



Valuing young lives

THE NATIONAL YOUTH SUICIDE PREVENTION STRATEGY AND ITS EVALUATION

The Australian Institute of Family Studies has recently completed an evaluation of the National Youth Suicide Prevention Strategy. This article provides an overview of the Strategy and a brief summary of findings from the evaluation.

The National Youth Suicide Prevention Strategy emerged out of a series of national and international events that drew attention to the need for a concerted and coordinated approach to prevention of suicide among young people.

In 1990 the World Health Organisation (WHO 1990) identified suicide as a major priority for public health action, and in the early 1990s the Secretary-General of the United Nations suggested that governments consider developing national strategies for dealing with severe dysfunctional conditions including anxiety, stress and suicide (United Nations 1996).

Australia is one of the few countries to have answered the call of the United Nations for member states to develop national strategies targeting suicide and other severe dysfunctional conditions. Other countries that have initiated comprehensive national strategies are Finland, New Zealand, Norway and Sweden. Certain countries – Netherlands, England, the United States, France and Estonia – have national prevention programs but not a comprehensive strategy. Japan, Denmark, Austria, Canada and Germany have carried out some initiatives but not national action. The majority of countries have no national strategies, relying primarily on the uncoordinated efforts of government agencies or

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non-governmental organisations, which usually have limited resources (Ramsay 1996).

The thinking behind the development of

Australia's National Youth Suicide Prevention Strategy – its goals, principles and major approaches – are described in two publications: *Youth Suicide in Australia: A Background Monograph* (CDHFS 1997a) and *Youth Suicide in Australia: The National Youth Suicide Prevention Strategy* (CDHFS 1997b).

The goals of the National Youth Suicide Prevention Strategy were to: prevent premature death from suicide among young people; reduce rates of injury and self-harm; reduce the incidence and prevalence of suicidal ideation and behaviour; and enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

The Strategy was based on the belief that youth suicide is a complex phenomenon caused by a number of interacting factors including biological, psychological, social and cultural factors. This understanding is widely referred to as the biopsychosocial model. The biopsychosocial model calls for a comprehensive variety of interventions including those that modify individual risk factors and protective factors, as well those that modify the physical, social and cultural factors that shape environments.

Accordingly, the National Youth Suicide Prevention Strategy adopted a *Public Health Approach* to the goal of prevention. Principles of the Public Health Approach which the Strategy sought to promote include: evidence-based practice; population-based and individual approaches; a planned approach incorporating national, state and local initiatives; involvement of communities, consumers and young people; and intersectoral collaboration.

Consistent with the biopsychosocial model of causality and the principles of the Public Health Approach, the National Youth Suicide Prevention Strategy employed a comprehensive variety of interventions including direct and system level activities. Direct prevention activities were aimed directly at young people or other target groups such as parents, families, peers, and community members directly connected to young people. Direct level activities also worked directly with environments to modify risk and protective factors present in these environments:

Direct prevention approaches of the Strategy included: primary prevention and cultural change; early intervention; crisis intervention and primary care; treatment, support and postvention; and access to means/injury prevention.

System level activities aimed to build capacity or facilitate the adoption of evidence-based practice throughout all the service systems relevant to youth suicide prevention. System level activities worked across a number of direct approaches and included: research and evaluation; communications (identification and dissemination of good practice); education and training; networking and intersectoral collaboration; and community development.

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

Consistent with the emphasis on population-based approaches the Strategy acknowledged the critical importance of social and cultural factors in determining health outcomes and inequalities in access to appropriate services and programs. The Strategy emphasised the importance of sensitivity to youth culture and the social issues of concern to young people. It also sought to enhance responsiveness to the needs rural and remote communities, Aboriginal and Torres Strait Islander communities, and young people who are disaffected and marginalised from mainstream society.

A total of \$31 million was allocated by the Federal Government to the National Youth Suicide Prevention Strategy from July 1995 to June 1999. Funds were distributed across 88 different projects and activities, including 44 National Demonstration Projects. Funds were allocated via a number of processes including competitive tendering and selective tendering.

