Queensland Government Submission

to the

Senate Community Affairs Reference Committee

Inquiry into Suicide in Australia

November 2009

Queensland Government

Foreword

The Queensland Government recognises the profound impact that suicide has on the community and acknowledges its important contribution to effective suicide prevention.

This is why the Queensland Government has made significant commitments to reducing suicide rates through *Reducing Suicide: the Queensland Government Suicide Prevention Strategy 2003-2008* (QGSPS) and its predecessor the *Queensland Government Youth Suicide Prevention Strategy 1998-2003.* Over the past 12 years the Queensland Government has allocated an annual budget of $2 million directly to cross-government suicide prevention initiatives in Queensland. These initiatives are endorsed by a cross-Government committee, comprising key departments, working together to prevent suicide and improve the mental health of Queenslanders. However, the combined contribution to reducing risk and building protection from Queensland Government programs across Health, Education, Employment, Communities, Police and Emergency Services far exceeds this figure.

The Queensland Government is currently preparing for the next phase of suicide prevention in the form of the *Queensland Government Suicide Prevention Action Plan* to be finalised during 2010. The foundation stones for effective suicide prevention strategy have come from the continued cooperative efforts of Queensland Government agencies to tackle this most serious issue, and the learnings from the comprehensive evaluations of the *Reducing Suicide: the Queensland Government Suicide Prevention Strategy 2003-2008* (QGSPS) and *Queensland Government Youth Suicide Prevention Strategy 1998-2003*.

Queensland has also increasingly aligned its day-to-day endeavours with the *National Suicide Prevention Strategy*, *Queensland Plan for Mental Health 2007-2017* and it's commitment to the priorities and actions in the *Fourth National Mental Health Plan* and *Healthier Future for All Australians Final Report June 2009*. We are making further progress by implementing the *Queensland Plan for Mental Health 2007-2017*, which represents the largest investment in mental health in Queensland's history.

The Queensland Government understands that more work needs to be done. However, I am confident this comprehensive and connected-up policy platform, which aligns with national effort, will continue to improve capacity and response, and have a positive and meaningful impact on reducing suicide.

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Introduction

Since 1997, Queensland Governments have implemented cross government strategies to reduce suicide risk and mortality, as well as build individual and community resilience. The actions taken have reflected best available evidence and independent evaluations have confirmed positive results while identifying areas for strengthening the Government response. The cycle of implementation and evaluation has supported the evolution over time, of enhanced knowledge and capacity, and established a sound policy and planning framework for suicide prevention in Queensland.

The phenomenon of suicide and its effective prevention is challenging for governments at all levels. Suicide is a complex public health problem resulting from the interaction of psychological, social, biological and environmental factors. The prevention of suicide is equally complex involving a series of activities ranging from environmental control of risk factors and means, through the early identification and effective treatment of people with mental illness, to the responsible reporting of suicide in the media. A comprehensive approach to preventing suicide addresses the population at large as well as particularly vulnerable groups, including people who have exhibited previous suicidal behaviour.

Preventing suicide unequivocally requires action across all levels of government - state, national and local. Actions are also required across all sectors of government, including health, education, police, emergency services as well as other human services sector agencies. Well coordinated and multi-faceted responses are required which boost the capacity of all sectors to contribute to preventing suicide.

Suicide prevention within Australia is at an important juncture. An unprecedented level of national, state and territory cooperation for suicide prevention is providing the strategic conditions for more effective action. In the past, national and state suicide prevention actions were not well integrated or coordinated leading to areas of duplication, inefficiency and limited sustainability of achievements. The recently endorsed *Fourth National Mental Health Plan* places clear priority on "coordinating state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them".

The Queensland Government is currently developing a new *Queensland Government Suicide Prevention Action Plan* (QGSPAP). A key feature of the QGSPAP will be greater alignment with the *National Suicide Prevention Strategy* (LIFE Framework) as well as integration across related areas of state and national mental health reform. This approach will enable greater efficiencies in the suicide prevention activities undertaken by the Queensland Government, and complement actions directed at reducing risk and building protection progressed by the Australian Government.

