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A Manual to Guide the Development of Local Evaluation Plans

Evaluating initiatives
within the *LIFE Framework*
using a program logic approach

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This Manual is based on '*LIFE: A framework for prevention of suicide and self-harm in Australia*', especially the Areas for Action document. You do not need to have read the *LIFE Framework* documents to be able to use this Manual.

If, however, you would like a copy of the *LIFE Framework*, it can be obtained from the Australian Government Department of Health and Ageing, <<http://www.health.gov.au>> or telephone 1800 066 247.

A glossary of frequently used terms and acronyms in the area of promotion, prevention and early intervention for mental health is provided at: <<http://auseinet.flinders.edu.au/glossary/index.php>>

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Introduction

Purpose of this manual

This Manual helps projects funded under the *LIFE Framework* to identify indicators and measures that could be used to evaluate their activities. It helps project staff identify all the critical components of their projects in terms of where and how they fit into the *LIFE Framework* as a whole. The procedure described in this Manual should also help projects to clarify their thinking about their work, and build a clear understanding of the rationale behind their activities.

Using a Program Logic Approach (described in the Background section that follows), the Manual sets out a simple ‘step-by-step’ procedure for identifying appropriate indicators. Each step is illustrated with the use of a practical example of how the procedure can be applied to a particular suicide prevention project. The example project used has the broad aim of encouraging young people to seek help when they need it.

All of the projects funded under the *LIFE Framework* share some important characteristics. The Manual is designed to help projects identify a set of indicators they can use that will be consistent with those projects with similar characteristics might also use. Each project is also unique because of the particular combination of strategies used, the characteristics of the client groups involved, and the communities and settings in which it is based.

Evaluation of the *National Suicide Prevention Strategy* needs to acknowledge this combination of commonalities and diversity among the funded projects. By developing individualised project evaluation plans that also fit into a larger common framework with common performance indicators, data gathered for project level evaluations can contribute to the evaluation of the *National Suicide Prevention Strategy* as a whole strategy. The data can be brought together to add to our overall knowledge about what works to achieve the broad goals of suicide prevention and mental health promotion.

The Program Logic Approach used in this Manual is just one of a wide range of frameworks that can be used in program evaluation. The Program Logic Approach is particularly useful in the evaluation of complex, multileveled or multifaceted interventions, and in the evaluation of ‘clusters’ of projects that share certain characteristics, such as in the case of the *National Suicide Prevention Strategy*.

Use of a Program Logic Approach to identify key indicators that are consistent with the *LIFE Framework* does not mean that projects cannot also use other evaluation or quality improvement approaches to assist in the design of local evaluation plans. The Program Logic Modelling work recommended here is complementary to these other approaches to evaluation.

Structure of this Manual

This Manual has four main sections:

- **Section One** (pages 1 to 28) is the core part of the Manual that all users should read thoroughly. It describes important background information that readers need to know in order to be able to use the Manual efficiently and purposefully, then sets out the procedure for constructing individualised Program Logic Maps and selecting indicators for projects.
- **Section Two** (pages 29 to 54) sets out the Program Logic Maps that have been developed for each of the 23 Action Area Outcomes of the *LIFE Framework*. Manual users do not need to read all of these. The steps in Section One will explain how you can select the Program Logic Maps (or components of these Maps) that are relevant to your project.
- **Section Three** (pages 55 to 72) and **Section Four** (pages 73 to 88) list different sets of performance indicators as well as recommended tools and data sets. Manual users do not need to read all of these. The steps in Section One will explain how you can select the indicators and tools that are relevant to your project.

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SECTION ONE

Background and
How to use this Manual

Background

Evaluating complex public health strategies using a Program Logic Approach

The *National Suicide Prevention Strategy* is a complex, multifaceted public health strategy. It comprises a large number of initiatives or projects directed towards multiple target groups (e.g., individuals, families, high-risk populations, whole communities) and being implemented at multiple levels of action (e.g., individuals, service agencies, service networks, areas/regions, health sector, intersectoral, whole-of-government). Many individual projects funded under the Strategy are also highly complex and multifaceted within themselves. These activities are also taking place in the context of other large-scale policy and service development initiatives being conducted by the Commonwealth and State/Territory governments.

The evaluation framework described in this Manual is based on a Program Logic Approach. The Program Logic Approach to evaluation has emerged from recognition that traditional research designs, such as randomised controlled trials, are often not appropriate or feasible in the evaluation of broad public health initiatives such as the *National Suicide Prevention Strategy*. Methodologically, the Program Logic Approach can provide a rigorous alternative to experimental methods of program evaluation.

Central to the Program Logic Approach is the exercise of developing Program Logic Models or Maps that provide a simplified diagram of the core elements or components of a program that may need to be considered in evaluation. These Program Logic Models or Maps include strategies or activities, processes, impacts and outcomes. The Program Logic Maps also provide a simplified representation of the theories or hypotheses that program planners hold about the relationships between activities, processes, impacts and outcomes. The general logic represented in the Program Logic Maps is that program activities *lead to, or contribute to changes* in processes and structures, which then lead or contribute to changes in impacts, which in turn lead or contribute to changes in outcomes. There is usually also a general assumption that the changes occurring at these different levels unfold gradually over time.

Once the core components of a program are clearly articulated and described, indicators of performance relevant to these program components, including implementation of strategies and the achievement of impacts and outcomes, can be identified and selected. Once appropriate indicators are selected, data are collected using appropriate measures of selected indicators. Data should be collected at more than one point in time, in order to assess change over time. It is also important to collect data on indicators from all key 'levels' of effect identified in the Program Logic Map. If empirical evidence of change can be demonstrated at all critical points along the continuum, in a way that is consistent with a predetermined theoretical expectation, this lends considerable credibility to attributing at least part of that change to the intervention program (Gabriel, 2000).

However, even when measurement at all relevant levels of effect is not possible, the process of developing Program Logic Models offers important benefits for program evaluation. These include:

- development of a common understanding or agreement between all relevant stakeholders about program goals, objectives, the rationale behind strategies and hypotheses regarding effects;
- provision of a clear and concise description of the program; and
- a framework for examining the fit between actual program activities/strategies and those activities/strategies that are theoretically required to achieve stated goals and objectives.

Navigating your way through the Program Logic Maps

Different authors have used somewhat different sets of terms to describe and explain Program Logic Modelling and the various components of Program Logic Maps. However, all share the basic concept that there are multiple domains or levels that need to be included in the map or model. The framework used in this Manual involves four (4) basic levels: (i) inputs/strategies, (ii) processes and structures, (iii) impacts and (iv) outcomes. Table 1 below provides definitions of the key terms applying to the different levels as they have been used in this Manual.

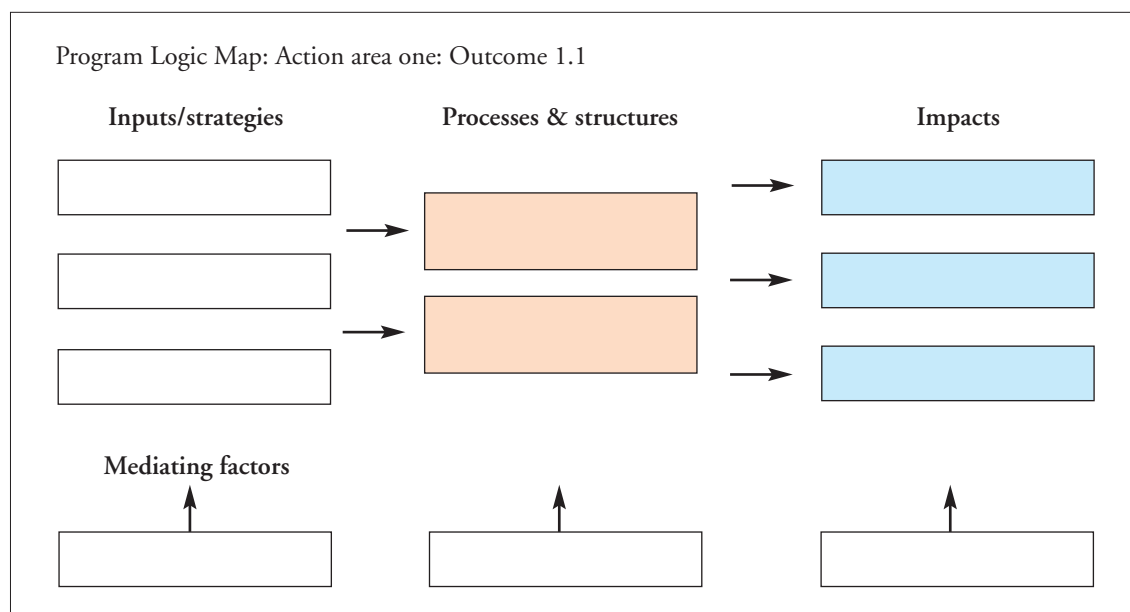
In addition to the four ‘levels’ of activity and effect shown in Table 1, the Program Logic Modelling approach used in this Manual recognises the fact that there is a range of factors operating within the community or environment in which any particular project is being implemented, which the project cannot influence, but which will ‘mediate’ the ability of the project to achieve its aims. These are called ‘mediating factors’, and are broadly described as political, cultural and socioeconomic factors, and rurality.

Table 2 shows a generic template for a Program Logic Map including the typical layout for the various components within the various levels (inputs/strategies, processes and structures, and impacts) as well as the mediating factors. Because all projects funded under the *National Suicide Prevention Strategy* have the same ultimate goals, the outcomes level has not been included in the Program Logic Maps shown in the Manual. The outcomes level is implicit in all of the Maps. Mediating factors are also represented at the bottom of the Program Logic Map template. The 23 Program Logic Maps do not include arrows to describe the relationships between the different levels. You will decide those for yourself when you clarify what it is that you believe your project is seeking to do.

Table 1: Definitions of Program Logic Terms

<p>(i) Inputs/Strategies – The resources, strategies and activities that the project or initiative entails.</p>	<p>Typical resource inputs to suicide prevention projects include funding for a Project Officer, and the experience, energy and wisdom of community members who volunteer their time. Typical activities or strategies include networking, conducting consultations and community needs assessments, training staff, and trialing the delivery of innovative interventions for clients.</p>
<p>(ii) Processes and structures – The enduring characteristics of services, service systems and other aspects of organised public social activity that are considered necessary to bring about enduring or lasting impacts for target populations. They include the characteristics and contributions of a wide variety of individuals, organisations and inter-organisational relationships. Processes and structures are different from activities that form part of the ‘inputs’ or ‘strategies’ implemented under funded suicide prevention initiatives, in that they should be maintained after the funded project is completed.</p>	<p>Examples of processes being developed by suicide prevention projects include protocols and procedures for identification and referral of individuals presenting to Emergency Departments with a suicide attempt. Typical structures being developed include networks of community-based service providers and improved service configurations that facilitate referral pathways or provide a wider range of program delivery options for communities including prevention and early intervention programs.</p>
<p>(iii) Impacts – Changes occurring in the ultimate target populations such as increases in protective factors and reductions in risk factors at the level of individuals, families or communities, as well as the experiences these target groups have of services and programs designed to affect risk and protective factors. Within the program logic perspective, impacts are essential precursors of the ultimate outcomes.</p>	<p>Typical impacts being pursued by suicide prevention projects include increases in community connectedness, increases in help-seeking behaviour among high-risk population groups, and reductions in the prevalence and consequences of risk factors such as depression and harmful drug use.</p>
<p>(iv) Outcomes – Outcomes refer to changes in the health and well-being of clients and populations including specific communities.</p>	<p>The ultimate outcome intended for all projects funded under the National Suicide Prevention Strategy is to reduce rates of suicide and deliberate self-harm, and increase levels of mental health and well-being.</p>

Table 2: General layout of Program Logic Maps



Development of the Program Logic Maps for the *LIFE Framework*

A separate Program Logic Map was developed for each of the 23 outcomes within the six ‘Areas for Action’ of the *LIFE Framework*. These Program Logic Maps are presented in Section Two of this Manual (mauve coloured pages 29 to 54). The indicators in these Program Logic Maps are categorised into (i) Process and Structure Indicators and (ii) Impact Indicators.

An overarching Program Logic Map was also produced for the *LIFE Framework* as a whole (see page 9). This was developed by organising the large number of indicators identified across the 23 outcome areas of the original *LIFE Framework* into 13 key domains: 6 Process and Structure Domains, and 7 Impact Domains. These key domains reflect concepts or constructs that are reasonably well recognised in the suicide prevention literature. Further to this, the 13 key domains were validated as accurately representing the major components of the *National Suicide Prevention Strategy* as a whole, in a workshop of suicide prevention experts from across Australia.

Development of Performance Indicators

After organising the various indicators of the Areas for Action document of the *LIFE Framework* into 13 key domains shown in the Overarching Program Logic Map, it was possible to reduce the number of indicators. This task was conducted during the workshop of suicide prevention experts from across Australia. Through a process of discussion and debate, the original 189 indicators were reduced and revised to the satisfaction of the majority of participants.

The final sets of recommended indicators are shown in Sections Three and Four of this Manual. The indicators relevant to the six (6) Process and Structure Domains are shown in Section Three (orange pages 55 to 72) while the indicators for the seven (7) Impact Domains are shown in Section Four (blue pages 73 to 88).

The various indicators are also referred to throughout the Program Logic Maps for each of the Outcome Areas shown in Section Two of this Manual. Here the Process and Structure Indicator Domains are prefixed with 'P' and numbered from Domain 1 (P-1) to Domain 6 (P-6). Each of the indicators within the particular domain is numbered consecutively (e.g., P-1.1 to P-1.7). Within two of the domains there are a number of sub-domains which are indicated by a letter (A to H). The Impact Indicator Domains are prefixed with 'I' and number from domain 1 (I-1) to domain 7 (I-7). Each indicator is numbered consecutively within each domain (e.g., I-1.1 to I-1.3).

Tables 3 and 4 below explain how the various indicators are organised and referred to throughout the Manual.

A glossary of frequently used terms and acronyms in the area of promotion, prevention and early intervention for mental health is provided at: <<http://auseinet.flinders.edu.au/glossary/index.php>>

Table 3: Domain structure and coding for indicators

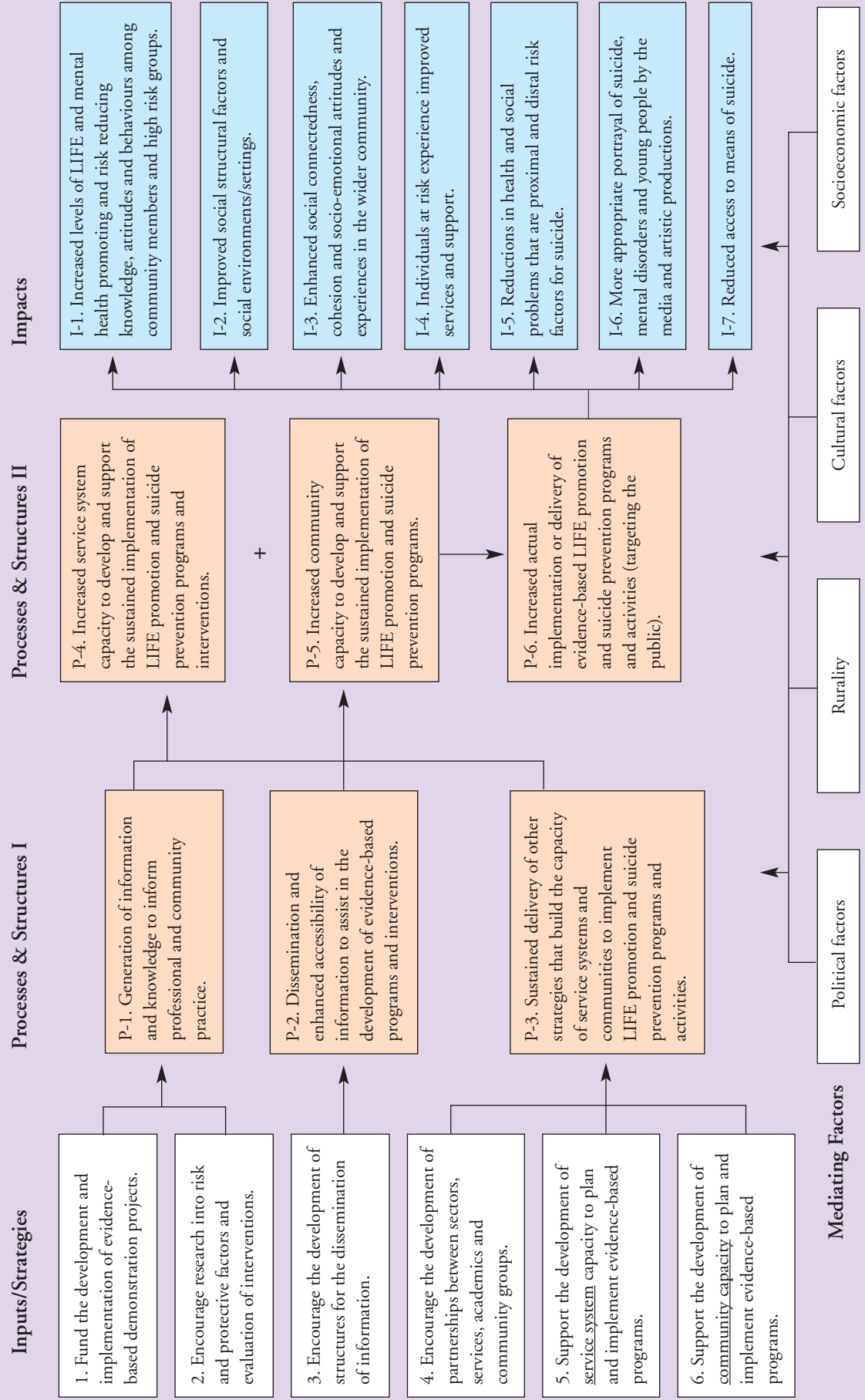
Process and Structure Indicator Domains		
Domain 1: Generation of information and knowledge to inform practice	7 indicators	P-1.1 to P-1.7
Domain 2: Dissemination and enhanced accessibility of information to assist in the development of evidence-based programs and interventions	6 indicators	P-2.1 to P-2.6
Domain 3: Sustained delivery of other strategies that build the capacity of service systems	5 indicators	P-3.1 to P-3.5
Domain 4: Increased service system capacity to develop and support the sustained implementation of life promotion and suicide prevention programs and interventions	22 indicators	
• Sub-domain A: Interagency and intersectoral collaboration	6 indicators	P-4.A.1 to P-4.A.6
• Sub-domain B: Community and consumer involvement	2 indicators	P-4.B.7 to P-4.B.8
• Sub-domain C: Information systems and access to information	1 indicator	P-4.C.9
• Sub-domain D: Needs assessment and evaluation	2 indicators	P-4.D.10 to P-4.D.11
• Sub-domain E: Knowledge, attitudes, confidence and skills among service providers	6 indicators	P-4.E.12 to P-4.E.17
• Sub-domain F: Management systems and resources	1 indicator	P-4.F.18
• Sub-domain G: Cultural sensitivity	4 indicators	P-4.G.19 to P-4.G.22
Domain 5: Increased community capacity to develop, and support the sustained implementation of, life promotion and suicide prevention programs	5 indicators	P-5.1 to P-5.5

continued over...

Table 3: Domain structure and coding for indicators *continued*

Domain 6: Increased actual implementation or delivery of evidence-based life promotion and suicide prevention programs and activities targeting the public	12 indicators	
• Sub-domain A: General	1 indicator	P-6.A.1
• Sub-domain B: Community education	2 indicators	P-6.B.2 to P-4.B.3
• Sub-domain C: Life and mental health promotion	3 indicators	P-6.C.4 to P-6.C.6
• Sub-domain D: Primary prevention and early intervention	2 indicators	P-6.D.7 to P-6.D.8
• Sub-domain E: Crisis intervention and followup support	3 indicators	P-6.E.9 to P-4.E.11
• Sub-domain F: Postvention	1 indicator	P-6.F.12
Impact Indicator Domains		
Domain 1: Increased levels of life and mental health promoting and risk reducing knowledge, attitudes and behaviours among community members and people at heightened risk	3 indicators	I-1.1 to I-1.3
Domain 2: Improved social structural factors and social environments/settings	3 indicators	I-2.1 to I-2.3
Domain 3: Enhanced social connectedness/cohesion and socio-emotional attitudes and experiences in the wider community	4 indicators	I-3.1 to I-3.4
Domain 4: Individuals at risk experience improved services and support	7 indicators	I-4.1 to I-4.7
Domain 5: Reductions in health and social problems that are proximal and distal risk factors for suicide	6 indicators	I-5.1 to I-5.6
Domain 6: More appropriate portrayal of suicide, mental disorders and young people by the media and artistic productions	4 indicators	I-6.1 to I-6.4
Domain 7: Reduced access to means of suicide	7 indicators	I-7.1 to I-7.7

Overarching Program Logic Map for the National Suicide Prevention Strategy



How to use this Manual

Projects funded or conceived within the *LIFE Framework* necessarily share one or more of the broad goals of the *National Suicide Prevention Strategy*. To a lesser extent, projects will also share strategies (inputs), and aims and objectives related to the intended effects or consequences. There is a wide variety of possible combinations of goals, aims, objectives and strategies. These particular combinations contribute to making each project unique. Projects will vary in the extent to which they are multidimensional or focused on particular factors. Recognising shared components as well as differences helps us to understand how our efforts work in synergy with the efforts of others to contribute to the whole.

This section of the Manual helps projects identify the various components of their project that are shared with others working within the *LIFE Framework* and use this information to identify appropriate performance indicators and measures, thereby building an evaluation framework capable of assessing the extent to which the project may have contributed to the achievements of the *National Suicide Prevention Strategy*.

There are a total of 5 steps to work through. To help illustrate the process of working through the steps, a worked example is provided in the green boxes at the end of each step.

The sections that you will need to refer to as you go through the five steps are printed on coloured pages to help you to navigate the manual.

- Program Logic Maps – Section Two (mauve)
- Process and Structure Performance Indicators: Recommendations – Section Three (orange)
- Impact Performance Indicators: Recommendations – Section Four (blue)

Example: Help-seeking project

A group of agencies has identified that young people are under-utilising mental health and other community-based support services in their area and want to do something to encourage young people to seek help from local services. The group believes that the services may not be well-known or that young people, especially young men, may not be willing to seek help when they need it, even when they do know of the services.

Thus, the key aim of the project is to **encourage young people, especially young men, to seek help when they need it.**

The project plan includes: (1) looking for existing programs that work to encourage help-seeking; (2) consulting with young people and service providers about strategies that encourage help-seeking; (3) sharing findings from the consultation with relevant people, services and sectors in the community; and (4) delivering community education strategies targeting young people to raise awareness and develop positive attitudes and help-seeking behaviours.

Step 1: Identifying the Action Area(s) that you are working in

The first step is to identify the Action Area(s) that your project or initiative fits within. You may already have done this in planning your project and applying for funding, but because the focus of projects can change over time it may be worthwhile to revisit this question.

The Action Areas from the *LIFE Framework* are very broad categories. Your project may not fit neatly within any one or two categories. Steps 2 and 3 of this Manual involve greater descriptive precision. The Action Areas should be viewed only as flexible starting points that are intended to help you save time in the next Steps. You should not spend too much time on this step.

There are six 'Action Areas' listed in the Department of Health and Ageing publication, *LIFE: A framework for prevention of suicide and self-harm in Australia – Areas for action* (blue volume).

How to recognise the Action Area(s) relevant to your project

The key question is:

What is the broad focus or scope of your project?

