within this amorphous group there are also pockets of organisations that are beginning to form closer links as a result of other AusEinet activities such as the Stream II reorientation projects and Stream III research projects. The same can be said for the general audience of the National Communications Project – the wider stakeholders of the Strategy.

While it is not yet possible to determine the extent to which communications activities of the Strategy have contributed to networking there is nevertheless reason to believe that effective communication is essential to successful networking, and particularly important for formal collaboration. One of the major barriers to closer interagency and intersectoral collaboration is a lack of knowledge about the roles and activities of organisations in other sectors and the principles, practices and roles of other sectors in general. Improving the emotional wellbeing of young people is a strong concern among practitioners and researchers working within a wide variety of sectors, but currently there remains very little knowledge or understanding about what is taking place within other sectors.

This lack of knowledge is experienced most acutely at the local service level in the form of widespread ignorance about the range of available services to which a young person at risk of suicide could be referred for appropriate assistance. This lack of knowledge can be addressed by the development of networking and direct communication systems within local areas. However, intersectoral communication and networking at local levels can be inhibited by barriers which operate at higher levels in regional, state/territory and Commonwealth departmental bureaucracies.

These problems require improved communication between stakeholders about a range of topics including: conceptual and philosophical frameworks; programs and activities; organisational systems; and Commonwealth and state/territory policy issues. At present there are few, if any, organisations that are oriented to, and have the capacity to conduct the kinds of communications functions needed to improve intersectoral understanding and collaboration.

Intersectoral collaboration and strategic communications models

As shown in Table 2.2, the National Communications Project and AusEinet each have particular strengths and weaknesses with regard to intersectoral understanding and collaboration. AusEinet has focused its communications content on the task of informing mental health and other related service providers with information relevant to clinical practice in early intervention in mental health problems, as well as capacity building change within particular service agencies. In contrast, the National Communications Project has focused on a wide range of risk and protective factors and intervention approaches relevant to youth suicide prevention, as well as issues relevant to organisational systems of a wide range of sectors.

TABLE 2.2 Key differences in the models used by the National Communications Project and AusEinet

Central focus	AusEinet	National Communications Project
Sector/problem	Mental health	All sectors
Intervention approach	Early intervention	All types of intervention approach
Capacity building	Within service provision agencies	Within agencies and across organisational 'systems'
Direction of information transfer	Within and outward from the mental health sector (instrumental)	Flow of information between sectors

Another major difference in the National Communications Project and AusEinet models concerns the direction of the flow of communication. Based firmly within the mental health sector, AusEinet primarily involved the dissemination of information collected "within" the mental health sector and "outward" to other sectors that the mental health sector sought to influence (see Figure 2.1). In other words, the communications activities of AusEinet were primarily instrumental in nature. In contrast, the National Communications Project was not representing the interests or philosophy of any particular sector. Rather from a "neutral" position it sought to facilitate the flow of information between all the different sectors that had a contribution to make to prevention of youth suicide (see Figure 2.2).

Both projects have achieved substantial success within their particular spheres of concern.

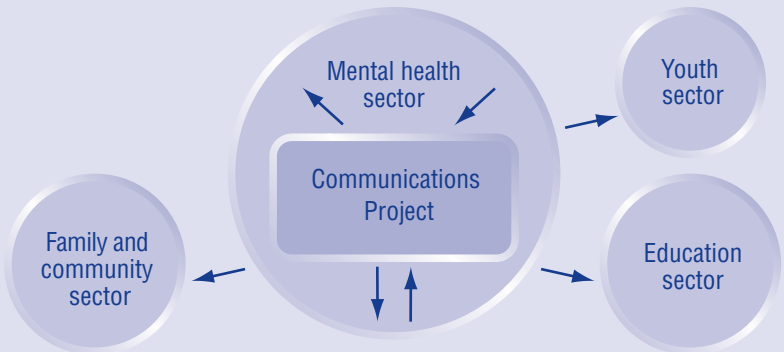
AusEinet provides a useful model of the development of communication and networking capacity "within'" a particular sector as well as communication of information outwards to other sectors (instrumental communication). It also stands as a tangible achievement of infrastructure development for communication "within" and "outward from" the mental health sector. Based within the mental health sector, AusEinet has the potential to be replicated or expanded to further enhance communications and networking within the mental health sector, and to act as a central point for the mental health sector to reach out and form links with other sectors.

The National Communications Project provides a useful model of how information might be effectively communicated "between" sectors. The project acts as a bridge or channel between sectors. However, it should be noted that the flow of information is not entirely equal as the project was fed considerably more information by the mental health sector compared to other sectors. This reflects the fact that the Commonwealth Mental Health Branch funded the National Youth

Suicide Prevention Strategy and used the Communications Project as a channel for dissemination of material published by the Commonwealth about the Strategy. It also reflect the fact that other sectors have not invested as much as mental health in developing their capacity to communicate coherently about issues relevant to youth suicide prevention.

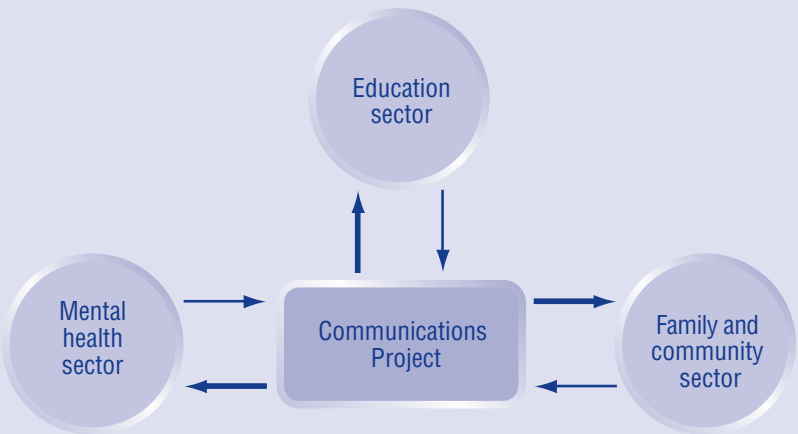
If all relevant sectors are to participate as equal partners in the project of preventing youth suicide it will be important for intrasectoral communications capacity to be enhanced. Such capacity could be developed independently, or intersectoral communications projects could be used as vehicles to help build such capacity.

FIGURE 2.1 Within sector and "outward from" (instrumental) communication



The Communications Project works on behalf of one sector to inform and change the behaviour of its own members as well as members of other sectors towards its point of view.

FIGURE 2.2 Intersectoral (between sector) communication



All sectors are communicating as equal partners and learning from each other. Communications Project helps clarify, organise and direct messages.

There is a need to maintain and somewhat expand communications activities "within", "outward from" and "between" sectors with an interest in youth suicide prevention. First, enhancement of communication "within" sectors is important in order to better identify, understand and harness the knowledge and resources that are available within particular sectors. This is a necessary precursor of any particular sector being able to effectively disseminate its message out to other sectors and to participate as a partner of equal status in dialogue between sectors.

User-driven and theory-driven content

Tanney (2000) found that the content of the National Communications Project was driven by the needs of users rather than being informed by theory. In contrast, AusEinet can be seen as more strategic or theory-driven in the content of its messages. These differences reflect the different functions of the two projects as described above.

Theory-driven content concentrates on communicating a discrete set of messages or themes which research and theory have identified as important to convey to particular groups of actors. In contrast, as a relatively neutral exercise in intersectoral communication, the National Communications Project did not seek to shape the ideas market in any particular direction. Rather, the project team encouraged contributions from stakeholders wishing to disseminate information about their projects and actively searched for unpublished research and high quality project material from a wide range of sources. There was a conscious effort to include material about topics that have not been covered well in the academic suicide prevention literature.

A theory-driven content approach is perhaps more appropriate when the aim of the project is to help a particular group of stakeholders to influence other groups in particular well defined ways. In this situation it would appear important for this content to be informed by theory and evidence about what sorts of information will be most effective in meeting their objectives. Developing such theory is a task for the particular sectors or information generators involved. On the other hand, generic communication specialists and communications projects could also play an important role in helping to develop such theory and designing communications strategies that are likely to be effective in influencing information users in particular ways.

Knowledge rather than information

Tanney (2000) observes that users of the National Communications Project expressed a preference for communication of "knowledge" compared to the communication of "information". For example, Tanney notes that users often request information that provides aid or assistance in "micromanaging" specific problems. Similarly, feedback from readers of the AusEinetter newsletter expressed a need for a stronger focus on the practical application of early intervention.

The "knowledge" requested by users appears to refer 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.

While the National Communications Project did provide a good proportion of such "knowledge" type communications, the advice of users is clearly for more of this. Tanney identifies two main barriers to meeting this need in the area of suicide prevention: first, there is often a lack of information or raw material from which to generate the requested knowledge; and second, the work required in transforming information into knowledge is very substantial and resource intensive.

Users are saying that there is currently a large gap between, on the one hand, the information or data that is generated by research publications, project descriptions and program evaluations, and, on the other hand, the kind of knowledge that they need to improve practice.

This makes intuitive sense when we consider the fact that there is indeed a very large volume of information or research data available but that service providers have very limited time to read, organise and distil key messages of relevance to their practice. Conventional publication media, such as scientific journals and professional conferences, also provide limited opportunities for the presentation of value-added material that goes beyond a description of the results of discrete research projects. Even in discussing their results, most traditional empirical researchers are shy of venturing too far from their own data into the realm of interpretation, context and implications of findings for practice and policy. Over attention to the generation of information at the expense of the dissemination of knowledge that can be used by practitioners has been previously identified as a major barrier to the achievement of many public health goals (Johnson, Green, Frankish, MacLean and Stachenko 1996).

This suggests that an important role for communication specialists in fields such as suicide prevention may be to organise and interpret the implications of research for practice. At the same time, however, knowledge is not something that can simply be imparted to users by communicators. The dissemination of knowledge via communications strategies would appear to require closer interaction or collaboration between users and producers of communication products.

Nevertheless, focused collaboration between communicators and service providers who do have time available could provide a more effective and time efficient method of generating useful "knowledge", which can then be distributed in digestible form, rather than simply expecting the majority of service providers to read basic research literature for themselves. Tanney (2000) recommends

that funding support be made available for action research models which involve service providers in the framing of questions.

Recommendations and suggestions

It is recommended that:

2.1 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.

(This is Recommendation 28 in the evaluation overview, "Valuing Young Lives".)

Project reports

Burgess, T., Fleming, J. & Browne, E. (1999), "AusEinet – The Australian Early Intervention Network for Mental Health in Young People: Final Evaluation Report", Burgess, Fleming and Associates. (Unpublished).

Tanney, B. (2000), "Evaluation of the Strategy Communication Project: Building an 'Information Highway' for Suicide Prevention". (Unpublished).

Other references

Johnson, J.L., Green, L.W., Frankish, C.J., MacLean, D.R. & Stachenko, S. (1996), "A dissemination research agenda to strengthen health promotion and disease prevention", *Canadian Journal of Public Health*, vol. 87, supplement 2, pp. S5-S10.

CHAPTER 3

Education and training

This chapter reports the results of the evaluation of the major education and training projects funded under the Strategy, as well as selected findings from the evaluation of education and training activities conducted by other projects.

The aim of education and training activity was to enhance the capacity of professionals from various disciplines to provide an appropriate service to young people and implement activities consistent with evidence concerning what is likely to be effective in preventing suicide among young people. More specifically, projects have aimed to develop and/or evaluate education and training programs targeting general practitioners, community health workers, youth workers, and other professionals who provide health and welfare services to young people. Valuable insights are also provided by several projects that have provided training to paraprofessionals and volunteers such as telephone counsellors.

Details of the main education and training projects and activities funded under the Strategy are shown below. Three recommendations (3.1, 3.2, 3.3) and five further suggestions (3.1a, 3.2a, 3.3a, 3.3b, 3.3c) are provided at the end of the chapter.

Education and training activities

Many of the projects funded under the Strategy included education and training activities. This section describes the five main education and training projects as well as the training activities of other projects that evaluated their training work (Table 3.1).

Major projects funded under the Strategy are: the National General Practice Youth Suicide Prevention Project; the Keep Yourself Alive Project; the National University Curriculum Project; the National Training Project for the Prevention of Youth Suicide; and the National Youth Suicide Prevention Strategy Resource Guide on Education and Training.

TABLE 3.1 **Summary of ten main education and training activities funded under the Strategy and conducted by other projects**

Program name	Organisation	Target groups	Modes of training	Evaluation methods
National General Practice Youth Suicide Prevention Project	Perth Central Coastal Division of General Practice	General practitioners, and community health professionals	Workshop (half-day); Handbook	Practice audit assessing competency; Standardised Instruments; Control Group
Keep Yourself Alive	Southern CAMHS and the RACGP Quality Assurance Unit	General practitioners, community health professionals, and a range of workers from other sectors	Workshop (full-day); Distance learning; VideoSatellite broadcast	Practice audit; Self-report questionnaire
National University Curriculum Project	Hunter Institute of Mental Health	Tertiary students of nursing, secondary education, and journalism	University curriculum	Pre- and post testing of knowledge and attitudes
National Training Project for the Prevention of Youth Suicide	Victoria University of Technology	Community health workers, Aboriginal health workers, and juvenile justice workers	Curriculum for the Diploma in Community Services: Youth Studies. Six units, total 64 hours. Can also be used as a stand-alone for in-services.	Pre- and post testing of knowledge and attitudes
National Youth Suicide Prevention Strategy Resource Guide on Education and Training	University of Wollongong	Purchasers of training programs	Printed and electronic resource book	Not evaluated
Kids Help Line	Kids Help Line	Telephone counsellors	Workshops (two blocks of 12 hours, each of several sessions) Manuals	Competency testing; Control group

table continued ➤

Program name	Organisation	Target groups	Modes of training	Evaluation methods
Lifeline	Lifeline	Telephone counsellors	Workshop Manuals	
Here for Life Youth Sexuality Project	Western Australia AIDS Council	A range of professionals	Workshop (full-day); Video	Pre- and post testing of knowledge and attitudes
Exploring Together Program	Victorian Parenting Centre	Potential program facilitators	Workshop	Pre- and post testing of knowledge and attitudes
Resourceful Family Project	School of Applied Psychology at Griffith University	Potential program facilitators	Workshop; Radio broadcast	Pre- and post testing of knowledge and attitudes

Other projects that conducted evaluations of training activities and which discussed the results include: Kids Help Line; Lifeline; Here for Life Youth Sexuality Project; the Exploring Together Program; and the Resourceful Family Project. More detailed information about these projects, including the results of evaluation of training activities, is provided in other volumes of this Technical Report series.

National General Practice Project

The National General Practice Youth Suicide Prevention Project, administered by the Perth Central Coastal Division of General Practice, developed an educational program for general practitioners. The program focused on enhancing the ability of GPs to recognise suicidal risk in young people and to manage psychological distress. The content of the training course includes five parts: issues; recognising the signs; raising the issue; risk assessment; and responding. It is available in the format of either a workshop or a handbook.

The Project worked with 34 Divisions of General Practice in Western Australia, Tasmania and Victoria. It conducted a total of 42 workshops which were attended by 280 GPs and 90 community health personnel. The project handbook was distributed to 6519 GPs through the Divisions, as well as 3281 community health personnel.

A further strategic aim of the project was to train at least one general practitioner from each Division of General Practice as a "moderator" or peer educator who would then be able to deliver the training program to other general practitioners. The project evaluated the effectiveness of training received and training delivered by these "moderator" GPs compared to the effectiveness of training obtained by use of the handbook.

Keep Yourself Alive

The Keep Yourself Alive Project was conducted by the Southern Child and Adolescent Mental Health Services in collaboration with the Royal Australian College of General Practitioners Quality Assurance Unit in Adelaide. The project developed training materials and provided training to general practitioners and community health care personnel in New South Wales, Australian Capital Territory, South Australia, Northern Territory and Queensland.

The Keep Yourself Alive training kit contains manuals, videos and audio tapes and can be delivered via a face-to-face workshop (one whole day or in up to four modules), or GPs can direct their own learning using the kit. The program has won a number of awards for excellence.

During the course of the National Youth Suicide Prevention Strategy, the Keep Yourself Alive project delivered the training program to 871 general practitioners and 933 community health professionals.

National University Curriculum project

The National University Curriculum Project, based at the Hunter Institute for Mental Health, developed university-level curriculum resource materials to encourage lecturers to allocate teaching time to issues relevant to youth suicide prevention. Students in the areas of nursing, secondary school teaching and journalism were targeted. For each discipline a package entitled 'Response . . . Ability' was developed which contained both discipline-specific resources (for academics only) and curriculum materials for use by both academics and students. The curriculum materials were trialed and evaluated in several universities around Australia. The resources are available for viewing on the Internet at: http://www.himh.org.au/Origin.html.

National training

The National Training Project for the Prevention of Youth Suicide, based at Victoria University of Technology, developed a nationally-accredited training program in suicide prevention for youth workers, Aboriginal health workers and juvenile justice workers. The program aims to improve awareness of suicide risk and the ability to respond to risk, and improve youth suicide prevention and response attitudes, skills and knowledge for workers in the vocational education sector.

The training package constitutes an elective subject which can form part of a Diploma course, such as the Diploma in Community Services: Youth Studies, or can be used as a stand-alone training package for in-service use. The package provides a comprehensive course of study in suicide prevention. The full six units of the course involve approximately 64 hours duration. On completion of training, participants can receive partial credit in the following competency areas: Youth Sector National Competency Standards; Aboriginal Health Worker and Torres

Strait Islander Health Worker National Competency Standards; and Child Protection/Juvenile Justice/Statutory Supervision National Competency Standards.

Resource guide on education and training

The National Youth Suicide Prevention Strategy Resource Guide on Education and Training, developed at the University of Wollongong, has not been evaluated, but it provides information about the process the project took in putting the resource together. The Guide reviews a large number of existing training programs against a set of educational criteria developed through broad consultation with key stakeholders. Programs are rated against these defined criteria by two independent reviewers.

Programs included in the Guide target four key groups: family and community; professionals; schools; and young people. The Guide contains basic information about education and training packages available within Australia, including costs, commitment time and whether or not experienced trainers are available to deliver particular programs The Guide is available both in printed form and on the Internet at: http://www.ysp.medeserv.com.au.

Kids Help Line

Kids Help Line is a telephone counselling service. Building counsellor competency in youth suicide intervention was the central focus of the Kids Help Line project. The main strategy used was provision of specialist training to enhance the capacity of counsellors to identify risk situations, seek appropriate assistance, provide direct interventions and make effective referrals to appropriate services. Two training modules were developed which between them involved 12 hours of training.

Lifeline

The Lifeline project, another telephone counselling service, developed training modules for counsellors as well as manuals for supervisors. One training module focused mainly on the telephone counsellors' role in suicide risk management. Another focused specifically on counselling young people.

Here for Life Youth Sexuality Project

The Here for Life Youth Sexuality Project, based at the Western Australia AIDS Council, developed a training package called 'Clearing the Way' which educates professionals about the issues facing young people with same-sex attractions. The training program is presented in the form of a one-day workshop. Training was provided to 257 participants from a wide variety of disciplines and sectors.

Exploring Together Program

The Exploring Together Program, based at the Victorian Parenting Centre, is an early intervention program targeting emotional and behavioural disorders in children and has been operating in Victoria and Western Australia for a number

of years. The National Youth Suicide Prevention Strategy provided funding to expand the number of trained facilitators able to deliver this program throughout Australia. The Project provided training to a total of 409 participants from a wide variety of disciplines.

Resourceful Family Project

The Resourceful Family Project is based at the School of Applied Psychology at Griffith University. The project was funded to enhance dissemination of the Resourceful Adolescent Program for Parents (RAP-P) across Australia. RAP-P aims to prevent problems like depression and anxiety in adolescents by developing the skills of parents. One of the main strategies used was to provide training in the program to professionals. Over 200 professionals based in 12 locations received training during the course of the project.

A variety of modes were used to deliver training: in addition to the traditional workshop involving mixed groups of professionals, the Project developed and trialed delivery of training via teleconferencing technology.

Results of the evaluation

There are few theoretically based models of training evaluation (Kraiger, Ford and Salas 1994). One model that does provide a systematic framework and which has been adopted by two projects in this group is Kirkpatrick's (1994) four-level model – reaction, learning, behaviour, and results. This chapter uses a modified version of Kirkpatrick's model to organise the results of the current group of projects:

- What works to enhance knowledge, attitudes, skills and confidence?
- What works to enhance behaviour and results (outcomes)?
- What works to enhance reach and exposure?

What works to enhance knowledge, attitudes, skills and confidence?

Changes in knowledge, attitudes, skills and confidence that occur within individuals as a result of attending training are what Kirkpatrick (1994) refers to as learning. These changes are the focus of process and impact evaluation of training programs.

Projects in this group have focused primarily on process and impact evaluation and have involved quite comprehensive assessment of changes in knowledge, attitudes, skills and confidence. Most have used a single group, repeated measures design. With a few exceptions, only modest improvements were reported.

The resources developed by the National University Curriculum Project were trialed in several universities. Impacts were assessed using brief multiple choice

questionnaires administered to students at baseline and follow-up. Students tended to show significant improvements in knowledge and attitudes on around one-quarter to one-third of the items. Baseline levels of knowledge tended to be high on around one-third of items and baseline attitudes were positive on around one-third of items. Occasionally negative changes in attitudes were observed. All groups of students showed strong improvements on the items measuring confidence (Waring, Hazell and Hazell 1999).

One area where secondary education students' knowledge was low at baseline and did not improve was in *teacher response to suicidal behaviour.* In their qualitative feedback, some secondary education students indicated the need for more information about strategies teachers can use to respond.

Interpretation of these results needs to consider the fact that due to the flexibility of delivery built in to the package students were not consistently exposed to all the materials relevant to answering the questionnaire items. The instruments used to measure changes were also very brief and had not been subject to psychometric testing.

The National General Practice Youth Suicide Prevention Project evaluated impacts of training on GPs skills (and behaviour) via a practice audit that assessed the ability of GPs to detect young people with depression, psychological disturbance and suicidal ideation (Pfaff, Acres and McKelvey 1998). The findings are reported here instead of the next section because there is evidence that the results were largely due to the 'learning' acquired during training. The audit involved a total of 539 GPs in 33 Divisions of General Practice in three states, as well as 3209 patients aged 15–24 years. The judgements of GPs about levels of depression, psychological distress and suicide risk status of patients were compared with data collected from three self-report measures completed by the young people themselves. The instruments used were the Center for Epidemiological Studies-Depression Scale (CES-D), the General Health Questionnaire (GHQ-12), and the Depressive Symptom Inventory-Suicidality Subscale (DSI-SS).

The Project reported GPs' detection rates as a function of the number of young people identified as at risk via the self-report measures. Significant differences in the overall rates of detection of depression, psychological distress and suicide risk were related to the level (amount and quality) of training received.

Evaluation of the *"Clearing the Way"* training program developed by the Here for Life Youth Sexuality Project involved assessing changes in knowledge and confidence through a 13-item self-evaluation questionnaire administered before and after the training workshop (Goldflam, Chadwick and Brown 1999). Data were analysed for 51 training participants. The proportions of respondents rating themselves as having adequate or strong knowledge or confidence increased two to seven fold for ten of the 13 items of the instrument from pre- to post-training.

The Exploring Together Program training was evaluated externally using three custom designed questionnaires, mainly multiple choice but with some open-ended questions, plus telephone interviews and focus groups towards the end of the evaluation period (Littlefield et al. 1999). The response rate to the post-training questionnaire was 88.5 per cent.

The Exploring Together Program training evaluation had a strong focus on the impacts on trainee confidence. Confidence has been identified as an important mediator between initial learning and the likelihood of learners attempting to put new skills into practice. The results showed that the majority of participants were very satisfied with the training, finding it interesting, relevant, pitched appropriately and competently facilitated. Pre- and post-training measures showed relatively large increases in both skills and knowledge immediately after the training. In addition, the majority of trainees agreed or strongly agreed that they were clear about their role as Exploring Together Program Group Leaders, and the steps to be taken to organise, conduct and evaluate their own Program. Immediately following training, participants' confidence levels were high that they would manage the three main aspects of conducting an Exploring Together Program.

A large number of the Exploring Together Program trained group leaders demonstrated in their written or verbal comments following the training, a strong belief in the Program's ability to make a difference to families with 'at-risk' children and many have demonstrated a strong commitment to running the Program.

Two projects in this group used evaluation designs that were conducive to identifying which factors were most important in determining levels of learning. There was also considerable variation in the amount of impact observed across the various training programs. A number of factors emerged quite strongly as being associated with greater learning.

➤ *Ensure relevance of materials through consultation*

Feedback from students and academics in all three disciplines involved in piloting the National University Curriculum Project resources (nursing, education and journalism) revealed very positive judgements about the appropriateness of the materials. Feedback from students indicated high levels of agreement that the materials were relevant to their career, that the material was realistic and interesting, and that it suited their learning style. Of the open-ended comments received from students, between 58 and 72 per cent of comments were positive and between 16 and 22 per cent involved suggestions for improvements.

Extensive consultation with the various target groups appears to have played an important role in ensuring high levels of resource relevance and appropriateness. The National University Curriculum Project included consultation with university students who had experience of suicide through ideation or attempt, or through being affected by the suicide of other people. The core educational approaches used in the packages (case studies and a problem-based approach)

were determined according to feedback from a national survey of universities. Academics in each of the disciplines targeted were intensively involved in the development of the discipline specific curriculum resource packages. Based on early feedback a number of substantial changes were made to the resources and new resources were developed.

Process evaluation of the National Training Project for the Prevention of Youth Suicide found that the curriculum materials were useful, interesting, well designed and comprehensive. This project also involved very extensive consultation with industry stakeholders in the development of the curriculum materials.

Development of the *"Clearing the Way"* training program was informed by consultation with young people as well as a survey of the workers to whom training was targeted. The Resource Guide on Education and Training gives the *"Clearing the Way"* training program a special commendation and notes this consultation with professionals and young people as an important factor in the quality of this training program. It states: An excellent resource in all respects and could well be used as a model for others developing resources. It is comprehensive, evidence-based, based on consultation, involves young people, and incorporates appropriate evaluation measures."

Development of the Keep Yourself Alive training program included input from, or consultation with, general practitioners and mental health professionals. It is unclear whether professional groups other than these were involved. Impacts of training were reported to be greater for general practitioners than for community health professions – a group that included professionals from a variety of sectors, not just the health sector. Certain components of the program that generated very poor knowledge gains were of questionable validity to professionals not from the health sector. Further development of this program to tailor it to the needs of specific professional groups is currently taking place in order to provide training to teachers in High Schools in South Australia and mental health professionals in Queensland.

The importance of consulting with the target group also applies equally well in the design of training evaluation materials. Important benefits of this were identified as an unintended impact of Kids Help Line. Supervisors and other senior staff of the project were involved in the development of a rating instrument designed to evaluate the impacts of training. Collection and joint analysis of test data by staff and members of the evaluation team highlighted variations in expectations and understandings of key concepts by different staff, including supervisors. This information helped inform changes to the design of the second round of training as well as refinement of the evaluation tool. It also heightened general awareness of the importance of developing a common language and common standards among a diverse group of counsellors.

The Resource Guide on Education and Training includes a set of criteria for reviewing the quality of education and training programs that were developed

through wide consultation with experts in the education and training sector. There are eight groups or sets of criteria. Consultation with the target audience and young people in the process of developing the resource is included as one of these sets of criteria.

➤ *Face-to-face training by skilled and experienced trainers*

Most of the National Youth Suicide Prevention Strategy projects that provided training to professionals used face-to-face workshops as the primary mode of delivery. Several projects also trialed other modes of delivery allowing direct comparisons of effectiveness to be made. The skills and experience of trainers delivering face-to-face workshops varied substantially. While there was some variation in results across different projects, there was a reasonably strong trend for learning and satisfaction among trainees to be greater when highly skilled professional trainers were used.

The most rigorous evaluation design was employed by the National General Practice Youth Suicide Prevention Project. The effectiveness of three different types of training was compared against a control group:

- "moderator" GPs, one from each of the 33 participating Divisions of General Practice, were provided with training by the project manager via a half-day (four-and-a-half hour) workshop;
- "sentinal" GPs received training in half-day workshops delivered by the "moderator" GP in their Division;
- "handbook" GPs were required to read the brief project guidebook "Managing Youth Suicidal Behaviour"; and
- "control" GPs did not receive any training or educational material.

In the practice audit described earlier, "moderator" GPs displayed the highest levels of skill development (ability to detect depression, psychological distress and suicide risk in young people) followed by "sentinal" GPs. "Handbook" GPs also demonstrated improvements above the detection rates displayed by "control" GPs. "Moderator" GPs completed practice audits both before and after training. Their ability to detect suicidal risk, psychological disturbance and depression (compared to the number of young people detected as such from self report instruments) increased from 24.4 per cent to 56.1 per cent, 42.5 per cent to 62.9 per cent, and 45.1 per cent to 62.9 per cent respectively. Unfortunately, before and after measures were not taken for the other groups of trainees.

Indications as to the critical elements of effective training for General Practice Project trainees were suggested by GPs' comments obtained after the training workshops. A proportion of "sentinal" GPs indicated dissatisfaction with aspects of their peer-presented workshop including the moderators' presentation skills. This reinforces the data indicating the greater effectiveness of highly skilled professional trainers as opposed to peer trainers.

The National Training Project for the Prevention of Youth Suicide aimed to develop, trial and evaluate youth suicide prevention curriculum materials for youth workers, residential care workers, child protection workers, workers in the justice system dealing with young people and Aboriginal Health Workers. This project produced a program of training which forms an elective unit within the Diploma in Community Services: Youth Studies. The full six units involve 64 hours duration. It can also be used as a stand-alone training package for in-service staff development purposes. The National Training Project piloted the training program in New South Wales and Tasmania. It is unclear whether these pilots involved teaching within the Diploma in Community Services: Youth Studies, or in-service settings. Impact evaluation has not yet been completed. Data reported were collected via interviews with trainers, participant questionnaires distributed after training (Tasmania only), and participant interviews (New South Wales and Tasmania).

