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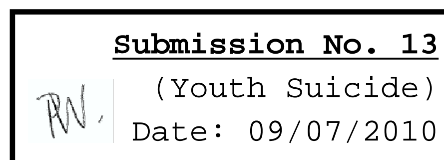


30 June 2010

Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
Canberra 2600

To Whom It May Concern:

Re: Roundtable Forum on Youth Suicide Prevention – Sydney, 30 June 2010

Thank you, for giving me the opportunity of speaking to you today on policy with respect to suicide prevention.

I would like to contribute some further information:

1. I have attached a recent supplement from the Medical Journal of Australia which provides some information about a number of the internet based services that you heard about today. These programs are both effective and popular. The supplement describes the work of ISPIRE (p.S22), the work of CRUfAD (s45), and the work of the ANU Centre for Mental Health Research (s40, s48). These programs target risk factors such as anxiety and depression. However, it is possible to develop new online e programs that target more direct risk factors for suicide such as suicide ideation and which also provide 'safe' internet support groups.

2. I am also providing the results of a trial we conducted using web technologies in the setting of the Lifeline telephone services. I have attached a brief outline of this program. The key feature of the program is that it used 'gold standard' methodology (RCT) to show that web self help programs significantly reduced depression and anxiety in this group of Lifeline callers. Importantly, it also showed that suicide ideation and suicide plans were reduced. It is the first (or at least one of the first) programs to demonstrate this conclusively both in Australia and internationally using best research methodology.

3. I am also including a paragraph about the importance of research, which is critical to the improvement of services and to the understanding of the causes of suicide. Without the latter, it is difficult to 'isolate" those individuals for whom prevention is needed. Suicide is one of the most poorly researched public health issues in Australia. The amount of NHMRC funding for suicide research fell from nearly 1M per year to approximately half that amount in 2006. No NHMRC grants for suicide prevention were awarded in 2009/10. Proportionately, far less NHMRC funding was awarded to suicide compared to disorders with similar mortality such as skin cancer, breast cancer or road accidents according to the RANZCP submission to Senate

Community Affairs Committee Inquiry into Suicide in Australia. In 2008, $790,786 was spent on suicide research while $17,482,128 was spent on breast cancer and $9,253,307 spent on skin cancer (p.11). This should be immediately addressed by providing 'ear marked' research funds through the NHMRC for suicide prevention research.

I also would like to emphasize that evaluation of programs while important, does not constitute "research" - the latter is needed to provide new knowledge about services and causation- and it needs to be high quality, because the demonstration that people get better when in contact with services is not conclusive, unless we know what might have happened to them without contact with services.

I hope my comments may prove useful to the committee in their deliberations on youth suicide prevention.

With kind regards

Professor Helen Christensen
Director
Centre for Mental Health Research

The Mental Health Services Achievement Awards
Part B: Full description of The ECCO Project

The ECCO project is a new service introduced into Lifeline whereby callers are provided with an evidence-based mental health care package. Callers to the Lifeline 131114 national line are screened for anxiety and depression and then provided with a 6-week Internet program consisting of web-based cognitive behaviour therapy (CBT) and depression psychoeducation. A dedicated Lifeline telephone counsellor offers a weekly call back service to support callers to complete different components of the Internet program week-by-week.

1. **Evidence that the program/person has made a significant contribution to the field of mental health on a local, state or national level.**

- The ECCO project is the first program in Australia that provides an evidence-based mental health care package to callers of a national, 24-hour telecounselling service. As such, it provides an innovative, forward looking model for the delivery of evidence-based care particularly to those with little access to assistance from health professionals. It also provides a targeted program to the substantial numbers of people who are known to call Lifeline repeatedly for help.
- The program provides consumers with an inexpensive, low-intensity, early intervention alternative to other more expensive services which employ case managers psychologists or other health care workers who are in short supply.
- The program is delivered distally to consumers, and as such it:
    - improves access to high quality care;
    - offers increased access for those who experience financial, geographical and other barriers to face-to-face treatments; and

- delivers treatment in the home at any time. This service is not only convenient for consumers, but it also provides critical access to treatment for those who cannot leave home due to the nature of their illness (many Lifeline callers experience panic disorder, for instance).