The Strategy was administered and coordinated through the Mental Health Branch of the Commonwealth Department of Health and Aged Care (formerly Health and Family Services). Advice from stakeholder representatives was provided by a number of bodies that included officers from other sectors of government including the States and Territories of Australia, researchers, service providers, non-government organisations, consumers (or service users), and young people.

ACTIVITIES OF THE STRATEGY

Primary prevention and cultural change

The goal of primary prevention of youth suicide is to prevent the development of problems (risk factors) that place people at risk of suicide (for example, preventing mental health problems), and to promote the development of resilience and protective factors such as optimism and interconnectiveness between people and communities. The purpose or nature of cultural change was not clearly defined in the Strategy documentation, however there has been a general understanding among many of those involved that promotion of values such as compassion and building social capital by increasing trust and social connectedness are fundamentally important to preventing suicide.

Primary prevention activity funded under the Strategy was concentrated in four areas: parenting education and support; school-based programs; media education; and community development.

The goal of parenting education and support projects was to prevent the development of emotional and behavioural problems in children and adolescents such as conduct disorder and depression which have been linked to self-harm and suicide in later life. Projects tended to focus on enhancing the dissemination of existing programs and reaching target populations that have experienced difficulty accessing parenting programs. The Strategy developed and trialed resources for the support of a whole-school approach to mental health promotion in secondary schools. The resources focus on curriculum; ethos and organisation; and building partnerships between schools and community agencies. Work with the media aimed to educate journalists about safe ways to report on and talk about youth suicide issues. A number of community development projects included a focus on primary prevention. These aimed to stimulate broad based community support for youth suicide prevention and ultimately to empower community members to develop their own suicide prevention programs in the future.

Early intervention

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

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

Early intervention activities of the Strategy included: efforts to enhance the accessibility and appropriateness of services for young people; provision of training to professionals such as general practitioners and community members to enhance identification and support of young people at risk; development of networks of service providers to smooth referral pathways; provision of information to young people, families and carers via the internet

Crisis intervention and primary care

Crisis intervention and primary care are short-term activities designed for young people who may be at immediate

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

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



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Treatment, support and postvention

Ongoing treatment, support and postvention activities are aimed at individual young people with long-term problems which place them at sustained risk of suicide. This group includes young people who have made suicide attempts or harmed themselves, as well as young people experiencing mental health problems and other sustained risk factors such as exposure to neglect and abuse, homelessness, and substance misuse which can lead to their being marginalised from the wider community. Postvention refers to interventions directed to family, friends, peers and other relevant contacts of young people who have completed suicide.

Treatment and support activities of the Strategy were focused in mental health services, youth health services and other non-government agencies. Projects in mental health services aimed to improve treatment for depression, psychosis and substance misuse. A major focus of the projects was exploration of strategies for engaging marginalised young people with helping services and ensuring that young people with highly complex problems receive a more holistic or comprehensive service that addresses all their needs.

Restricting access to means

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

Activity in the area of access to means was mostly limited to research into the issues surrounding the development of strategies. Initially a background report was prepared which examined trends in methods of suicide over the past twenty years up to 1994. Other projects focused on identifying strategies to combat the methods of firearms; hanging; motor vehicle exhaust gas; and jumping from heights.

Research and evaluation

A variety of information gathering and generating activities were funded with a view to enhancing the evidence base for youth suicide prevention. These included: a consultation with young people on mental health and suicide issues (Keys Young 1998); a series of literature reviews focusing on epidemiology (Cantor et al. 2000), risk factors (Beautrais 2000), and the effectiveness of interventions (Patton & Burns 2000); support for the enhancement of the National Coronial Information System; a study of suicide in indigenous communities of North Queensland (Hunter et al. 1999); and two national stocktakes of programs and activities in youth

YOUTH SUICIDE – THE STATISTICS

The increase in youth suicide since the 1950s is a major public health trend throughout the world. According to De Leo et al. (2000: 3): 'Today suicide provokes almost as many deaths as road accidents and more than double the number of all the armed conflicts around the world. In almost every country, suicide is now one of the three leading causes of death among people aged 15–34 years. . . . A global increase in suicide rates, from 10.1 (per 100,000) to 16 has been registered from 1950 to 1995.'