Students in both New South Wales and Tasmania indicated that curriculum material itself was useful, interesting, well designed and comprehensive. However, the satisfaction of participants and their perceived increases in knowledge and skills as a result of the course were very high in the Tasmanian pilot and very low in the New South Wales pilot. Very different procedures were used to conduct the training in the two states. The evaluator concluded that poor facilitation of the training sessions and a lack of follow-up contact and support by the trainer and other tutors was a major factor in participants' expectations not being met in the New South Wales pilot. In contrast, many students in the Tasmanian pilot emphasised the important and valuable role played by the training facilitator, especially her presentation and analysis of the curriculum material.

In its conclusion, the author of the Final Report of the National Training Project (Balsamo 1999) argues that "in order that training of a high quality be delivered, it is essential that trainers delivering the training meet a minimum criterion of industry experience and training skills". It is suggested that trainers should be credentialed by completing qualifications such as Certificate IV in Workplace Training which is a nationally recognised qualification that provides experienced workers with the skills and expertise to train others.

➤ *Self-directed learning*

As noted above, the National General Practice Youth Suicide Prevention Project found that self-directed learning methods were effective in improving the skills of GPs compared to a control group that received no training. However, the effect size was not as great as for face-to-face training delivered by a highly skilled trainer.

The Keep Yourself Alive Project also evaluated the impacts of training on GPs' skills via a practice audit. Impacts were compared across three different training conditions: Workshop GPs received training via a full day (seven-hour) face-to-face workshop; Distance Learning GPs directed their own learning using the program kit and videos; and "control" GPs received no training.

The results suggested that the ability of Workshop GPs to detect suicidal risk in young people during a practice audit did not improve relative to untrained "control" GPs. Distance learning GPs exhibited significantly better ability to detect suicidal risk. However, caution should be exercised in interpreting these results as the methods used in the Keep Yourself Alive practice audit were different from those used in the National General Practice Youth Suicide Prevention Project, and the data are likely to be less reliable.

➤ *Involve young people in the training program*

Involvement of young people through a video presentation is a feature of the *"Clearing the Way"* training program and the Keep Yourself Alive training package. Involvement of young people is noted by training participants and the Resource Guide on Education and Training as an important factor in the effectiveness of the *"Clearing the Way"* training program.

The Resource Guide describes the video as: "well edited, lively and often humorous and is based solely on the experiences of young people from different ethnic and social backgrounds, explaining/discussing their experiences of coming out, family reactions, morality/religion, meeting people, isolation, experiences with service providers and more."

➤ *Provide training of adequate length*

The Kids Help Line training involved two blocks, each of 12 hours conducted over several sessions. The evaluators were of the opinion that this was consistent with sound training principles and likely to optimise learning opportunity and consolidation of knowledge and skill. King, Nurcombe and Bickman (1999) note that single one-hour lectures could be considered "token training" and are inappropriate. They cite authors (Bleach and Claiborn 1974) who have advocated that more than one period of training is necessary to ensure skills are consolidated and maintained.

The training programs trialed in the current group of projects varied considerably in their length. One program that was associated with significant increases in competency was quite short in length. It is likely that the optimum length of training would vary with other factors such as the existing knowledge and skills of trainees and the scope of behavioural change that the program is aiming to achieve.

What works to enhance behaviour and results (impacts and outcomes)?

Kirkpatrick's (1994) model theorises that increased knowledge, skills and confidence, along with changes in attitudes gained in training, are only one of the factors that need to be present if behaviour is to change so as to make a

contribution to the achievement of desired results or outcomes. This section aims to identify characteristics of education and training that make a specific contribution to the process of translating knowledge, attitudes, skills and confidence into behavioural changes for learners, and ultimately, outcomes for young people.

Kirkpatrick's model also recognises that various factors not directly related to education and training of individual learners can exert an influence on this process. It is important for evaluation of training to recognise and account for such factors. Design of professional development programs should address or accommodate such factors if they are to be maximally effective.

While Kirkpatrick (1994) makes a distinction between trainee behaviour (impacts) and results (outcomes), the projects in this group have tended to focus only on the level of behaviour. Where outcomes for young people have been addressed it is generally not possible to isolate the factors that have contributed to this independently of changes in trainee behaviour.

The National Youth Suicide Prevention Strategy projects have not generated convincing evidence that the training provided has led to meaningful behaviour change among trainees or improved outcomes for young people. Only one project to date has provided evidence of increased competency as a result of training. However, evaluation of several projects is still in progress.

As reported in the previous section, the National General Practice Youth Suicide Prevention Project observed improvements in GPs ability to detect depression, psychological disturbance and suicidal ideation in young people as a result of training as well as increments in detection ability as a function of the level or quality of training received. GPs involved in this training also identified substantial barriers to the implementation of the good practices they had learned.

The evaluation of the Exploring Together Program training was explicitly founded on Kirkpatrick's four-level model. Evaluation is still in progress and at the time the Australian Institute of Family Studies Evaluation Report was written only impacts at the levels of reaction and learning had been evaluated. Data about behaviour change was still being collected. This involved asking trainees to submit progress reports. Progress reports were submitted by 61.6 per cent of trainees. Of these, 10.6 per cent indicated that they had completed or were currently running a Program and 64.4 per cent indicated that they were currently organising or planning one. The project also included detailed exploration of the factors that were perceived by trainees and Program staff as inhibiting and facilitating the ability of trained group leaders to conduct Exploring Together Programs.

Use of new skills acquired by GPs was assessed in the evaluation of the Keep Yourself Alive training via a follow-up survey. These were sent to GPs six weeks to six months after attendance at the workshop, or in the case of Distance Learners, six to twelve weeks after the completed post-test had been returned. Seventy-

eight per cent of the Keep Yourself Alive trained GPs reported that they had used some or all of the skills taught in the risk assessment module *"Recognising the Signs"*. Similar proportions reported using one or more of the skills presented under Brief Family Therapy (72.4 per cent), and Cognitive Behavioural Therapy (77.6 per cent). In the area of Narrative Therapy, 59 per cent of GPs reported using one or more of the skills, while 56 per cent reported using one or more of the postvention skills.

Evaluation of the National General Practice Youth Suicide Prevention Project explored the views of GPs about the factors that affected their ability to implement the skills and practices they had learned.

Data from tape recordings of real counselling sessions were used to evaluate the effects of training on the competency and effectiveness of Kids Help Line counsellors. Ratings were generated for a large number of specific counsellor behaviours. Changes in levels of psychological distress and suicidality of young callers were also measured. Some of the tape-recorded counselling sessions were conducted by counsellors who had not received training. It was therefore possible to compare their performance with those who had received training.

There was no evidence that counsellor competence and effectiveness were increased for those who received training compared to those who did not. A difficulty in interpreting the results is that counsellors were not allocated randomly to the training or no training conditions, rather the groups were self selected. The evaluators identify a number of factors that could explain the failure to observe increased competency for counsellors who had received training.

➤ *Practice*

The evaluators of the Kids Help Line Project (King, Nurcombe and Bickman 1999) hypothesise that the failure to observe increased counsellor competence or effectiveness in those counsellors who received training compared to those who did not may have been due to the limited opportunities provided for counsellors to practice the new skills they had learned. "It is likely that a period during which learning is applied and skills consolidated is necessary before the impact of training is evident in external rating scores" (King et al. 1999: 49-50).

Two of the four recommendations from the evaluation of Keep Yourself Alive for general practitioners are concerned with practice-based learning. It is asserted that practice-based activities such as practice audits which include collection of data from clients and personal reflection on practice "reinforces learning" as well as providing evidence about the effectiveness of a program. These evaluators recommend that: "Continuing medical education programs that receive substantial funding should have such approaches built in as part of the learning model, not just the evaluation. That is, learning and evaluation are undertaken in a fully integrated manner" (Beckinsale, Martin and Clark 1998a).

Feedback from participants in the National General Practice Youth Suicide Prevention Project audit is also reported as indicating that the practice audit alone may be an effective teaching tool. It is noted that a follow-up audit with the project's "control" GPs could provide information on the impact of practice audits on GPs behaviour. It is further speculated that providing practice audit information to GPs before and after receipt of educational material may provide learners with greater incentive to implement newly acquired training. The General Practice project has obtained funding to further evaluate the effectiveness of practice audits as a learning tool.

➤ *Address barriers in the practice environment*

Data from the evaluation of Keep Yourself Alive and the National General Practice Youth Suicide Prevention Project suggest that there are a number of barriers in the practice environment that seriously limit the ability of general practitioners to provide improved quality of care to young people at risk of suicide.

Sixty per cent of GPs who participated in the National General Practice Project evaluation identified such barriers. The difficulties most frequently reported included: low confidence in local resources (72 per cent); a lack of accessible resources (60 per cent); and limited knowledge of local resources (32 per cent).

The evaluators of the National General Practice Youth Suicide Prevention Project (Pfaff, Acres and McKelvey 1998) recommend that future training programs address these barriers by providing GPs with management strategies that are tailored to the general practice milieu. In addition, it is recommended that there be a continued focus on enhancing cooperation between service providers. "Workshops and other events that bring GPs and [other service providers] together are recommended, to enhance knowledge and cooperation between these service providers" (p. 40).

In the literature review for the Keep Yourself Alive GP project evaluation, Beckinsale, Martin and Clark (1998a) note evidence from previous research by Kendrick et al. (1995) who conducted a randomised controlled trial of training general practitioners to carry out structured assessments of mentally ill patients. It was found that training increased GPs involvement in care but that other structural supports were needed to enhance long term outcomes such as increased access to mental health workers.

The Exploring Together Program evaluation included detailed exploration of factors in the environment that facilitate and inhibit group leaders from conducting the program they have been trained to deliver. One of the most important factors was the availability of other staff who could share the work of organising and conducting group programs. The Exploring Together Program has attempted to build-in a peer support mechanism by requiring that each ten-week program be conducted by four facilitators. Case studies have demonstrated that establishing a critical mass

of workers with training in the program in any particular community helps it become self-sustaining in those communities. However, barriers related to workload and lack of availability of financial support from local agencies present ongoing problems. Collaboration between different agencies is generally required in rural and remote communities to ensure sufficient numbers of professionals are trained and actively supported to run programs. The evaluation of the Exploring Together Program also emphasised the value of having national and regional coordinators in place to provide ongoing support and resources to trainees. (See Chapter 1 of Technical Report Volume Two for more detail).

Exploring Together Program trainees noted additional benefits they had received by attending the training workshops. The most common of these was improvement in networking, communication and cross-referrals between their diverse agencies. This is an advantage you would not get from modes of training delivery that target individuals such as distance learning via handbooks.

The Resource Guide on Education and Training has a set of criteria specifically for training resources that target professionals. This set of criteria includes that: the resource encourages the development of appropriate institutional policies, procedures and practices; and the resource encourages development of inter-agency and intersectoral collaboration, protocols and procedures.

These criteria clearly acknowledge that developing the competencies of individual workers is usually insufficient to ensure changes in practice adequate for achieving the ultimate goals of training. Changes are also required within the organisations in which professionals work and in the wider service systems. However, some of the skills required to initiate such changes can be developed via training and it is good training practice to address these.

➤ *Characteristics of the learners*

General practitioners involved in the Keep Yourself Alive training evaluation tended to perform better on the follow-up test of knowledge retention if they: were female; worked in a large group practice; had been in practice for a shorter time rather than longer time; had done the Distance Learning Program; worked part-time rather than full-time; worked in the country. There was no drop off in scores when the follow-up test was conducted later rather than sooner.

Uptake of new skills was found to be significantly higher for GPs who had reported using a wider range of techniques prior to receipt of training. No other characteristics of GPs were found to be significantly related to uptake of skills. However there was a trend for GPs to adopt more skills if they: were distance learners; were more highly qualified; and were less experienced.

A number of the learner qualities associated with greater adoption or retention of knowledge and skills appear indicative of a general predisposition or openness to the uptake of new ideas. It will be important for further evaluation to explore qualities of the training that help sustain learning for less open trainees.

➤ *Self-efficacy*

King, Nurcombe and Bickman (1999) argue that counsellor self-efficacy is a key mediating factor in the process of translating information and skills acquired during training into actual behaviours and competencies.

➤ *Reach and exposure*

When measuring outcomes at the level of whole populations, it is clear that the effects of training will depend upon how many relevant workers receive the training. As reported earlier, positive outcomes often depend on changes occurring in the wider service environment as well as within individual workers. Initiation and implementation of necessary changes in the service environment may require, or be facilitated by the awareness and support of a critical mass of staff.

What works to enhance reach and exposure?

The National Youth Suicide Prevention Strategy projects achieved varying levels of success in engaging members of the groups that they targeted.

The National University Curriculum Project evaluators were very pleased with the level of involvement they obtained from universities (Waring, Hazell and Hazell 1999). With regard to actual usage of resources, feedback from academics involved in the project trial indicates that the resources had wide applicability and were successfully integrated within a broad spectrum of academic approaches and teaching styles.

The Keep Yourself Alive Training Program trained 871 GPs, and 933 community health professionals from a wide range of sectors. The majority of the GPs (734 or 84.3 per cent) undertook the face-to-face workshops and 137 (15.7 per cent) undertook the Distance Learning Program. The original intention had been to train 2000 GPs and 1000 community health professionals, however the project managers were very pleased with the reach of the program. The Keep Yourself Alive Project was funded for three years.

The National General Practice Youth Suicide Prevention Project trained a total of 329 GPs – 280 in workshops and 49 using the handbook – as well as 90 community health personnel through face-to-face workshops. The project managers expressed concern that a disappointingly low proportion of GPs in the targeted Divisions of General Practice elected to take up the offer of training. This project was funded for two years.

The Strategy provided funding to expand the number of trained facilitators able to deliver the Exploring Together Program throughout Australia. This project provided training to a total of 409 participants from a wide variety of disciplines. The main training strategy was a two-day workshop, of which a total of 17 were conducted in urban and rural locations throughout all states and territories. Each

of these workshops involved 20 to 30 participants, and a total of 380 people were trained. An additional 29 people were trained via participation in two demonstration Exploring Together Programs conducted at La Trobe University in Melbourne. Through a one-way screen trainees observed the program of ten weekly sessions being delivered.

Reach or coverage of the workforce was identified as an area requiring careful attention in ongoing professional development strategies for Lifeline and Kids Help Line. Both of these projects experienced difficulty achieving adequate coverage of their counselling workforce.

Sixty-nine per cent of Kids Help Line's counselling staff attended the first training module and 58 per cent completed the second module. Between the first and second modules 39 staff left the service (44 per cent of the total employed at Time 1) of whom 16 had completed the first training module. This meant that of the 49 counsellors employed during both the first and the second training module, only 20 (41 per cent) completed both. The evaluators of the Kids Help Line project (King, Nurcombe and Bickman 1999) found that the reach of training was less than optimal.

The Lifeline project developed a set of training manuals and employed a train-the-trainer model to extend the reach of training. Once the resources were completed, trainers from every Lifeline centre were invited to a one-day session to orient them to the resources and obtain their input into their application. These trainers were then asked to implement the training in their own centres. Not all centres have adopted the new training resources. Some have adopted them in full, others have chosen to use parts and others see no need to upgrade their approach to training.

The length of time that a training program operates is clearly the most important factor in determining the reach of the program. Other factors identified as enhancing reach and exposure of training fall into three main categories:

- factors related to mode of delivery and design of training materials;
- factors related to the promotion of particular training programs to individual participants; and
- factors related to the ongoing support of education and training by service systems.

Mode of delivery and design of training materials

Traditional group-based training workshops are limited in their capacity to deliver training to workers in rural and remote areas where populations are spread over vast geographic areas. Rural and remote professionals have great difficulty attending traditional training workshops offered in centres far from their usual place of work. Certain types of professionals such as general practitioners also have difficulty attending training during normal business hours.

Particular settings also vary in their specific training needs. For example, groups of trainees may vary in their previous exposure to the content of training programs.

➤ *Flexibility in the mode of delivery*

The Resourceful Family Project was successful in disseminating the Resourceful Adolescent Program for Parents (RAP-P) across Australia. More than 200 professionals based in 12 locations received training during the course of the project.

The Resourceful Family Project used a variety of modes to deliver training. In addition to the traditional workshop involving mixed groups of professionals the project developed and trialed delivery of training via teleconferencing technology. The trainee group leaders were sent manuals in advance so that they could familiarise themselves with the program. The Resourceful Family Project Team (Shocket and Harnett 1999) note that a major barrier to implementation of the program in indigenous communities is a lack of indigenous professionals who can run the workshops. A video was developed to help support group facilitators based in indigenous communities who may lack professional qualifications.

The resources developed by National University Curriculum Project for nursing, secondary education and journalism students were designed to be flexible with regard to the way in which they are used. For example, the amount of time allocated to the material and the manner in which it articulated with the broader curriculum were determined by the academics involved in teaching or course coordination. Interviews conducted with academics involved in the trialing of the resources confirmed that the resources were used in a variety of ways. For example, the materials could be used in a variety of topic areas within second and third year undergraduate courses, or even postgraduate courses, and could be used within lectures or tutorials. The flexibility of use appeared to be important to the ability of a wide range of universities to use them profitably.

The structure of the materials appeared to enhance their flexibility and ease of use, as indicated in these comments from academics in nursing and secondary education:

> "I could take this little part and then blend it with this part and then return. It was a nice framework out of which I could take the parts I wanted and jigsaw them together."
>
> "It was really good to have the materials in bite-sized chunks that the students can get into."

The National General Practice Youth Suicide Prevention Project and Keep Yourself Alive also used a variety of modes of training delivery in addition to traditional workshops. These are detailed below.

➤ *Self-paced and distance learning*

The distance learning program offered under the Keep Yourself Alive project was taken up by a sizable proportion (15.7 per cent) of general practitioners who were trained under this project. Although learning impacts were modest for both the workshop and distance learning, there was a trend for the distance learning approach to produce greater impacts.

One of four recommendations of the Keep Yourself Alive GP training evaluation is that: "The opportunity for general practitioners to participate in high quality distance learning programs should be encouraged and supported as this has the potential for better learning outcomes" (Beckinsale, Martin and Clark 1998a).

The handbook was the most popular form of training among GPs in the National General Practice Youth Suicide Prevention Project. The evaluation revealed significant learning gains for GPs trained using the handbook alone, however these gains were not as substantial as for GPs trained in the face-to-face workshops. It was speculated that GPs may have preferred the handbook option over workshops because it is self-paced and provides greater flexibility. However, even use of the handbook was considered to be lower than desirable.

The report authors hypothesise that traditional forms of professional education such as workshops and books are not the preferred medium for GPs today. It is suggested that exploration of more interactive mediums such as CD-ROM and/or Internet Website should be undertaken. This is noted as a strategy that could potentially reach a much larger proportion of Australia's general practitioners for a fraction of the cost required to organise and convene several workshops.

It is likely that the cost per trainee is substantially less for distance learning than for face-to-face workshops. The distance learning program offered by Keep Yourself Alive is being made available to GPs at a price of $100, borne by the GP. Information on the costs per workshop participant was not provided in the Keep Yourself Alive evaluation.

➤ *Satellite broadcast (plus prompt follow-up)?*

The Keep Yourself Alive project broadcast a training session via satellite to 450 different sites on 11 August 1998. Unfortunately the impacts of the broadcast were not evaluated. No information is provided about the numbers of people who attended these locations to listen to the broadcast or the reaction of people who attended.

The Here for Life Networking project in Queensland (see Chapter 4, this volume) planned to use the Keep Yourself Alive broadcast as a trigger to stimulate ongoing training among recently estabished networks of GPs and other professionals using the Keep Yourself Alive training kits. Unfortunately it is reported that much of the momentum gained from this broadcast was lost due to the delay in developing and distributing the training kits.

➤ *Make training materials available on the internet?*

At the time of writing the evaluation report, over 300 people were recorded as having downloaded the Adobe Acrobat.pdf version of the Keep Yourself Alive manual from the AusEinet website. No information is available about how many people have utilised the downloaded manual to provide training to others or in what manner.

Promotion of training programs to potential participants

➤ *Captive audience*

The National University Curriculum Project had the advantage of students in universities being a relatively captive audience for training once the involvement of academics was secured. General practitioners who are out working in the field are far from being a captive audience.

➤ *Personal contact with targeted organisations*

A strategy employed by the National University Curriculum Project which appeared to be highly successful was personal contact. Deans or Heads of Departments in targeted disciplines were asked to nominate a key academic within their department with whom the project team could make personal contact regarding the project. The response to this invitation was reported as very encouraging.

➤ *A large number of narrowly targeted publicity strategies*

The National University Curriculum Project used a large number of different strategies that were all narrowly focused on the target audience. These strategies included: formal notification to universities in writing; personal contact; a project newsletter; publications in professional journals; conference presentations; distribution of a project flier through university Heads of Departments; and internet contact.

In contrast, the National General Practice Youth Suicide Prevention Project used a smaller number of strategies that were much more broadly targeted. These included: a national media launch to promote public awareness (numerous media covered the event including television, radio and newspapers); presentations at conferences; and publications of pilot study findings in peer reviewed journals.

Support of education and training by service systems

Projects identified a range of structural barriers to the delivery of training. High staff turnover and decentralisation of services are problems in a number of service systems, particularly in rural and remote areas. Ensuring that staff who receive training have opportunities to maintain new knowledge and skills is difficult.

➤ *Continuous training*

The evaluation of the Kids Helpline project (King, Nurcombe and Bickman 1999) conclude that for services with regular staff turnover, the only way to ensure that all staff receive suicide prevention training is to provide frequently repeated training sessions or restrict recruitment to people who have received comparable training elsewhere.

➤ *Formal training of trainers*

The National Training Project team (Balsamo 1999) point out that the pool of people able to deliver suicide prevention training needs to be expanded and that

these trainers need to have formal training qualifications. It is suggested that the Certificate IV in Workplace Training, which is a nationally recognised qualification, could be customised to complement the National Training Program in Youth Suicide Prevention. Two of the four formal recommendations arising from this project are concerned with expanding the pool of trainers properly qualified to delivery youth suicide prevention training.

Specifically, Balsamo (1999) it is recommends that the Commonwealth develop a policy for training trainers who will, or potentially will, undertake youth suicide prevention training, and that the Commonwealth provide funding for a national program of training for those who will deliver training in youth suicide prevention. It is further suggested that "delivery of this trainer training should be undertaken by a training organisation which has the capacity to delivery training on a national basis, experience and expertise in the delivery of training to the Human Services sector, and especially in youth suicide prevention" (p. 13).

➤ *Divisions of General Practice*

Both the National Training Program in Youth Suicide Prevention and Keep Yourself Alive relied heavily on the support of various Divisions of General Practice to conduct their projects. For example, Divisions provided considerable amounts of advertising, secretarial support, assistance with arranging venues and catering. An inability to reimburse Divisions due to funding limitations was reported as restricting the ability of the Keep Yourself Alive Project to make better use of the Divisions' infrastructure.

➤ *A systematic approach to quality enhancement*

For Lifeline, the difficulties in achieving adequate coverage of the workforce were identified as being associated with the highly decentralised nature of the organisation. This is a problem for many service systems. The Lifeline Interim Evaluation Report (Rolfe and Turley 1999) recommends that Lifeline continue to work on development of suicide intervention competency via a benchmarking approach that seeks to ensure competency is consistent with best practice in the field and *that all counsellors in every centre* meet this agreed graduation and accreditation standard.

➤ *Backfill or temporary replacement of staff attending training*

A common barrier to further education of professionals cited by Strategy projects is the strain experienced by organisations in meeting their usual commitments when staff are absent on training. Funding is rarely, if ever, available to replace staff who would benefit from attending training. The Final Report of the National Training Project on Youth Suicide Prevention (Balsamo 1999) recommends that the Commonwealth provide funding for agencies and organisations that provide services to young people to undertake youth suicide prevention training.

➤ *Professional incentives*

While the National General Practice Youth Suicide Prevention Project was not totally content with the reach of the project to targeted general practitioners, there is some evidence that it is easier to attract GPs to training programs that offer incentives in the form of Continuing Medical Education points compared to programs that do not offer such incentives. It is also easier to attract GPs to such training programs than some other groups of professionals for whom such incentives for continuing education are not provided.

➤ *Train-the-trainer?*

The train-the-trainer strategy was been trialed by a number of projects. No clear evidence emerged as to its effectiveness.

The Keep Yourself Alive program is available in a self-contained kit that has been distributed to over 350 locations including every Royal Australian College of General Practitioners training post in Australia. It has been reported that a number of workshops based on the Keep Yourself Alive materials have been held by community health professionals who attended primary training delivered by the Keep Yourself Alive Project team. The project team requested that people inform the team of any sessions they conduct and how many people attend. However, this feedback appears to have been inconsistent thus it has not been possible to estimate the reach of the training achieved via the train-the-trainer strategy.

The National General Practice Youth Suicide Prevention Project evaluation found the impact of training delivered by secondary trainers to be reasonable, although not as powerful as training delivered by primary expert trainers.

The evaluation of the National Training Project for the Prevention of Youth Suicide raises a serious challenge to the concept of train-the-trainer. This evaluation found the skill of the trainer to be critical to the effectiveness of the training. These author argues that all trainers in youth suicide prevention should have formal credentials in training (Balsamo 1999).

The *Family Wellbeing Course* (see Technical Report Volume Two, Chapter 1) was originally intended to operate according to the train-the-trainer model. However, the evaluator of the Tangentyere trial of the *Family Wellbeing Course* found that participation in the course was not sufficient to equip participants to deliver the course to other parents, even when these graduates were service providers.

The most positive evidence regarding the potential value of the train-the-trainer strategy comes from the Exploring Together Program. Each ten-week program requires a total of four facilitators. Two facilitators run the childrens group and two are required to run the parents group. This arrangement provides the basis for incorporation of a train-the-trainer strategy in the dissemination of the program. Untrained facilitators can work with formally trained facilitators to deliver the

program and in this way acquire the practical skills in program delivery. This process allows the program to be maintained in particular agencies or clusters of agencies even if original personnel leave the agency or area. It is critical to note that the process used by the Exploring Together Program goes further than most train-the-trainer programs because secondary trainers work closely with primary trainers on an ongoing basis and thereby receive practice-based learning.

General discussion

Evaluation of the education and training activities funded under the National Youth Suicide Prevention Strategy has provided some reasonably consistent findings regarding promising future directions, and has also revealed some major gaps in knowledge and practice that require further evaluation research.

Some of the major issues that require further attention in policy and program research, development and evaluation are:

- enhancing reach and coverage;
- achieving and sustaining behaviour change; and
- content of suicide prevention training.

Enhancing reach and coverage

Although a large number of professionals have received training in suicide prevention under the National Youth Suicide Prevention Strategy, there is a need to increase coverage of relevant sections of the workforce. Major barriers to achieving adequate reach and coverage of the workforce groups targeted by Strategy projects were identified.

Strategy projects trialed a variety of methods of providing training to professionals in rural and remote areas or who find it difficult to attend face-to-face training. Handbooks and manuals, videos, radio and satellite broadcasts, teleconferencing, and the internet were used. Unfortunately, with the exception of self-paced learning handbooks and manuals, projects did not include comprehensive evaluation of these various distance learning strategies. This will be an important task for the future *(Recommendation 3.1, first dot point)*. Specifically, process and impact evaluation is required to determine whether methods such as broadcasts, teleconferencing and the internet are accessible and acceptable to target groups, and whether these methods are capable of stimulating skill development and behaviour change.

Evaluation also needs to focus on whether self-paced distance learning techniques can achieve sustainable changes in behaviour and what other supports may be required to ensure distance learners are able to implement new learning in their daily practice. Distance learning may also offer cost effectiveness benefits over traditional workshop based training, and evaluation should explore this possibility. Statewide training bodies such as the New South Wales Institute of

Psychiatry and tertiary children's hospitals as well as universities and Divisions of General Practice would be in a position to carry out this work if provided with the necessary funding *(Suggestion 3.1a).*

In New South Wales, the New Children's Hospital has piloted psychological telemedicine services to mental health services in Bourke and Dubbo. Telemedicine may also be a means of providing ongoing practice-based training, supervision, and support for primary health care providers in rural and remote areas who are caring for people with mental health problems or otherwise at risk of suicide.

The train-the-trainer model remains popular as a way of expanding delivery of primary prevention and health promotion programs targeting the general population. It is also being adopted by early intervention programs. The train-the-trainer model has not been adequately tested by any of the projects funded under the Strategy but the balance of evidence suggests that it is not likely to be capable of delivering training outcomes of an acceptable standard unless, perhaps, it is accompanied by ongoing practice-based support. Programs considering its adoption should conduct rigorous process, impact and outcome evaluation of pilot programs before embarking on large scale implementation of train-the-trainer programs. Evaluation needs to determine whether secondary trainees deliver the program with adequate fidelity and whether they achieve impacts and outcomes for the target population that are co-measurate with those achieved by primary trainees.

Achieving and sustaining behaviour change

Most of the Strategy projects focused primarily on the measurement of immediate learning including knowledge, attitudes, skills and confidence. Given this focus it is of considerable concern that few of the training programs were able to demonstrate substantial improvements in the areas of knowledge taught and tested. Nevertheless some programs were able to demonstrate changes in skills and behaviour. It has been suggested that merely concentrating on the issue of suicide for an intensive period of time could be sufficient to account for the effects of suicide prevention training (Tierney 1994). The current group of projects do not provide a convincing rejection of this hypothesis.

Improved understanding of the processes by which suicide prevention training leads to behaviour change and improved outcomes for clients is critical. This will require more fine grained measurement and testing of the effects of specific features and components of training including content, mode of delivery and ongoing support and the interaction between these. The current group of projects have provided some useful hypotheses about factors that may play important roles. Further work is required to refine this knowledge *(Recommendation 3.1, second dot point).*

One strong finding emerging from the current group of projects is that one-off training sessions can achieve initial increases in knowledge and skill and

positive changes in attitude among trainees but that meaningful and sustained changes in behaviour may not be possible unless trainees are provided with some form of follow-up to this training.

