Crisis intervention and primary care

TECHNICAL REPORT VOLUME 3
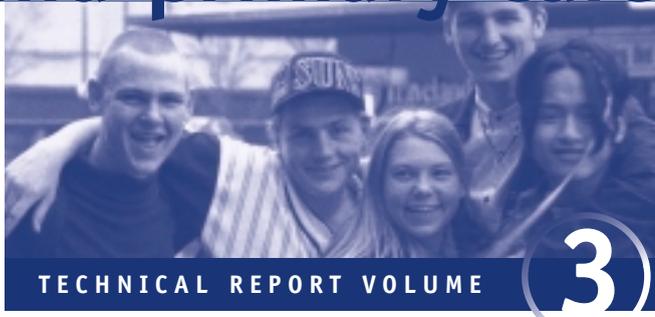
*Evaluation of the National
Youth Suicide Prevention Strategy*

Penny Mitchell

Australian Institute of Family Studies

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Acknowledgements

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 of the Strategy 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 about 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 interven-
  tion 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 experi-
  ences 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 origi-
nal 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 sug-
gestions" which complement and elaborate upon the basic recommendations.

Introduction

Introduction

Crisis intervention is a short-term activity designed to protect and support young people who may be at immediate risk of suicidal behaviour. Crisis intervention aims to quickly ameliorate crises that could result in self-harm or suicide attempt.

Primary care services act as a first point of call for people who may require assistance in tackling problems. Primary care providers such as general practitioners and community health services are in a position to identify young people who may be at risk, provide immediate support through crises, and link people into specialist services if required.

This volume, the third of the technical reports, presents the results of a meta-analysis (or meta-evaluation) of the evaluations of crisis intervention and primary care projects funded under the National Youth Suicide Prevention Strategy.

Crisis intervention and primary care activities were focused in hospital accident and emergency departments, general practice, and telephone counselling services.

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

Three projects focused on developing the skills of general practitioners and other primary care providers to identify young people at risk and intervene effectively. Training focused on improving the ability to recognise risk signs such as depression and provide appropriate support and referral. One of these projects focused on the development of networks involving general practitioners and other service providers. Networks aimed to facilitate the sharing of information, smooth referral pathways for young people through the health system, and enhance cooperation between service providers.

Resources were provided to *Lifeline* and *Kids Help Line* to expand their capacity to provide telephone counselling services to young people. These services have been extended and training provided to staff to increase their skills in counselling young people in crisis. Community education was also used to raise general awareness about suicide and ways to support young people at risk and to enhance knowledge of the availability of telephone counselling services.

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.*
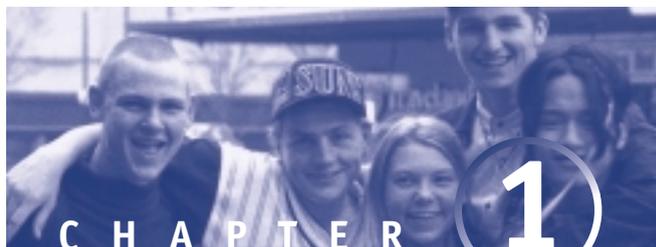
Hospital accident and emergency departments

This chapter presents and analyses information about the projects funded under the National Youth Suicide Prevention Strategy that were based in or focused on hospital accident and emergency departments.

The goal of this group of projects was to reduce rates of repeat suicide attempt and deliberate self harm among young people who present with such to hospital accident and emergency departments.

Projects aimed to enhance the quality of care provided to young people presenting to accident and emergency departments who have made suicide attempts or harmed themselves deliberately. This aim was addressed strategically by seeking to develop a more systematic, coordinated and comprehensive response to presentations of deliberate self harm. Development of protocols was a central component of the strategic response.

Hospital emergency department projects

As shown in Table 1.1, demonstration projects were based in seven different locations: Blacktown in Western Sydney NSW; Central Sydney Area Health Service in NSW; South Eastern Sydney Area Health Service in partnership with Northern Rivers Area Health Service (YARDS Project); Shoalhaven on the NSW South Coast; Maroondah in Melbourne, Victoria; The Mornington Peninsula in Victoria; and Mackay and Moranbah in Queensland.

Discussion has also drawn on findings of a consultation conducted by the Australasian College of Emergency Medicine and the Royal Australian and New Zealand College of Psychiatry who were contracted under the Strategy to develop a set of draft guidelines for the management of deliberate self harm in young people in hospital emergency departments. A set of guidelines was published in May 2000.

Blacktown Project

The Blacktown Youth Suicide Prevention Project was conducted collaboratively by the Blacktown City Mental Health Service and the Blacktown and Mt Druitt

TABLE 1.1	Summary of hospital emergency department activities of the Strategy		
Program name	**Organisation**	**Main ainterventions**	**Evaluation design and methods**
Blacktown Youth Suicide Prevention Project	Blacktown City Mental Health Service and Blacktown-Mount Druitt Health	Review of current practice; development of protocols; implementation of routine assessment and follow-up.	Monitoring of clinical outcomes; interviews with young people.
Central Sydney	Adolescent Medical Consultancy Service, Royal Prince Alfred Hospital	Research; consultation with staff; review of existing practice; and development of a Critical Pathway Model	Analysis of routine data; interviews with staff, stakeholders and young people.
Youth At Risk of Deliberate Self Harm (YARDS)	South Eastern Sydney Area Health Service and Northern Rivers Area Health Service	Trial of standardised assessment instruments and the Green Card system.	Analysis of service utilisation data; surveys and interviews with staff and stakeholders; interviews with young people.
Shoalhaven Combined Services Meeting	Shoalhaven Combined Services	Regular meeting between the range of services with a role in caring for young people who attempt suicide.	Analysis of service utilisation data; interviews with small number of clients; project documentation.
Mackay and Moranbah	Mackay and Moranbah Child and Youth Mental Health Service	Practice audit; development of protocols and a brief structured assessment tool; staff training; Green Card.	Staff surveys; key informant interviews; client satisfaction questionnaire; client follow-up assessment.
Peninsula Youth Suicide Prevention Project	Peninsula Health Care Network	Consultation with stakeholders, mapping of pathways to care, development of "best practice" indicators and protocols, information kit for young people.	Analysis of service utilisation data; examination of case notes; interviews with key informants.
The Staying Alive Project	Maroondah Hospital Area Mental Health Service	Consultation with stakeholders and development of protocols; interviews with young people; development and distribution of a Suicide Information Kit.	Process evaluation involving detailed documentation of project implementation; interviews with young people; interviews with staff.
Guidelines for the management of deliberate self harm in young people	Australasian College for Emergency Medicine and Royal Australian and New Zealand College of Psychiatrists	Consultation with stakeholders and development of guidelines.	Not evaluated

Hospital Emergency Departments. Blacktown is located in the western suburbs of Sydney and has one of the most culturally and linguistically diverse populations in Australia.

Factors contributing to the development of the project were perceptions of increasing numbers of young people attempting suicide in the area and an identified gap in the service provided to them, particularly for young people who were not identified as having a mental disorder.

The major aims of the project were to: improve the care of young people at risk of suicide presenting to emergency departments, and develop protocols. A secondary aim was to improve strategic alliances between existing services caring for young people at risk of suicide by developing education programs and reciprocal learning opportunities.

Current practices were reviewed in the hospitals' emergency departments, including assessment processes and triage. Protocols were subsequently developed for emergency department staff, the psychiatric liaison service and mental health service staff. Guidelines developed included a Hospital Assessment of Risk and Mental Status (HARMS) Checklist, a Symptom Checklist and a Checklist for Triage. The Project also developed an in-service education program specifically for clinicians in the emergency department.

The major interventions trialed by the project were routine comprehensive assessment of all young people presenting with deliberate self harm and implementation of an assertive coordinated care plan for each young client following departure from the emergency department. Young people were followed up and monitored for six months following their presentation to the emergency department, and outcomes measured at the end of this period.

The Project Report included information about groups with special needs who were represented in the study: young migrants; Aboriginal and Torres Strait Islander peoples; gay and lesbian youth; and those with a history of sexual abuse. An exploratory survey of 131 police officers was also conducted, which examined the role of police in working with mentally disturbed people and liasing with health services.

Central Sydney

Youth suicide and risk related issues were identified as priority health issues in the 1996 Central Sydney Area Health Service (CSAHS) Child, Adolescent and Family Health Strategic Plan. While the incidence of completed suicide was low, community concern was rated as high and the effectiveness of current interventions was identified as minimal. Particular concern was expressed that young people presenting to acute care facilities with attempted suicide may not be accurately identified as such, but be incorrectly classed as having suffered accidental harm or exhibiting attention-seeking behaviour. The project was conducted in

two stages. Stage One involved collation of baseline data on the characteristics of adolescents presenting at acute care facilities with an attempted suicide; exploration of staff attitudes towards young people and suicide; and review of current assessment and management practices. Stage Two involved the development of a critical pathway model for the management of adolescents who have attempted suicide. A resource manual for nursing staff and an area-wide directory of support services were also developed.

Youth at Risk of Deliberate Self Harm (YARDS) Project

The YARDS project was conducted by the South Eastern Sydney Area Health Service and Northern Rivers Area Health Service. The general aim of the YARDS project was to enhance mental health care for young people with a history, or evidence, of deliberate self harm, and to assess the impact of such enhancement on mental health outcomes. The project involved trialing the use of standardised instruments in the assessment of young people presenting with evidence of self harm. The project also trialed the Green Card system which is designed to increase attendance of young people at follow-up appointments. Training was provided for emergency department and mental health service staff. Evaluation of the project included interviews with young people who used the service.

Shoalhaven Combined Services

Shoalhaven Combined Services were provided with funds 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 emergency departments in the region of Shoalhaven, New South Wales.

This mechanism was a regular fortnightly Combined Services Meeting which has developed and adopted a specific protocol for the identification, immediate care and follow-up of intentional self harm clients. The meeting itself 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. The meeting also provides interdisciplinary peer support for providers involved in managing self harming clients.

The main method used in the evaluation was an analysis of data about young people presenting at the Shoalhaven emergency department with intentional self harm between 1988 and December 1996. A number of clients were also interviewed regarding their perception of the value of the service provided at the emergency department and at their first referral follow-up appointment with a service provider. The project also documented the history of the service development process.

Mackay and Moranbah

A distinctive feature of the Mackay and Moranbah Child and Youth Mental Health Services project was its focus on developing the capacity of staff, including emergency department and non-mental health staff (for example, school guidance officers), to conduct brief suicide risk assessments and make appropriate referrals of young people presenting with self harm.

Project activities included:

* development of a structured instrument to facilitate brief assessment and appropriate referral – The Child and Youth Deliberate Self Harm Risk Assessment and Referral Sheet;
* development of a structured instrument to facilitate comprehensive psychosocial assessment – The Psychosocial Assessment of Youth at Risk of Deliberate Self Harm;
* development of protocols dealing with major aspects of care in the emergency department and other health services;
* trial of a Green Card system;
* comprehensive awareness raising about the new protocols;
* provision of training to staff in the use of the structured instruments; and
* a file audit.

Peninsula Youth Suicide Prevention Project

The Peninsula Youth Suicide Prevention Project attempted to address key problems in liaison between various Peninsula Health Care Network services that hinder the optimal provision of appropriate and continuous care to young people aged 13–24 presenting at the Frankston Hospital Emergency Department with deliberate self harm. Key activities of the project included: a comprehensive literature review; an across hospital and community enquiry including interviews with a wide range of stakeholders; analysis of data to identify characteristics of young people admitted to the Frankston Hospital Emergency Department as a consequence of self harming behaviours; mapping of pathways to care; and the development of a list of "best practice" indicators and use of indicators to develop service protocols. Also developed were a discharge brochure with information about available services for young people and carers, and a wallet-sized card with relevant telephone numbers. The literature review and consultation provided the basis for the development of a list of best practice indicators that guided the drafting of protocols. While the project experienced success in negotiating protocols with some local service providers, difficulties were encountered with other service providers as the project had little authority to implement change and its role could only be to promote protocol development through persuasive argument and encouragement.

Staying Alive Project

The Staying Alive Project was conducted by the Maroondah Hospital Area Mental Health Service. Fragmentation of services provided by adult and adolescent mental health services was identified as a major problem affecting young people after discharge from emergency departments after a suicide attempt.

The major aim of the Staying Alive Project was to provide a coordinated proactive response to young people aged 14–25 presenting to hospital emergency departments following a suicide attempt. A second key aim was to develop and implement a process for involving young people in the ongoing modification of responses to suicidal behaviour. Key project activities included: liaison and negotiation between adult mental health services, adolescent mental health services and emergency departments; development of a protocol that identified responsibilities and referral processes; interviews with young people about their experiences prior to and after an attempted suicide event; and interviews with mental health staff. A Suicide Information Kit was distributed to schools, general practitioners and community agencies. This kit contained protocols which defined suicide attempt, age groups targeted by each service and geographic coverage. It also outlined processes of referral to mental health services, contact points, timelines and responsibility for responding.

Guidelines for the management of deliberate self harm in young people

The Australasian College for Emergency Medicine (ACEM) and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) collaborated to produce a set of Guidelines for the Management of Deliberate Self Harm in Young People. A draft report released in 1999 details the findings of the consultation and a final set of guidelines was released in May 2000.

The Colleges worked in collaboration to review the relevant literature, identify and visit "best practice" centres and develop a proposal for standard clinical practice guidelines or management options. A questionnaire of twenty questions was developed following a pilot study in Western Australia and discussions with clinicians in that State. Of 74 questionnaires distributed to emergency physicians and psychiatrists in Australia and New Zealand, 65 were completed and returned. Only four hospitals seemed satisfied with their current practice and policies, one each from New South Wales, Victoria, Western Australia and New Zealand.

From among the others surveyed there was a surprising consensus on the problems identified which preclude efficient and satisfactory management of this group of patients. These problems included: failure of psychiatric services to provide timely and appropriate assistance to emergency departments; prolonged periods on the telephone to identify, recruit and often to coerce community

agencies in arranging appropriate follow-up; a need for improvement in information technology within emergency departments to provide a database for tracking patients and for evaluation and research purposes; inadequate training of emergency department staff; and inadequate availability of child and adolescent services in most areas, as well as psychiatric services in outer suburban and rural areas. A valuable feature of the joint initiative of the Colleges was the opportunity it provided for the two disciplines to meet and discuss mutual problems and responsibilities.

The Guidelines provide a proposal for the management of deliberate self harm within a framework of changes in attitudes and practice and improvements in systemic, organisational and physical resources. The guidelines establish triage and assessment procedures; indicate three broad groups of relative risk; outline requirements for immediate and continuing management; recommend the physical resources and personnel required for optimal management; allow for flexibility and variation to accommodate local circumstances; and provide a structure with the potential for the evaluation of outcomes by a multicentred approach.

Results of the evaluation

The projects began from very different starting points in terms of original practice in the management of people presenting to emergency departments with self harm. As a result the projects have tended to attribute varying levels of importance to different aspects of the care process. They have also tended to approach similar issues in different ways. The projects therefore provide a wealth of comparative information about process and effectiveness.

Approaches to evaluation of processes, impacts and outcomes have also varied. Taken together these seven projects provide a comprehensive picture of current experience and opinion in Australia regarding good practice in the management of young people presenting to emergency departments with self harm and suicide attempt.

There are five overarching domains of information that emerged from the projects:

- recognition and assessment of suicide attempt and deliberate self harm among young people presenting to accident and emergency departments;

- referral to ongoing care following treatment in the emergency department;

- improving attendance of young people at follow-up care;

- enhancing wellbeing and reducing rates of repeat suicide attempt and self harm;

- building capacity for a more comprehensive and systematic response to suicide attempt and deliberate self harm among young people.

Acknowledgment that suicide attempt and deliberate self harm are under-recognised as well as poorly assessed in emergency departments was a key rationale for the substantial amount of attention given to hospital emergency departments in the National Youth Suicide Prevention Strategy.

Interestingly however, relatively little attention was directed to the problem of recognition or detection by this group of projects. Most of the work reported in this section centres around assessment that takes place after suicide attempt or deliberate self harm has been recognised.

The Blacktown Project found that staff in emergency departments are sometimes reluctant to identify intentional self injury as the presenting problem and to commit it to the permanent and legal case record unless there is incontrovertible evidence to that effect. It is asserted that such reluctance may result in some cases of attempted suicide being unrecognised and inadequately treated. The YARDS Project observed that deliberate self harm presentations may be hard to distinguish from harm that is accidental in nature.

➤ *Appropriate triage*

Triage is a process of "sorting patients into groups according to the severity of their illness or injury and their need for urgent medical and nursing care" (Australasian College of Emergency Medicine 1993). Relative waiting times for a medical assessment in the emergency department are largely determined by the triage code allocated to the patient.

The final Guidelines for the Management of Deliberate Self Harm in Young People produced by the Australian College of Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists (ACEM and RANZCP 2000) suggest that presentations with evidence of deliberate self harm should normally be assigned an Australian Triage Scale (ATS) of 3 or higher.

The Blacktown, YARDS and Central Sydney projects included a focus on triage and identified a number of problems with the triage process. People presenting with suicide attempt and self harm may be experiencing excessively long waiting times in emergency departments. Excessive waiting times for medical and mental health assessment exacerbate problems in engagement and increase the likelihood that young people will leave the emergency department before appropriate assessment or intervention can be provided.

The Australian Triage Scale is open to varying interpretation and clinicians frequently fail to adequately consider mental health issues and suicidality as opposed to manifest physical illness or trauma. There is no known triage assessment tool for suicidal patients presenting to emergency departments.

The Blacktown and YARDS Projects both introduced prescriptive triage assessment tools as adjuncts to good clinical judgement. The Blacktown Guidelines specify that three direct questions should be used to determine immediate suicide risk of suspected suicidal patients:

• What happened?

• Were you trying to kill yourself?

• Do you still intend to kill yourself?

It was deemed that the confronting nature of the questions was consistent with the urgency of the situation and setting and that aggressive overtones could be avoided by use of a gentle and caring manner.

Blacktown succeeded in getting the triage code for self harm patients changed from a median of between 4 and 5 (semi urgent and non-urgent) to a median of 3 (urgent). The waiting time for codes 4 and 5 is up to two hours while the waiting time for code 3 is up to 30 minutes.

The YARDS Project Triage Identification Form collects information about: type of presentation; potential history of other deliberate self harm presentations; whether or not intoxication was present at time of self harm and whether the presentation occurred alone or with family. Introduction of the Triage Identification Form was found to increase the awareness of emergency department staff to the possibility of the presentation being self harm and resulted in further investigations being performed to confirm this. Several of the ten sites involved in the YARDS Project are developing formal Mental Health Triage guidelines as a result of increased interest in mental health identification consequent upon the project.

➤ Routine assessment of all persons presenting to emergency departments with self harm

The project reports revealed great variability between emergency departments across the country in regard to which patients receive a comprehensive assessment (suicide risk, mental health or psychosocial assessment) following suspected suicide attempt or self harm. In a few areas comprehensive psychiatric assessment was already routine for all self harm presentations before the projects were initiated. In most areas the conduct of assessment was haphazard. Typically, assessment would only be called for if emergency department staff identified the patient as a "high suicide risk" or as having a "mental disorder". Procedures and criteria used by emergency department staff for determining high suicide risk or mental

disorder were unclear. "Many of those who attempt suicide receive medical attention but scant assessment and assistance with their psychosocial situation" (Brann and Sutherland 1999).

In areas where comprehensive psychiatric or mental health assessment was not already routine, projects generally aimed to develop policies and procedures which specify routine assessment for all people (irrespective of age) presenting with self harm. Success has been variable. Agreement from relevant service units has been difficult to negotiate.

For projects based in Victoria the question of who is provided with a mental health assessment has been circumvented by the decision of the Victorian Government, following the recommendation by the Victorian Suicide Prevention Taskforce, to provide enhanced recurrent funding for mental health crisis assessment and treatment teams, specifically focused on emergency departments and suicide prevention. This funding, which was made available in 1998, has allowed emergency departments involved in hospital protocol projects in Victoria to provide for routine assessment of all people presenting to an emergency department following suicide attempt or self harm.

➤ *Prompt assessment*

As noted earlier, people presenting with self harm already experience considerable waiting times for a medical assessment. Waiting times for a mental health assessment are generally longer than waiting times for medical assessment and may vary from one hour to 24 hours.

Delays in assessment increase the likelihood that patients will leave the emergency department without either a medical or mental health assessment being conducted.

In an effort to reduce total waiting times for people presenting with self harm the Peninsula and Maroondah protocols call for emergency department staff to contact the mental health crisis assessment or consultation-liaison team immediately following triage. Thus the psychiatric assessment may take place before medical assessment.

The authors of the Blacktown Project report raise concerns about conducting a mental health assessment before a medical assessment and recommend against this. Fry et al. (1999) argue that mental health assessment is inappropriate unless the patient is medically stabilised and that medical stabilisation should always be the priority. They also assert that: "The danger of conducting psychiatric assessment prior to medical assessment is that it risks reinforcing negative stereotypes and dismissing all problems as mental and or social when an organic illness may be identified. Such poor practices are negligent in that physical health can be ignored and negative attitudes towards people suffering from mental illness reinforced."

Fry et al. (1999) recommend that protocols specify exactly what is a minimum acceptable waiting time for an assessment and that this should be within one hour outside of working hours and within two hours during working hours.

Ensuring a prompt assessment would appear to necessitate the assessment taking place in the emergency department. Some emergency departments refer patients to mental health or other agencies and assume that assessment will take place there. However, young people may or may not present for this assessment.

➤ Assessment by appropriately trained professionals

Most projects operated on the assumption that comprehensive mental health assessment should be conducted by mental health professionals and exploration of the assessment process has focused on the roles of mental health professionals.

While consensus on this issue was very strong among the current group of project staff and evaluators, this opinion is not necessarily widely shared by staff in mental health services who are increasingly being asked to take up this work. These issues are explored in depth in the next section because they are perhaps more relevant to the objective of ensuring appropriate referral than to the objective of accurately recognising self harm and suicide attempt.

Emergency departments based in non-metropolitan areas have even greater difficulties than those in metropolitan areas in accessing mental health professionals for the purpose of conducting assessments. Thus the role of emergency department staff in conducting assessments, is necessarily greater.

A major focus of the Mackay and Moranbah Project was to develop the skills of emergency department staff to conduct assessments that would enable them to recognise and assist young people in crisis (Ward, Neville and Jones 1999). It was also noted that in usual circumstances some young people do not wait for mental health staff to arrive. Thus assessment at first contact with emergency department or with other health staff who are properly trained may give more time for mental health staff to arrive.

The Mackay Project developed new protocols and a brief structured assessment tool for use by medical, nursing and para-medical staff in emergency departments. A varied and comprehensive training and awareness raising program was also implemented which aimed to encourage use of the new protocols and the assessment tool. This was implemented over an extended period of time.

Ongoing evaluation revealed great variation in levels of cooperation and performance across the six hospitals involved. The small number of staff who had used the assessment tool rated it a high level of user friendliness. Staff who had not used it reported a number of difficulties. The major difficulty was that of engaging young people during the initial assessment procedure. Some staff also reported a lack of understanding about their role within the protocols and clinical pathways. Staff also reported a belief that they have poor assessment skills.

The Project team observe that "substantial knowledge of the protocols and processes involved in ensuring a successful risk assessment is required by all disciplines including administrative staff, allied health staff, nursing staff and medical staff" (Ward, Neville and Jones 1999). They recommend that yet further training needs to be provided to emergency department and other health service staff to provide them with adequate assessment skills. The nature of in service training required to develop adequate assessment skills is not explored. It is reported that the numerous training sessions that were conducted were poorly attended.

The Blacktown Project team argue that medical officers in the emergency department cannot be expected to conduct adequate assessments because they do not have the time for quality listening. It is also pointed out that proper assessment requires adequate privacy. It is suggested that hurried attempts to elicit the patient's story are best avoided at the medical assessment stage and left to the mental health expert (Fry et al. 1999).

The final Guidelines for the management of deliberate self harm in young people (ACEM and RANZCP 2000) recommend that patients should be provided with a basic mental health assessment as well as a physical examination by the emergency physician or doctor and that following this patients should be given a "mental health examination" by a psychiatrist or mental health clinician.

What works to ensure self harm patients are provided with a referral to appropriate support services following treatment in the emergency department?

Historically, health service responsibility for the management of patients presenting to emergency departments with attempted suicide of deliberate self harm has not extended beyond the hospitalisation period. An exception to this has sometimes applied to patients who were already regular clients of mental health services. However, treatment in the emergency department for such patients has usually been quite separate from ongoing mental health care, and regular mental health service providers may or may not be informed of admissions for suicide attempt.

That *every* young person presenting with suicide attempt or self harm to an emergency department needs to be provided with a referral to an ongoing care agency is an assumption that was explicitly or implicitly adopted by most of the current set of projects. The rationale for this assumption includes (i) the general assumption underlying the hospital protocol projects that in order to reduce suicide rates, health services need to provide a more systematic response to young people presenting with self harm; and (ii) evidence that it is not yet possible for clinicians

to accurately predict who is likely to make a repeat suicide attempt. The wisdom of this assumption is not questioned by any data emerging from the projects and so it will not be debated here. Instead the analysis focuses on identifying the extent to which routine referral is being practiced and the factors that facilitate referral.