Action Area from the <i>LIFE Framework</i>		✓
<i>Tick the Action Area(s) that apply best to your project</i>		
1	Promoting well-being, resilience and community capacity	
2	Enhancing protective factors and reducing risk factors for suicide and self-harm	
3	Services and support within the community for groups at increased risk	
4	Services for individuals at high risk	
5	Partnerships with Aboriginal and Torres Strait Islander peoples	
6	Progressing the evidence base for suicide prevention good practice	

Example: Help-seeking project

Step 1: Identifying the Action Area(s)

The project is ultimately seeking to change the attitudes and behaviours of young people towards help-seeking. These attitudes and behaviours could be viewed as risk/protective factors for suicide and self-harm. Thus the project is working in **Action Area 2**.

The project also wants to collect information about evidence-based interventions and data about factors that affect help-seeking among young in the local community and disseminate these findings. In this sense the project is seeking to build the evidence base for good practice and is therefore contributing to **Action Area 6**.

Step 2: Identifying the Outcome Area(s) that you are working in

Within each of the Action Areas, the *LIFE Framework* describes a number of Outcome Areas. These are all listed in the table below.

Within the Action Area(s) that you have identified for your project, consider each of the Outcome Areas and note which of these best describe the effects that you are hoping to bring about through your project/initiative.

The page numbers in the table refer to the Program Logic Map for each Outcome Area (see Background pages 3 and 4 for explanation of Program Logic Maps). You might want to look quickly at the Program Logic Maps for particular Outcome Areas in order to gather more information about whether or not a particular Outcome Area is relevant to your project. The Program Logic Maps are in the mauve section of this Manual (see pages 29-54).

There may be more than one Outcome Area that is relevant to your project. You should think about all the different kinds of effects that you are hoping for. These include changes for ultimate target groups including individuals and/or communities (impacts) as well as changes to the system or systems that you are working within (processes and structures).

Some of the Outcome Areas listed below may be described at a more general level than those of your project, or may not seem to correspond perfectly with what you are doing. Select the Outcome Areas that appear to be closest to what your project is trying to do. As you read through the list some of the Outcome Areas may also seem a bit similar to one another. The similar sounding Outcome Areas are likely to belong to different Action Areas, and this is what makes them unique.

How to recognise the outcomes relevant to your project

The key question is:

What kinds of changes is your project trying to bring about for individuals, high-risk groups, communities and service systems?

Tick those Outcome Areas that seem to be relevant to your project.

Action Area	Outcome Area	✓	Manual page
1. Promoting well-being, resilience and community capacity	1.1 Increase community capacity and emotional well-being across Australia.		32
	1.2 Improve social structural factors that promote well-being, community capacity, and mental health.		33
	1.3 Increase community acceptance of and support for marginalised groups, people with risk factors for suicide, and those affected by suicide.		34

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Action Area	Outcome Area	✓	Manual page
2. Enhancing protective factors and reducing risk factors for suicide and self-harm	2.1 Enhance factors that protect against the adverse social conditions associated with suicide risk.		35
	2.2 Reduce the prevalence of the known risk factors for suicide and self-harm.		36
	2.3 Increase awareness of early signs and symptoms of mental health problems and mental disorders.		37
	2.4 Increase the acceptability of help-seeking to respond to mental health problems and other issues.		38
	2.5 Identify and promote good practice in the portrayal, in the media and artistic productions (school and other drama, film, painting etc.) of young people, high risk groups, suicide, mental disorders and related issues.		39
	2.6 Reduce access to identified lethal methods of suicide.		40
3. Services and support within the community for groups at increased risk	3.1 Enhance the response of services in the community to the full range of needs of groups who are at increased risk of suicide.		41
	3.2 Enhance the capacity of services in the community to recognise, respond to and refer individuals showing signs of high suicide risk.		42
	3.3 Increase awareness and implementation in rural and remote communities of models of suicide prevention and response suitable for such communities.		43
4. Services for individuals at high risk	4.1 Improve emergency response and provision of follow-up support of incidents of attempted suicide and self-harm.		44
	4.2 Reduce the risk of suicide and self-harm among people with, or at risk of, mental disorder.		45
	4.3 Enhance support for people who are involved with, or likely to become involved with, the criminal justice or juvenile justice system.		46
	4.4 Reduce the risk of suicide and self-harm associated with harmful drug and alcohol use.		47

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continued

Action Area	Outcome Area	✓	
	4.5 Provide prompt and effective support for people bereaved or directly affected by suicide.		48
5. Partnerships with Aboriginal and Torres Strait Islander peoples	5.1 Share information about and implement life-affirming and suicide-prevention programs that are community-based and ground in the culture of Aboriginal and Torres Strait Islander peoples.		49
	5.2 Increase the relevance of mainstream services and suicide prevention programs and services to the culture, needs and strengths of Aboriginal and Torres Strait Islander peoples.		50
6. Progressing the evidence base for suicide prevention good practice	6.1 Support strategic research and evaluation of programs, ongoing and longitudinal research, and the dissemination of knowledge gained to facilitate good practice.		51
	6.2 Provide timely access to accurate and up-to-date data on suicide, self-harm, risk factors and good practice initiatives.		52
	6.3 Increase the percentage of the health, welfare, education and other human services workforce that has undertaken training in suicide prevention.		53
	6.4 Implement guidelines and protocols consistent with good practice identified through research, evaluation, consumer consultation and expert consensus.		54

Example: Help-seeking project

Step 2: Identifying the outcome area(s) that you are working in

Within Action Area 2, the help-seeking project corresponds well with Outcome 2.4

2.4	Increase the acceptability of help-seeking to respond to mental health problems and other issues.	✓	Page 38
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Within Action Area 6, the help-seeking project corresponds best with Outcome 6.2

6.2	Provide timely access to accurate and up-to-date data on suicide, self-harm, risk factors and good practice initiatives.	✓	Page 52
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Note that the match on Outcome 6.2 is not perfect but the project is intending to collect and provide data that is useful, so it is most likely that relevant indicators will be found under this Outcome in Step 3. Outcome 6.1 also seems like it might be relevant so it would be worth looking at the Program Logic Map for Outcome 6.1 (page 51).

Step 3: Using the Program Logic Maps to decide performance indicators relevant to the National *LIFE Framework*

You may have identified several Outcome Areas and hence several Program Logic Maps that are relevant to your work. Consider each Map in turn. Program Logic Maps are described in general terms on pages 3 and 4.

You should look through each Map and identify which of the boxes under each column heading best describe key aspects of your project. Not all of the boxes (or performance indicators) in each Program Logic Map will be relevant to your project. Select only the ones that are relevant. You might like to use the blank Program Logic Map provided on page 18 to note down the relevant performance indicators. (If you photocopy the blank Program Logic Map you will be able to make as many copies as you need.)

The key question is:

Precisely what is your project seeking to change, and exactly how does it intend to bring about that change?

There are 3 key questions to ask when looking at each of the Program Logic Maps to develop your own Program Logic Map.

Firstly, describe the Inputs/Strategies that your project entails

What are the resources being applied and the activities being undertaken?

Each Program Logic Map includes the strategies recommended for the relevant outcome area in the *LIFE Framework* 'Areas for action' document. You will probably find that there is at least one input/strategy described on the Program Logic Map that is consistent with the strategies being used by your own project. The description may not be an exact match, but if your project is consistent with the *LIFE Framework*, the strategies described in the relevant Program Logic Map should have some degree of similarity with the kind of activities you are undertaking.

You may also wish to consider whether some of the other inputs/strategies described in the Program Logic Maps are also possible activities that you might need or want to undertake.

Secondly, describe the Processes and Structures that your project seeks to change.

How will services, service systems and other aspects of organised public social activity be changed?

The indicators shown under the heading 'Processes and Structures' in the Program Logic Maps have been identified as the priority indicators that are most important for the overall evaluation of the *National Suicide Prevention Strategy* at the national level. They are also relevant to local project level evaluations. It is intended that local project evaluations will provide data consistent with these indicators in order to contribute to the evidence base for suicide prevention.

You should find at least one Process and Structure Indicator that reflects the kind of change/s that you expect as a result of the work of your project.

You may find more than one relevant Process and Structure Indicator. Note them so that you can return to select the most important ones.

Finally, describe the Impacts you hope to achieve.

What kinds of changes would you like clients or community members to experience as a result of your project?

The Impact Indicators shown in each Program Logic Map are the indicators that have been selected as being most important for the overall evaluation of the *National Suicide Prevention Strategy* at the national level. Most of them are also relevant to local project level evaluations, and it is intended that local project evaluations will provide data that is consistent with these indicators to inform knowledge about suicide prevention.

Some of the Impact Indicators are described in general terms, or describe a particular target group. You may have to add more details, such as a specific target group that your project focuses on, or a specific location or setting that you are working in, to make them accurately describe your project.

You should find at least one Impact Indicator that reflects the kind of change/s that you expect as a result of the work of your project.

You may find more than one relevant indicator. Note them so that you can return to select the most important ones.

As you go through the three questions for each Program Logic Map, keep in mind the following.

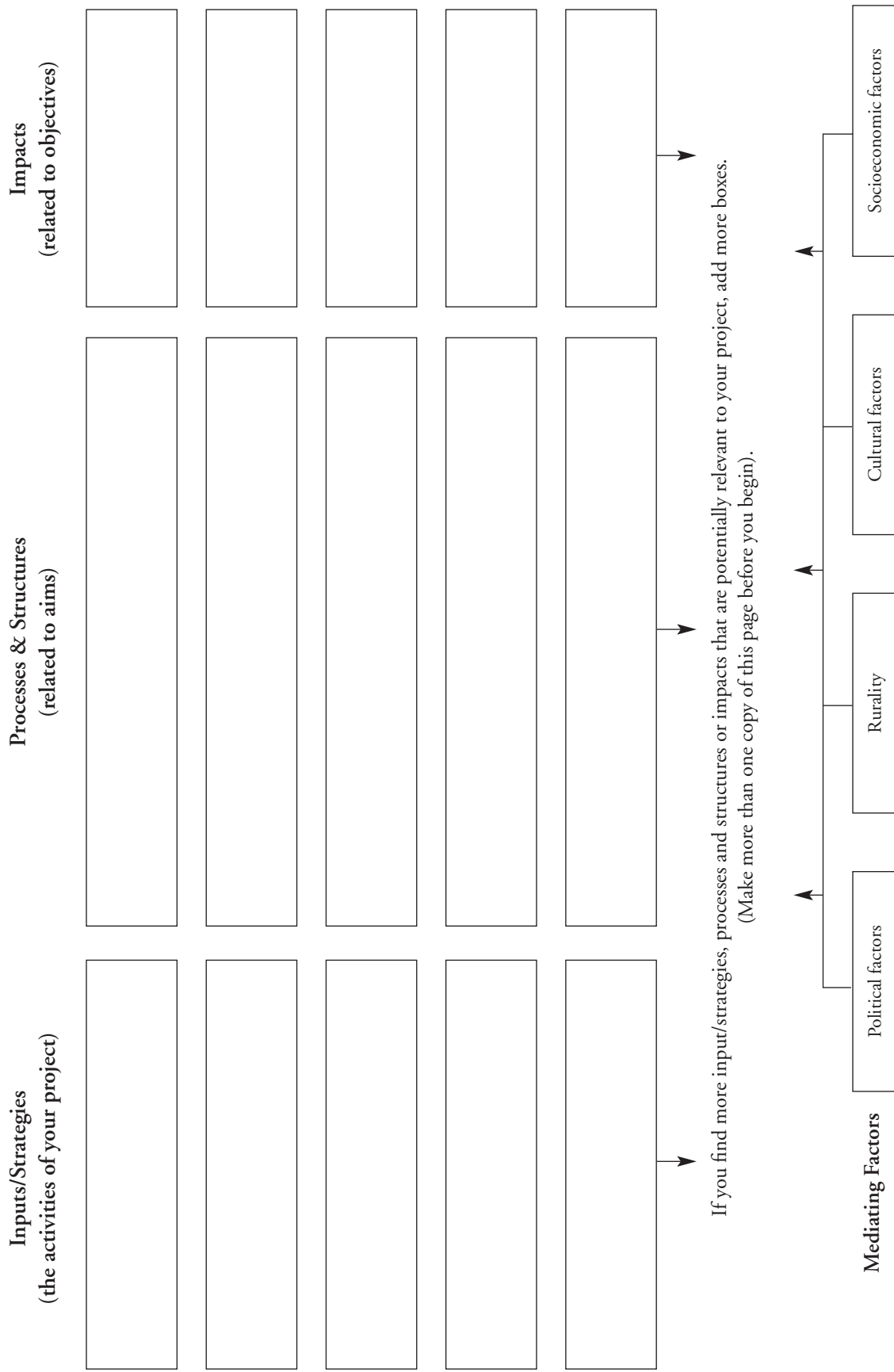
There is some conceptual overlap between the various strategies, Process/Structure Indicators and Impact Indicators in different Program Logic Maps. If you find this, you will need to select the ones that are most relevant to your project by considering the whole Map and what it is about.

Across all the levels of the Program Logic Maps, it is better to include all the indicators that seem relevant at this stage, even if there seem to be a lot. The aim at this stage is to develop an accurate, detailed description of your project. The next steps will provide some help to reduce the number of indicators if you have too many.

You should have some idea of how you think the different indicators you have identified relate to each other. That is, what kinds of changes to structures and processes do you believe will be caused by the inputs or strategies you are implementing? And what kinds of changes or impacts do you believe will follow from the changes to structures and processes? Thinking about the way that you expect change to happen will guide you in adding arrows to your Program Logic Map in order to represent the expected effects of your project.

After you have answered each of the three questions described above for each of the Outcome Areas that you have identified as relevant to your project, you will have a Program Logic Map that represents your individual project, but which connects it to all other projects and activities that fit within the *LIFE Framework*.

You should consider whether there are any gaps in the logic that you have represented. Step 4 includes information on how to identify any additional indicators that you might think you need, and also how to reduce the number of indicators if you think that you have too many.



Example: Help-seeking project

Step 3: Using the Program Logic Maps to decide performance indicators relevant to the National LIFE Framework

When we look at the Program Logic Map for Outcome 2.4 we can see that three of the four Inputs/strategies apply to the help-seeking project.

Review of the research into programs and current initiatives associated with help-seeking behaviour and its acceptability.

Consult young people (particularly young males) and youth agencies on possible strategies, with particular attention to gender (etc).

Disseminate information about effective strategies for encouraging help-seeking to schools, universities, workplaces, employment and training agencies and community organisations.

When we look under the Processes and Structures column for Outcome 2.4 we can find three boxes that are relevant to the aims of the help-seeking project.

Increased proportion of policy jurisdictions that generate data and information relevant to *help-seeking patterns and barriers* for their local populations. P-1.7

Increased availability and accessibility of information relating to *help-seeking and effective interventions*. P-2.4

Increased collaboration including joint planning, sharing of expertise, collaborative service delivery and program implementation between mainstream services and those for high-risk populations. P-4.6

When we look under the Impacts column for Outcome 2.4 we can find three boxes that are relevant to the objectives of the help-seeking project.

Increased level of knowledge of mental health and mental illness within the community, *and especially among young people*. I-1.1

Improved knowledge of and attitudes towards help-seeking options in the community, especially in males and others at heightened risk. I-1.2

Increased rate of help-seeking among groups with low rates of help-seeking. I-1.3

Note: Text in italics has been added to make the indicator more accurately describe this particular project.

Example: Help-seeking project

Step 3: Using the Program Logic Maps to decide performance indicators relevant to the National LIFE Framework (continued)

When we look at the Program Logic Map for Outcome 6.2 we can see that one of the four Inputs/strategies applies to the help-seeking project.

Collect, collate and disseminate information about good practice in suicide prevention (etc)

When we look under the Processes and Structures columns for Outcome 6.2 we can find four boxes that are relevant to the aims of the help-seeking project.

Increased proportion of policy jurisdictions that generate and report data and information relevant to suicide prevention on their local populations. P-1.7

Service planners, managers and users have ready access to local data about suicide, mental health, risk and protective factors, service utilisation, referral options and prevention programs across a range of sectors in their local area. P-4.C.9

Increase the number, regularity and range of community needs assessments aimed at identifying and appraising the needs of local groups at higher risk of suicide. P-4.D.10

Increased knowledge of risk factors for suicide, the signs and symptoms of high risk, and effective interventions among staff in relevant services. P-4.E.12

When we look at the Program Logic Map for Outcome 6.1 we can see that two Inputs/strategies apply to the help-seeking project.

Conduct epidemiological and sociological studies of suicide and self-harm in specific groups of interest, especially research that involves partnerships between researchers and members of specific groups.

Disseminate research and evaluation findings.

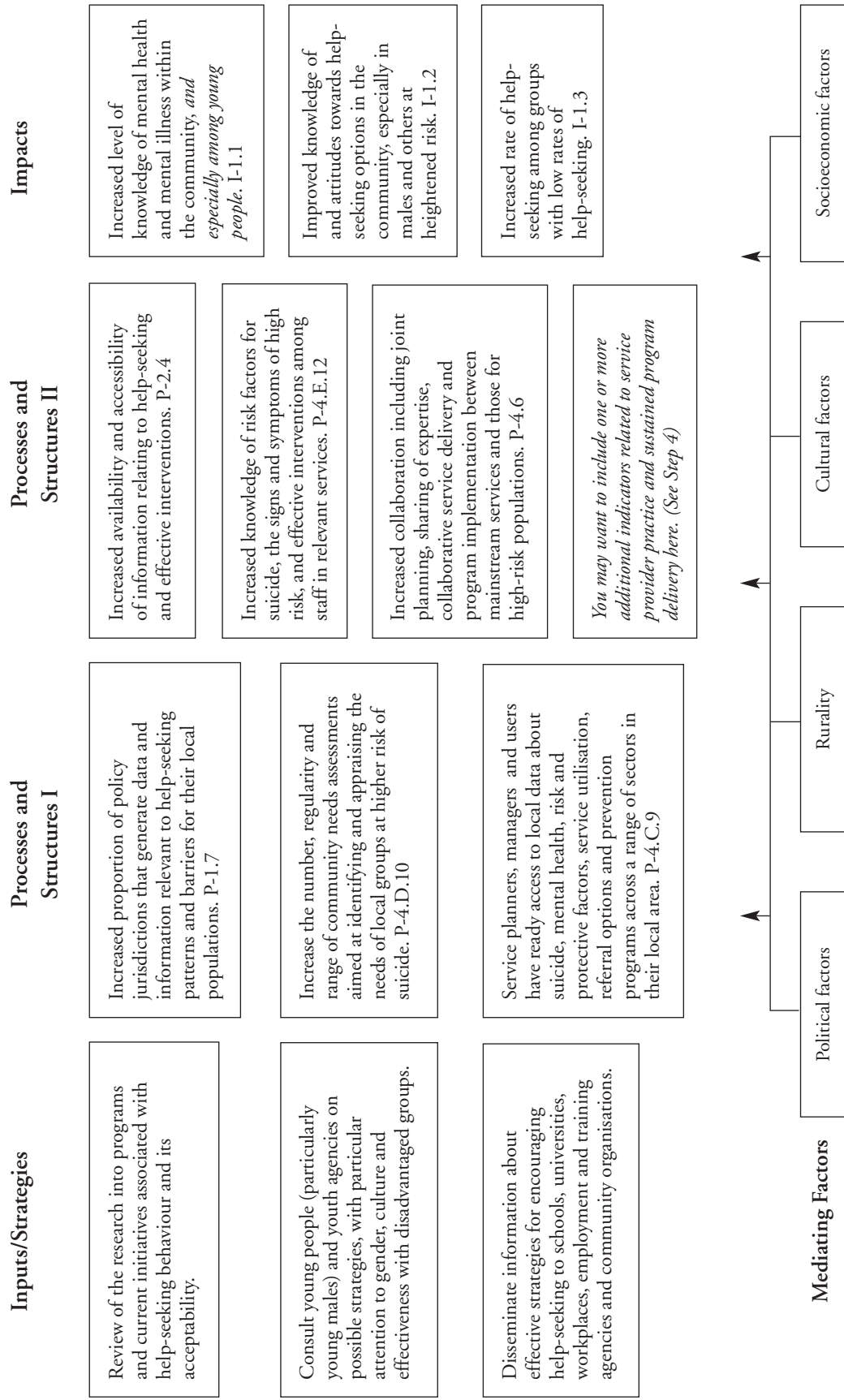
When we look under the Processes and Structures columns we can find at least one box that is relevant to the aims of the help-seeking project.

Increased availability and accessibility of information relating to suicide prevention. P-2.4

Note that there is some conceptual overlap between the various strategies, and process/structure and impact indicators identified as potentially relevant under Outcomes 2.4, 6.1 and 6.2. Project staff need to select the ones that are most relevant to the project.

We can now combine the indicators derived from Outcome areas 2.4, 6.1 and 6.2 to create a Program Logic Map that is specific to the help-seeking project example (see page 23).

Program Logic Map for Help-seeking project (example): Increase the acceptability of help-seeking among young people, especially young males



Step 4: Identifying the tools to use

The key question is:

How do you measure the indicators you have identified for your project?

As described earlier (pp 6-8), at the end of each indicator described in the boxes in the Program Logic Maps you will find a number that tells you where to find the indicator in the 'Process and Structure Performance Indicators: Recommendations' (orange pages) or 'Impact Performance Indicators: Recommendations' (blue pages) sections of this manual. Each indicator has a reference to recommended or known methods for measurement, or to existing data sets that might provide useful information.

The indicators have been grouped under the Domains that summarise the intended effects of activities undertaken as part of the *National Suicide Prevention Strategy*.

Turn to the relevant tables in Sections 3 and 4 to see what methods and/or tools are recommended to measure the performance indicator/s that you have identified as most relevant to your project.

You should now have a number of indicators with recommended tools (where available) to use to evaluate the process outcomes and impacts of your project.

As you work through the recommended Indicators, keep in mind the following.

Critical scrutiny of your Project Program Logic Map may have revealed some gaps in the logic. If you read systematically through the Process and Structure and Impact Indicator Recommendations tables you may find other indicators that help fill the gaps you have identified. You may choose to adapt your Program Logic Map (or even your project) at this point.

Example: Help-seeking project

Step 4: Identifying the tools to use

For each of the process and structure indicators identified we look for recommendations in the orange section of the Manual.

The Process and Structure recommendations table suggests the following tools and methods for the indicators shown.

Process and structure indicators	Recommended tools/methods
Increased availability and accessibility of information relating to <i>help-seeking and effective interventions</i> . P-2.4	<ul style="list-style-type: none">• Survey of a sample of end users involving questionnaires, interviews or focus groups.
Increased proportion of policy jurisdictions that generate data and information relevant to <i>help-seeking patterns and barriers for their local populations</i> . P-1.7	<ul style="list-style-type: none">• Recommended for the national level.
Increased collaboration including joint planning, sharing of expertise, collaborative service delivery and program implementation between mainstream services and those for high risk populations. P-4.6	<ul style="list-style-type: none">• Network analysis.• Interviews with key informants.

And continue for each of the identified process and structure indicators.

Note: Text in italic is interchangeable text that has been added, and can be altered to suit the particular strategies, settings or target groups to which the indicator is being applied.

The Impact indicator recommendations table suggests the following tools and methods for the indicators shown.