This finding is consistent with one of the most extensive evaluations of suicide prevention training ever conducted. This involved a depression education program targeting general practitioners on the Swedish island of Gotland (Rihmer, Rutz and Pihlgren 1995). The suicide rate on the Island did fall (among women only), but long-term follow-up of outcomes found that the suicide rate returned to baseline after three years. The evaluators concluded that to have sustained benefit, education programs may need to be repeated every few years.

Projects funded under the National Youth Suicide Prevention Strategy have not been able to rigorously test the effectiveness of repetition of training but they have identified a variety of follow-up options which would facilitate the repetition or reinforcement of learning impacts. These include: practice-based learning; repeated training sessions; and provision of handbooks or manuals that trainees can continue to study at their own pace.

Training participants identified barriers in the practice environment that inhibited the application of skills and practices learned in training. In his seminal work on the evaluation of training programs, Kirkpatrick (1994) has pointed out that barriers often stand in the way of learners who want to apply new learning. Training programs that are effective in instilling new knowledge and skills cannot be effective in achieving 'results' unless environmental factors are conducive to the effective application of new learning.

An aspect of the results of the National General Practice Youth Suicide Prevention Project evaluation that is cause for interest and concern is the fact that general practitioners who received training did not nominate some of the key recommended detection strategies (specifically, increased asking, more direct inquiry, being aware of risk) as strategies they would employ any more frequently than untrained general practitioners. This suggests that untrained GPs have equal knowledge about or insight into these recommended strategies.

This raises questions about impacts of training on the use of these strategies. The National General Practice Youth Suicide Prevention Project team suggest that the difference provided by training may lie in skills and confidence to employ what is known. Another plausible explanation is that these recommended strategies do not fully capture or represent the techniques that trained GPs were using that enabled them to improve detection of psychological distress and suicidal ideation and whether these recommended strategies are in fact the most important ones. Other intuitive skills unrelated to knowledge such as empathic listening are also likely to be important.

This finding underscores the importance of conducting evaluation research aimed at dissecting the process of translating new knowledge into behaviour. Qualitative

follow-up research that encourages trainees to reflect on their developing practice may be valuable in this regard.

Practice-based learning has been identified as a mode of training that is likely to be the most effective in stimulating learning and sustained behaviour change. Practice-based learning appears to work by ensuring that the content of training is highly relevant to the target group and is responsive to factors in the practice environment that can inhibit the implementation of new learning.

The efforts of the National Youth Suicide Prevention Strategy provide substantial opportunities to advance this work. The projects that have provided training to general practitioners have identified practice audits as a method of both evaluating and providing training in an integrated fashion. The National General Practice Youth Suicide Prevention Project has received funding to explore the possibilities for expanding the use of practice audits with general practitioners.

It is recommended that funding be provided to explore the utility of practice audits in training and evaluating the long term impacts and outcomes of training with other groups of professionals *(Recommendation 3.1, third dot point)*. This work could begin with a systematic long-term follow-up of the cohorts of professionals that have recently received training under the Strategy.

Content of suicide prevention training

The major suicide prevention training programs funded under the National Youth Suicide Prevention Strategy focused strongly on the task of conducting suicide risk assessment. While some also aimed to address management of suicidal behaviour this tended to not be covered in depth.

That suicide risk assessment is equally important for all types of workers appears to have been assumed uncritically and is not founded on published research evidence. A more plausible hypothesis is that systematic risk assessment or monitoring of suicide risk is an important practice for general practitioners and case managers who work individual clients over a length of time and who are in a position to modify management strategies in response to changes in risk status. But it is not as clear that detailed risk assessment is as important for other types of workers such as, for example, telephone counsellors.

There are several areas of competency other than suicide risk assessment that have been identified as critically important to youth suicide prevention but which have not been adequately addressed in the Strategy training programs.

Several Strategy-funded projects provided training to professionals in primary prevention and early intervention programs. These were not generally perceived as providing "suicide prevention training" but it is reasonable to suggest that skills in primary prevention and early intervention are just as important to suicide prevention as skills in suicide risk assessment and management of suicidal behaviour. This is particularly true for general practitioners and community health professionals.

One area of competency particularly relevant to early intervention with young people at risk of suicide are skills in engagement. Engagement skills are also critical for high quality risk assessment and ongoing management of problems. The results of projects that have worked with marginalised young people at high risk of suicide and young people with mental health problems (see Technical Report Volume Four) indicate that assessment is a process rather than an event. Young people, particularly young males, rarely open up to professionals or other helpers about their emotional problems on their first visit or counselling session. Rather, issues are revealed gradually as trust is built up. Engagement skills are essential if a professional or any other helper is to win the trust of a young person.

Staff and evaluators of projects targeting marginalised and disaffected young people, and young people who have attempted suicide, identified the need for training of primary health care, youth health and welfare agency staff in the area of mental health and mental disorders, particularly the management of mental disorders – especially depression and personality disorders (Martin, Roeger, Marks and Allison 1999).

In summary, suicide prevention requires more than suicide risk assessment. The content of suicide prevention training needs to reflect the diversity of approaches required in order to address the youth suicide problem comprehensively including mental health promotion, primary prevention, early intervention and community development, in addition to crisis intervention and management of mental disorders *(Recommendation 3.2, first dot point).*

Clearly the content of any particular suicide prevention training program needs to vary according to the professional group targeted for training. The design of training programs needs to be sufficiently flexible to accommodate variations in the previous knowledge and skills of specific groups of trainees both between and within professional groups. Modular designs may often provide such flexibility.

While it is important for training providers to have awareness of how the suicide prevention training needs of different groups of professionals may vary, benefits may also accrue from increased awareness of where training needs do actually converge. One area of convergence that stands out strongly concerns the role of training in facilitating collaboration between professionals in different sectors.

The National Youth Suicide Prevention Strategy projects described in other volumes of this Technical Reports series revealed evidence of negative attitudes that professional groups hold about each other. For example, youth workers frequently believe that most doctors and mental health professionals are overly formalistic and controlling and are therefore unable to engage with young people. Conversely, doctors and mental health professionals frequently believe youth workers are unprofessional because they do not put sufficiently clear boundaries around their relationship with young people. While these judgements may be

accurate in some cases they are often over-generalised to all members of the professional group in question, and held with a level of conviction that limits openness to the possibility of working more closely together.

Because intersectoral collaboration is so critical to youth suicide prevention it will be important for suicide prevention training programs to include content that explores and challenges professional attitudes and other barriers to working together *(Recommendation 3.2, second dot point).*

It was noted in various project reports that training sessions involving mixed groups of professionals from different services can facilitate increased levels of networking (see Chapter 4 in this volume). This appears to result from increased levels of knowledge, understanding and trust between the different groups of professionals involved. Mixed training provides professionals with the opportunity to learn about the kinds of services provided by other professionals and the constraints they are working under. It was occasionally reported that long held assumptions and negative attitudes were challenged and dispelled.

Designing and delivering training programs that facilitate the exchange of knowledge and skills between different partners, including mental health services, youth health services, general practitioners and non-government agencies will require the development of training systems with the capacity for engaging relevant partners at all levels in service systems including senior management. Considerable infrastructure development is required to create such systems. Mental health services should adopt a leadership role in this infrastructure development *(Suggestion 3.2a).*

Priorities for policy and program development

Increasing the number of professionals who have training in suicide prevention relevant to their professional roles, and ensuring that those who receive training have opportunities to reinforce and build on this learning, is critical. Mechanisms to provide this ongoing professional development are required. Identifying the most appropriate mechanisms requires consideration of the issues of content as well as factors within practice environments that inhibit or facilitate implementation of good practice for particular groups of professionals.

As noted earlier, content in the area of mental health and mental disorders, particularly the management of mental disorders, has been identified as requiring greater attention. General practitioners, community health professionals, youth workers, and staff of welfare agencies have also identified lack of access to support from specialist mental health services as the major barrier to fulfilling their roles in providing primary health care and other welfare services to young people at risk of suicide (see Technical Report Volumes Three and Four).

This suggests the potential value of increasing the involvement of specialist mental health services in provision of training and ongoing professional development

and support to primary health care professionals and staff of welfare services. At the same time, mental health service providers can learn much from professionals in youth health services and non-government agencies about working with young people especially in the areas of engaging young people and making services more accessible, as well as community-based approaches to primary prevention and early intervention (see Technical Report Volume Four for more details).

There is a lack of infrastructure for the proper training of professionals who would deliver training and support in suicide prevention and child and adolescent mental health to professionals in primary health care services, non-government agencies and mental health services. Development of such infrastructure should be a priority for the Second National Mental Health Plan, the new National Suicide Prevention Strategy, and state and territory governments.

In addition to formal training of professional trainers, Area and Regional Mental Health Services will need to identify the specific mechanisms by which they will provide ongoing education and support in suicide prevention and child and adolescent mental health to both primary health care professionals and their own staff. These mechanisms will vary according to the demographics of particular regions and the availability of resources. Many regional mental health services will lack sufficient resources unless additional funds are made available. This will also be a problem for many youth health services and non-government agencies who may be called upon to provide training.

Thus a key consideration is how Area Health Services and state and territory governments can ensure that adequate funds are made available for this purpose. Areas that do not have specialist mental health services available locally will require assistance from other sources. Similarly, states and territories should ensure that all agencies and organisations requiring training are provided with funds that allow them to undertake youth suicide prevention training, including funds for temporary replacement of staff attending training *(Recommendation 3.3)*.

It may be beneficial for governments and authorities such as Area/Regional Health Services to develop Action Plans which describe how infrastructure for training in suicide prevention and child and adolescent mental health could be developed *(Sugestion 3.3a)*.

In addition to the resourcing issues noted above, other important points that would need to be addressed in Action Plans include: mechanisms for harnessing the expertise of all relevant partners including mental health services, youth health services, Divisions of General Practice, universities, TAFE; content of training for professional trainers and general guidelines for training of professionals in different sectors; and how training will be delivered to both professional trainers and at the local level.

The Action Plans should also document possible models of collaboration for state and territory governments such as interdepartmental committees or special

collaborative training units as well as area and regional service systems (see Chapter 4 in this volume).

The need to develop stronger partnerships between specialist mental health services, the primary health care sector, and the non-government sector has been prioritised in the Second National Mental Health Plan (Australian Health Ministers 1998). The partnership approach acknowledges that all partners have an important contribution to make to reaching the aim of reducing suicide or improving the mental health and wellbeing of young people.

It would appear important for all states and territories to develop specific plans consistent with National Mental Health Policy regarding the development of partnerships. New South Wales has made a commitment to this work in its child and adolescent mental health policy, *NSW Strategy for Children and Adolescents: Making Mental Health Better* (NSW Health 1999), which specifies that specialist child and adolescent mental health workers will provide assistance to primary health care sector professionals in the form of liaison, consultation, education and support. New South Wales has developed a Child and Adolescent Mental Health Education Program which is incorporating the provision of training for primary health care workers "in a collaborative work-based context to identify and respond appropriately to a range of mental health problems" (p.7). It is important that all states and territories make similar commitments *(Suggestion 3.3b)*.

The current group of projects have demonstrated that training is more likely to be received well by trainees and to result in learning gains and behaviour change when it is delivered by expert, professional trainers. In many parts of Australia, child and adolescent mental health services are newly established and staff of these services are only beginning to acquire the knowledge and skills required to provide a quality service to children and adolescents with mental health problems and their families. Expertise in suicide intervention, early intervention and primary prevention in particular is poorly developed throughout mental health services.

Serious questions need to be raised about the competency of most child and adolescent mental health workers to deliver effective training and support to primary health care professionals in regard to suicide prevention and management of mental health problems in adolescents. Child and adolescent mental health workers who provide training to primary health care professionals need to have high levels of expertise in the content areas they are teaching. In addition to this, general expertise in child and adolescent mental health services will need to ensure such staff have received adequate training in, first, suicide prevention and, second, in adult education *(Suggestion 3.3c)*.

The Certificate IV in Workplace Training, which is a nationally recognised qualification, could be customised to complement existing training modules in suicide prevention and child and adolescent mental health. Further consultation will be required with professionals in different sectors to identify core suicide

prevention and child and adolescent mental health training requirements. As recommended by Balsamo (1999), training of professional trainers should be undertaken by a training organisation which has the capacity to deliver training on a national basis, experience and expertise in the delivery of training to the Human Services sector, and especially in youth suicide prevention.

Other issues in the evaluation of training

Development of theory and models of evaluation in suicide prevention training is an area in need of attention. In 1993, Kraiger, Ford and Salas noted there were no theoretically-based models of training evaluation. Little progress has been made in this area. However, development of theoretically-based program evaluation requires theoretically-based programs. While theory is reasonably well advanced in many areas of training practice, this is not the case in suicide prevention training. Rather, the design of training programs has been based on a limited set of largely untested assumptions about what sorts of knowledge and skills professionals should have in order to intervene effectively with a person who is suicidal.

Development of suicide prevention training theory could be enhanced by greater critical reflection upon issues such as how knowledge and skill requirements might vary for different types of professionals and settings and the processes by which particular training programs lead to behaviour changes in trainees and enhanced outcomes for clients. Understanding of such issues is weak even in the most basic area of the content of materials.

There is a suggestion in the findings of the current set of projects that learning is enhanced when training materials are highly relevant to the target group and that this relevance is associated with consultation with the target group. Future evaluation research could fruitfully explore the implications of this finding and the complexity of factors that might need to be considered when designing suicide prevention training for different groups of professionals. Unfortunately, the current group of projects did not provide much discussion of this important issue.

Future evaluation should include formative and outcome evaluation in addition to the usual process evaluation. Formative evaluation should focus on clarifying the appropriate goals and objectives of training. Outcome evaluation is needed to determine whether indicators of process such as satisfaction of participants and their perception of the amount of learning obtained, actually translate into objectively measureable changes in practice and improved outcomes for clients.

This will require greater clarity in regard to the broader goals and objectives of training. Goals and objectives need to extend beyond the immediate impacts on skills and knowledge of learners and define a vision of how services and programs should be delivered. An attempt should be made to incorporate into all training programs a follow up program in the work places, in order to support practice change.

Clear and measurable performance indicators for individual services and service systems would provide valuable guidance to the design of training programs and relevant evaluation that is cognisant of the broader service, community and policy context.

Recommendations and suggestions

It is recommended that:

3.1. 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.

(This is Recommendation 29 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

3.1a The Commonwealth and the states and territories provide resources to further develop, pilot and evaluate methods of providing training and ongoing professional development and support relevant to suicide prevention via distance learning to primary health care and specialist mental health professionals in rural and remote areas. Statewide training bodies such as the NSW Institute of Psychiatry and tertiary children's hospitals as well as universities and Divisions of General Practice would be in a position to carry out this work.

It is recommended that:

3.2 Training in youth suicide prevention should prioritise the following content issues:

- mental health promotion, primary prevention, early intervention and community development, in addition to crisis intervention and management of mental disorders;
- exploring and challenging professional attitudes and other barriers to working intersectorally.

(This Recommendation 30 in the evaluation overview,"Valuing Young Lives".)

It is further suggested that:

3.2a Training systems be designed to support the exchange of knowledge and skills between different partners, including mental health services, youth health services, general practitioners and non-government agencies. Considerable infrastructure development is required to create such systems. Mental health services should adopt a leadership role in this infrastructure development.

It is recommended that:

3.3 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.

(This Recommendation 31 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

3.3a Governments and authorities should develop Action Plans for provision of training in suicide prevention and child and adolescent mental health. Key considerations for Action Plans include:

- mechanisms for harnessing the expertise of all relevant partners including mental health services, youth health services, Divisions of General Practice, universities, TAFE;
- content of training for professional trainers and general guidelines for training of professionals and other providers in different sectors; and
- how training will be delivered to both professional trainers and at the local level.

3.3b State and territories should develop child and adolescent mental health policies and plans that specify mechanisms through which child and adolescent mental health services will provide ongoing education, consultation, liaison and support to primary health care services including general practitioners, community health workers, youth health services as well as relevant non-government agencies and hospital accident and emergency departments.

3.3c Mental health professionals and others who provide training in suicide prevention and child and adolescent mental health need to have high levels of expertise in the content areas they are teaching. In addition to general expertise in child and adolescent mental health, services will need to ensure such staff have received adequate training in, first, suicide prevention and, second, adult education/workplace training.

Project reports

Balsamo, F. (1999), *National Training Project for the Prevention of Youth Suicide: Final Report*, Victoria University of Technology, Melbourne.

Beckinsale, P., Martin, G. & Clark, S. (1998a), *Keep Yourself Alive Evaluation Report: General Practitioners*, Southern Child and Adolescent Mental Health Services, Bedford Park, SA.

Commonwealth Department of Health and Aged Care & University of Wollongong (1999), *National Youth Suicide Prevention Strategy Resource Guide on Education and Training*, Department of Public Health, University of Wollongong.

Goldflam, A., Chadwick, R. & Brown, G. (1999), *'Here for Life' Youth Sexuality Project: Evaluation and Final Report.*,WA Aids Council, Perth.

King, R., Nurcombe, B. & Bickman, L. (1999*), Kids Help Line Suicide Intervention Strategy Evaluation: Report 2 – Iplementation, Impact and Outcome of Suicide Prevention Training for Telephone Counsellors*, Department of Psychiatry, University of Queensland, Brisbane.

Littlefield, L., Burke, S., Trindor, M., Woolcock, C., Story, K., Wilby, A. & Falconer, B. (1999), *Exploring Together Program: Final Report – Training Component of the Project.*,Victorian Parenting Centre, Carlton South.

Martin, G., Beckinsale, P. & Clark, S. (1999b), *Keep Yourself Alive Evaluation Report: Community Health Professionals*, Southern Child and Adolescent Mental Health Services, Bedford Park, SA.

Martin, G., Roeger, L., Marks, L. & Allison, S. (1999), *Final Evaluation Report for the Centacare Youth Suicide Intervention Program*, Southern Child and Adolescent Mental Health Service, Adelaide.

Pfaff, J.J., Acres, J.G. & McKelvey, R.S. (1998), *National General Practice Youth Suicide Prevention Project: Final Report*, Perth Central Coast Division of General Practice, Subiaco.

Rolfe, A. & Turley, B. (1999),"Lifeline Australia Youth Suicide Prevention Project: Interim Evaluation Report Volume 1", Lifeline. (Unpublished).

Shocket, I. & Harnett, P. (1999), *Resourceful Family Project: Final Report: A National Project Funded by the Department of Health and Aged Care Under its Supporting Families: National Parenting Initiative*, School of Applied Psychology Griffith University, Brisbane.

Waring ,T., Hazell, P. & Hazell, T. (1999), *Youth Suicide Prevention: National University Curriculum Project: Summary Report*, Hunter Institute of Mental Health and University of Newcastle, Newcastle.

Other references

Australian Health Ministers (1998), *Second National Mental Health Plan*, Mental Health Branch, Commonwealth Department of Health and Family Services, Canberra.

Kirkpatrick, D. (1994), *Evaluating Training Programs: The Four Levels*, Berrett-Koehler Publications, San Francisco.

Kraiger, K., Ford, K. & Salas, E. (1994), "Application of cognitive, skill-based, and affective theories of learning outcomes to new methods of training evaluation", *Journal of Applied Psychology*, vol. 78, no. 2, pp. 311-328.

Neimeyer, R.A. & Pfeiffer, A.M. (1994), "Evaluation of suicide intervention effectiveness", *Death Studies*, vol. 18, pp. 131-166.

NSW Health (1999), *NSW Strategy for Children and Adolescents: Making Mental Health Better*, NSW Health, Sydney.

Rihmer, Z., Rutz, W. & Pihlgren, H. (1995), "Depression and suicide on Gotland: an intensive study of all suicides before and after a depression-training program for general practitioners", *Journal of Affective Disorders*, vol. 35, pp. 147-152.

Tierney, R.J. (1994), "Suicide intervention training evaluation: a preliminary report", *Crisis*, vol 15. no. 2, pp. 69-76.

CHAPTER 4

Networking and intersectoral collaboration

This chapter presents and analyses information about the networking and intersectoral collaboration activities funded under the National Youth Suicide Prevention Strategy.

Networking and intersectoral collaboration are instrumental activities which aim to improve the effectiveness and efficiency of service or program planning, delivery and evaluation. Projects and activities in this group have sought to develop formal and informal links between a wide range of organisations as well as individual professionals and community members involved in activities directly or indirectly related to suicide prevention.

Details of the main networking and intersectoral collaboration projects and activities funded under the Strategy are shown below. Two recomendations (4.1 and 4.2) and one further suggestion (4.2a) are provided at the end of this chapter.

Networking and intersectoral collaboration activities

The information reported here derives from nine projects that used networking or intersectoral collaboration either as the main strategy or as a secondary strategy (Table 4.1).

Projects that used networking and intersectoral collaboration as the main strategy were: AusEinet; Here for Life Networking Project; the Community Linkage Project at High Street Youth Health Service; and the Community Linkage Project at Cellblock Youth Health Centre.

Projects that used networking and intersectoral collaboration as a secondary strategy were: Centacare Youth Suicide Prevention Program; Connexions; Limelight; Mind Matters; and Shoalhaven Combined Services.

Many other Strategy projects involved collaboration with agencies in their own or other sectors, too many to cover in detail here. Interested readers should refer to other chapters and volumes of the Technical Report series for information about networking and collaboration relevant to those approaches.

TABLE 4.1 Summary of networking and intersectoral collaboration activities of the Strategy

Project name	Organisation	Targets for networking and collaboration	Evaluation design and/or methods (networking component)
AusEinet	Flinders University and the University of Adelaide	Clinicians, researchers, policy makers, consumers and carers in a variety of sectors	Survey of network members
Here For Life Networking Project	Logan Area Division of General Practice and the Southern Queensland Rural Division of General Practice	General Practitioners; Community Health and other community based services	Review of project documentation
Community Linkage Project	High Street Youth Health Service	Hospital accident and emergency departments; Mental health services; Other community based services	Review of project documentation; Interviews with stakeholders
Community Linkage Project	Cellblock Youth Health Centre	Hospital accident and emergency departments; Mental health services; Other community based services	Review of project documentation; Interviews with stakeholders
Centacare Youth Suicide Intervention Program	Centacare, Adelaide	Mental health services Other non-government agencies	Interviews with staff in target agencies
Connexions	Jesuit Social Services	Community based services	Ethnographic research; Interviews with service providers
Limelight	The Bridge Youth Health Service	Community based services	Review of project documentation Interviews with stakeholders
Mind Matters	Youth Research Centre University of Melbourne and partners	Schools Community agencies in schools' local areas	Interviews with school personnel and project team members
Shoalhaven Combined Services	Shoalhaven Combined Services	Hospital Accident and Emergency Department Social Work Department Mental health services Youth service Other community based services	Analysis of data from emergency department patient database; Historical documentation

AusEinet

AusEinet (Australian Early Intervention Network for Mental Health in Young People) was funded jointly by the National Youth Suicide Prevention Strategy and the National Mental Health Strategy. Its aim is to promote the development of early intervention services and programs for children and young people with mental health problems. During the course of the National Youth Suicide Prevention Strategy the AusEinet project had three interrelated streams. Stream I involved the development and maintenance of a national network involving clinicians, researchers, policy makers, consumers and carers. Communications were a major component of Stream I activities and these are described and discussed in Chapter 2 of this volume. Stream II and Stream III of AusEinet are described in Volume Two of this Technical Report series.

Here for Life Networking Project

The Here For Life Networking Project was implemented in one urban and one rural location in Queensland – Logan, a satellite city near Brisbane and Southern Queensland. The project involved a consortium of members including the Logan Area Division of General Practice, the Southern Queensland Rural Division of General Practice, the Queensland Department of Education – South Coast Region, and the Training Program of the Royal Australian College of General Practitioners.

The higher order goal of the Here For Life Networking Project was to develop a model that would facilitate the identification, referral and treatment of young people at risk of self-harm. Development of community networks was the main strategy employed. Secondary strategies that were attempted include: engaging general practitioners as "key" stakeholders in the networks; providing training for network members to improve their capacity to identify and respond to young people at risk of self harm; and develop and implement an action plan involving a model for the networks to identify, refer and treat youth at risk.

High Street Community Linkage Project

High Street is a Youth Health Service in the western suburbs of Sydney. The Community Linkage Project aimed to enhance service linkages and referral networks for young people aged 12–25 years at risk of attempting suicide in the Parramatta, Baulkham Hills and Holroyd areas of Sydney.

Specific aims of the project were to: identify other youth suicide prevention projects and activities in the area; check for duplication, gaps and barriers to integration; develop a collaborative working culture to address the former objective; consult with target groups about the use of youth health services and encourage informed discussion; and undertake an evaluation of the project with a view to implementing "best practice" strategies for enhancing linkages. Organisations identified as the primary target groups for the project included: child and adolescent medicine and

psychiatry units, child and family teams; emergency departments in local hospitals; community services; and the Western Sydney Area Mental Health Service. Findings from the consultations were documented and distributed to the target groups.

At the time of its completion, the project had established a Hospital Protocol Working Party; was developing a Youth Mental Health Working Party; had developed a position for a Youth Suicide Nurse Liaison; and was contributing to Area policy development and facilitating change in agency level values and practice. Ongoing meetings of separate working groups and intergroup networking are proceeding.

A resource manual for workers in mainstream and community-based services, *Link-Up: A Suicide Prevention Resource for Working with Young People*, was developed which provides a directory of services, emergency contact numbers and details of crisis services including description and criteria for referral.

Cellblock Community Linkage Project

Cellblock is a Youth Health Service based near the inner city of Sydney. The Cellblock Community Linkage Project had very similar aims to the High Street Community Linkage Project, however it was not implemented as comprehensively as its sister project.

Centacare

The Centacare Youth Suicide Intervention Program was developed to enhance the support services available to young people at high risk of suicide and promote best practice. The project focused on enhancing the capacity of non-government welfare services to provide an appropriate service to young people with mental health problems. The major activities of the project included: provision of mobile assessment and consultation; input into case planning and management; training in suicide risk assessment; development of links between mental health and community-based services; and development of support networks and resources, including both peer and family supports.

The Centacare team comprised two clinicians who worked in collaboration with agencies supporting young people at risk of suicide. Assessment and consultation services provided by the team included: primary assessment (one-to-one with the young person) and secondary assessment (with the agency worker). About 250 primary and secondary consultations (essentially broad psycho-social assessments) were undertaken with a range of agencies including Supported Accommodation Assistance Program services, health services, sexuality services and schools, both public and private. Consultation took place wherever the young person was located.

Suicide Risk Assessment training was developed and provided as in-service training. The project provided training to a total of 409 participants.

Other activities undertaken by Centacare which were aimed an enhancing networking and interagency collaboration included: a seminar on mental health issues for young people; participation in the development of the Supported Accommodation Assistance Program (SAAP) Suicide Intervention Guidelines; consultations on developing a formal protocol between non-government and mental health services assisting young people; and participation in three committees operating to improve service delivery and interagency linkage. (More details about the Centacare project are provided in Volume 4 of this Technical Report series.)

Connexions

Connexions is a program of Jesuit Social Services in inner Melbourne which provides a service to young people experiencing a variety of complex problems that place them at high risk of suicide. Connexions has a strong orientation to enhancing collaboration with other service providers in order to enhance the access of marginalised young people to all needed services and to enhance the competency of providers in working with young people with complex problems. Collaborative strategies used by Connexions staff include: provision of training; provision of clinical supervision; secondary consultation; and co-case management of clients. (More details about the Connexions Project are provided in Volume 4 of this Technical Report series.)

Limelight

The Limelight project was based at the Bridge Youth Health Service in Shepparton Victoria. The project mainly involved a therapeutic drama group for young people who have attempted suicide. Two productions were completed. The project worked closely with professionals in other agencies who were providing services to the young people involved in the project. (More details about the Limelight project are provided in Volume 4 of this Technical Report series.)

Mind Matters

The Mind Matters project developed and trialed structured resources to support a whole-school approach to mental health promotion in secondary schools. Mind Matters focused on curriculum; ethos and organisation; and building partnerships between schools and community agencies. The program was piloted in 24 schools throughout Australia.

The Mind Matters project was managed by an intersectoral consortium consisting of the Youth Research Centre at the University of Melbourne, the Faculty of Education at the University of Sydney, the Faculty of Health and Behavioural Sciences at Deakin University and the Australian Council for Health, Physical Education and Recreation. (More details about the Mind Matters project are provided in Volume 2 of the Technical Report series.)

Shoalhaven Combined Services

Shoalhaven Combined Services were provided with funding under the National Youth Suicide Prevention Strategy to evaluate the impacts of a mechanism to enhance collaboration between agencies involved in crisis intervention following self-harm and suicide attempt presentations to emergency departments in the region of Shoalhaven, New South Wales.

The major collaborative mechanism was a regular fortnightly Combined Services Meeting which developed and adopted a protocol for the identification, immediate care and follow-up of intentional self-harm clients. The meeting provides an opportunity for staff from each agency to monitor, provide feedback and review action that has been taken in regard to patients identified as in need of follow-up. Case histories are discussed and the current and potential roles of each service in regard to clients are identified. Information about outcomes for clients is also presented. (More details about the Shoalhaven project are provided in Volume 3 of this Technical Report series.)

Results of the evaluation

The results of the evaluation of networking and intersectoral collaboration activity are organised around two questions:

- What facilitates the process of networking and intersectoral collaboration?
- What facilitates the achievement of higher order aims of networking and collaboration?

One of the problems faced in evaluating the impacts and processes of these projects is a lack of clarity regarding to the definition of a good or effective network or collaboration. Is an effective network only one that can be shown to be instrumental in achieving its higher order goals and objectives? If achievement of higher order outcomes cannot yet be measured are there "process indicators" of a successful network? Are these distinguishable from the factors that contribute to the instrumental effectiveness of the network or the factors that facilitate the process of establishing networks or collaboration? These questions are not addressed in the project reports. Also, at times, there is a considerable lack of clarity with regard to the higher order goals, objectives and aims of networking and collaboration in the projects discussed here.