The processes leading up to referral and the referral process itself were a strong focus of most projects. Unfortunately project evaluations did not explore impacts of the projects on referral rates comprehensively. Only the YARDS Project reports evidence of increased rates of referral from emergency departments. A number of projects report on rates of referral to ongoing care before or after the project or intervention. Some projects do not examine this question and some use methods that address the question only indirectly. Data about referrals tends to be unreliable and data collected prior to the projects tends to be more unreliable than data collected during the projects. Projects also varied considerably in the types of referrals that they included in their overall rates of repeated referral.

The YARDS Project found a baseline referral rate of 73 percent. After the inter-vention the referral rate increased to 83 per cent (Tobin et al. 1999). These figures refer to "any sort of referral" including the making of definite appointments through to giving young people a phone number to ring.

The evaluation report of the Shoalhaven project reported retrospective data on referrals for clients presenting with suicide attempts. In the years 1988 to 1996, 22 per cent of female and 32 per cent of male suicide attempt patients were not provided with any referral (Preston 1999). No data are provided in the project report on whether rates of referral of self harm clients increased in the years since service enhancements were initiated.

The Central Sydney Project conducted a review of four other current hospital protocols in New South Wales and found that only one of these protocols made mention of any specific procedures for referring patients to ongoing care. How-ever coverage of all areas of referral were judged inadequate in this policy.

The importance of identifying the appropriate service to refer to was noted by several projects, but this process was not studied in detail.

➤ *Routine referral of all clients presenting with deliberate self harm*

As indicated above, there has been an assumption among the current set of pro-jects that every self harm and suicide attempt patient should be provided with a referral to an aftercare agency. It is worth emphasising this here again. Including referral to aftercare as a routine item of care for all young people presenting with self harm relieves individual staff of the burden of deciding on a case by case basis who is likely to benefit from ongoing care.

The Green Card system (described below), which is designed to increase atten-dance at aftercare, appears to facilitate routine referral of deliberate self harm

clients. Most of the increase in referral rates observed by the YARDS Project was observed in services that implemented the Green Card system during the project. A number of other services involved in the YARDS Project had very high rates of referral before and after the project. These services were using other systems that encouraged routine referral of all clients presenting with deliberate self harm.

➤ Routine comprehensive mental health assessment

An underlying assumption of most projects has been that routine "mental health" assessment of *all* patients presenting with self harm would greatly facilitate identification of patients requiring referral and the kinds of services they require.

The rationale for routine mental health assessment of all patients presenting with self harm is that it is beyond the capacity of staff in emergency departments to adequately identify the ongoing care requirements of these young people and to make appropriate referrals. Evidence presented throughout the project reports seems to attest to the validity of this assumption.

As noted in the previous section, information about practice prior to the Strategy projects indicates that mental health assessment was conducted in a haphazard fashion. Patients may have received an assessment if emergency department staff judged that they "constitute a suicidal risk" or have a mental health problem. Criteria for determining suicidal risk or the presence of mental disorder were not clear. In some locations routine psychiatric assessment of all patients presenting with self harm was already part of usual practice before the projects were initiated (for example, Central Sydney and Blacktown). Several projects (Maroondah and Peninsula) reported implementation of routine assessment of young people presenting with self harm since initiation of the projects.

Data from the current set of projects are insufficient to determine whether increases in rates of mental health assessment do in fact lead to increased rates of appropriate referral.

What does appear clear is that routine "psychiatric assessment" is insufficient for ensuring that young people presenting with attempted suicide receive a referral to after care. One of the projects conducted a prospective follow-up study of 23 young people presenting with definite suicide attempt, and found that only 26 per cent were provided with a definite referral to immediate aftercare even though they received a psychiatric assessment. The principal author of the report indicated that there was no pattern in the making of referrals in the Area. Rather, the process was described as "highly ad-hoc and based on the registrar's experience, clinical judgement and community contacts" (Personal communication, September 1999).

Literature reviews and the experience of the Strategy projects indicate that there is no widely accepted method for conducting assessments (suicide risk,

psychiatric or psychosocial) with deliberate self harm patients in emergency departments.

Several projects included a strong focus on identifying the elements of assessment that are most important in facilitating appropriate referral and treatment. Critical aspects of assessment identified by one or more projects are detailed below.

➤ *Routine comprehensive psychosocial assessment*

Peninsula project staff (Gibbs and McMahon 1999) argue that suicide risk assessment that focuses only on documenting the degree of risk for further self harm may not provide adequate information to ensure appropriate referral of people presenting with self harm. It is noted that a wide variety of circumstances surround different episodes of self harm and needs vary substantially with regard to the nature and extent of follow-up required. In order to ensure adequate assessment of need for follow-up, the Peninsula Project team recommend that a holistic and comprehensive psychosocial assessment be conducted. These writers also formed the view that "the full weight of psychiatric assessment for all cases of deliberate self harming was unnecessary and possibly stigmatising" (Gibbs and McMahon 1999).

The Blacktown Acute Assessment Mental Health Team provides a comprehensive psychosocial assessment for every person attending emergency departments in that area with intentional self harm.

➤ *Assessment and referral by an appropriately trained professional*

As indicated in the previous section, there is a general consensus among the Strategy projects that comprehensive mental health or psychosocial assessment must be conducted by an appropriately trained professional, usually a mental health professional.

Two main issues emerged from the project evaluation reports. The first concerns who, in the structure of the health service, should be conducting assessments and the second concerns what level of training they should have.

During the process of review and consultation involved in the efforts to develop protocols, several projects encountered high levels of disagreement and tension among the various stakeholders. In some areas there was strong reluctance by mental health services to become involved in providing assessments for patients presenting to emergency departments with self harm or suicide attempt.

Many mental health service providers were reported as expressing the belief that involvement by mental health services in suicide attempts was inappropriate because it may lead to unnecessary stigmatisation of young people as mentally ill. There was also a worry that if these young people were provided with an

assessment, an ongoing duty of care by mental health services would be implied. Members of one project team were surprised and disturbed by the depth of the concerns expressed by mental health professionals. The process of working through these issues in order to develop protocols was long and arduous, in some cases involving serious breakdowns in the negotiations along the way.

In general, agreement was eventually reached between the stakeholders that mental health services had a duty to provide mental health assessments routinely to all patients presenting with suicide attempt or deliberate self harm.

The mental health service at Maroondah also recognised that it has a duty of care to provide ongoing support to people presenting with suicide attempt if no other appropriate service is available. Prior to the project the conduct of psychosocial assessment was very haphazard.

In Mackay, where the project aimed to encourage and support a greater role for emergency staff in assessment, substantial confusion was identified among emergency department and hospital staff about their roles versus the roles of Community Mental Health Workers and the linkage between hospital and community health services. The Mackay and Moranbah Project sought to address this by ensuring that Mental Health Services provide better feedback to hospital staff about clients referred to Mental Health Services and have more regular educational contact in the form of in-services.

Staff of two projects also point out that mental health professionals do not necessarily possess sufficient training to adequately assess young people presenting with self harm. During interviews, several key informants expressed concern that a traditional specialist psychiatric assessment is not always appropriate or sufficiently youth friendly, especially when the specialist is not adolescent or paediatrically trained. Consultation with mental health staff identified a lack of skills and confidence and the need of these staff for further training and support in the area of adolescent mental health and suicide.

The Central Sydney Project staff (Vajda and Steinbeck 1999) recommend that a mental health professional trained in child and adolescent mental health or psychiatry should be made available to provide psychiatric and psychosocial assessments for young people. Vajda and Steinbeck also recommend that Mental Health Nurses should be appointed to emergency departments on a 24-hour basis to facilitate prompt assessment, referral and follow-up. The Mental Health Nurse would provide backup to consulting psychiatrists in regard to assessment of adult clients, facilitate the provision of a more appropriate psychosocial assessment and broaden the range of after care options provided to the young person.

Another minor issue that arose in one project concerned whether the person conducting the assessment should also make the referral. Research conducted by the Central Sydney Project found that staff in emergency departments tend to be unsure about who is responsible for making referrals for young people

presenting with self harm and suggest that protocols should include specification of who is responsible. The Central Sydney and Blacktown Project teams recommend that the mental health professional who conducts the mental health or psychosocial assessment should be responsible for making a referral for the client.

➤ *Include significant others in the assessment*

Peninsula project report authors (Gibbs and McMahon 1999) recommend that "significant others" are included in the assessment and decision-making processes. It is noted that significant others in the young person's life can play a critical role in continuing care for young people who have self harmed. For example, they can be asked to help get the client to their next appointment. However assumptions should not be made regarding the significance of people to the young person.

Analysis of current practice at Peninsula revealed that emergency department staff usually acknowledge and seek to address the support needs of people attending with the young person. However, it is noted that those accompanying the young person to the emergency department, especially parents, may not be the most important in terms of a continuing care role. An exclusive focus on relatives, present or not, may fail to capture the most significant person for continuing care. For some young people, the most significant person to support continuing care may not be present or aware of the situation. It is recommended that the assessment procedure include asking the young person about who they feel can play an ongoing supportive role for them.

Vajda and Steinbeck (1999) also recommend including family or significant others as appropriate in the intervention plan.

➤ *Engaging the young person by demonstrating respect and caring*

The Blacktown Project conducted a focus group with six young consumers who had recently used emergency departments following self harm. This revealed other ways in which management of young people in the emergency department could be improved to enhance engagement. Consumer satisfaction with care received in the emergency department was generally negative. Young people generally reported the attitude of staff in the emergency department to be "rude" and displaying a "lack of caring": "I've found they just ignore[d] me when I was in Accident and Emergency . . . I think there is an attitude attached to it . . . with nurses about the mental health area."

Young people also identified dissatisfaction with treatments, waiting, staff availability and restrictive rules. It was perceived that there was poor communication regarding the rationale for treatments given. Staff were seen as sometimes forcing treatment on young people instead of explaining and discussing what was happening. Some also reported that staff consulted more with their relatives and

friends than with the young person him or herself and that relatives were some-
times contacted without their permission.

A lack of privacy was identified as a major problem in the emergency department.
Emergency departments often lack a quiet place where patients can be interviewed
without being overheard by other people. Lack of privacy will discourage
openness and the development of rapport. This was also identified as an issue by
two other projects.

In contrast, young people interviewed by the Blacktown Project tended to report
positive experiences of the Acute Assessment Mental Health Team. Most respon-
dents reported contact with the Acute Assessment Mental Health Team to be
the most positive aspect of the whole recovery experience. Some of the terms used
to describe the Acute Assessment Mental Health Team were "helpful", "gen-
tle", "caring", "nice", "excellent". One criticism of the Mental Health Team con-
cerned the manner in which the structured assessment tool was being used. It was
felt that the way the tool was used was too "impersonal" and made the young per-
son feel as though their situation was being simplified and categorised. Some
respondents understood the need for some form of assessment tool but felt the
delivery could be improved.

➤ Awareness of precipitating factors

In the Blacktown and Central Sydney Projects a substantial proportion of the
young women presenting to emergency departments with self harm reported
a history of sexual abuse or rape in their recent or distant past. Other research
indicates that there is a high prevalence of sexual assault and sexual abuse among
young people who attempt suicide (Beautrais 1999).

Project staff suggest that the high prevalence of sexual abuse among adolescents
who self harm indicates the need for careful assessment. Due to a reluctance
on the part of many young people to discuss this problem, it is recommended
that the issue be approached sensitively, with respect to the young person's bound-
aries. Asking the young person several questions about the extent to which they
currently feel safe at home is recommended as helpful in broaching the topic
during assessment. Workers also need to be aware of issues of trust, fear, gen-
der, power and secrecy that may be present for young people who have been
sexually abused by adults.

➤ Sensitivity to cultural diversity and individual differences

Only one project explored the issue of diversity among young people at any
length. The Blacktown Project report includes detailed discussion of issues
identified as affecting young people from culturally diverse backgrounds,
Aboriginal and Torres Strait Islander youth and same sex attracted young peo-
ple. Recommendations centre on the implications for assessment and referral to
appropriate ongoing care.

Overall, the proportion of young people involved in the Blacktown study who were born in non-English-speaking countries was lower than their representation in the population. However, there was an over representation of young women from non-English-speaking backgrounds. Intergenerational conflict embedded in gender roles was identified as a precipitating factor for suicide attempt for most of these young women (Fry et al. 1999).

Immediate implications of these findings for practice in the emergency department identified by Fry and colleagues include the need for cultural sensitivity on the part of care providers. Use of professional interpreters is considered routine good practice when working with clients whose English is poor. Consultation with bicultural mental health professionals can assist staff conduct a comprehensive assessment when there is concern that cultural issues may be implicated. Concern about gender issues by family members highlights the need for awareness about when female professionals may be preferred over male professionals. Fry et al. (1999) also suggest that practitioners must be able to examine their own ethnocentricity and how it influences their thinking as well as the way in which ethnocentricity is embedded within institutions.

Similarly, when working with Aboriginal and Torres Strait Islander young people, Fry et al. (1999) recommend that the help of an Aboriginal Liaison Officer be enlisted with the permission of the young person.

Relationship breakdown and other conflict is a common precipitant of suicide attempt for young people. A comprehensive assessment should include questions about relationships with significant others. Young people who are attracted to someone of the same sex or who are experiencing sexual or gender identity confusion may be unwilling to volunteer this information due to fear of judgement and rejection. Fry et al. (1999) recommend that questions about sexual orientation and relationships with boyfriends and girlfriends should be routine in mental health assessments. Such questions delivered in a "warm, open and matter of fact" manner, may facilitate disclosure and subsequent engagement by "normalising" the situation.

➤ Formal referral systems that include accurate record keeping

File audits conducted at various health services by two projects identified a variety of problems including: patients who were not provided with a referral; patients who were referred but not followed up and patients who were referred but no reason for the referral or rating of urgency was provided. Consultations with staff revealed that referrals were being made in a very informal way, often by word of mouth. Staff tended to operate as independent practitioners and completion and forwarding of forms was haphazard. In response to one of these projects the need for more formal and consistent referral and follow-up processes has been acknowledged and steps to develop more systematic procedures are being explored.

While the audit exercises proved valuable as a mechanism for identifying problems in the referral system that needed to be addressed, this process was hampered by gaps in record keeping. Errors and inconsistencies in medical record keeping included: no or incomplete data; no or incomplete documentation; no or illegible signature; charts containing records for more than one client. Following consultation with various department managers, ward staff and administrative staff in one location, the need for regular internal medical record audits and in-services about record keeping has been identified and agreed.

Including "needs for service or aftercare" as a routine item in a standard assessment form could act as a prompt for assessing staff to consider this. During the course of the Peninsula project, the Peninsula Health Care Network Department of Psychiatry restructured its clinical information system along with the adoption of standard formats for assessment. This included risk assessment, needs for service assessment and linkage with and notification to, continuing care agents. The project concluded before uptake of the new assessment format could be monitored or its impacts evaluated.

➤ *Standardised instruments*

Introducing the use of standardised instruments to enhance assessment was one of the key strategies employed by the YARDS project. Prior to the commencement of the project no service had a comprehensive assessment package that was used with all clients. The project was successful in encouraging nine out of ten services to use some or all of the recommended instruments with at least some clients. In a follow-up survey of staff, most said they would continue to use the structured risk assessment package in the future.

Problems were encountered in convincing clinicians to use the instruments. The major barrier was a perception that the instruments were being used only for research purposes and their potential value to the clinical process was not appreciated. After beginning to use the instruments many clinicians reported finding that they did provide useful information that aided clinical decision-making. Extensive training was provided in some services and this was found to improve the rate of use to varying degrees.

➤ *Interagency meetings?*

The Guidelines for the Management of Deliberate Self Harm in Young People, produced by the Australian College of Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists (ACEM and RANZCP 2000) recommend that because of the need for very close collaboration between emergency departments and mental health services, regular meetings should be held to review the management of mental health patients.

A regular interagency meeting was the main intervention examined by the Shoalhaven Combined Services project. This meeting (the Combined Services

Meeting) involves the emergency department, mental health services and a variety of other agencies that are in a position to provide ongoing care to young people presenting with self harm. The Combined Services Meeting developed and adopted a specific protocol for the identification, immediate care and follow-up of intentional self harm clients. The meeting itself 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 presented and the meeting provides interdisciplinary peer support for providers involved in managing self harm clients.

Funding from the National Youth Suicide Prevention Strategy was used to evaluate the effectiveness of this mechanism in enhancing the management of patients presenting with deliberate self harm. The evaluation report of the Shoalhaven project reported retrospective data on referrals for clients presenting with suicide attempts. In the years 1988 to 1996, 22 per cent of female and 32 per cent of male suicide attempt patients were not provided with any referral. No data are provided in the project report on whether rates of referral of self harm clients increased in the years since the Combined Services Meeting was initiated. Data for repeat attempt presenters were examined however and these suggest that rates of "no referral" for this extremely high risk group have declined over the years. This decline began before the initiation of the Combined Services Meeting.

It is notable that in 1996, five years after the Combined Services Meeting was initiated, 21 per cent of female and 30 per cent of male repeat attempters were not provided with a referral following presentation to the emergency department. These figures for repeat attempters are similar to those reported above for all suicide attempters over the 1988 to 1996 period. This suggests that no improvements in referral rates have occurred. These data are not discussed in the Shoalhaven evaluation report nor are the reasons for non-referral explored.

What works to improve rates of attendance for follow-up appointments?

The YARDS Project found that 565 young people presented with suicide attempt or deliberate self harm to Emergency Departments in 10 services throughout South Eastern Sydney Area Health Service and Northern Rivers Area Health Service during the project. Of those who were provided with a referral to aftercare, 87.6 per cent of these attended the first follow-up appointment. This compares to 76.7 per cent during the second half of 1996, before the project was initiated. However follow-up attendance rates varied substantially across the different hospitals in this project.

The other projects did not report data on rates of attendance at follow-up appointments but discussion with Project staff revealed a view that follow-up attendance rates are generally much lower than those reported by the YARDS Project. Some of the hospitals in the YARDS study were already employing practices that have been identified as enhancing follow-up attendance, prior to the Strategy Project.

➤ *The Green Card System*

The Green Card System originally described by Morgan, Jones and Owen (1993) provides clients with information about how to access support and assistance 24 hours a day, seven days a week in times of future crises and uses specific procedures to ensure follow-up referral to mental health services.

The YARDS Project trialed the Green Card and examined the impact of this intervention on attendance at follow-up appointments. Patient attendance at follow-up was compared for three services that used the Green Card against two services that did not use the Green Card. In these two services clinicians usually told the person about the recommended service and gave them the phone number (Clarke, personal communication, September 1999).

Client attendance at follow-up was significantly higher for services that used the Green Card system compared to services that did not use the system (Chi square = 24.32, p < .001). Approximately 84 per cent of patients who received a Green Card, attended their appointment, compared with 40 per cent who did not receive a Green Card.

➤ *Make an appointment for the young person*

The Guidelines for the Management of Deliberate Self Harm in Young People (ACEM and RANZCP 2000) recommend that on discharge from hospital all young people presenting with deliberate self harm should be provided with a time and place for a follow-up appointment.

In the prospective follow-up research conducted by the Central Sydney Project, of the six young people for whom a definite appointment was made, five presented at the appointment. This compares to none of the nine young people who were just provided with a telephone number. It is concluded that providing young people with a card and a phone number to call on their own accord is not sufficient and may not adequately communicate the importance of after care to the patient.

In several services involved in the YARDS Project, assessing clinicians from mental health teams made an appointment for follow-up care with the young person themselves in addition to giving them a Green Card. These services had retention rates of nearly 100 per cent (Clarke, personal communication, September 1999).

The Critical Pathway recommended by the Central Sydney Project specifies that the mental health professional who makes the referral (the same one who

conducts the mental health or psychosocial assessment) should contact the after-care service provider and organise an appointment for the client. The Blacktown protocol also specifies that an appointment should be made for the young person before they leave the hospital.

The Central Sydney Project team note barriers to the making of appointments for young people. Interviews with staff revealed a widespread perception that after-care providers are not adequately responsive and are usually not contactable out of business hours when many patients who have self harmed leave hospital. It is noted that protocols should include consideration of how definite appointments are to be made out of business hours. Establishment of permanent "intake" times with particular agencies that could be booked out of hours is suggested.

The YARDS project trialed the use of a permanent intake time or clinic for self harm clients referred from the emergency department. Professionals were found to prefer the permanent intake time system compared to a condition where individual appointments were made. However, insufficient data were available to assess whether this system resulted in equivalent rates of client attendance at appointments.

➤ *Minimise the delay between presentation at the emergency department and the time of the first follow-up appointment*

The prospective research conducted by the Central Sydney Project found that of nine young people who were given a phone number to initiate their own after-care, only one young person contacted the recommended agency. However this young person said she did not attend the service because she would have had to wait for two weeks for an appointment.

In line with the New South Wales Health Department circular 98/31, 1998, the Central Sydney and Blacktown protocols specify that an appointment should be made for within 24–48 hours following discharge for a young person at low risk and within 24 hours for a young person identified as at high risk. The ACEM and RANZCP Guidelines for the Management of Deliberate Self Harm in Young People recommend that patients at "serious" or high risk should be followed up within 48 hours of discharge while patients of "lesser" risk should be followed up within three days.

The YARDS project studied and addressed the question of waiting times for appointments and managed to reduce the average delay for an appointment from 2.9 days in 1996 to 1.9 days in 1998. It was also found that the number of patients who kept appointments was related to the number of days between crisis contact and first follow-up appointment.

In follow-up interviews conducted as part of the evaluation of the YARDS project, patients reported that they wanted appointments to be sooner rather than later. Convenience of the appointment time was also reported to be an important factor in attendance. A common reason for failure to contact patients for the

evaluation survey was that they had relocated to another area. This is consistent with research literature which finds that a large proportion of young people who deliberately self harm are highly transient. This reinforces the importance of immediate follow-up by mental health services.

➤ Provide comprehensive quality information to young people and nominated continuing care agents

Staff and evaluators associated with several projects identified the need for young people and their carers to be provided with better quality information about mental health issues, suicide and self harm, the care process and the options available to them.

It was noted that young people often do not understand what is happening to them in the hospital and why. This was thought to exacerbate aggressive behaviour and management difficulties. Provision of educational materials about forthcoming procedures to young people at presentation, during hospitalisation or as part of nursing care was suggested as a strategy to avoid these problems. Providing an educational package on presentation was noted as potentially useful for reaching those young people who do not wait for an assessment.

The YARDS project found that the client's belief about the value of counselling was an important factor in determining their attendance at ongoing care and that a significant proportion do not believe counselling would be helpful. It is suggested that explaining the importance of follow-up attendance is likely to be of value.

Information from interviews conducted by the Peninsula project also suggests that the capacity of continuing care agents to provide appropriate support would be greatly enhanced if they are provided with quality information about the self harm episode of the young person by the emergency department. For instance, knowing about the self harm episode would enable the carer or provider to respond more appropriately when they next see the young person or stimulate them to contact the young person if the young person fails to make contact.

In addition to a wallet sized Green Card with relevant telephone numbers, the YARDS Project Team developed a discharge information brochure to be provided to the young person and continuing care agents including relatives and friends. This includes information about self harm and about services available.

Similarly, as part of its recommended Critical Pathway, the Central Sydney Project included the provision of a written management plan along with relevant contact details to the client prior to discharge from the emergency department or hospital ward.

➤ Proactive follow-up and monitoring of follow-up processes

As noted earlier, the prospective follow-up research conducted by the Central Sydney Project found that of the nine young people who were given a phone

number to initiate their own aftercare, only one young person did so. Eventually 44 per cent of the group who had been given phone numbers did receive further professional help but this was only sought after being followed up by the social worker/researcher from the Project. A total of eight young people were not provided with any referral when they left the emergency department. Four of these had made previous suicide attempts. During the follow-up phone call three of these young people requested assistance from the social worker as they did not know where to seek help.

Some of the young people contacted by the researcher were pleasantly surprised and were pleased to receive further help. One said: "Thanks for bothering to call me, I didn't think anyone would – no one has before." Another commented: "I really wanted to talk to someone in hospital but nobody came . . . thanks for your help."

Results of interviews with key informants in the Central Sydney research indicated that: "There was a tendency for informants to assume that someone else apart from themselves was responsible for following-up patients. None of the informants were familiar with how successful ambulatory/community referrals were, or with patient outcomes. That is, it has not been ascertained as to whether the young person had made and/or attended a follow-up appointment. Most informants said that it would be helpful if some form of link could be made so that staff in their units received feedback about patients." (Vajda and Steinbeck 1999)

Vajda and Steinbeck (1999) interpret their results as indicating that assertive follow-up is acceptable to young people and may help improve rates of attendance at after care and that further research is warranted to explore the utility of assertive follow-up in this regard. The draft Critical Pathway recommended by the Central Sydney Project specifies that all clients should be followed up within three working days to establish whether or not they had attended the follow-up appointment or contacted the service provider. It is further recommended that protocols should specify who is responsible for follow-up, what the response should be if the client has not attended, and that information systems should be designed to ensure client outcomes are reported back to the hospital staff involved in their care.