Impact indicators	Recommended tools/methods
Increased level of knowledge of mental health and mental illness within the community, <i>and especially among young people</i> . I-1.1	<ul style="list-style-type: none">• The instrument used in the Canberra Longitudinal Study conducted by the Centre for Mental Health Research at the Australian National University includes questions on mental health literacy. <http://www.anu.edu.au/cmhr/>
Improved knowledge of and attitudes towards help-seeking options in the community, especially in males and others at heightened risk. I-1.2	<ul style="list-style-type: none">• Perceived Needs for Care Focus Group: Young People.
Increased rate of help-seeking among groups with low rates of help-seeking. I-1.3	<ul style="list-style-type: none">• Perceived Need for Care Questionnaire that was used in the National Survey of Mental Health and Well-being.

And continue for each of the identified impact indicators.

Note: Text in italics is interchangeable text that has been added, and can be altered to suit the particular strategies, settings or target groups to which the indicator is being applied

Example: Help-seeking project

Step 4: Identifying the tools to use – adapting the Project’s Program Logic Map

In checking the selected Impact Indicators against the Process and Structure Indicators that project staff have located from relevant Outcome Areas, they may decide that there are insufficient process and structure changes specified to actually achieve the listed impacts. By reading systematically through the Process and Structure Indicator Recommendations table during Step 4, they may find other indicators that help fill the gaps they have identified.

Project staff might note that some descriptions are broader in scope than their project. For example, the project intends to bring about the effect of increasing programs that target protective factors, but only those that relate specifically to ‘help-seeking’. The project staff may decide this is an important change to try to measure, so they can change the description of the indicator to make it more accurate and include it in the Program Logic Map. (See P-6.C.4 below.)

Some additional process/structure indicators that may be relevant to this project include:

Increased availability (for the public) of information on mental health, mental disorders and services from a range of sources including GPs, media, and youth and community services. P-6.B.2

Increased number of media articles or segments conveying positive mental health messages. P-6.B.3

Increased number of evidence-based universally targeted programs implemented that address protective factors such as *help-seeking attitudes and behaviours*. P-6.C.4

Increased proportion of service providers across a range of sectors who participate in activities aimed at identifying individuals who may be at risk and engaging them in programs designed to reduce risk. P-6.D.8

Note: Text in italics is interchangeable text that has been added, and can be altered to suit the particular strategies, settings or target groups to which the indicator is being applied.

What to do if you think you have too many indicators

The Program Logic Map is meant to provide a comprehensive representation of your project. It outlines the full scope of your activities and the intended effects. Ideally, evaluation based on a Program Logic Approach should aim to collect data relevant to all domains or levels of effect. For various reasons, however, it may not be possible for your evaluation to measure progress in all relevant domains. If you think that you have too many indicators or data collection demands, you will need to select the best or most important indicators to use in your evaluation. This decision may be guided by considerations of the cost of data collection compared to your budget for evaluation, and various logistical constraints. Another key issue to consider is how likely it is that your project can actually exert a significant influence on a particular indicator. It is best to select the indicators for which the likelihood of generating and detecting a significant change is greatest.

If you have identified a very large number of indicators it is also possible that the scope of your project may be too broad. Consider whether you are trying to do too much, or decide which are the most important strategies to focus on.

You also need to remember that your project is part of a broader national effort. There may be other projects in your local area, region or State/Territory that are helping to contribute towards achievement of the impacts and outcomes that your project is focusing on. If this is the case then there may be advantages in collaborating with other projects and initiatives to collect data relevant to shared aims and objectives. Data from the evaluation of unique and shared components of a cluster of initiatives could be brought together and interpreted in the context of knowing that there are numerous synergistic strategies in place. Furthermore, it may be appropriate for projects with shared aims and objectives to pool resources in the collection of relevant data. This approach may yield considerable cost efficiencies in evaluation.

If there are no recommended tools in Sections 3 or 4 for the indicators that you have identified, or you need to find tools that are appropriate for a specific target group or setting, you can use the description of the indicator domain to search for suitable instruments or methods.

Step 5: Finalising a comprehensive evaluation plan

You should now have a number of agreed indicators with recommended tools (where available) to use to evaluate the process/structure effects and impacts of your project. These indicators are consistent with the framework being used for the overall evaluation of the National Suicide Prevention Strategy at the national level. The data that you provide by using these indicators and the recommended tools will add to the evidence base about suicide prevention in Australia.

The basic principle that has been used in determining recommendations for tools to use at the local project level is to encourage the use of existing databases, questionnaires, surveys and/or methods. In some instances the questions that are relevant to a particular indicator may represent one section or component of a much larger survey. By using these questions in local project level evaluations, it is possible to consider the relationship between data gathered from smaller samples against the data gathered from populations or larger similar samples.

For this reason, it is very important that survey questions are used exactly as they are written in the survey of origin. That is, projects using such questions should not reword any items. Even small changes can make comparisons between data invalid, making it much more difficult to use data generated by projects to build a comprehensive evidence base about suicide prevention in Australia.

You need to determine the best time to gather the data. In general, for most indicators, you will probably want to gather data before, or in the early stages of undertaking the major activities of your project, as well as after you have finished your activities.

Other evaluation tasks

There are additional aspects of your project that you will need to document that are not covered in detail in this book and by this process. These elements include:

(I) PROJECT IMPLEMENTATION

It is important to provide a detailed description of the way in which the project was developed and implemented. Readers need to know what was done, when or in what sequence, by whom, and how. This constitutes critical information for interpreting the data collected on performance indicators and for readers interested in replicating or improving on your intervention.

Some important details include:

- the nature of the organisations involved in the project;
- the project management structure;
- the professional backgrounds of project staff;
- the range of stakeholders consulted to inform the design of the project;
- the findings from such consultations;
- the steps taken to secure collaboration from key participants outside of the immediate project group; and
- progress against any other deliverables described in the funding agreement for your project.

(II) REACH AND IMMEDIATE EFFECTS

It is also important to provide information about the reach of the project activities in terms of how many people or organisations were touched by, or participated in interventions. Those 'reached' by the project may manifest immediate effects. These immediate effects are different from 'processes and structures'. They are temporary or transitional changes that may or may not lead to more sustained changes in processes and structures. An example of reach is the number of staff members who participate in a training program. An example of an immediate effect is the initial reaction of those staff to the training program; whether they enjoyed the training and whether they believe that it was useful for them.

In considering immediate effects it is particularly critical to record any unintended effects that could possibly lead to negative effects for target groups.

Information about immediate effects may lead to refinement or redesign of activities. Information about unintended negative effects is also essential to assist other projects that may be similar to your own. Do not feel that it is a sign of failure of your project to document negative effects. Such information is critical for learning.

Example: Help-seeking project

Step 5: Finalising a comprehensive evaluation plan

Other evaluation tasks will include:

- Description of the findings of the review of research into programs and current initiatives focused on help-seeking behaviour and its acceptability, including a note of gaps in information.
- Description of the methods and findings of the consultation with young people (particularly young males) and youth agencies on possible strategies, including record of gaps in current efforts.
- Description of any information package or other product/s developed.
- Description of how information about recommended strategies for encouraging help-seeking was disseminated such as the range of settings (e.g., schools, universities, workplaces, employment and training agencies and community organisations) and number of each such settings; as well as details about how each was engaged.



SECTION TWO

Program Logic Maps
for Outcome Areas

Program Logic Maps for Outcome Areas

This section presents the 23 Program Logic Maps that have been devised to represent the 23 Outcome Areas within the six 'Areas for action' of the *LIFE Framework*.

Indicators are organised into two broad categories:

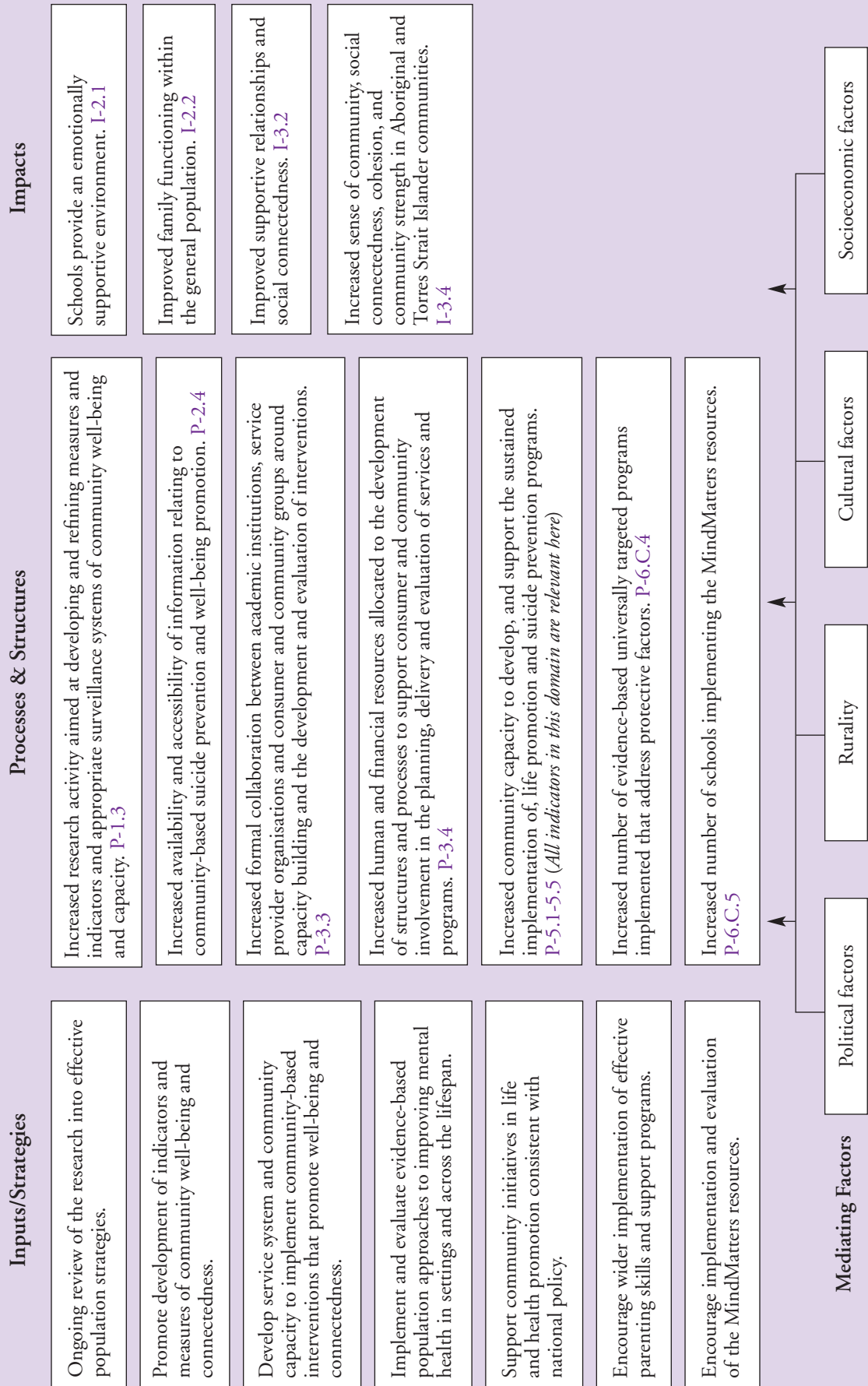
- (i) Process and Structure Indicators; and
- (ii) Impact Indicators.

The indicators are represented in a logical sequence – with effects that could be expected to occur relatively early in time (Process and Structure Indicators) through to effects that could be expected in the longer term (Impact Indicators). For further description of these stages of hypothesised change, see page 6.

The overarching program logic map (page 9) represents a summary of the Process and Structure Domains (6 domains) and the Impact Domains (7 domains).

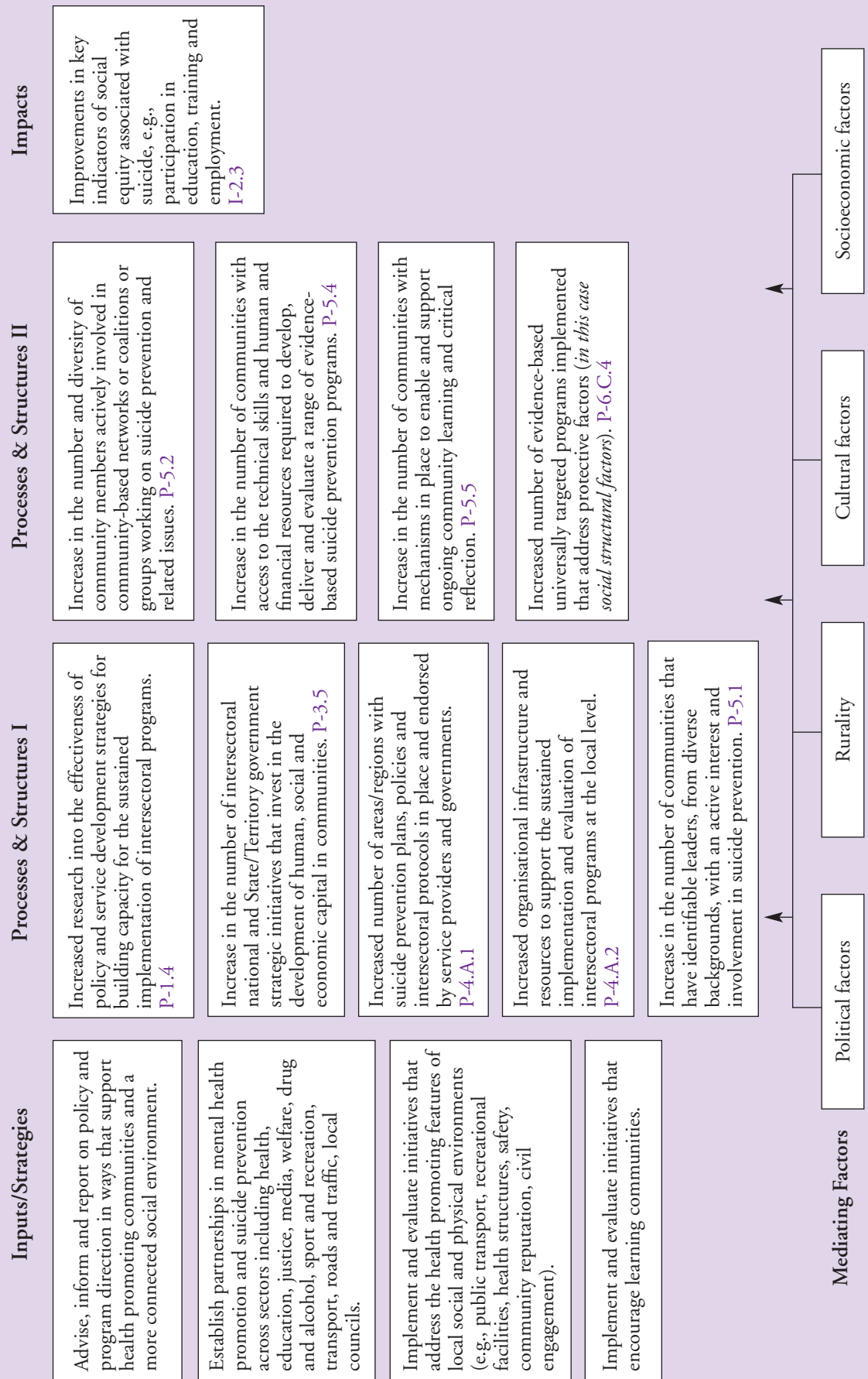
LIFE Framework Program Logic: Action Area One:

Outcome Area 1.1 Community Capacity and Emotional Well-being

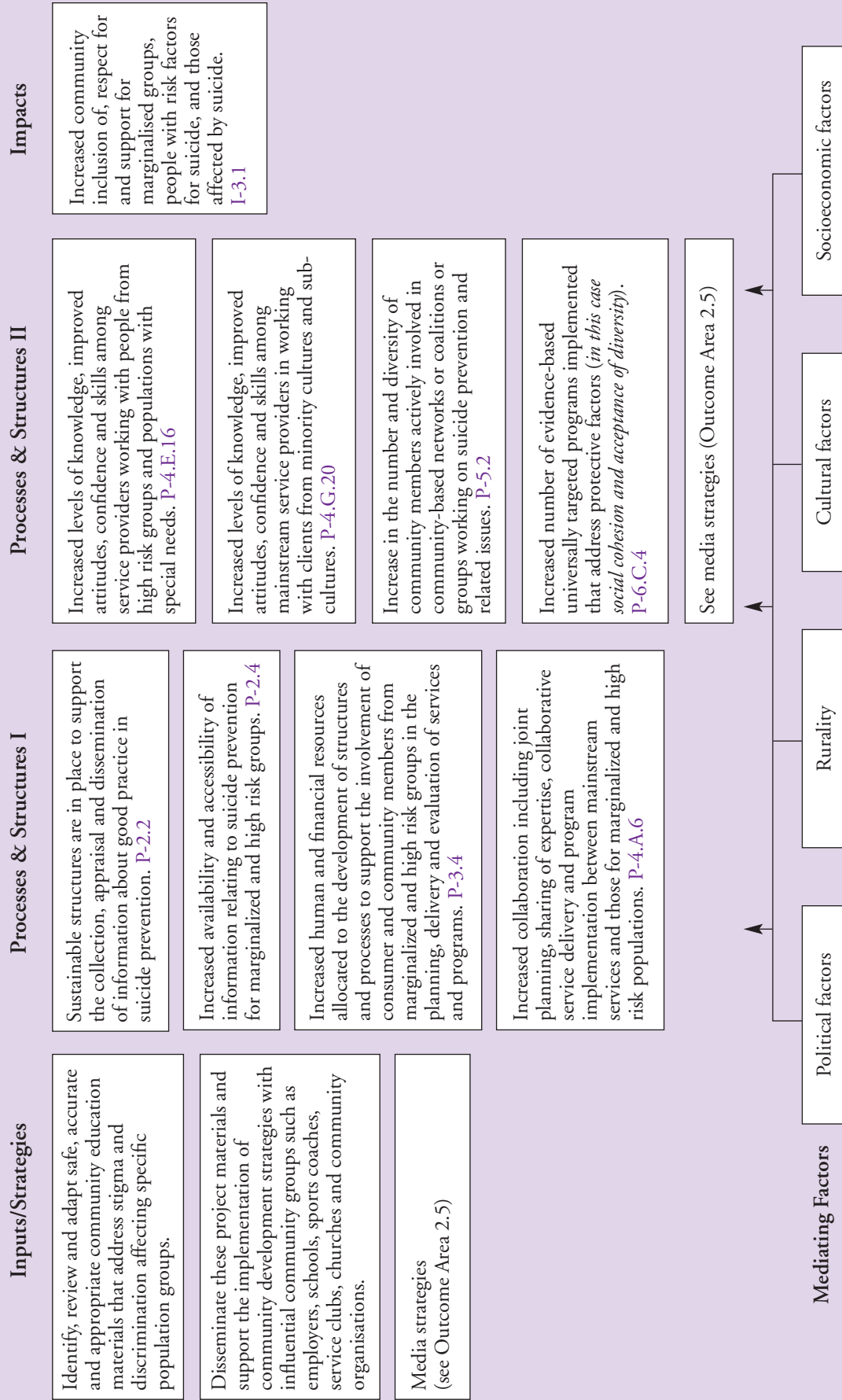


LIFE Framework Program Logic: Action Area One:

Outcome Area 1.2 Improve social structural factors

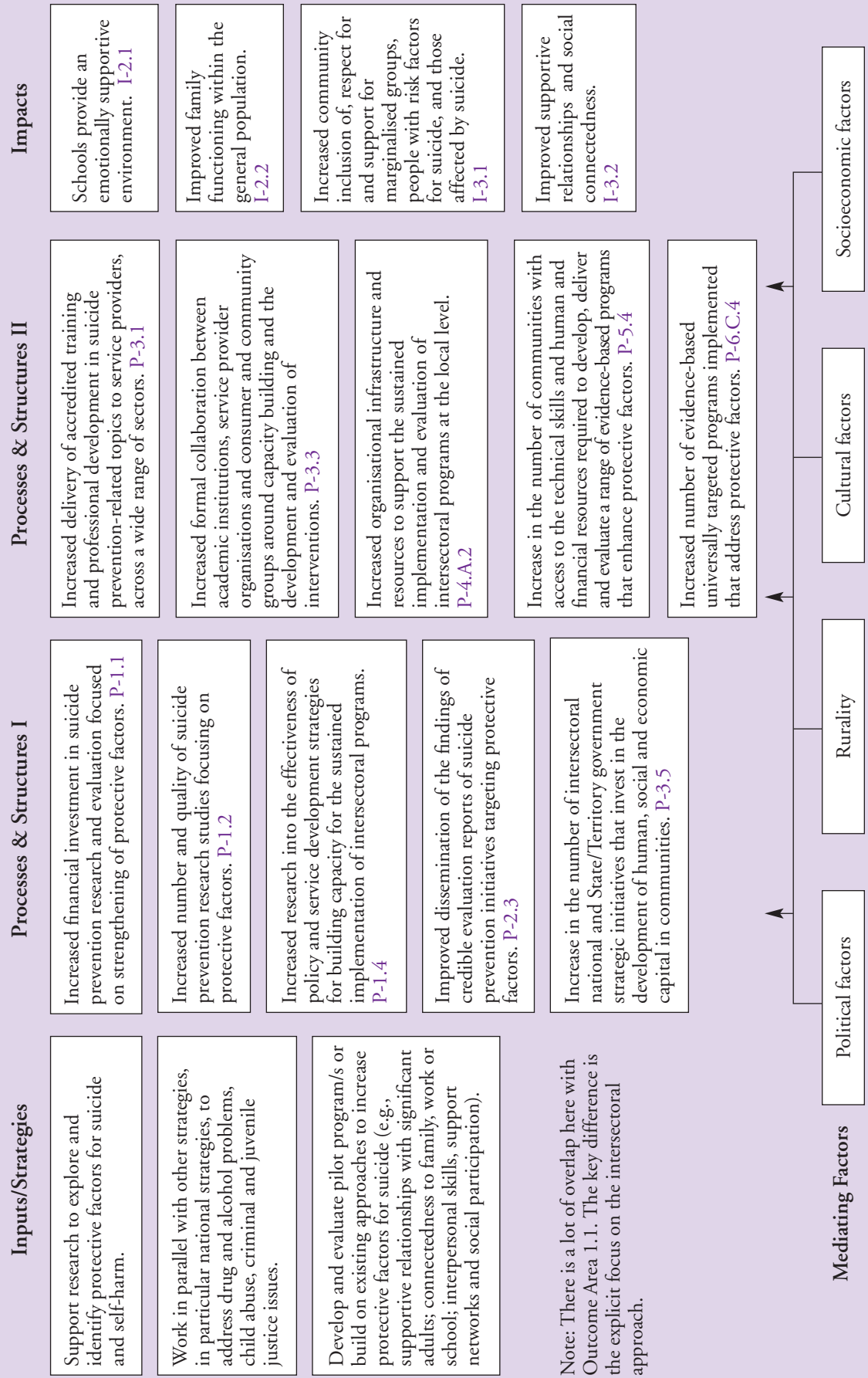


LIFE Framework Program Logic: Action Area One: Outcome Area 1.3 Community acceptance of and support for marginalised groups, people with risk factors for suicide and those affected by suicide