This Queensland Government Submission to the Senate Inquiry presents a snapshot of the direction taken and achievements associated with Queensland Government suicide prevention implementation. It also responds from a Queensland perspective to the specific issues raised by the Inquiry's Terms of Reference, and supports the continuation of current state and national directions in a coordinated, cooperative and value-adding manner. It acknowledges that future success will rely on the continued strategic investment; increased quality of suicide prevention research and best possible suicide data surveillance; and state and commonwealth leadership in maintaining the stated commitment to alignment and coordination across and between all levels of government.

1. Key issues for suicide prevention in Queensland

1.1. Data Issues

The Queensland Government has placed great value on improving quality of suicide surveillance and reporting through its partnership with the Australian Institute of Suicide Research and Prevention (AISRAP). The Queensland Suicide Register is a comprehensive database of suicide mortality data, managed by AISRAP and funded by Queensland Health since 1990.

Accurate and meaningful data is essential to determine the success of suicide prevention strategies. Commonwealth, state and territory governments in Australia largely rely on indicators of reduction in suicide rates for evaluating effectiveness of suicide prevention strategies. It is widely accepted that a wide range of problems affect the reliability of suicide data within Australia. The Australian Bureau of Statistics (ABS) has acknowledged the issues and introduced changes to improve the quality of data for the period starting 1 January 2007.

Although the Queensland Government acknowledges any death by suicide is tragic, the limitations with national suicide surveillance mean it is not possible with any certainty to compare the situation in Queensland with other jurisdictions. Further, it demonstrates the limitations in evaluating effectiveness of suicide prevention strategies through a singular focus on suicide statistics.

1.2. The Size and Scope of the Problem in Queensland

The information in this section is derived from the Queensland Suicide Register maintained by AISRAP. The database gathers information on deaths presumed to have occurred by suicide within Queensland including data obtained from police reports, post-mortem and toxicology reports and psychological autopsy questionnaire (since 1994).

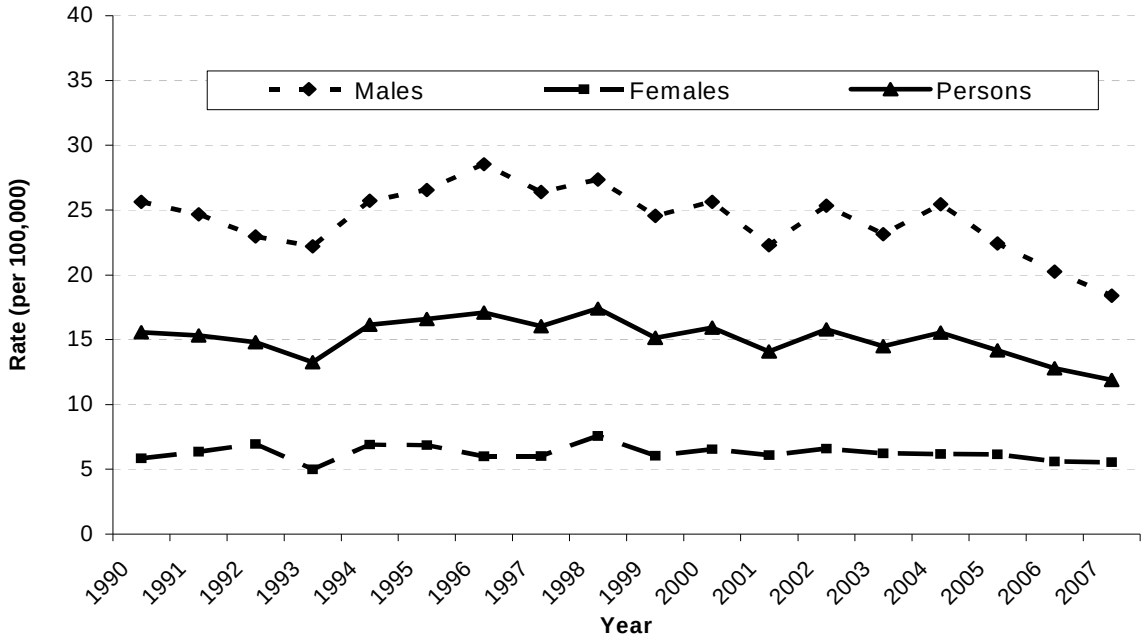
Since the establishment of the Queensland Suicide Register, its reports on suicide mortality in Queensland aligned with those of the ABS, with fluctuations within the range of 5%. However, from 2002 onward, the discrepancy between the two systems has been increasing, with the Queensland Suicide Register recording almost 200 additional suicide deaths for 2006 (De Leo, 2009) in comparison to the ABS data. The Queensland Suicide Register, like the ABS, uses information obtained through the Office of States Coroners and cross-checks them with the data available on the National Coronial Information System (NCIS). Causes of death are then scrutinised in the Queensland Suicide Register following the Suicide Classification Flow Chart, developed by the AISRAP and, and categorised into ‘Beyond reasonable doubt’, ‘Probable’, or ‘Possible’. The latter are excluded from analyses, as the available information is not sufficient to determine suicide as the most likely cause of death (i.e. death might be due to other external causes such as accident).