The evaluators of the Peninsula project (Gibbs and McMahon 1999) note that the literature shows that provision of more assertive follow-up, such as active support in attending a first appointment, is required to ensure continuity of treatment and care for young people. It is noted that improved assessment tools are required to facilitate more appropriate follow-up according to need.

Political barriers were observed to the conduct of assertive follow-up. In one of the projects, follow-up was initiated as part of the project research. Even though the Project researcher had obtained approval from the Area Research Ethics Committee, objections to the follow-up were raised by Psychiatry and Emergency

Department staff. It was argued that the follow-up research may involve a conflict of interest and compromise the therapeutic alliance between patient and service provider. Later it was argued that informed consent would be needed. Eventually the issue was reviewed by the Area Director of Clinical Services and it was resolved that follow-up of patients post discharge is within the hospital's duty of care and within the realms of proper quality assurance. Hence it was deemed that it was unnecessary to obtain formal consent from young people before making a follow-up contact.

The ACEM and RANZCP Guidelines specify that patients classified as being at "immediate" risk of suicide at presentation "should receive rigorous and long-term follow-up". The nature of the follow-up that should be provided to this group and those at lesser degrees of risk but including "serious" risk (involving a history of psychiatric illness, alcohol and drug abuse, previous suicide attempts, continuing ideation, chronic physical illness and access to firearms) is not outlined in the Guidelines.

What works to enhance wellbeing and reduce repeat suicide attempt presentations?

The assumption underlying all the hospital protocol projects is that improvements in the quality of care provided to young people by emergency departments and following discharge will improve their wellbeing and thereby reduce suicidal ideation and the impulse to self harm.

The Strategy projects have generally concentrated on care provided in the emergency department and have given relatively little attention to the nature of ongoing care and the measurement of long-term or even medium-term outcomes. Only one of the hospital projects focused on ongoing care at any length. Some other projects that have targeted this population are included in Volume 4 of this Technical Report series however these projects did not include a focus on the highly problematic process of transition from treatment in the emergency department to an ongoing care service.

The present group of projects have not generated any evidence of reductions in rates of repeat suicide attempt presentations. Some evidence of improved mental health and wellbeing was reported by the Blacktown Project.

➤ Make an appointment with an appropriate after care provider

A regression analysis was conducted on data from the Shoalhaven project to identify predictors of repeat suicide attempt presentations. For younger patients (aged 15–29 years) having an appointment made at an ongoing care service was the only predictor variable that was negatively associated with repeat attempt presentation

(odds ratio = 0.17, CI: 0.035 to 0.843). Other variables entered into the regression analyses were: living alone, exposure to abuse, presence of chronic mental illness, being unemployed, Aboriginal and Torres Strait Islander descent, gender, further intervention by the mental health team and two others which are not defined in the report.

Having an appointment made was not as important for the older age group as for the younger age group. When all age groups were considered, being referred to the mental health team on first attempt was found to significantly reduce the odds of a reattempt presentation (odds ratio 0.16, all age groups). Having an appointment made also reduced the odds of a reattempt presentation (odds ratio 0.4, all age groups).

If the likelihood of presentation with a repeat attempt is reduced by having an appointment made then it would be interesting to know whether rates of appointment making have increased since the intervention being evaluated was introduced. Unfortunately the Shoalhaven Project does not report whether rates of appointment making have increased over time since the initiation of the Combined Services Meeting. No other projects explored this question either.

It is important to refer to an appropriate agency. Some young people involved in a focus group conducted by the Blacktown Project mentioned that they had been referred to inappropriate agencies. The Blacktown Project notes that the nature of the specialist referral required is often indicated by the nature of the precipitating factors eg sexual assault, domestic violence, relationship issues, drug and alcohol problems. Several projects note the importance of involving the young person in developing the ongoing care plan.

➤ *Long-term follow-up in the community/a coordinated care plan*

Improving the quality of ongoing care was a major focus of the Blacktown Project. A key rationale for the project was an observation that people identified as at risk of suicide but not diagnosed with a mental illness appeared to experience poorer continuity of care and poorer compliance with recommended aftercare than those linked directly into mental health services. The Blacktown Project appears to have reduced reattempt with long-term supportive follow-up.

The nature of the follow-up support provided was negotiated with each individual young person and varied according to their preferences and needs. The care plan was documented. Intervention usually consisted of phone calls, supportive home visits, and referrals to other services as necessary. Appointments for particular forms of therapy were booked for the clients rather than expecting clients to make their own appointments. Follow-up was provided mainly by the clinician who made the initial psychiatric assessment (which included a comprehensive

psychosocial assessment). This strategy was thought to build on the rapport and trust established during the assessment. From this central position the clinician then rallies existing supports and helps establish new ones.

The theoretical underpinnings of the intervention were Crisis Theory, Supportive Therapy and Problem Solving Therapy (D'Zurilla and Goldfried 1971). Crisis Theory postulates that crisis is characterised by a high level of disorganisation. When in crisis people apply their energies, not to problem solving, but to relieving their internal distress (Janosik 1994). Provision of emotional support and practical assistance in solving problems is thought to be important for helping the individual through the crisis period. Ongoing Supportive Therapy and Problem Solving Therapy are then used to help build the persons social support system and provide them with strategies for avoiding crises when psychosocial stressors emerge in the future.

Numerous studies have observed that perceived lack of social support is a risk factor for suicidal behaviour among adolescents (Beautrais 1999). Problem Solving Therapy has been found to be more effective in reducing depression and hopelessness in suicidal individuals than Supportive Therapy (Lerner and Clum 1990) and has been recommended for parasuicidal individuals (Salkovskis, Alth and Storer 1990).

The Blacktown Project team (Fry et al. 1999) suggest that the precise social supports and problem solving skills required tend to be indicated by the factors that precipitated self harm. Immediate precipitants of suicide attempt are usually acute psychosocial stressors that are amenable to short-term problem solving. Thus appropriate follow-up care includes referral to therapy focusing on the particular problem involved, be this family conflict, relationships, sexual abuse or sexual orientation.

A total of 69 young people were followed up after presenting to the Blacktown Emergency Department with intentional self harm. This represents 87 per cent of the total number presenting. Ten young people refused participation in the study. A mean of 8.7 contacts were made with each young person in the six month follow-up period. Most of these contacts were phone calls, an average of 7 per client. Ninety six home visits were made (an average of 1.4 per client) and 31 clients attended the Centre. Young people tended to express a preference for telephone contact as it was less intrusive and provided them with greater control over their privacy.

Thirty-five of the young people (50 per cent) were located at the end of the six month follow-up period. There were no statistically significant differences between the groups of young people who could and could not be located in terms of age, sex, ethnicity, living situation, education and level of employment (Fry et al. 1999). However, there was a suggestion that young people who dropped out had patterns of life characterised by transience, instability of relationships and

conflict at home: "Some families indicated to clinical staff seeking these clients that they did not know where they were and furthermore they were not particularly interested" (Fry et al. 1999).

Mental health outcomes for young people were measured using a number of standardised instruments including the Adolescent Suicide Questionnaire (ASQ-R), the Center for Epidemiological Studies – Depression Scale (CES-D), the Health of the Nation Outcomes Scale (HoNOS) and the Adolescent Drug Abuse Diagnosis (ADAD). All measures are brief and have been proved user friendly. They take less than 30 minutes to complete.

At six-month follow-up, clients were significantly less suicidal than at initial contact and there were significant reductions in the level of depression and psychiatric disability. In contrast to these positive changes in mental health status and suicidality, the number of clients using alcohol, marijuana, amphetamines and heroin increased. Only one of the 35 young people who were assessed at six months had intentionally self harmed in this period and all denied any suicide attempts.

The lack of a control group in this study means that it is not possible to infer that these outcomes are superior to those that might have been achieved under "usual care" or even whether the outcomes were a result of the intervention. However, the project evaluator argues that it is unlikely that the positive results are an artefact of regression to the mean because the positive trends were not observed across all the measures used (Teesson, in Fry et al. 1999).

While only limited data are available about outcomes for the 34 young people who could not be located at six months and the ten who did not participate in the follow-up intervention, information from the Emergency Department Information System (EDIS) suggests that around one-quarter presented again with self harm. Unfortunately, no information is provided about when in the follow-up period these young people were last contacted or what their circumstances were at this time.

It is reported that the underlying "problems" of those who re-attempted were psychosis, antisocial personality disorder and borderline personality disorder. One young woman diagnosed with borderline personality disorder represented 36 times – 15 times with minimal self harm and 11 times with other minor physical ailments.

The Blacktown Project recommends that long-term follow-up in the community be provided and that this service should be provided by the mental health worker who assesses the person in the emergency department. It is also recommended that follow-up be provided assertively in the first instance, then by a mutually agreed arrangement. It is not indicated whether long-term follow-up should be provided to all clients or a specified group.

While the Peninsula Project did not include evaluation of interventions provided to young people after discharge from the emergency department, the team provide some reflections on what they believe is required. One of the points made

is that traditional psychiatric services are not necessarily the most appropriate services to provide ongoing follow-up support. Rather, a service that can provide a holistic response capable of addressing the diverse predisposing and precipitating factors underlying youth suicide is recommended.

These writers also call for a much better coordinated or more integrated response: "The PYSPP sought an ideal state where young people leaving the ED could, as required, easily access the youth specific community service system. What was discovered was a loose alliance of youth specific agencies, usually funded from different sources and with distinct functional boundaries, sometimes competing with each other for limited additional resources, lacking coordination of access to a range of services and using scarce resources in a continual effort to maintain networks" (Gibbs and McMahon 1999).

During the course of the project the Salvation Army's Peninsula Youth and Family Service approached the team and offered to act as a point of referral and service for self harming young people from the Emergency Department requiring follow-up. A protocol was developed to clarify this role. If a young person in need of follow-up does not nominate another specific community based worker or if such a worker cannot be enlisted to provide support, the young person is referred to the Peninsula Youth and Family Service.

The Peninsula project staff speculate that their experience suggests the value of: "A coordinated service system that relies less on the goodwill of relationships and protocols and more on an integrated organisational structure within which funding from multiple sources can be used flexibly to maintain a service system that meets the diverse needs of young people" (Gibbs and McMahon 1999).

What works to facilitate uptake of a more comprehensive and systematic response to suicide attempt and deliberate self harm among young people?

The assumption of most of the Strategy projects based in emergency departments has been that the key to a more comprehensive and systematic response to deliberate self harm is the development of protocols and procedures.

Projects have generally experienced considerable difficulty in achieving the development and implementation of protocols and procedures. For example, the Central Sydney Project managed to develop a draft Critical Pathway but did not succeed in its stated aim of trialing and evaluating the Pathway in hospital services in that Area. Development of protocols was a major aim of the Peninsula project, which was funded for two years from February 1997 until March 1999. The Project identified the need for protocols covering 13 critical points in the pathway of self harming clients through the Emergency Department. Only three

protocols were achieved in this timeframe, however, it was planned to continue work on protocol development after project funding ceased.

The projects generated detailed information about the factors that inhibited and facilitated the development and implementation of protocols and other mechanisms aimed at ensuring a systematic response.

➤ *Development of understanding, collaboration and communication between relevant stakeholders*

Relevant stakeholders and the processes used to establish the required level of understanding and communication varied widely between different settings depending on the stage of development of the services and their history.

In the Shoalhaven, the initiative to develop a protocol emerged gradually out of a process of relationship building that had been going on for several years. The number of participating agencies grew naturally and gently and incorporated a wide variety of relationships by the end of the project evaluation. In other projects the key stakeholders had not previously worked closely together and relationships had to be forged rapidly during the projects.

In several projects development of protocols took place against a background of considerable tension and poor communication between the adult and adolescent mental health services, which relied on different philosophies and practices in their response to young people. Because service provision to young people crosses the boundaries of adult and adolescent services these tensions were seen as contributing to considerable fragmentation in the care provided to young people presenting with suicide attempts.

Another key problem concerned varying perceptions among service providers about whether suicide should be seen as an issue for mental health services. For a considerable number of years mental health policy in most states has encouraged mental health services to focus on "serious mental illness" interpreted primarily as schizophrenia and bipolar disorder. Mental health services that are oriented to these diagnostic groups do not see themselves as having a role in assessment or treatment of attempted suicide or self harm.

Disagreement among key stakeholders about appropriate ways to manage attempted suicide, particularly among young people, was a major issue in other areas. A concern raised by a number of stakeholders was that precious resources should not be concentrated on a minority group; that being, young people who attempt suicide. There were clear differences in professional ideologies and philosophies. In one project members of a mental health service expressed a conviction that attempted suicide was already being appropriately managed within the current system and that changes were not necessary.

Development of understanding and agreement between stakeholders appeared to be hindered by certain factors and facilitated by others. Ensuring broad ownership of the change process appears to be important.

In one Area the Project was based in a relatively new service that was not perceived to be among the stakeholders traditionally involved in managing attempted suicide. This was thought to have hindered acceptance of the Project by key stakeholders. The project team also acknowledge that consultation and lobbying components of the Project may have been inadequate.

In the Shoalhaven by contrast, the Project was clearly seen as a partnership between a number of services that had already been meeting on a regular basis for several years in order to improve communication and collaboration on suicide prevention. 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 joined by the Social Work Department, the hospital Aboriginal Liaison Officer, representatives from Youth Health and the Community Health Centre Drug and Alcohol Service. The fortnightly meeting now goes for 90 minutes.

The Blacktown Project staff reported remarkably few difficulties in the implementation of the project. The only notable difficulties were related to staff shortages. It is stated that "the Project was only viable due to the cooperation of pre-existing staff and resources". Extraordinarily good working relationships between the partner agencies, particularly the two emergency departments and mental health services and a high level of enthusiastic support from key management staff appear to have been major factors in the success and smooth running of this project.

➤ *Multidisciplinary steering groups with authority*

Experience across all the projects in this group is that project steering groups or coordinating committees that include representation from all relevant stakeholders and which are imbued with the authority to make and implement decisions are very important, if not essential mechanisms in the change process. The projects that did have such steering groups were generally able to overcome the difficulties that arose more quickly and with less disruption to relationships.

The Maroondah Project report authors note that the Advisory Group, which provided support to the project worker throughout the negotiation process was a considerable help. Members of the advisory group were also able to talk about the issue throughout the mental health service whenever the opportunity arose. It was also noted that the advisory group enabled the gravity of the slow response to be understood by key decision-makers.

It is important that steering committees have sufficient authority. The active involvement of top level management ensures that the steering committee has

the authority to negotiate with all relevant parties and uphold decisions. The benefits of external authority such as national standards and state policy were also noted. It is also important that decision-making bodies include representation from all relevant professional groups and service units so that these groups can have input into decisions and that information about decisions can be communicated back to all relevant staff.

Continuity in the membership of such committees is highly valuable. The Peninsula Project suffered discontinuity of Steering Committee membership, with the original authors of the project brief not remaining. This led to considerable difficulties in maintaining active and persistent commitment to the project.

➤ *Leadership by key individuals*

In addition to steering groups with authority, the active support of key leaders was also identified as critical by several projects. Insufficient involvement by senior managers was identified as a major barrier to progress in several projects. However when their involvement increased, project staff and evaluators generally observed rapid resolution of major issues.

Where senior management were not involved in the project at the outset, winning their support was found to be difficult. Intensive consultation early in the course of the project was identified as an alternative strategy for engaging senior managers not directly involved in projects.

The YARDS project found that key clinical opinion leaders within services also played a critical role in encouraging other staff to discuss and adopt the new practices. It was important for the project to identify and work with these clinical opinion leaders in addition to service directors. Placement of Project Officers within each site of the YARDS project was also judged to have greatly augmented the uptake of practice changes in most sites. The Mackay Project recommends that each health care service appoint a key staff member who is directly responsible for quality assurance activities in relation to protocol adherence.

Project Managers and staff are also key leaders in the change process and they require strong leadership qualities.

Composition of the Project Team also appears to be an important factor in the team's ability to lead change successfully. The Mackay Project Officer and Project Assistant were from nursing backgrounds and they report that this helped establish their credibility with the nursing staff who were the main target group of the project. It was also noted that having team members from other disciplines assisted in opening a wider variety of doors than would have otherwise been possible. In contrast, the Central Sydney Project Team appeared to lack acceptance by certain key stakeholders, because they had not traditionally been involved in the management of attempted suicide.

➤ Address the structural, functional and resource demands

A conclusion that emerges very strongly across all the hospital protocol projects is that emergency departments have very limited capacity to make changes that create extra work for staff. Even brief psychosocial or psychiatric assessment of people presenting with suicide attempt or self harm would appear to be beyond the capacity of emergency departments unless additional resources are made available specifically for this purpose.

Most projects have attempted to harness resources for comprehensive assessment through development of protocols which specify assessment by mental health services. This exercise has also proven difficult for most projects.

Following the recommendations of the Victorian Suicide Prevention Taskforce the Victorian Government provided enhanced recurrent funding for crisis assessment and treatment teams, specifically focused on emergency departments and suicide prevention. This funding, which was made available in 1998, has allowed emergency departments involved in Victorian based projects to provide routine psychiatric assessment of all young people presenting to an emergency department following suicide attempt or self harm.

Project staff at the Peninsula Project report that the establishment of the Consultation-Liaison Psychiatry Service at the Peninsula Health Care Network made substantial impacts on the shape and progress of the project. The presence of a team whose responsibility it is to conduct an assessment of all people presenting to the emergency department with self harm has substantially reduced the burden of demand that was originally being placed on staff in the emergency department. In addition to assuming responsibility for the routine psychiatric assessment of all patients presenting with self harm, this team has also taken over the role of ongoing coordination of protocol development with respect to persons presenting to the Emergency Department with self harm. It is unclear whether or not this work would have continued beyond the life of the funded project if this team had not been established. Some stakeholders interviewed during the Peninsula project also reported improvements in communication and the quality of information provided about patients since the introduction of the Consultation-Liaison Psychiatry Service.

At Maroondah the funding has allowed the establishment of a similar team called the Psychiatric Emergency Assessment and Triage Service (PEATS). This has raised confidence that the achievements of the Staying Alive Project will be sustained and built on in the future.

➤ Mapping of clinical pathways

Clinical pathway mapping aims to trace all possible pathways that a client can take through a service. The mapping exercise facilitates the identification of risk points and the changes that could be made to reduce exposure to problems at these risk points.

Combination of data from the mapping exercise as well as interviews with staff, and quantitative data from electronic databases and case files conducted for the Peninsula project revealed the extent to which criteria for directing patients though different pathways were unclear and haphazard.

The mapping process was found to be very popular in the YARDS project. Three services were originally targeted for involvement, but members of the project Reference Group from other services requested that their service also be involved.

➤ *Mapping of critical pathways*

A major aim of the Central Sydney Project was to trial a "Critical Pathway" approach to improving service provision to young people presenting with suicide attempt and self harm. While the project did not achieve the aim of trialing the pathway approach, a draft Critical Pathway was developed and the Project Team strongly advocate for further effort to be dedicated to trialing this strategy.

Consistent with Williams (1996) a "Critical Pathway" is identified as being slightly different from a "Clinical Pathway". The focus of clinical pathways is on documenting all aspects of daily care without regard for outcome, impact, cost and utilisation management. A critical pathway is understood as a subset of clinical pathways. It involves identification and documentation of only the most vital (critical) aspects of patient care that must occur for a particular case type or cohort of patients to move along a continuum toward a desired outcome in a defined period of time. The critical pathway is then used as a best practice model to help organise and integrate all levels of health care delivered by providers from a number of disciplines. It also allows for documentation of variations from standardised care processes (Vajda and Steinbeck 1999).

The critical pathway is identified as an important part of a larger clinical system called managed care that focuses on continuity of care and reduction of inefficiency through collaboration across different services. Critical Pathways form a map on to which guidelines or protocols addressing each critical point are built (Jaggers 1996).

The Central Sydney Project literature review identifies some barriers to the development of a critical pathway approach to patient management. These include territorialism and feelings of insecurity by professional groups and organisational structures that are centred on the preferences of service providers rather than patient outcomes.

According to Vajda and Steinbeck (1999): "The development of critical pathways challenges health care providers to critically review their methods for planning, delivering and evaluating patient care, and to question traditionally held views about the roles and responsibilities of health care professional teams."

➤ Data systems that provide meaningful and complete information about each client

An important step in the development of clinical and critical pathways is auditing of former patients records to identify characteristics of patients, current management practices, critical events, timeframes and outcomes. Several projects attempted to analyse data about patients presenting to the emergency department with self harm in order to develop a picture of client characteristics and to analyse the pathways they have taken through the service.

Use of data was severely hindered by non-uniform or inaccurate recording and coding practices. Several project teams and evaluators recommend development of a standardised format for recording data on patients who have attempted suicide to improve reporting in the medical records.

The Peninsula Project team report that the two electronic databases relevant to the Emergency Department were incompatible and collectively unreliable. It is noted that the prospect of such deficits in data systems being more generalised throughout the health system is a cause for substantial concern. Health information systems are observed as being oriented towards monitoring service utilisation and financial management purposes rather than monitoring the quality of service provision.

It was concluded that: "For acute health services to enhance youth suicide prevention they need to be supported by information systems that routinely and accurately collect meaningful data" (Gibbs and McMahon 1999: viii).

The Peninsula Project Report makes a formal recommendation that: "The Commonwealth Government should work with the States/Territories to agree on national standards for data collection to enhance suicide prevention activities" (Gibbs and McMahon 1999: 31).

The Mackay and Moranbah project managers and evaluators report that hospitals in that region, particularly in outlying areas, did not have access to computerised record keeping and did not comply with the requirements for completing injury surveillance forms, let alone new forms introduced for the project. This made obtaining accurate statistics on presentations of suicide attempt and self harm extremely difficult and all figures reflect an underestimate.

Ward, Neville and Jones (1999) write: "On requesting access to a triage book for one Emergency and Outpatients Department the project officer was shown an "exercise" book with a list of names and dates of presentation. It was not possible to discern from the records kept the reasons for presentation, the National Triage Scale or the treatment outcome."

The Mackay project liaised further with the emergency departments and agreement was reached to collect more comprehensive data including: date of presentation; unit record number; client name; reason for presentation; triage scale; and treatment outcome.

The Blacktown Project team note that the Emergency Department Information System (EDIS) running in that Area is a computerised system that tracks patient attendances, movement and care, enables access to medical and nursing clinical data and patient demographic data. EDIS has a number of defined mandatory fields each with a selection of codes that enables reasonably accurate data entry by clinical and clerical staff. The Project used EDIS to enter and process data from the instruments used to measure patient outcomes and reported this as facilitating rapid analysis and providing significant assistance to the project.

➤ Sensitivity to the particular circumstances of the individual service

The term "protocol" implies the use of a standardised set of guidelines. Standardised protocols and guidelines aim to enshrine and reinforce the use of widely accepted elements of good practice in all relevant service settings.

The experience of the YARDS Project is that the aims of standardisation need to be balanced against the unique circumstances facing particular service environments. Protocols must be sensitive to the diversity of different service environments.

If protocols are going to be implemented it is also critical that staff have knowledge of the existence of the protocol and a favourable attitude toward its use. During discussion of hospital protocols at the Second National Workshop of Strategy Projects held in Melbourne in April 1999, it was pointed out that uptake of protocols depends strongly on the level of ownership felt by staff in the service, particularly senior staff and opinion leaders. Protocols cannot be simply imported from elsewhere and imposed on staff in new settings. All relevant staff members need to be involved in the development of protocols and they need to be grounded in local positions, structures and systems.

Thus effective protocols have three key characteristics: they are based on evidence about effective practice; they represent and enshrine an agreement or a common understanding among key stakeholders; and they are flexible to the needs of particular services.

These three characteristics are not necessarily conflicting; indeed they can be achieved through a common process. The YARDS Project used a development strategy that elegantly fostered a combination of these three qualities. The process basically involved combining project-driven and service-driven approaches to goal setting. Each individual service was provided with an outline of what (based on the literature and broader consultation) the project team considered to be an "evidence-based practice" system of care for deliberate self harm. This was followed by a process of consultation within each service in which senior staff discussed the meaning of items in the outline, assessed their capacity in relation to the evidence-based practice system, and made choices about the amount of change that they would target in their service.

➤ *Generic mechanisms for enhancing quality improvement*

The authors of the Peninsula project report note in their conclusions that the practices they identify as contributing to youth suicide prevention are the hallmarks of contemporary best practice in many areas of health care. They further note that this implies that activity directed towards client-centred practice improvement across the health care system would, in itself, contribute substantially to youth suicide prevention without the need for a focused response to the issue.

The YARDS project observed that the greatest gains were made in services that were judged to be "already well functioning" and where there was strong philosophical orientation towards continuous quality improvement. The specific factors associated with the largest changes in service provision were: a pre existing belief in suicide attempters being a priority group; strong links between crisis contact points and mental health services; support by management for service enhancement, and a willingness of the team to adopt new ideas.

➤ *Training*

Staff from a number of projects recommended that increased levels of training need to be provided to staff in order to enhance the quality of services for young people. Some of the issues around training in assessment and referral skills specifically have been discussed previously.