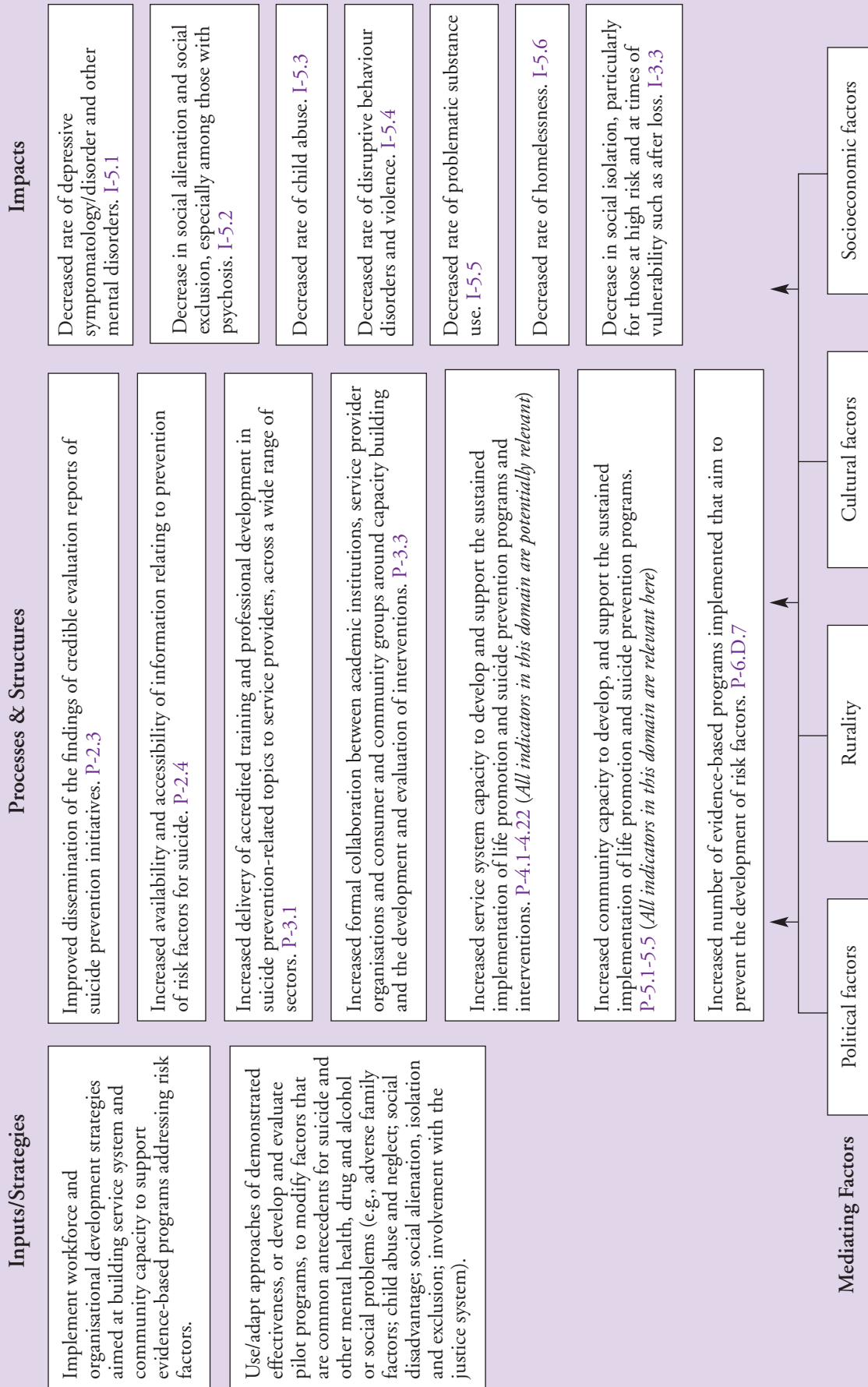
LIFE Framework Program Logic: Action Area Two:

Outcome Area 2.1 Protect against adverse social Outcome Areas



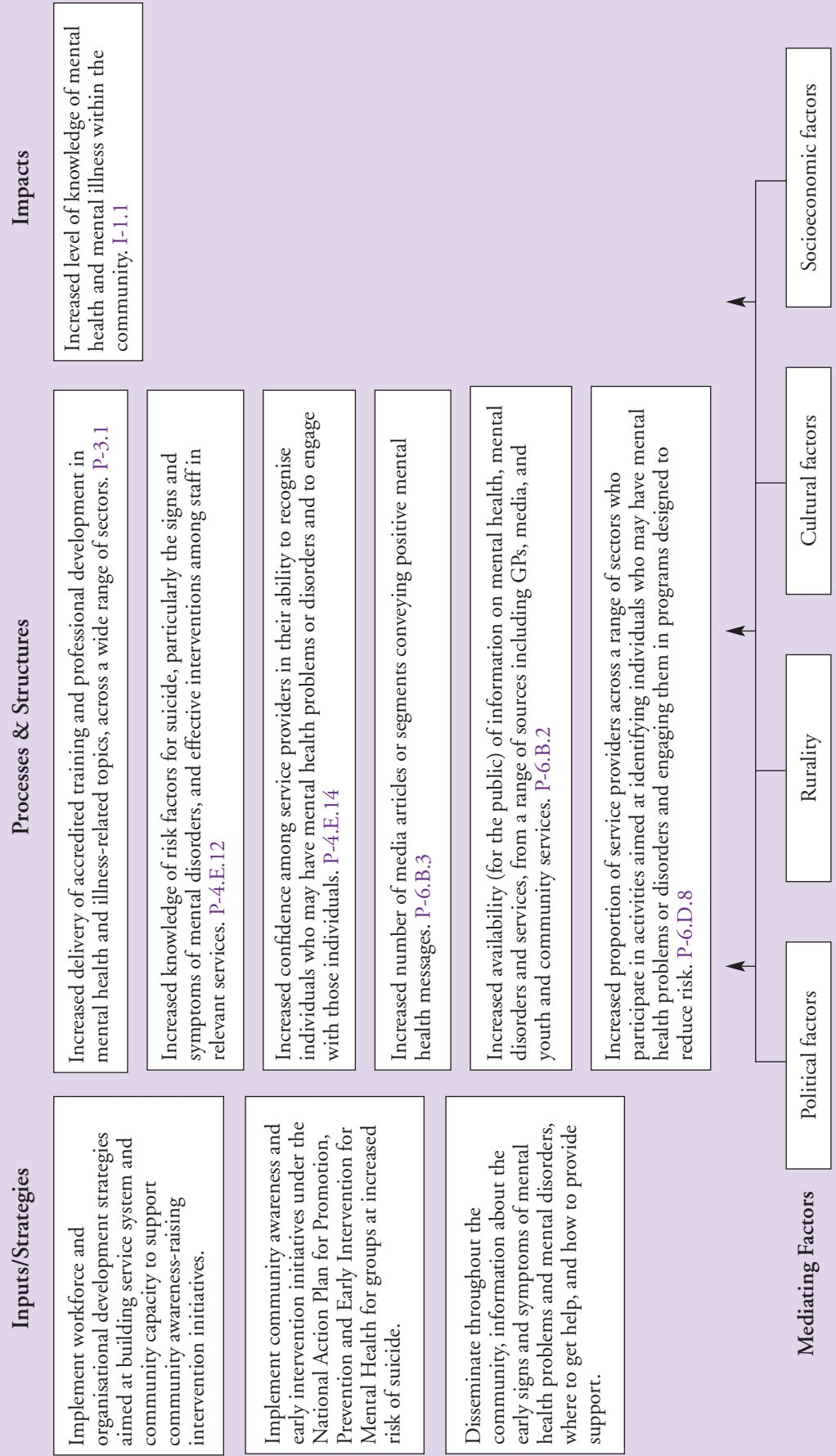
LIFE Framework Program Logic: Action Area Two:

Outcome Area 2.2 Reduce the prevalence of known risk factors



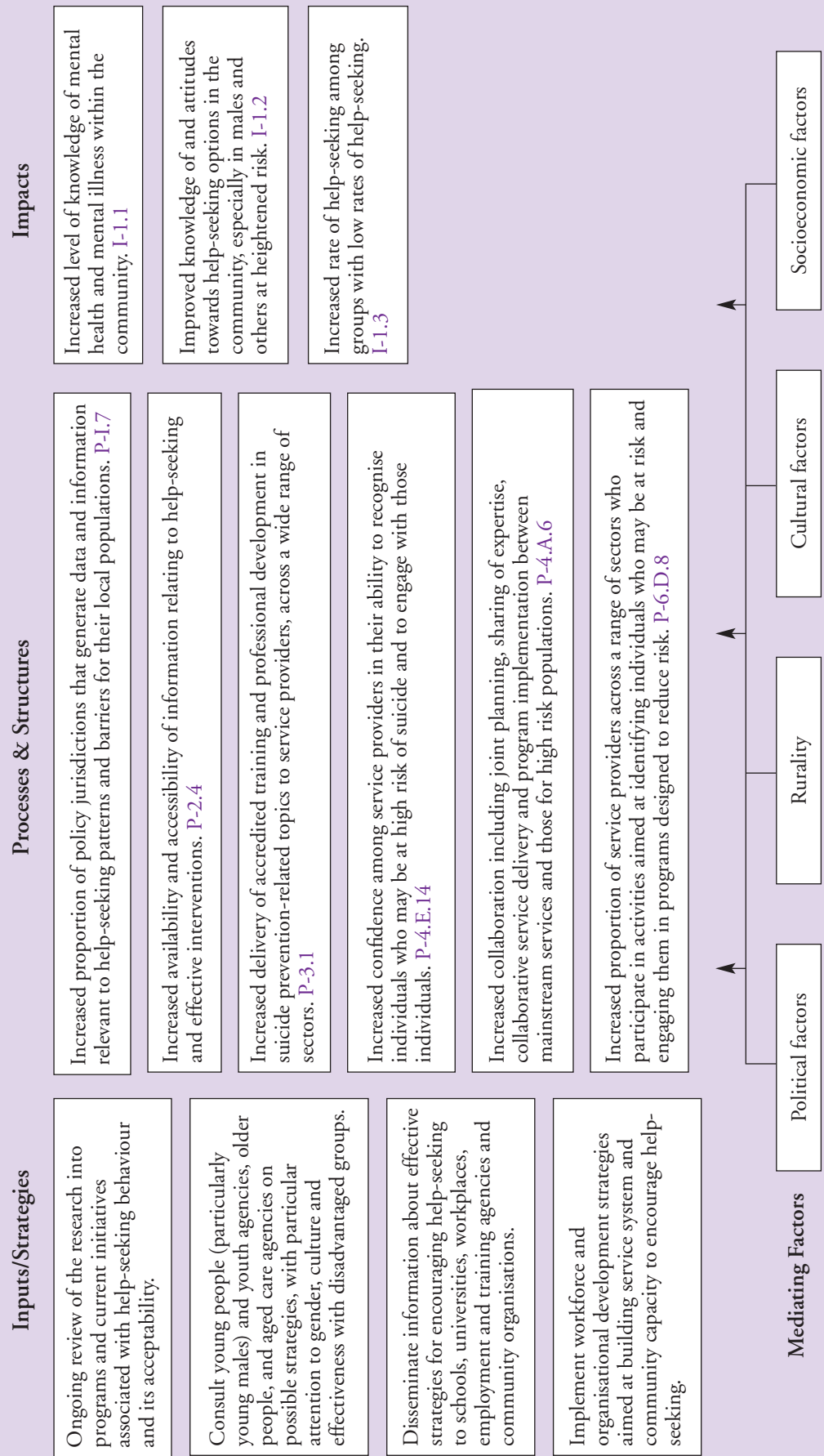
LIFE Framework Program Logic: Action Area Two:

Outcome 2.3 Increase awareness of early signs and symptoms of mental health problems and disorders



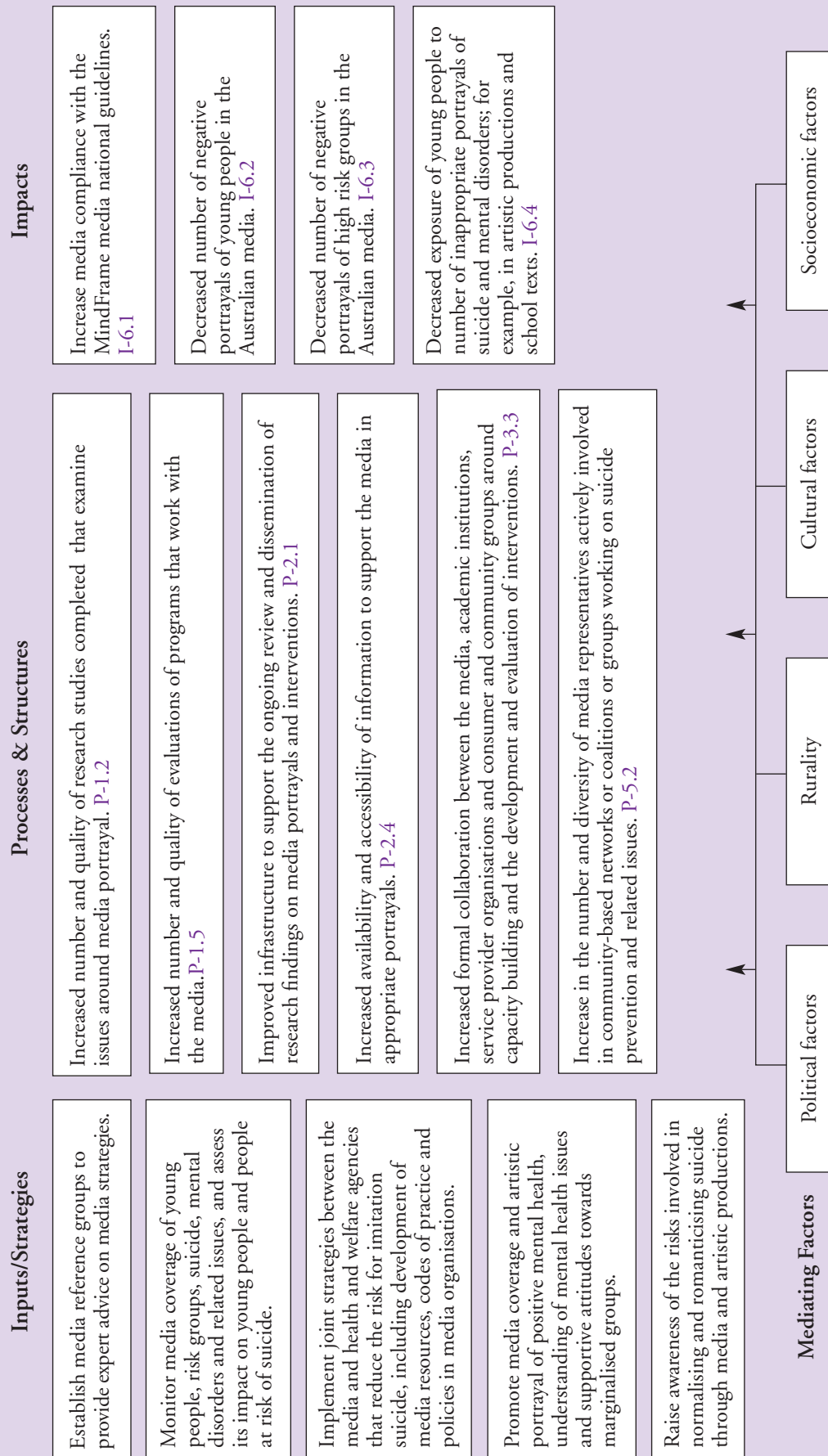
LIFE Framework Program Logic: Action Area Two:

Outcome 2.4 Increase the acceptability of help-seeking to respond to mental health problems and other issues



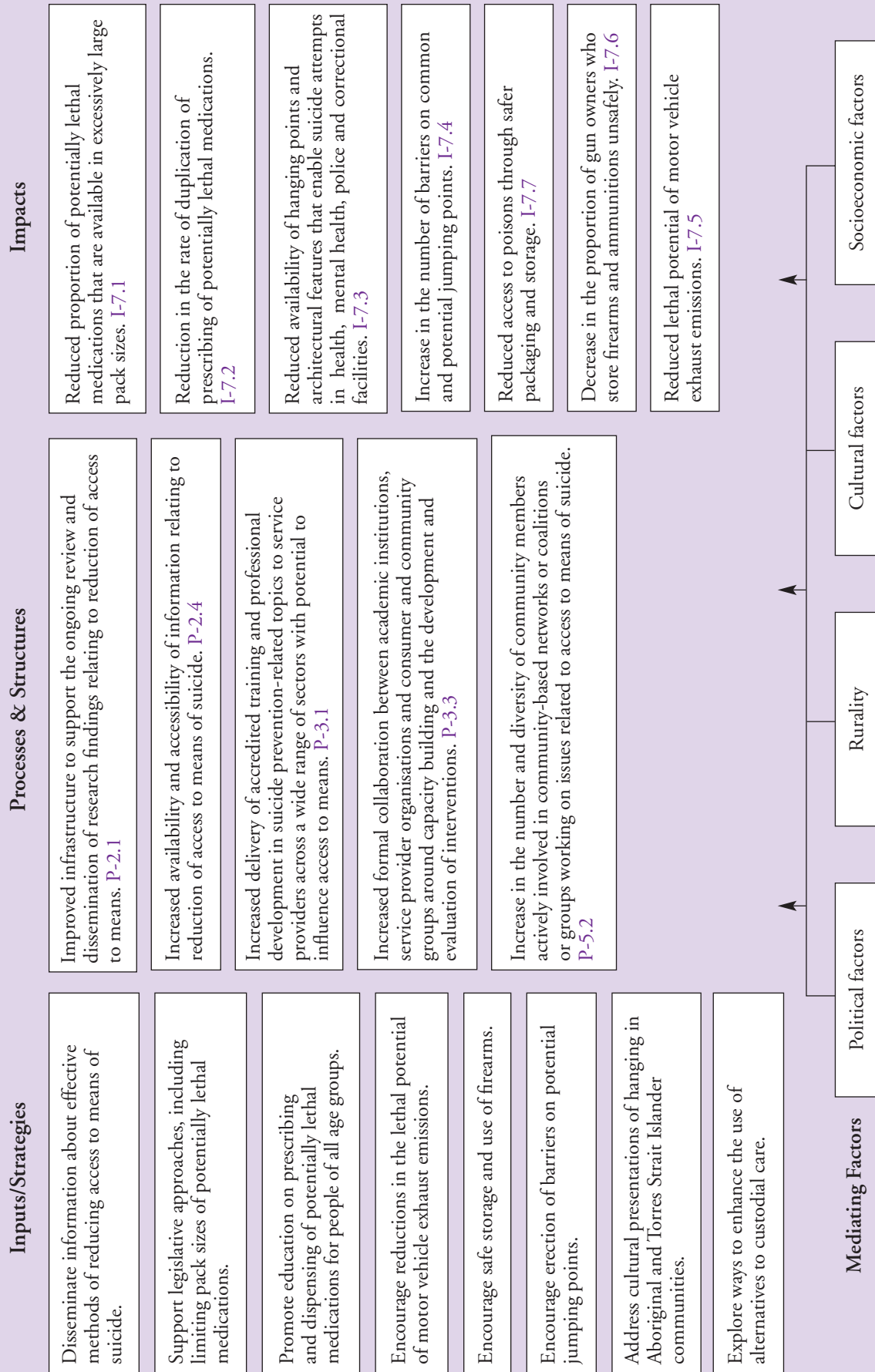
LIFE Framework Program Logic: Action Area Two:

Outcome 2.5 Identify and promote good practice in the portrayal, in the media and artistic productions, of young people, high risk groups, suicide, mental disorders and related issues



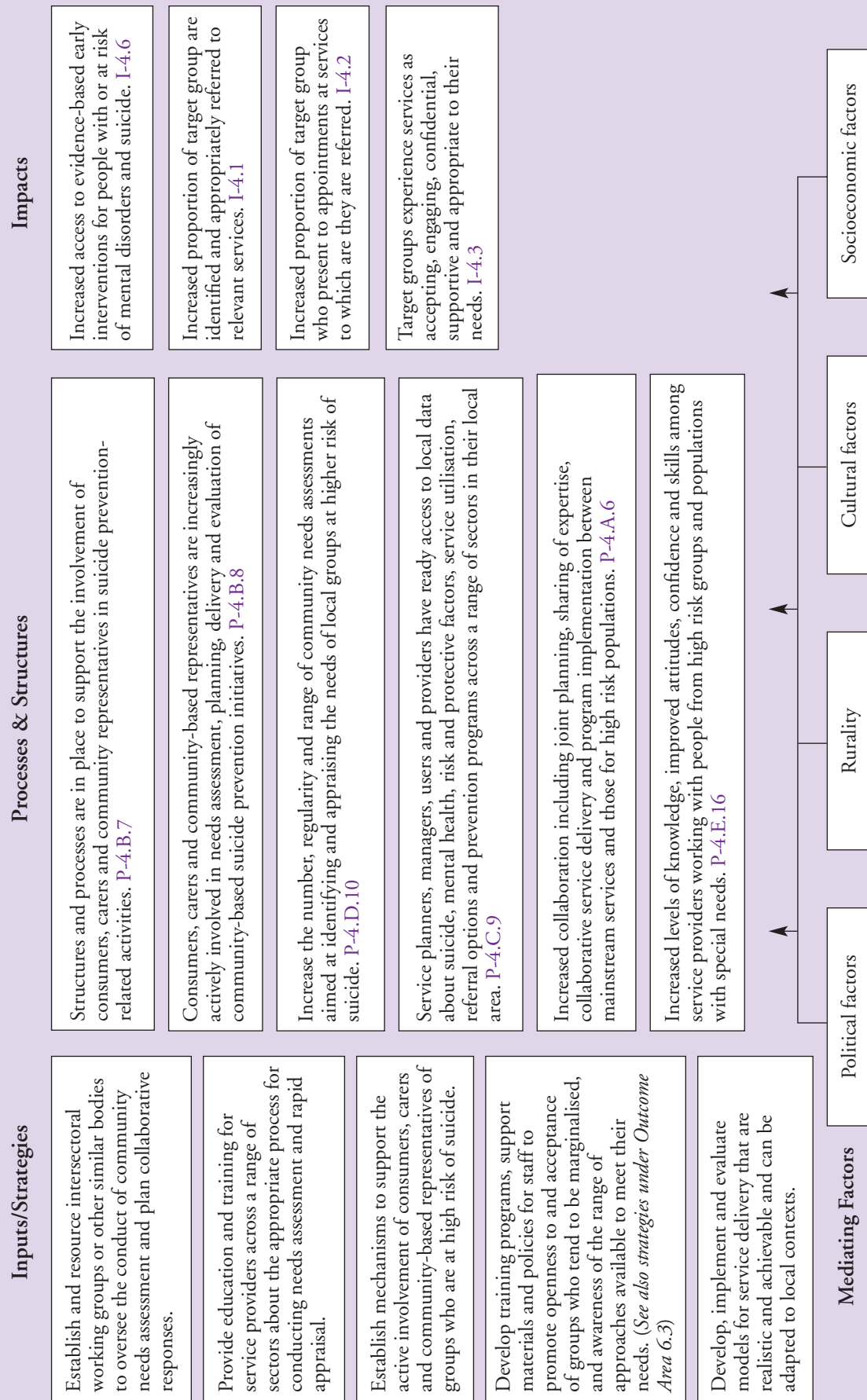
LIFE Framework Program Logic: Action Area Two:

Outcome 2.6 Reduce access to identified lethal methods of suicide



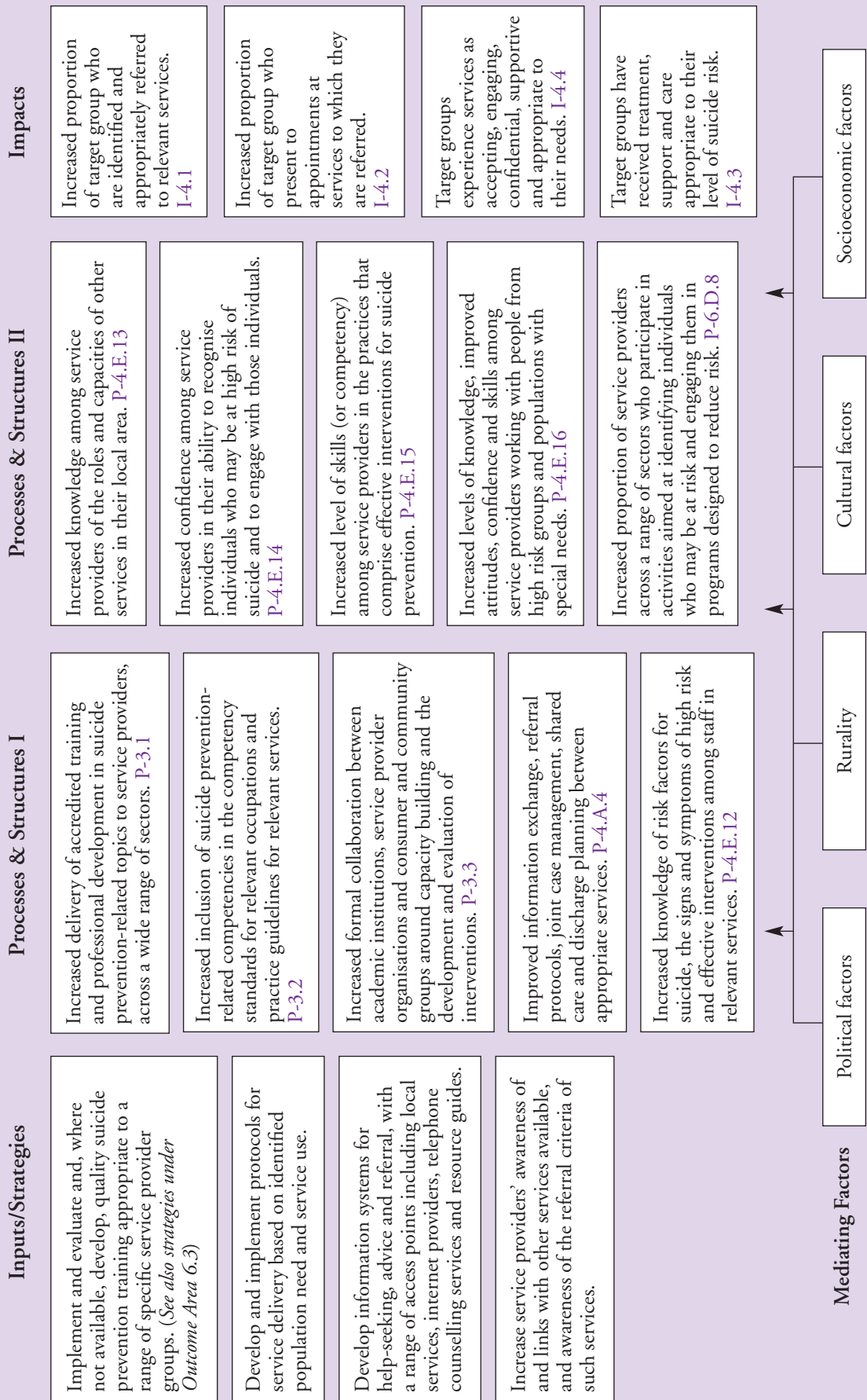
LIFE Framework Program Logic: Action Area Three:

Outcome 3.1 Enhance the response of services in the community to the full range of needs of groups who are at risk of suicide



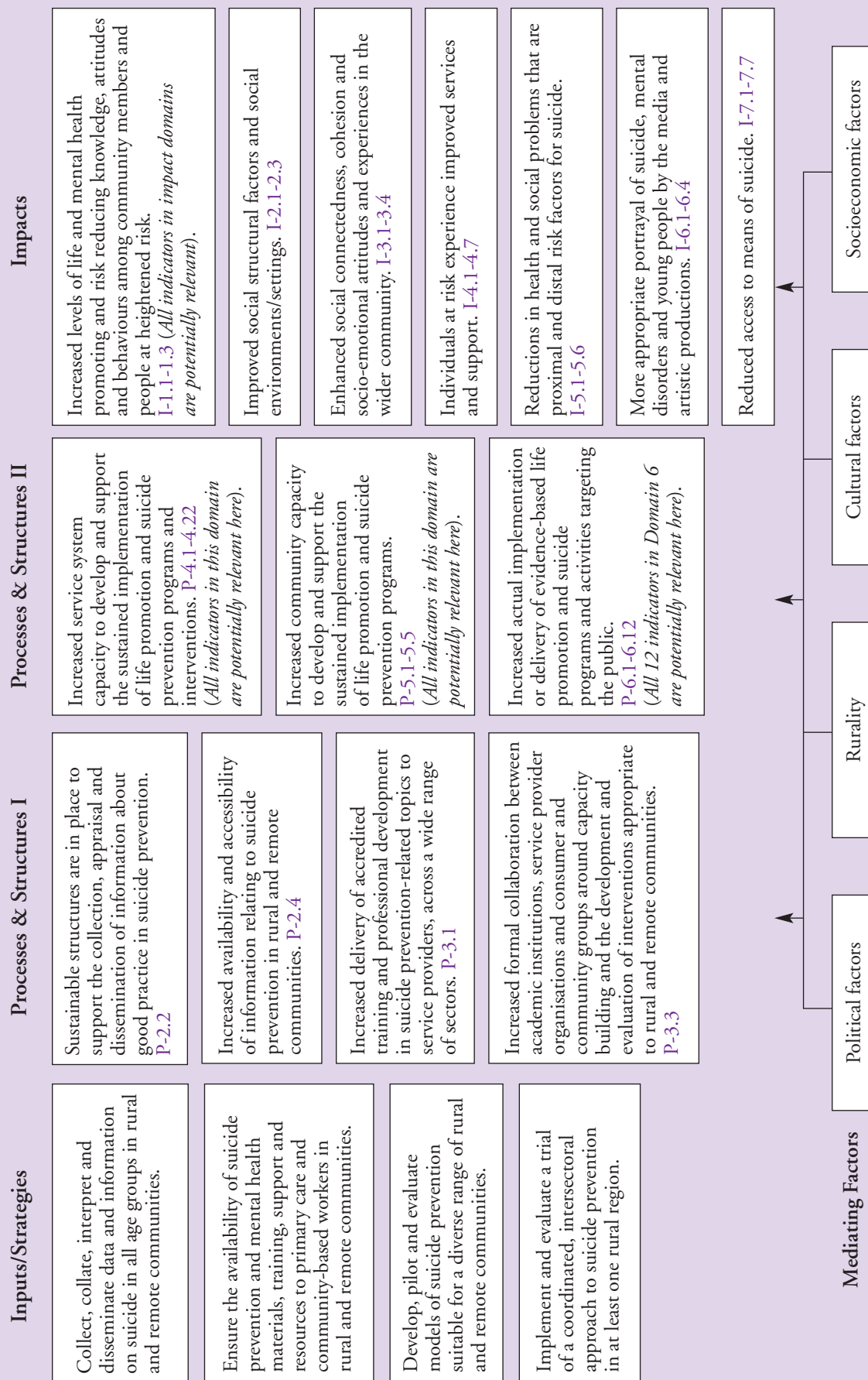
LIFE Framework Program Logic: Action Area Three:

Outcome Area 3.2 Enhance the capacity of services in the community to recognise, respond to and refer individuals showing signs of high suicide risk



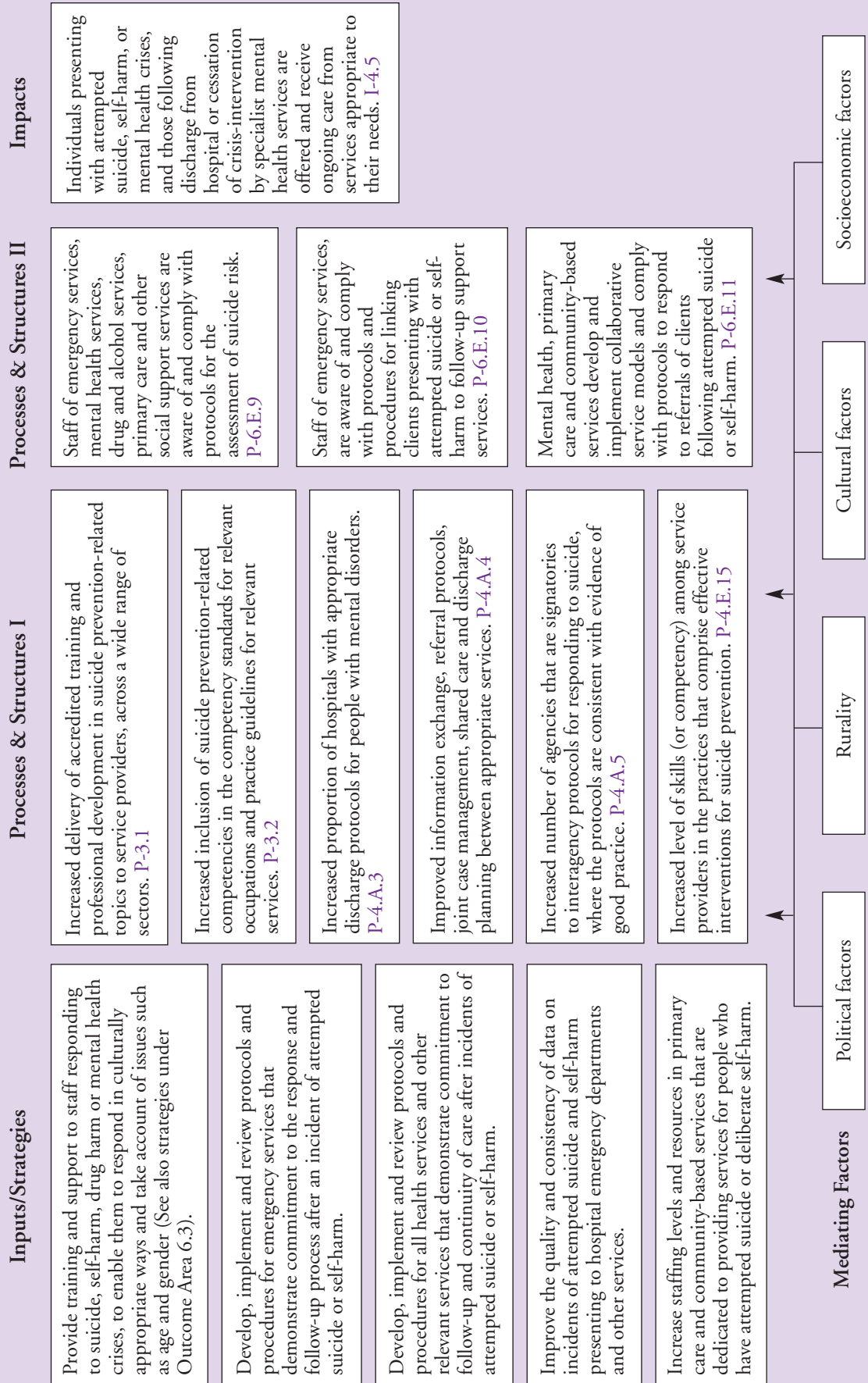
LIFE Framework Program Logic: Action Area Three:

Outcome Area 3.3 Increase awareness and implementation in rural and remote communities of models of suicide prevention and response suitable for such communities



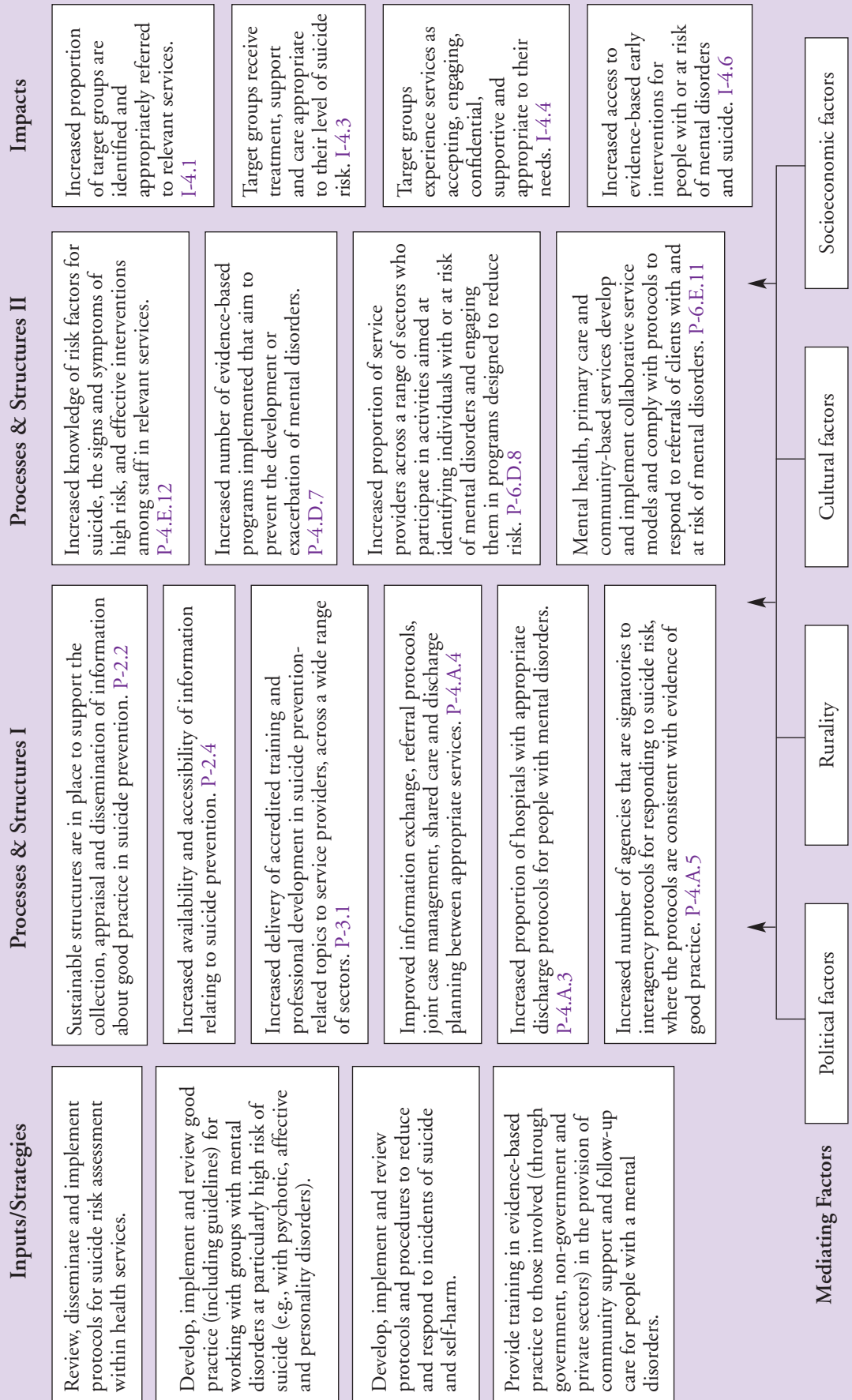
LIFE Framework Program Logic: Action Area Four:

Outcome 4.1 Improve emergency response and provision of follow-up support for incidents of attempted suicide and self-harm



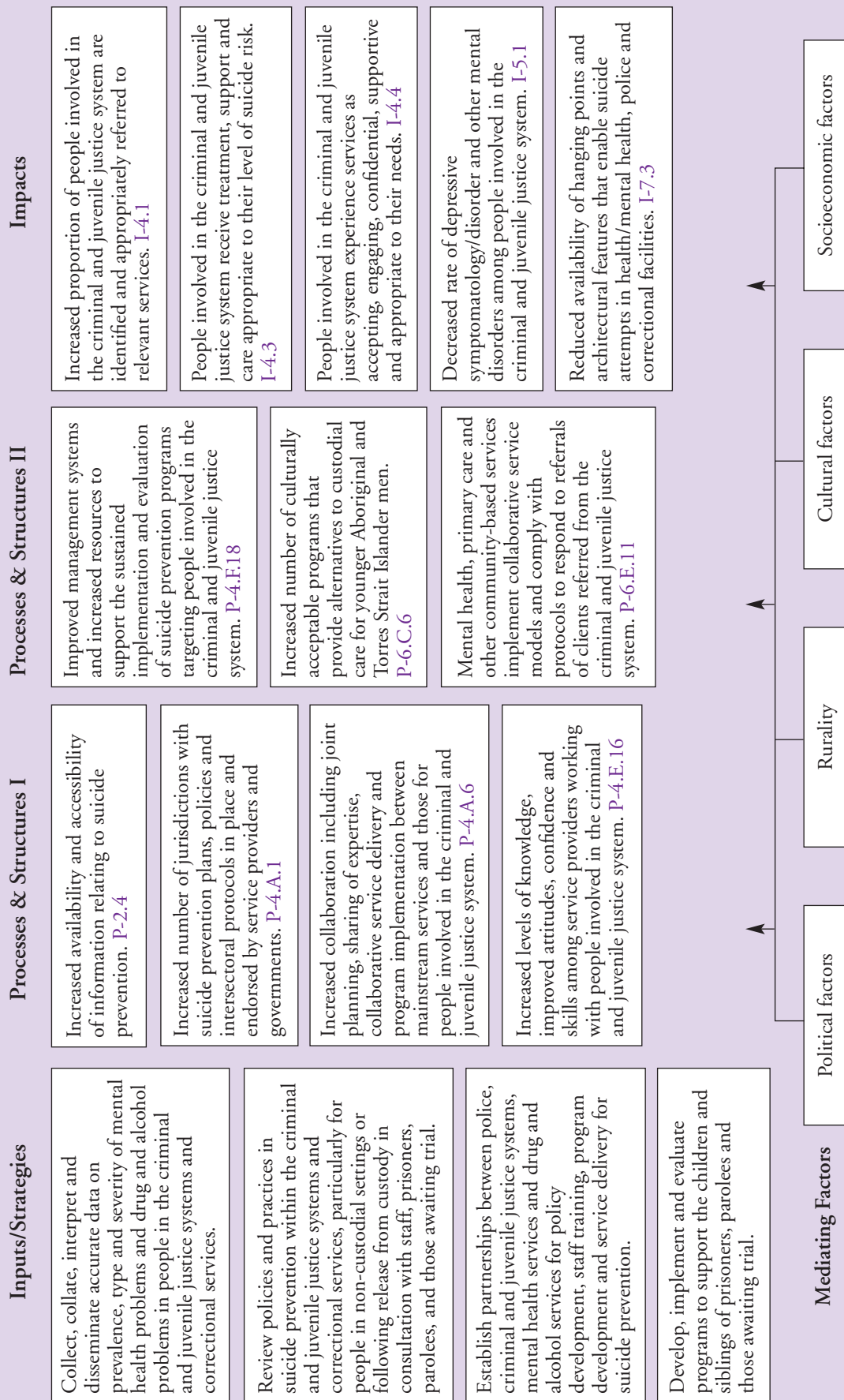
LIFE Framework Program Logic: Action Area Four:

Outcome 4.2 Reduce the risk of suicide and self-harm among people with, or at risk of, mental disorder



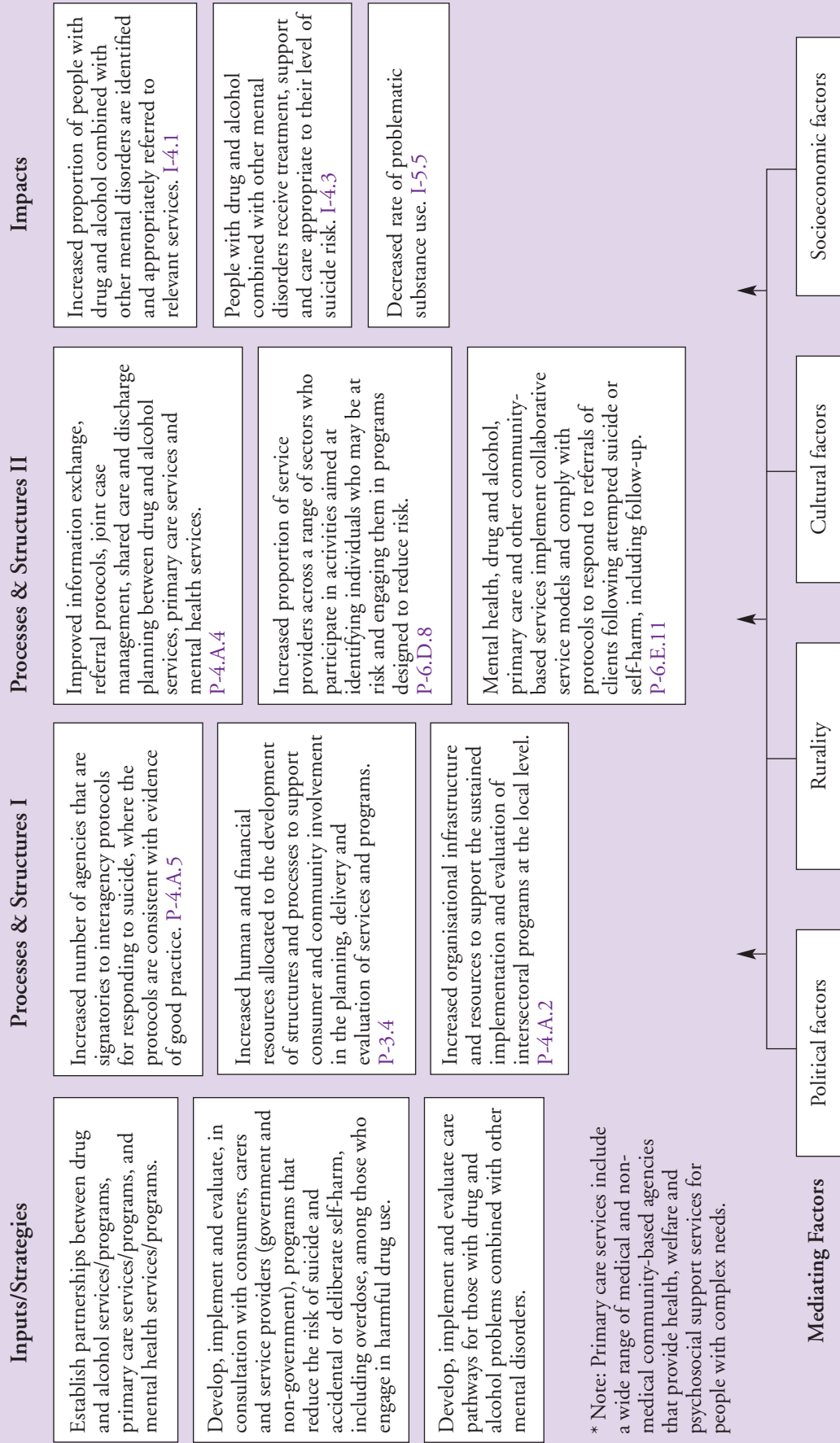
LIFE Framework Program Logic: Action Area Four:

Outcome 4.3 Enhance support for people who are involved with, or likely to become involved with, the criminal justice or juvenile justice system