There are two major reasons for the observed differences in suicide incidence reported by the ABS and that of the Queensland Suicide Register. Firstly, Where coroners’ cases are not finalised and the findings are not available to the ABS in time for publication, deaths are coded to other accidental, ill-defined or unspecified causes rather than suicide (ABS, 2009). The proportion of deaths coded to non-specific causes has increased steadily over the last 10 years from 0.5% (635 deaths) in 1998 to 1.4% (1,895 deaths) in 2007. Changes in ABS processes for obtaining information regarding coroner certified deaths has contributed to the increase in coding as non-specific causes. Secondly, the Queensland Suicide Register publish suicide statistics in periodical publications (every three years), allowing for a more comprehensive picture of suicide mortality with inclusion of cases that require a more lengthy coroners investigation.

According to the Queensland Suicide Register on average, around 540 people die by suicide annually in Queensland. **Figure 1** (below) presents suicide rates, age-standardised based on the 2001 Australian population for males, females and all persons in Queensland between 1990 and 2007. Over this time period, there was an average rate of 24.3 suicides per 100,000 for males, 6.2 per 100,000 for females and 15.1 per 100,000 for all persons. Suicide rates in males were on average 3.9 times higher than in females.

Highest suicide rates were recorded in 1998 for all persons (17.4 per 100,000) and females (7.6 per 100,000), while for men the highest rates were in 1996 (28.5 per 100,000). Since then a decrease has been observed, most notably in the years after 2005. In 2007, suicide rates for males were 18.4, for females 5.6 and for all persons 11.9 per 100,000.