- The project adds to existing knowledge about the use of Internet interventions in the treatment of high prevalence mental health problems. The effectiveness of telephone counselling services is typically not evaluated using best practice standards. The ECCO project has evaluated the new service in-situ using a randomised controlled trial, the 'gold standard' benchmark for evaluating the effectiveness of an intervention.
- The program maximises the workforce potential of the volunteer sector by providing an evidence-based tool which can be delivered effectively by a lay facilitator with little training.
- Significantly, the program demonstrates that cultural change is possible within an organisation staffed primarily by volunteers. Many Lifeline counsellors held pre-existing, long standing views about the type of service that 'should' be provided by Lifeline. This project provided evidence that new models can be successfully implemented and that they lead to improved outcomes for consumers.

2. Evidence that the program/person is doing something innovative or is maintaining a high standard of service.

- CBT has been successfully delivered through the telephone by therapists and others (Mohr, 2005). However, to the best of our knowledge, the ECCO project is the first Internet evidence-based intervention to be implemented in a telephone counselling service in Australia. The Internet applications used in this project are automated. Consequently, they do not require delivery by an expert psychologist or therapist.

- Before the present service was introduced, very little was known about the mental health of users of telephone counselling services and their preferences for telephone help. Before commencing the ECCO service we therefore conducted a survey asking Lifeline callers directly about their mental health, and their willingness to receive longer interventions from Lifeline (Burgess et al.,2008). Contrary to the prevailing views and assumptions of the volunteer workforce, consumers' indicated that they would be willing to disclose their personal information (including contact details) to Lifeline in order to receive the new Lifeline service. We also found that many callers to Lifeline had longstanding anxiety and depression difficulties, which were not supported by conventional health services. Providing consumers with the opportunity to express their views enabled us to:

    (a) gain a more accurate understanding of the value placed on anonymity by consumers (74% were willing to provide their personal information to Lifeline); and

    (b) ascertain the needs of callers and the methods that could be employed to enhance Lifeline's service into the future.

- In designing and implementing the service within Lifeline, we found that research and evaluation was typically not perceived by volunteer counsellors as an important activity for a telecounselling service and did not fit well with their perceptions of their role as a counsellor. In order to successfully undertake the project it was necessary to develop innovative methods for addressing and changing these perceptions. To ensure that the knowledge gained from our experience was conveyed to others, we have published an evaluation of the utility of the methods and processes that we used within the organisation to produce cultural change amongst the volunteer staff (Burgess, et al. in press).

3. **Evidence that the program has involved the participation of consumers, family members and/or carers in the planning, implementation and evaluation of mental health service delivery.**