Interviews with Central Sydney staff found that formal training amongst nurses relevant to working with young people was uncommon. A high proportion of nurses reported insufficient training to manage a number of adolescent health related problems. Informants also reported a lack of knowledge and understanding about young people and suicide. Lack of skills in communicating with adolescents was identified as a major barrier to the effective management of any adolescent. It was also highlighted that ineffective communication between staff and young people may lead to inaccurate documentation in patients' progress notes.

A number of barriers and limitations were identified as hampering the wider delivery of effective training to staff in emergency departments. The major barrier to training identified is the lack of funds to provide relief staff while regular staff attend training. Current in-service training mechanisms may also be insufficient. One respondent in the Central Sydney Project is quoted as saying: "Although in-services are given, they are too short and intensive so that a lot of the material is quickly forgotten. Also in-services are often far removed from reality in that the material provided cannot be applied in a real setting" (Key informant comment, Vajda and Steinbeck 1999).

Project staff in several projects recommend that some form of training needs to be made compulsory for all staff working in emergency departments and other relevant wards. It is noted that many of those most in need of training are the ones least likely to present to voluntary training.

Verbal feedback from staff reported in the YARDS project evaluation suggested that a change in attitude towards deliberate self harm and mental health clients was an important outcome of training provided to emergency department staff. However, evaluation of training conducted by the projects in this group did not provide any evidence for the effectiveness of training in changing staff knowledge and behaviours.

Training provided to staff by the Mackay and Moranbah project was evaluated by looking at changes pre-test and post-test in answers to several questions including prevalence of suicide, myths about suicide, beliefs about the behaviour of people who are suicidal, experience of dealing with suicidal individuals, beliefs about the influence of own attitudes and beliefs, comfort discussing suicide, confidence dealing with suicide, questions they would ask a person, procedures in place in their workplace, where they would refer people, where they would seek advice and support. No significant changes were found for any questions.

It is notable that clear learning goals relevant to training emergency department staff have not been identified.

General discussion

The hospital protocol projects funded under the National Youth Suicide Prevention Strategy appear to have generated substantial momentum for change within the services in which they were based. While few projects achieved all their stated objectives, most report that work continues to develop protocols and build on the knowledge and relationships generated by the project experience.

Taken together, the projects have generated valuable collective wisdom about good practice in prevention of suicide among young people presenting with suicide attempt or deliberate self harm to emergency departments. This work provides a firm platform from which to proceed in advocating for wider implementation and trial of protocols and evaluation of outcomes.

It is important to note that no single project explored each part of the care process comprehensively. The demonstration projects tended to focus on one or two main components of care and even within these component areas, no single project was able to identify and address all the issues that were identified as important collectively. This highlights the value of the Strategy approach of exploring similar issues in multiple settings and from multiple perspectives, and draws attention to the limitations of individual services relying solely on their own experience and resources in comprehensively defining problems and developing solutions.

While the Guidelines for the management of deliberate self harm in young people prepared by ACEM and RANZCP (2000) cover all major domains of the care process, they do not provide detailed coverage of the clinical and professional issues that need to be addressed within these domains. Nor do they provide information about the complex problems that practitioners and service managers are

likely to encounter when developing and implementing protocols and procedures in specific service settings.

It is vital for all accident and emergency departments to continue to work in partnership with mental health services and other community agencies to develop protocols for the management of people who present with suicide attempts or deliberate self harm. These protocols need to include consideration of issues that may be specific to young people *(Recommendation 1.1)*.

The present discussion seeks to provide a detailed analysis of the components of service delivery that appear most critical to improving continuity of care and clinical outcomes for young people. These components of care might provide the basis of a generic "critical pathway" for young people presenting to emergency departments with self harm. A critical pathway is a plan of care for a specific health problem that defines the appropriate use and timing of therapeutic interventions to optimise resource management, minimise costs and improve patient outcomes (Jaggers 1996).

Identification, immediate care and assessment

Triage

Triage is the first point in the critical pathway and has been identified as a key danger point in the pathway. Because of their extreme psychological distress and behavioural volatility, young people who have attempted suicide or deliberately self harmed may be more vulnerable than other types of patients to negative effects of long waits for medical assessment. It appears likely that young people presenting with suicide attempt and self harm are experiencing excessive waits for medical assessment. Greater attention to the importance of mental health criteria can influence triage codes and reduce waiting times for this patient group. Participants at the Second National Project Workers Workshop for the National Youth Suicide Prevention Strategy also noted that psychiatric emergencies tend to be attended to last and recommended that National Triage Scales must include mental health criteria in order to redress this problem *(Recommendation 1.1, first dot point)*.

Assessment

There is a general consensus that all young people presenting with self harm or suicide attempt should be provided with a comprehensive assessment by a mental health professional. If assessment by mental health is not a routine procedure for all presentations of self harm then it is left to emergency department staff to determine whether or not mental health assessment is required. This constitutes a critical danger point which can be circumvented if assessment is made routine.

Comprehensive mental health assessment should also be conducted as promptly as possible in order to enhance engagement and minimise the possibility of young

people leaving the emergency department without being assessed *(Recommendation 1.1, second dot point)*. The balance of opinion appears to be that mental health assessment can be conducted prior to medical assessment as long as the client is not medically compromised.

Care should be exercised here however. The Blacktown Project team point out that conducting a mental health assessment prior to medical assessment risks stigmatising the young person. This concern appears to be based on a body of anecdotal evidence which indicates that emergency department staff sometimes dismiss patients' physical needs when patients are believed to be suffering from mental health problems. The suggestion is that instituting a procedure which endorses conducting a mental health assessment before a medical assessment runs the risk of reinforcing the attitude that the physical needs of clients who self harm are unimportant.

Conversely, overemphasis on avoiding this could lead to inappropriate dismissal of the importance of mental health problems. An alternative interpretation of allowing a mental health assessment to be conducted prior to a medical assessment if medical assessment is delayed is that such a practice gives equal importance to mental health issues as physical health issues. Such an approach does not stigmatise mental health but gives it equal status with other health problems. Negative attitudes towards people with mental illness are reinforced if their physical needs are dismissed. Negative attitudes are also reinforced if mental illness is dismissed as not being as important as physical illness.

Nevertheless, it is clear that mental health assessment cannot take place unless the patient is medically stabilised and is not suffering from an altered state of consciousness. When triage judges the urgency of medical assessment to be low, the need for medical stabilisation prior to mental health assessment is very unlikely and the importance of mental health issues relative to medical issues becomes increasingly compelling.

Emergency departments based in rural locations may lack access to mental health crisis assessment services. In other locations, 24-hour services may not be available. Further work is required to identify ways in which young people presenting to emergency departments can be assured access to prompt and comprehensive psychosocial assessment. Consideration may need to be given to enhancing availability of mental health crisis assessment and treatment (CAT) services. Alternatively, ways of better supporting emergency department and other hospital staff in conducting assessment and referral could be pursued further *(Suggestion 1.1a)*. Training emergency department staff in the use of structured assessment instruments appears to be a lengthy and highly costly exercise and it is very uncertain whether this path will produce positive results.

Even if protocols specify that mental health assessment be routine for all presentations of self harm, this will not ensure that all such presentations will receive

an assessment. The current analysis suggests that recognition of self harm in the emergency department is not straightforward and that recognition is a critical danger point in the clinical pathway.

This critical point has been inadequately addressed by the current group of projects, even when taken together. Projects that specify routine mental health assessment of all self harm patients have generally not given attention to the issue of how emergency department staff identify such patients. Further work is required to define the ideal role of emergency departments in identifying self harm presentations. It is important that protocols clearly differentiate the assessment role of emergency department staff from that of mental health staff.

Available information about assessment tasks relevant to the emergency department centres on the role of triage in identifying patients whose injury is self inflicted. Triage processes in place in most emergency departments appear insufficient for this identification process. It has been suggested that triage should include more focused questioning of suicidal intent and the use of specific mental health triage guidelines. In addition, some form of brief assessment, perhaps using structured instruments appears appropriate *(Suggestion 1.1b)*. If self harm or suicidal intent is identified at triage or on brief assessment, the balance of evidence suggests that further mental health assessment is indicated.

The assessment role of emergency department staff should perhaps be limited to triage, medical assessment, brief assessment aimed at accurately identifying self harm, as well as monitoring. Further work is required to identify the parameters of any further assessment by emergency department staff prior to comprehensive mental health assessment.

It is notable that the two projects that explored the assessment role of emergency department staff both trialed the use of structured instruments. Structured instruments appear to provide assistance to non-specialist health professionals by ensuring assessment covers all relevant domains of questioning and observation.

One important research finding that requires consideration in this regard is that self report measures of suicidal ideation tend not to correlate well with clinicians' assessments (Cantor 1994; Kaplan et al. 1994). Kaplan et al. (1992) found that subjects were more likely to disclose concerns about recent suicidal ideation on the self report measure than during interview. According to Kaplan et al. (1994): "Whereas clinicians may rely on their intuition and omit or fail to enquire about specific data relevant to suicide risk, standardised self-rating instruments encourage a more complete and non-judgemental assessment of suicidal behaviours."

On the other hand, Cantor (1994) argues that assessment by a clinician also involves dynamic and interactive processes such as rapport building and ongoing monitoring as necessary. Clearly self report instruments and clinician assessment are complementary rather than alternative.

Psychiatric or mental health assessment is designed primarily to identify the presence of mental disorders and the need for psychiatric treatment. Failure to detect mental disorder could increase the likelihood of the young person not being referred to mental health services or other services. There appears to be considerable variation in opinion within and across mental health services about whether self harm in itself is sufficient to warrant assistance from mental health services. Unless self harm is recognised as important enough in its own right to warrant intervention, even in the absence of a recognised psychiatric diagnosis, it is highly likely that there will continue to be people who fail to receive appropriate follow-up care.

Policy development work is required to clarify these questions. At issue are the validity of the criteria that mental health services use to determine eligibility for treatment services and the breadth and depth of the role that mental health services ought to play in the assessment and management of mental health related problems. What are the responsibilities of mental health services if it is determined that an individual is not suffering from a recognised psychiatric disorder, but is clearly suffering from psychic distress and mental health problems defined more broadly? This policy issue is not confined to the case of young people who have self harmed or made suicide attempts. It is also central to the issue of early intervention. Research involving broad consultation with stakeholders including mental health service providers and consumers is required to examine these questions with a view to informing future mental health policy development *(Suggestion 1.1c).*

This research might also include examination of patterns of referral and the reasons why assessing clinicians do and do not make referrals to particular types of agencies.

The evidence as it stands suggests that appropriate referral of young people presenting with self harm for ongoing care is more likely when a comprehensive (psychosocial) mental health assessment is conducted by an appropriately trained professional who then makes the referral.

"Appropriately trained" implies professional training in generic mental health assessment skills as well as specialist training in suicide risk assessment and child and adolescent mental health. Mental health professionals receive extended training in psychosocial and psychiatric assessment skills as part of their tertiary education. The balance of opinion from the current set of projects is that comprehensive psychosocial assessment (as opposed to brief risk assessment) should be conducted by mental health professionals. However, mental health professionals will not always possess the necessary skills to assess young people presenting with deliberate self harm. Information presented by several projects raises the concern that many mental health professionals conducting assessments of young people lack sufficient training in child and adolescent mental health.

Several project reports also discuss the need for professionals making assessments to be sensitive to the diversity of circumstances affecting young people who present with self harm. Assessment that is focused on the individual circumstances and needs of young people is required in order to identify the factors responsible for their self harming so that referral to ongoing care that addresses these factors can be made.

Several projects recommend that extensive training should be provided to mental health and emergency department staff in order to develop their skills in assessing and managing young people who present with self harm. It is suggested that training needs to be made compulsory. However, logistical barriers to extended training are well known and ways these could be overcome have not been identified. This raises the question of the feasibility of providing adequate training in specialist areas to staff whose specialty or interest lies elsewhere. The availability of specialist child and adolescent mental health personnel to provide the necessary support to emergency departments needs to be considered.

Further service development work and evaluation research needs to be directed towards exploring the level of infrastructure, training and other support that is necessary to ensure quality comprehensive assessments are conducted on all young people presenting to emergency departments, whether these are conducted by mental health or non-mental health staff. It is necessary to determine the level of staffing, skill and training that is required in the three areas of (i) mental health assessment; (ii) suicide risk assessment; and (iii) child and adolescent mental health *(Suggestion 1.1d).*

The difficulty experienced by emergency departments in accessing mental health professionals emerged as the most pressing concern from the consultation undertaken by the Australasian College for Emergency Medicine and the Royal Australian College of Psychiatrists to develop draft guidelines for the management of deliberate self harm in young people by hospital emergency departments (Hamilton and Cook 1999). These difficulties were especially acute in regard to the availability of child and adolescent mental health services as well as after hours services more generally. Access problems were greatest in rural, outer urban and low socioeconomic areas but were also evident in other urban areas.

Hamilton and Cook (1999) indicate that the widespread lack of personnel and other resources "require to be addressed and will provide a significant challenge to governments and health administration with the political and organisational will to effect change and improvements" (Hamilton and Cook 1999, Section 4: 3).

The Central Sydney Project recommends that in addition to ensuring the availability of child and adolescent mental health services to conduct psychosocial assessments for young people, specialist mental health nurses should be appointed to emergency departments. This suggestion is also strongly supported by Hamilton and Cook (1999).

Specialist mental health nurses based in emergency departments could fulfil a number of vital functions including: assisting emergency doctors in conducting brief risk assessments; engaging and monitoring young people in the emergency department; organising prompt assessment, referral and follow-up; providing backup to consulting psychiatrists conducting assessments; and continuing liaison with mental health and other community-based services in the provision of ongoing follow-up and monitoring.

Hamilton and Cook (1999) note that employment of specialist psychiatric nurses (often community psychiatric nurses) in emergency departments has been shown to be effective in the United Kingdom. They also note that in four Australian and two New Zealand centres the success of interdepartmental collaboration was greatly enhanced by the presence of a dedicated mental health nurse or social worker based in the emergency department. The final ACEM and RANZCP Guidelines (p.9) on the management of deliberate self harm in young people indicate that employment of a mental health nurse in emergency departments of all major hospitals as "an essential step for guideline implementation". *(Suggestion 1.1e).*

Feedback from young people consulted about their experiences indicates that emergency department staff are generally poor at engaging and communicating with young people who present with self harm. Mental health professionals were found to be better at engaging young people. Engagement was facilitated by staff displaying a caring and respectful attitude. However, mental health staff were experienced somewhat negatively when using a structured assessment instrument.

This feedback from young people highlights an important issue or tension that has emerged from several of the Strategy projects in this group and others. On the one hand, advocates of a more systematic response to young people from mental health services have identified the wide variability in assessment procedures as one of the major problems to be addressed. Use of standardised instruments has been proposed as a strategy for promoting a more systematic approach to assessment. On the other hand, some professionals claim that engagement is the major problem area and advocate for assessment procedures that stress the display of warmth and caring attitudes. Some members of the latter group feel that use of standardised instruments is incompatible with the display of warmth and caring necessary to promote engagement by young people. Critics of standardised instruments have also argued that instruments tend to influence interviews in a direction that will not suit all young people's needs (Brann, personal communication, September 1999).

Further work is needed to help resolve these issues. The reluctance of a large proportion of mental health clinicians to embrace the use of standardised instruments is a major barrier to the advance of rigorous evaluation of mental health services.

The concerns of this group of stakeholders need to be addressed if progress is to be made. The core concerns articulated by critics of standardised instruments appear to centre around the way in which instruments are used, not the use of instruments per se. Standardised assessment instruments are recommended as a tool for assisting clinicians to cover all necessary issues in an interview. If they are used in a way that limits exploration of key issues of importance to particular young people, then they are not being used correctly. In other words standardised assessment tools are designed to set and maintain a minimum standard based on current knowledge, not place limits on the development of better practice. Similarly, if standardised instruments are used in a manner that reduces the expression of empathy and caring then this may be more the fault of the assessing clinician than the instrument itself.

Valuable skills in assessing adolescents may include an ability to use a structured instrument using a manner and language that is friendly, flexible, caring and avoids harsh formality. For example, it should not be necessary for assessing clinicians to complete forms while they are talking to young people. The form could simply be used as a guide to prompt the clinician to cover all necessary issues. Comprehensive case notes and completion of forms may best be conducted later.

Whether or not use of standardised instruments for assessment and evaluation is capable of promoting better outcomes for clients is a highly controversial issue that is unlikely to be resolved quickly one way or the other. However, higher levels of discussion about the benefits and disadvantages of standardised instruments and the factors that may enhance benefits or exacerbate disadvantages would be valuable. A delphi study may be a useful exercise for gathering information from the field in a way that acknowledges and responds to disagreement, while at the same time seeking development of a consensus position. Additional evidence from the evaluation of other National Youth Suicide Prevention Strategy projects is presented in other volumes of this Technical Report series, particularly Chapter 1 of Volume 1.

Routine assessment of young people presenting with self harm by mental health services has been implemented in a number of the sites covered by the National Strategy Hospital Protocol projects. Further evaluation work is vital. Outcome and impact evaluation research should focus on determining whether increases in rates of mental health assessment do in fact lead to increased rates of "appropriate" referral, client compliance with recommended follow-up care, client satisfaction with services and clinical outcomes.

Process evaluation is also needed to explore whether particular aspects of assessment practice are more effective than others in generating desired outcomes *(Suggestion 1.1f)*. Satisfaction of young people is likely to be a key indicator of the appropriateness of assessment and referral. Information about the factors that enhance the appropriateness of referrals would also be valuable. Qualitative

research exploring clinicians reasons for making (or not making) referrals to particular agencies would also be useful.

Management and ongoing care

Referral

An assumption underlying most of the current set of projects is that all young people presenting to emergency departments with suicide attempt or deliberate self harm should be provided with a referral to an appropriate ongoing care agency following discharge from the emergency department or hospital *(Recommendation 1.1, third dot point).*

Referral means that a service provider makes a clear arrangement for the client to visit a particular agency or service provider, and preferably makes an appointment for the young person. Providing young people with a telephone number to ring in the event of a crisis is not considered to constitute making a referral.

It is important to refer to an appropriate agency. Some young people involved in a focus group conducted by the Blacktown Project mentioned that they had been referred to inappropriate agencies. At the Second National Project Workers Workshop of the National Youth Suicide Prevention Strategy, participants in one of the hospital protocol groups also noted inappropriate referrals as a major problem. It was suggested that a referrals database would be helpful. Such a database should provide detailed, up to date information about the services available in the area.

There are several databases in existence that could be adapted or further developed for this purpose. The Strategy provided funding to Lifeline to enhance coverage of services for young people in their referrals database. The MHIRRA (Mental Health Information in Rural and Remote Areas) database could also be used for this purpose. MHIRRA is a joint project of the New South Wales Association for Mental Health and the Gilmore Centre at Charles Sturt University. Currently information from these databases is only accessible by contacting the organisations that maintain them. This is not adequate when young people leave hospital outside of business hours. It would be necessary to make such databases accessible 24 hours a day on the Internet or on an up-datable CD-ROM *(Suggestion 1.1g).*

Identification of the appropriate agency to refer to should be guided by the nature of precipitant as well as longer term antecedent factors (for example, mental illness, sexual identity issues, past sexual abuse). These and precipitating factors need to be adequately identified at assessment.

Critical pathways research could provide a framework for identifying which types of agencies are best placed to provide ongoing care to clients with particular types of problems. One limitation of the critical pathways approach is that it may only

be capable of identifying the most appropriate path amongst current options (Brann, personal communication, September 1999). If none of the current options is ideal then the critical pathways approach may have limited value. Critical pathways research also depends heavily on the particular agencies that are playing a role in caring for a client group. The validity of the critical pathway identified may be substantially undermined if key agencies lose funding and are forced to withdraw their participation or change their role (Brann, personal communication, September 1999). Thus in the absence of a more stable funding environment, critical pathways may need to be reviewed regularly.

On the other hand, critical pathways research based on data from multiple settings may be capable of generating a generic critical pathway that represents a best practice model. Information about the range of agency types that are necessary to achieve best practice could be used to support funding submissions and argue for interagency collaboration that will allow implementation of best practice. A number of generic pathway types could be developed to represent best practice in a manner that is sensitive to key variations affecting service settings that cannot be modified.

Make an appointment

The data that are available suggest that making a definite appointment for the young person with an aftercare agency improves the likelihood of their attending the first appointment.

Young people desire prompt follow-up appointments and delay is associated with reduced likelihood of attendance. It has been suggested by several sources that an appointment should be made for within 24–48 hours following discharge for a young person at low risk, and within 24 hours for a young person identified as at high risk (*Recommendation 1.1, third dot point*).

Further evaluation research is required to determine the essential elements of "making a definite appointment". Slightly different procedures were trialed by Central Sydney and the YARDS Project: (i) flexible appointments; and (ii) fixed clinic times. Insufficient numbers of subjects were involved in these trials to determine which if either of these procedures was more effective.

Because many agencies in a position to provide ongoing care are only open during normal business hours, it can be difficult for staff to organise a definite appointment before the young person is discharged from hospital. Establishment of permanent "intake" or clinic times with particular agencies that could be booked out of hours appears to provide a way around this problem. A mechanism to record appointment bookings out of hours would be necessary to ensure that the referral agency knows that an appointment has been made and to expect the young person. A centralised computer booking system that can be used by all partner agencies might facilitate this.

A problem with the fixed clinic time system is that fixed clinic times will not be suitable for all clients and greater flexibility in appointment times may be necessary for these individuals.

Further evaluation research should be conducted to compare the effectiveness of (i) fixed clinic times and (ii) flexible appointments, compared to other referral systems in increasing attendance of young people at aftercare. This research should also explore the preferences of clients and whether certain client characteristics may interact with referral procedures, rendering them differentially effective with different clients (*Suggestion 1.1h*).

Assertive follow-up

Ensuring that young people have access to ongoing care following self harm is clearly the most essential step in enhancing wellbeing. Making an appointment for young people with an ongoing care agency was found to be a significant predictor of not making a repeat presentation with suicide attempt (*Recommendation 1.1, third dot point*).

The ACEM and RANZCP Guidelines (2000: 6) recommend that young people assessed as being at high risk of suicide should be provided with "rigorous and long-term follow-up" *(Recommendation 1.1, fourth dot point).*

Findings from the Central Sydney Project suggest that assertive, proactive follow-up may be an effective means of increasing attendance at follow-up care. While this project involved small numbers of young people, the results appear impressive and suggest the need for further evaluation of assertive follow-up. A program of research is needed to address a range of questions in this area.

Some questions that need to be addressed include:

- Does follow-up increase the likelihood of clients attending ongoing care?
- How soon should follow-up be initiated in order to increase attendance at appointments?
- How regular do contacts need to be?
- How long should follow-up continue?
- Who is responsible for conducting follow-up (trials and routine)?

Some research data suggest that risk for suicide following treatment for an attempt is very high in the first day or two. This suggests that it may be important to initiate contact and seek to secure engagement within one day of the young person leaving the hospital. Other research indicates that risk for completed suicide is highest in the first 6–12 months following an initial attempt (Hawton and Fagg 1988; Isometsa and Lonnqvist 1998); this suggests that follow-up should continue for at least six months and perhaps 12 months for those at greatest risk.

An additional reason for conducting follow-up is to monitor long-term outcomes for the target population. Implementation of routine monitoring of attendance at

follow-up appointments for a reasonable amount of time constitutes a critical component of ongoing evaluation of the hospital protocol projects along with monitoring of mental health outcomes for young people. Evaluation resources should be dedicated to this task.

The Blacktown Project was the only project that reported on the implementation and evaluation of a specific follow-up intervention. Blacktown was only able to retain half of the young people who originally entered the follow-up study. Nevertheless, the Blacktown study indicates that it is possible to follow up young people who present to emergency departments with self harm and measure outcomes in a reasonable sample.

The data suggest that maintaining contact for six months may be associated with reduced rates of repeat presentation with self harm. Outcomes for those not retained were poor. Around one–third presented again with self harm. However, firm conclusions cannot be drawn and further work is required. While the two groups in the Blacktown study did not differ on age, sex, ethnicity, living situation, education or level of employment, other potential confounding factors were not included in the analysis and it is possible that the young people who were retained in the follow-up for the full six-month period were more stable and resilient than those who were not retained in follow-up. Thus those retained may have had better outcomes even without the follow-up intervention.

Some previous controlled studies of outcome following treatment among young people have found substantial improvements in both treatment (experimental) and comparison groups, and no significant differences between the groups (Bickman 1996; Hawton et al. 1981, cited in Salkovskis, Atha and Storer 1990). However, the study by Salkovskis and colleagues did find significantly greater improvement in a treatment group using a cognitive behavioural problem solving skills intervention that was delivered in the patients' own homes. Importantly, there were no dropouts from treatment and all subjects were able to be assessed at six month follow-up. This suggests that loss to follow-up might be reduced by providing interventions assertively in locations most convenient to clients. The Cochrane Review also found some support for the effectiveness of assertive outreach in combination with intensive aftercare compared to standard aftercare (Hawton et al. 1999).

The value of assertive supportive follow-up is also consistent with a key premise of crisis theory which suggests that people in crisis tend to become focused on relieving internal distress rather than applying themselves to rational problem solving (Janosik 1994). If this is true then it is to be expected that people in crisis would have difficulty applying themselves to the complex task of identifying and making appointments at agencies for ongoing care. Assertive follow-up by the ongoing care agency or some other provider could act as a stabilising and guiding influence during periods of disorganisation.