Figure 1: Age-standardised suicide rates, Queensland 1990



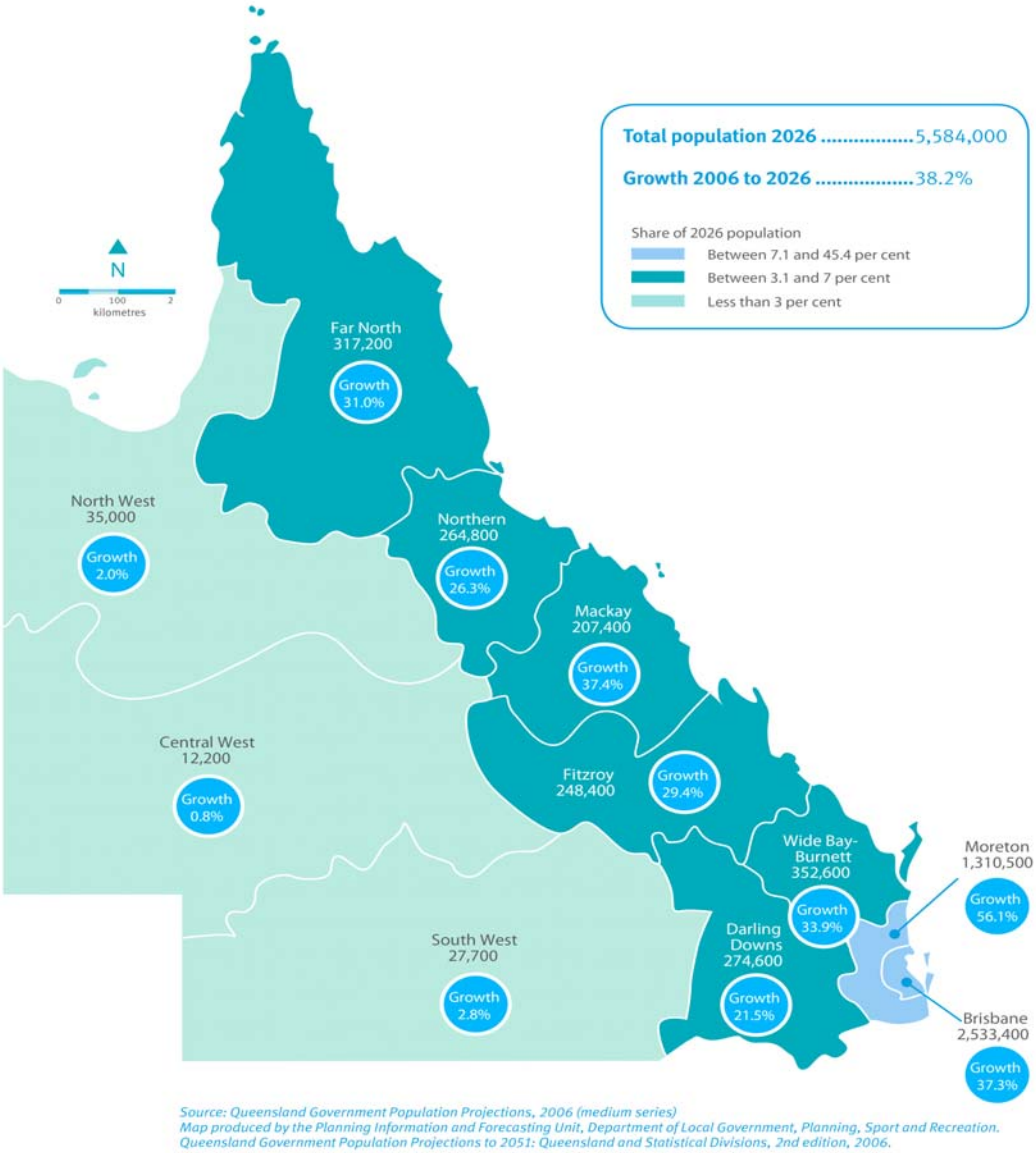
Source: Queensland Suicide Register, Australian Institute for Suicide Research and Prevention, Griffith University

1.3. A growing and ageing population

Between September 2006 and September 2008, Queensland experienced the second highest annual rate of population growth in the country (2.3%; equal with Northern Territory), while the national average was 1.5% during the same period (ABS data, published 30 June, 2008). Queensland's population growth is concentrated in metropolitan and regional areas along the east coast (see Figure 2). Within 25 years, south east Queensland is expected to have a population the same size as Queensland's current total of 4.3 million people, accounting for three-quarters of the State's total population increase.

A significant proportion of future population growth is projected for the older age groups, with the number of people aged 65 years or more increasing four fold by 2051 (ABS data, published June, 2008). Queensland faces the challenge of ensuring equitable distribution of suicide prevention actions across the state and responding to a changing population distribution.

Figure 2: Queensland Population Projection 2026



Source: Queensland Government Population Projections, 2006 (medium series)
Map produced by the Planning Information and Forecasting Unit, Department of Local Government, Planning, Sport and Recreation.
Queensland Government Population Projections to 2051: Queensland and Statistical Divisions, 2nd edition, 2006.

1.4. Population Priority Suicide Prevention Groups

1.4.1. People with a mental illness

Mental illness is a major contributing factor to suicidal behaviour in people of all ages (Beautrais, 1998; Goldney, 2008). The strongest links between mental illness and suicide have been shown to include clinical depression, bipolar disorder, schizophrenia, alcohol and other substance misuse disorders, borderline personality disorder, and behavioural disorders in children and adolescents. Access Economics highlighted the significant suicide risk for people living with schizophrenia with the highest risk usually within a year or two of symptoms starting (Access Economics, 2002). The World Health Organisation calculates the lifetime risk of suicide globally for people with schizophrenia as 10–13%, which is 12 times the population risk (Barbato, 1997). Inpatient suicides in psychiatric facilities have been identified as 25% higher than suicides reported in custodial settings (De Leo & Evans, 2002). Individuals experiencing mental illness are at highest risk of suicide immediately following discharge from psychiatric inpatient care (Appleby et al. 1999). Although mental disorders are present in the majority of suicides a significant proportion are untreated at the time of death. It is accepted that even the very best health systems

will not prevent all suicides. However, central to the Queensland Government commitment to suicide prevention is continuous strengthening of the detection and effective management of mental illness across the primary care and public mental health systems including enhanced coordination and linkages.