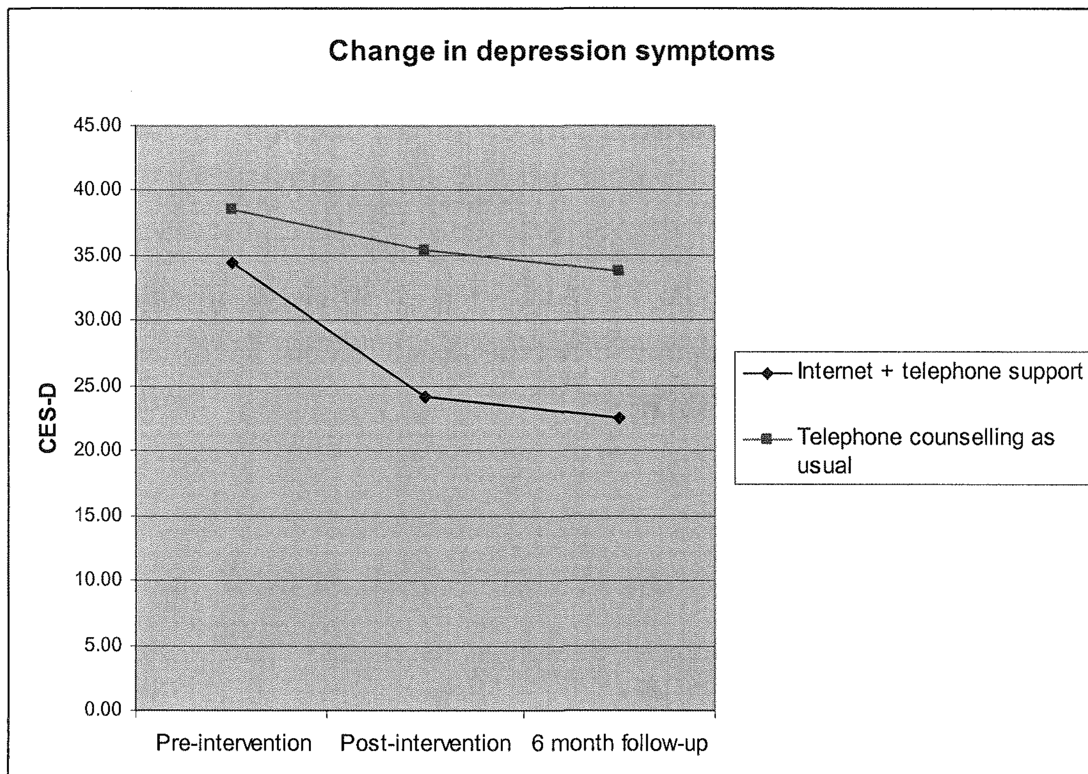
- As noted above, consumer feedback was critical in the initial scoping phase of the project. In a scoping survey of callers, we directly asked Lifeline users about their mental health and associated needs and concerns. The survey not only enabled us to construct a more complete, and accurate picture of who calls Lifeline, but it also gave a "voice" to a large population of consumers whose mental health needs were unknown and largely inferred on the basis of little or no evidence.
- A Consumer academic (Professor Kathy Griffiths) has co-led the project through the planning, implementation and evaluation stages.
- Consumers have provided feedback via telephone interviews conducted at the end of their involvement in the service. These interviews provided consumers the opportunity to provide feedback not only about the service, but also about the psychological (self-efficacy, expectations, illness-specific factors) and practical (time-restraints, lack of support/access) factors that impacted on their use of the service. Data from these interviews has provided important feedback about how to improve the service into the future and prevent dropout.
- Finally, all consumers involved in the program have provided written feedback about the service in post-service evaluation surveys.

4. **Verification of the program's effectiveness (quality improvement activity, data collection and its use including graphs and tables, achievement of performance indicators, e.g. attendance figures, outcome measures, number of document downloads, page views, click through rates).**

   - The service was evaluated by a randomised controlled trial, which is the gold standard for evaluating an intervention program. We compared consumers provided with the standard Lifeline service with consumers who completed the online CBT and psychoeducation with weekly telephone support.

- 155 Lifeline callers were enrolled in the service.
- The new service was found to be effective. Both immediately following completion of the program and at 6-month follow-up, consumers provided with the mental health websites had **improved levels of depression compared to a control group.** The program halved the number of people meeting criteria for clinical depression on the CES-D at 6 month follow-up (see Table 1). **Those receiving the program also had lower levels of hazardous alcohol use**. Finally, they had **improved mental health literacy, improved quality of life, and better knowledge about depression (depression literacy)**. These outcomes are shown in the graphs and table below.