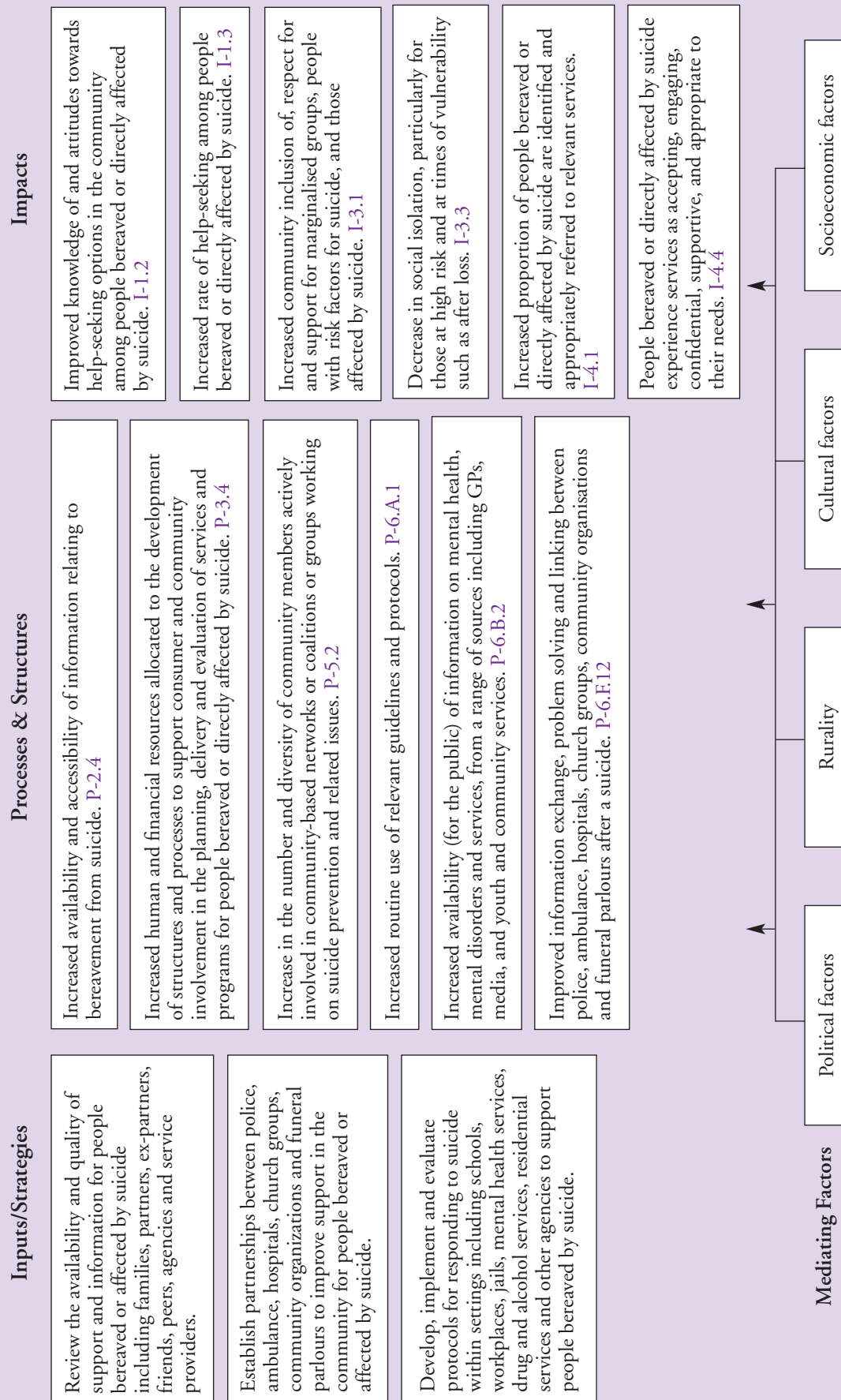
LIFE Framework Program Logic: Action Area Four:

Outcome 4.4 Reduce the risk of suicide and self-harm associated with harmful drug and alcohol use



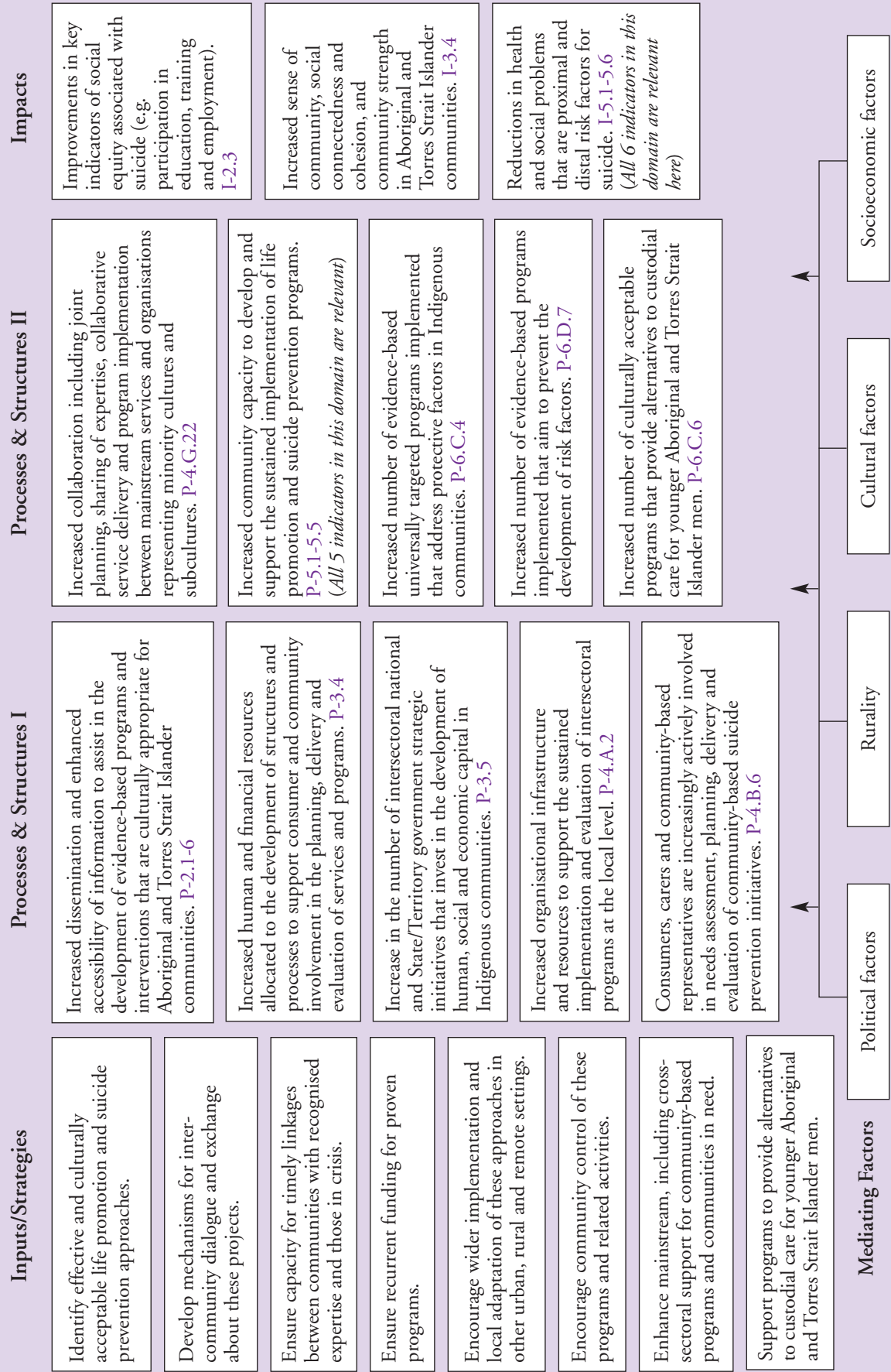
* Note: Primary care services include a wide range of medical and non-medical community-based agencies that provide health, welfare and psychosocial support services for people with complex needs.

LIFE Framework Program Logic: Action Area Four: Outcome 4.5 Provide prompt and effective support for people bereaved or directly affected by suicide



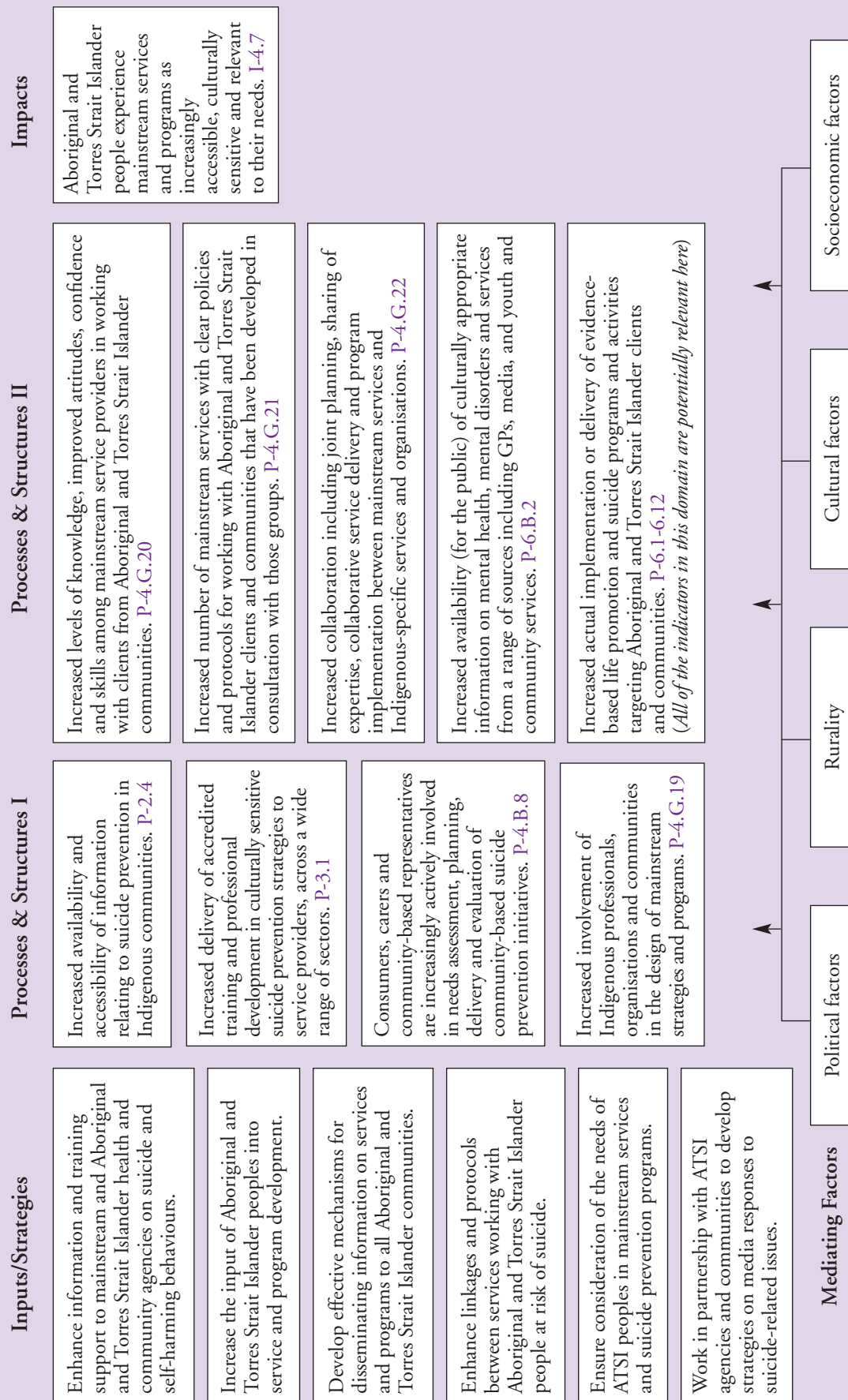
LIFE Framework Program Logic: Action Area Five:

Outcome 5.1 Suicide prevention programs are community-based and grounded in the culture of Aboriginal and Torres Strait Islander people



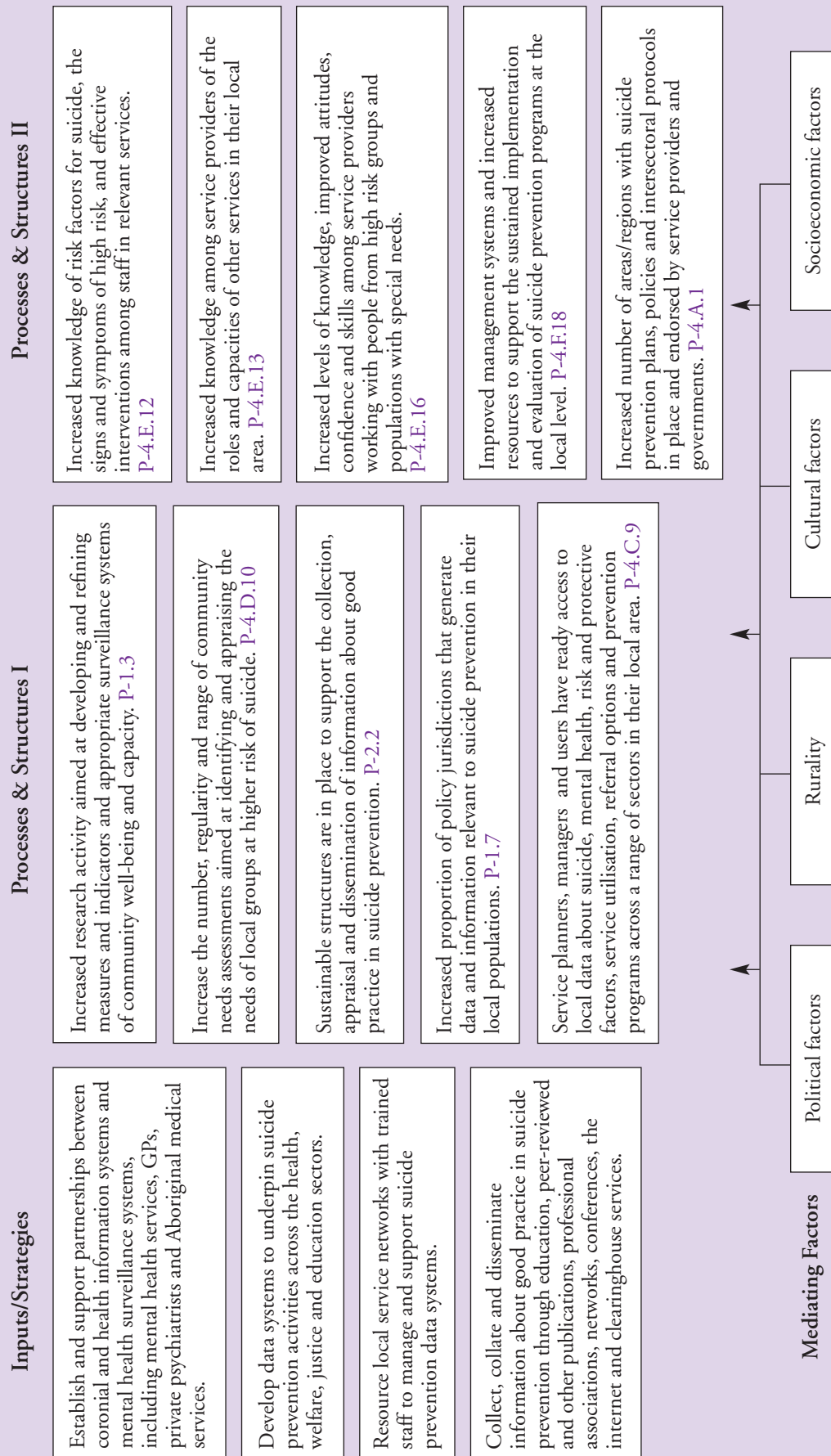
LIFE Framework Program Logic: Action Area Five:

Outcome 5.2 Increase the relevance of mainstream services and suicide prevention programs and services to the culture, needs and strengths of Aboriginal and Torres Strait Islander peoples



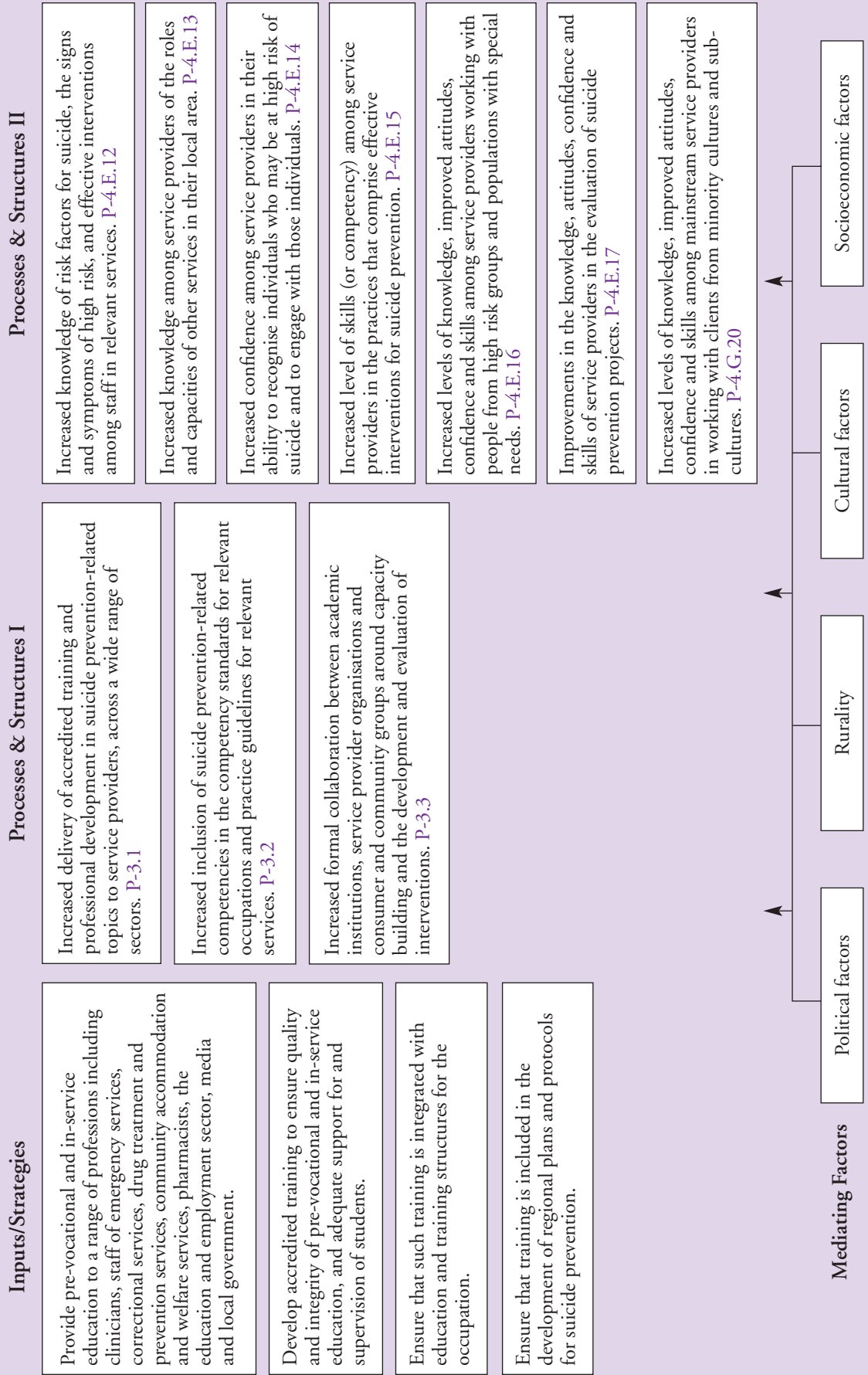
LIFE Framework Program Logic: Action Area Six:

Outcome 6.2 Provide timely access to accurate and up-to-date data on suicide, self-harm, risk factors and good practice initiatives



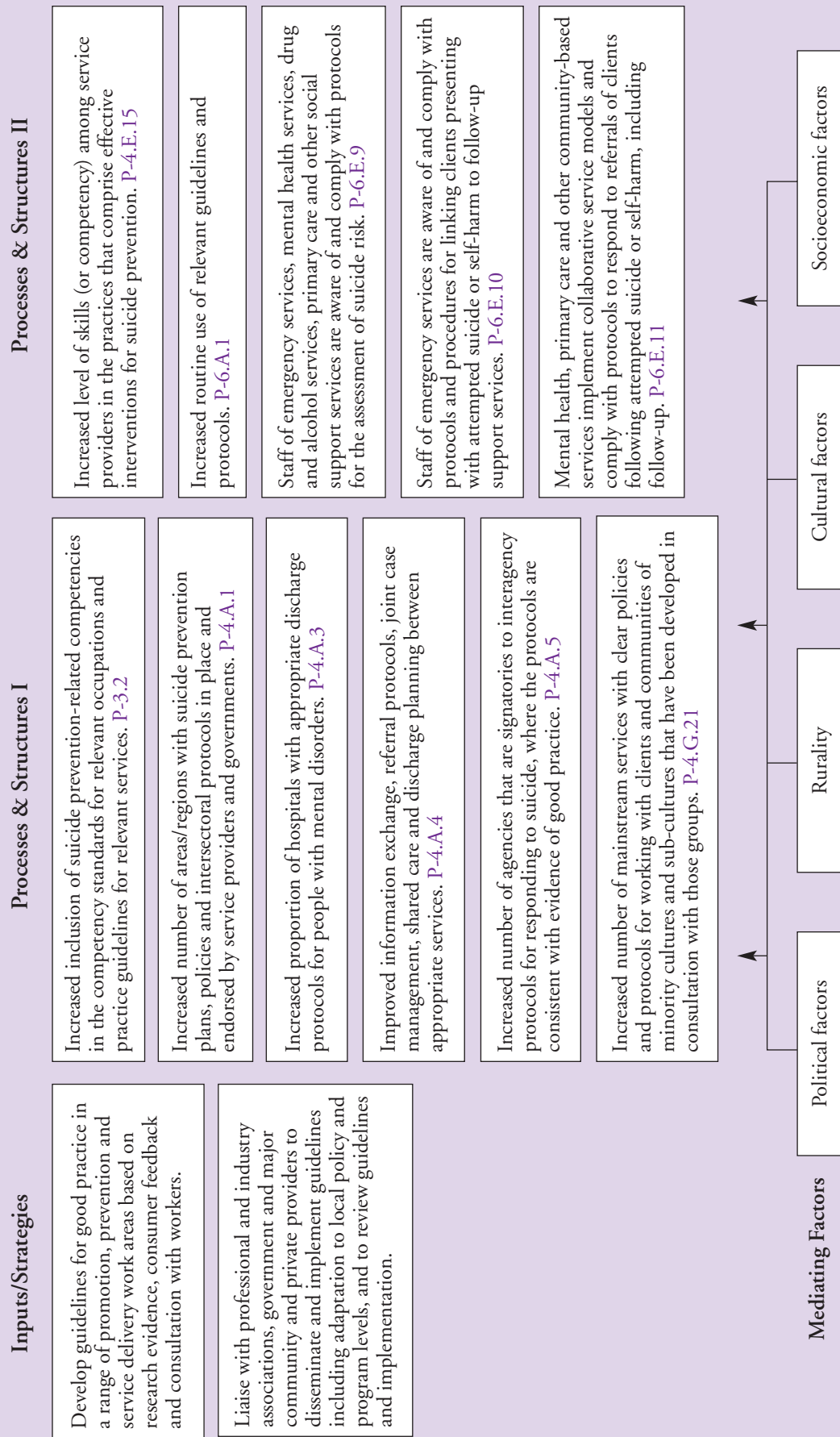
LIFE Framework Program Logic: Action Area Six:

Outcome 6.3 Increase the percentage of the health, welfare, education and other human services workforce that has undertaken training in suicide prevention



LIFE Framework Program Logic: Action Area Six:

Outcome 6.4 Implement guidelines and protocols consistent with good practice identified through research, evaluation, consumer consultation and expert consensus



3



SECTION THREE

Process and Structure
Performance Indicators:
Recommendations

Note: Numbers after each Indicator/descriptor refer to the Outcome Area/Program Logic Map (mauve section, pages 29-54).