1.4.2. Indigenous Peoples and Communities

Three-quarters of Aboriginal and Torres Strait Islander peoples in Queensland live outside major cities. Approximately half live in regional areas and almost a quarter in remote or very remote areas (including an estimated six per cent living in the Torres Strait region). Cultural barriers reduce access to mainstream services for Aboriginal and Torres Strait Islander peoples.

Internationally, Indigenous populations demonstrate consistently higher suicide rates than non-Indigenous populations. This also seems the case for Australia and Queensland. Data between 2003-2007 show that suicide rates were higher for Indigenous people (between 10.9 and 42.2 per 100,000 population) than non-Indigenous people (between 8.3 and 15.1 per 100,000 population) in NSW, QLD, WA, SA and the NT. Indigenous people aged 25-34 years have particularly high suicide rates (between 26.0 and 100.4 per 100,000). However, significant inadequacies in Indigenous suicide data collection get in the way of an accurate and current understanding of the rate of Indigenous suicide. Further there is a significant lack of empirically sound knowledge and understanding regarding the specific risk factors and causal pathways that operate in regard to suicide risk and behaviour for Indigenous peoples.

Queensland Health recently commissioned an analysis of data from the Queensland Suicide Register to profile the incidence and characteristics of suicide among the Queensland Indigenous population during the period 1994-2006. The analysis found that while suicide in Indigenous peoples in Queensland has remained fairly stable, particularly in younger age groups the Indigenous suicide rate remains disproportionately high. The study has also provided much needed potential to inform future directions for more effective suicide prevention initiatives targeting Indigenous populations.

1.4.3. Young people

Reportedly, young people in Queensland continue to have the highest rates of youth suicide of any jurisdiction in Australia (*Discussion Paper: Reducing Youth Suicide in Queensland, Commission for Children and Young People and Child Guardian, 2009*). Help-seeking and service utilisation trends among young people are also significant to suicide prevention program development. A comprehensive Queensland study has confirmed previous findings that the majority of young people are most likely to approach family and friends for help when feeling unhappy or distressed, and almost a third of males reported that they do not seek help (Donald et al., 2000). A range of targeted partnerships with education, youth and primary care sectors have been developed by the Queensland Government to improve mental health literacy, and detect and reach early young people at risk of suicide.

1.4.4. Older people

With the Australian population ageing, a greater number of older Australians will find themselves physically and economically dependent on others, and affected by mental and physical ill health for the first time. Depression is strongly linked to suicidal thoughts and acts among this population group, particularly older men. In an analysis of recent Queensland suicide data this older age group was confirmed as of specific concern, reporting males aged 75 years and over as having unstable but particularly high suicide rates (De Leo & Evans, 2002). Furthermore, elderly males living in rural areas had significantly elevated rates compared to their urban counterparts (De Leo

& Evans, 2002). Evidence suggests that an effective way of reducing suicide among older people is improved detection and treatment of depression (Lawrence et al, 2000). However depression in older people continues to be under-detected and under-treated remaining an area for continued suicide prevention focus.

1.4.5. People from culturally and linguistically diverse backgrounds

The lack of suicide ethnicity data within Australian has resulted in a relative lack of attention to the issue of suicide relating to people from CALD backgrounds. However research confirms this is an important issue, demonstrating the complex interactions between culture, immigration, acculturation and suicide demonstrate that the risk associations. Suicide rates of immigrants are closely aligned with the suicide rates in their country of origin. Higher rates of suicide among first and second generation migrants suggests that there are host country factors related to the settlement process such as acculturative stress relating to cultural adaptation, identity and family issues which may increase the risk. Other settlement experiences such as breakdown of traditional and family support structures, unemployment, racism & discrimination, isolation, barriers to accessing services may become risk factors for mental health problems or situational crisis which in turn become risk factors for suicidality.

Research has identified elevated suicide risk particularly for older and young people from CALD backgrounds (McDonald & Steele, 1997). In particular, older migrants (CALD males aged 65 and over 65% higher, and females 177% higher than Australian born); immigrant women (CALD women from a number of ethnic backgrounds, especially Eastern European, significantly higher than Australian born women), and CALD young people (significantly higher risk factors). Queensland Health through the Queensland Transcultural Mental Health Centre has developed a multifaceted and culturally responsive suicide prevention approach involving strategies targeting mental health literacy, individual and community resiliency building and enhancing pathways to care across CALD communities.