The present Blacktown results are sufficiently promising to indicate the desirability and feasibility of further controlled evaluation of assertive follow-up. Patton and Burns (1999) and Hamilton and Cook (1999) also note that prospective studies of intervention, compliance with treatment and prevention of treatment dropout are warranted. Since intensive assertive follow-up is not routinely used nor even widely accepted as a critical element of service provision to this population, it may be ethical to conduct a randomised controlled trial of such follow-up in order to assess its impacts on compliance with aftercare appointments/referrals, mental health outcomes and further self harm (*Suggestion 1.1i*).

Long-term follow-up research conducted overseas suggests that the period of greatest risk for completed suicide is 6–12 months after an index attempt (Hawton and Fagg 1988, Isometsa and Lonnqvist 1998). However, cumulative rates of completed suicide continue to increase in the following years.

Any long-term follow-up study should also explore the factors capable of improving follow-up capacity, retention in treatment and outcomes. Number of contacts made was not a factor in determining retention in the Blacktown study. It would be useful to have information about: the precise nature of services provided; the young people's satisfaction with services and support received; and their perceptions about the factors that are impacting on their wellbeing, at more regular intervals in the follow-up period.

At present it would appear to be extremely difficult to routinely monitor key indicators such as whether or not first appointments are attended, even in focused evaluation research because data systems in emergency departments are inadequate for this task.

While outcomes such as completed suicide could be monitored using coronial data, other long-term outcomes such as suicide attempts, mental health status and emotional wellbeing will require long-term follow-up of individual young people.

Projects have reported difficulty in maintaining a reasonable number of young people in follow-up samples. In contrast research in the United Kingdom that has dedicated sufficient resources to the task has been able to obtain long-term follow-up data on 77 per cent of the initial sample (Hawton and Fagg 1988). However, retention of young people was not quite as high as for adults.

An ability to conduct follow-up will depend on the existence of formal referral systems that include accurate record keeping. Hawton and Fagg (1988) note that a high standard of case notes for patients treated at the emergency service in their study had been maintained since the service was established in the early 1970s. Improved record keeping in services to which clients are referred would also facilitate the task of tracking clients through the system and may provide access to information about changes in address that would facilitate follow-up. It is also important to obtain information about young people who do not

voluntarily present for follow-up appointments or who withdraw from contact with services. Currently it appears that no Australian data are available about this population. Regular phone calls from an agency responsible for conducting follow-up may be required to retain these young people in long-term outcomes research.

The question of who should be responsible for conducting follow-up is problematic. The answer will depend largely on the main purposes of this work. In the context of evaluation research, the agencies conducting the projects are highly motivated to assume this role. However, the role of such agencies in follow-up conducted more routinely is problematic. One project experienced considerable resistance to the idea of conducting follow-up from key stakeholders in the health system. If the purpose of follow-up is primarily to monitor impacts and outcomes for all clients presenting to the emergency department then it is not appropriate for particular referral agencies such as mental health services to conduct this work.

At present, long-term follow-up of clients is a task that extends far beyond the role of emergency departments. It is possible that a case could be made for fostering an attitude among emergency departments that a duty of care extends beyond making a referral. It has been suggested that health services need to appoint staff who are responsible for conducting continuous quality improvement work. Routine monitoring of outcomes would be an appropriate role for a team of such staff. If follow-up includes a clinical care component, other systems for supporting this function may need to be identified. If specialist mental health nurses were appointed to emergency departments to facilitate assessment and referral processes, quality assurance, including follow-up of self harm clients, could easily be included as part of their role.

Information about attendance at follow-up services might, in some jurisdictions, be more successfully obtained from routine data collections rather than asking clients. Silburn, Zubrick and Acres (1997) used record linkage to the Western Australian registers of hospitalisations and mental health services to estimate relative service use by patients exposed to different qualities of emergency department care during 12 and 24 month follow-up periods. Poor quality of routine data collections would make this difficult in most jurisdictions.

Resources need to be allocated to the development of data systems capable of tracking clients within the emergency department, hospital and community services and capable of generating data suitable for evaluation and research. This will require inclusion of modules for recording information about attendance at ongoing care and mental health outcomes (*Suggestion 1.1j*).

The need to develop a database capable of tracking clients within the emergency department, hospital and community and capable of generating data suitable for evaluation and research was also identified at several points in the consultation with emergency physicians and psychiatrists conducted by the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists (Hamilton and Cook 1999).

Develop a care plan in collaboration with the young person

Development and documentation of a follow-up care plan appears to be an important element of a more systematic approach to follow-up care. Several projects note the importance of involving the young person in developing the ongoing care plan. Engagement with after care is likely to be much higher if the young person feels that the plan is appropriate to them and that they were listened to.

The Mackay Project reported that a disturbingly low number of young people are being provided with a follow-up plan. It would be valuable to have information about the factors that determine whether or not a follow-up plan is developed for a young person to inform the design of interventions to promote this practice. Factors that may be important include whether or not a comprehensive psychosocial assessment takes place, who conducts this assessment, where, when and over what length of time it takes place.

It is recommended that follow-up care plans be developed in collaboration with the young person and significant others, by the person who conducts the comprehensive assessment and makes the referral to ongoing care. The plan should be documented and a copy provided to the young person (*Recommendation 1.1, fifth dot point*).

Treatment

The Central Sydney Project found a diagnosis of personality disorder to be significantly associated with reattempt (Chi square = 6.71, p=0.01). This finding is consistent with evidence from the literature that a diagnosis of personality disorder, particularly antisocial and borderline personality disorder, is a risk factor for ongoing suicidal behaviour, all age groups considered (Beautrais 1999). Beautrais notes that there has been little study of personality disorder as a risk factor for suicide attempt in adolescents and suggests the need for further research in this area. Follow-up evaluation and other service development research should also be sensitive to the question of how compliance with ongoing care and outcomes vary for young people who have a diagnosis of personality disorder.

There is still a remarkable dearth of research examining the effectiveness of particular treatments aimed at reducing suicide reattempt and deliberate self harm. Most studies have included too few subjects to detect statistically and clinically significant effects. Several recent reports have highlighted the urgent need for large trials of promising therapies (Hamilton and Cook 1999; Hawton et al. (1999); Patton and Burns 1999).

Problem Solving Therapy and Supportive Therapy show some promise in the Blacktown results. A trend in favour of problem solving therapy compared to standard aftercare was also reported in the Cochrane Review (Hawton et al. 1999). Further work could be conducted in this area. The issue of personality disorder raises the broader question of diversity among young people. It is unlikely that any one type of treatment will be appropriate for all young people who self harm

or attempt suicide. Treatments tailored to particular risk factors, combinations of risk factors and the characteristics and strengths of particular groups of young people need to be developed and evaluated (*Suggestion 1.1k*). A range of mental health and psychosocial outcome measures will need to be studied in addition to suicide attempt and deliberate self harm.

If sufficient numbers of subjects are to be included to generate meaningful results, trials of particular therapies will need to involve collaboration across multiple centres. A major barrier to the conduct of such evaluation research (and the wider implementation of effective treatments) is likely to be the availability of service providers willing and able to participate in the trials. Until the staffing and resource deficiencies affecting child and adolescent mental health services are addressed, participation in the development and testing of new treatments for young people who have attempted suicide and deliberately self harmed will remain severely limited.

Provide information

There is strong consensus that more comprehensive information needs to be provided to young people to encourage and assist them to engage with alternatives to self harm. Young people and their nominated carers should be provided with information about: procedures in the emergency department; the ongoing support systems available that they could draw on; mental health issues and self harm (*Recommendation 1.1, sixth dot point*).

Building capacity in service systems

Coordination of services

The assumption underlying the current set of projects is that developing a systematic response to young people presenting to emergency departments with self harm or suicide attempt requires the adoption of protocols and procedures that are agreed and understood by all relevant service providers. This task is far from simple. The current analysis has identified a number of conditions that facilitate the process of protocol development and adoption.

Protocols require understanding, agreement and collaboration between all relevant stakeholders. The strongest foundation for understanding, agreement and collaboration appears to be the presence of goodwill that can develop naturally as organisations learn about each others roles and what they have to offer each other. This natural goodwill allows the negotiation of protocols through a process of open consultation and consensus decision-making. Goodwill based on knowledge and familiarity appears to require time, perhaps many years, to develop. When goodwill is lacking, work must be directed towards it in order for effective working relationships to be forged. This task proved extremely difficult for most projects. Developing a sense of ownership of the project and the change process by all key stakeholder groups is critical. Most important among these are the establishment of Steering Committees with wide representation and authority to

make decisions as well as intensive consultation with senior managers not directly involved in the project or the Steering Committee.

Even with an inclusive approach to building consensus, the difficulty of achieving organisational change involving collaboration between disparate service units cannot be overestimated. The Peninsula Project team conclude that effective collaboration capable of achieving continuity of care for clients requires "an integrated organisational structure that relies less on the goodwill of relationships and more on clear lines of authority and communication". The question of formal versus informal structures and the role of authority within these was raised as an issue by other projects and deserves further reflection.

The discussion may benefit from clearer thinking about what is meant by "an integrated organisational structure". A perception of the need for an integrated structure that provides clear lines of authority was one of the main motivations behind the development of Area and Regional Health Services in various states of Australia. It remains unclear whether the integrated Area Health Service model has lived up to the expectation of ensuring greater continuity of care for patients within the health system.

The difficulties experienced by several of the current projects in securing the cooperation of service units that actually belonged to the same Area Health Service suggests that the Area Health Service model may not be delivering what it was intended to. It is also worth noting that current National Mental Health Policy directs the integration of inpatient and community mental health services under one line of authority. As yet no evaluation data are available as to whether integration has led to improvements in continuity of care within Area Mental Health Services.

It has been suggested that integration of health services in Australia has tended to result in bigger but not better services (Le Bas, 1999, personal communication). The Fort Bragg Demonstration Project conducted in the United States failed to find improvements in clinical outcomes as a result of integrating mental health services for children and adolescents using a very generous managed care model (Bickman 1996).

Further service development and evaluation research is clearly needed to investigate the relative effectiveness of different models of coordination aimed at improving continuity of care for young people who have attempted suicide. Such research needs to be integrated into a wider evaluation of the effectiveness of the various structural arrangements that have been implemented throughout the health and other relevant sectors in recent years (*Suggestion 1.2a*).

Evaluation of coordinated care also needs to take into account the quality of the specific services and treatments that are provided in the continuum (Bickman 1996) as well as impacts other than short-term clinical outcomes. For example research by Le Bas, King and Block (1998) found that mental health service integration led to improvements in the service environment from the perspective of staff.

Le Bas (personal communication, 1999) argues that: "Integration breeds satisfaction, which leads to better relationships between consumers and staff and staff with staff. A more functional milieu leads to innovation, which in turn will facilitate action research. Integration leads to less wasted staff time, which can then be devoted to service development."

Service integration is about more than establishing clear lines of administrative authority. Le Bas et al. (1998: 667) argue that "the achievement of continuity of service provision at a local level requires significant clinical and organisational cohesion and high levels of staff commitment to the process". Thus even if formal administrative integration is put in place it may still require further concerted effort over several years to generate the enhancements in service functioning that will ultimately lead to improved mental health outcomes.

A series of national trials of coordinated care is currently taking place in Australia. Unfortunately none of these trials include a specific focus on suicide prevention, mental health or young people. However, the results should provide information of value to the design of research that does address these subjects.

Resources

Progress towards the aim of implementing a more structured response to deliberate self harm among young people presenting to emergency departments has generally been greater for those projects based in areas where infrastructure support is greater. Provision of routine comprehensive mental health assessment by mental health services is the most notable aspect of infrastructure support identified in the current analysis.

The Report of the National Inquiry into the Human Rights of People with Mental Illness (HREOC 1993) found that "apart from relatively few metropolitan districts in several cities, the need for around-the-clock crisis teams is largely unmet".

These difficulties are not restricted to emergency departments but extend to a wide range of situations. Since the Burdekin Report of 1993, anecdotal reports continue to amass which together indicate serious and ongoing difficulties experienced by youth services and community welfare services in obtaining mental health assessments for young clients experiencing crises involving high risk of suicide.

Some of the major barriers cited include: (i) unavailability of 24-hour services in many areas; and (ii) eligibility criteria placed by crisis assessment and treatment (CAT) services. Eligibility criteria applied by many CAT services that are most problematic include: age restrictions (often 16 and 17 year olds are refused a service by teams that have 18 to 64 year age parameters); evidence of an existing psychiatric diagnosis; and clear evidence of current psychotic symptoms. It remains unclear what the purpose of these eligibility criteria is, or whether or how their application results in better quality and more effective service for the populations living in their catchment areas.

A thoroughgoing review of the current mental health crisis assessment service system appears to be in order. This review should examine both the absolute level of services available to children, adolescents and young adults within each state and across geographic zones as well as the various models of operation being used including the function and effectiveness of eligibility criteria (*Suggestion 1.2b*). No national data are publicly available pertaining to the resourcing of crisis assessment and treatment services. Slightly more detailed reporting of the mix of spending within ambulatory service budgets in the National Survey of Mental Health Services would facilitate an ability to monitor overall supply and resourcing of CAT services.

However, it is important to note that the availability of a crisis mental health service with a mandate to conduct routine assessment does not necessarily ensure high quality ongoing care. Effective mobilisation of such resources would appear to require adoption of procedures that are comprehensively researched, agreed and thoroughly understood by all key service providers involved in the care pathway.

Training

There appears to be a generally held opinion among the projects that staff training is essential to the implementation and institutionalisation of a more structured approach to managing deliberate self harm. However, evaluation of training conducted does not reveal evidence of any impacts except on staff attitudes. Further critical evaluation of training provided to emergency department and other hospital staff is required. It is notable that projects failed to articulate clear measurable learning goals against which to assess the impact of training on knowledge, attitudes, skills and practice.

Future work also needs to identify what forms of training are necessary to achieve particular change objectives. Thorough consultation in the development of procedures operates as one form of training as does feedback to staff about progress in the change process. These forms of professional development and involvement appear indispensable for ensuring staff are sufficiently informed to participate in the change process. Regular inservices that inform new staff and remind old staff about protocols would also appear necessary. Education appears to be of value in improving understanding of and attitudes towards young people who engage in suicidal behaviour among emergency department and mental health staff.

However, questions need to be asked about the appropriateness and cost effectiveness of trying to enforce ongoing intensive education and training for emergency department staff aimed at developing skills in suicide risk assessment, referral and follow-up. There is evidence that these activities may be best conducted by professionals with specialist expertise.

Further work is required to clarify the training needs of emergency department and other hospital and health service staff. Clear learning goals need to be

developed based on agreed roles and responsibilities of particular groups of staff and particular change objectives identified by services. Evaluation of training should assess changes in attitudes, knowledge, skills and practice defined in terms of measurable learning goals and change objectives (*Suggestion 1.2c*).

Continuous quality improvement

As suggested by the authors of the Peninsula project report, most of the service development practices identified as contributing to youth suicide prevention are the hallmarks of contemporary best practice in health care. The Peninsula Project team note further that this implies that activity directed towards client-centred practice improvement across the health care system would, in itself, contribute substantially to youth suicide prevention without the need for a focused response to the issue.

This conclusion has merit. A further argument in favour of this approach is that trying to induce substantial behavioural change is much more difficult when the rationale is limited to meeting the needs of minority groups. An appeal to the benefit of the total client population is likely to be more compelling for most staff.

However, the conclusion that there need be no focused response to the issue is questionable when viewed from the perspective of a public health strategic planning approach to service development. In recent years, service development practice in public health has been characterised by a strategic planning approach that focuses on articulating goals and objectives and working towards clear and measurable outcomes, impacts, targets or performance indicators. Identification of desired health outcomes and strategies targeting particular health problems and sub-populations is recognised as essential for ensuring that quality improvement activity addresses issues of access and equity.

Change also seems to require a clear understanding by staff of the reasons why change is required and identification of areas of unmet need appears to be an important impetus for change initiation. However, having said this, it is likely that change maintenance may be more effective when incorporated or institutionalised within a general quality improvement approach.

The findings of this review add to a growing body of evidence which suggests that measurement of clinical outcomes on a routine basis is currently beyond the capacity of most service systems. It is particularly disturbing that this task also appears to be beyond the capacity of most service development projects that include funding for evaluation. Barriers include restrictively short time lines, poor data systems, reluctance of service providers to participate in outcomes measurement and a shortage of expertise in the design of methodologically sound outcome evaluation.

Continual quality improvement, evaluation and monitoring of clinical outcomes are centrally important mechanisms for sustaining change. Attention needs to be directed to enhancing the infrastructure and resources available to support this work *(Recommendation 1.2, first dot point)*.

Good quality data for determining baselines, monitoring progress and providing feedback on changes achieved is essential. There is strong and consistent evidence from all the hospital protocol projects that data systems in emergency departments are inadequate for the purpose of high quality clinical management or service development research. This is likely to be true for other parts of the health system as well. Future evaluation will also provide more valuable information if there is more uniformity in the types of data collected across different services.

Consideration should be given to the development of a national minimum data set for emergency departments that includes a module containing data pertinent to the management of suicide attempt and self harm according to best practice *(Recommendation 1.2, second dot point).* In addition to basic demographic data and details about each presentation, it is suggested that the following indicators be included in the self harm and suicide attempt module:

* waiting time for a medical assessment;
* whether or not the client receives a comprehensive (psychosocial) mental health assessment while in the emergency department;
* waiting time for a mental health assessment;
* whether or not the client receives a referral;
* name and contact details of agency client is referred to;
* whether or not an appointment is made for the client;
* whether or not a care management plan is developed;
* whether or not client attends the first follow-up appointment, second appointment etc;
* whether or not the client is in contact with services at 3, 6 and 12 months;
* reasons for ending contact with services;
* mental health outcomes (particularly depression, hopelessness and suicidal ideation);
* repeat presentations for self harm or suicide attempt; and
* completed suicide.

A major barrier to the more effective use of data is poor data completion by emergency department and mental health service staff. More emphasis needs to be placed on the importance of staff cooperating with service development research and continuous quality improvement. The YARDS Project Team recommend that participation in quality improvement needs to be part of the job description of all health service staff. Completing routine clinical file forms should be mandatory. Professional development oriented towards educating staff about the importance of this activity may also be helpful. Action Research is a model of continuous quality improvement that is oriented towards engaging staff in

critical reflection. Adequate resources also need to be available to services to secure appropriate technical expertise in evaluation.

Increasing demands on staff of health services to provide more and better clinical services with less resources, while at the same time increasing their participation in quality improvement and evaluation activity, may be unrealistic. The current set of projects found this task extremely difficult even when specific resources were dedicated to quality improvement and evaluation activities. Simply enhancing financial resources through project work may also be an inadequate response. It appears that structural problems may constitute the primary barrier to wider implementation and maintenance of quality improvement and evaluation activity. A comprehensive review of the infrastructure available to support quality improvement, service evaluation and monitoring of clinical outcomes by health services including emergency departments and mental health services may be in order *(Suggestion 1.2d)*.

The concept of a critical pathway emerged from the concept of total quality management (TQM) and continuous quality improvement (CQI) that the most effective way to improve quality of care is to decrease unnecessary variation in the process of providing service (Jaggers 1996). The critical pathway includes the elements of care that are most critical or essential to good outcomes. While they are intended to guide clinical judgement about care provision they are not intended to stifle clinical judgement or preclude care that is tailored to the needs of individual patients. Rather, individualised care based on clinician and client collaboration is built on to the framework of the critical pathway.

It may be useful for emergency departments that are developing critical pathways or other types of protocols to consider the ways in which the components of care identified in the present analysis can be included in their response. Further evaluation is required to confirm the extent to which each of the components of care identified here are critical to outcomes. This work is likely to take a number of years. In the meantime, these hypothesised critical components of care might provide a basis for focused consultation aimed at developing nationally agreed standards of care.

Williams (1996) analysed the costs and benefits of three different approaches to the development of critical pathways. Use or adaptation of previously developed pathways was identified as the least expensive method. A major problem with this approach identified by Williams is the "not invented here" syndrome which arises from the common belief of institutions that their patient population is unique and that they therefore need to develop their own customised pathways. Development of institutional pathways through a process of internal review was identified as highly expensive and the most expensive method of the three reviewed. It was also identified as the least scientifically based because the process tends to rely heavily on consensus building rather than analysis of data.

Involvement of staff from individual services in developing solutions is important for ensuring that protocols or pathways are sensitive to environmental diversity.

It is also important for educating staff and instilling a sense of ownership and commitment. However, drawing on outside experience can throw light on issues that may not come to light through a purely internal review process. Most of the current set of projects also suffered from a lack of authority to initiate change and a lack of adequate support from managers with decision-making power. A nationally driven process of clinical guidelines or standards development would provide external authority to the cause of reform and might provide substantial cost effectiveness benefits at this point in time *(Recommendation 1.2, third dot point).*

Recommendations and suggestions

It is recommended that:

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

- triage rating system that gives appropriate consideration to psychiatric criteria;

- prompt comprehensive (psychosocial) mental health assessment by an appropriately qualified, trained and experienced mental health professional;

- formal referral to an appropriate ongoing care agency. Appointments should be arranged for within 24 to 48 hours following discharge;

- assertive follow-up of young person to encourage attendance at ongoing care;

- development of an ongoing care plan in collaboration with the young person and carers nominated by the young person; and

- provision of detailed information about the emergency department, suicide attempt and support services available.

(This is Recommendation 12 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

1.1a. Further work should be conducted to identify ways in which young people presenting to emergency departments can be assured access to prompt comprehensive assessment when the hospital does not have access to 24-hour mental health crisis assessment and treatment services. Alternative ways of better supporting emergency department and other hospital staff in conducting assessment and referral should be explored.

1.1b. Structured instruments or other forms of direct uniform questioning should be used by emergency department staff to facilitate accurate identification of the presence of suicide attempt or self harm.

1.1c. Policy development should be conducted in the area of eligibility for mental health services and the role of mental health services in the assessment and ongoing care of individuals suffering from psychic distress but who do not have a diagnosis of a recognised psychiatric disorder. Research involving broad consultation with stakeholders including mental health service providers and consumers is required with a view to informing future mental health policy development.

1.1d Further service development work and evaluation research should be directed towards determining the level of infrastructure, training and other support that is necessary to ensure quality comprehensive assessments are conducted on all young people presenting to emergency departments, whether these are conducted by mental health or non-mental health staff. It is necessary to determine the level of staffing, skill and training that is required in the three areas of (i) mental health assessment; (ii) suicide risk assessment; and (iii) child and adolescent mental health.

1.1e Specialist mental health nurses should be appointed to emergency departments to conduct the following vital functions: assisting emergency doctors to conducting brief suicide risk assessments; engaging and monitoring young people who have presented with suicide attempt or self harm; organising prompt assessment, referral and follow-up; providing backup to consulting psychiatrists conducting assessments; continuing liaison with mental health and other community based services in the provision of ongoing follow-up and monitoring.

1.1f Outcome and impact evaluation research should be conducted to determine whether increases in rates of mental health assessment do in fact lead to increased rates of "appropriate" referral, client compliance with recommended follow-up care, client satisfaction with services and clinical outcomes. Process evaluation is also needed to explore whether particular aspects of assessment practice are more effective than others in generating desired outcomes.

1.1g Funding be made available to establish a database that provides detailed, up to date information about all the services available in each area of Australia to which it might be appropriate to refer young people who present with suicide attempt or self harm at emergency departments. The Lifeline or MHIRRA databases could be made freely available across Australia, 24 hours a day, via the Internet or on updateable CD-ROM.

1.1h Further evaluation research be conducted to compare the effectiveness of (i) flexible appointments and (ii) fixed clinic times, compared to other referral systems in increasing attendance of young people at aftercare. This research should also explore the preferences of clients and whether certain client characteristics may interact with referral procedures, rendering them differentially effective with different clients.

1.1i A randomised controlled trial should be conducted to explore the effectiveness of assertive follow-up in promoting the attendance of young people at ongoing care appointments and improving clinical outcomes.

1.1j Resources should be allocated to the development of data systems capable of tracking clients within the emergency department, hospital and community services and capable of generating data suitable for evaluation and research. This will require inclusion of modules for recording information about attendance at ongoing care and mental health outcomes.

1.1k Treatments tailored to particular risk factors, combinations of risk factors and the characteristics and strengths of particular groups of young people should be developed and evaluated. A range of mental health and psychosocial outcome measures will need to be studied in addition to suicide attempt and deliberate self harm. If sufficient numbers of subjects are to be included to generate meaningful results, trials of particular therapies will need to involve collaboration across multiple centres.

It is recommendesd that:

1.2 Governments should collaborate to:

- provide resources to support continual quality improvement by emergency departments and mental health services;

- develop a National Minimum Data Set for emergency departments that includes a module on the management of suicide attempt and deliberate self harm;

- develop a nationally agreed multidisciplinary set of clinical guidelines or standards pertaining to the management of people presenting with suicide attempt and deliberate self harm to emergency departments. These guidelines/standards should include consideration of the special needs of young people.