What works to facilitate the process of networking and intersectoral collaboration?

Information presented in the reports of the projects in this group suggests that the National Youth Suicide Prevention Strategy projects achieved varying success in developing functioning networks or establishing intersectoral and intrasectoral collaboration.

Developing a national network for early intervention in mental health in young people was one of the three major strategic aims of the AusEinet Project and developing the network comprised one of the three streams of the project. The main method used to evaluate Stream I of AusEinet was a General Evaluation Survey which examined knowledge of and attitudes towards AusEinet in a random sample of AusEinet members. A total of 277 questionnaires were distributed and 154 completed replies were returned, a response rate of 56 per cent.

The external evaluation of the AusEinet Project (Burgess, Fleming and Browne 1999) found that AusEinet was successful in developing the Network. Indicators of success identified in the evaluation were: first, the substantial number of network members (2710 people and organisations) and the breadth of professions and sectors included in the Network database; and, second, the value of AusEinet activities to the membership.

Two limitations in the achievement of AusEinet identified by the external evaluators were the failure to effectively engage consumers in the Network, and a low level of active participation by network members.

The original intention was that AusEinet would be the "hub" of a network with a series of "spokes" or local support groups for early intervention. However, the evaluators find that this has not eventuated due to a lack of funding to support a variety of small groups and a lack of coordinators to help establish and maintain groups. Burgess, Fleming and Browne (1999) suggest that this aim might have benefited from greater involvement by individual members of the AusEinet Network.

In evaluating the achievements of the AusEinet Network, Burgess, Fleming and Browne (1999) examined several other similar networks that have been developed in the United States and elsewhere. It is noted that network development is a slow process and that considerable time and resources are needed to maintain membership awareness and participation. It is noted that AusEinet achieved a substantial number of members on the database compared to some other similar networks, but a proportion of these have little awareness of AusEinet. The evaluators recommend that the network should be nurtured, expanded and maintained. An important element of this process may be strategies that encourage more active input and participation by a wider range of members. This range of members should include consumers.

The higher order goal of the Here For Life Networking Project was to develop a model which would facilitate the identification, referral and treatment of young people at risk of self-harm. Development of community networks was the main strategy employed. Secondary strategies that were attempted included: engaging general practitioners as "key" stakeholders in the networks; providing training for network members to improve their capacity to identify and respond to young people at risk of self harm; and develop and implement an action plan involving a model for the networks to identify, refer and treat youth at risk.

The final report of the Here For Life project (Groom 1999) concluded that these strategies were only partially implemented. Considerable difficulties were encountered in the implementation of this project, particularly in the Logan Area, but also in Southern Queensland. These difficulties resulted in changes to the project and evaluation staff and changes in the direction of the Logan project. Key aspects of the project, particularly in the early phase, were not adequately documented or evaluated.

As part of the Here For Life Project, the Southern Queensland Rural Division of General Practice established 29 youth suicide prevention networks: 13 of the 29 networks were described as "operative" and these met between four and 11 times over the period of the project. Approximately 300 people were estimated to be actively involved. "Active involvement" was defined as having attended more than one meeting.

In Logan, a network consisting of five separate clusters of stakeholders was established. Clusters were associated with defined geographic areas and usually included general practitioners, teachers, police officers, youth workers, university lecturers, school guidance officers, community development officers, counsellors and child health nurses.

Even though the cluster groups were formed and four educational workshops were conducted for each cluster, the final project report concludes that "there is little evidence that the clusters actually functioned as an effective network in the broader community" (Groom 1999). The project final report does not clearly specify criteria for a "functioning" or "effective" network other than a vague reference to network members contacting each other for purposes of referral or support outside of meetings that form part of the formal project activities. It is indicated that there was no evidence that such contact took place, however neither the methods used to detect or measure such contact nor the results of this inquiry are presented in the report.

The involvement of general practitioners in the networks was not as substantial as desired. Although they were involved to an extent, Groom (1999) concludes that the objective of involving GPs as key stakeholders was not met. Of the 29 networks that were initiated in the Southern Queensland Area, only five reported GP involvement. Young people were not formally involved in the networks.

The external evaluator of the Community Linkage Projects conducted by High Street Youth Health Service in Western Sydney (Kelk 1999a) and the Cellblock Youth Health Service in Central Sydney (Kelk 1999b) found that the High Street Project was highly successful but that the Cellblock Project was much less so. Both these projects aimed to improve the coordination of agencies working with suicidal or distressed youth in the respective health areas of Western and Central Sydney.

Indicators of the effective collaboration identified by Kelk focused around: an increase in the collaborative culture of the host and target agencies; improved

quality of communication between staff in the relevant agencies; and the sustainability of relationships and collaborative arrangements.

The High Street Project was found to have achieved considerable gains in these areas while the Cellblock Project did not. Kelk identifies a number of key differences in practice within these two organisations that he believes can explain this differential success.

The major aim of the Connexions Project was to enhance the quality of care provided to marginalised young people at high risk of suicide (Ridge, Hee and Aroni 1999). A key secondary aim was to strengthen collaborative links with stakeholders in the wider service system. In standardised interviews conducted with wider service system stakeholders during the evaluation of Connexions, 20 per cent reported that Connexions provided good follow-up and expressed appreciation of the level of communication Connexions had developed with their agency or other agencies. Many interviewees felt their organisation needed to access Connexions more often and were keen to further develop and formalise their links in the future. A number of respondents were impressed by the quality of linkages Connexions had managed to develop with certain services considered by some as difficult to work with such as psychiatric services.

However, staff at Connexions reported that considerable difficulties remained in linkages with mental health services in some areas. For example, Crisis Assessment and Treatment (CAT) teams and emergency departments in some locations were noted as reluctant to assist young people even if they were clearly suicidal. According to the evaluator reporting staff comments (Ridge, Hee and Aroni 1999): "A CAT team may reject a call for help if it does not involve psychosis, while an emergency department, once medical assistance has been administered, might disregard the mental health of the patient despite clear indications of suicidality."

The Limelight Project was found to be very successful in maintaining the engagement of workers who referred young people to their project (French and Kelk 1999). The success of the project and outcomes for young people depended on maintaining support worker involvement. A number of strategies were employed.

Mind Matters can be considered to be a successful exercise in collaboration between academics, mental health professionals and schools as the project was successfully piloted in 24 schools throughout Australia. Mind Matters also sought to encourage schools to develop partnerships with community agencies in their local area. This part of the project had limited success (Waring, Hazell, Holbrook and Hazell 1999).

The evaluators of the Centacare Youth Suicide Intervention Program (Martin, Roeger, Marks and Allison 1999) identified only limited achievements in the area of building links between non-government agencies and government mental

health services. The relationship between these services was identified as remaining highly problematic. Martin, Roeger, Marks and Allison (1999) suggest that the development of effective collaboration between SAAP agencies and mental health services is too formidable a task for locally based projects and that the relationship between the sectors needs to be tackled at a broader level.

➤ *Relationships based on clear communication, learning and respect*

One of the clearest themes to emerge from the networking and intersectoral collaboration projects is that of relationships. The concept of relationship is central in two ways. First, it is core to the definition of effective networking and collaboration and, second, the factors that sustain healthy relationships between human beings in any situation are also the most important factors facilitating the creation and maintenance of collaboration between organisations. Active engagement in respectful communication based on an attitude of learning from each other appears to be the essence of a healthy network or collaboration as well as the approach required to initiate, develop and sustain it. In other words effective networking and collaboration involves and requires a process of "getting to know" people and organisations by listening and learning and growing together.

Several of the factors described below are also connected to the challenge of developing organisational relationships through communication and learning.

➤ *Shared values and philosophy*

Development of collaborative relationships was easier when the organisations involved had similar values or shared a philosophical approach to the problem being addressed.

Connexions staff felt that development of effective linkages was only really possible when organisations had some commonality of culture, values and philosophy.

The evaluator of the Community Linkage Project at Cellblock Youth Health Service (Kelk 1999b) found that certain staff at Cellblock who were centrally involved with the project held a particular set of values that contrasted quite markedly with those of key stakeholders in other organisations and that these values may have made it difficult for the project to communicate effectively with these stakeholders.

These values include negative attitudes towards medicine, and psychiatry in particular, and a relatively conflictual model of the nature of institutional change. These values and attitudes were identified by people working outside of Cellblock as characterising the style of thinking of youth workers in general and Cellblock staff in particular. Kelk (1999b) notes evidence that there is a strong dislike of any form of psychiatric medication among most non-medical Cellblock staff and that these negative attitudes extend to a blanket dislike of

doctors in some instances. Cellblock staff were also observed to have very rigid views about what certain hospital institutions are like, for instance, that they are "incapable of change". Kelk (1999b: 21) notes that "curiously, this holding of fixed ideas contrasts very strongly with their own expressed views about the dangers of labelling young people with such terms as diagnostic categories", and he surmises that these negative attitudes towards medical institutions may have limited the ability of the project staff to try and initiate a dialogue with bodies such as the Department of Psychiatry in the local major tertiary hospital.

The Centacare Youth Suicide Intervention Program evaluation (Martin, Roeger, Marks and Allison 1999) found that the philosophical approaches and practices preferred by Supported Accommodation Assistance Program (SAAP) services and Child and Adolescent Mental Health Services were perceived as highly divergent by SAAP staff, to the point where they believed that Child and Adolescent Mental Health Services were largely inappropriate for SAAP clients with mental health problems. There was a widespread perception among SAAP staff that staff in mental health services needed to understand adolescent development in a broader framework, develop a more positive and respectful attitude, offer something more than "endless assessments", and receive education about the non-government sector and the Supported Accommodation Assistance Program in particular.

➤ *Communication and openness*

Communication is essential to the development of the common understanding that forms the basis of shared values and philosophy. Communication of useful information also contributes to a sense among network members that they are receiving benefits from their involvement. Kelk (1999a and 1999b) identifies openness as a critical dimension of communication aimed at enhancing collaboration. Open communication means conducting activities in a highly public manner so that stakeholders are fully aware of the project's agenda and have the information that they need in order to make choices about their involvement.

Differences in the quality of communication and openness were one of the most important factors determining the differential success of the Community Linkage Projects conducted by High Street Youth Health Service and Cellblock Youth Health Service. Activities and practices of the High Street Project that contributed to its greater openness included:

- systematic identification of key stakeholders and formal consultation with these agencies;
- documentation and publication of the results of the consultation;
- creation of a Project Reference Group with partial responsibility for directing the project;

- development of a documented project outline or plan;
- project publicity, updates, and other information distributed;
- thorough documentation of the process of project development and implementation; and
- keeping minutes of all meetings and circulating them to all those attending meetings as well as to other stakeholders.

Kelk (1999a and 1999b) discusses the importance of clear documentation of the process of project development and implementation at length. Thorough documentation appears to be critical to ensuring clear and open communication. The High Street Project was identified as being "extremely well documented". For example, almost all of the meetings between High Street staff and staff of other agencies were minuted. Interviews with key stakeholders conducted by the evaluator found that stakeholder accounts of the High Street Project were highly consistent with those of the Project Officer. In contrast, there were extraordinary variations in the perceptions of different players with regard to the aims and activities of the Cellblock Project. It is suggested that minuting of meetings provides stakeholders with the opportunity to reflect on communications that have taken place, check on the perceptions of other players and address differences as they arise.

The High Street Project is also reported as having prepared background documentation on the project to distribute to participants and as having developed a set of working guidelines which directed its work. In contrast, Kelk (1999b: 23) concludes that the activities of the Cellblock project "were kept only semi-public at best" and that project staff were "unable to engage openly with other 'key stakeholders' even in order to understand the views of key stakeholders". Kelk argues that "if the background of the project is not spelled out clearly it is possible that ambiguities will arise in the work and participants will become reluctant or puzzled participants" (Kelk 1999b: 10).

The validity of this assessment was further supported by reports of a number of situations that arose within the organisation that suggested an inability to openly acknowledge and resolve disputes between different groups of staff.

Communication was a central activity of the Networking Stream (Stream I) of the AusEinet Project. While communication and learning are aims of the network they also proved to be important facilitators of network development. AusEinet can be seen as having paid attention to the infrastructure, vehicles and content required for effective communication.

The external evaluation found that the AusEinet Database of members was the core of the Network (Burgess, Fleming and Browne 1999). The database formed the distribution system for most of the communications generated by AusEinet and was found to be an effective tool for this purpose. Burgess et al recommend that the AusEinet network database be maintained.

The AusEinetter Newsletter served an important communication function by providing information about a wide range of early intervention activities that were taking place across Australia and providing discussion of key theoretical and practical issues confronting the field. The external evaluators concluded that the AusEinetter was the most useful and accessible of AusEinet activities and "a major contributor and an effective strategy in developing and sustaining the national network" (Burgess, Fleming and Browne 1999: 20).

The other key strategies of Stream I – the *AusEinet* Website and the Einet Email Discussion Group – were also oriented towards communication between network members and the facilitation of learning. The website was designed to "establish a network presence and provide mechanisms for key stakeholders to influence the field" (Martin and Kosky 1997; cited in Burgess et al. 1999: 27).

Burgess et al. (1999) found that it is difficult at this point to assess the contribution the website has made to the Network as a whole. The evaluation found that the website was not yet being widely accessed by the child and adolescent health community. However it was argued that if the website is expanded to include information currently being prepared, regularly updated to reflect current practice and promoted through a variety of sources, it would become more widely used. Burgess et al also suggest that it could become more integral as more and more people access the internet (Further details on the evaluation of the website are presented in Chapter 2 of this volume.) The evaluation report does not include details about the impact of the email discussion list to network development.

Another major AusEinet Stream I activity was the conduct of workshops and seminars in all states and territories throughout Australia. The aim of these was to stimulate interest and discussion on early intervention and to raise awareness as well as collect information from stakeholders about their activities and the issues they were concerned about. Eleven workshops were held around Australia between October 1997 and July 1998 with over 1000 people attending. Internal evaluation of the workshops indicated that they were successful in: connecting people directly involved with or interested in the mental health of young people; expanding the AusEinet Network membership; and conveying information about the AusEinet project.

The external evaluators of the AusEinet Project conclude that "sustainability and maintenance of Stream One strategies are vital to the ongoing process of improving knowledge, commitment and reorientation of early intervention in mental health in young people in Australia (Burgess et al 1999: 35).

➤ *Flexibility and problem solving capacity*

Kelk (1999a and 1999b) found that organisational problem solving ability was an important factor behind the different levels of success experienced by the High Street and Cellblock Community Linkage Projects. In the High Street project, increased emphasis was given to activities seen as being likely to achieve positive outcomes while activities unlikely to achieve positive results were scaled down

or abandoned in a clear and public manner. It is noted that the Project Officer and her colleagues maintained "a highly flexible awareness of the project environment" and "an intimate and sensitive understanding of both the organisational needs of the target agencies and the personal needs of the staff of the target agencies". Excellent interpersonal skills of the Project Officer and other High Street Youth Health Service staff were identified as critical to this process.

➤ *Mutual benefits*

Key Commonwealth government and national non-government stakeholders consulted via individual interviews conducted by the evaluator emphasised that a critical ingredient for effective collaboration is a clear understanding of the benefits that can accrue to each of the partners from the collaborative exercise.

The difficulty of progressing when mutual benefits are not apparent is illustrated by the experience of the Here For Life Networking Project (Groom 1999). There was a high rate of attrition in the attendance of general practitioners in the Logan network meetings. Anecdotal feedback to the Division from those GPs who ceased to participate indicated that the reasons for this included an expectation from other network members that GPs would be the resource people for the group.

According to Groom (1999): "Many of the GPs reported feeling inadequate in the cluster workshops because it was not uncommon for other participants to turn to them for the answers. These GPs made the point that their motivation for participating in the cluster meetings was attributable to their desire to improve their skills and to find support, not to provide all the answers to others . . . they felt that their participation would have been enhanced if they had received some structured and targeted training prior to participating in the cluster meetings."

➤ *Clear aims and objectives*

Ability to perceive the benefits that could arise from working collaboratively may partly depend on the existence of clear aims and objectives. This factor may partly explain why special projects are often successful in achieving collaboration between multiple agencies during the course of the project. When special projects end the reasons for continuing to work together may become less clear and participation in collaborative groups tends to drop off.

Lack of clear aims and objectives appeared to be one of the major barriers to schools developing partnerships with community agencies. The Mind Matters evaluators noted that there was some confusion for schools and community agencies about the nature of the relationships that they were being asked to form (Waring, Hazell, Holbrook and Hazell 1999). There appeared to be uncertainty about the goals and objectives of partnerships, the types of activities that should be conducted in partnership as well as a lack of models that could be used to guide the development of relationships.

➤ *Education, training and consultancy*

One of the most common strategies used to address philosophical differences and build a common understanding is education and training. This work tends to have a strong flavour of promotion and advocacy.

In an effort to bridge philosophical differences identified above and to promote the organisation's model to the wider service system, Connexions has been conducting in-service training sessions for staff in other organisations. This has included, for example, training around trauma and suicidality for social workers in the health, juvenile justice and welfare sectors. Other sessions have focused on suicidality, marginality and therapy. Interviewees from the wider service system who had received this training provided positive feedback. A number of agencies that had less contact with marginalised young people (for example, a telephone counselling line and some Crisis Assessment and Treatment teams) felt that they could benefit from some training in these areas.

The Limelight Project conducted information sessions about the project and invited all agencies working with young people in their area (Shepparton, Victoria) to attend.

The Logan Area Division of General Practice delivered four three-hour training sessions. Ten GPs from the area participated in the workshops, with between eight and nine attending each session. The Final Report of the Here For Life Networking Project states that provision of training was an effective way of encouraging General Practitioners to become involved in the networks (Groom 1999), however other statements provided in the report contradict this conclusion. Even though anecdotal reports from GPs suggested they believed training would enhance their participation, only very small numbers of GPs actually remained involved in the networks, even after training was eventually provided.

Education and training was another major strategy of AusEinet. As noted earlier, a series of workshops and seminars were conducted throughout Australia. These had an education, as well as a broader communications function. A significant number of respondents to the AusEinet General Evaluation Survey indicated that the workshop/seminar did not provide them with enough tools to begin including early intervention in their daily work; however, 91 per cent of respondents indicated that they would like to attend another seminar in the next 12 months. This suggests that AusEinet members see the value and desire the provision of further education in early intervention practice.

➤ *Train mixed groups of professionals*

Providing training sessions to mixed groups of different professionals was noted by several projects to be a stimulus to the natural development of links between the professionals who attend. For example, many of the Keep Yourself Alive Project workshops were attended by mixed groups of general practitioners and professionals from other sectors including community health, education,

community welfare and the defence forces (see Chapter 3 of this volume). This mixing gives different professionals the opportunity to learn more about each other and dispel myths and misconceptions they may hold about each other, thereby removing barriers to the natural formation of trusting relationships.

The Keep Yourself Alive Project evaluation report notes that existing networks of professionals, and knowledge about who to go to when a mental health crisis occurred, were very poor in the locations where the project delivered training. It is recommended that collaborative local area networks for the development of knowledge, attitude, practice and skill in mental health be further encouraged.

Care must be taken to ensure that training provided to mixed groups is actually appropriate to the diversity of the group (see Chapter 3 of this volume).

➤ *Supervision*

During the National Youth Suicide Prevention Strategy, Connexions began trialing an interagency supervision and support group which aims to provide support, supervision and guidance to workers in the youth field around issues of dual diagnosis. The first session was reported as a success, with many participants requesting ongoing sessions to further assist their capacity to deal with dual diagnosis clients.

The Limelight Project also included fortnightly supervision of young people's support workers as the core component of a concerted effort to ensure their ongoing engagement with their creative arts project. Supervision included a strong focus on developing the support workers' knowledge and understanding of the therapeutic principles underlying the arts project and reinforcing the ongoing role of the worker in supporting the young people referred to the project.

➤ *Allowing relationships to develop naturally*

A number of projects that attempted to improve collaboration between different groups of professionals went through painful periods of conflict before any improvements in collaboration were achieved. This experience was especially problematic for some of the projects based in hospital accident and emergency departments that tried to develop formal protocols (see Chapter 1 of Technical Report Volume 3 for more details). In some cases the conflict was part of a process of learning and change that ended positively. In others, the process appears to have been unnecessarily disruptive and it is possible that serious damage was done to some of the individuals involved.

One project stands out from the others by virtue of the lack of reported conflict on the path to collaboration. The Shoalhaven Combined Services Project aimed to evaluate the impacts of a mechanism to enhance collaboration and communication between agencies involved in crisis intervention following self harm and suicide attempt presentations to Hospital Emergency Department's in the Shoalhaven

region of New South Wales. The mechanism under evaluation was an interagency collaboration called the Combined Services Meeting. The Shoalhaven Combined Services Meeting began in 1991 with the initiation of liaison between the Emergency Department Nurse Unit Manager and the Mental Health Team Leader. This evolved into a regular fortnightly meeting of 30 to 45 minutes with half Emergency Department and half Mental Health Team representation. Over the years the meeting was gradually joined by the Social Work Department, the hospital Aboriginal Liaison Officer, representatives from Youth Health, and the Community Health Centre Drug and Alcohol Service, and the meeting now goes for 90 minutes.

➤ *Stability in staffing*

High staff turnover is also likely to be a problem for building sustainable links if communication depends heavily on relationships between individual staff members, as seems to be the case. The evaluators of the Centacare Youth Suicide Intervention Program (Martin et al. 1999) noted that of the 26 staff from 18 Supported Accommodation Assistance Program agencies included in the original interviews, only 11 were still available one year later. Many of those not followed up had left the agency or were on maternity leave. Formal mechanisms at the service management level would appear essential for maintaining links that are robust to the transitions of individual staff.

➤ *Resources for coordination*

An original intention of the AusEinet Project was that AusEinet would evolve into the "hub" of a network with a series of "spokes" or local support groups for early intervention. The evaluators found that this had not eventuated, largely due to a lack of funding to support a variety of small groups and a lack of coordinators to help establish and maintain groups.

Injection of resources and coordination is likely to be one of the reasons why special projects can often be successful in achieving collaboration between multiple agencies during the course of the project. It is usually difficult to maintain active collaboration once project funding ends.

➤ *Evaluation – "wanting to know"*

It is notable that the interviews conducted for the evaluation of Connexions prompted some respondents to follow up their linkages with that organisation.

What facilitates the achievement of higher order aims of networking and collaboration?

Networking and intersectoral collaboration are instrumental activities which aim to facilitate achievement of higher order goals, objectives or aims. Projects in this group did not articulate goals phrased in terms of health outcomes or

objectives phrased in terms of impacts on risk and protective factors in target populations. Rather, projects tended to have aims that revolved around facilitating changes or building capacity within service systems.

The higher order aim of the Here For Life Networking Project was to "implement an action plan and develop a model for the networks to identify, refer and treat youth at risk" (Groom 1999: 4). Implementation of the project was seriously disrupted by management problems and the project did not attempt evaluation of any impacts on the identification, referral and treatment of young people at risk of self harm. The final report also states that the project was not successful in its aim of "implementing an action plan" or "developing a model".

The aims of AusEinet are not articulated clearly in the final evaluation report but the project was generally concerned with facilitating the adoption of early intervention activity throughout relevant service systems.

A further problem affecting both AusEinet and Here For Life was an absence of performance indicators that could be used to evaluate progress towards aims, whether stated or unstated. There remains considerable work to be done in developing indicators of system activity or capacity to undertake early intervention in suicide prevention. The findings presented below tend to be based on qualitative data gained from interviews with stakeholders about their opinions or experiences as well as the opinions of evaluators.

The higher order aims of the Community Linkage Projects based at High Street and Cellblock Youth Health Services were also not clearly articulated but they revolved around improving the quality and continuity of follow-up care provided to young people at high risk of suicide. Evaluation of the projects did not extend to exploring the impacts of the projects on this aim. The evaluator (Kelk 1999a and 1999b) notes that detection of impacts on the clinical practice of agencies requires longer term follow-up. However, he does identify a number of indicators that may be capable of predicting changes in practice. These include:

- an increased orientation towards community and policy based work within the host agency;
- an increase in the collaborative culture within the host and target agencies;
- an increase in network development in local child and adolescent agencies;
- an improvement in target agencies' knowledge of local resources;
- an improvement in the perceived ability of target agencies' staff to work with suicidal youth; and
- an increase in the level of advocacy for youth suicide prevention and youth mental health in the local area.

Kelk (1999a) reports that the High Street Community Linkage Project demonstrated clear progress against these indicators. Specifically, he identifies a number

of developments in the Area Health Service that he attributes to the impacts of the High Street Project. These include: the development of a Youth Mental Health Working Party; the creation of a Youth Suicide Nurse Liaison position; the development of a Youth Suicide Prevention Planning Committee; and the first ever visit to High Street from a director of the local child psychiatry inpatient service.

Kelk also notes that the High Street Community Linkage Project has resulted in some changes in referral processes, with High Street Youth Health Service now being used, "for the first time", as a resource to refer young people to after discharge from hospital following deliberate self harm.

It is concluded that the final outcomes of the project will depend upon whether or not Western Sydney Area Health Service chooses to maintain a commitment to youth suicide prevention. If so, it is argued that the project has created a culture in which local youth oriented agencies will be in a far better position to make a positive contribution to this ongoing work.

In spite of the difficulties in working collaboratively experienced by the Cellblock Community Linkage Project, the evaluation found that the project did achieve some positive changes in service systems. Specifically, there is some evidence that the Project played a key role in stimulating changes in the practices of Child and Family Teams as well as Mental Health Crisis Teams in the Central Sydney Area Health Service.

On consulting with all the Child and Family teams in the area, the project found that there were wide variations in practice affecting the readiness of teams to offer the kind of emergency response or crisis intervention work that might be required in the management of young people at high risk of suicide. This matter was reported to senior Community Health management in early 1998 and there have been reports from Cellblock Community Linkage Project staff as well as senior Community Health management that systematic changes have been implemented in the way that Child and Family Teams are taking referrals. A Child and Family Team Strategic Plan for the Area has also been developed and partially implemented.

A member of the Cellblock counselling staff took on the role of liaising with mental health services including an assessment of their needs and difficulties in working with suicidal young people. The evaluator reports that as a result of this, efforts have been made within the whole Area to increase education and training for mental health teams (Kelk 1999b). Cellblock staff also drew the attention of senior management to substantial variations across the Area in respect to the roles and responsibilities of Mental Health Crisis Teams in managing crises experienced by young people and providing consultation and support to staff in Emergency Departments. Some Emergency Departments had close relationships with Mental Health and others never consulted them. It is reported that the roles and responsibilities of Mental Health Crisis Teams have now been clarified and that they are now more frequently used in Emergency Departments.

➤ *A clear and agreed plan of action*

The final report of the Here For Life Networking Project refers to several inadequacies in the planning of the project. The project appeared to be characterised by a lack of any clear direction at all in relation to the roles and activities of the networks once they were established.

The external evaluator of the High Street and Cellblock Community Linkage Projects observes that the High Street Project had a clearly documented Project Outline which articulated goals, aims, objectives and activities. Most importantly, the project goals and plan were developed through a well publicised community consultation process and the Project Outline was widely distributed to contacts of the project. This apparently was not the case for the Cellblock Project. The highly public way in which the High Street project was conducted was seen as facilitating contributions to the project by stakeholders because they could more clearly see the extent to which it reflected their interests.

➤ *Ensure necessary resources and knowledge are available*

The final report of the Here For Life Networking Project notes that several of the networks took on a client intervention and referral role. However, it is also stated that: "The evaluator was unable to conclude that networks which have undertaken this path are adequately trained, resourced or supported for this role" (Groom 1999).

Network facilitators in southern Queensland were provided with the Keep Yourself Alive suicide prevention training kits developed in South Australia. The evaluator appears to believe that provision of these kits was not sufficient to support the role of community networks in the role of client intervention and referral.

The Here For Life Networking Project report does not provide a description of the "client intervention and referral" activities attempted by these networks, nor any data to support the implication that the networks were not competent to undertake this role. No data are provided about the precise level of training received by the members of the specific networks that have undertaken this role.

In his conclusion to the evaluation of the High Street Community Linkage Project, Kelk (1999a) observes that whether or not the project's initial impacts will translate into substantive changes in the system and improved outcomes for young people will depend upon the ongoing commitment of the Western Sydney Area Health Service to youth suicide prevention. It is indicated later that the necessary commitment includes a commitment of resources in addition to changes in the way services relate to each other: "[T]here appears to be a low limit to the extent to which a major social and health problem like youth suicide can be modified by changes in efficiency and collaboration between existing agencies and staff. A number of people involved with the Community Linkage Project pointed out that it would be impossible to implement widely recommended changes in agency practice without significant increases in recurrent funding" (Kelk 1999a: 4).

➤ *A properly trained and resourced facilitator*

The final report of the Here For Life Networking Project concludes that: "The role and expertise of the facilitator is pivotal in determining network direction and outcomes and demands more thoughtful planning than was evident in this project" (Groom 1999).

In the Southern Queensland part of the Here For Life Project, community volunteers were used to develop and coordinate a lot of the local networks. It appears that little training or support was provided to these volunteer coordinators. Only one part-time Project Officer was employed for the Southern Queensland Rural component of the project. This worker focused on the development of new training resources.

The final report recommends that care needs to be directed towards the selection, orientation, training and ongoing resourcing of network facilitators. The Here For Life evaluation did not undertake a systematic comparison of impacts of networks according to the qualifications or experience of network facilitators. No data collected directly from network facilitators were reported.

➤ *Formal project advisory or steering groups*

Project advisory groups or steering committees with representation from key stakeholder groups appear to be associated with improvements in the effectiveness of collaborative projects. Formal advisory or steering groups seem to provide an important source of stability and enhanced process to collaborative projects by providing a mechanism for:

- bringing interested players together;
- ensuring regular multilateral communication;
- identifying and harnessing skills and sharing the workload;
- planning;
- solving problems, and
- making joint decisions involving all relevant parties.