Variations in data collection procedures mean that caution must be taken in comparing suicide rates among countries. However, Australian suicide rates appear consistent with those in similar nations (Cantor et al. 2000) – that is, predominantly English-speaking countries with colonial histories, indigenous peoples, and multicultural populations such as Canada, New Zealand and the United States (Cantor et al. 2000; La Vecchia et al. 1994).

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

36.6 per 100,000 for males aged 35–39 (ABS 2000). The age-specific rate of suicide for young males aged 15–19 was 17.2 per 100,000. For males aged 20–24 the rate was 35.9 per 100,000. The age-specific rate of suicide for young females aged 15–19 was 5.5 per 100,000, and for females aged 20–24 it was 7.1 per 100,000 (ABS 2000).

While female rates have been relatively stable, Australia's male youth suicide rate has increased disturbingly over the past 20 years. In 1998, deaths for young males outnumbered those for young females by a ratio of more than four to one (ABS 2000). Rates for young females have been consistently lower than those for young males over the last 20 years. One reason for this difference may be the methods used. When comparing methods of suicide between 1961–1981, Hassan and Tan (1989) found that males more commonly used violent methods such as firearms, with higher levels of lethality, than females.

While rates have increased much more dramatically for young males than females over the past 20 years, there is a trend towards a slow

suicide prevention (AIFS 1998, 1999). Evaluation of each individual project funded under the Strategy and this summative evaluation also constitute a major research and evaluation initiative. In addition many of the projects focusing on particular direct prevention approaches have had a major or minor research component.

Communications (or Identification and dissemination of good practice)

Identification and dissemination of good practice is closely related to research and evaluation but goes some steps further with the aim of enhancing wide access to information.

Individual projects funded under the National Youth Suicide Prevention Strategy were encouraged to use a variety of communications strategies to promote awareness of their projects and influence the opinions of stakeholders. Major communications strategies included presentations at conferences and seminars, publication of newsletters and reports and the development of good practice guides.

The Strategy also provided national coordination of communications. Project staff and other stakeholders were encouraged to contribute information and this was distributed using a variety of media including printed publications; the internet; an email discussion list; organisation of seminars and workshops at conferences; and a clearinghouse or library service.

Education and training

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

Activity focused on professional groups that have been identified as well placed to make a greater contribution to the prevention of youth suicide including general practitioners, community health workers, youth workers,

indigenous health workers and juvenile justice workers.

Extensive consultations were conducted with professional groups to identify their training needs, preferred learning methods and the usefulness of existing training materials. Existing materials were collated and critically reviewed in a resource guide. Where necessary new training programs were developed for delivery by tertiary institutions and via in-service training. A good practice guide for the development of suicide prevention training has also been published.

Networking and intersectoral collaboration

Networking and improving collaboration between services is widely understood as essential for enhancing the access of young people at risk of suicide to appropriate services. There is a need to better link individuals and services capable of identifying young people at risk – such as schools, other community organisations and primary health care services – to specialist services that can assist them manage problems and to which they can refer clients requiring more intensive intervention.

Service networking has been particularly popular in rural and regional areas, where it is seen as critical for identifying and coordinating the limited resources that are available in rural areas, and a key starting point in the task of harnessing skills and resources that may be available in communities. In urban areas also service networking has been used in an effort to improve coordination, smooth referral pathways, seal gaps in the system and share skills and knowledge.

Community development

Community development projects aimed to assist communities develop their own programs in ways that would be self sustaining in the long term. A key ingredient of community development is the integral involvement of community members in the planning, decision-making and implementation of programs and activities. Genuine community development needs to be distinguished from community support programs that develop community services or provide community education about suicide but are not

but steady increase in the rate for young females aged 15–19 over the period 1995–1998. The suicide rate for males aged 15–19 appears to have stabilised over the period 1988–1998 and the rate for males aged 20–24 also appeared to stabilise in the second half of the 1990s, but this trend was disturbed by a peak in 1997. The 1997 figure may represent an aberration from a plateau to which 1998 rates return.