2. Queensland Government Strategic Approach to Suicide Prevention

The Queensland Government has long recognised the gravity of the situation in regard to suicide mortality and risk within the state. Since 1997, formal strategic suicide prevention frameworks have been supported by recurrent funds. Activities have targeted responding to individuals at risk, reducing risk factors at individual and community levels, as well as building community and individual resilience and capacity for suicide prevention.

2.1. Queensland Government Youth Suicide Prevention Strategy 1997-2002

The *Queensland Government Youth Suicide Prevention Strategy 1997-2002* (QGYSPS) provided the first Queensland cross-Government blueprint for suicide prevention. It was established in 1997 in response to the dramatic increase in the rate of Australian youth suicide that was observed over the final three decades of the twentieth century. While this trend was consistent with suicide rates in most developed countries, the evidence suggested that Queensland youth suicide rates were among the highest of the Australian states. Rates for young males, and in particular young Indigenous males, were exceptionally high.

The aim of the QGYSPS was ‘to prevent self-harming behaviour, particularly youth suicide, and to reduce the impact of youth suicide on families and communities through coordinated and integrated life affirming strategies which enhance the quality of life for young people, their families and their communities’.

The cornerstone of the QGYSPS was the establishment of local community networks to strengthen the capacity of families and communities to take ownership of suicide prevention and respond to the needs of young people at the local level. Nineteen Community Network Support Workers (CNSWs) were established across Queensland to facilitate the establishment of local networks and to coordinate local suicide prevention strategies. These included community awareness raising; training for staff in key settings; and specific projects targeting Aboriginal and Torres Strait Islander communities.

Additional targeted programs supported activities funded directly under the QGYSPS. For example the Queensland Health *Young People at Risk Program*, commenced as a pilot program in 1995 and in 1998 was implemented on a statewide basis throughout Public Health Service Networks in Queensland. The goal of the program was to improve the mental health and well-being of young people (10-24 years) with a focus on the prevention of suicidal and self-harming behaviour. The *Rural and Remote Suicide Prevention Program* was a jointly funded initiative between Queensland Health and the Commonwealth Department of Health and Aged Care under the National Suicide Prevention Strategy, operating as part of the QGYSPS. The joint funding enabled the establishment of full-time project officer positions in Winton, Longreach, Biloela, Emerald, Charters Towers and Atherton to build the capacity of these communities to prevent suicide across the lifespan.

The QGYSPS was externally evaluated in 1999, with the findings reinforcing the direction taken. A key recommendation was to build on the achievements through the development of a five year strategic plan. This recommendation provided the platform for the development and implementation of the *Queensland Government Suicide Prevention Strategy 2003-2008 (QGSPS).*

2.2. Queensland Government Suicide Prevention Strategy 2003-2008

The QGSPS commenced in early 2003, providing a comprehensive and whole-of-Government approach to suicide prevention. In line with contemporary evidence, the QGSPS moved from a singular focus on young people and adopted a whole-of-life approach with priority attention directed to high-risk populations. Priority was given to young people, Indigenous peoples, people from culturally and linguistically diverse backgrounds, people in custody, people with mental illness, and gay, lesbian and bisexual people. The strategy covered the full range of activities including promoting positive mental health and well-being, illness prevention and early intervention, through to access to treatment for those at risk. The QGSPS clearly identified five targets and seven outcome areas contained in Appendix 1.

Central to the QGSPS was the emphasis on partnership and coordinated activity between government agencies and other sectors. The active involvement of Departments of Premier and Cabinet, Health, Education, Police, Corrective Services, Families, Employment and Training, Primary Industries, Aboriginal and Torres Strait Islander Policy, Housing and Emergency Services in suicide prevention was formalised under the QGSPS and the accompanying QGSPS Action Plans. Despite changes in departmental structures formal cross-Government participation endured throughout the life of the Strategy.