The composition, structure, role and responsibilities of the advisory group and its relationship to the project and host organisation needs to be well thought through and clearly defined.

Kelk (1999a) notes that the High Street Community Linkage Project Reference Group ran very effectively for a significant period of time, despite some strong differences of opinion on various issues, due to the selection process prior to its formation and sensitive management by the Project Officer and the Coordinator of High Street Youth Health Service. The Cellblock Community Linkage Project appeared not to have a project reference group.

The Here For Life Networking Project experienced serious difficulties in the relationship between the Project Team, the Logan Area Division of General Practice, and the Project Steering Committee. Disagreements developed between the Project Steering Committee and the other bodies with regard to the direction of the project. The initial idea of the project had been to focus primarily on the networking of health professionals with a particular focus on supporting the role of GPs. Collaboration across sectors and with the community was planned but was intended to be a secondary focus. However, the Project Steering Committee was comprised primarily of members from non-health sectors and the focus of the project moved away from the needs of the health sector and GPs. Open discussion and resolution of these difficulties was complicated by a possible conflict of interest, with some overlap of membership between the Project Team, the Logan Area Division and the Steering Committee.

➤ *Education and training*

Education and training was a major strategy of AusEinet. As already noted, a series of workshop and seminars were conducted throughout Australia. These had an education as well as a broader communications function. A significant number of respondents to the AusEinet General Evaluation Survey indicated that the workshop/seminar did not provide them with enough tools to begin including early intervention in their daily work, however 91 per cent of respondents indicated that they would like to attend another seminar in the next 12 months. This suggests that AusEinet members see the value and desire the provision of further education in early intervention practice.

Kelk (1999a) observes that the High Street Community Linkage Project has developed a number of resources, such as a directory of local services, which he feels will have only limited impact unless they are used as the subject of training for local practitioners.

➤ *Equality within the service structure*

A major theme that emerged from evaluation of the High Street and Cellblock Community Linkage Projects was the problems that arise when attempting to forge partnerships between organisations that operate at different levels within the administrative structure of service systems. The Project Officers from both these projects noted that it is extremely difficult to engage with and stimulate change when the change agent has relatively low status in the organisational hierarchy and the targets of change have higher authority. For instance, both these projects were based in youth health services and key targets for change were Departments of Psychiatry or the equivalent. It is notable that the major impacts of the High Street and Cellblock projects were on agencies that were on the same level of the structural hierarchy within the Area Health Services.

Kelk (1999a and 1999b) concurred that the low positioning of the youth health services in the structural hierarchy was indeed a key structural weakness in both projects and suggests that consideration should be given to these issues when funding similar projects in the future. Specifically, it is suggested that such organisational change projects should be located closer to a more authoritative policy and planning setting. It is also recommended that the staff employed on such projects should be in positions of at least moderate authority with respect to the processes at which change is directed.

Kelk (1999c) also observes that funding aimed at structural change should be located, at least in part, in those agencies in which change is seen as needed. It is suggested that locating such projects across multiple agencies might be more productive. For example funding could be provided to a consortium of agencies which might be involved in collaborative action during the course of the project.

Problems with the location of organisational change projects were also observed in other instances. For example, the staff of the Central Sydney Area Health Service Critical Pathways Project (see Chapter 1, Volume 3 of this Technical Report series) felt that the location of this project in a relatively new agency that was not part of the mental health service structure created barriers to its acceptance among key stakeholders that the project sought to influence.

➤ *Consultation at a state and Area level, and awareness of and responsivity to related activities*

Another development reported by the evaluator of the High Street Community Linkage Project appears to reinforce the argument for careful consideration of the political issues surrounding projects concerned with organisational change.

Towards the end of the project the evaluator and the Project Officer became aware of two other initiatives relevant to youth suicide prevention in Western Sydney Area Health Service. One of these was the publication by the Centre for Mental Health of the *Policy Guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospital facilities*. The other was the establishment of a temporary position in the Mental Health Services of Western Sydney to write a further document clarifying how the *NSW Policy Guidelines* might be applied in the Western Sydney Area Health Service. This position was established towards the end of the High Street Community Linkage Project. The Project Officer was concerned that the *NSW Policy Guidelines* contained no references to special needs groups such as young people. She approached and lobbied the staff member who was writing the Western Sydney Area report in an effort to encourage the inclusion of material relevant to young people. She achieved no results at all and became fearful that the results of her work were going to be wasted, "swept away by the tides of history".

Kelk (1999a) observes that it is not clear that the results of the Community Linkage Project will be wasted and that, while it has not resulted in changes to

formal documented policies and procedures, processes were under way that indicated greater commitment to improving the service's response to the needs of young people. However, he expresses the view that acknowledgment of special needs groups in policy guidelines is a key indicator of the likelihood that systematic attempts will be made to address their needs.

The Project Officer and the external evaluator recommend that Commonwealth funding bodies consult with state and Area/Regional level bodies before providing funding to service development projects located within services under their jurisdiction.

General discussion

Numerous Commonwealth health policy documents and reports published in recent years have emphasised the critical importance of intersectoral collaboration if Australia is to achieve significant health gains for the population. It is recognised that many of the determinants of health, particularly mental health and wellbeing, such as family structure, employment status, socioeconomic status and place of residence, are outside the control of the health sector.

The National Youth Suicide Prevention Strategy was built on this recognition and the Strategy as a whole can be seen as a model of intersectoral collaboration. Advisory bodies for the Strategy were comprised of representatives from a range of sectors, and the Strategy funded projects based in a variety of different sectors other than health. A number of projects worked across two or more sectors even when intersectoral collaboration was not the major focus of the project.

The experience of the Strategy demonstrates the way in which intersectoral collaboration and networking are frequently the province of "special projects". Special projects often do this work well because the "special project model" tends to incorporate some of the factors that have been identified as most critical to effective intersectoral collaboration (for example, dedication of resources and planning). However, the special project model poses some major dilemmas. The aim of special projects concerned with intersectoral collaboration is usually to initiate changes in the wider service systems within which the project is embedded so that agencies will continue to work more closely together on an ongoing basis.

Unfortunately, while special projects frequently involve some active collaboration during the course of their implementation, there is generally a lack of evidence that special projects are effective in instituting lasting change in service systems. Thus we are not able to say at this stage whether or not Strategy projects have contributed to robust increases in levels of collaboration between agencies from the various sectors that have a role in youth suicide prevention. As suggested by Kelk (1999a), this will largely depend on whether state and territory governments and Area and Regional service managers maintain a commitment to preventing suicide among young people.

However, evaluation of the Strategy has confirmed and extended our understanding of a range of problems that service systems may need to grapple with if they are to work towards greater intersectoral collaboration.

Previous research on intersectoral collaboration

In acknowledgement of the importance of, and the difficulties associated with intersectoral collaboration, the then Commonwealth Department of Human Services and Health commissioned a study into the factors that facilitate intersectoral action for health advancement under the National Health Advancement Program. The study involved an international literature review, meetings with stakeholders in all the states and territories, international meetings and project case studies. A report was published in 1995 (Harris, Wise, Hawe, Finlay and Nutbeam 1995). Many of the factors identified in this study as facilitating intersectoral collaboration anticipate the findings of the National Youth Suicide Prevention Strategy (see Table 4.2).

Unfortunately, many of the difficulties identified by Harris et al. (1995) around the establishment of these conditions appear to be just as problematic now as they were in the early 1990s. However, the National Youth Suicide Prevention Strategy has provided further insight into the effectiveness of strategies for addressing these issues.

Building trusting relationships

Consistent with the findings of Harris et al. (1995) development of trusting and respectful relationships emerged as a key theme from the evaluation of Strategy projects. Philosophical issues were identified as central. For example, Connexions staff felt that development of effective linkages was only really possible when

TABLE 4.2 Conditions for effective intersectoral action identified by Harris, Wise, Hawe, Finlay and Nutbeam (1995)

• The parties have identified that there is a *necessity* to work together if they are to achieve their goals (requires clarity regarding each organisation's goals as well as joint goals).
• *Opportunities* exist in the wider operating environment that enable intersectoral collaboration (eg the community understands and is supportive).
• Organisations have the *capacity* to take action (have resources, time, skills, knowledge).
• The parties have developed a *relationship* on which to build cooperative planned action (relationship is clearly defined and is based on trust and respect).
• The *planned action* is well conceived and can be implemented and evaluated (the action is clear, agreed and roles and responsibilities are clear).
• Provision has been made to *sustain outcomes* (provision has been made to monitor outcomes).

organisations had some commonality of culture, values and philosophy. To an extent, this observation simply restates the problem but in a more positive language. The divergent philosophies, priorities and ways of working adhered to by different sectors has been commonly noted as the major barrier to intersectoral collaboration. The question that arises here is how these divergent philosophies can be overcome or worked with.

Education and training was identified as an effective tool for enhancing intersectoral collaboration primarily because of its capacity to bridge philosophical differences. Provision of education and training provides a direct means for change agents to communicate their philosophy to potential partners in order to interest and engage them in their ideas. Training sessions also provide a channel for feedback from 'target' agencies or individuals to the change agent about their perspective on the issues that need to be addressed.

Another important aspect of relationship identified by Commonwealth Government stakeholders consulted for the Evaluation is *mutual benefit*. It was argued that agencies need to be able to see the way in which they will benefit if they are to be willing to enter a partnership. This is the second area in which education and training was seen as making a contribution to building relationships. By providing education and training the change agent is seen to be making a tangible contribution to the general capacity of target agencies or individuals to pursue their own priorities, to the extent that these overlap with those of the change agent. Attendance at certain accredited training programs accrues Practice Points for GPs, thus provision, or the promise, of such training could be effective in attracting initial interest in a network. However, provision of training does not appear sufficient to sustain GP involvement in service provider networks.

Providing training sessions to mixed groups of different professionals was noted by several projects as a stimulus to the natural development of links between the professionals who attend. This mixing gives different professionals the opportunity to learn more about each other and dispel myths and misconceptions they may hold about each other, thereby removing barriers to the natural formation of trusting relationships. Training may also be necessary to build the capacity of participants to draw on the professional resources they have available to share with each other.

It would appear to be important for training programs in youth suicide prevention to pay more attention to the potential of training as a tool for enhancing collaboration. Most existing training programs include a focus on attitudes and beliefs about suicide and young people but neglect to explore the attitudes professionals hold about themselves and their profession in contrast to others. In light of the evidence that certain groups that are centrally important to suicide prevention (for example, mental health professionals and youth workers) tend to hold very negative attitudes towards each other, it would appear to be critical for youth suicide prevention training to address these attitudinal barriers to collaboration.

It would also appear advisable, in some situations, for such training to be followed up with ongoing forms of professional development such as supervision suited to reinforcing new understanding about the ways in which other professional groups and services operate. Historically, practices such as supervision have been recognised as valuable tools for reinforcing professional values and certain modes of practice *within* particular professional groups and trainees sought supervisors only within their own profession. Increased recognition of the need for different professionals to work together suggests the need for professional supervision to be complemented by interprofessional supervision.

There was a strong suggestion in the evaluation of Strategy projects that interagency collaboration develops best when relationships develop naturally out of a realisation of mutual need. Allowing the process to develop naturally allows doubtful potential partners to stand back and critically observe the process and weigh up the costs and benefits before deciding to make a commitment. Relationship building may require a long process of negotiation before understanding and trust is sufficiently developed for agencies to enter into formal partnerships. This was also found by Harris et al. (1995).

It also appears that it is difficult, and may even be harmful, to force this process artificially. This raises a dilemma because intersectoral collaboration is increasingly seen as essential to service reform and improvement of health outcomes. Is it appropriate to wait for this process to develop at its own pace? Collaboration must start somewhere and will often need to be initiated in pursuit of improved outcomes. In situations where collaboration needs to be initiated it may sometimes be necessary to take one step at a time. The presence of a strong relationship between the major players appears to provide a foundation stone that is essential for attracting, holding and supporting additional, less central partners. Attempting to create instantaneous collaboration between a large number of agencies that have never worked together before is far less viable.

The dilemma about what strategies are most appropriate for facilitating genuine and effective collaboration may be partly addressed by understanding the distinction between facilitating and inhibiting factors at the local agency level and factors that operate in the wider social policy environment. Forces in this wider environment such as increasingly limited resources and the shift towards compulsory competitive tendering have been identified as creating conditions that are sometimes experienced as antagonistic to collaboration. While resource shortages and the need for greater cost effectiveness are frequently cited as a reason why collaboration is required, resource scarcity can lead some organisations to retreat to perceived core business. Harris et al. (1995) have argued that the health sector must continue to supply resources for extended periods of time, otherwise their interest in intersectoral partnerships may be perceived by other sectors as simply motivated by cost-shifting.

Progressing towards intersectoral action

Identification of goals and the development of planned action is an area that was particularly problematic for Strategy networking projects, with projects generally struggling to establish any planned action involving joint action of network participants. Various activities were conducted involving network participants but these tended to be haphazard and not part of a well considered plan of action.

This problem can perhaps be understood when viewed from the perspective of Diffusion of Innovation Theory which suggests that all projects aimed at organisational change go through a series of stages – formation, implementation, maintenance, and goal attainment (Harris et al. 1995). Diffusion of Innovation Theory posits that different strategies and skills are required at each of these stages and failure to recognise this can prevent a project from being widely accepted and implemented. Action needs to be appropriate to the stage of development of the project.

This requires project participants to have a common understanding of whether the project is at the stage of formation, implementation or maintenance. It is likely that the Strategy networking projects were mostly within the formation stage but that some projects attempted activities that belonged to later stages. Harris et al. (1995) observe that there is a lack of research data about the factors that help projects proceed from one stage to the next.

Models of intersectoral collaboration

Just as awareness of the stage of development of projects appears important for planning appropriate activities, awareness of the forms and models that projects are using, and the options available may be useful for assisting projects work through the stages more smoothly.

The National Youth Suicide Prevention Strategy focused on a relatively narrow range of models of intersectoral collaboration. The policy literature on partnerships is short on discussion of models. One of the problems with discussion of models of collaboration in policy is that there is an extremely wide variety of models that could be used and the most useful models will vary considerably depending on the characteristics of the service environment and the higher order goals of the activity. Nevertheless, it may be useful to develop a framework for thinking about the different models of collaboration that could be used to assist service providers and managers make more conscious decisions about what paths to pursue.

Choices about models of collaboration should be guided primarily by higher order aims of collaboration. The functions of the particular agencies involved, resources available and other factors in the environment will also shape choices about models. Table 4.3 outlines just some of these.

The Strategy projects focused primarily on the less formal models of intersectoral collaboration. The project evaluations suggest that informal modes of collaboration are not always effective. Informal models tend to suffer from a lack of

clear goals and a limited ability to harness the resources and commitment necessary to meet higher order goals. Unless they are provided with specific resources for this, informal models would generally lack an ability to implement strategies for addressing various barriers to collaboration such as communication strategies and education and training to address philosophical and attitudinal barriers. Projects such as Shoalhaven Combined Services, Limelight and Connexions which incorporated more formal mechanisms have had greater success in maintaining the active involvement of collaborators and moving on to a true partnership approach.

Gradual movement from informal to more formal approaches is likely to be a natural process in development of effective partnerships. Initiatives that involve major deviations from this process may generate additional difficulties.

Following training, networking is the second most important strategy identified by Strategy projects for enhancing the capacity of communities and service systems to refer young people to appropriate support once they have been identified as being at risk. Unfortunately no projects have been able to provide evidence which demonstrates that higher levels of networking are associated with, or lead to, more efficient and effective referral of individuals at risk. Such research might be fruitful. One major task for such evaluation research will be to identify whether particular kinds of networking activity are more effective than others in facilitating effective referral. One barrier to furthering knowledge in this area is the current lack of clarity with regard to indicators of quantity and quality of networking.

Intersectoral collaboration and the politics of change

Understanding the barriers to the establishment of effective and sustained forms of intersectoral collaboration requires acknowledgment and understanding of the ways in which power is distributed within systems. Usually networking projects

TABLE 4.3 Some models of collaboration suitable for different higher order aims and activities

	Treatment and support of individual young people	Population-based activities (eg primary prevention, research and evaluation, advocacy)
Less formal ↓ More formal	Loose professional networks. Loose interagency networks. Advocacy. Regular interagency meetings. Formal referral protocols. Consultation and liaison. Interprofessional supervision. Clinical placements. Shared Care.	Loose professional networks. Loose interagency networks. Involvement in community-based organisations and committees. Consultation and liaison Joint projects. Consortia. Associations of professionals, consumers and other interested parties.

are initiated by one particular agency which seeks to initiate or strengthen its links with other agencies. Whether or not this is consciously recognised, the act of forming links is usually associated with an effort to influence the behaviour of other agencies in some way. It is inevitable that issues of power will arise here.

Harris et al. (1995) observe that intersectoral action often takes place at the margins of organisations, by workers who have little management responsibility because they are less concerned about resource issues and their own organisation's performance. Such workers may have little support from management but must seek it. Fear of loss of organisational autonomy was found to be a major barrier to relationship building. Service managers in particular are often reluctant to enter into formal agreements that may limit their ability to make decisions about the use of their agency's resources. Harris et al. conclude that organisations may need to look to internal operations, structures and decision-making processes in order to ensure sufficient flexibility and support to participate in intersectoral work.

The power dynamic described by Harris et al. (1995) can be seen as a microcosm of the power dynamic that appeared to be operating for several National Youth Suicide Prevention Strategy projects. The agencies that were funded to conduct networking and build collaboration tended to be on the margins of the service systems they were trying to influence, and the projects had little support from senior managers in those service systems. These projects had some success in influencing agencies at the same level in the power hierarchy as themselves but little or no success in changing those that were more powerful.

Kelk (1999a) suggests that organisational change projects should be located closer to a more authoritative policy and planning setting. He also observes that funding aimed at structural change should be located, at least in part, in those agencies in which change is seen as needed. Specifically, Kelk recommends that funding could be provided to a consortium of agencies which might be involved in collaborative action *(Recommendation 4.1, first dot point).* This approach could help overcome a number of other power related difficulties associated with locating funding within single agencies. Organisational change projects involving interagency collaboration are usually initiated by agencies that have developed an awareness of problems in the system (including outside their own agency) and are motivated to work for change. Allocating funding solely to such agencies to support their change efforts can lead to political problems because these activities may easily be perceived as critical of other agencies.

On the other hand, if funding for organisational change involving interagency collaboration is located with consortiums of agencies, the principle of power sharing and joint ownership of the process would be clearly embedded in the project from its *public* inception, thereby placing agencies on a collaborative footing from the beginning and avoiding the appearance of certain agencies being criticised or manipulated by the agency running the project. Even though projects will often be initiated by one agency that most clearly recognises the need for change,

political problems may be avoided or minimised if targets of change can be consulted and engaged *privately*, outside of the public domain of nationally funded projects. External funding may then be used more efficiently to build sound structures for ongoing collaboration.

It needs to be acknowledged at this point, that state and territory governments and the Commonwealth have actually established structures that are designed to facilitate intersectoral collaboration and networking.

One of the most disquieting aspects of the efforts of Strategy projects in the area of networking and intersectoral collaboration is a widespread failure of projects to build on structures that were already in place. While project managers frequently acknowledged that networks already exist in every community (or service system), this acknowledgment rarely extended to active engagement with formal structures and processes that were already in place. For example, it is particularly noteworthy that in 1996 formal Agreements on Aboriginal and Torres Strait Islander Health were reached 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. A function of the Agreements is to establish 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."

It is remarkable that not one of the National Youth Suicide Prevention Strategy projects that sought to establish networks for suicide prevention, not even community development projects based in rural and remote communities, mentioned having made links with these mechanisms, or the bodies involved in the Agreements on Aboriginal and Torres Strait Islander Health in the relevant states and territorries, or even noted their existence. It could be argued that Strategy rural networking projects should have been *required* to work in partnership with these bodies. The fact that they did not even contact them is a major oversight.

Similarly, in most major urban centres, interagency bodies representing ethic community organisations and multicultural health agencies have been functioning effectively for many years. But not one of the Strategy networking projects mentioned having made links with these bodies. New South Wales has a Regional Coordination Program which is administered by the Premier's Department. Several Areas in New South Wales are quite advanced in the establishment of intersectoral service networks. This program was not mentioned by any of the Strategy projects.

Harris et al. (1995) also stress the importance of building on existing structural opportunities such as the Integrated Local Area Planning process which is being

promoted through local government and planning bodies, as well as state planning structures.

The role of government

The failure of National Youth Suicide Prevention Strategy projects to adequately link with existing state and territory planning processes is unfortunate because opportunities to build youth suicide prevention activities onto the foundation of more centralised government programs, with the backing of senior government ministers and administrators may have been missed.

It is difficult to understand the reasons behind the failure of the networking projects to do the networking that they should have done before and during implementation of their own projects. Perhaps the time frame around the projects created pressures to initiate activities at the local community level as soon as possible and liaison with state and territory structures was seen as a low priority. It is also possible that the staff employed on the projects were insufficiently senior or otherwise inadequately familiar with the general policy environment to be able to identify relevant state and territory planning processes. Part of the responsibility could also be attributed to a failure of government planning processes themselves.

During consultations that were held with Commonwealth Government officers in various departments as well as other stakeholders, the view was expressed that the National Youth Suicide Prevention Strategy in general had not sufficiently involved the states and territories. In addition to informing state and territory officers about the Strategy, such consultation could have facilitated improved awareness among Commonwealth administrators and project officers of relevant service development work taking place in the states and territories, and the opportunities available for Strategy projects to forge links and build onto these developments. This may in turn have increased the likelihood that the work of Strategy projects would be taken into account in state and Area policy and service development.

There is evidence that issues relevant to young people's mental health continue to receive low priority in some Area Health Services. This underscores the critical importance of consultation and collaboration between different levels of government as well as senior Area Health Service managers if the structural changes required to support real service reform are to be achieved.

It is strongly recommended that before receiving funding, future suicide prevention projects involving networking and intersectoral collaboration identify existing state/territory, local government and area/regional planning structures and processes and specify the ways in which the project will liaise with these *(Recommendation 4.1, second dot point).* Kelk (1999a) also recommends that the staff employed on such projects should be in positions of at least moderate authority

with respect to the processes at which change is directed *(Recommendation 4.1, third dot point).*

A number of Strategy projects experienced problems which they attributed to a lack of clear policies within certain sectors with respect to the roles of particular agencies in enhancing the wellbeing of young people. For example, several projects that sought to work with schools found a lack of consistency between schools regarding their role in 'welfare' and the structures and processes in place for responding to crises or approaches from agencies wanting to run prevention programs.

Increasing intersectoral collaboration in youth suicide prevention at the level of local agencies may require complementary collaboration at the level of Commonwealth and state and territory governments. As a first step it would be useful for state and territory governments to ensure that all relevant departments (particularly health, education, employment and training, community services) have policies that are consistent in their approach to enhancing the wellbeing of young people *(Recommendation 4.2).*

One of the problems with existing policy statements in the area of intersectoral collaboration is that they generally lack sufficient detail to assist agency managers make the organisational changes that are necessary to facilitate collaboration. In some areas, broad policy statements may need to be complemented by specific plans of action that specify ways in which government departments will work with other departments as well as guidelines for the agencies under their jurisdiction *(Suggestion 4.2a).*

Recommendations and suggestions

It is recommended that:

4.1 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.

(This is Recommendation 32 in the evaluation overview, "Valuing Young Lives".)

4.2 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.

(This is recommendation 33 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

4.2a Where appropriate, broad policy statements should be complemented by specific plans of action that specify ways in which government departments will work with other departments as well as guidelines for the agencies under their jurisdiction.

Project reports

Burgess, T., Fleming, J. & Browne, E. (1999), "AusEinet: The Australian Early Intervention Network for Mental Health in Young People: Final Evaluation Report", Burgess, Fleming and Associates. (Unpublished).

French, C. & Kelk, N. (1999), "Final Report on Limelight Productions", The Bridge Youth Health Service, Shepparton, Victoria. (Unpublished).

Groom, G. (1999), "Here For Life: Final Report", Logan Area Division of General Practice. (Unpublished).

Kelk, N. (1999a), "Report on the Community Linkage Project at High Street Youth Health Service", School of Community Medicine, University of New South Wales. (Unpublished).

Kelk, N. (1999b), "Report on the Community Linkage Project at Cellblock Youth Health Centre", School of Community Medicine, University of New South Wales. (Unpublished).

Kelk, N. (1999c), "Some General Comments on Eight Here For Life Projects Conducted at Three Youth Health Services", School of Community Medicine, University of New South Wales, Sydney. (Unpublished).

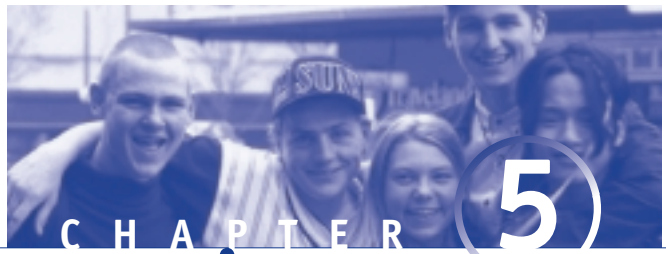
Martin, G., Roeger, L., Marks, L. & Allison, S. (1999), "Final Evaluation Report for the Centacare Youth Suicide Intervention Program", Southern Child and Adolescent Mental Health Service, Adelaide. (Unpublished).

Ridge, D., Hee, A. & Aroni, R. (1999), "Evaluation of the Connexions Youth Suicide Prevention Initiative", School of Public Health, La Trobe University, Melbourne. (Unpublished).

Waring, T., Hazell, T., Holbrook, A. & Hazell, P. (1999), "National Mental Health Schools Project: Mind Matters Evaluation Project, Draft Evaluation Report Volume 1: Overall Evaluation", Hunter Institute of Mental Health, Newcastle. (Unpublished).

Other references

Harris, E., Wise, M., Hawe, P., Finlay, P. & Nutbeam, D. (1995), *Working Together: Intersectoral Action for Health*, Commonwealth Department of Human Services and Health, AGPS, Canberra.



CHAPTER 5

Community development

This chapter presents and analyses information about the community development activities funded under the National Youth Suicide Prevention Strategy.

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.

Details of the main community development projects and activities funded under the Strategy are shown below. Three recommendations (5.1, 5.2, 5.3) and one further suggestion (5.2a) are provided at the end of the chapter.

Community development activities

The information reported in this chapter derives from projects that aimed or purported to use a community development approach to suicide prevention, as well as a research project that includes a descriptive analysis of a community development process that has taken place in an Aboriginal community in Far North Queensland over a 10–15 year period. These six projects are summarised in Table 5.1.

The main projects in this group which provided a final report are: Support to Rural Communities Project; An analysis of suicide in indigenous communities of North Queensland: the historical, cultural and symbolic landscape (the Yarrabah Study); and Galiwin'ku Youth/Parent/Worker Youth and Life Education Training Project.

A further project funded under another prevention approach – Support for young people who are marginalised and disaffected – included a strong element of community development: Here For Life Youth Sexuality Project.

Two projects originally funded under the Strategy's community development approach did not provide a final report or evaluation report: Kyogle Youth Action (Project X); and Lumbu Foundation.

TABLE 5.1 **Summary of community development projects and activities funded under the Strategy**

Project name	Organisation	Targeting and activities	Evaluation design and/or methods
Support to Rural Communities Project	Gilmore Centre at Charles Sturt University, Australian Sports Commission, Centacare Australia, NSW Institute of Psychiatry	Demonstration project which trialed one model of community development in five different rural communities	Descriptive, qualitative methods
An analysis of suicide in indigenous communities of North Queensland: the historical, cultural and symbolic land-scape (Yarrabah Study) (Hunter, Reser, Baird & Reser 1999)	University of Queensland Department of Social and Preventive Medicine, Gurriny Yealamucka Health Service & the Yarrabah Community Council, James Cook University of North Queensland School of Psychology and Sociology.	Research project that included a study of one Aboriginal community in North Queensland (Yarrabah) which has been developing its own community-based responses to suicide and other health problems	The research project includes an analysis of suicide statistics, literature review and a historical descriptive study of a community development process.
Galiwin'ku Youth/Parent/ Worker Youth and Life Education Training Project	Galiwin'ku Community Council	Project based in one Aboriginal community	Original evaluation was methodologically unacceptable and the project was reviewed by an external reviewer.
Here For Life Youth Sexuality Project	WA Aids Council & Gay and Lesbian Counselling Service	Same sex attracted young people	Interviews with staff, stakeholders, and young people.
Lumbu Foundation	Lumbu Foundation	Foundation which aims to provide funds for ongoing community devel-opment activities in Aboriginal communities	Not evaluated
Project X	Kyogle Youth Action	Community development project based in one rural community	Have not provided a final or evaluation report

Support to Rural Communities Project

The Support to Rural Communities Project was managed by a consortium of members including the Gilmore Centre at Charles Sturt University; the Australian Sports Commission; Centacare Australia; and the New South Wales Institute of Psychiatry.

The overall aim of the project was to trial and evaluate the effectiveness of state, territory or regional networks representing a substantial geographic area in supporting a number of rural or remote communities to prevent and respond to suicide attempts by young people. The project was conducted in five rural communities – the Tiwi Islands (Northern Territory), Atherton (Queensland), Bourke (New South Wales), Oatlands (Tasmania), and Millicent (South Australia).

The project supported the development of networks within each of these communities using a variety of strategies. Major strategies common across the sites included: establishment of a local auspice body; recruitment of a Project Officer from within each community; identification of existing networks, including professional service providers and other community members who had regular contact with young people; and provision of training in suicide prevention.

A training resource manual aimed at rural populations, *Lives Worth Living*, was developed to provide professionals and non-professionals with information and strategies to assist young people who are considering suicide or who have previously harmed themselves. The manual outlines what formal and informal networks can do to prevent suicide in their community.