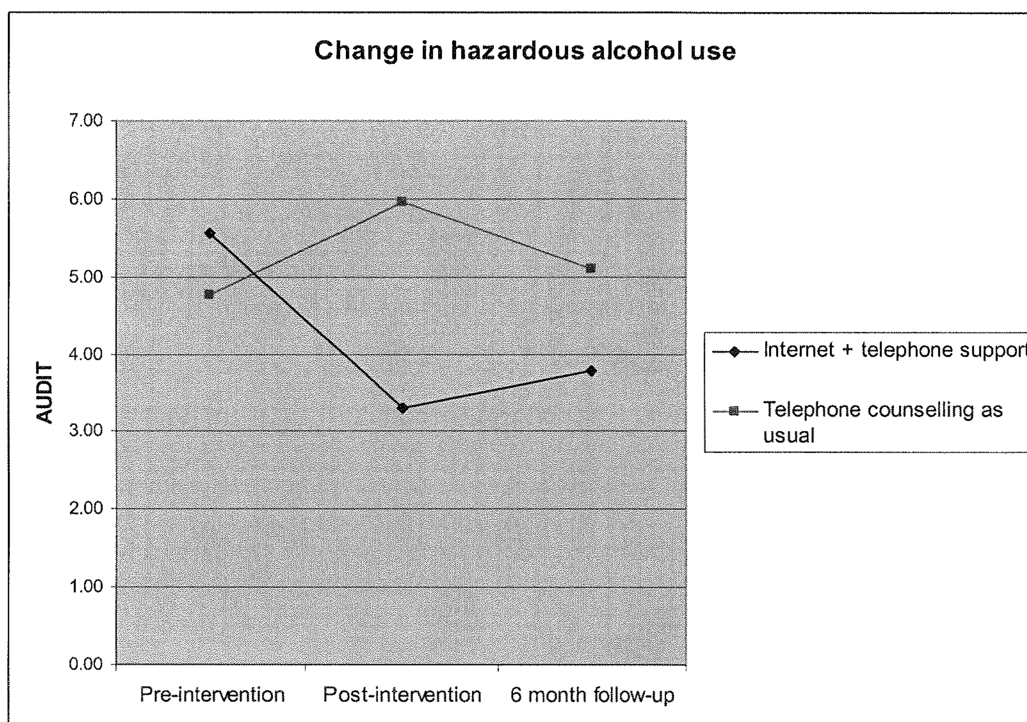
Outcomes – Depression symptoms



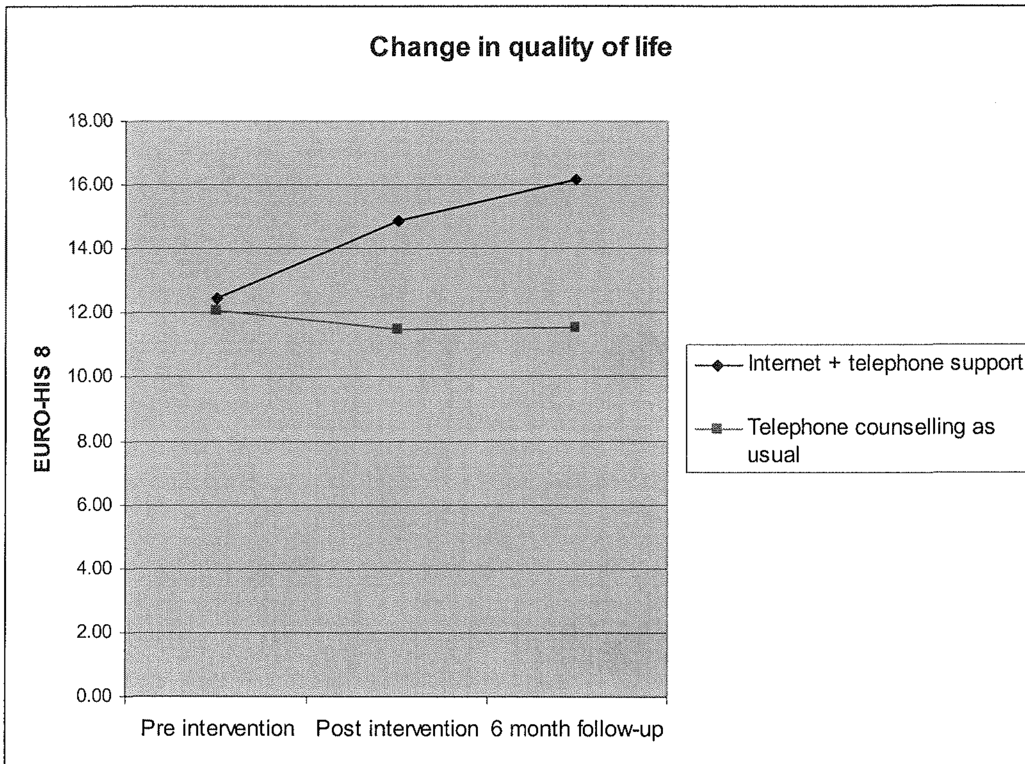
Outcomes – Number of 'cases' of depression