(This is Recommendation 13 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

1.2a Further service development and evaluation research be conducted to investigate the relative effectiveness of different models of coordination aimed at improving continuity of care for young people who have attempted suicide. Such research needs to be integrated into a wider evaluation of the effectiveness of the various structural arrangements that have been implemented throughout the health and other relevant sectors in recent years.

1.2b Governments should collaborate to conduct a comprehensive review of current mental health crisis assessment service systems. This review

should examine both the absolute level of services available to children, adolescents and young adults within each state and across geographic zones as well as the various models of operation being used including the function and effectiveness of eligibility criteria.

1.2c Further work should be conducted to clarify the training needs of emergency department and other hospital and health service staff. Clear learning goals need to be developed based on agreed roles and responsibilities of particular groups of staff and particular change objectives identified by services. Evaluation of training should assess changes in attitudes, knowledge, skills and practice defined in terms of measurable learning goals and change objectives.

1.2d Governments should collaborate to conduct a comprehensive review of the infrastructure available to support continual quality improvement, service evaluation and monitoring of clinical outcomes by emergency departments and mental health services.

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Map of program logic: hospital emergency departments

Goals/outcomes

- Reduce rates of completed suicide among young people who present at emergency departments with suicide attempt or deliberate self harm.

- Reduce rates of repeat suicide attempt and deliberate self harm.

- Enhance the mental health and wellbeing of young people who present at emergency departments with suicide attempt or deliberate self harm.

Objectives/impacts

- Increase the proportion of young people who attend follow-up appointments.

- Increase the satisfaction of young people with services received.

Aims/processes

- Enhance the quality of care provided to young people presenting to accident and emergency departments with suicide attempt or deliberate self harm.

Performance indicators

- Waiting times for medical assessment in the emergency department.

- Proportion of young people presenting with self harm who are provided with a comprehensive (psychosocial) mental health assessment.

- Waiting times of comprehensive mental health assessment.

- Proportion of young people who are provided with a referral to an appropriate ongoing care agency.

- Proportion of young people for whom an appointment is made with an appropriate ongoing care agency, with that appointment being within 24 hours (high risk) or 48 hours (low risk) following discharge.

- Proportion of young people presenting who are provided with appropriate follow-up care.

CHAPTER 2
General practice and other primary health care settings

This chapter presents and analyses information about the projects funded under the National Youth Suicide Prevention Strategy that focused on general practice and other primary health care settings.

Projects in this group aimed to improve the quality of care provided to young people by general practitioners and other primary health care services.

Two broad strategies were employed: education and training; and networking and interagency collaboration.

Training of general practitioners and community health staff focused on enhancing knowledge and skills in three main areas: detection and assessment of psychological distress and suicide risk; management of young people at risk of suicide presenting in general practice and community health settings; and postvention. Networking strategies aimed to develop formal and informal links between general practitioners and a wide range of organisations and individuals involved in activities directly or indirectly related to suicide prevention.

General practice and primary health care projects

As shown in Table 2.1, the projects in this group include: the *National General Practice Youth Suicide Prevention Project (NGPYSPP)* administered by the Perth Central Coast Division of General Practice; the *Keep Yourself Alive Project* based at Southern CAMHS and the RACGP Quality Assurance Unit in Adelaide; and the *Here For Life Networking Project*, based at the Logan Area Division of General Practice and Southern Queensland Division of General Practice.

National General Practice Youth Suicide Prevention Project

The National General Practice Youth Suicide Prevention Project (General Practice Project) developed an educational program for general practitioners and other primary health care professionals. The program focused on enhancing the ability of GPs to recognise suicidal risk in young people and to manage psychological

TABLE 2.1	Summary of general practice and primary health care activities of the Strategy		
Program name	**Organisation**	**Main strategies**	**Evaluation design**
National General Practice Youth Suicide Prevention Project (NGPYSPP)	Perth Central Coast Division of General Practice	Training of GPs and community health staff	Measurement of changes in knowledge and attitudes; Practice audit.
Keep Yourself Alive	Southern CAMHS and the RACGP Quality Assurance Unit	Training of GPs and a range of other professionals	Measurement of changes in knowledge and attitudes; Practice audit.
Here For Life Networking Project	Logan Area Division of General Practice and Southern Queensland Division of General Practice	Networking	

distress. The content of the training course includes five parts: Issues; Recognising the Signs; Raising the Issue; Risk Assessment; and Responding, and 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 Southern Child and Adolescent Mental Health Services (CAMHS) in collaboration with the Royal Australian College of General Practitioners (RACGP). 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 GPs and 933 Community Health Professionals.

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 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.

Results of the evaluation

The information reported here focuses on knowledge gained from Strategy projects pertaining to the nature of practice required to enhance the quality of care provided to young people at risk of suicide by general practitioners and other primary health care service. Specific themes covered are:

- Detection and assessment of psychological distress and suicide risk; and

- Management of young people at risk of suicide presenting in general practice and community health settings.

The General Discussion includes a focus on some of the major gaps in the efforts of the National Strategy in the realm of primary health care including issues surrounding access to services, models of service delivery, and primary health care for indigenous youth.

Most of the achievements and lessons related to education and training and networking are of very general relevance rather than being specific to the primary health care setting. This information is therefore described in Chapters 3 and 4 of Technical Report Volume One. Important information relevant to good practice in the provision of primary health care services is also covered in Chapter 2 of Volume One (Early Intervention) and Chapter 2 of Volume Four (Services for young people who are marginalised and disaffected).

What works to enhance detection of psychological distress and suicide risk?

Certain forms of training used in the National General Practice Project were found to improve the ability of general practitioners to detect psychological distress and suicidal ideation in young people (see Chapter 3, Technical Report Volume One). This was not the case for Keep Yourself Alive. The data from both the General Practice Project and the Keep Yourself Alive Project suggest that even with fairly intensive training (a half-day workshop or full day workshop respectively) a substantial proportion of young people experiencing "clinically at-risk" suicidal ideation are not being detected by their GP and may be missing out on timely intervention. Detection of suicide risk was even lower for patients in the youngest age group.

Following training, general practitioners were asked questions aimed at identifying the most important lessons learned in relation to assessment of psychological distress and suicide risk. The lessons reported by GPs were in line with the intended content and aims of the training. These messages are elaborated in the arrow points below as they appear to constitute the key elements of effective engagement and assessment of psychological wellbeing.

➤ *Ask the patient more frequently and more directly*

When asked to indicate two "take home" messages gained from attendance at the training workshop, 88 per cent of GPs from the National General Practice Project identified the importance of asking direct and specific questions of their young patients.

When asked to identify the most useful aspects of the workshop, a substantial proportion of respondents indicated the use of role plays to practice asking difficult questions. This reinforces the conclusion of the Project Team regarding the importance of the preparedness of general practitioners to ask questions. Participants in the patient audits were provided with feedback on their results and provided with the opportunity to reply. They were asked about strategies they intended to use to improve their practice. Prominently cited was an intention to increase the frequency (68 per cent) and directness (52 per cent) of inquiry about suicide risk.

Findings from the survey of young people conducted for the Keep Yourself Alive General Practice Audit also support the importance of practitioners asking the young person directly rather than relying on impressions based on personal familiarity with the patient. The survey found that there was no difference in the suicide risk index according to the number of visits a young person had made to their general practitioner.

It is also reported that: "Young people who had a high suicide risk index did not feel as much at ease with the GP as others . . . [They] did not feel that the doctor made it easy for them to ask difficult or personal questions, nor did they feel that

they could initiate a discussion about difficult problems without the doctor asking a specific question (Beckinsale, Martin and Clark 1998a).

The Keep Yourself Alive researchers interpreted this as indicating that having previous knowledge of a young patient does not necessarily make it easier for a GP to detect suicidal risk, nor reduce the likelihood of the young person engaging in suicidal plans.

➤ Conduct a suicide risk assessment

When asked to indicate two "take home" messages gained from attendance at the training workshop, 68 per cent of GPs from the National General Practice Project identified the importance of performing a suicide risk assessment.

➤ Allocate time and effort

Another take home message indicated by 64 per cent of GPs attending the National General Practice Project training workshop is that time and effort is required to screen and assess this patient group adequately. Lack of consultation time was the most frequently identified barrier to the ability to raise issues about suicide with young patients (identified by 38 per cent of GPs). Thirty-one per cent of the GPs who participated in the patient audit indicated an intention to increase the time allocated to assessment of young people.

➤ Vigilance to the risk of psychological distress and suicidal ideation among young people

General practitioners participating in the patient audits used by the National General Practice Youth Suicide Prevention Project and the Keep Yourself Alive Project tended to underestimate the level of psychological morbidity and suicide risk in their young patients. Detection of suicide risk was even lower for patients in the youngest age group.

When provided with feedback as part of the patient audit, GPs in the National General Practice Project were surprised at the high level of psychological distress and suicidal risk among their young patients. Forty-three per cent of these GPs indicated that heightened level of awareness of the possibility of suicide risk in their youth patients was a strategy they intended to use to enhance their detection of youth at risk.

Feedback from the National General Practice Project GPs indicated that low detection rates may be related to the screening strategies employed by many of them: "Several participants indicated that they were unprepared to ask all young people about their current mental health and would only explore the possibility of suicide if a clear warning sign was present or the young person was visibly distressed . . . "

Patients scoring above the cut-off on the Depressive Symptom Inventory-Suicidality Subscale (DSI-SS) who were undetected by general practitioners tended to be male, younger, and had a psychological-based chief complaint. This latter

observation regarding psychological-based chief complaints is counter intuitive and should be a cause for considerable concern. Results of interviews conducted by the Maroondah Hospital Staying Alive Project with young people who had attempted suicide suggest that these young people disclose their thoughts and actions or reveal other signs even more rarely than was previously considered to be the case.

These findings, and the findings of the National General Practice Project of high prevalence of suicidal ideation among young people presenting to GPs, further highlight the critical importance of professionals being vigilant about the possibility of young patients requiring concerted enquiry into their psychological well-being – *as a matter of course.*

➤ *Other strategies that encourage young people to reveal issues of concern*

Feedback from stakeholders provided during evaluation of the Here for Life Youth Sexuality Project suggests the value of displaying educational promotional material in waiting rooms that encourages young people to talk about issues of concern.

According to a Manager in a Youth Service, cited in Goldflam, Chadwick and Brown (1999): "Through . . . accessing appropriate education materials such as that produced in your Project we have more service users disclosing sexuality issues and seeking support. We believe that by displaying empathic poster and information in our centre we were able to let young people know that we were accessible, non-judgemental and supportive on these issues."

What works to enhance management of young people at risk of suicide presenting in general practice and community health settings?

The National Youth Suicide Prevention Strategy projects in this group did not include a significant focus on the management of young people at risk of suicide presenting in general practice and community health settings. Information about care provided by youth health services to young people who are marginalised and disaffected is presented in Chapter 2, Technical Report Volume Four. However, this material is concerned primarily with access and engagement rather than the details of management strategies.

In addition to a module on risk assessment, the Keep Yourself Alive Project workshop includes a module on crisis intervention, a module on Brief Therapy Interventions, and a module on postvention.

➤ *Crisis intervention*

The Keep Yourself Alive training workshop teaches six steps to crisis intervention: Define the problem; Ensure safety; Provide support; Examine alternatives; Make plans, and Obtain commitment not to attempt self harm.

➤ *Brief Therapy Interventions*

Brief interventions covered in the Keep Yourself Alive workshop include narrative approaches, cognitive behavioural approaches and Brief Family Therapy.

Evaluation of the training suggested that many general practitioners and community health professionals were confused about key distinctions between the different approaches. The authors of the Keep Yourself Alive evaluation speculate that: "The difficulty presented in a workshop where several novel forms of therapy are presented briefly and consecutively, and probably in nowhere near the depth necessary to avoid conceptual misunderstanding, is that blurring may occur between the (memory of the) therapeutic approaches" (Martin, Beckinsale and Clark 1999b).

➤ *Strategies that address barriers in the practice environment*

The National General Practice Youth Suicide Prevention Project evaluation identified limited impacts of training on the management strategies employed by GPs. Of particular concern was a lack of a shift in referral rates following training that might be expected to follow the elevation in detection rates.

Other data arising from the evaluation of Keep Yourself Alive and the National General Practice Project suggest that there are a number of barriers in the practice environment that seriously limit the ability of general practitioners to provide ongoing care of sufficient quality to young people at risk of suicide.

Sixty per cent of GPs identified barriers to management, most frequently reporting: 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 Project recommend that future training programs address these barriers by providing GPs with management strategies 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."

In the literature review for the Keep Yourself Alive GP project evaluation, the authors cite Kendrick et al. (1995) who conducted a randomised controlled trial of training general practitioners to carry out structured assessments of patients with mental illnesses. 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 specialist mental health workers.

➤ *Networking*

Networking, and involving primary health care providers such as GPs in professional networks, has been identified as critically important for enhancing the

management of young people at risk of suicide. Networking has specifically been identified as a mechanism for enhancing continuity of care by:

- increasing GPs' knowledge about the range of agencies available in their communities to which they can refer young people who require ongoing care or treatment;

- promoting information sharing and the provision of feedback to GPs from tertiary services;

- facilitating education and skill sharing among network members; and

- facilitating collaboration between different professionals in the provision of ongoing care.

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. Engaging general practitioners as key stakeholders was a major aim, but GP involvement in the networks was not as substantial as desired. Of the 29 networks initiated in the Southern Queensland Area, only five reported GP involvement. Substantial barriers to involving GPs in professional networks were identified and these are discussed in Chapter 4, Technical Report Volume One.

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 the evaluator was not confident that these networks were adequately trained, resourced or supported for this role (Groom 1999). The report does not provide a description of the "client intervention and referral" activities attempted by these networks, nor any data to support the suggestion that the networks were not competent to undertake this role. No data are provided about the precise level of training received by members of the specific networks that have undertaken this role.

General discussion

Projects focusing on general practice and primary health care concentrated on the provision of education and training, and the development of networks. A large number of GPs and a lesser number of community health professionals received training in suicide prevention. The effectiveness of these strategies and the insights gained from the process are discussed primarily in Chapters 3 and 4 of Technical Report Volume One.

The data analysis presented in this chapter has sought to distil lessons specific to informing good practice in youth suicide prevention in primary health care. Relatively little knowledge has been generated in this area compared to other major approaches to suicide prevention such as parenting programs, school-based programs, crisis intervention by emergency departments, and mental health service provision.

One major finding is that substantial barriers exist in the practice environment which hinder meaningful changes in practice for most general practitioners. These include a lack of appropriate services to which GPs can refer young people at risk of suicide and, when they do exist, the frequent failure of such agencies to provide feedback and ongoing support to GPs in their role.

The practices that have been identified by the National Youth Suicide Prevention Strategy projects as facilitating detection and management of psychological distress and suicide risk in young people by GPs, and the barriers surrounding the use of these practices, are consistent with those identified in previous studies and reviews (eg O'Regan and Wilton 1997). Previous studies and reviews have also identified other issues that were not addressed by the Strategy projects. These barriers and issues have important implications for the ability of general practitioners to implement the kinds of practices that are being advocated in suicide prevention training programs for GPs. Some of the key issues and barriers are outlined in Tables 2.2 and 2.3.

TABLE 2.2	Some major issues for GPs and Primary Health Care identified in the adolescent health literature
• The roles of GPs in mental health promotion, primary prevention and community education;	
• Models of service provision that enhance access for young people;	
• The role of primary health care in addressing health inequalities;	
• Structural barriers to service reform.	

At present there is a lack of clarity surrounding youth suicide prevention activity in the primary health care sector in regard to the distinction between: (1) "goals and objectives" related to population health outcomes; (2) the appropriate roles of GPs and other primary health care professionals in relation to these population health goals (outcomes); and (3) the kinds of strategies that are required at the systems level to enhance the contribution of GPs.

This problem is manifest most obviously in the area of networking where the objectives and aims of involving GPs in networks were generally very unclear. Networking was often spoken about as if it was as an end in itself. The importance of developing greater clarity about the distinction between population health outcomes, roles of primary health care professionals and strategies is further underscored in the failure of the training projects to even consider the roles of GPs beyond detection and management of suicide risk, and the failure of the National Strategy as a whole to address structural barriers in the health care system that have been identified repeatedly in Australian studies of GP involvement in mental health care (see O'Regan and Wilton 1997 for a review).

Some of the key population health outcomes, practitioner roles, strategies and structural issues identified by Strategy projects and in the literature are outlined in Table 2.3. Structural issues are related to problems in the way service systems are organised, including mental health service systems and primary health care systems.

TABLE 2.3	Key health outcomes, prevention approaches, roles and structural issues for general practitioners and other primary health care services in youth suicide prevention		
Population health outcomes	**Prevention approaches**	**Roles of GPs and primary health care professionals**	**Structural issues and systems strategies**
Reduce incidence of mental health problems and other risk factors for suicide, enhance protective factors	Primary prevention	Help families, schools and communities provide a safe and nurturing environment for children and young people.	Linking into area/regional wide primary prevention programs targeting parents, schools and communities. Address financial reimbursement barriers which act as disincentives for GPs to allocate time to community based activities.
Reduce prevalence of mental health problems and other risk factors for suicide	Early intervention	Detection of early signs.	Make the practice or service accessible for young people. Develop skills in communicating with adolescents. Develop skills in assessment and referral. Participate in service provider networks. Availability and accessibility of referral services. Address financial reimbursement barriers which act as disincentives for GPs to allocate sufficient time for young people.
Reduce morbidity associated with mental health problems and other risk factors for suicide	Treatment and ongoing care Postvention	Treatment of less severe and complex cases in collaboration with specialist mental health services. Treatment and ongoing management of most mental health problems and disorders. Shared Care with specialist mental health services.	Making the practice or service accessible for young people. Develop skills in communication and treatment. Availability and accessibility of specialist mental health services to provide support and work in partnership. Address financial reimbursement barriers which act as disincentives for GPs to allocate sufficient time for young people.

The roles of general practitioners and other primary health care professionals

The National Youth Suicide Prevention Strategy only scratched the surface of the issues surrounding the roles of general practitioners and other primary health care service providers in youth suicide prevention. Projects focused on a very narrow set of roles, primarily the detection of suicide risk. Even management of young people so identified did not receive adequate attention. Issues such as the potential role of primary health care providers in primary prevention, early intervention, mental health shared care, community education and community development were not addressed.

The evaluation explores issues relevant to the roles of primary health care providers in primary prevention, early intervention, treatment and ongoing care as well as community development in other volumes of this Technical Report series.

Strategies for supporting general practitioners

Networking was the only strategy that the National Youth Suicide Prevention Strategy trialed in an effort to enhance the availability of ongoing support for GPs who wish to improve the quality of care they provide to adolescents. The little data that are available suggest that involving GPs in professional networks is very difficult and that substantial barriers exist to this involvement. In general, efforts to develop networks of service providers have failed to adequately involve GPs. Important limitations of networking initiatives include a failure to develop clear goals as well as a failure to develop structures (see Chapter 4, Technical Report Volume One). While the value of networking in enhancing the capacity of GPs has not yet been adequately explored, it is important to recognise that it is just one of a range of strategies that deserve further investigation (see Table 2.4).

TABLE 2.4   Major approaches to building support for GPs
• Networking
• Shared care
• Alternative models of service provision

A considerable amount of work was conducted during the 1990s by Divisions of General Practice and Mental Health Services throughout Australia towards the development of models of "Shared Care". Some promising models have been identified (Integration Support and Evaluation Resource Unit 1998; Meadows 1998). However, it is apparent that despite strong and repeated exhortations in policy documents, the majority of GPs and mental health services have either not made serious efforts to develop appropriate methods of sharing mental health care, or have tried and failed. The lack of activity in this area is particularly apparent with respect to management of mental health problems in young people.

There is a lack of information that can be used to diagnose the barriers to the wider uptake of Shared Care in the management of mental health problems in young people. It is possible that knowledge gained from this work has not yet filtered widely through to people who are working on youth suicide prevention within Divisions of General Practice and mental health services. Another possibility is that national and state/territory policy documents calling for the formation of partnerships between mental health services and primary health care services have not provided adequate guidance about the types of collaboration that are required and how these might be formulated and managed.

Models of service provision

The National Youth Suicide Prevention Strategy did not adequately consider the variety of models of primary health care service provision that are available or the relative strengths of these models in addressing the health and wellbeing of young people and supporting general practitioners and other primary health care professionals in the wide range of roles that they are suited to play.

Models of service provision have also been neglected in previous efforts aimed at enhancing the role of GPs in mental health care. For example, a review of mental health shared care projects funded under the Divisions and Projects Grants Program of the GP Branch of the then Commonwealth Department of Health and Family Services found that the bulk of activity conducted between 1993 and 1996 focused on training, and that relatively few projects addressed methods or processes of service provision for people with mental health problems or disorders (Integration Support and Evaluation Unit 1998b). While a fair proportion of projects was aimed at managing risk factors for mental disorders (primary prevention and early intervention) in primary care settings, there was little evidence of projects examining processes of collaborative program implementation.

Recognition of the ways in which organisational factors affect the ability of service providers to form effective partnerships highlights the value of what can be learned from the study of innovative models of service provision. One alternative model of service provision that has been identified as holding considerable promise in improving the accessibility and effectiveness of health care for young people is the community-based youth health service model (O'Regan and Wilton 1997; NSW Health 1999). Essential elements of the community-based youth health service model are outlined in Table 2.5.

A variety of such services is funded under the Innovative Health Services for Homeless Youth Program. Some Divisions of General Practice have also established youth health services based on this general model (O'Regan and Wilton 1997; Success Works 1999). A number of evaluations and reviews of community-based youth health services is consistent in finding that such services are highly accessible and appropriate to the needs of young people, particularly those who experience difficulty accessing mainstream health services model and who are

at high risk of poor health outcomes (O'Regan and Wilton 1997; NSW Health 1999; Success Works 1999).

General practitioners are frequently involved in working in such services, usually on a sessional basis. Evaluation of the Clockwork Youth Health Service (Success Works 1999), funded by the Victorian Department of Human Services, suggests that the Youth Health Service model provides an environment where GPs have adequate time to provide young people with longer appointment times.

In contrast, the fee-for-service model has been identified as severely limiting the incentives for GPs to provide young people with adequately long appointment times. O'Regan and Wilton (1997) and Success Works (1999) found that the multidisciplinary team environment of youth health services provides GPs with access to high quality professional development and support that enhances their skills in working with young people at risk. This conclusion is particularly noteworthy in view of the finding that one-off training sessions appear insufficient to support meaningful behaviour change in GPs across a comprehensive range practices and that practice-based learning approaches may be required (see Chapter 3, Volume One of this Technical Report series; and Davis, Thomson, Oxman and Haynes 1992).

TABLE 2.5	Essential elements of the Youth Health Service model
Target population	Adolescents and young adults (no specific age limits) with a focus on marginalised young people at high risk of poor health outcomes.
Key theoretical concepts	Primary Health Care Youth specific service Emphasis on access, engagement, non-judgemental, outreach, responsiveness Holistic service provision Advocacy for young people's access to other services Youth involvement in service development
Location and environment	Community based, accessible central location, close to public transport, schools and youth venues Preferably a converted house, with comfortable relaxed furnishings
Roles	Range of services relevant to youth including: • Medical services • Counselling • Health promotion • Community education • Primary prevention • Drug and alcohol services • Sexual health care • Basic care facilities (eg showers, cooking) • Welfare and advocacy
Staffing	Multidisciplinary including GPs, Community Health Nurses, youth workers, counsellors or psychologists, arts workers

O'Regan and Wilton (1997) also observe that young people at high risk of poor health outcomes frequently use a large number of different services but receive little benefit from these. They suggest that the improved service coordination and stability of engagement offered by the youth health service model may offer considerable cost effectiveness savings compared to the fragmented assortment of services usually available to young people at high risk. Finally, O'Regan and Wilton (1997) note that a number of youth health services have been successful in involving young people in the development and ongoing management of services, an achievement rarely matched by mainstream health services.

A number of National Strategy projects targeting young people who are marginalised and disaffected and at high risk of suicide were based in youth health services (see Chapter 2, Technical Report Volume Four). These evaluations found evidence that such services were effective at engaging youth at high risk of suicide who had previously had negative experiences with mainstream services including general practitioners. Many of the young people using these services were suffering from serious mental disorders including depression, substance misuse disorders, personality disorders and psychosis and were not being treated by mainstream mental health services. Little information was provided in the project reports about the forms of treatment that were being provided for these mental health problems other than long term counselling therapy and other general medical and support services. The precise extent to which youth health services are the sole or major providers of mental health care for young people with mental disorders and the nature of treatments being provided are important questions for further research.

The characteristics of the youth health services that were identified by the Strategy project evaluations as facilitating engagement of these alienated young people (for example, holistic service provision, being non-judgemental, informal treatment styles, giving young people time to engage at their own pace) have been previously identified as characterising many such youth health services (O'Regan and Wilton 1997; NSW Health 1999; Success Works 1999). This suggests the strong potential of the youth health service model for expanding the range of options that are available for providing mental health services to young people and improving the quality of care. It has been recommended in Technical Report Volume Four that demonstration projects be funded to evaluate the relative effectiveness of a number of alternative approaches to enhancing the capacity of youth health services to provide mental health services (within a holistic approach) to young people whose needs are not being addressed by other services.