Domain P1: Generation of information and knowledge to inform professional and community practice

Notes:

- ‘Research’ refers here to systematic investigation into a broad range of topics including epidemiology; etiology; risk and protective factors; the efficacy and effectiveness of universal, selective and indicated interventions; issues for particular socio-demographic and risk groups; and policy and service development research.
- ‘Research’ includes the collection or generation of new data and the analysis of existing data.
- ‘Quality’ refers to the rigour of the study design and methods, and the comprehensiveness of the reporting of results.

Indicator/descriptor

Recommended or known methods for measurement or existing data sets

1. Increased financial investment in suicide prevention research and evaluation.
Outcome Area 2.1, 6.1
 - Records held by funding bodies

Funding bodies should be encouraged to maintain electronic databases of funded projects and identify suicide prevention research and evaluation as specific categories.
2. Increased number and quality of suicide prevention research studies completed.
Outcome Area 2.1, 2.5, 6.1
 - Records held by funding bodies
 - Journal publications and conference proceedings
3. Increased research activity aimed at developing and refining measures and indicators and appropriate surveillance systems of community well-being and capacity.
Outcome Area 1.1, 6.2
 - Records held by funding bodies
 - Journal publications and conference proceedings
 - Monitoring of content of data development and collection by bodies such as the Australian Bureau of Statistics, Australian Institute of Health and Welfare, Australian Institute of Family Studies, and Area/Regional Health Services

continued

Indicator/descriptor

Recommended or known methods for measurement or existing data sets *continued*

- | | |
|---|---|
| <p>4. Increased research into the effectiveness of policy and service development strategies for building capacity for the sustained implementation of intersectoral programs.
Outcome Area 2.1, 1.2, 6.1</p> | <ul style="list-style-type: none">• Records held by funding bodies• Journal publications and conference proceedings |
| <p>5. Increased number and quality of evaluations of programs.
Outcome Area 1.1, 2.5, 6.1</p> | <ul style="list-style-type: none">• Records held by funding bodies• Surveys or audits of relevant local authorities |
| <p>6. Increased involvement of service providers in research and evaluation activities in collaboration with research institutions.
Outcome Area 6.1</p> | <ul style="list-style-type: none">• Routine activity reporting mechanisms currently in place
<i>Some refinement of activity categories may be required for some services in order to elicit data of sufficient specificity</i>• Surveillance of service agreements and funded projects |
| <p>7. Increased proportion of policy jurisdictions that generate data and information relevant to suicide prevention in their local populations.
Outcome Area 2.2, 2.4, 6.2</p> | <ul style="list-style-type: none">• Surveillance of data-related activities of relevant authorities |

Domain P2: Dissemination and enhanced accessibility of information to assist in the development of evidence-based programs and interventions

Notes:

- ‘Dissemination’ refers to the processes of distribution; the availability and accessibility of the information for end users, and the uptake of, or engagement with, that information by end users.
- ‘Availability’ refers to the physical existence or presence of information in forms that can be understood by intended audiences and in quantities sufficient to reach intended users.
- ‘Accessibility’ refers to the ability of end users to gain access to the information that has been distributed.
- ‘Uptake and engagement’ refer to the actual receipt and use of information by the end users.
- The intention is to increase the dissemination of (1) a wide variety of information types including the results of research and evaluation, practice-based knowledge; and resources and tools to assist in the design of suicide prevention programs; (2) higher quality information; and for (3) a variety of end users including service providers, policy-makers, consumers, community members and researchers.

Indicator/descriptor

Recommended or known methods for measurement or existing data sets

- | | |
|--|--|
| 1. Improved infrastructure to support the ongoing review and dissemination of research findings.
Outcome Area 2.5, 2.6, 5.1, 6.1 | <ul style="list-style-type: none"> • Surveillance of: relevant university departments, institutes; and centres; libraries based in government departments and services |
| 2. Sustainable structures are in place to support the collection, appraisal and dissemination of information about good practice in suicide prevention.
Outcome Area 1.3, 3.3, 4.2, 5.1, 6.1, 6.2 | <ul style="list-style-type: none"> • Existence of a permanent clearinghouse with responsibility for these functions • Surveillance of: relevant university departments, institutes and centres; libraries based in government departments and services; peak bodies and lead agencies or centres of excellence in relevant service sectors |
| 3. Improved dissemination of the findings of credible evaluation reports of suicide prevention initiatives.
Outcome Area 2.1, 2.2, 5.1, 6.1 | <ul style="list-style-type: none"> • Publication in peer-reviewed journals • Records held by funding bodies (re funded dissemination activities) • Surveillance of: relevant university departments, institutes and centres; libraries based in government departments and services; peak bodies and lead agencies or centres of excellence in relevant service sectors |

continued

Indicator/descriptor

Recommended or known methods for measurement or existing data sets *continued*

- | | |
|--|--|
| <p>4. Increased availability and accessibility of information relating to suicide prevention. Outcome Area 1.1, 1.3, 2.2, 2.4, 2.5, 2.6, 3.3, 4.2, 4.3, 4.5, 5.1, 5.2, 6.1</p> | <ul style="list-style-type: none">• Review of collections held by relevant libraries and clearinghouses• Survey of a sample of end users involving questionnaires, interviews or focus groups |
| <p>5. Improved reporting on suicide prevention programs in relevant publications and peer-reviewed journals. Outcome Area 5.1, 6.1</p> | <ul style="list-style-type: none">• Electronic databases of academic journals• Conference proceedings |
| <p>6. Increased access by service providers to understandable and appropriate evaluation resources and tools for suicide prevention projects. Outcome Area 5.1, 6.1</p> | <ul style="list-style-type: none">• Survey of service providers |

Domain P3: Sustained delivery of other strategies that build the capacity of service systems and communities to implement life promotion and suicide prevention programs and activities

Notes:

- The intention is to build capacity for a wide variety of suicide prevention interventions including universal, selective and indicated interventions and to build this capacity in a wide variety of sectors including specialist mental health services, primary health care services, and services that are designed to address specific risk factors for suicide.
- ‘Training’ refers to training in the design, delivery and evaluation of interventions as well as training in the implementation of capacity building strategies.

Indicator/descriptor

Recommended or known methods for measurement or existing data sets

1. Increased delivery of accredited training and professional development in suicide prevention-related topics to service providers, across a wide range of sectors.
Outcome Area 2.1, 2.2, 2.3, 2.4, 2.6, 3.2, 3.3, 4.1, 4.2, 5.2, 6.3
 - Surveys or audits of relevant local authorities including area/regional health services, education offices, local government and services, as well as from accredited training providers
2. Increased inclusion of suicide prevention-related competencies in the competency standards for relevant occupations and practice guidelines for relevant services.
Outcome Area 3.2, 4.1, 6.3, 6.4
 - Review of published competency standards and practice guidelines
3. Increased formal collaboration between academic institutions, service provider organisations and consumer and community groups around capacity building and the development and evaluation of interventions.
Outcome Area 1.1, 2.1, 2.2, 2.5, 2.6, 3.2, 3.3, 6.3.
 - Current routine accountability mechanisms in some jurisdictions
 - Records held by funding bodies
 - Key stakeholder interviews and focus groups

continued

Indicator/descriptor

Recommended or known methods for measurement or existing data sets *continued*

4. Increased human and financial resources allocated to the development of structures and processes to support consumer and community involvement in the planning, delivery and evaluation of services and programs.
Outcome Area 1.1, 1.3, 4.4, 4.5, 5.1
 - Current routine accountability mechanisms in some jurisdictions
 - Records held by funding bodies
 - Surveys or audits of relevant local authorities including area/regional health services, education offices, local government and services
5. Increase in the number of intersectoral national and State/Territory government strategic initiatives that invest in the development of human, social and economic capital in communities.
Outcome Area 1.2, 2.1, 5.1
 - Review of Commonwealth and State/Territory government initiatives

Domain P4: Increased service system capacity to develop and support the sustained implementation of life promotion and suicide prevention programs and interventions

A. Interagency and intersectoral collaboration

Recommended or known methods for measurement or existing data sets

1. Increased number of areas/regions with suicide prevention plans, policies and intersectoral protocols in place and endorsed by service providers and governments.
Outcome Area 1.2, 2.2, 3.3, 4.3, 6.2, 6.4
 - Current routine accountability mechanisms in some jurisdictions
 - Surveys or audits of relevant local authorities including area/regional health services, education offices, local government and services
2. Increased organisational infrastructure and resources to support the sustained implementation and evaluation of intersectoral programs at the local level.
Outcome Area 1.2, 2.1, 2.2, 3.3, 4.4, 5.1
 - Current routine accountability mechanisms in some jurisdictions
 - Surveys or audits of relevant local authorities including area/regional health services, education offices, and local government
3. Increased proportion of hospitals with appropriate discharge protocols for people with mental disorders.
Outcome Area 2.2, 3.3, 4.1, 4.2, 6.4
 - Surveys of hospital accident and emergency departments
 - Quality audits of discharge protocols
4. Improved information exchange, referral protocols, joint case management, shared care and discharge planning between appropriate services.
Outcome Area 2.2, 3.2, 3.3, 4.1, 4.2, 4.4, 6.4
 - Network analysis (e.g., Milward & Provan, 1998¹; Morrissey, Johnsen, & Calloway 1997²; Provan & Milward, 1995³).
 - Interviews with key informants

continued

- 1 Milward, H.B., & Provan, K.G. (1998). Measuring network structure. *Public Administration*, 76, 387-407.
- 2 Morrissey, J.P., Johnsen, M.C., & Calloway, M.O. (1997). Evaluating performance and change in mental health systems serving children and youth: An interorganizational network approach. *Journal of Mental Health Administration*, 24(1), 4-22.
- 3 Provan, K.G. & Milward, H.B. (1995). A preliminary theory of interorganizational network effectiveness: a comparative study of four community mental health systems. *Administrative Science Quarterly*, 40(1), 1-33.

A. Interagency and intersectoral collaboration

Recommended or known methods for measurement or existing data sets *continued*

5. Increased number of agencies that are signatories to interagency protocols for responding to suicide, where the protocols are consistent with evidence of good practice.
Outcome Area 2.2, 3.3, 4.1, 4.2, 4.4, 6.4
 - Surveys of agencies or area/regional/local suicide prevention working groups and/or quality audits of protocols
 - Tools for Reviewing Australian Mental Health Services (TRAMHS) <<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-mhinformatds-reviewtools.htm>>⁴
6. Increased collaboration including joint planning, sharing of expertise, collaborative service delivery and program implementation between mainstream services and those for high risk populations.
Outcome Area 1.3, 2.2, 3.1, 3.3, 4.3
 - Network analysis (See Indicator A4 above)
 - Interviews with key informants

B. Community and consumer involvement

Recommended or known methods for measurement or existing data sets

7. Structures and processes are in place to support the involvement of consumers, carers and community representatives in suicide prevention-related activities.
Outcome Area 2.2, 3.1, 3.3, 6.1
 - Records held by funding bodies
 - Surveys of government branches, regional authorities and service managers in relevant policy jurisdictions.
 - Tools for Reviewing Australian Mental Health Services (TRAMHS) <<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-mhinformatds-reviewtools.htm>>
8. Consumers, carers and community-based representatives are increasingly actively involved in needs assessment, planning, delivery and evaluation of community-based suicide prevention initiatives.
Outcome Area 2.2, 3.1, 3.3, 5.1, 5.2
 - Records held by funding bodies
 - Qualitative methods such as interviews and focus groups with project staff and with consumers, carers and community-based representatives

4 Peter Gianfrancesco. (1998) Volume 1 provides a self-assessment task for use by services and Volume 2 provides a detailed process, including lists of questions, for undertaking the review *continued*

C. Information systems and access to information

Recommended or known methods for measurement or existing data sets

9. Service planners, managers, users and providers have ready access to local data about suicide, mental health, risk and protective factors, service utilisation, referral options and prevention programs across a range of sectors in their local area.
Outcome Area 2.2, 3.1, 3.3, 6.2
- Surveys of appropriate regional authorities, service and program managers in relevant policy jurisdictions, as well as local community-based suicide prevention working groups or committees

D. Needs assessment and evaluation

Recommended or known methods for measurement or existing data sets

10. Increase the number, regularity and range of community needs assessments aimed at identifying and appraising the needs of local groups at higher risk of suicide⁵.
Outcome Area 2.2, 3.1, 3.3, 6.2
- Surveys of appropriate regional authorities, service and program managers in relevant policy jurisdictions, as well as local community-based suicide prevention working groups or committees
11. Increased number of service providers actively involved in evaluation and practice-based research activities.
Outcome Area 2.2, 3.3
- Current routine accountability mechanisms in some jurisdictions
Some refinement of activity categories may be required for some services in order to elicit data of sufficient specificity (See also Domain 1. Indicator 6).
 - Surveys or audits of relevant services

⁵ The wording of this indicator has been adjusted to improve precision. The ratings reported refer to the original wording.

continued

E. Knowledge, attitudes, confidence and skills among service providers⁶

Recommended or known methods for measurement or existing data sets

12. Increased knowledge of risk factors for suicide, the signs and symptoms of high risk, and effective interventions among staff in relevant services.
Outcome Area 2.2, 2.3, 3.2, 3.3, 4.2, 6.1, 6.2, 6.3
 - Surveys of staff in relevant services
 - Australian Institute of Health and Welfare (AIHW) – General Practice Activity as it relates to services provided by GPs, including presenting problem, diagnosis and treatment. <<http://www.aihw.gov.au/mentalhealth/generalprac/index.html>>
 - Attitudes of service providers – <<http://www.anu.edu.au/cmhr/literacy.html>> for example, Jorm, A.F., Korten, A.E., Jacomb, P.A., et al (1997c): Helpfulness of interventions for mental disorders: beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, 171, 233-237; Jorm, A.F., Korten, A.E., Jacomb, P.A., Christensen, H. & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33, 77-83.
13. Increased knowledge among service providers of the roles and capacities of other services in their local area.
Outcome Area 2.2, 3.2, 3.3, 6.2, 6.3
14. Increased confidence among service providers in their ability to recognise individuals who may be at high risk of suicide and to engage with those individuals.
Outcome Area 2.2, 2.3, 2.4, 3.2, 3.3, 6.1, 6.3
15. Increased level of skills (or competency) among service providers in the practices that comprise effective interventions for suicide prevention.
Outcome Area 2.2, 3.2, 3.3, 4.1, 6.3, 6.4

⁶ Interventions referred to in this section include the full spectrum of effective interventions for suicide prevention including universal, selective and indicated interventions. The service providers referred to include those working in all relevant sectors.

continued

E. Knowledge, attitudes, confidence and skills among service providers

Recommended or known methods for measurement or existing data sets *continued*

16. Increased levels of knowledge, improved attitudes, confidence and skills among service providers working with people from high risk groups and populations with special needs.
Outcome Area 1.3, 2.2, 3.1, 3.2, 3.3, 4.3, 6.2, 6.3
 17. Improvements in the knowledge, attitudes, confidence and skills of service providers in the evaluation of suicide prevention projects
Outcome Area 2.2, 3.3, 6.1, 6.3
- Surveys of staff in relevant services
 - Australian Institute of Health and Welfare (AIHW) – General Practice Activity as it relates to services provided by GPs, including presenting problem, diagnosis and treatment. <<http://www.aihw.gov.au/mentalhealth/generalprac/index.html>>
 - Attitudes of service providers – <<http://www.anu.edu.au/cmhr/literacy.html>> for example, Jorm, A.F, Korten, A.E., Jacomb, P.A., et al (1997c) Helpfulness of interventions for mental disorders: beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, 171, 233-237. Jorm, A.F, Korten, A.E., Jacomb, P.A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33, 77-83.

F. Management systems and resources

Recommended or known methods for measurement or existing data sets

18. Improved management systems and increased resources to support the sustained implementation and evaluation of suicide prevention programs at the local level.
Outcome Area 2.2, 3.3, 4.3
- Surveys of relevant regional authorities, service and program managers in relevant policy jurisdictions, as well as local community-based suicide prevention working groups or committees
 - Key stakeholder interviews
 - Monitoring of agency data on resource allocation

G. Cultural sensitivity⁷

Recommended or known methods for measurement or existing data sets

19. Increased involvement of culture and sub-culture-specific professionals, organisations and communities in the design of mainstream strategies and programs.
Outcome Area 2.2, 3.3, 5.2
- Records held by funding bodies
 - Surveys or audits of relevant authorities including area/regional health services, education offices, local government, services, and local community-based suicide prevention working groups or committees

⁷ Cultural sensitivity refers to awareness, understanding and sensitive practice in relation to the particular needs of individuals from diverse cultural backgrounds (e.g., Aboriginal and Torres Strait Islander peoples and people from non-English speaking backgrounds) and particular sub-cultures (e.g., same-sex attracted people and youth).

continued

G. Cultural sensitivity

Recommended or known methods for measurement or existing data sets *continued*

20. Increased levels of knowledge, improved attitudes, confidence and skills among mainstream service providers in working with clients from minority cultures and sub-cultures.
Outcome Area 1.3, 2.2, 3.3, 5.2, 6.3
- Surveys of staff in relevant services
 - Checklists for Cultural Assessment is not an evaluation tool, but provides an indication of the kind of content.
<<http://www.health.qld.gov.au/hssb/cultdiv/check/home.htm>>
 - Evaluation mental health services for non-English speaking background communities, Long, Pirkis, Mihalopoulos, Naccarella, Summers and Dunt offers an evaluation tool 'which can be used to improve access to services for people of CALD'. Available at cost from Multicultural Mental Health Australia (MMHA)
<<http://www.mmha.org.au/MMHAPublications/Store/EvaluatingMHS>>
21. Increased number of mainstream services with clear policies and protocols for working with clients and communities of minority cultures and sub-cultures that have been developed in consultation with those groups.
Outcome Area 2.2, 3.3, 5.2, 6.4
- Surveys of appropriate regional authorities, service and program managers in relevant policy jurisdictions, as well as local community-based suicide prevention working groups or committees
 - Document analysis and key stakeholder interviews
22. Increased collaboration including joint planning, sharing of expertise, collaborative service delivery and program implementation between mainstream services and organisations representing minority cultures and subcultures.
Outcome Area 2.2, 2.4, 3.3, 5.1, 5.2
- Network analysis (See Indicator A4 above)
 - Key informant interviews

Domain P5: Increased community capacity to develop, and support the sustained implementation of, life promotion and suicide prevention programs

Notes:

- ‘Communities’ in this context generally refer to geographic communities, but may include communities of shared interest or culture. The indicators should be applicable to all types of communities and national level monitoring should compare progress across these different types of communities.
- The ‘capacities’ referred to include capacities to support the full spectrum of suicide prevention interventions including universal, selective and indicated interventions.
- ‘Diverse’ and ‘diversity’ refer to diversity of professional, cultural, sub-cultural and socio-demographic backgrounds of people.

Indicator/descriptor

Recommended or known methods for measurement or existing data sets

1. Increase in the number of communities that have identifiable leaders, from diverse backgrounds, with an active interest and involvement in suicide prevention.
Outcome Area 1.1, 1.2, 2.2, 3.3, 5.1
 - Description of communities – activities related to this domain should be defined and described at regular intervals to monitor change
 - The ‘Community Readiness Questions Interview’ (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000)⁸ is suitable for individual projects to use.
<<http://www.triethniccenter.colostate.edu>>
 - See also Community Participation Index, Baum et al. (2000) and Community Capacity Audit, Bush and Mutsch (1997) referred to in Outcomes and indicators, measurement tools and databases for the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000), Spence, Donald, Dower, Woodward and Lacherez, DHA (2002).
 - Australian Institute of Family Studies’ Study Families, Social Capital and Citizenship.
<<http://www.aifs.gov.au/institute/research/progC.html>>
2. Increase in the number and diversity of community members actively involved in community-based networks or coalitions or groups working on suicide prevention and related issues.
Outcome Area 1.1, 1.2, 1.3, 2.2, 2.5, 2.6, 3.3, 4.5, 5.1
3. Increase in the number of communities conducting community-based needs assessments and developing comprehensive suicide prevention plans tailored to local needs.
Outcome Area 1.1, 2.2, 3.3, 5.1

8 Edwards, R.W., Jumper-Thurman, P., Plested, B.A., Oetting, E.R., & Swanson, L. (2000). Community readiness: Research to practice. *Journal of Community Psychology*, 28(3), 291-307.

continued

Indicator/descriptor

Recommended or known methods for measurement or existing data sets *continued*

4. Increase in the number of communities with access to the technical skills and human and financial resources required to develop, deliver and evaluate a range of evidence-based suicide prevention programs.
Outcome Area 1.1, 1.2, 2.1, 2.2, 3.3, 5.1
- Description of communities – activities related to this domain should be defined and described at regular intervals to monitor change
 - The ‘Community Readiness Questions Interview’ (Edwards, Jumper-Thurman, Plessted, Oetting, & Swanson, 2000)⁸ is suitable for individual projects to use.
<<http://www.triethniccenter.colostate.edu>>
 - See also Community Participation Index, Baum et al. (2000) and Community Capacity Audit, Bush and Mutsch (1997) referred to in Outcomes and indicators, measurement tools and databases for the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000), Spence, Donald, Dower, Woodward and Lacherez, DHA (2002).
 - Australian Institute of Family Studies’ Study Families, Social Capital and Citizenship.
<<http://www.aifs.gov.au/institute/research/progC.html>>
5. Increase in the number of communities with mechanisms in place to enable and support ongoing community learning and critical reflection.
Outcome Area 1.1, 1.2, 2.2, 3.3, 5.1, 6.1

Domain P6: Increased actual implementation or delivery of evidence-based life promotion and suicide programs and activities targeting the public

A. General

Recommended or known methods for measurement or existing data sets

1. Increased routine use of relevant guidelines and protocols.
Outcome Area 3.3, 4.5, 5.2, 6.4

B. Community education

Recommended or known methods for measurement or existing data sets

2. Increased availability (for the public) of information on mental health, mental disorders and services, from a range of sources including GPs, media, and youth and community services.
Outcome Area 3.3, 4.5, 5.2

3. Increased number of media articles or segments conveying positive mental health messages.

Outcome Area 3.3, 5.2

- Monitoring at the national level is currently being undertaken. See Pirkis, J. et al (2001) The Media Monitoring Project: A Baseline Description of How the Australian Media Reports and Portray Suicide and Mental Health and Illness, Commonwealth Department of Health and Ageing, Canberra. <<http://www.mindframe-media.info/>>

C. Life and mental health promotion

Recommended or known methods for measurement or existing data sets

4. Increased number of evidence-based universally targeted programs implemented that address protective factors.
Outcome Area 1.1, 1.2, 1.3, 2.1, 3.3, 5.1, 5.2

- Records held by funding bodies
- Current routine accountability mechanisms in some jurisdictions
- Surveys or audits of relevant local authorities including area/regional health services, education offices, and local government

continued

C. Life and mental health promotion	Recommended or known methods for measurement or existing data sets <i>continued</i>
<p>5. Increased number of schools implementing the MindMatters resources. Outcome Area 1.1, 3.3, 5.2</p>	<ul style="list-style-type: none"> • Current routine accountability mechanisms in some jurisdictions • Surveys or audits of relevant local authorities
<p>6. Increased number of culturally acceptable programs that provide alternatives to custodial care for younger Aboriginal and Torres Strait Islander men. Outcome Area 3.3, 4.3, 5.1, 5.2</p>	<ul style="list-style-type: none"> • Records held by funding bodies • Current routine accountability mechanisms in some jurisdictions • Consultation with relevant Aboriginal stakeholders
D. Primary prevention and early intervention ⁹	Recommended or known methods for measurement or existing data sets
<p>7. Increased number of evidence-based programs implemented that aim to prevent the development of risk factors. Outcome Area 2.2, 3.3, 4.2, 5.1, 5.2</p>	<ul style="list-style-type: none"> • Records held by funding bodies • Current routine accountability mechanisms in some jurisdictions • Surveys or audits of relevant local authorities including area/regional health services, education offices, and local government
<p>8. Increased proportion of service providers across a range of sectors who participate in activities aimed at identifying individuals who may be at risk and engaging them in programs designed to reduce risk. Outcome Area 2.3, 2.4, 3.2, 3.3, 4.2, 4.4, 5.2</p>	<ul style="list-style-type: none"> • Sample survey or audit of relevant services.