Suicide rates in Australia tend to be higher in rural than in urban areas. A recent comparison of metropolitan and rural trends in youth suicide (Dudley et al. 1998) revealed that while suicide rates for 15–24-year-old Australian men have doubled since the 1960s, they have increased as much as 12-fold in some towns with fewer than 4000 people. However, this is not the case for all rural areas, and rates vary widely between areas.

Suicide data on the Aboriginal and Torres Strait Islander population are unreliable, but it is estimated that the overall suicide rate may be 40 per cent higher than in the non-indigenous population (CDHAC 2000).

Overall rates for immigrants are similar to those of Australian-born youth. However, males born in a country other than Australia have a lower suicide rate than Australian-born males, whereas the reverse applies for young women born in a country other than Australia (Morrell et al. 1999).

The extent of attempted suicide is hard to determine. The term implies that the self-harming behaviour is intended to cause death, but the true motive behind self-harming behaviour and many apparent suicide attempts is generally very difficult to determine. The extent of self-harming behaviour is also difficult to determine because of a lack of generally accepted reporting procedures or definitions. Hospital presentations or admissions are most commonly used, although these grossly underestimate numbers of attempts. This is because most attempters do not present to hospital, and there is considerable variability in the coding used by hospitals with those who do present.

In a consultation among young people on mental health issues conducted as part of the National Youth Suicide Prevention Strategy (Keys Young 1997), 7 per cent of the young people studied said that they had attempted suicide, while 40 per cent said that they knew someone who had attempted suicide. Cantor et al. (2000) estimate that there are possibly up to 50 male and 300 female attempted suicides for each completed suicide. Thus whereas the completed suicide rate is far higher among young males than young females, the reverse is true for attempted suicide. However, the female predominance of attempted suicides, as judged by hospital admissions, has declined in recent years in Australia, with the female to male gender ratio now being about 1-2:1 (Cantor et al. 2000).

oriented towards community ownership and empowerment. The NYSPS supported several projects that attempted to use a genuine community development approach.

THE EVALUATION

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

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

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

The Public Health Approach to program evaluation emphasises the importance of examining program effects at three levels (Hawe, Degeling and Hall 1990). *Outcomes* are the changes in the health and wellbeing of the target population or program participants that are attributable to the intervention. *Impacts* are changes in modifiable risk and protective factors in individuals (behaviours, skills, attitudes and knowledge) and environments. *Processes* are changes in service and program delivery systems.

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

Five main methods were used to collect and analyse data for the evaluation: a qualitative meta-analysis (meta-evaluation) of project evaluation reports; survey of key stakeholders; informal consultation with key stakeholders; review of research and practice literature; and review of policy and program context.

Did the Strategy meet its aims?

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

The Strategy also included most of the elements that have been identified as essential to coherent national strategies (United Nations 1996; WHO 1990; Taylor, Kingdom and Jenkins 1997). However, the Strategy cannot be considered to be a fully 'comprehensive nationally coordinated

approach' to youth suicide prevention throughout Australia. Rather, it is more accurately understood as a phase of developmental research.

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

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

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

Nevertheless, a number of projects demonstrated positive outcomes for young people and significant impacts on target groups participating in trial programs.

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

Good practice findings

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

Multidimensional approach

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

Access

The concept of access has emerged as central as the Strategy unfolded. One of the concerns underlying the Strategy



Evidence is mounting that adolescence, in addition to early childhood, is a critical period for effective prevention and early intervention.

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

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

Engagement

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

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

Effective intervention

Effective intervention was a particularly problematic issue among the good practice findings. Previous literature on the topic of evidence-based intervention has focused on the need to increase the extent to which interventions are based on epidemiological data about risk and protective factors and evidence about the efficacy of model interventions. The experience of the Strategy has also demonstrated

the importance of service agencies actively engaging in an ongoing process of generating, reflecting and acting on evidence about the effectiveness of their own daily practice.

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

Capacity building

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

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

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

The evaluations of the demonstration projects funded under the National Youth Suicide Prevention Strategy

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

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

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

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

Future directions

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

Development of learning organisations

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

Researchers and specialists in the area of organisational development have recommended the concept of learning organisations as the epitome of an organisation with capacity for learning and development. The concept of the learning organisation was developed within the business management sector (Senge 1990) but it has demonstrated substantial relevance and utility in the public sector as well (Birleson 1998; Hawe et al. 1997). The learning organisation model provides a comprehensive framework for

ensuring that an organisation places quality improvement at the centre of its concern and is able to adapt quickly to new demands.