Yarrabah Study

A collaboration of researchers was funded to conduct a study of various issues around suicide in indigenous communities of North Queensland (Hunter, Reser, Baird and Reser 1999). The research project included an analysis of suicide statistics, a literature review and a historical descriptive study of a community development process that has been taking place in one Aboriginal community in North Queensland. The Yarrabah community has been developing its own community-based responses to suicide and other health problems.

While the community development initiatives described in the research project by Hunter et al. (1999) were not funded by the National Youth Suicide Prevention Strategy, the intention was that this study would contribute to an understanding of effective community engagement and empowerment.

Galiwin'ku

The Galiwin'ku community is situated on Elcho Island in East Arnhem Land of the Northern Territory. The project was intended to be a community development process focusing on the Galiwin'ku Security Group which is a mixed group of elders, seniors and young people. It was anticipated that the Security Group would work in partnership with at risk young people to address issues related to youth

suicide and other self-destructive behaviours, including Kava drinking, violence, petrol sniffing and gambling.

As part of the project, a Training Resource and Community Education Team known as Life Skills Workers was employed. The team was expected to study crisis work, counselling, debriefing, stress management, mediation, conflict resolution, parenting skills, and mental health from a mainstream perspective. The team was then expected to provide support to the rest of the community in gaining access to these skills in ways that were culturally appropriate.

The project was not implemented in the way that was indicated in the contract. Although the funds were allocated to and managed by the Galiwin'ku Community Council, the people who submitted the project proposal and who conducted the project did not in fact represent the Council in the manner claimed. For various reasons the Galiwin'ku Community Council did not actively engage in the management of the project and the community development aspects of the project did not eventuate.

Here For Life

The Here For Life Youth Sexuality Project was jointly conducted by the Western Australia AIDS Council and the Gay and Lesbian Counselling Service (Western Australia) and was based at a drop-in centre, the Freedom Centre, which runs courses, workshops and other youth development strategies for young people with same-sex attraction.

The project's specific objectives were to: reduce the isolation of young people and assist them to develop positive attitudes towards their sexuality; and increase positive attitudes and actions within the community towards young people with same-sex attraction.

A wide variety of strategies were employed in addressing these objectives including: the production of resources, courses and programs for young people; enhancing the operation of the Freedom Centre; providing counselling for young people; community education, including production and dissemination of a booklet entitled *Someone You Love*; training of professionals in other agencies, peer education volunteers and volunteer gay and lesbian counsellors; a public awareness strategy using the media; and making other youth agencies aware of the project and the services offered.

A vital part of the philosophy and success of the project was the direct and indirect involvement of young people. This was done in a number of ways, with young volunteers and those attending either the Freedom Centre or the various courses and programs consulted on an ongoing basis. Young people were also involved in the creation of promotional materials and resources. While the project was funded for only a limited period, many of its initiatives are still being continued by the Freedom Centre, the Western Australia Aids Council, the Gay and Lesbian Counselling Service, and some other services.

Lumbu Foundation

The National Youth Suicide Prevention Strategy contributed $1 million towards the establishment of the Lumbu Foundation for indigenous families and children in collaboration with 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.

Funding has been allocated to scope opportunities and build partnerships for suicide prevention initiatives where future directions are currently unclear. These include drug harm minimisation services and correctional and juvenile justice services. The Lumbu Foundation will also provide funds to supplement existing projects funded from other sources that require additional assistance with finalising evaluation or particular activities.

The Lumbu Foundation was not asked to provide an evaluation report.

Project X

Project X was significant in that it was entirely managed and driven by young people and was the only project of its kind funded under the National Youth Suicide Prevention Strategy. Based at Kyogle Youth Action, it aimed to foster the belief that nurturing children and young people is a broad community responsibility. Project X 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. Through focusing on cultural attitudes and the quality of the community environment, the main focus was on primary prevention.

Kyogle Youth Action did not succeed in completing an evaluation of the project.

Results of the evaluation

The evaluation data are organised around three questions:

- What works to ensure that the community is engaged and empowered in the community development process?
- What works to ensure that young people are engaged and empowered in the community development process?
- What facilitates the achievement of higher order aims of community development?

What works to ensure that the community is engaged and empowered in the community development process?

Community involvement, engagement, empowerment, ownership and self-determination are widely acknowledged as key principles underlying community development approaches to the advancement of public health. That members

of the community would be so engaged and empowered was an intention of the Commonwealth in funding the projects in this group.

The projects included here suggest a lack of clarity, or perhaps disagreement, among practitioners and researchers about what is meant by terms such as "empowerment" and "community self-determination" in the context of community development. For example, the nature of the empowerment and self-determination demonstrated by the Yarrabah Community in the study by Hunter, Reser, Baird and Reser (1999) is different in critical respects from the phenomena that the Project Team of the Support to Rural Communities Project (Jarvis, Dunn and King 2000) call empowerment and self-determination.

Jarvis et al. (2000: 8) claim that: "The community development model has maintained the principle of empowerment and self-determination with respect to many, if not all, of the decisions made about project direction locally". The definitions of empowerment and self-determination used by Jarvis et al. appear to be much narrower than those used by Hunter et al. (1999).

In their account of the success of the Yarrabah Community in significantly reducing suicide rates, Hunter, Reser, Baird and Reser (1999: 100) demonstrate the absolute necessity of the community "owning the problem and seeking the core elements to solutions within the community itself". This is particularly critical in indigenous communities where the social and cultural factors that have led to increased risk for suicide are in large part due to historical factors that have removed and actively suppressed self-determination over a long period of time, leading to chronic feelings of helplessness and hopelessness at an individual and community level. Solutions brought in by outsiders cannot address these fundamental predisposing risk factors.

Hunter et al. (1999) also show how suicide, particularly hanging suicide, has become incorporated into the contemporary culture of some indigenous communities as a symbol of, and response to, ongoing dispossession, social inequality and injustice. The "enculturation" of suicide in this manner further indicates the fundamental importance of indigenous communities developing their own cultural counter-response.

While community leaders may have been responsible for most of the decisions made during implementation of the Support to Rural Communities Project within particular trial sites, this project was essentially a solution that was brought in by outsiders. It did not involve communities "seeking the core elements to solutions within the community itself". It is noteworthy in this regard that the Support to Rural Communities Project experienced considerable difficulties in maintaining the engagement of community members at several of the trial sites in this project.

In contrast, Hunter et al. (1999) present convincing evidence that the Yarrabah community was highly engaged in the task of identifying and developing solutions and that it was the community itself that drove the process.

The external review of the Galiwin'ku Project found that at no stage was the community effectively engaged in the project.

➤ *Community ownership of the problem and the program*

The terms "engagement" and "ownership" are often used interchangeably, but it can also be helpful to understand ownership as a separate phenomena or process that begins early in a successful community development process, and which facilitates engagement and empowerment in the medium to long term. Understandings of the meaning of ownership appeared to vary between the projects. Hunter et al. (1999) see community ownership as a political commitment to action that is widely shared across the community. Jarvis et al. (1999) do not clearly define ownership.

The Support to Rural Communities Project identified community ownership as an important principle of the community development "approach" and the community development "model" used by the project aimed to encourage the community to own the problem of suicide and the program of activities leading to its prevention. However, the Support to Rural Communities Project experienced considerable difficulties in "generating" community ownership of the youth suicide problem. In contrast, Hunter et al. (1999) provide convincing evidence that the Yarrabah community owned the problem in a very deep sense.

The community development model of the Support to Rural Communities Project incorporated a number of strategies aimed at encouraging community ownership. The three main strategies were to: (i) recruit a local person as a change agent who was familiar with the culture and norms of the community and knew the key stakeholders; (ii) establish a local auspice body who had an investment in the future of the community; and (iii) establish a local project steering committee. The Final Report does not provide a clear conclusion about whether or not the project was successful in achieving community ownership of the project. In fact, the Final Report does not make a distinction between these strategies aimed at securing community ownership, and community ownership as an impact or outcome. For example, in the first paragraph of Chapter 7 (p. 82) entitled "Positive community outcomes" it is stated that: "Ownership was provided within the project framework by inviting a local group who were also responsible for employing someone for the position of Project Officer, to act as the auspice body". Secondary or derived manifestations of ownership are not clearly defined, either conceptually or in terms of events and activities that took place during the project.

However, various pieces of information provided in the Final Report suggest that community ownership was patchy. This is illustrated most clearly in the extent of commitment to steering committees. Jarvis et al. (1999) report that some of the trial sites experienced problems securing the commitment of members of steering committees. Some sites found members were unreliable in attending meetings and had fewer meetings than other sites. In the case of one site (Bourke,

New South Wales), the initial response from the community was described in terms of "apathy". While a steering committee was eventually established at Bourke (comprised only of professionals) the committee at the nearby town of Brewarrina ceased to operate before the end of the project. Attendance at the Millicent (South Australia) committee dropped to an average of two people and it is not envisaged that the Oatlands (Tasmania) committee will continue after the project ceases. Community ownership was more robust in the Tiwi Islands (Northern Territory) and Atherton (Queensland). At Tiwi Islands a committee of six to eight professionals provided an informal support network for the Project Officer and this group is committed to continue to work with one another after Project funding ceases. At Atherton, the Steering Committee remained motivated throughout the life of the project and has now become a Taskforce which is committed to continuing strategies such as the development of service policies and ongoing community education using the *"Lives Worth Living"* resource manual.

Levels of community ownership or commitment appeared to be related to the extent to which youth suicide was identified as a priority issue by the communities concerned. Suicide had been seen as a major issue for the Tiwi Islands communities, as for other Aboriginal communities in Northern Australia since the mid-980s. In Millicent, a consultation with young people held in 1995 identified "alcohol and drugs" as the priority issue of concern rather than suicide. A major factor in Oatlands in regard to the prioritisation of issues appeared to be the fact that very few young people actually live in the town. The community indicated that the group they were most concerned about in relation to suicide was those over the age of 24 with financial and family problems, thus youth suicide was not an issue for the Oatlands community. Bourke and Brewarrina are racked by a range of other severe social problems including "massive levels of unemployment, racial tension and subliminal and overt violence. There are many broken windows in the township and heavily boarded and barred shop fronts" (p. 52). Interestingly, it is reported that there had not been a suicide in Bourke for ten years.

Community ownership at Tiwi Islands may also have been facilitated by aspects of the process by which the project was brought to the community. Several senior Northern Territory Government officers saw the project as offering opportunities to build on work that had already been initiated in the community, mostly by local women. A wide range of stakeholders were actively involved in the process of making a decision about whether or not Tiwi Islands would participate in the project. It is notable that this decision making process appeared to be relatively open and collaborative compared to the process that took place at other sites. For example, two community meetings were held at Tiwi Islands which were both attended by a wide range of stakeholders. Key decisions were not made until these meetings. At other sites by contrast the Project Team found themselves negotiating with stakeholders in a serial fashion for a relatively long period of time and open meetings were not held until after decisions to base the project in those sites had already been made.

Employing a local change agent from the target community was also identified as a facilitator of community ownership by the Support to Rural Communities Project. This is illustrated most clearly by comparing the Bourke and Tiwi experience. While Bourke-Brewarrina has a large Aboriginal community, this community was not the major focus of the project and the Project Officer was not from this community. The Aboriginal community at Bourke-Brewarrina never engaged positively with the project at any stage. At Tiwi, in contrast, the Aboriginal community was the major focus and the Project Officer was a local. The Tiwi Project Officer was also employed full-time, while Project Officers in other sites were part-time.

However, comments in parts of the report suggest that ownership by the Tiwi community was also less than ideal, despite the Project Officer being a member of the local community: "There was a need to continually refresh Tiwi people's awareness and understanding about the project as structures and management positions within the local councils and Tiwi Health Board changed. Constantly having to reiterate the purpose of the project and the work done to date tended to make the PO feel defensive about his position" (Jarvis et al. 1999: 91).

Hunter et al. (1999) describe how the Yarrabah Community progressed through a series of stages before entering into a state of full ownership of the suicide problem. Full ownership is seen as stemming from an understanding that lasting solutions can only be found within the community itself, and it manifests as a widely shared political commitment to action. The process was slow despite much pain and grief due to suicide over a long period of time.

Hunter et al. (1999: 79) note that when the first suicides occurred in the late 1980s, there was a stage of *"consternation and confusion"*. There was "limited ability for residents to make sense of events for which there was no precedent". The response was one of grieving, not responding. As the first "wave" of suicides progressed and as people became aware, through the findings of the Royal Commission into Aboriginal Deaths in Custody, that this problem was occurring in other communities there was a stage of *"despair and desperation"*.

Hunter et al. relate how different groups attempted to locate responsibility with particular single causes such as alcohol or mental illness, and sought solutions from outside such as mental health services and suicide prevention workshops. "At this point suicide was clearly a concern for many members and groups within the community, but was not, in a political sense, a shared community concern" (1999: 80).

With the succeeding waves of suicide the people of Yarrabah became increasingly sceptical of external solutions. There was a feeling of *"resignation and rejection"*, but there was also an increasing level of critical reflection, a "looking in" to identify causes and solutions within the community and a "looking around" at broader related social issues.

Eventually, after considerable critical reflection, the community came together in a number of meetings to talk and identify solutions. At these meetings it became clear that a stage of *"commitment and collaboration"* was being reached. There was a sense of shared realisation that the problem had to be addressed by the whole community working together. Groups that had previously been working on isolated approaches began to collaborate. Community organisations made commitments to support certain initiatives. According to Hunter et al., this was the stage during which true community ownership was achieved. Following this, Yarrabah moved on to a phase of *"persistence and planning"*, focusing on building sustainable structures for social, emotional, cultural and spiritual wellbeing.

It is noteworthy that the Support to Rural Communities Project appears to have adopted what could be described as a "top-down" model of community development. Although the Final Report acknowledges the importance of the community "being involved" in making decisions, the project appeared to offer this involvement within quite clear parameters that were fixed and dictated by the central Project Management group. This is evidenced by the fact that the trial was highly standardised across the five sites. In all locations the core strategies were the same (primarily networking between service agencies and training in suicide awareness and adolescent mental health). Only the processes of implementation were varied in response to logistical demands created by specific local conditions.

The strategic aim of the "community development" process was also clearly set in advance – to support local networks to develop strategies "to respond to young people at risk". In other words, the agenda of the project was oriented towards developing community capacity for crisis intervention rather than developing capacity for whatever approaches that the community decided were appropriate for them.

Throughout the Final Report the language used also suggests an orientation towards the proactive provision of advice to communities rather than listening and responding to the expressed needs of community members: "The PO was *made aware* of the nature of the evaluation process incorporating formative and summative evaluation processes. The NPO also met with the steering committee at each site (where relevant) to *once again explain or advise* what their role was and what the nature of the project entailed" (Jarvis et al. 1999: 69).

The external reviewer of the Galiwin'ku Project found that the project never involved ownership by the Galiwin'ku community (GLETP 1999). The external reviewer found that the project was generated and conducted by a small group of individuals who did not consult widely with community members or community organisations. The project was not discussed with the Galiwin'ku Council before it was funded, indeed the Council was not informed that a funding submission had been sent to the Commonwealth in their name.

The external reviewer reports that when the Council did eventually express some concerns to the Commonwealth these concerns were not addressed adequately:

"At the point that the Council expressed concern with the project the process should have been delayed to allow a much more detailed and slower consultation process to take place to ensure that the Community had ownership and control of the project. . . . Instead, a letter was sent to the Galiwin'ku Council justifying the actions already taken in the apparent belief that once the Council understood what had actually happened they would be happy to manage the project (GLETP 1999: 9).

While the Council eventually agreed to accept the task of administering the funds, they were very reluctant to try and direct the project in any way. Later, when a new Council Clerk began to take some serious interest, the individuals running the project were observed to be reluctant to accept any advice or management from the Council. Eventually, after the Council received Evaluation Report Number 6 from the original evaluator, the situation was reported as having deteriorated badly and the Council ceased the project.

➤ *Democratic, community controlled decision-making structures*

The process of community empowerment that took place in the Yarrabah Community was associated with the growth and formalisation of structures for community self management that have developed gradually since the mid-1980s. In 1986, Yarrabah and several other communities in North Queensland were gazetted as State reserves as Deed of Grant in Trust. Following this the Yarrabah Council began to exercise significant decision-making power. In 1998 Yarrabah became a self-governing local government body. Such local government bodies are linked under the Cairns-based Aboriginal Coordinating Council, which is the peak state body representing the interests of residents of Queensland's discrete Aboriginal communities. It is important to note that these Aboriginal local government bodies have responsibility for the administration of a wide range of community services, including health services. In this respect the powers of such bodies are considerably greater than most other local government bodies throughout Australia.

Historical analysis by Hunter et al. (1999) demonstrates that citizens' perceptions and acceptance of their civic responsibilities increased when formal democratic decision-making structures and processes were made accessible to them. For example, when the Federal Department of Aboriginal and Islander Affairs (DAIA) owned the housing at Yarrabah, people took little pride or interest in trying to maintain their overcrowded and rapidly deteriorating houses. When buildings needed repair people would wait passively for the DAIA to fix them. Decades of missionary, then government intrusion and control led to the entrenchment of a culture of institutional dependency in many indigenous communities such as Yarrabah. However, as Departmental responsibility decreased and community control increased, people gradually began to take a more active interest and involvement in community issues such as housing, health services, alcohol use, interpersonal violence and suicide.

The Yarrabah Community Council was centrally important as a structure for "facilitating" and "responding to" a range of community-based initiatives on suicide and other health issues during the 1990s.

The Support to Rural Communities Project did not operate through democratic, community controlled decision-making structures, except perhaps in the case of the Tiwi Islands. At Tiwi Islands "local councils and governing bodies" were actively involved in a democratic decision-making process as to whether or not the community would host the project. The National Aboriginal Community Controlled Health Organisation was consulted but advised that it did not have any association with Tiwi Islands at that stage. No mention is made of engagement with any other community controlled health organisations at Tiwi or at other sites.

While the Galiwin'ku Project was eventually given formal recognition, and the funds were administered by the Galiwinku Council, the project cannot be described as having been conducted through democratic decision-making structures. The external reviewer found that the project was generated and conducted by a small group of individuals.

The external reviewer of the Galiwin'ku Project notes that: "In a resource poor community, where most people are only able to get CDEP jobs (Community Development Employment Program, or "work for the dole"), any injection of funds is keenly sought and people are quick to position themselves so that they get as much of the money for their family as possible" (p. 8). The reviewer speculates that had the Council perceived ownership from the beginning and taken a more active role in managing and monitoring the project, they may have been able to create more community interest and achieved a better result. Alternatively, closer monitoring might have saved as much money being wasted.

One positive effect was observed as coming out of the Galiwin'ku Project or, more precisely, the external review: "During this evaluation we have been approached by Yolgnu people to discuss the re-establishment of a dilak mala leader Council at Galiwin'ku. Issues such as this highlight for senior decision makers their role in the community if culture and Law are to be kept alive, intact and relevant. Some of those Yolgnu involved in the evaluation are keen to see once again at Galiwin'ku a partnership between the Galiwin'ku Council (the contemporary decision makers) and the dilak mala (the traditional decision makers)" (GLETP 1999: 16).

➤ *A social–historical understanding of health*

Throughout the mid to late 1980s, as the first wave of suicides occurred in Yarrabah, a number of health professionals and students completed studies of the health problems of the Yarrabah community. These researchers noted the extremely poor and crowded housing conditions as one of the greatest obstacles to improved health.

> "If someone wanted to design a system to keep people down, the Yarrabah housing system would certainly be part of it. [If] people are wondering why there are so many suicides, they need look no further than this" (Powder Law Report 1987, cited in Hunter et al. 1999: 61).
>
> "Invariably as the Child and Welfare Committee unravels the problems of children they find themselves staring at the problem of overcrowding. It does not matter if the problem is one of parental neglect, continual sickness, truancy, child abuse, incest or alcohol or drug abuse, it always has the same roots in the overcrowded housing situation. Sometimes families have to be broken up because they simply have nowhere they can live together . . . Permanent unemployment is the norm. For the 850 people eligible for work there are 145 permanent positions, the rest are on unemployment benefits" (Director of Nursing, 14/4/87, cited in Hunter et al. 1999: 62).

Hunter et al. (1999) also note historical factors which they believe exacerbate social tensions, poor social connectedness and interpersonal violence in communities such as Yarrabah. This community was not based on natural or traditional tribal and kinship groupings but was an artificial creation of various state and federal departments responsible for Aboriginal and Islander affairs. Over many decades, Aboriginal people were forcibly removed from traditional lands and relocated to Yarrabah. In this situation, families and kinship groups with long histories of disputation and emnity often found themselves living in close proximity and traditional processes for dealing with conflict were not able to function normally.

As (Craig 1979, cited in Hunter et al. 1999: 57) states:

> "By relocating everyone into one township, the DAIA created an artificial community whereby enemies often found that they had each other as neighbours. The high population density within the main settlement increased social tensions and led to a rapid rise in drinking, violence and public disturbance."
>
> ". . . men are suffering most acutely from the stresses of the reserve system. Great numbers have turned to alcohol, and wives often have to drive their inebriated husbands from their homes . . . destabilisation of the family is impairing its function as an agent of social control."

Hunter et al. (1999) argue that the development of this understanding of the social–historical roots of contemporary health problems was a necessary precursor to the community eventually taking responsibility for addressing their own health problems including suicide.

➤ *A Primary Health Care approach*

Based on the findings of the social research which emphasised the social–historical factors underlying the poor health of the Yarrabah population, and as

the Royal Commission into Aboriginal Deaths in Custody began to shift the emphasis of its inquiries to "underlying causes", a "Proposed Health Care Plan for Yarrabah Community Council" was completed in 1988. This Plan identified a set of core problems which needed to be addressed including: (i) no local control; (ii) fragmented service; (iii) no commitment to training; (iv) primary health care principles not being employed; (v) reluctance of community members to use the doctor on the community; (vi) local skills not used; (vii) poor attendance at the antenatal clinic.

The Plan called for the setting up of a community-based health committee to work towards the establishment of an independent and integrated health care system based on the principles of Primary Health Care as defined by the World Health Organisation – which is, "essential health care made universally accessible to individuals and families in the Community by means acceptable to them through their full participation".

The Plan also spells out explicit guidelines for ensuring full community participation in the Primary Health Care model:

- the community is the subject, not the object of health care;
- community direction is established internally rather than externally;
- staff will be generalists and interchangeable within this Health Care System;
- priority health problems will determine Health Service functions;
- all staff will be resources to people; and
- only the medical work will be supervised by medical practitioners.

The Yarrabah Health Council was duly formed in 1988. Funding was obtained from the Aboriginal and Torres Straight Islander Commission (ATSIC) for a building. The Yarrabah Community Council then established an arm called Council Health, employing one Council funded health worker and two other workers funded through CDEP.

Along with the Yarrabah Community Council, the Primary Health Care approach to health service development adopted by the Yarrabah Health Council provided a valuable conceptual and practical framework for supporting a range of community initiated responses to the suicide problem at Yarrabah.

➤ *A focus on community risk rather than individual risk*

During the 1990s, the Yarrabah Health Council and the members of the community worked together and initiated a varied range of responses to the suicide problem which manifest itself in two further distinct clusters during 1991 to 1993 and 1995 to 1996.

Hunter et al. (1999) conclude that responses focused at the individual risk level were largely ineffective, and note that through a process of trial and error the Yarrabah community eventually came to focus more strongly on interventions

that addressed community level risk factors. They note two main advantages of the community risk approach. First, it acknowledges and addresses the true underlying causes of self-harming behaviour in Aboriginal communities. Second, it provides a conceptual and practical framework that accommodates the involvement of ordinary community members in a way that the individual risk focused approach does not.

At the same time as the community-controlled Primary Health Care service was being established, other smaller scale community driven responses began to emerge. A small group of women in the community began to work with Anglican and Catholic churches and the Department of Family Services to organise a series of educational and practical activities focusing on alcohol use and misuse in the community, including its role as a cause of self harm. These activities included educational sessions on family dynamics, dependency and co-dependency, videos by the Canadian Nechi Institute exploring indigenous community responses in Canada, a visit from representatives from the Nechi Institute, and a visit to Canada by members of the Yarrabah Community.

In contrast, an illustration of the failure of approaches that rely too heavily on individual level risk is provided in an account of the effort to establish a visiting specialist psychiatric service. Even though this was an initiative of the community controlled Yarrabah Health Council, and the visiting psychiatrists tried to work very closely with the local community health workers at all times, it proved too difficult to ensure that individuals with serious and chronic mental illnesses (and identified by health workers as needing specialist psychiatric care) turned up at appointments when the psychiatric team made their monthly visits. Hunter et al. (1999) conclude that the psychiatric service was not properly equipped to deal with the problem it was confronting. The "clinical" response was not informed by an analysis of the situation as a whole and could only deal with problems that presented clinically.

While the psychiatric service struggled to meet its objectives during 1991 to 1993 a second wave of suicides was sweeping through Yarrabah. Toward the end of this period community driven responses re-emerged and a more cohesive sense of "community ownership" of the suicide problem began to crystallise. Community members put increasing pressure on the Health Department, through a local MP, for the provision of specific training in "suicide prevention". In early 1993 a special meeting was held at Yarrabah to discuss the suicide problem and review current responses. The view of the meeting was that the way attempted suicides were currently being handled was not acceptable (too many admissions to hospital in Cairns), and that local health workers would be in a position to respond appropriately if they were provided with adequate training and support.

At a subsequent meeting the community moved on to address a range of other related social issues that could be contributing to the suicides in the community, such as authority over children, the situation at the school, and local economic

issues. Funding was obtained from the Health Department and community members organised for training in counselling to be provided by the Aboriginal Studies Program at Curtin University. Attendance was open to everyone. The course focused on historical traumatisation and "cultural healing".

During 1994 there were no suicides at Yarrabah but in early 1995 a third wave of suicides began, with several attempts and three deaths in three months. In response, a community meeting was called and organised with cooperation across Council Health, Yarrabah Hospital and the Yarrabah Community Council. The Community Council organised time off work for all workers, and 300 people attended the meeting. The meeting provided a forum for an outpouring of emotions including sadness, anger, bitterness and despair. But in addition to this, sub-groups were formed that workshopped various issues and reported back to the main meeting.

The following day another meeting was convened between community members, community workers, and representatives from mainstream health and mental health services. The Health Department announced allocation of funding to address the problem and the Cairns-based Aboriginal Coordinating Council was approached to fund a suicide prevention workshop run by Rose Education. The community members who attended this workshop became the core of a Crisis Intervention Group which became involved in planning and implementing the recommendations that came out of the community meetings and the workshop. Key strategies included the development of networks across family and clan groups, and formation of a base of local voluntary workers.

While the initial impetus for the formation of this group was a sense of crisis due to the new wave of suicides, and a perceived need for crisis intervention and provision of locally based counselling, the group very quickly shifted towards a broader approach focused on positive life promotion. At an early meeting held in April 1995, and in the following weeks, the Crisis Intervention Group developed a "Draft plan for Yarrabah suicide prevention, intervention, aftercare and healthy life promotions" which would become the basis of the Yarrabah Family Life Promotion Program.

In contrast to Yarrabah, the Support to Rural Communities Project focused explicitly on individuals at risk of suicide. The emphasis of community education was on helping community members identify and intervene with young people at risk. Education and training provided to professional network members focused on crisis intervention skills and adolescent mental health. While some of the community workshops, particularly in Tiwi Islands, included identification of social factors operating in the community, the project did not progress to the point of trying to develop strategies to address these community-based risk factors.

Jarvis et al. (1999) actually note that although the Tiwi community identified some positive strategies, project activities in Tiwi became increasingly focused on

the role of the mental health team. The mid-project review process identified community needs as being more workshops and discussion rather than individual casework.

➤ *Development of knowledge and skills*

The story of Yarrabah shows that the capacity of the community to identify causes and solutions was associated with a long process of study and reflection. Knowledge was initially generated by a series of studies of health and social issues affecting the Yarrabah Community by researchers and health professionals from outside the community. Over a period of time the community reflected on this research, as well as their own experience, and were able to begin to make sense of the suicide issue. Eventually the community began to commission research into specific issues that they needed more information about in order to inform decision making and planning. On several occasions the Yarrabah Community also sought training in specific suicide prevention skills, such as crisis intervention and counselling that they believed were needed by community members.

Suicide prevention skills training was a central plank of the Support to Rural Communities Project. Project Officers drawn from the local communities were trained in suicide prevention and community education. The decision to employ Project Officers who were committed members of the target communities was in part intended to ensure that the skills, knowledge and experience gained would remain in the communities at the end of the project. Network members were provided with training workshops focusing on suicide awareness. In relation to the workshops, Jarvis et al. (1999: 104) state that "they provided something tangible in the site and were the single most significant part of the project".

Committee meetings and group forums also had an educational role, and selected local service providers were given training in adolescent mental health. A suicide prevention resource manual was also developed. Jarvis et al. (1999: 90) note that while the "content of the manual was adequate and sound, [it] was not presented in a format useful for Aboriginal communities". The Tiwi community was asked to suggest ways in which the manual could be adapted to better suit their needs, but this was not achieved.

Jarvis et al. (1999) report that a major achievement of the Support to Rural Communities Project was a rise in community awareness of suicide, They also find that the skills and competence of the Project Officers, along with their commitment to the job, was a key factor behind the successes that the project had.

There is little evidence that the content of training included a focus on issues relevant to community development or participation such as how services can provide greater opportunities for ordinary people to participate in service and program development.

A key aim of the Galiwin'ku Project was that the project team would study and gain skills (including crisis work, counselling, debriefing, stress management,

mediation, conflict resolution, parenting skills and mental health) from a mainstream perspective, which they would then bring back and impart to the rest of the community in ways that were culturally appropriate. The external reviewer of the project found that this was not achieved. The reason given for this is that the methods of learning and teaching that were used were not culturally appropriate for this purpose.