	Internet + telephone support	Telecounselling as usual
Pre-intervention	93%	100%
Post-intervention	70%	93%
6 month follow-up	55%	91%

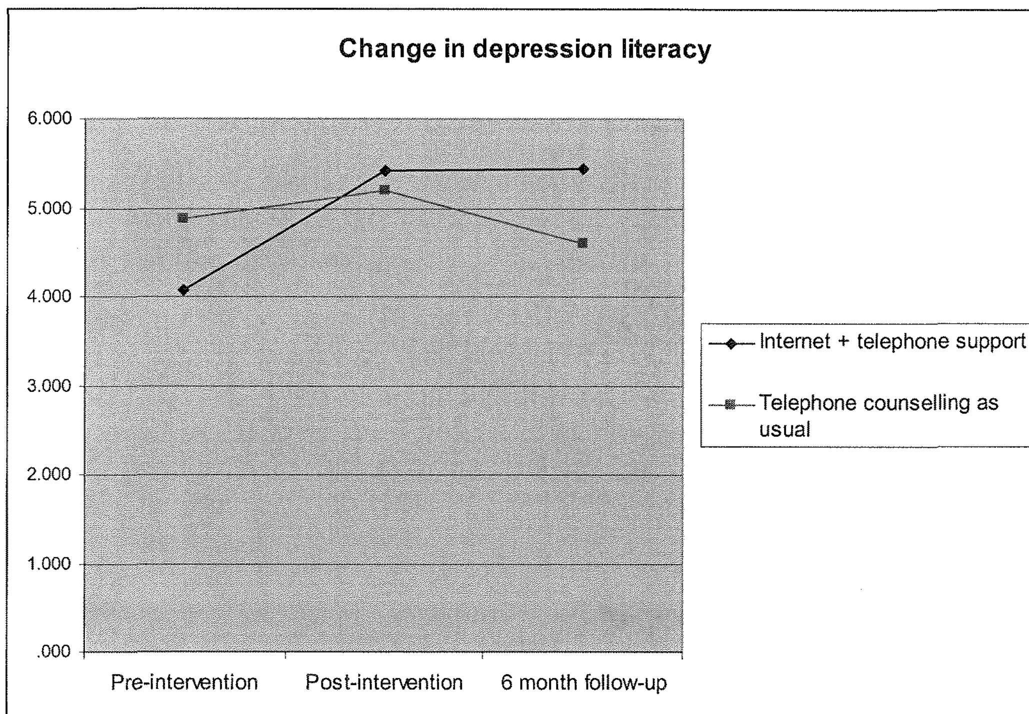
Outcomes – Hazardous alcohol use



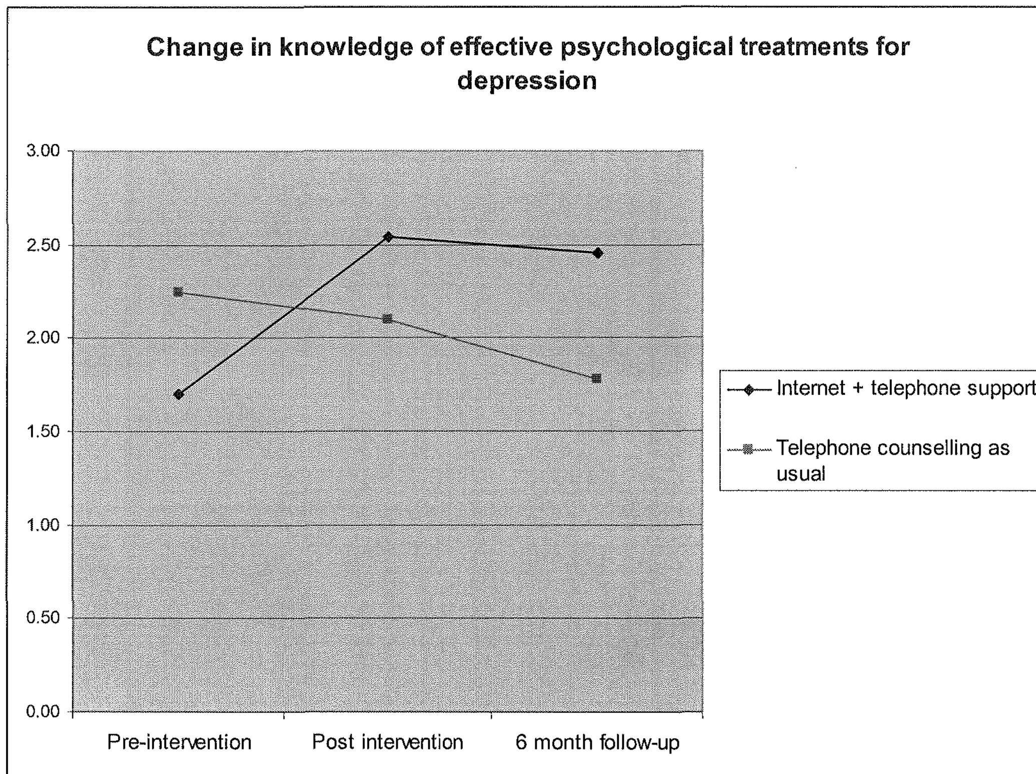