An independent evaluation of the QGSPS was conducted by the Centre for Health Policy, Programs and Economics at the University of Melbourne. The evaluation noted an extensive range of programs and activity had occurred under the QGSPS during its five year term. As well as aiming to reduce risk and vulnerability, an underlying focus was on increasing engagement of a wide range of agencies and, where possible, building capacity to support suicide prevention into sustainable, mainstream processes. Examples of the program achievements identified by the evaluation are summarised in Appendix 2.

The evaluation also concluded that the QGSPS had made important achievements including improved coordination of responses to suicide across Queensland Government agencies, and increased internal capacity for ongoing suicide prevention efforts for participating agencies. The evaluation clearly confirmed the QGSPS's effectiveness in broadening the engagement of agencies and the community in suicide prevention actions. In particular it was concluded that Queensland Government departments outside the health sector had been assisted to better understand their important role in suicide prevention and follow this with actions.

2.3. Broader Queensland Government support for Suicide Prevention

2.3.1. Queensland Plan for Mental Health 2007-2017

The Queensland Government has been undertaking an unprecedented level of mental health service reform. Improving the systemic response to people at risk of suicide as well as enhancing the response to risk in consumers of mental health services has been an integral component of the broader reform process.

The *Queensland Plan for Mental Health 2007-2017* (QPMH) provides a comprehensive blueprint for the development of a comprehensive mental health system, which promotes mental health, prevents the development of mental health problems where possible, and provides timely access to high quality assessment and treatment services. Evidence-based targets for the provision of inpatient mental health beds, public community mental health staffing and a range of disability support and accommodation services are identified.

The QPMH draws on the national directions in the *National Mental Health Strategy* and the Council of Australian Government's *National Action Plan on Mental Health 2006-2011*. At a state level, priority areas in the QPMH align with actions identified in *Queensland Health's Statewide Health Services Plan 2007-2012* and state government priorities identified in *Advancing Health Action*.

When launched in June 2008 implementation had already commenced, supported by the investment of $528.8 million in the 2007-08 State Budget for the first four years of the 10 year plan. In 2008-09 the Queensland Government committed a further $88.6 million. Implementation of the QPMH is led by Queensland Health and supported by other Government departments responsible for implementing components of it.

Funding for the Plan has focused on addressing five key priority areas including:

- $9.35 million for a range of mental health promotion and early intervention initiatives including the establishment of the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention;
- $345.8 million to expand the continuum of mental health care by establishing 479 new community mental health positions, developing new or upgraded inpatient beds, and implementing the recommendations from the *Review of the Mental Health Act 2000*;
- $98.09 million to purchase a range of non-government operated accommodation and personal support places to better support people with a severe mental illness to live in the community;
- $4.77 million to establish 20 new Service Integration Coordinator positions to improve links across mental health sectors; and
- $70.82 million to strengthen the capacity of mental health services through a range of workforce recruitment and retention activities, as well as enhancing the technology infrastructure needed to deliver contemporary mental health services.

2.3.2. Future Queensland Government Directions for Suicide Prevention

The evaluation of the QGSPS clearly supported the continued need to strengthen the focus on suicide prevention within Queensland. Future directions are currently being developed according to the national platform for planning and provision of suicide prevention activities released as part of the National Suicide Prevention Strategy, *The Living Is For Everyone (LIFE) Framework (2007).* This will ensure a coordinated plan for Queensland which integrates and aligns relevant actions and achievements initiated under the QGSPS with strategies being progressed under the QPMH, and those being driven by the Australian Government under the *Fourth National Mental Health Plan* and National Suicide Prevention Strategy.

The QPMH identifies mental health promotion, prevention and early intervention as one of five priority areas for action, and has established the Queensland Centre for Promotion, Prevention and Early Intervention (QC MHPPEI). Suicide prevention is identified as a key area for action including:

- dedicated strategies to reduce suicide risk and mortality with a focus on specific high risk groups including Aboriginal and Torres Strait Islander populations, rural communities and young people;
- development of a risk management framework for the detection and management of suicide risk;
- development of mechanisms to review all available information in relation to people who suicide in Queensland; and
- increased capacity to follow-up people presenting to Emergency Departments with deliberate self-harm or attempted suicide.

During 2009-2011, QPMH funding has been allocated to continuing support for:

- a suicide prevention project targeting the construction industry;
- a state-wide program for improving follow-up of people presenting to Emergency Departments with attempted suicide or self-harm;
- state-wide coordination and leadership for the improving mental health literacy;
- strengthening uptake and engagement in *beyondblue: the national depression initiative*;
- developing expertise and coordination of delivery of perinatal and infant mental health services; and
- developing interdepartmental processes to improve early intervention in schools.