The external reviewer (GLETP 1999: 3) points out that: "Yolngu people are 'contextual' learners. That is, they learn best when the learning takes place in the context in which it will be applied. People tend to give greater authority to knowledge/skills which they can see people learning. That is community based training. Learning which takes place away from the community tends to be given little if any credibility because people have not seen the learning taking place."

The Galiwin'ku Project Team mostly went away from the community to obtain their training. Little information was brought back to the community. On one occasion three young people were brought to a course conducted at James Cook University in Townsville. "They said that most of the time they had no idea what was being talked about, and it didn't make sense to them. It was tiring and hard to understand. They were unable to take anything useful back to the community" (GLETP 1999: 12).

It is noted that on one occasion when one of the two main team members did some training with the young team members at Galiwin'ku on family violence, this was reported by the young people as easier to understand and useful. However, training provided at Galiwin'ku on the topic of suicide was not found to be useful.

The external reviewer (GLETP 1999) also raises concerns about the process of translating concepts from mainstream cultural understandings of suicide and self harm into concepts that make sense in Yolngu culture. This is much more complex than the simple translation of words. The external reviewer consulted with the Aboriginal Resource Development Service, a training team operating in North East Arnhem Land which has considerable experience translating underlying concepts from balanda culture (white culture) to Yolgnu culture. It is reported that this team expressed the view that "they would not have expected this project to work because the people working on it, both Yolgnu and Balanda, lacked the skills and knowledge to do this conceptual translation" (GLETP 1999: 4).

According to the external reviewer (GLETP 1999: 4): "The skills they were expected to be trained in rise from the mainstream culture's world views and understandings. The way in which they are described and applied may not have a direct equivalence in Yolngu culture, though it may be possible, with extensive consultation in the local language, to identify parallel structures. It would appear that no attempt was made in this project to find parallel structures to allow the new information and skills to be transferred to Yolngu people, who spend their entire

life in a language other than English, that is, Yolngu matha. There is no evidence whatever that the rest of the community was able to gain access to the new skills in a culturally appropriate manner."

The external reviewer of the Galiwin'ku Project also found that the resources allocated to the project under the National Youth Suicide Prevention Strategy were inadequate to the task of competently implementing such a complex transcultural education and training process.

➤ *Networking?*

Networking was a central focus of the Support to Rural Communities Project. The overall aim of the project was stated to be to "trial and evaluate the effectiveness of state, territory or regional networks representing a substantial geographic area in supporting a number of rural or remote communities to prevent and respond to suicide attempts by young people" (Jarvis et al. 1999: 14).

The wording of this stated aim suggests that networks are perceived in instrumental terms, that they can be a driver and supporter of an ongoing community-based approach to suicide prevention.

The Support to Rural Communities Project recognised that networks exist naturally in each rural community. The initial part of the network development process was to identify and describe these in order to support them in developing local strategies to respond to young people at risk. The project made a distinction between formal and informal networks. (Jarvis et al. 1999: 75) identify formal networks as "comprising people in a community who are recognised by their profession and involve working with or treating young people", and informal networks as "comprising people in a community identified as having rapport with young people".

Identifying formal network members involved a process of "listing services and people, who, through their general course of business had dealings with young people. The local steering committee and auspice body assisted in this process using their knowledge of the area" (p. 75). Identifying informal networks was described as "a little more difficult". Again, the steering committee and auspice body assisted by referring the Project Officer to people who they thought fitted the description. The Project Officer also visited community organisations such as service clubs, local auxilliaries and church and school-based groups, talked about the project and distributed a "network identification sheet". This process of community networking continued throughout the project.

Jarvis et al. (1999: 22) identify the development of networks "within both the local professional groups and community at large" as one of two major achievements of the project. Evidence presented in support of this claim is largely descriptive, comprising accounts of the process of bringing people together. For example, the Final Report describes how community meetings, forums and workshops were

conducted which involved various stakeholders who may not have known each other previously.

According to Jarvis et al. (1999: 72): "One of the most efficacious aspects of the workshops in all sites was the opportunity for networking. It was amazing that in each of the locations there were a number of people who did not know each other. Clearly, the workshop provided a means of facilitating further cooperation between service providers."

The external evaluators of the Support to Rural Communities Project also report that in Atherton, health and community workers believe that the Project has "helped to create a human service community where previously there existed a combination of visiting workers and unrelated practitioners and service organisations" (Vinson, Webster and Baldry 1999, in Jarvis et al. 1999: 120). In Millicent, Vinson et al. observe that "there emerged a stirring of awareness of the existence of a human service community, beyond the preoccupations of separate services and organisations" (p. 138).

Unfortunately, the Final Report of the Support to Rural Communities Project does not succeed in conveying to the reader an answer to the question of whether networks were effective in supporting communities to prevent and respond to suicide attempts. At no time does the Final Report identify clear criteria regarding successful or effective networks. While the range of "intended" formal and informal network members are listed, there is no description of the actual number and range of network members enlisted, no description of the levels of participation by different categories of members – for example, attendance at workshops and other meetings by formal (professional) compared to informal (ordinary community) members – and no concise or critical analysis of the various processes that an "effective" network might go through during its development.

However, the evidence that is available suggests that, outside of the "network identification" process, and some educational workshops, "network development" activity was primarily focused on professionals, rather than ordinary community members. Furthermore, the education and training activity that was provided to formal (professional) network members was focused on developing the clinical skills and other intervention capacities of professionals to work with individual young people, rather than skills in community development.

➤ *Time*

Securing the engagement of a significant number and cross-section of people in a community requires a considerable length of time. As already noted, Hunter et al. (1999) describe how the Yarrabah community had to pass through a series of stages before they developed an understanding of what was happening in the community and came to realise the necessity of working together for common goals. The Support to Rural Communities Project also spent a considerable length of time consulting with community organisations about the project before particular

agencies stepped forward to make a commitment. Despite this, Jarvis et al. and the external evaluators (Vinson, Webster and Baldry 1999, in Jarvis et al. 1999) observe that problems in building community ownership might have been reduced if more time had been available for the project to consult more thoroughly with all relevant stakeholders and for the local communities to discuss issues around the project.

Time is also required to negotiate with relevant service agencies regarding their formal involvement. These negotiations can be complicated in remote areas if service agencies are administered from offices in regional centres and state capitals which may be a long distance from the communities concerned. Vinson, Webster and Baldry (1999, in Jarvis et al. 1999: 134) note that this limits the autonomy of local service providers, reducing their capacity to be responsive to issues arising in the local community: "The health services took months to approve the involvement of local health staff . . . The fact that many agencies of government and non-government are managed from outside these townships means that local decision-making, and enthusiasm, is stifled."

The external reviewer of the Galiwin'ku Project notes that the timeframes provided under national and state/territory project funding processes are generally completely inadequate for ensuring proper ownership by Aboriginal communities.

According to (GLETP 1999: 8): "What tends to happen is that someone, usually a non-Aboriginal person, who has an interest in a particular issue hears about the money and suggests to local people they should apply. Having got approval from local people this person or organisation then prepares the documentation and 'assists' with the passage of the application through the necessary channels. There is nothing wrong with this process except the pace at which it all happens and the lack of time available for the local people to truly understand what might be expected of them if their application is successful. This project (Galiwin'ku) would appear to provide us with an example of why this is not the best way to fund programs in remote Aboriginal communities."

What works to ensure that young people are engaged and empowered in the community development process?

Youth participation was a contractual requirement of the Support to Rural Communities Project. Jarvis et al. (1999) report that this proved problematic throughout the entire duration of the project. They argue that the difficulties were due to problems that lay outside of the Project's control including: "ethical guidelines, youth representation within geographical site locations, apathy of young people, and the workload of the POs (which developed into more than what was originally planned for)" (p. 59).

Youth participation was a contractual requirement of the Galiwin'ku Project. The external evaluation found that no effort was made to engage young people in the project.

Some other projects funded under the Strategy, which included a community development component, had considerable success in engaging young people as active participants in the projects.

➤ *A variety of informal as well as formal mechanisms*

The Here for Life Youth Sexuality Project based at the Western Australian AIDS Council and the Gay and Lesbian Counselling Service of Western Australia placed very strong emphasis on involving young people from the target population in program development and delivery. The project used a variety of strategies in the effort to gain this input. Young people were involved in:

- developing publicity material;
- conducting community education and promotional activities to raise the profile of the project and increase community awareness;
- developing a video used as part of a professional training program;
- facilitating peer education and peer support programs;
- development of a youth advocacy group;
- formal focus group consultations; and
- a young person's position on the Project Steering Committee.

The project evaluation found that this variety in the opportunities for participation was an important factor behind the success achieved. The Here For Life staff felt that the availability of a drop-in centre, the Freedom Centre, was particularly beneficial.

The opportunity just to "hang out" in a comfortable and accepting environment that does not place immediate expectations on young people appears to be particularly important to engagement. By providing acceptance and non-judgemental support as well as a variety of activities, young people can choose to become involved at their own pace and in the ways they choose for themselves. Informal activities also provide an ideal form of participation for marginalised young people because the social component provides an immediate intrinsic reinforcement for involvement.

➤ *Training and opportunities*

The Here For Life Youth Sexuality Project provided training to young people to act as facilitators of peer support and peer education programs.

Training and work as a volunteer peer leader develops confidence and leadership qualities that encourage peer leaders to move on to more challenging work.

Several paid Freedom Centre staff first became involved in the program through volunteer work. Peer leadership also provides role models for other young people, empowering them with confidence that they too have the capacity to develop leadership and work skills.

➤ *Youth are represented in the population*

One of the main reasons for the failure of the Support to Rural Communities Project to involve young people identified by Jarvis et al. (1999) was the fact that young people were not well represented (present) in the populations of the geographical locations where the Support to Rural Communities Project was trialed. Jarvis et al. note that many young people move out of rural and remote communities for further education, training and employment opportunities.

➤ *Organisational structures that represent and support young people*

Jarvis et al. (1999) note that youth groups were identified in only two of the five sites and suggest this was a barrier to identifying and involving young people.

As noted above, the organisational structure provided by the Freedom Centre appeared to be a major facilitator of the Here For Life Youth Sexuality Project being successful in engaging young people. The Freedom Centre provides a venue for a range of activities and services which attract young people and provides a youth friendly "space" where young people feel comfortable and can talk and organise themselves.

➤ *Workshops and forums?*

The Support to Rural Communities Project organised workshops and/or forums in an effort to inform and consult with young people and hopefully engage them as ongoing participants in the project. This strategy was successful at only one trial site – Tiwi Islands. Here a two-day workshop was attended by 80 young people ranging from 12 to 18 years. Group discussions focused on a wide range of topics relevant to young Aboriginal people including drugs, family fighting, child abuse, jealousy, suicide and petrol sniffing. The strong attendance at the youth workshop at Tiwi Islands occurred in the context of relatively strong engagement of the wider Tiwi community with the project, and youth suicide being a subject of great concern to community members and service providers.

At Atherton the first forum was attended by two young people and no young people attended the second. The remaining two forums were cancelled. At Bourke the Advisory Panel and Project Officer advised that no youth forums should be organised based on experience of poor attendance at such forums in the past. At Oatlands one forum was organised in collaboration with Lifeline but after this the young people were not interested in attending another one as they felt recommendations were never followed up. Just prior to the initiation of the Support to Rural Communities Project a workshop for youth had been held at

Millicent by the Minister for Youth Affairs, the Local Government Association of South Australia and the Department of Education, Training and Youth Affairs. The young people were not interested in attending another forum so soon after this, especially since no recommendations were implemented.

➤ *Culturally appropriate mechanisms*

There is a widely held belief among health promotion professionals in western countries that young people are more likely to listen to other young people when seeking advice or assistance in dealing with problems. This belief has encouraged growing commitment to involving young people as peer educators in community education programs. The external reviewer of the Galiwin'ku project cautions that this assumption may not be universally valid cross culturally, and that it is definitely invalid in the case of Yolgnu culture.

According to (GLETP 1999: 10): "All the people who were spoken to as part of this evaluation said that in Yolgnu culture young people have little credibility with other young Yolgnu people, or with older people. While they can assist with helping they can not direct or take a high profile. They are not the educators or the givers of knowledge. This is the role of older people, preferably 'dilak mala', clan elders. Unfortuately, no clan elders were involved in this project."

Furthermore, it is argued that it is not just any elder that Yolgnu young people will listen to and learn from: "Yolgnu people are born into a kinship system that dictates the intimacy of their relationships from birth to death. If people are not within your close kinship network, then they will not listen to you, and will passively or actively, even sometimes violently, resist any attempts that are made to direct their behaviour" (GLETP 1999).

In order to engage with Yolngu youth it is therefore necessary to formally engage appropriate senior male members of the young person's kinship group and work with and through these elders (dilak mala).

Another cultural consideration concerns the readiness of Aboriginal people to openly express true opinions. This readiness varies across different situations. In formal meeting environments Yolngu people can be reluctant to express views that may be perceived as confrontational or disturbing of harmony. Thus informal discussion is necessary to ensure that they have opportunities to express their true opinions (GLETP 1999). Young people especially and those who have not achieved formal elder status will rarely speak up on formal occasions.

➤ *Clear policy*

The staff and evaluators of the Support to Rural Communities Project report that a major barrier to the involvement of young people was a lack of clarity regarding the ethical appropriateness of this. There is an indication that the Consortium was provided with contradictory messages from the Commonwealth and from other experts regarding whether or not it was ethical to involve young

people under the age of 18 in discussions or educational workshops about suicide. This uncertainty deterred the Consortium from more actively pursuing opportunities to involve young people under 18 years of age on the few occasions when this was possible.

This problem appears to have arisen as a particular misunderstanding or miscommunication between the Support to Rural Communities Project and the Commonwealth. No other National Youth Suicide Prevention Strategy projects identified this as an issue.

What facilitates the achievement of higher order goals and objectives of community driven initiatives?

Following the three increasingly severe waves or clusters of suicides that occurred in 1986–1987 (three deaths), 1991–1993 (nine deaths) and 1995–1996 (eight deaths), there were no suicides in Yarrabah during 1997 or 1998. In the three quarters to June 1996 there were between 45–50 incidents of self harm per quarter for males and 20–25 for females. These numbers fell to between 10 and 20 incidents for both sexes in late 1996, and continued to fall to below five incidents per quarter throughout most of 1998 for both males and females (Hunter et al. 1999). During this period there was also a reduction in police interventions for alcohol related problems and a reduction in hospital presentations for accidental trauma (Baird, Mick-Ramsany and Percy 1998, cited in Hunter et al. 1999).

Because the on site activities of the Support to Rural Communities Project spanned only a 12–18 month period it is not possible or appropriate at this stage to determine whether this project has achieved higher order objectives such as reductions in suicide rates. The demonstrable achievements of the project are generally limited to "processes" such as: increased awareness of suicide issues in the community; "formation of networks"; development of some service-based policies and protocols; formation of three ongoing Taskforces; and intentions to continue with some activities and implement some new ones (depending on funding).

Nevertheless, the project staff and evaluators (Jarvis et al. 1999) do provide some reflections on the factors they believe will determine whether or not these "process achievements" will lead to measurable impacts and outcomes in the course of time.

The Galiwin'ku Project was intended to reduce youth suicide and other self-harming behaviours including Kava drinking, gambling, violence and petrol sniffing. The external reviewer concludes that no progress was made towards ameliorating these problems (GLETP 1999).

➤ *Community ownership of the problem and the program*

The underlying principle of the community development approach is that only solutions that are driven from within the "risk community" will ultimately be successful in reducing community based risk conditions. Thus ensuring that the community does drive the process is the first and most important factor determining achievement of higher order goals and objectives. However while this is a necessary ingredient for effectiveness, it is not sufficient. A number of other factors were identified as critical if community driven initiatives are to be successful.

➤ *Appropriate support and resources*

Allocation of resources for the development of infrastructure as well as ongoing community-based needs assessment and planning was critical to the success of the community development process at Yarrabah.

Initially, resources and support from the Yarrabah Community Council allowed the community to begin to address its severe health problems by developing the "Proposed Health Care Plan for Yarrabah Community Council" and implementing the recommendation to develop a comprehensive Primary Health Care service. As noted earlier, the Yarrabah Health Council was formed in 1988. Funding was obtained from ATSIC for a building. The Yarrabah Community Council then established an arm called Council Health, employing one Council funded health worker and two other workers funded through CDEP.

The existence of this Primary Health Care service and ongoing support and collaboration from the Community Council were instrumental in allowing the community to identify and express its concerns and aspirations and play an active role in identifying, planning and implementing solutions to the problem of suicide.

Following the development of the "Draft plan for Yarrabah suicide prevention, intervention, aftercare and healthy life promotions", by the Crisis Intervention Group, the Yarrabah Community Council agreed to continue funding the two primary health care workers (originally funded by CDEP) under the new Yarrabah Family Life Promotion Program. A grant of $50,000 from the Health Department allowed their salary to be increased to a professional full-time rate with some left over to cover modest incidental costs. The Council also provided office space, computer facilities and administrative support. The Cairns Mental Health Service also supported the Yarrabah Family Life Promotion Program by extending the services of a Social Worker for three months to provide training and support to the Family Life Promotion Officers. Later in 1995 the Health Department agreed to continue funding a part-time mental health nursing position (two days per week) for a further three months to provide training to the Family Life Promotion Officers.

Resources are also essential if the community is to be involved in ongoing needs assessment and planning. In April 1997 Queensland Health made funding

available to conduct a feasibility study into a multi-purpose health care service for Yarrabah. An Action Research Model was used involving widespread community consultations over an eight month period (Baird, Mick-Ramsamy and Percy 1998, cited in Hunter et al. 1999).

Jarvis et al. (1999) argue that maintenance of funding is essential for ongoing coordination of activities initiated by community development projects, at least until structures sustained by the community have emerged: "Once resources such as money and paid positions are removed from rural towns, who is then available to be the driving force behind the community development approach to suicide prevention, if no Taskforce has emerged?" (p. 25).

When community development activity is focused around a problem like suicide prevention it makes intuitive sense that "appropriate" support and resources will include those that have specific relevance to risk factors for suicide. The Support to Rural Communities Project placed considerable emphasis on the provision of clinical support. A number of strategies were used to provide this support: training in adolescent mental health was provided to certain groups of professionals in the project networks; a member of the Project Team with extensive clinical experience in adolescent mental health attended a number of community workshops; the project organised for the Project Officers at each site to have access to locally based clinical support; and constant supervision and support was provided to the site-based Project Officers by the National Project Officer.

Evaluation conducted by the Project Officers and people who attended workshops suggests that the clinical involvement at each site contributed positively. The clinicians own assessment was that: "The giving of (clinical) information is useful, but far more important is the recognition and support, by someone with expertise, of the efforts of the local community. Educating and empowering local people who are more likely to remain in the local area is both more cost effective and likely to produce longer-term benefits" (Jarvis et al. 1999: 74).

This was also the firm conclusion of the Yarrabah Community. Simple provision of specialist clinical services by externally based providers was not found to be effective or acceptable by the Yarrabah Community.

➤ *Formal program structure, protocols and ongoing needs assessment and planning*

The Yarrabah Family Life Promotion Officers experienced considerable difficulties during the early stages of the program in the latter part of 1995 and early 1996. The supports that had been provided were largely focused on crisis intervention and counselling skills. Thus the Officers tended to focus primarily on this aspect of the work. Despite the training support that was provided this work became excessively demanding for the two Officers. There was a lack of protocols that could ensure provision of adequate and timely back up to the Officers by

other professionals when this was needed. Transport and worker safety was also a problem. Workers experienced burnout and there was turnover of the staff.

However, with persistence and by maintaining active involvement of the community network, stability was achieved and protocols were developed for responding to crises which specified the roles of other services such as the hospital and the police, as well as families and friends.

Hunter et al. (1999) note that the apparent lack of structure to the Family Life Promotion Program in 1995 resulted in considerable reticence on the part of the Health Department to continue supporting the program. However, funding support for further training was forthcoming following appeals from the community. The nurse who provided this training also helped clarify and formalise the roles of the Family Life Promotion Officers which were identified by the nurse as: (i) crisis intervention; (ii) support and networking with other services; (iii) long-term Family and Life Promotion Programs.

In mid-1996 Mercy Baird was commissioned to undertake community consultations and produce a five-year plan for the program. The priorities for the program identified by the community were (i) family life skills; (ii) culturally appropriate services; (iii) education and training; and (iv) other projects.

A clear Mission Statement for the Family Life Promotion Program was also formalised:

> "To use a Community Development Suicide Prevention Model to heal individuals, promote family life, support, encourage, develop, improve and empower the people of Yarrabah to help reduce the suicides and attempted suicides in the community."
>
> "To develop a locally owned culturally relevant Primary Health Care and Treatment model such as Intervention, Prevention and Postvention to encourage individuals and families to move to a more healthy lifestyle, spiritually, physically, mentally and emotionally so to create a more socially acceptable environment."

As noted earlier, during 1997 an Action Research study was commissioned to examine the feasibility of establishing a multi-purpose health care service. This involved widespread community consultations over an eight month period and provided opportunities for the community to be involved in ongoing reflection on a range of issues (Baird, Mick-Ramsamy and Percy 1998, cited in Hunter et al. 1999). In relation to the Family Life Promotion Program, the community expressed a desire to build further on the program by employing two more Family Life Promotion Officers to extend the counselling service and develop community education and prevention programs.

Note that formal program structure does not appear necessary for "engaging" the community as active partners or engendering ownership. In fact too much

formality and structure may to work against this. It is possible that only after community ownership and commitment has been established that formal structured programs can flourish without hindering ongoing community involvement.

➤ *Provide a comprehensive range of interventions that are culturally appropriate to the community*

The community development approach is based on a social understanding of health that emphasises risk and protective factors operating at the community level as well as the level of individuals. Thus in order to maintain fidelity to the community development model it is critical for communities and the agencies operating on the behalf of communities to support a comprehensive range of interventions that are appropriate to the needs and context of the particular communities involved.

Consistent with this the Yarrabah Family Life Promotion Program has evolved consistently towards this comprehensive approach. Specific strategies implemented under the Program include:

- education and training programs for individuals and families to empower them with the knowledge, skills and understanding to deal with the suicide problem from a holistic healing perspective;
- crisis intervention including: a Crisis Centre/Safe Place that provides short-term (24 hour) support during crises; a Telephone Crisis Line;
- one-on-one counselling; grief and loss counselling; family support groups;
- postvention including information and self awareness programs for survivors of suicide and those who are at risk;
- promotion of healthy family life through workshops on parenting and personal relationship development; and
- networking and coordination with community agencies to encourage and support all people in the community, especially youth at risk, to be involved and participate in sporting, recreational and cultural activities, to promote unity amongst family and the community.

As noted previously, the Family Life Promotion Program at Yarrabah also exists in the context of a Primary Health Care service that is, to a significant extent, controlled by the community as well as other community-based initiatives aimed at limiting the harm caused by alcohol use. For example in August 1997 the Yarrabah Community Council decided to close the canteen that sold alcohol in the community. This eliminated the canteen as a focal point for gatherings thereby reducing the extent to which alcohol could exacerbate public disputes and violence.

The Galiwin'ku Project was intended to develop the skills of local people in a wide variety of suicide prevention interventions including crisis work, counselling, debriefing, stress management, mediation, conflict resolution, parenting skills and mental health. Instead of providing this training the Project Team

focused more and more on one activity – attempting to forcibly prevent young people from sniffing petrol by patrolling around the community in vehicles and scattering groups of young people away from their favourite places into the bush (that is, a Security Patrol). The Police observed that while this strategy reduced levels of petrol sniffing for a short period, young people, parents and other community members became increasingly hostile to the activities of the Security Patrol. Young people began to fight back.

The impacts of the project on the petrol sniffing problem were actually negative. Prior to the project, a group of local people which included older and younger men worked to reduce sniffing by taking young people home to their parents when they were found wandering around at night. While the work of this original Security Group was low key it was perceived to be having some positive impacts. The older men in the group were fathers and were respected in the community. The Council was providing some support through the CDEP. The Galiwin'ku Life Education Project ended up "taking over" the original security group and the previous gentle low key approach was described as developing into an authoritative and punitive vigilante process. The older men left the group. Since the project finished, the old Security Group has re-grouped and resumed the original supportive low-key approach.

➤ *Comprehensive, community controlled Primary Health Care services*

Hunter et al. (1999) note that efforts to expand and improve the Primary Health Care system at Yarrabah, and to achieve greater community control, are ongoing and that this process has been facilitated and given momentum by the mobilisation of the community around the issue of suicide. In 1996 a five-year development plan was produced for Yarrabah by external consultants who noted that existing services remained limited and tended to operate in isolation from each other. Consistent with the "Proposed health care plan for Yarrabah Council" produced a decade earlier, the consultants recommended that a clear network between service providers is necessary.

A major finding of the 1997 Action Research study (Baird, Mick-Ramsamy and Percy 1998, cited in Hunter et al. 1999) was that community control in the planning of Primary Health Care services is critical if any short term health improvements gained through service delivery are to translate into long-term health gain for the community.

According to Baird, Mick-Ramsamy and Percy (1998), cited in Hunter et al. (1999: 77):

> "The Yarrabah community identified the reclamation of 'spirit' or responding to the experience of hopelessness, as fundamental to the achievement of health improvement. The community reports that what comes with 'healing the spirit' is self-determination, the opportunity to be the author of one's destiny and to take responsibility for one's life."

> "Addressing social and spiritual health concerns does not, in the short term, respond to the ongoing high rates of morbidity and mortality in the community. Effective health planning and development of locally relevant primary health care services, at least in the forseeable future, will be required to address the high incidence of morbidity and mortality."

The Yarrabah community plans to set up a Socio-Emotional and Spiritual Well-being Centre of Excellence to address the socio-emotional problems within the community.

General discussion

Definitional issues

The projects in this group demonstrate that there is a considerable lack of clarity, or perhaps disagreement, among professionals in the field about what is meant by terms such as "community ownership", "empowerment", and "self-determination" in the context of community development. There is also evidence of confusion between "networking" and "community development". This perhaps reflects different understandings of what is meant by the term "community development". It may be beneficial for the public health and community health fields to establish greater consensus around the meaning of these terms. Baum (1998: 326) suggests that it is "crucial that practitioners make a critical examination of the concept of participation they are using and not claim it to be something it is not". This recommendation about "participation" applies equally well to all the other terms mentioned above. Clarification of the meaning of these terms is particularly critical for the purpose of evaluation of community development "projects".

In the present discussion the term "community development" is used to refer to a process in which *a community grows or builds its capacity to protect and enhance the health and wellbeing of its members*. "Community" in this context refers to a group of people living in a particular geographic location such as a town or local government area. However "community" can also refer to groups of people that share particular characteristics such as ethnic or cultural identity (for example, particular Aboriginal or Torres Strait Islander tribal groups) or religious or professional affiliation (see, for example, Peterson and Lupton 1996; Sozomenou, Mitchell, Fitzgerald, Malak and Silove 2000). The "capacity" that is built or grown during community development can include a wide variety resources that contribute to health and wellbeing but public health practitioners generally emphasise the importance of social resources such as social capital and social structures (Baum 1998; Baum, Palmer, Modra, Murray and Bush 2000) as well as networks, values, skills, leadership, knowledge of history, and critical reflexivity (Goodman et al., 1998 cited in Hawe, King, Noort, Jordens and Lloyd 2000).

A fundamental tension present among the "community development" activities described here concerns the effect or the role of the stimulus or driving force behind the community development process. In Yarrabah, the driving force behind community development was the community itself. In others cases Strategy projects act as stimuli and drivers.

Baum (1998) draws the distinction between participation as a means (instrumental participation) and participation as an end (structural participation). Instrumental participation is when participation is used as a means of achieving a set objective or goal. "The emphasis is on rapid mobilisation and direct involvement in the task at hand. . . . An example would be an external agency coming to a community with a predetermined program that required the implementers to work with the community" (Baum 1998: 325). Structural participation is a process that is more fundamental than a specific project. Changes take place within the organisational structures of the community which provide a foundation for increased community involvement in a wide range of decision-making processes and which ultimately allow the community to control key aspects of their environment. The process of structural participation is more closely aligned with traditional notions of community development as fundamentally concerned with empowerment.

According to Israel, Checkoway et al. (1994, cited in Baum 1998: 327): "Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations."

While the process at Yarrabah can be considered a good example of structural participation, or community development, the Support to Rural Communities Project may be more accurately understood as instrumental participation.

Arguments for structural community development

Baum (1998: 326) states that "structural participation may be a fine ideal but it is not always achievable". This statement requires unpacking. If structural participation is the ideal then it would be valuable to know more about the conditions that facilitate it. If these conditions are not always present then it would be good to know how they can be created. The projects funded under the National Youth Suicide Prevention Strategy provide some useful insights.

In considering the value of structural versus instrumental forms of participation it is also important to consider the wider policy environment. Over recent years governments have expressed increasing interest in the concept of empowering communities to develop local solutions to local problems. This orientation is growing in a number of different areas of social policy including suicide prevention, prevention of youth homelessness, and broader family policy (Department of Family and Community Services 2000). Primary prevention and early intervention research in a range of areas is also highlighting substantial overlap in the risk and protective factors underlying many health and social problems. This

recognition is stimulating increased calls for intersectoral collaboration, especially among practitioners working in community based approaches. The need for intersectoral collaboration in this context suggests that approaches which emphasise creating conditions whereby communities are empowered to address a wide range of issues (that is, structural participation or community development) will be more productive than approaches which are focused on assisting communities to address a specific issue (instrumental participation).

It is also important to note that the Support to Rural Communities Project team had the intention that the target communities would be empowered to develop their own suicide prevention activities after the project was finished. In this sense, there was a hope that a form of structural participation would ensue.

The critical question from an evaluation perspective is whether the process of instrumental participation can be effective in stimulating true structural participation in due course or whether it may be more productive to promote structural community development from the outset.

Community ownership

The results of the current studies indicate that the ongoing engagement (participation, ownership, empowerment) of community members is more robust when interventions and activities are initiated and driven from within the community involved rather than brought in by outsiders. This has also been observed by previous investigators, particularly in relation to high-risk communities (Minkler 1990, cited in Hawe, King, Noort, Jordens and Lloyd 2000).