Outcomes – Quality of life

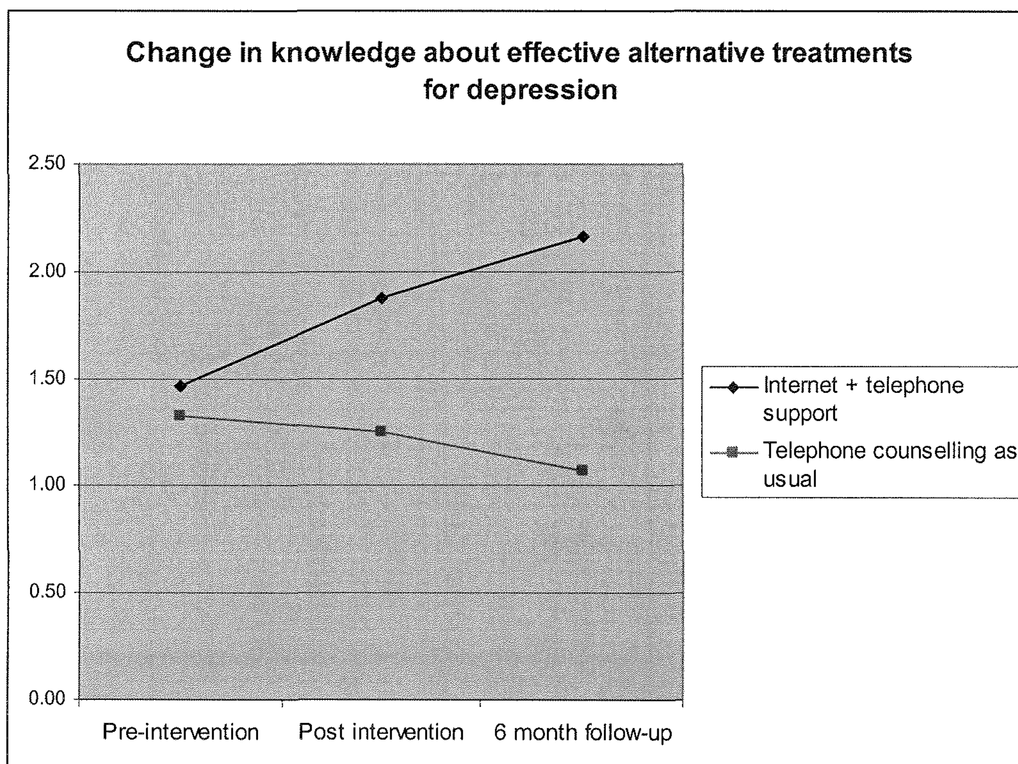


Outcomes – Depression literacy



Outcomes – Literacy about psychological and alternative/lifestyle treatments for depression





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