The fruitfulness of this strategy will depend heavily upon the strength of the youth health service approach within the broader primary health care sector. Unfortunately there is evidence that the youth health service approach is relatively marginalised and underfunded, even compared to other primary health care services. The National Youth Suicide Prevention Strategy did not give adequate attention to the potential role of youth health services within the perspective of the primary health care approach. These gaps need to be addressed in future suicide

prevention initiatives in the primary health care field. Considerable work is needed at the state and territory government policy level. A key role for the new National Suicide Prevention Strategy will be to advocate for the further development of models of primary health care that are appropriate for young people at risk of suicide and which are capable of supporting the full range of suicide prevention activities identified as requiring the involvement of the primary health care sector.

At least one state government has recognised that youth health services are not available to all young people throughout the state, particularly young people in rural areas, and has recommended that all Area Health Services identify at least one Community Health Centre and develop this Centre to be "youth friendly" (NSW Health 1999: 24). While this recommendation allows for considerable flexibility in the range of models that could be used, it is also stated that: "In order to increase access to services, existing successful models should be further developed and where appropriate, replicated or modified to suit local circumstances" (NSW Health 1999: 25).

It is recommended that governments work in partnership with Divisions of General Practice, Mental Health Services, and youth health services to identify strategies for expanding the range and quality of primary health care services available for young people at risk of suicide. General models could include: community-based youth health services; multipurpose youth services; and GP Mental Health Shared Care (*Recommendation 2.1*).

Specifically, it is strongly suggested that all state and territory governments, and Divisions of General Practice, consider ways in which they might encourage the wider establishment of community-based youth health services, especially in rural and regional areas (*Suggestion 2.1a*).

Unfortunately, despite strong consensus about their benefits, community-based youth health services established by Divisions of General Practice have experienced difficulties in recruiting general practitioners to work within them (O'Regan and Wilton 1997). Some GPs have requested assurance that such services are addressing unmet need and are not competing with existing services. As noted by O'Regan and Wilton (1997), this highlights the importance of ensuring that development of such services takes place within the context of community-based needs assessment and broad consultation with stakeholders, including GPs, other service providers, and young people (*Suggestion 2.1b*).

The Access Support and Evaluation Resource Unit (1999) has produced a guide for general practitioners and Divisions of General Practice on improving young people's access to health care through general practice. This guide contains a section on youth health needs assessment. It also contains sections on policy development, health promotion and monitoring and evaluation.

The importance of considering and involving all relevant services in such needs assessment raises questions about the responsibilities of different parties in

primary health care service planning and development. As noted previously and elsewhere (see Chapter 4 Technical Report Volume One), informal networking and consultation between services is not an adequate alternative to formal collaboration. There is a need to establish mechanisms or structures that can support a genuine partnerships in service planning and delivery. State and territory governments have a critical role to play in this regard. The Primary Care Partnerships Strategy administered by the Victorian Government Department of Human Services (2000) is an example of the kind of initiative that may be required on the part of state and territory governments.

There are also strong arguments for increasing the direct involvement of mental health services with primary care providers (see Chapter 3 Technical Report Volume Two and Chapter 1 Technical Report Volume Four). Much of the work that has been conducted on GP-Mental Health Shared Care models has relevance to development of collaboration between mental health services and other primary health care providers including community and youth health services. States and territories, Divisions of General Practice and Area Mental Health Services need to consider ways of promoting wider adoption, within general practice as well as other primary health care settings, of models of Shared Care that have been found to be beneficial. Future youth suicide prevention activity in the area of Mental Health Shared Care should focus on identifying the most effective models of "working together" including models of collaborative service provision and collaborative delivery of early intervention and primary prevention programs (*Suggestion 2.1c*).

A meta-evaluation of models or projects that have been documented in some form would be valuable. This meta-evaluation needs to identify which kinds of models are best suited to advancing collaboration within the various approaches to youth suicide prevention, and provide a critical analysis of factors in service environments that can inhibit and facilitate the development of partnerships. Information about effective models needs to be communicated to mental health service managers and policy makers and incorporated into national and state/territory policies and plans.

Structural and systemic barriers may also have worked to limit the wider uptake of models of Shared Care in mental health service provision for young people. Most of the Shared Care models that have been identified may suffer from very real limitations in their capacity to address structural barriers operating in many service environments. The Integration Support and Evaluation Research Unit (1998) has noted that some organisational changes are generally required on the part of mental health services if they are to successfully adopt Shared Care approaches. Many mental health services might be expected to experience difficulties in making these adjustments without clearer guidance about the kinds of changes that are necessary. Service development research is required to identify the broader service characteristics that are associated with mental health services embracing the Shared Care approach (*Suggestion 2.1d*).

Primary health care and health inequalities

Another shortcoming of National Youth Suicide Prevention Strategy efforts in the area of primary health care concerns social and health inequalities. *The Health of Young Australians: A health policy for children and young people* (Commonwealth Department of Health and Family Services 1996) identifies social inequality as a major cause of health problems and inequalities in the health status of young Australians. For the past 20 years the World Health Organisation has maintained its position that the Primary Health Care approach is fundamentally important for addressing risk factors derived from social inequality. The Primary Health Care approach as defined by the World Health Organisation is a philosophy that aims to alter major sociopolitical barriers to achieving and maintaining health, such as poverty, unemployment, ethnic, gender and religious discrimination (Barnes et al. 1995).

A critical strength of the Primary Health Care approach in this regard is its emphasis on population-based needs assessment and the involvement of local community members in the planning, design, management and evaluation of services and programs. This also makes the Primary Health Care approach particularly useful in addressing the health disadvantages suffered by people in marginalised ethnic groups such as Aboriginal and Torres Strait Islander people and people from non-English-speaking backgrounds (Mitchell et al. 2000).

The Primary Health Care approach, including community control of health service planning, has been identified as particularly important for improving the emotional wellbeing of Aboriginal and Torres Strait Islander people (Swan and Raphael 1995), and enhancing the mental health service provision capacity of primary health care services forms the central thrust of the *Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan* (Commonwealth Department of Health and Family Services 1996). An important role for the new National Suicide Prevention Strategy will be to work more closely with the primary health care initiatives of this action plan, the Office of Aboriginal and Torres Strait Islander Health, and the National Aboriginal Community Controlled Health Organisation, to identify and advance promising models of primary health care for indigenous youth (*Recommendation 2.2*).

Recommendations and suggestions

It is recommended that:

2.1   Governments should work in partnership with Divisions of General Practice, Mental Health Services, and youth health services to identify strategies for expanding the range and quality of primary health care services available for young people at risk. General models could include: commu-

nity-based youth health services; multipurpose youth services; and GP Mental Health Shared Care.

(This is Recommendation 14 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

2.1a All state and territory governments and Divisions of General Practice should give consideration to ways in which they might encourage the wider establishment of community based youth health services, especially in rural and regional areas.

2.1b Development of such services should take place within the context of community-based needs assessment and broad consultation with stakeholders including GPs, other service providers and young people.

2.1c States and territories, Area Mental Health Services and Divisions of General Practice should consider ways of promoting wider adoption of models of Mental Health Shared Care, both within general practice and other primary health care settings. Future youth suicide prevention activity in the area of Mental Health Shared Care should focus on identifying the most effective models of "working together" including models of collaborative service provision and collaborative delivery of early intervention and primary prevention programs.

2.1d Service development research should be conducted to identify factors in the mental health service environment that are associated with successful implementation of Mental Health Shared Care.

It is recommended that:

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

(This is Recommendation 15 in the evaluation overview, "Valuing Young Lives".)

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Map of program logic: general practice and primary care

Goals/outcomes

- Reduce rates of completed suicide among young people who present to general practitioners and other primary care services.

- Reduce rates of suicide attempt and deliberate self harm.

- Enhance the mental health and wellbeing of young people who present to general practitioners and other primary care services.

Objectives/impacts

- Young people experiencing problems are provided with the support, care, knowledge and skills that enable them to develop positive solutions and avoid the emergence of crises.

- Increase the proportion of young people with mental health problems and other risk factors for suicide who regularly visit a general practitioner or primary care service.

- Increase the satisfaction of young people with services received from general practitioners and other primary care services.

Aims/processes

- Enhance the quality of care provided to young people with mental health problems and other psychosocial problems presenting to general practice and other primary care services.

- Expand the accessibility, diversity and appropriateness of primary care services for young people with mental health and other complex problems.

- Expand the availability of primary health care services and programs appropriate for indigenous young people.

- Enhance the knowledge, skills, competencies and practice of general practitioners and other primary care professionals in working with young people.

Performance indicators

- Availability of "youth friendly" and culturally appropriate primary care services within catchment areas, especially in regional and rural areas.

- Development of formal partnerships between Divisions of General Practice, mental health services, youth health services, Aboriginal Community Controlled Health Organisations and other primary care services.

- Implementation of regular community-based health needs assessment including youth health needs assessment.

- Involvement of young people along with other consumers and carers in local primary care service planning.

Telephone counselling

This chapter presents and analyses information about the projects funded under the National Youth Suicide Prevention Strategy that were based in telephone counselling services settings.

The goal of this group of projects was to reduce rates of suicide attempt and deliberate self harm among young people who make calls to telephone counselling services.

The two projects in this group aimed to improve the quality of telephone counselling services provided to young callers at risk of suicide and strategically enhance the role played by these services in the national effort to prevent suicide among young people.

The projects did not aim to evaluate the efficacy or effectiveness of telephone counselling in reducing rates of suicide or self harm among young people, and it is acknowledged that evidence of this effectiveness is currently lacking. Rather, based on the evidence that is available, there is an assumption that telephone counselling can be of considerable value, provided certain conditions and standards are met. The projects sought to improve the quality of service provision in the direction of these standards as identified in the literature.

The literature reveals three main reasons why telephone counselling may not be effective: services may fail to reach those at greatest risk; the assistance and advice may not be appropriate or acceptable; no systematic attempts are made to follow up the caller to encourage compliance with advice or help resolve difficulties in help seeking.

Specific aims of the projects have been to:

- increase the use of telephone counselling services by young people at risk;
- enhance the capacity of community gatekeepers to identify and refer young people at risk by building networks and providing training to parents, peers and other caregivers;

- increase the effectiveness of suicide crisis intervention by building the competencies of telephone counsellors in youth suicide intervention and enhancing continuity of followup care for callers at risk; and

- strengthen service accountability, strategic planning and evaluation.

One of the projects (*Lifeline)* focused on all four of these aims, while the other (*Kids Help Line*) focused on the third and fourth.

Telephone counselling projects

As shown in Table 3.1, two projects are included in this group: the Lifeline Australia Youth Suicide Prevention project, and the Kids Help Line Suicide Intervention Strategy.

At the time of writing, *Lifeline* provided an Interim Evaluation Report only. Several components of the project were still in the process of being evaluated at the time the Interim Report was submitted, and only preliminary data were available for inclusion in this Technical Report of the evaluation of the National Strategy.

Lifeline

Lifeline is a well known national telephone counselling service available to all age groups. Lifeline's telephone counsellors seek to offer hope by providing

TABLE 3.1	Summary of telephone counselling activities of the Strategy		
Project name	**Organisation**	**Main strategies**	**Evaluation design**
Lifeline Australia Youth Suicide Prevention Project	Lifeline Australia	Research with young people; analysis of service utilisation data; staff training; development of a supervisor manual; caller follow-up; community education; development of a nationally networked referral database; variety of local projects	Monitoring changes in service utilisation; measurement of changes in staff knowledge, confidence, and attitudes; assessment of client satisfaction, impacts and outcomes.
Kids Help Line Suicide Intervention Strategy	Kids Help Line	Staff training; analysis of service utilisation data	Monitoring service utilisation data; measurement of changes in staff knowledge, skills, competency and behaviour using a standardised ratings instrument (and comparison with a control group); assessment of client satisfaction, impacts and outcomes using a standardised ratings instrument.

help to all callers and particularly to young people at risk of suicide and families affected by suicidal behaviour. Counsellors work at Lifeline on a voluntary basis, receive thorough training, and are supported by paid professional staff.

Lifeline's commitment under the Strategy was to: (i) increase the use of Lifeline by young people at risk of suicide; (ii) provide networks and training to help parents, peers and other caregivers to identify and refer young people at risk; (iii) enhance telephone counsellors' competence in youth suicide intervention; (iv) promote follow-up care for callers at risk; and (v) and strengthen service accountability and forward planning.

Focus groups with young people were used to inform a comprehensive strategy designed to promote awareness and utilisation of Lifeline by young people at risk of suicide. Four new training resource modules were developed and implemented and are in the process of being evaluated. Seventy-two people, not including Lifeline staff, were trained in Lifeline's suicide awareness and intervention skills workshops – LivingWorks – increasing the proportion of trainers from outside Lifeline and forging a wider range of community partnerships through the workshops. Over 5000 people have participated in LivingWorks two-day suicide intervention workshops since the program was first introduced in 1996.

Eighteen local initiative projects were implemented by regional Lifeline centres via an internal submission bidding process. The projects addressed local factors involved in youth access to telephone crisis counselling as well as continuity of care and community skills training.

A computerised database was developed to enter data at each centre and send it electronically to one data collection point. A standardised 24-item anonymous data gathering instrument was piloted and then introduced into all 42 Lifeline crisis centres. Detailed profile data are now available on over 22,000 suicide related calls received by Lifeline during 1998, providing a much clearer picture of the characteristics and needs of people who call Lifeline in crises surrounding suicide. The database will be available to all centres.

Overall, the project has embedded new principles, practices and accountabilities within the operations of Lifeline centres. Central to this is the empowering of local centres (with their variable resource strengths) to embrace a culture of service evaluation in practical, achievable ways.

Kids Help Line

Funded by Boystown Family Care, Kellogg and Optus, Kids Help Line is a national telephone counselling service for children aged 5–18 years. Kids Help Line seeks to provide a child-centred service to callers, which focuses on the needs and wider social environment of the child. Empowerment is a central objective of Kids Help Line, and the "development of personal competence and resilience" to enable "young people to influence their world in a positive manner".

Kids Help Line received National Youth Suicide Prevention Strategy funding to promote and extend the reach of services, enhance counsellor suicide management skills, and upgrade equipment. Funding was also used to evaluate the service and to undertake a comprehensive analysis and evaluation of caller trends. A number of newsletters and other publications were produced which examined data on calls to Kids Help Line concerned with suicide issues. Enterprise Competency Standards for Kids Help Line staff were also developed.

The analysis of Kids Help Line call data showed that the vast majority of callers to the service have issues peripheral, but nevertheless related to mental health, including relationship, family, school, employment and financial issues, as well as substance use and self-concept issues. Preliminary results indicated that the call rate relating to all aspects of mental health had increased significantly, and that the call rate relating directly to suicidal intent and ideation had doubled (although callers at risk of suicide represented only about 0.5 per cent).

Results of the evaluation

Information from the evaluation of the Lifeline and Kids Help Line Projects is organised into four domains which correspond closely to the aims of the projects:

- increasing the use of telephone counselling services by young people at risk;
- enhancing the capacity of community gatekeepers to identify and refer young people at risk;
- increasing the effectiveness of telephone counselling based suicide crisis intervention; and
- strengthening service accountability, strategic planning and evaluation.

What works to increase the use of telephone counselling services by young people at risk?

The Lifeline Project included substantial efforts to enhance the quality of service use data. It is planned to monitor changes in caller profiles as one method of evaluating whether initiatives of the project have been effective in increasing service utilisation by young people at risk of suicide.

In 1998 Lifeline responded to over 430,000 calls. The largest percentage of callers were in the 35–54 year age group (41 per cent) and 25–34 year age group (34 per cent). Young people aged 20–24 comprised 11 per cent of callers while young people aged 15–19 comprised 3.7 per cent. Only 0.4 per cent of callers were in the 0–14 age bracket. Note that the age of the caller is estimated by telephone counsellors in 60 per cent of cases. Actual ages are more likely to be given by younger and older callers. Females are greater users of the service in all age

groups. The proportion of males using the service is lowest among the 15–19 year age group (20 per cent) but is as high as 39 per cent in some older age groups.

Over 20,000 of the calls received during 1998 were related to suicide, mostly suicidal ideation of the caller. This represents between 4–8 per cent of all counselling calls depending on the centre. About 15 per cent of these were from young people aged under 25. Males comprised 35 per cent of suicide-related calls in all age groups, but this figure dropped to 20 per cent in the 15–19 year age group. The majority of suicide-related calls (81 per cent) were related to the caller's own thoughts of suicide while 15 per cent involved concern about someone else's risk.

The Lifeline Project also began to collate and analyse data about population characteristics in order to provide a context for interpreting patterns of service use and to provide more reliable estimates of service reach and relative accessibility for different population groups.

Data were collected for insufficient time to allow accurate identification of any changes in caller profiles as a result of the project strategies (see below). However there was an apparent increase in suicide related calls. This is thought to be due to counsellors' increased sensitisation to detecting and responding to suicidality and to more precise information gathering. It is concluded that substantial barriers to access for young people remain in place.

Currently available information about the effectiveness of strategies to enhance service utilisation by young people at risk largely consists of the perceptions of project staff and evaluators about what appears to have been useful.

➤ *Develop a stronger understanding of the client group*

Lifeline conducted 42 focus groups involving over 400 young people from around Australia. The sample consisted of groups of young people who had experienced one or more known risk factors for suicide. Over half of the participants were young males. Particular attention was given to including those living in remote areas or marginalised by homelessness, ethnic background or sexual preference. Methods of recruitment are not reported. Eighty-nine youth organisations were also interviewed.

Although recognition of Lifeline's name was universal, young people's knowledge of how to access Lifeline varied across the country. Only 6 per cent knew the national Lifeline phone number and only one in five young people said they would call if they were thinking about suicide.

Project evaluators (Rolfe and Turley 1999: 1) reflect that "these findings need to be understood in the context of young people's frequent preference for peer rather than adult help".

Project staff and evaluators report that the information from the consultation with young people was valuable for informing the design of project publicity and has

generated plans to improve the youth-friendliness of the service. The impact of the publicity strategy is still being evaluated.

Some young people from the focus groups were retained as members of a reference group for the remainder of the project.

The Lifeline Interim Evaluation Report identifies the need for Lifeline to strengthen its understanding of and links with youth culture and youth networks and organisations. Based on feedback from the focus groups and the well-established preference of many young people for talking with their peers, the interim report recommends that Lifeline develop a strategy for recruiting a greater proportion of young people as telephone counsellors.

The Lifeline Project also conducted a case study involving analysis of service use data and comparison with population data in a number of regions of Western Australia. Despite a disappointing level of participation by some centres in the collection of necessary data, this study provided an interesting picture of the pattern of calls across different areas that is potentially useful for informing the design of more effective local targeting and service promotion strategies. Areas characterised by social disadvantage and poor availability of health and social services tended to have a high concentration of calls.

➤ Promote the service

A range of methods was used to promote community awareness of Lifeline's national telephone number as a source of support. While the community training workshops (see below) were not aimed at promoting Lifeline they nevertheless provided an important opportunity for raising awareness of the services Lifeline offers.

Following findings from the focus group consultation with young people, Lifeline has also aimed to promote Lifeline's services in a more youth-friendly manner that involves young people in the process. Initial publicity was directed to the whole population of young people. This has shifted to a focus on high risk groups and individuals. Specific initiatives have included community service announcements, a folding card and messages on beer coasters.

Much of the service promotion activity took place as part of projects based in 18 local centres. Specific initiatives related to service promotion that were included in these local projects include: production and distribution of stickers and cards; locally based advertising; development of partnerships with local agencies; trial of a local free-call phone line; trial of a special Youthline; trial of a designated buddy counsellor system; and a help-seeking project in a prison.

In addition to monitoring of service use data described above, impacts of service promotion activities are being monitored via street surveys in four regional centres. Baseline data indicate that young people under 25 years are less aware of

Lifeline than respondents in older age groups. Males, particularly young males, are less aware than females. Data from the second, post-campaign survey are not yet available. Evaluations of a number of local projects revealed substantial increases in calls to Lifeline from young people in those localities.

What works to enhance the capacity of community gatekeepers to identify and refer young people at risk?

➤ *Training workshops*

The Lifeline Project chose to expand the availability of the LivingWorks suicide intervention training programs. LivingWorks is a two-day workshop designed to increase participants' ability to intervene with a person at imminent risk of suicide. Their emphasis is on suicide first aid – learning how to recognise and refer a person at risk. LivingWorks programs have been operating in Canada and the United States since the early 1980s.

The Commonwealth funded field trials of the LivingWorks program prior to the National Youth Suicide Prevention Strategy. Evaluation data collected during the field trials indicated a significant and stable increase in participants' readiness for suicide intervention as indicated in self reported levels of comfort, confidence and competence to intervene with a person at risk. These changes were found to be stable at four months follow-up. Workshop attendance also facilitated clarification of values and beliefs about suicide, and there were moderate trends towards a greater willingness to intervene and greater optimism that intervention could make a difference (Turley and Tanney 1998 cited in Rolfe and Turley 1999).

The Lifeline Project funded under the Strategy involved provision of training to new groups of workshop leaders and the conduct of a new series of workshops. Since the new leaders were trained in May 1998, over 115 Suicide Intervention workshops and 70 Suicide Aware presentations were conducted in all states and territories and these were attended by over 3500 people.

Evaluation work conducted for the Strategy project is assessing the extent to which changes in knowledge, confidence and comfort translate into increased skills and enhanced competency in responding to simulated suicide intervention situations. The evaluation will also seek to identify whether the training results in increased referral of young people at risk to appropriate services. Results of this evaluation research are not yet available.

A survey of the current base of LivingWorks trainers was conducted during 1999. Sixty-five of the total 126 trainers as at March 1999 participated. All of the trainers rated the program positively and the majority (83 per cent) planned to continue in the role. A number of constraints were identified including time

constraints imposed by other work commitments, lack of support in organising workshops, costs involved for trainers and participants and the lack of support in promoting LivingWorks. The absence of other trainers was an issue for several respondents in rural areas. Since the survey regional coordinators have been employed and it is anticipated that these staff will provide support in addressing these constraints.

➤ Build community networks

The LivingWorks training workshops have an advantage of bringing together professionals from a variety of organisations as well as individuals from the community thereby providing opportunities for participants to form links with one another. The opportunity provided by such training events has also been observed by staff and evaluators of several other projects that conducted suicide prevention training workshops for mixed groups of professionals. The Lifeline Interim Evaluation Report recommends the development of a strategy to build on the networking potential provided by the workshops.

The evaluation of the LivingWorks programs referred to above will seek to identify whether there is enhanced collaboration among service providers as a result of attendance at the workshop and whether this impacts on referral of young people at risk to appropriate services.

What works to increase the effectiveness of telephone counselling based suicide crisis intervention?

Both Lifeline and Kids Help Line included measurement of outcomes for young people among the methods used to evaluate project efforts to increase the effectiveness of suicide crisis intervention. Lifeline used a three-month follow-up study of a sample of young callers under 25 years of age. The follow-up study examined a range of indicators including those concerned with client satisfaction, impacts and outcomes.

The Lifeline three-month follow-up study involved the use of structured questionnaires administered over the phone by trained interviewers who were not associated with the original counselling call. Young people were contacted three times: approximately one week, five weeks, and twelve weeks after the index call. The follow-up study encountered substantial methodological problems which have reduced the representativeness of the follow-up sample. Only 16 of the 42 Lifeline centres participated in the study. There was strong reluctance on the part of some counsellors to invite callers to participate. Some centres had higher participation rates than others. Only 53 per cent of eligible callers were invited to take part in the study. Callers not asked for consent were significantly more likely to

have a suicide plan and access to means. More females than males were included. A total of 76 callers were eventually followed up but participation dropped off over the three follow-up points. Thirty young people completed all three follow-up interviews.

The Lifeline follow-up found that a large majority of respondents under 25 years of age were satisfied with the service, with around 84 per cent rating it as either helpful or very helpful and very good or good. Satisfaction levels of young people were sustained over the three month follow-up period. Some critical comments included concern around the long delays sometimes experienced in getting through to Lifeline and the fact that Lifeline could offer no immediate practical help. Several young callers expressed dissatisfaction with having to talk to a different counsellor each time they call and having to retell their story.

In terms of impacts it was found that the majority of respondents followed through with one or more of the referral options provided to them by the telephone counsellor. The proportion who did so increased over the course of the follow-up from two-thirds at week one to 90 per cent at week 12. Ninety-three per cent of those who took action found the actions taken to be helpful. A sizable minority of respondents reported that the problem they had called about had either resolved or got better. This proportion increased from 38 per cent at week one to 54 per cent by week five and 46 per cent by week twelve. However, the problem had got worse for 21 per cent of respondents by the twelfth week.

Outcomes, assessed in terms of suicidal ideation did not show such impressive effects. At the initial call, 88 per cent of participants had current thoughts of suicide or self harm. At the week one follow-up 60 per cent of respondents reported still experiencing thoughts of suicide. This did not decrease further over the three-month follow-up period.