Systematic policy frameworks

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

To be sustainable and effective, local partnerships must be complemented and supported by strategic partnerships between: Commonwealth Government departments; the Commonwealth and the States and Territories; and State/Territory governments and area/regional/district authorities.

The dominance of traditional funding categories for government programs based on problems (such as suicide, drug misuse) and service systems or functions (such as health services, education, community services) places limits on the formation of intersectoral partnerships and the ability of service agencies to respond to diverse local needs (Buchanan 2000). New policy and funding frameworks incorporating a wider array of conceptual dimensions including structural social issues, populations and places or localities may be needed in order to provide adequate flexibility. There are positive signs of a move towards this flexibility with the emergence of several new national policies focused on social issues and incorporating key health promotion concepts.

Valuing young lives

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

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

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

However, the evaluation of the Strategy has also revealed evidence that many of the structural deficiencies in service systems remain as problematic as they have ever been. At the end of the National Youth Suicide Prevention Strategy, there is considerable readiness to begin the work of seriously tackling these problems. Long-term political commitment is vital.

References

- ABS (2000), *Suicides 1921–1998*, Australian Bureau of Statistics, Catalogue No. 3309.0, Canberra.
- AIFS (1998), *Youth Suicide Prevention Programs and Activities: National Stocktake, April 1998*, Australian Institute of Family Studies, Melbourne.
- AIFS (1999), *Youth Suicide Prevention Programs and Activities: National Stocktake, October 1999*, Australian Institute of Family Studies, Melbourne.
- Beautrais, A. (2000), 'Risk factors for suicide and attempted suicide amongst young people', in *Setting the Evidence-based Research Agenda for Australia: A Literature Review*, National Youth Suicide Prevention Strategy, Department of Health and Aged Care, Commonwealth of Australia, Canberra.
- Bickman, L. (1996), 'The application of Program Theory to the evaluation of a managed mental health care system', *Evaluation and Program Planning*, vol. 19, no. 2, pp. 111-119.
- Birlson, P. (1998), 'Learning organisations: a suitable model for improving mental health services?', *Australian and New Zealand Journal of Psychiatry*, vol. 32, pp. 214-222.
- Buchanan, D.R. (2000), *An Ethic for Health Promotion: Rethinking the Sources of Human Wellbeing*, Oxford University Press, New York.
- Burdekin, B. (1993), *Human Rights and Mental Illness: Report of the National Enquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra.
- Cantor, C.H., Neulinger, K., Roth, J. & Spinks, D. (2000), 'The epidemiology of suicide and attempted suicide among young Australians', in *Setting the Evidence-based Research Agenda for Australia: A Literature Review*, National Youth Suicide Prevention Strategy, Department of Health and Aged Care, Commonwealth of Australia, Canberra.
- CDHAC (2000), *LIFE: A National Framework for Prevention of Suicide and Self Harm 2000–2004*, Mental Health Branch, Commonwealth Department of Health and Aged Care, Canberra.
- CDHFS (1997a), *Youth Suicide in Australia: A Background Monograph*, Commonwealth Department of Health and Family Services, AGPS, Canberra.
- CDHFS (1997b) *Youth Suicide in Australia: The National Youth Suicide Prevention Strategy*, Commonwealth Department of Health and Family Services, AGPS, Canberra.
- De Leo, D., Cantor, C.H., Hickey, P. & Neulinger, K. (2000), *Suicide Across the Lifespan*, Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane.
- Department of Finance (1994), *Doing Evaluations: A Practical Guide*, AGPS, Canberra.
- Dudley, M.J., Kelk, N.J., Florio, T.M., Howard, J.P. & Waters, B.G.H. (1998), 'Suicide among young Australians 1964–1993', *Medical Journal of Australia*, vol. 169, pp. 77-80.
- Hassan, R. & Tan, G. (1989), 'Suicide trends in Australia 1901–1985: an analysis of sex differentials', *Suicide and Life Threatening Behaviour*, vol. 19, no. 4, pp. 362-380.