⁹ The intention is to increase prevention and early intervention programs and activities targeting all known risk factors for suicide. *continued*

E. Crisis intervention and follow-up support¹⁰

Recommended or known methods for measurement or existing data sets

9. Staff of emergency services, mental health services, drug and alcohol services, primary care and other social support services are aware of and comply with protocols for the assessment of suicide risk.
Outcome Area 3.3, 4.1, 5.2, 6.4
- Sample survey or audit of relevant services
10. Staff of emergency services are aware of and comply with protocols and procedures for linking clients presenting with attempted suicide or self-harm to follow-up support services.
Outcome Area 3.3, 5.2, 6.4
- Sample survey or audit of relevant services.

11. Mental health, primary care and other community-based services implement collaborative service models and comply with protocols to respond to referrals of clients following attempted suicide or self-harm, including follow-up.
Outcome Area 3.3, 4.1, 4.2, 4.3, 4.4, 5.2, 6.4
- Sample survey or audit of relevant services.

E. Postvention

Recommended or known methods for measurement or existing data sets

12. Improved information exchange, problem solving and linking between police, ambulance, hospitals, church groups, community organisations and funeral parlours after a suicide.
Outcome Area 3.3, 4.5, 5.2
- Not recommended.

¹⁰ These indicators refer to all services that regularly come into contact with people who have attempted suicide or who are at high risk.

4



SECTION FOUR

Impact Performance Indicators:
Recommendations

Domain 11: Increased levels of life and mental health promoting and risk reducing knowledge, attitudes and behaviours among community members and people at heightened risk.

Notes:

- ‘Community’ in this context refers to the general community; however, individual projects may define their community of interest and/or influence more specifically. The indicators should be applicable to all types of communities and national level monitoring should compare progress across these different types of communities.
- The term ‘knowledge of mental health and mental illness’ is preferred to ‘mental health literacy’.

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets

1. Increased level of knowledge of mental health and mental illness within the community.
Outcome Area 2.3, 2.4, 3.3
 - Surveys at the national level and/or at the level of specific populations/communities are required.
 - Questions on mental health literacy have been developed by the Centre for Mental Health Research at the Australian National University <<http://www.anu.edu.au/cmhr/>> Described as the National Survey of Mental Health Literacy, Jorm et al., *Medical Journal of Australia*, 1997.
 - Monitoring awareness of and attitudes to depression in Australia, Hightet, Hickie and Davenport, *Medical Journal of Australia*, 2002. Includes some questions done as a national survey.
2. Improved knowledge of and attitudes towards help-seeking options in the community especially in males and others at heightened risk.
Outcome Area 2.4, 3.3, 4.5
 - Surveys, questionnaires, or focus groups of community or groups targeted by projects.
 - Perceived Need for Care Questionnaire used in the National Survey of Mental Health and Well-being (e.g., Meadows, Burgess, Fossey, & Harvey, 2000)¹¹. Also child and adolescent component of the same survey.
 - Perceived Needs for Care Focus Group: Young People – developed by the Centre for Development and Innovation in Health, La Trobe University to contribute to the evaluation of the NSPS Community Initiative Projects in Victoria.

¹¹ While this survey focused on mental disorders the questions can be readily applied to help-seeking for a variety of psychosocial problems.

continued

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets *continued*

3. Increased rate of help-seeking among groups with low rates of help-seeking.
Outcome Area 2.4, 3.3, 4.5
 - Perceived Need for Care Questionnaire that was used in the National Survey of Mental Health and Well-being includes relevant questions (Meadows, Burgess, Fossey, & Harvey, 2000).
 - Relevant questions are also available in an instrument used by Hight, Hickie, & Davenport (2002).
 - Collaborative Health and Wellbeing Survey
<<http://www.health.wa.gov.au/publications/documents/Designmethod.pdf>>
and Child Health and Wellbeing Survey
<http://www.health.wa.gov.au/publications/documents/2001_Child_Health_Design_and_Methodology.pdf> include brief questions

Domain 12: Improved social structural factors and social environments/settings

Notes:

- The definition of social structural factors is potentially broad. Social equity is a critical principle in selecting which social structural factors should be considered.
- ‘Capacity’ should include reference to sustainability of programs/activities

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets

1. Schools provide an emotionally supportive environment
Outcome Area 1.1, 2.1, 3.3
 - MindMatters kit audit tool <<http://online.curriculum.edu.au/mindmatters/index.htm>>
Information from MindMatters audits (de-identified) collated to monitor school environments.
 - Local projects focusing on specific issues in schools should encourage use of the MindMatters audit. It can be applied to focus on supportiveness for specific groups within school environments such as same sex attracted young people and refugees.
 - Relevant questions from school teacher resources such as those found at <http://www.responseability.org/ConstructionFiles/22302_TeachersGuideToMental.pdf>
 - Reviews, audits and program development guidelines from the Gatehouse Project conducted by the Centre for Adolescent Health in Victoria.
<http://www.rch.org.au/cah/research/index.cfm?doc_id=1009>
2. Improved family functioning within the general population.
Outcome Area 1.1, 2.1, 3.3
 - Surveys such as the National Longitudinal Study of Australian Children (n=5,000)
<<http://www.aifs.org.au/growingup/quest.html>>
 - Household, Income & Labour Dynamics in Australia Survey
<<http://www.melbourneinstitute.com/hilda/sinstruments.html>>
 - Indicators of Social and Family Functioning – ISAFF reference Instrument designed by Institute for Child Health Research.
<<http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/families-isff.htm>>
Local projects may use components of this survey to measure particular aspects of family functioning.

continued

Indicator/Descriptor

3. Improvements in key indicators of social equity associated with suicide (e.g., participation in education training and employment).
Outcome Area 1.2, 5.1, 3.3

Recommended or known methods for measurement or existing data sets *continued*

- National level data are collected in the Census and progress on relevant indicators is published regularly by various research institutes.
- Longitudinal data pertaining to youth specifically are available from the Longitudinal Survey of Australian Youth (Australian Council for Educational Research)
<<http://www.acer.edu.au/research/vocational/lsay/TechnicalReports/TPNo26.pdf>>
- The Department of Immigration and Multicultural and Indigenous Affairs publishes data relevant to assessment of equity in employment and education
<<http://www.dima.gov.au/research/lisia/lisia08.htm>>
- Negotiating the Life Course is a longitudinal study undertaken by the Centre for Social Research, the Demography and Sociology Program of the Research School of Social Sciences, Australian National University and the School of Social Science, University of Qld.
<<http://lifecourse.anu.edu.au/>>
- This explores issues around participation in the labour market over the life course.
- Statistics on equity of access to education are available through Departments of Education, the Australian Bureau of Statistics and national longitudinal studies such as the Household, Income & Labour Dynamics in Australia Survey
<<http://www.melbourneinstitute.com/hilda/sinstruments.html>>

Domain 13: Enhanced social connectedness/cohesion and socio-emotional attitudes and experiences in the wider community

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets

<p>1. Increased community inclusion of, respect for and support for marginalised groups, people with risk factors for suicide, and those affected by suicide. Outcome Area 1.3, 2.1, 3.3, 4.5</p>	<ul style="list-style-type: none"> • Australian Bureau of Statistics data related to social capital theme • Department of Immigration and Multicultural and Indigenous Affairs' Longitudinal Survey of Immigrants <http://www.dima.gov.au/research/lsia/lsia08.htm> especially Section 5: Health <http://www.dima.gov.au/research/lsia/index.htm> • At local project level a qualitative methodology including focus groups may be appropriate.
<p>2. Improved supportive relationships and social connectedness. Outcome Area 1.1, 2.1, 3.3</p>	<ul style="list-style-type: none"> • Australian Institute of Family Studies' Study, <i>Families, Social Capital and Citizenship</i>. The methods tested in this research could be further applied at the national and local level. <http://www.aifs.gov.au/institute/research/progC.html> • At the level of local projects, components from the following larger surveys may be useful: <ul style="list-style-type: none"> – Young people: Adolescent Health and Well-being Survey <http://www.rch.org.au/cah/research/index.cfm?doc_id=1009> – Older people: <http://www.stanford.edu/~yesavage/GDS.html> and – Older women: <http://www.newcastle.edu.au/centre/wha/surveys.htm>
<p>3. Decrease in social isolation, particularly for those at high risk and at times of vulnerability such as after loss. Outcome Area 3.3, 4.5</p>	<ul style="list-style-type: none"> • The Australian Centre on Quality of Life (ACQOL) has a directory of instruments that local projects can access for consideration. <http://acql.deakin.edu.au/instruments/index.htm> • The Australian Longitudinal Study of Ageing (ALSA) contains questions about family relationships and support, social activities, social interactions between couples and 'successful' ageing as well as health indicators. <http://www.cas.flinders.edu.au/sanra/research/proj0020.html>

continued

Indicator/Descriptor

4. Increased sense of community, social connectedness, cohesion, and community strength in Aboriginal and Torres Strait Islander communities.
Outcome Area 1.1, 3.3, 5.1

Recommended or known methods for measurement or existing data sets *continued*

- The National Centre for Aboriginal and Torres Strait Islander Statistics (NCATSI) offers expert advice and has national responsibility for quality statistics relating to Australia's Indigenous peoples. (Australian Bureau of Statistics website: 'Indigenous')
- Local projects may consider past methods and tools used in research available on <<http://www.healthinfonet.ecu.edu.au>>
- The Aboriginal Health and Community Development courses at The University of Sydney undertake a community profile for which they provide a web knowledge base with methodology. <<http://www2.fhs.usyd.edu.au/bach//pub/community/thisite.htm>>

Domain 14: Individuals at risk experience improved services and support

Notes:

The indicators covered under this domain may be conceptualised in terms of their place on 3-axes representing:

1. at risk groups/ groups at heightened risk
2. types of services within the Mental Health System
3. the chain of care – access to care/continuity of care/quality of care

For each of these indicators it may be necessary to use different measurement tools for specific target groups; however, it is intended that the underlying dimension be the same to allow for national level monitoring.

Target groups are not specified in the following summary indicators but include:

- Clients of primary care and community-based services with key risk factors for suicide (e.g., Mental disorders and substance use problems)
- Individuals and groups at increased risk for suicide living in rural and remote areas
- People with mental disorders
- People involved with the criminal and juvenile justice system with mental disorders
- Children and siblings of prisoners, parolees and people awaiting trial
- People with substance misuse problems combined with mental disorders
- Family members and friends bereaved by suicide
- Aboriginal and Torres Strait Islander people

Judgement of how 'appropriate' services are to different needs requires further definition/elaboration.

It should be understood that all services, programs, activities should be 'evidence-based' within all indicator domains.

The chain of care should reflect:

- access to care
- ongoing support (for those with mental health issues and their families, friends, carers, etc.)
- continuity of care, particularly following crises including presentation to emergency services
- quality of care at all points of chain

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets

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| <p>1. Increased proportion of target group are identified and appropriately referred to relevant services.
Outcome Area 3.1, 3.2, 3.3, 4.2, 4.3, 4.4, 4.5</p> | <ul style="list-style-type: none">• Consumer surveys. The AIHW report: <i>Mental Health Services in Australia 2000-01</i> may provide a guide to the kinds of questions for local projects to focus on, and comparative data. <http://www.aihw.gov.au/publications/hse/mhsa00-01/index.html>
Information from community-based residential services is available: <http://www.aihw.gov.au/mentalhealth/community/index.html>• At the local project level, surveys, interviews or focus groups of the community or groups targeted by projects:<ul style="list-style-type: none">– service audits of a national sample would be possible– case audits at the local service level– rates of identification compared with research-based prevalence estimates based on National Survey of Mental Health and Well-being (Ciarlo, J.A., Tweed, D.L., Shern, D.L., et al. (1992). Validation of indirect methods to estimate need for mental health services. <i>Evaluation and Program Planning</i>, 15, 115-131.) |
| <p>2. Increased proportion of target group who present to appointments at services to which they are referred.
Outcome Area 3.1, 3.2, 3.3</p> | <ul style="list-style-type: none">• As above.• At the local project level, key methods:<ul style="list-style-type: none">– Service audits– Case audits– Targeted follow-up of referred groups |
| <p>3. Target groups have received treatment, support and care appropriate to their level of suicide risk.
Outcome Area 3.1, 3.2, 3.3, 4.2, 4.3, 4.4</p> | <ul style="list-style-type: none">• As above.• At the local project level, key methods:<ul style="list-style-type: none">– Service audits– Case audits– Targeted follow-up of referred groups |

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| <p>4. Target groups experience services as accepting, engaging, confidential, supportive and appropriate to their needs
Outcome Area 3.2, 3.3, 4.2, 4.3, 4.4, 4.5</p> | <ul style="list-style-type: none"> • As above. • At the local project level, key methods <ul style="list-style-type: none"> – Consumer surveys within services – Consumer surveys to targeted samples |
| <p>5. Individuals presenting with attempted suicide, self-harm, or mental health crises and those following discharge from hospital or cessation of crisis-intervention by specialist mental health services are offered and receive ongoing care from services appropriate to their needs
Outcome Area 3.3, 4.1</p> | <ul style="list-style-type: none"> • At the national level: Collation of RAPID data in Victoria and equivalent data in other states/territories. • Local level projects should focus on particular services and target groups. Key methods include: <ul style="list-style-type: none"> – file audits and discharge summaries – service audits – follow-up surveys |
| <p>6. Increased access to evidence-based early interventions for people with or at risk of mental disorders and suicide.
Outcome Area 3.1, 3.3, 4.2</p> | <ul style="list-style-type: none"> • Surveys of Services and consumers, with particular attention to barriers to accessing early interventions. |
| <p>7. Aboriginal and Torres Strait Islander people experience mainstream services as increasingly accessible, culturally sensitive and relevant to their needs
Outcome Area 3.3, 5.2</p> | <ul style="list-style-type: none"> • Surveys of consumers • Audits around cultural sensitivity. • OATSIH National performance indicators and targets may provide some guidance <http://www.health.gov.au/oatsih/pubs/npi.thm> • Methods that have been used are reported by the Cooperative Research Centre for Aboriginal and Tropical Health <http://www.ath.crc.org.au/crc/> |

Domain I5: Reductions in health and social problems that are proximal and distal risk factors for suicide

Indicator/Descriptor

1. Decreased rate of depressive symptomatology/
disorder and other mental disorders
Outcome Area 2.2, 3.3, 4.3, 5.1

Recommended or known methods for measurement or existing data sets

- Australian Bureau of Statistics, National Health Survey includes mental health questions. As well as questions about 'long-term mental or behavioural problems', the survey includes the Kessler 10 Scale (K10) measuring "current psychological distress". <<http://www.abs.gov.au>>
- The National Survey of Mental Health and Well-being of Adults uses the Composite International Diagnostic Interview (CIDI). The CIDI is a comprehensive, fully standardised interview that can be used to assess mental disorders according to the definitions and criteria of ICD-10 and DSM-IV. <<http://www.crufad.unsw.edu.au/cidi/cidi.htm>>
- Outcomes and indicators, measurement tools and databases for the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, Commonwealth Department of Health and Ageing. Includes measures for different target groups and lifestages. Available from DHA.
- The Australian Institute of Health and Welfare Hospitals and Mental Health Services Unit provides routine statistical reporting based on the National Minimum Data set for admitted Patient care which forms the basis for the National Hospital Morbidity Database. <<http://www.aihw.gov.au/aboutus/health/hmhsu.html>>
- Local level projects should use questions from National Health Data Dictionary wherever possible: (available online) <<http://www.aihw.gov.au/publications/hwi/nhdd10/nhdd10.pdf>>
- Other sources for questions that may suit particular target groups include:
 - Mental health instruments in non-English languages <http://www.vpu.org.au/resources/translated_instruments/instruments.html>
 - <<http://www.dima.gov.au/statistics/index.htm>>
 - Victoria Mental Health Branch recommended tools <<http://www.mentalhealth.gov.au/mhinfo/ccf/pdf/outcomes.pdf>>
- Other measures available: <<http://www.library.adelaide.edu.au/guide/med/mentalhealth/index.html>>

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| <p>2. Decrease in social alienation and social exclusion, especially among those with psychosis
Outcome Area 2.2, 3.3, 5.1</p> | <ul style="list-style-type: none"> • National Survey of Mental Health and Well-being of Adults. • At the local project level methods include: <ul style="list-style-type: none"> – Surveys/focus groups with target group – Follow-up surveys of groups of patients • Local projects should consider the applicability of measurement tools around social connectedness identified above in Domain 3 to the target group. |
| <p>3. Decreased rate of child abuse
Outcome Area 2.2, 3.3, 5.1</p> | <ul style="list-style-type: none"> • Current routine accountability mechanisms in some jurisdictions. • Australian Institute of Health and Welfare child protection reports for national monitoring
<http://www.aihw.gov.au/chilyouth/childprotection/index.html> |
| <p>4. Decreased rate of disruptive behaviour disorders and violence
Outcome Area 2.2, 3.3, 5.1</p> | <ul style="list-style-type: none"> • At the national level ABS crime statistics are reported using the Australian Standard Offence Classification (ASOC). • Clinical data from longitudinal studies such as the Western Australia longitudinal study RASCALS (Randomly Ascertained Sample of Children in Australia's Largest State), the Australian Temperament Project, LSAC and the Gatehouse project provide statistics on children and school aged teenagers. • Education Department data relevant to disruptive behaviour and violence. • At the local project level, projects should use scales and classifications included in other larger studies. • The HoNOSCA was recommended in 'Consumer Measurement Systems and Child and Adolescent Mental Health' report to Mental Health Branch:
<http://www.liv.ac.uk/honosca/index.htm> |

continued

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets *continued*

5. Decreased rate of problematic substance use
Outcome Area 2.2, 3.3, 4.4, 5.1
 - National Alcohol Drug Research Centre
<<http://ndarc.med.unsw.edu.au/ndarc.nsf/website/IDRS.NIDIP>>
 - National Drug Strategy Household Survey conducted by the Australian Institute of Health and Welfare (www.aihw.gov.au)
Drug Statistics Series Report: Statistics on Drug Use in Australia
<<http://www.aihw.gov.au/publications/index.cfm?type=detail&cid=8390>>
 - Local projects should use standard questions as far as possible to allow for comparison.
(National Dictionary)
6. Decreased rate of homelessness
Outcome Area 2.2, 3.3, 5.1
 - Australian Bureau of Statistics, including census data and other relevant reports. The Housing Unit of the Australian Institute of Health and Welfare regularly reports on housing and homelessness.
 - Local level projects that focus on homelessness should use definitions consistent with these publications.

Domain 16: More appropriate portrayal of suicide, mental disorders and young people by the media and artistic productions

Notes:

- The term 'media' is used to refer to all forms of media including fictional and non-fictional media, and print, electronic and performance media

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets

1. Increase media compliance with the MindFrame-media national guidelines Outcome Area 2.5, 3.3	<ul style="list-style-type: none"> • At the national level, monitoring of compliance with the MindFrame-media guidelines¹². <http://www.mindframe-media.info/> • Local projects may monitor compliance before and after particular inputs/strategies to assess impact.
2. Decreased number of negative portrayals of young people in the Australian media Outcome Area 2.5, 3.3	<ul style="list-style-type: none"> • At the local level, projects may monitor portrayals in a defined set of media before and after particular inputs/strategies to assess impact.
3. Decreased number of negative portrayals of high risk groups in the Australian media Outcome Area 2.5, 3.3	<ul style="list-style-type: none"> • Stigma Watch at <http://www.sane.org/> • At the local level, projects may monitor portrayals in a defined set of media before and after particular inputs/strategies to assess impact.
4. Decreased exposure of young people to inappropriate portrayals of suicide and mental disorders; for example, in artistic productions and school texts Outcome Area 2.5, 3.3	<ul style="list-style-type: none"> • Local projects may focus on particular environments (e.g., local communities or schools) and monitor portrayals before and after interventions.

¹² Jane Pirkis, R Warwick Blood, Catherine Francis, Peter Putnis, Philip Burgess, Belinda Morley, Andrew Stewart, & Irish Payne of the Centre for Health Program Evaluation, University of Melbourne, and the School of Professional Communication, University of Canberra. *The Media Monitoring Project: A Baseline Description of how the Australian Media Report and Portray Suicide and Mental Health and Illness.*

Domain I7: Reduced access to means of suicide

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets

<p>1. Reduced proportion of potentially lethal medications that are available in excessively large pack sizes Outcome Area 2.6, 3.3</p>	<ul style="list-style-type: none"> Monitoring of legislation, including monitoring of extensions of child resistant packaging, and of reduced package sizes. The Monash University Accident Research Centre monitors deaths and advises about potential strategies for avoiding future deaths. <http://www.general.monash.edu.au/maarc/>
<p>2. Reduction in the rate of duplication of prescribing of potentially lethal medications Outcome Area 2.6, 3.3</p>	<ul style="list-style-type: none"> National Health Survey for consumer information about levels and reasons for usage of medications and demographic and socio-economic characteristics of persons involved. Surveys of clients through pharmacies/GP/District Nursing; e.g., GP client survey BEACHES <http://www.fmrc.org.au/beach.htm> The National Prescribing Service <http://www.medicinesline.com.au/index.html> includes clinical audits for health professionals
<p>3. Reduced availability of hanging points and architectural features that enable suicide attempts in, health/mental health, police and correctional facilities Outcome Area 2.6, 3.3, 4.3</p>	<ul style="list-style-type: none"> The Australian Institute of Criminology collates, analyses and reports on deaths in custody. <http://www.aic.gov.au/research/dic/> Monitoring of guidelines and building specifications by Departments of Corrections could be undertaken at the national level to consider implementation of recommendations arising from reviews of deaths in custody.
<p>4. Increase in the number of barriers on common and potential jumping points Outcome Area 2.6, 3.3</p>	<ul style="list-style-type: none"> Local government could undertake analysis of physical environments with a view to potential jumping points.
<p>5. Reduced lethal potential of motor vehicle exhaust emissions Outcome Area 2.6, 3.3</p>	<ul style="list-style-type: none"> Monitoring of legislation and research related to the impact of emission controls, and other implementation of known design solutions to this method of suicide is recommended (see Monash University Accident Research Foundation).

continued

Indicator/Descriptor

Recommended or known methods for measurement or existing data sets *continued*

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| 6. Decrease in the proportion of gun owners who store firearms and ammunition unsafely
Outcome Area 2.6, 3.3 | <ul style="list-style-type: none">• No relevant data are currently available at the national level, and accurate data is likely to be difficult to collect. |
| 7. Reduced access to poisons through safer packaging and storage
Outcome Area 2.6, 3.3 | <ul style="list-style-type: none">• Monitoring of legislation relating to packaging of poisons. |

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