The Kids Help Line evaluation examined implementation (or process), impacts and outcomes. The outcome data is the most relevant of these in attempting to address the question of the effectiveness of telephone counselling based suicide intervention. Kids Help Line examined immediate outcomes for young callers using standardised independent ratings of tape recordings of real counselling sessions. A standardised rating instrument was developed especially for the purpose. Ratings were made by members of the evaluation team as well as Kids Help Line supervisors. Inter-rater reliability was found to be acceptable for the majority of items. A total of 100 suicide-related calls were taped and analysed. In 22 cases, a suicide was actually in progress or the caller was regarded as in imminent danger of completing suicide.

The data indicate that young people's levels of suicidal ideation, suicidal intent and general emotional distress were significantly reduced during the course of telephone counselling sessions.

➤ *Build the competency of telephone counsellors in youth suicide intervention*

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.

Implementation evaluation of the Kids Help Line Project involved benchmarking the content, duration and process of training against standards extracted from the international literature and determining the reach of training. The evaluators were satisfied that the Kids Help Line training was consistent with current international guidelines.

Impact evaluation of the Kids Help Line training involved objective testing of counsellor knowledge and self-reported counsellor efficacy in a range of suicide prevention tasks before and after training. Significant increases were observed in overall counsellor self efficacy as well as knowledge of risk factors for suicide, lethality indicators, protective factors, and crisis management steps. King, Nurcombe and Bickman (1999) note that the increases in knowledge were from a very low base, and in some areas the post training scores remained below 50 per cent of the maximum possible. However, they conclude that the training was effective in its basic educational processes.

Data from tape recordings of real counselling sessions were used to assess the actual skills and competencies of Kids Help Line counsellors. Ratings were generated for a large number of specific skills and behaviours. In general counsellors were rated as having good or adequate emergency intervention, risk assessment, crisis intervention and general counselling skills. They were rated as being relatively weaker in imminent danger intervention, referral and termination. Around 60–70 per cent of counsellors were identified as requiring further development of most specific skills in these areas.

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 or effectiveness were increased for those counsellors 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 results could suggest that training was not effective, however it is also possible that factors related to counsellor self selection reduced the ability of the evaluation to detect any effects. For example, counsellors who did not attend training may have had higher base levels of competence or they may have already received suicide intervention training elsewhere.

The Lifeline Project developed training modules for counsellors as well as manuals for supervisors. One training module focused mainly on the telephone counsellor's role in suicide risk management. Another focused specifically on counselling young people. Evaluation of the Lifeline training included seeking feedback from the trainers via surveys on two occasions – two months after the orientation workshop and again nine months later. The surveys indicated a high level of acceptance of the new resources and satisfaction with the orientation workshop. A manual produced for training of supervisors on call attracted highest levels of support.

Impacts on the knowledge, attitudes and skills of Lifeline counsellors were also evaluated via a survey conducted before and after training. Preliminary results from a small sample of trainees who completed both surveys (n=29) are reported as demonstrating significantly higher readiness to intervene in a suicide, significantly increased optimism in relation to perceived outcomes of intervention and a significant increase in suicide intervention knowledge at the completion of training. Data collection and analysis of trainee survey data are continuing. A three-month follow-up is also being conducted to determine the sustainability of changes over time.

Evaluation of the *Lifeline Supervisor on Call Manual* revealed that supervisors in centres where the manual was being used demonstrated significantly greater knowledge of supervision in relation to suicide calls than supervisors in centres that had not implemented the manual. Counsellors in centres that had implemented the manual had significantly more positive attitudes about the supervision they received.

The Lifeline training evaluation did not include a control group. Thus it is not possible to determine whether the effects observed were due to training or to an extended period of increased focus on suicide within the organisation. The Interim Evaluation Report authors (Rolfe and Turley 1999) suggest that future evaluation of training would benefit from including comparison groups where participants are exposed to no training as well as groups that are exposed to different forms of training such as purely didactic compared to experiential (Tierney 1994).

Five key aspects of training emerged from the Lifeline and Kids Help Line Projects as being important in determining its overall effectiveness: amount of training; content of training; reach or coverage; practice, and counsellor self efficacy.

➤ *Amount of training*

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. King et al. conclude that training should be provided continuously.

➤ Content of training

King et al. (1999) stated that the Kids Help Line training modules "impressed" them as covering most of the priority content areas. The priority content areas identified were:

• knowledge of and capacity to assess risk factors;

• crisis intervention, especially management of imminent danger;

• knowledge of mental health factors and the relationship between mental disorders and suicide risk;

• self knowledge, especially awareness of how personal attitudes and values affect the counselling of a suicidal person; and

• ability to access and refer to appropriate specialist treatment services.

The only area of content weakness in the Kids Help Line training identified by King et al. (1999) was mental disorders and mental health assessment. Specifically they were concerned that there was little or no attempt to identify and describe major forms of mental illness that are associated with high risk for suicide. Where mental health issues were covered, it was noted that terms used were somewhat inconsistent with conventional psychiatric terminology.

Some Lifeline centres reported difficulty incorporating the new training manuals into their regular training programs. This suggests that some centres were attempting to modify the materials. Others have provided suggestions for revision of some of the materials. Some of this feedback was noted as contradictory. Smaller and less well resourced centres tended to find the materials more valuable than larger centres. At the orientation workshop several participants commented on the value of having a uniform Australian telephone counsellor training program, materials and terminology.

The Lifeline Interim Evaluation Report recommends that appropriately qualified experts should review the staff development process to determine the final content of the training resources.

➤ Reach or coverage

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 projects experienced difficulty achieving adequate coverage of their counselling workforce. For Lifeline this was mostly due to the highly decentralised nature of the organisation. This is not a problem for Kids Help Line which

operates from a single national centre. High staff turnover was the major barrier to adequate coverage here.

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. King, Nurcombe and Bickman (1999) find that the reach of training was less than optimal but note that it may be difficult to achieve higher coverage with a casual workforce and regular staff turnover.

King, Nurcombe and Bickman (1999) conclude that the only way to ensure that all staff receive suicide prevention training is to provide frequently repeated training modules or restrict recruitment to people who have received comparable training elsewhere. They also note that whether this is warranted depends on careful impact and outcome evaluation of such training.

Lifeline employed a train-the-trainer model to extend the reach of training. Once the resources were completed, trainers from every 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.

A major problem for the Lifeline training initiative is that 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 Lifeline Interim Evaluation Report 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.

➤ Practice

King, Nurcombe and Bickman (1999: 49-50) hypothesise that the failure to observe increased counsellor competence or effectiveness in those Kids Help Line 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 before their performance was tested. They say: "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."

➤ 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.

➤ *Enhance continuity of follow-up care for callers at risk of suicide*

Sixty per cent of respondents in the Lifeline follow-up study reported still experiencing thoughts of suicide one week after their index call. This did not decrease further over the course of the 12-week follow-up period.

Lifeline Project staff and evaluators interpret this result as highlighting the importance of providing systematic follow-up in the form of professional help to individuals who contact telephone counselling services with a suicidal crisis.

At the time of the initial call, 73 per cent of callers under 25 in the follow-up study were currently in contact with some other form of support. The most common sources were family (27 per cent), psychiatrists (24 per cent), general practitioners (24 per cent), friends (22 per cent), and counsellors (22 per cent). These findings are interpreted as indicating that telephone counselling is part of a network of supports used by young people.

Other mental health related problems as well as difficulties with psychiatric services were prevalent as a current crisis or background issue. It is also notable that less than 40 per cent of persons "of concern" were thought to be accessing support. Many of those who were accessing support were likely to be receiving it from family or friends.

Seventy-eight per cent of participants in the follow-up study were given some form of referral advice at the time of their initial call. By week one, two-thirds of respondents had followed through with one or more of the referral options provided to them by the telephone counsellor. Significantly more females than males took some form of action. Over half the participants in the study saw a counsellor at some stage after their call to Lifeline. Callers who were given referral information were more likely to take action than those who were not given referral information but this difference was not statistically significant.

It is particularly noteworthy that the percentage of respondents who had taken action increased over the follow-up period from 68 per cent at week one to 80 per cent at week five and 90 per cent at week twelve. This increase in percentage taking action over time could have been prompted or enhanced by the follow-up process. The original evaluation design included a control group that was only followed up at twelve weeks. Unfortunately, the centres allocated to this group had very low participation levels and only three callers were allocated to this group.

Of those who took actions suggested by the Lifeline counsellors, by week one 97 per cent found the actions taken to be helpful. The percentage seeing these actions as helpful decreased slightly by week five (87 per cent) and week twelve (72 per cent), but this effect was not significant.

The main strategy used by Lifeline to enhance follow-up care for callers at risk was the development of a nationally networked referral database. The database

contains over 23,000 records ranging from sources of emergency help to providers of ongoing assistance and support. Development of the database has taken longer than expected and Lifeline only commenced use of the database in late 1999. Evaluation is currently taking place.

Rolfe and Turley (1999) note that the Lifeline final evaluation report will document further results and provide discussion of broader issues surrounding the way in which Lifeline and other telephone counselling services relate to the wider spectrum of mental health and suicide intervention services.

The Lifeline Interim Evaluation Report recommends that Lifeline counsellors receive specific initial and ongoing training to improve their understanding of help seeking in young people and knowledge of youth services in their local community. It is also recommended that Lifeline consider trialing a systematic call back system for young callers at risk within all Lifeline Centres.

What works to strengthen service accountability, strategic planning and evaluation?

➤ *Address the culture of the organisation*

The Lifeline Project team note that research and evaluation have not been strongly supported or practiced within the telephone counselling service culture. It was recognised early in the course of project planning that rigorous evaluation of the project and Lifeline services in general would require a shift in the culture of the organisation.

Several philosophical principles underlying the telephone counselling approach combine to create an organisational culture which views certain key activities required for evaluation with concern and scepticism. Perhaps the most important cultural barrier to evaluation within telephone counselling services derives from the long standing commitment of such services to the principle of complete confidentiality and anonymity for callers. Asking callers for information that is required to conduct follow-up, such as contact phone numbers is seen as directly contradictory to this principle. Some counsellors were even reluctant to ask for information required to monitor service utilisation patterns such as postcodes and other basic demographic details because it was seen as intrusive and possibly threatening to confidentiality.

The Lifeline Project involved a difficult process of challenging this thinking and encouraging counsellors to understand that quality assurance can coexist with client confidentiality. The project team conclude that the evaluation component of the project has played an important role in developing a greater awareness of the need for accountability and the importance of evidence-based practice within the service. As counsellors learned from experience, asking for a few simple items

of information did not compromise rapport with callers nor violate anonymity, cooperation with data collection and attitudes towards evaluation improved.

➤ Provide adequate resources

Rolfe and Turley (1999) feel that the substantial financial commitment to evaluation provided by the project has given both resources and impetus to enhance Lifeline's ongoing commitment to evaluation. However, despite goodwill and good support for the project, local centres were found to experience difficulties in stretching limited resources to cover both service delivery and evaluation requirements. While most centres recognised the importance of service evaluation, they needed considerable support to accomplish evaluation tasks.

➤ Build management and supervisory structures

Some Lifeline centres had high levels of participation in evaluation activities while others did not. This suggests that the ways in which centres are managed and supervised have a strong impact on the willingness of counsellors to become involved in evaluation.

The organisational structure of Lifeline was also seen as exacerbating the difficulty of implementing organisational changes through policies and procedures. Each Lifeline centre is largely autonomous and retains local responsibility for setting service and budget priorities.

This problem is not unique to Lifeline, it characterises many service systems and arose as an issue for a number of Strategy projects. The severity of the problem varies across the states and territories. Some states such as Victoria and Queensland have power more centralised with state government departments, while in others power is more decentralised to area and regional authorities. Advantages and disadvantages of both systems have been identified in the public policy literature.

➤ Provide appropriate technical tools

The authors of the Lifeline Interim Evaluation Report suggest that a major achievement of the project evaluation has been the development of standardised instruments for collection and management of data about service use and effectiveness. Use of these instruments has been implemented in most Lifeline centres across Australia. It appears that this approach, which includes computerised national recording of information about suicide-related calls and follow-up data, has not been reported before in the telephone counselling sector – within Australia or overseas.

Similarly, development of the *Kids Help Line Telephone Counsellor Evaluation Form* was identified as probably the first attempt to provide a standardised measure for rating telephone counsellors in suicide prevention contexts. King et al.

(1999) observe that such an instrument is crucial for practical use at Kids Help Line as well as for further evaluation research into telephone counselling. They assess the current instrument as showing considerable promise. It has developed out of the competency standards approach of the organisation through extensive consultation with staff and has strong acceptability within the organisation. King and colleagues recommend that further psychometric testing be conducted in the areas of inter-rater reliability, internal consistency, construct validity, sensitivity to change and predictive validity.

King et al. (1999) also observe that use of the *Kids Help Line Telephone Counsellor Evaluation Form* will contribute to the development of a more standardised language for communicating about mental state and risk assessment and that this in turn will result in increased reliability and utility for the instrument.

The long-standing practice of Kids Help Line of tape recording counselling calls was identified as an ideal means of collecting data for the purpose of evaluating counsellor performance.

General discussion

There has been little research into the effectiveness of telephone counselling. In Australia there had been no such research with suicidal callers before the National Youth Suicide Prevention Strategy. A major achievement of the Strategy telephone counselling projects is the contribution they have made to the wider field of telephone counselling through the evaluation work they have conducted.

The role of telephone counselling services

In the past, telephone counselling services have operated in relative isolation from other services. The telephone counselling projects funded under the Strategy have helped enhance our understanding of where and how this particular type of service might fit into the larger picture. The Strategy projects have demonstrated that telephone counselling services have a part to play, alongside other services, in facilitating identification of young people at risk, directing them to appropriate services, helping them through suicidal crises and enhancing the continuity of care provided to individuals at risk.

Telephone counselling services have the potential to play an important role as a "first point of contact" and help direct young people and those who care for them to appropriate services. Telephone counselling services are also used heavily by people who are already receiving treatment and assistance from other services. Telephone counselling services could be seen as providing a safety net for catching individuals who are "falling over the edge", including those who are using a variety of other services unable to meet all their needs. Access to counselling support 24 hours a day is a function that few if any other services can provide.

It is important that any future expansion or development of telephone counselling services give careful consideration to the place and role of telephone counselling services in relation to other services involved in youth suicide prevention, and focus on enhancing the relationships between these services (*Recommendation 3.1, first dot point*).

It would be useful for further research to examine what other services callers to telephone counselling services are using, and the extent to which these services are perceived as meeting the various needs they are experiencing. This information would help identify gaps in the system that, if sealed, might better prevent the development of crises and the need for suicide crisis intervention (*Suggestion 3.1a*).

The Lifeline evaluation suggests that telephone counselling intervention can lead to an increase in use of services after the initial call but it is not possible from the data presented to ascertain exactly how much the use of particular services or services in general increased after the initial call to Lifeline. The study design does not appear to have been suitable for this as a structured interview was not used in the initial call. It would be valuable for future evaluation to explore how the pattern of service use changes, whether callers shift towards greater use of particular kinds of services, and whether these are more appropriate (*Suggestion 3.1b*).

Counsellor training

Training was a major focus of the Lifeline and Kids Help Line Projects. Training was generally assessed as being of high quality, as being well received by staff, and as leading to increased knowledge and confidence. Only the Kids Help Line Project examined effects on counsellor competency, and the data did not demonstrate increases in competency. Both projects experienced difficulties in engaging an adequate number of staff in training.

The evaluators of the Kids Help Line Project (King, Nurcombe and Bickman 1999) recommend that more research is required to explore the complex relationships between training and performance. They also note that more ambitious evaluation designs are required that include adequate measurement of hypothesised mediating factors such as practice and self efficacy, and measurement of performance at regular set intervals. Such a design would allow researchers to track and describe the learning and skill development process.

King et al. (1999) also speculate that the potential contribution of training to counsellor performance may have been overrated and that training effects are at best modest. Nevertheless, they believe that the telephone counsellors at Kids Help Line would benefit from further specialist training in suicide prevention.

Future research might also be guided by more critical examination of what training content is actually critical to the achievement of *appropriate* behaviour

change for particular groups of trainees and outcomes for young people. King et al. (1999) argue that risk assessment is a fundamentally important area of training for telephone counsellors, and they recommend that future training place even greater emphasis on the detailed and systematic assessment of risk. However, in contrast to other topics discussed in this report, King and colleagues provide little or no evidence to support the assumption that detailed systematic risk assessment is an essential component of the range of suicide interventions that can be provided by telephone counsellors.

Systematic risk assessment or monitoring of suicide risk may be a very important behaviour for gatekeepers and specialist service providers such as general practitioners and case managers who work with individual young people over a length of time, and who are in a position to modify management strategies in response to variations in risk status. However, it is not as clear that systematic detailed risk assessment is as important for telephone counsellors whose repertoire of possible interventions is much more limited. Is it really necessary for telephone counsellors to categorise suicidal callers into fine grained levels of risk? Do different levels of risk indicate different management strategies for telephone counsellors? Even if accurate suicide risk assessment is theoretically important, is it possible for telephone counsellors to achieve a reliable risk assessment and use this information to inform and improve management decisions? In contrast, understanding the nature of the problem, including the nature of key precipitating and predisposing factors could be more important for telephone counsellors in order to inform appropriate referral advice. Such information is not specific to suicide management, but fundamental to the general counselling process.

King et al. (1999) note that there may be limitations to the capacity of further training to address some of the risk assessment deficiencies identified in the evaluation. They observe that much of the success and user support of Kids Help Line derives from its child-centred approach to counselling while systematic risk assessment derives from a more clinical tradition. This suggests that creating the conditions where staff can develop strong expertise in systematic risk assessment may require a philosophical shift within the whole organisation and it is not clear that this would be desirable.

While there are limitations to what can be achieved through provision of training it is clear that ongoing education and training will need to be a major focus for telephone counselling services as part of a broader approach to enhancing capacity for youth suicide prevention. Following the recommendations of Rolfe and Turley (1999) and King et al. (1999), it is recommended that telephone counselling services supplement training with ongoing systems of professional development such as supervision, development and implementation of competency standards, and performance monitoring (*Recommendation 3.1, second dot point*).

It may be fruitful for future research and evaluation of telephone counsellor training to include exploration of such questions about the appropriate roles of telephone counsellors, and the training needs arising from these (*Suggestion 3.1c*).

Referral and follow-up

One additional area where training might need to be directed is referral and follow-up. King et al. (1999) found that making referrals was one of the main areas of weakness in the competencies of Kids Help Line counsellors. Although rates at which young people took up referrals were high among the group that were included in the follow-up study, this sample was biased and it is likely that referral uptake would be lower among the general population of suicidal young people calling telephone counselling services. It was also found that males were significantly less likely than females to take up referral options. There was some evidence that the follow-up exercise conducted for the evaluation had an effect of increasing the rate at which young people took action on referrals provided.

These results suggest that a more active and systematic approach to referral and follow-up may be a valuable role for telephone counselling services. Telephone counselling services could consider ways of developing a more active and systematic approaches to referral and follow-up of young callers who are at high risk of suicide. (*Recommendation 3.1, third dot point*)

The electronic referral database developed by Lifeline will be a vital resource in this regard. It is recommended that funding be provided to develop this database further, ensure is it regularly updated, and make it widely available to the full range of services that could make use of it, as well as the general public and young people for the purpose of self referrals (*Suggestion 3.1d*).

In addition, training would need to focus on providing counsellors with the knowledge about appropriate referral options as well as the confidence and skills to encourage young people at risk, particularly young males, to consider referrals. Skills in suicide risk assessment would need to be complemented by general psychosocial assessment skills and engagement strategies. Training would also be necessary if telephone counselling services were to institute follow-up as a routine part of service provision for callers at high risk of suicide. The evaluation found that counsellors were actually less likely to invite callers to participate in the follow-up study if they had developed a suicide plan. Males were less likely than females to be invited to participate. Training would need to encourage exploration of the attitudes that may discourage counsellors from actively inviting young males and callers at higher risk and challenge these attitudes (*Suggestion 3.1e*).

Funding issues

The ability of telephone counselling services to continue to enhance the quality of services provided to young people will depend on their obtaining access to resources that can be dedicated to this work. If telephone counselling services are

to work more closely with other services in order to enhance early intervention and continuity of care for clients of other government and non-government funded services, then it is appropriate that telephone counselling services have access to an equivalent range of funding options as other services.

Most agencies that provide services direct to the public are funded by state and territory governments. But unlike these services, which have discrete catchment areas within state and territory boundaries, telephone counselling services such as Lifeline and Kids Help Line are national.

State and territory Departments of Community Services might consider ways in which they could pool resources in order to provide ongoing funding support to Lifeline and Kids Help Line to continue enhancing the quality of service they provide to young people and to facilitate their working in partnership with other state and territory government and non-government agencies. (*Suggestion 3.1f*).

Recommendations and suggestions

It is recommended that:

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

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

- ongoing professional development of telephone counselling staff including training, supervision, development of competency standards and performance monitoring; and

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

(This is Recommendation 16 in the evaluation overview, "Valuing Young Lives".)

It is further suggested that:

3.1a   Research should be conducted to examine what other services callers to telephone counselling services are using and the extent to which these services are perceived as meeting the various needs they are experiencing. This information would help identify gaps in the system that, if sealed, might better prevent the development of crises and the need for suicide crisis intervention.

3.1b   Future evaluation should explore if and how the pattern of service use changes after young people make calls to telephone counselling services

and whether callers shift towards greater use of particular kinds of services and whether these are more appropriate to their needs.

3.1c Further development of training programs for telephone counsellors should give consideration to the full range of roles of telephone counselling services and the specific training needs arising from these.

3.1d Funding should be provided to further develop the electronic referral database developed by Lifeline, provide for regular updating, and ensure that it is made widely available to the full range of services that could make use of it, as well as the general public and young people for the purpose of self referrals.

3.1e Suicide prevention training for telephone counsellors should include (in addition to other previously identified items):

- information about appropriate referral options and use of the electronic database;

- skills to encourage young people at risk, particularly young males to consider referral options;

- skills mental health assessment and general psychosocial assessment;

- skills in engagement strategies; and

- exploration of the attitudes that may discourage counsellors from actively inviting young males and callers at higher risk to be involved in follow-up and challenge these attitudes.

3.1f State and territory Departments of Community Services should consider ways in which they could pool resources to provide ongoing funding support to Lifeline and Kids Help Line to continue enhancing the quality of service they provide to young people and to facilitate their working in partnership with other state and territory government and non-government agencies.

Project reports

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.

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

Other references

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

Map of program logic: telephone counselling

Goals/outcomes

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

- Prevent the development of acute crises.

Objectives/impacts

- Distress suffered by young people experiencing acute crises is minimised.

- Young people experiencing acute crises are enabled to resolve crisis situations as promptly as possible.

- Increase willingness among young people, especially young males, to ring telephone counselling services in a crisis.

- Increase the satisfaction of young people with services received from telephone counselling services.

Aims/processes

- Expand the capacity of telephone counselling services to respond to calls from young people, to make appropriate referrals and to provide follow-up as appropriate.

- Develop formal collaboration between telephone counselling services and other treatment and support services.

- Develop the knowledge, skills and competencies of telephone counsellors to work with young people at risk of suicide including skills in engagement, assessment, problem resolution, referral and follow-up.

- Ensure that telephone counsellors have access to a regularly updated electronic database about appropriate referral agencies throughout Australia.

- Increase the representation of young people among the staff of telephone counselling services.

- Develop the capacity of telephone counselling services to provide supervision, monitoring and to evaluate service provision.

- Develop the skills and awareness of young people and other community members in crisis intervention and how to access appropriate services.

Performance indicators

- Proportion of telephone counselling staff who have received training in youth suicide prevention.

- Proportion of counselling centres that regularly deliver training programs, provide professional supervision, implement performance benchmarks and monitoring systems.

- Proportion of counselling centres with documented policies and procedures regarding referral and follow-up of callers at high risk of suicide.

- Proportion of counselling centres that implement relevant manuals and comply with relevant guides.

- Proportion of counselling centres that have access to a regularly updated electronic database about appropriate referral agencies.

Index of projects referred to in this volume

List of contact details for projects referred to in this volume

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

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

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

Lifeline Australian Youth Suicide Prevention Initiative
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148 Lonsdale Street
Melbourne VIC 3000
Phone: 03 9662 1677
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mailbruce@compuserve.com
Contact person: Dr Bruce Turley

Logan Here for Life Youth Suicide Prevention Project
Southern Queensland Rural Division of
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PO Box 814
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sqrdgp@medeserv.com.au.

Mackay and Moranbah
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Contact person: Ms Trish Ward

National General Practice Youth Suicide Prevention Project
Perth Central Coastal Division of General
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Contact person: Mr Jon Pfaff

Peninsula Youth Suicide Prevention Project
Frankston Hospital
Peninsula Health Care Network
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Phone: 03 9784 7777
Contact person: Dr John Reilly

Shoalhaven Youth Suicide Initiative
PO Box 70
Culburra Beach NSW 2540
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Contact person: Ms Wendy Preston

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

Youth At Risk of Deliberate Self-Harm (YARDS)
Mental Health Centre
South Eastern Sydney Area Health Service
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21- 25 King Street
Rockdale NSW 2216
Phone: 02 9597 2644
Fax: 02 9597 4756
Contact persons: Mr Garry Stevens 02 9350 2501 and Mr Blake Hamilton