- Hawe, P., Degeling, D. & Hall, J. (1990), *Evaluating Health Promotion*, MacLennan and Petty, Australia.
- Hawe, P., Noort, M., King, L. & Jordens, C. (1997), 'Multiplying health gains: the critical role of capacity-building within health promotion programs', *Health Policy*, vol. 39, pp. 29-42.
- Hawe, P., King, L., Noort, M., Jordens, C. & Lloyd, B. (2000), *Indicators to Help with Capacity Building in Health Promotion*, NSW Health and the Australian Centre for Health Promotion, Sydney.
- Hunter, E., Reser, J., Baird, M. & Reser, P. (1999), *An Analysis of Suicide in Indigenous Communities of North Queensland: The Historical, Cultural and Symbolic Landscape*, Department of Social and Preventive Medicine, University of Queensland.
- Keys Young (1997), *Research and Consultation with Young People on Mental Health Issues*, Commonwealth Department of Health and Family Services, AGPS, Canberra.
- La Vecchia, C., Lucchinin, F. & Levi, F. (1994), 'Worldwide trends in suicide mortality 1955–1989', *Acta Psychiatrica Scandinavica*, vol. 90, pp. 53-64.
- Mitchell, P. (2000), *Valuing Young Lives: Evaluation of the National Youth Suicide Prevention Strategy*, Australian Institute of Family Studies, Melbourne.
- Morrell, S.L., Taylor, R.J., Slaytor, E. & Ford, P. (1999), 'Urban and rural differentials in migrants and the Australian born: New South Wales, Australia 1985–1994', *Social Science and Medicine*, vol. 49, no. 1, pp. 81-91.
- Patton, G. & Burns, J. (2000), 'Preventive interventions for youth suicide: a risk factor based approach', in *Setting the Evidence-based Research Agenda for Australia: A Literature Review*, National Youth Suicide Prevention Strategy, Department of Health and Aged Care, Commonwealth of Australia, Canberra.
- Ramsay, R. (1996), 'Suicide prevention strategies within a United Nations context', in R. Ramsey & B. Tanney (eds) *Global Trends in Suicide Prevention: Towards the Development of National Strategies for Suicide Prevention*, TATA Institute of Social Science, Mumbai, India.
- Senge, P.M. (1990), *The Fifth Discipline: The Art and Practice of the Learning Organisation*, Doubleday Currency, New York.
- Taylor, S.J., Kingdom, D. & Jenkins, R. (1997), 'How are nations trying to prevent suicide? An analysis of national suicide prevention strategies', *Acta Psychiatrica Scandinavica*, vol. 95, pp. 457-463.
- Vimpani, G. (2000), 'Child development and the civil society: does social capital matter?', *Developmental and Behavioural Pediatrics*, vol. 21, no. 1, pp. 44-47.
- WHO (1990), *Consultation on Strategies for Reducing Suicidal Behaviours in the European Region, 1989, Summary report*, World Health Organisation, Geneva.
- Wilkinson, R. & Marmot, M. (1998), *Social Determinants of Health: The Solid Facts*, World Health Organisation, Geneva.
- United Nations (1996), *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies*, United Nations, New York.

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EVALUATION PUBLICATIONS

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 provides an overview of the Strategy, what the Strategy achieved and what was learned from the Strategy as a whole. The report includes the policy context, conceptual basis, evaluation methodology, and a description of activities within each of the main approaches adopted by the Strategy, and a summary of major achievements and good practice findings.

Building Capacity for Life Promotion: Technical Report, Volume 1 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.

Primary Prevention and Early Intervention: Technical Report, Volume 2 focuses on activities in the areas of parenting education and support, mental health promotion in schools, access to means/injury prevention, as well as early intervention.

Crisis Intervention and Primary Care: Technical Report, Volume 3 focuses on activities taking place in hospital accident and emergency departments, and primary health care settings – including general practice and telephone counselling services.

Treatment and Support: Technical Report, Volume 4 describes the results of projects based in mental health services and those providing support for marginalised and disaffected young people.

These books, by Penny Mitchell (2000), may be obtained from the Australian Institute of Family Studies.