Being "driven by the community" means that the community comes to an awareness of a problem on its own rather than being told by outsiders that it is a problem that should be addressed. Building community ownership is a process (see Table 5.2). As a community develops an awareness or shared *understanding* that a particular issue is a problem that needs to be addressed, different groups may gradually develop a shared political *commitment* to addressing the problem, and they begin to work together, or *collaborate*, to seek solutions. The community may then approach outsiders to assist them develop and implement the kinds of solutions it has identified.

In contrast, instrumental community-based approaches rest on an assumption that recognition of the importance of a particular issue (in this case, youth suicide) is underdeveloped in certain communities and needs to be actively promoted. The experience of the Support to Rural Communities Project is that it is difficult to

TABLE 5.2 The process of community ownership

• Shared understanding
• Commitment
• Collaboration

TABLE 5.3 Factors that facilitate ownership and engagement
• Widespread recognition that an issue is a priority for the community
• Communities identify their own solutions
• Structures that support the process of participation
• Knowledge and skills

engender community ownership and sustained commitment when the community concerned has not previously identified the issue as a priority concern. Engendering such prioritisation is a time consuming and labour intensive task and may not succeed, particularly when other issues are pressing. Serious questions need to be asked about the cost effectiveness, and even the ethics of such an approach when a community has clearly identified other issues as of greater importance to them. Is it appropriate for community developers to ignore previously identified priorities and seek to change people's minds about what their priorities should be? Is this consistent with the principle of self determination and empowerment? It might be much more productive for the resources of community development activity to be allocated to issues that have already been identified as priorities by the communities concerned *(Recommendation 5.1, first dot point).*

A second factor that distinguished the community development process at Yarrabah from the instrumental participation process used by the Support to Rural Communities Project was the extent to which community members were responsible for identifying the solutions or strategies that would be implemented. The community development process at Yarrabah was consistently driven from the inside. At all times it was locals who came up with ideas about what the community needed to do. With experience it became apparent that some of these solutions were not the most appropriate, but these experiences contributed to the community's own learning process.

By comparison, the Support to Rural Communities Project clearly adopted what could be described as a top-down model of community development. Although the importance of the community "being involved" in making decisions was emphasised, the project nevertheless offered this involvement within parameters that were fixed and dictated by the central Project Management group. This is evidenced by virtue of the fact that the trial was highly standardised across the five sites. In all locations the core strategies were the same (primarily networking between service agencies and training in suicide awareness and adolescent mental health), only the processes of implementation were varied in response to logistical demands created by specific local conditions. The strategic aim of the "community development" process was also clearly set in advance.

In contrast to this relatively controlled approach to community participation, Oakley (1989) observes that the process of structural participation is "dynamic, unquantifiable and essentially unpredictable" (cited in Baum 1998: 325).

On balance, the evidence suggests that community development programs should be flexible and oriented toward encouraging communities members to identify solutions to the problems they have prioritised *(Recommendation 5.1, first dot point).*

Social structures

A third key finding of the current set of projects is that community ownership and sustained engagement in addressing community issues is greatly facilitated, and may even depend on the existence of structures that are capable of supporting processes of debate, discussion and decision-making. The role of structures tends to be neglected in discussions of community development but their importance has recently been emphasised by leading theorists in the field of capacity building in health promotion (Hawe et al. 2000).

The community development process that took place at Yarrabah occurred in association with the growth and formalisation of clear structures for community self management, especially the Yarrabah Community Council and the Yarrabah Health Council. The growth of these organisations was stimulated by, and in turn supported further increases in, community empowerment. Features of these organisations that appear to be critical to their capacity to facilitate community development include that they are democratically controlled by the community, and that they have significant decision-making powers with respect to the management of services in the community. In contrast the failure of the Galiwin'ku Project to fully connect with legitimate community controlled organisations was a major factor in the ultimate failure of the project.

An increasing number of Aboriginal and Torres Strait Islander communities have Community Councils which are responsible for administering many of the services and functions operating in those communities. These Councils appear to vary in the extent to which representatives are elected in a democratic fashion and are able to pursue their duties in a manner that is free from the pressures of kinship ties.[1] Increasing the number and resources of such democratically controlled councils would appear to be a key strategy for enhancing the capacity of indigenous communities to take control of major issues affecting their lives.

Local Councils representing non-Aboriginal communities generally do not have the range of functions and responsibilities that would allow them to act as instruments of comprehensive community control over a sufficient proportion of the decisions that affect the social environment.

A key function of community development activity should be to help develop structures that are capable of sustaining ongoing community participation in the decisions that affect community wellbeing. Therefore it is pertinent to ask why

1. This point was made by Aboriginal people during discussion of the Yarrabah community experience in a workshop entitled "Far North Queensland Community Action for Youth Suicide Prevention", conducted by Connolly, Baird and Bowen at the Suicide Prevention Australia Conference, Melbourne, 2 April 2000.

so few community development initiatives appear to actually address themselves to such structures (Mitchell 1999) with a view to determining how this orientation might be facilitated.

The Support to Rural Communities Project did not work through democratic decision-making structures, except to secure the agreement of the Tiwi Islands community to participate in the project. Instead the basis of the project was the development of loose "networks" of professionals and ordinary community members. The assumption was that these networks would support communities in preventing and responding to suicide attempts by young people.

Unfortunately, the Final Report of the Support to Rural Communities Project (Jarvis, Dunn and King 1999) does not succeed in conveying an answer to the question of whether networks were effective, or could be effective, in supporting communities to prevent and respond to suicide attempts. There are two groups of reasons for this.

First, there is a lack of clarity about the definitions of key terms. At no time does the project's Final Report clearly define the concepts of networks or community development. There is considerable confusion evident throughout the report regarding the relationship between networking and community development. At times there appears to be an unstated assumption that the two concepts are identical rather than being instrumentally related to one another. Second, there is a failure to clearly identify the nature of the evidence necessary to determine whether loose networks are actually capable of providing communities with the kind of support structures needed for true community development or suicide prevention. The report fails to identify clear criteria regarding successful or effective networks. No indicators of effective process, impact or outcome are articulated.

It is important for greater clarity to be established regarding these issues. Blurring between the concepts of networking and community development is widespread. The concept of networking has gained considerable prominence in suicide prevention and health promotion circles in recent years but there appears to be little clarity or consensus around its definition or its place within the broader context. In practice, networking appears to be used increasingly as a substitute for intersectoral collaboration, community participation and community development with little critical reflection on the distinctions that might be profitably be made between these concepts and practices.

Networks and networking

Recent interest in the concept of networking may stem from the prominence given to it in the literature on social capital. Based on a critical analysis of the work of several major theorists, Winter (2000: 5) concludes that social capital is best understood as a "resource to collective action . . . [which] comprises the norms and sanctions of trust and reciprocity that operate within social networks". According to this view networks are a mesh or fabric of relationships within which trust and

reciprocity are embedded, within which social capital can be generated. Thus networks are a substrate, or a base ingredient for the generation of social capital.

Winter (2000) argues that social capital as a resource needs to be clearly distinguished from the collective action which is an outcome of social capital, not a direct indicator. Similarly, networks as a substrate which supports the generation of social capital need to be distinguished from social capital (as a resource) and from collective action (as the outcome). While networks are necessary for the generation of social capital and collective action they are not sufficient. They are just one ingredient. Trust and reciprocity need to flow within networks for social capital to be generated, and then presumably yet another ingredient is needed for collective action to arise. Similarly, Goodman et al. (1998, cited in Hawe et al. 2000) identify social and interorganisational networks as one component of community capacity for health promotion. Other components include resources, understanding of community history, community leadership, skills, community values and critical reflexivity.

Winter (2000) also argues that social capital and its outcomes need to be distinguished from the conditions or factors in the wider society that mediate (facilitate or inhibit) levels of social capital. So too do networks need to be distinguished. As a substrate that supports the generation of social capital, the quality of networks is likely to be a very important factor in determining levels of social capital and in mediating the outcomes of social capital (social action). This appears to be the implicit assumption underlying the current popularity of networking as a health promotion activity. However, the practice of networking appears to suffer from a lack of clarity with respect to the kinds of networks that are intended. This may vary depending on the ultimate goals of the people driving the networking process. There is currently a distinct lack of clarity and knowledge about what kinds of networks are needed in particular situations.

The relationship between networks, networking and community development also needs to be clarified. Is it correct or useful to equate networking with

TABLE 5.4 Some indicators of the quality or strength of networks

• number of individuals or agencies involved;
• intensity of people's involvement;
• breadth of the composition of active network members;
• skills of the individuals and resources of the organisations involved
• levels of formality in the structure of networks;
• links across local, regional, state/territory, national domains; and
• engagement with local, regional, state/territory and national planning structures

community development, or is networking better understood as a component of community development? Is community development fundamentally a process of building and strengthening social networks within communities, or is community development much more than this?

The answer to this question may partly depend on the definition of networks and networking that we adopt. If our definition of networking or network development is limited to building loose informal connections between individuals, then networking probably should not be count as community development if we understand community development to be a process of empowering communities to take collective action in pursuit of enhanced community wellbeing. The findings of the current group of projects suggest that much more formal structures and much more focused activities are needed if such empowerment is to be achieved.

However, if we expand our definition of networking to include the development of formal structures, including democratic decision-making bodies, then this would probably count as community development. In order to enhance social capital (that is, trust and reciprocity between citizens and governance bodies), this work would need to be oriented towards increasing community engagement with and control over such decision-making bodies.

In conclusion, it seems important for community development activity to aim to build community organisations or other structures (such as formal coalitions) that represent a wide cross section of the population, and which are controlled by the community in a democratic fashion *(Recommendation 5.1, second dot point)*.

Involving young people

Community organisations that provide an appropriate physical infrastructure appear to be particularly important if young people are to be included among the wide cross section of the population that need to be involved in community development activities.

Community development practitioners, both professional and lay people, need to pay careful attention to the needs of sections of the population that may be disadvantaged in gaining access to and exercising power in community development processes. Only a minority of the projects funded or studied by the Strategy were successful in involving young people.

Jarvis et al. (1999: 60) state that: "Apathy within the young people to attend a group discussion or even show interest in the project makes it difficult to gather young people together". This does not appear to be a satisfactory conclusion in the context of a discussion about the results of a community development project focusing on youth suicide prevention. Community development, particularly in the context of youth suicide prevention, is intended to be a strategy for overcoming or mending breakdowns in the social fabric of communities (anomie) which is thought to be a risk factor for suicide in a population. According to Durkheim, apathy and disengagement among members of the population rather than active

engagement with the community is a result or a symptom of this anomie (Giddens 1978). If a community development project fails to engage members of the target group (in this case young people) then this should be interpreted as evidence of a failure of the project to meet its objectives. It is disingenuous to blame this failure on the potency of the problem or risk factor that the project is aiming to ameliorate.

There is an increasing body of evidence that young people are generally not interested in attending one-off workshops and forums on specific topics unless they are already actively engaged in some capacity with community organisations that are addressing related issues. It makes little sense for a community development project to be operating along these lines in such a context. The young people they reach do not appear to be in need of additional opportunities for involvement and they do not reach the young people who might benefit from increased opportunities. Alternative strategies for engaging marginalised young people are needed.

Providing a physical youth friendly space where young people can gather, spend time and feel they belong is very important for engaging marginalised young people in services (see Volume 4 of this technical Report series) and appears even more essential for engaging them as participants in service and or community development activities.

The suggestion that the existence of structures which provide a venue or space for young people to gather, and where they feel they belong is a facilitator of their engagement in community activities is highly consistent with Durkheim's theory of suicide (Giddens 1978). An absence or breakdown of such structures is a central dimension of anomie. Community development projects should include strategies aimed at creating and supporting such organisational structures. When young people are a central concern then the aim should be to create structures that are appropriate for young people *(Recommendation 5.1, third dot point).*

Political governance

Jarvis et al. (1999) note that one of the main barriers to increasing local control is the fact that many agencies in small rural towns are administered from regional centres or state/territory offices. It is noteworthy that the stated aim of the Support to Rural Communities Project refers to state, territory or regional networks. Unfortunately, this dimension of networking is not referred to again in the Final Report. However, the effectiveness of networking in impacting upon processes like community development and outcomes like suicide may be strongly influenced by the extent to which the network engages with relevant stakeholders and structures across local, regional, state/territory and national domains.

The networking activities of the Support to Rural Communities Project appeared to be very much focused on strengthening *informal relationships between individuals* (professionals and non-professionals) based in the local communities.

There was no evidence that networking included development of, or strengthening of connections between local, regional and state/territory structures that have been established, or are in a ready position, to help promote improved planning and greater collaboration between local service agencies.

It is recommended that future suicide prevention projects involving a community development approach include strategies aimed at building formal links between local communities and existing local, regional, state/territory and national planning and governance structures *(Recommendation 5.1, fourth dot point).*

Building capacity for community development among service providers

Commentators in the field of public health and community development have pointed out that health professionals are not provided with training in the skills needed to work in partnership with community members and that they generally lack these skills (for example, Baum 1998; Buchanan 2000). Community organisations and service agencies wishing to play a leadership role in community development need to direct considerable attention to addressing this problem *(Recommendation 5.1, fifth dot point).*

At present most community education and training ostensibly aimed at community empowerment is actually focused on specific topics consistent with government dictated priorities. For example, the education and training provided by the Support to Rural Communities Project and community education activities identified in the First National Stocktake of Youth Suicide Prevention Activities and Programs (Mitchell 1999) was focused strongly on the instrumental objective of crisis intervention. Little training appears to be focused on issues relevant to community development or participation in general. Professionals need training in strategies for providing greater opportunities for community members to participate in service and program development. Conversely, community members may benefit from education in civics or the processes of government and as well as particular health and social issues.

The benefits of education and training are also likely to be more profound when the education process is driven internally. While the Yarrabah Community was provided with fairly traditional forms of suicide prevention education, it is important to see this in the broader context. From an early point in the process, the community was actually the initiator of the learning process. They experienced and used this learning as one tool in a highly complex social change process. The knowledge development process at Yarrabah was also strongly focused on developing an understanding of the historical social and cultural factors that were contributing to the suicide problem within the community. This contributed to the community developing an understanding of community-risk as a major factor underlying the suicide problem. This in turn facilitated the community coming

to realise that the solution could only be found within the community, thereby leading to community ownership.

The role of government

The Support to Rural Communities Project was an attempt at a nationally coordinated approach to facilitating a community development approach to suicide prevention. The experience of this project in contrast to the Yarrabah experience raises critical questions about the role of national government in community development. Several of these questions have been noted previously in the community development literature.

One of the most fundamental problems with relying on instrumental participation projects as a stimulus to structural community development revolves around funding. A universal problem for externally driven projects such as Support to Rural Communities Project which involve the temporary injection of project funds, is that when external project funding ceases (and dedicated Project Officers are no longer available) stakeholders often experience difficulty making the transition to assuming responsibility for ongoing activities. If activities cease or drop off substantially and no sustainable gains have been made, serious questions need to be raised about whether the project has been worth the investment at all. Structural community development (that is, ensuring that community based activities or projects are fully driven by the community) may provide some major benefits in terms of the cost effectiveness of community based health promotion initiatives.

Difficulties making a transition to broader based community ownership may be at least partly related to the common practice of instrumental community-based projects of employing a specific change agent such as a Project Officer. While employing a Project Officer tends to be viewed as highly efficient in the short term this approach may have negative effects in the long term because responsibility tends to be concentrated in one person. This concentration of responsibility may actually inhibit others from taking up tasks that they might otherwise recognise as theirs. People may tend to become dependent on the Project Officer.

If the change process is initiated and driven by the community from the outset, there might be no need for particular individuals in paid positions to act as coordinators. However, this does not mean that resources are not needed; rather, resources might need to be deployed more diffusely. Community members, including various local professionals, could drive the process by working through services and governance bodies if these have sufficient resources and are structurally orientated to be responsive to community needs and desires. If the change process begins as an externally driven instrumental community participation project, sustainable impacts might require structural changes in relevant agencies and governance bodies towards community responsiveness and control. In other words, instrumental community participation may need to evolve into structural

community development if the process is to be self sustaining. However, this would not ensure the existence of a sufficient number of people within the community with the understanding and commitment to drive the process.

The problem of a lack of local ownership jeopardising the long-term sustainability, and hence the cost effectiveness of externally driven change, is not specific to the realm of community focused activities. Externally driven service reform processes also experience similar problems. For example, if transitional funds are provided to "reorient" services to a new way of working such as early intervention in mental health problems or health promotion, practice often reverts to baseline after funding ceases. Even if new funds are permanent it may take many years for local service managers to actually implement the structural or organisational changes that are required to ensure the new resources are directed to the activities for which they are intended. This problem is partly related to a lack of "local ownership" of the issue for which the new funding is provided. If local service providers are more concerned with other issues which they have not yet been able to solve to their satisfaction they will be reluctant to reorient to new priorities identified by outsiders.

This dilemma points to the potential advantages of promoting local ownership, not only of community-based community development activities, but of service reform processes as well. When we consider that the success of community development projects depends on the support of local service agencies, and that community development projects will often aim to enhance community involvement in service development, then the difficulty of maintaining distinct approaches to community-based versus service-based activities becomes apparent.

Facilitating community ownership of community-based public health activities (a bottom-up approach) may not be possible if service reform continues to be driven entirely in a top-down fashion. How can service agencies be responsive to the priorities identified by local communities when they are also required to make priorities of the issues identified as such by state/territory and Commonwealth governments?

If community development is to be progressed as an approach to the advancement of population health and wellbeing, structural barriers to the autonomy of local agencies need to be addressed. This will be very difficult to implement or support on a wider scale within the current context of the way governments do business. Enhanced local autonomy does not necessarily imply a reduced role for centralised planning; rather, changes may be needed in the way centralised planning is conceptualised. The strategic aims of centralised planning may need to be altered to place greater emphasis on ensuring responsiveness to locally identified priorities and the need to work in collaboration with other sectors.

At present, coordinated strategic planning tends to involve the creation of goals, objectives and strategies that are specific to particular sectors and their

particular concerns (for example, health outcomes, educational outcomes, welfare or justice outcomes) with scant regard for how these goals and strategies relate to those of other sectors. While there is an important place for the articulation of desired national and state/territory outcomes, achievement of these outcomes may actually be facilitated by balancing top-down planning with planning that is concerned with assisting local communities develop and implement strategies that address the issues and priorities as they understand them. Thus centralised coordinated planning needs to include strategies for creating the conditions that facilitate community driven initiatives.

At a practical level the most immediate barrier to local control is categorical funding (Buchanan 2000). National and state/territory programs tend to be organised into vertical streams that each address one particular issue. These funds are allocated to services or community organisations on the undertaking that they will be spent on that issue. In combination with centrally dictated goals and objectives this categorical approach makes it difficult for communities to adopt a comprehensive approach to addressing interrelated social and health problems. It is also a barrier to intersectoral collaboration in addressing risk and protective factors that may be common across a number of different problems (for example substance misuse, violence and suicide). Buchanan (2000) argues that in order to expand local control over the allocation of resources governments need to move away from categorical funding towards block community grants.

Another barrier to local control, closely linked to central control of funds, is a fear among government administrators that accountability for the use of funds will not be adequate if government does not maintain active control over decisions about how funds will be used. However, accountability is just as important for true community development as it is for other approaches to public service. The finding of the National Youth Suicide Prevention Strategy projects is that community engagement and ownership is enhanced when there is clear accountability to the local community. It is enhanced when locally based democratically controlled organisations are strong and major decisions take place via processes auspiced by such organisations. Buchanan (2000) also argues that accountability via evaluation can be also maintained even when highly specific goals and objectives are not set in advance.

These considerations suggest the need for new, more flexible policy and funding frameworks that incorporate a wider array of conceptual dimensions including structural social issues, populations and places or localities This topic is discussed in detail in *Valuing Young Lives* (Mitchell 2000: 128-131). 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) *(Recommendation 5.2, first dot point).*

It is further recommended that a trial of a block grant funding approach to community development be conducted on a demonstration project basis within a

number of communities with the broad aim of enhancing communities' control over their social and emotional wellbeing *(Recommendation 5.2, second dot point).*

This could involve several relevant Commonwealth Departments (including: Health and Aged Care; Family and Community Services; Education, Training and Youth Affairs; Attorney General's; Sport and Recreation; and the Aboriginal and Torres Strait Islander Commission) pooling a small proportion of their resources and providing these in the form of block grants to appropriate community organisations or, preferably, coalitions of organisations *(Suggestion 5.2a).* Aboriginal communities with a well functioning community council, and/or a community controlled primary health care service, would provide an ideal environment for an initial trial of this approach.

The trial would need to operate for a period of at least five years. General aims of the demonstration project would be to:

- assess the effectiveness of block community grants as a means of enhancing community control over social and emotional wellbeing;
- develop intersectoral collaborative planning structures and processes at the Commonwealth, state/territory and local government levels, and between levels of government; and
- identify the conditions that facilitate the effectiveness of a block community grants approach including conditions operating within: Commonwealth government; state/territory government; local government; service systems and the broader community.

As noted in Chapter 4 of this volume, on networking and intersectoral collaboration, there is a need for increased collaboration between levels of government (national, state/territory and local) if intersectoral collaboration at the level of local communities is to be progressed *(Recommendation 5.2, third dot point).* Further, some structures already exist which would appear to provide useful platforms or levers with which to strengthen collaboration between the various levels of government.

One key set of planning structures that should have been central to the Support to Rural Communities Project is the *State and Territory Agreements on Aboriginal and Torres Strait Islander Health.* These involve signed agreements (established in 1996 in the case of New South Wales, Victoria, Western Australia, South Australia, Australian Capital Territory; in 1998 in the Northern Territory and Tasmani: and 1999 in the case of Queensland) between all state and territory Health Ministers, the Commonwealth Minister for Health, 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 for Aboriginal and Torres Strait Islander peoples by:

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

The *State and Territory Agreements on Aboriginal and Torres Strait Islander Health* provide a valuable mechanism for addressing structural and political governance factors that have been repeatedly identified as blocking improvements in the health and wellbeing of Aboriginal and Torres Strait Islander populations. Whether or not the potential of the Agreements is realised is likely to depend on the extent to which they are used or invoked by signatories and other relevant stakeholders. The Agreements provide a ready vehicle for community development and other health initiatives to obtain the engagement and cooperation of relevant state and territory government departments as well as the other signatories. It would appear highly beneficial, if not critical, for community development and, indeed, all public health initiatives aimed at improving indigenous health and wellbeing, to work with and through these Agreements in some fashion *(Recommendation 5.3)*.

Recommendations and suggestions

It is recommended that:

5.1 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.

(This is Recommendation 34 in the evaluation overview, "Valuing Young Lives".)

It is recommended that:

5.2 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-centred" 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.

(This is Recommendation 35 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

5.2a The trial of a block grant funding approach to community development could involve several relevant Commonwealth departments (including: Health and Aged Care; Family and Community Services; Education, Training and Youth Affairs; Attorney General's; Sport and Recreation; and the Aboriginal and Torres Strait Islander Commission) pooling a small proportion of their resources and providing these in the form of block grants to appropriate community organisations (or preferably, coalitions of organisations). The trial would need to operate for a period of at least five years. General aims of the demonstration project would be to:

- assess the effectiveness of block community grants as a means of enhancing community control over social and emotional wellbeing;
- develop intersectoral collaborative planning structures and processes at the Commonwealth, state/territory and local government levels, and between levels of government; and
- identify the conditions that facilitate the effectiveness of a block community grants approach including conditions operating within: Commonwealth government; state/territory government; local government; service systems and the broader community.

It is recommended that:

5.3 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.*

(This is Recommendation 36 in the evaluation overview, "Valuing Young Lives".)

Project reports

GLETP (1999), "Galiwin'ku Youth/Parent/Worker Youth and Life Education Training Project". (Unpublished).

Goldflam, A., Chadwick, R. & Brown, G. (1999), *'Here for Life' Youth Sexuality Project: Evaluation and Final Report*, WA Aids Council, Perth.

Hunter, E., Reser, J., Baird, M. & Reser, P. (1999*), An Analysis of Suicide in Indigenous Communities of North Queensland: The Historical, Cultural and Symbolic Landscape*, Department of Social and Preventive Medicine, University of Queensland.

Jarvis, A., Dunn, P. & King, R. (1999), *Support to Rural Communities Project: Rural Youth Suicide Initiative*. The Gilmore Centre, Charles Sturt University, Wagga Wagga, NSW.

Other references

Baum, F. (1998), *The New Public Health: An Australian Perspective*, Oxford University Press, South Melbourne.

Baum, F., Palmer, C., Modra, C., Murray, C. & Bush, R. (2000), "Families, social capital and health", in I. Winter (ed.) *Social Capital and Public Policy in Australia*, Australian Institute of Family Studies, Melbourne.

Buchanan, D.R. (2000), *An Ethic for Health Promotion: Rethinking the Sources of Human Wellbeing*, Oxford University Press, New York.

Department of Family and Community Services (2000), "Stronger Families and Communities Strategy", http://www.facs.gov.au

Giddens, A. (1978), *Durkheim*, The Harvester Press, Sussex.

Hawe, P., King, L., Noort, M., Jordens, C. & Lloyd, B. (2000*), Indicators to Help with Capacity Building in Health Promotion*, NSW Health, North Sydney.

Mitchell, P. (1999), "Community development approaches to preventing youth suicide: first national stocktake of youth suicide prevention activities, Australian Institute of Family Studies*Youth Suicide Prevention Bulletin*, no. 3, pp. 2-13.

Mitchell, P. (2000*), Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy*, Australian Institute of Family Studies, Melbourne.

Peterson, A. & Lupton, D. (1996), *The New Public Health: Health and Self in the Age of Risk*, Allen & Unwin, Sydney.

Sozomenou, A., Mitchell, P., Fitzgerald, M., Malak, A .& Silove, D. (2000), *Mental Health Consumer Participation in a Culturally Diverse Society*, (2nd edn), Australian Transcultural Mental Health Network, Sydney.

Stewart-Weeks, M. (2000), "Trick or treat? Social capital, leadership and the new public policy", in I. Winter (ed.) *Social Capital and Public Policy in Australia*, Australian Institute of Family Studies, Melbourne.

Winter, I. (2000), *Towards a Theorised Understanding of Family Life and Social Capital*, Working Paper 21, Australian Institute of Family Studies, Melbourne.

Appendix One

Map of Program Logic: 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; and
- 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: 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 & 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 Anne Fry

Cellblock Youth Health Service – Suicide Prevention Project
Cellblock Youth Health Service
142 Carillon Avenue
Camperdown NSW 2050
Phone: 02 9516 2233
Fax: 02 9516 3591
Contact person: Program Manager

Central Sydney Area Health Service
Adolescent Medical Consultancy Service,
Department of Paediatrics
Royal Prince Alfred Hospital,
Level 9, QM Building
Grose Street
Camperdown NSW 2050
Phone: 02 9515 3822
Fax: 02 9515 4821
kss@diab.rpa.cs.nsw.gov.au
Contact person: Ms Jacqueline Vajda

Centacare 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: Mrs 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
mrbarnes@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 NYSPS
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 Penny Mitchell

Exploring Together
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 & Training
FNQ Indigenous Consortium for Social and Emotional Health and Well Being 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

Galiwin'ku Project
Galiwin'ku Security Group
East Arnhem Rural Mental Health Team
PO Box 421
Nhulunbuy NT 0881

Gatekeeper report
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 & 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 youth suicide prevention project
Dept 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

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
Mackay District Health Service
Staff Development Unit
PO Box 5580

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 Sue Allen

Media Resource Kits – Consultations
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
Contact person: Ms Rohan Pigott

Meerindoo Integrated Life Skills Program
Meerindoo Youth Accommodation Services
Auspiced by the Gippsland and East Gippsland Aboriginal Co-operative
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
gabriela.taloni@health.gov.au
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
Contact person: Ms Sharon Evans

Peninsula Youth Suicide Prevention Project
Frankston Hospital
Peninsula Health Care Network
PO Box 52
Frankston VIC 3199
Phone: 03 9784 7777
Contact person: Dr John Reilly

Post-IASP Seminars
Lifeline – International Experts Seminars
148 Lonsdale Street
Melbourne VIC 3000
Phone: 03 9662 2355
Fax: 03 9663 1135
Contact person: Mr Bruce Turley

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
Contact person: Mrs Constance Jenkin

Project Officer and Evaluator Workshop
Department of Health and Family Services
Mental Health Branch
2nd Floor Alexanda Annex and Alexanda 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
Kyogle NSW 2474
Phone: 02 6632 2972
Fax: 02 6632 2590
Contact person: Ms Heidi Green

Reach Out
Inspire Foundation
PO Box 43
Westgate NSW 2048
Phone: 02 9568 4288
Fax: 02 9568 4354
jackh@reachout.asn.au
Contact person: Mr Jack Heath

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
Contact person: Dr Michaela Skopek

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
Contact person: Adam Clarke

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
Contact person: Ms Rohan Pigott

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: MsSarah 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 Prevention Australia conference
Australian Institute for Suicide Research and Prevention
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

Yarrabah Project
University of Queensland
Department of Social and Preventive Medecine
PO Box 1103
CairnsQLD 4870
Contact person: Ernest Hunter

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 (YARDS)
Mental Health Centre
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 person: Mr Garry Stevens
02 9350 2501

Youth suicide prevention initiative for young people with severe mental health problems
Centre for Young People with Mental Health
Life Span
Locked bag 10
35 Poplar Road
Parkville Victoria 3052
Phone: 03 9342 2806
Fax: 03 9387 3003
Contact person: Ms Tanya Hermann

YouthLink Parenting Project
Inner City Mental Health Service
Royal Perth Hospital
70–74 Murray Street
Perth WA 6000
Phone: 08 9224 1700 1800 066 247
Fax: 08 9224 1711
Contact person: Mr Steven Edwards

Index of projects