Terms of Reference

(a) The Personal, Social and Financial Costs of Suicide in Australia

The individual cost of suicide is beyond measurement. The experience involves profound trauma, loss and grief. Guilt, stigma and shame compound the situation faced by many families and friends of people who have died by suicide. The impact on children affected by suicide is multiplied many times over and often endures throughout their lives. The historical non-reporting of child suicide deaths hinders the estimation of the personal, social and economic cost of suicide in Australia.

The statistical rarity of suicide can make the issue appear of less significance from a policy perspective. This is a limited analysis of a problem that involves significant social and economic burden. Better understanding and quantification of the multiple costs will highlight the relevance of the issue across areas of government policy and planning. It will also strengthen the case for the shared benefit and responsibility in regard to effective suicide prevention and early intervention.

Methodological issues with measurement of suicide

The conventional method of measurement is the age-standardised suicide (count) rate, depicted in Queensland data since 1920. Increasingly it has been cautioned that a focus on 'head count' in this way seriously masks the major costs associated with suicide. An alternate measure is the Potential Years of Life Lost (PYLL) (Demsey, 1947). This measure takes into greater account the nature and circumstances of the death. The PYLL establishes the 'burden of the death' through identification of lost productivity. The Australian Bureau of Statistics (ABS, 2000, 2008) now reports both measures.

The count measure and the age weighted PYLL measure were applied to Queensland suicide data over an 86 year period beginning in 1920 (Doessel, 2009). The conventional measure (count) indicates that suicide is not a particularly large contributor to mortality rates. However, when the PYLL measure is applied suicide is quantitatively a more important issue (by a factor larger than two for males and larger than three for females). This research also demonstrates that the differences are larger in recent years. In 2005, the PYLL measure for males was larger than the count measure by a factor of 3.5 and by a factor of 5.2 for females. In other words, the two measures of suicide have diverged through time and suggest suicide when compared to circulatory diseases, cancer and motor vehicle accidents, is of greater importance than previously recognised.

'The Costs of Suicide to Society 2007', a report produced by the Ministry of Health New Zealand, calculated the cost of suicide to New Zealand. The average economic cost of services used per suicide, in 2004 dollars excluding GST was, NZ$10,200. The average economic cost of services used per attempted suicide in 2004 dollars excluding GST was, NZ$3,750.

Lost production costs were calculated by multiplying years lost from potential workforce participation by average market income. This formula indicates an economic cost per suicide of NZ$448,250; and an economic cost per attempted suicide of NZ$6,350. Taking account of non-economic costs, including loss of life years and disability-free life years, the average value of lost life years per suicide was about NZ$2.25 million. Costs such as emergency services, courts and funeral expenses are small by comparison. It is highly likely that if this costing was repeated in Queensland very similar costs would be found. The evidence presented by the New Zealand study provides a compelling reason for Queensland (and Australia) to maintain its whole of government investment in suicide prevention.

(b) The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk)

Key stakeholders have long cautioned that the official Australian Bureau of Statistics (ABS) suicide statistics are an underestimation of the true suicide rates. In contrast to reports of declining Australian suicide rates, it is increasingly accepted that since 1997 (the peak year for both numbers and rates in suicide mortality in Australia) suicide rates have remained relatively stable. This level of uncertainty concerning the actual suicide rates highlights the futility in drawing meaningful conclusions from comparisons across jurisdictions or against the national figures. Further, it demonstrates the limitations in judging effectiveness of suicide prevention strategies through a singular focus on suicide statistics.

Data quality

The Queensland Government has placed great importance on improving the reliability and accuracy of suicide mortality data. The Queensland Suicide Register funded by Queensland Health and managed by the Australian Institute of Suicide Research and Prevention (AISRAP) is purportedly the best databank on suicide existing in Australia. It contains approximately 10,000 cases of suicide from the State, each one with police report, pathology report and, since 1994, psychological autopsy.

Queensland Suicide Register results for the period 1990 to 2006 show no significant changes over time in crude suicide rates for Queensland for all persons, males and females. Between 1990 and 2006 there was a relatively stable average crude rate of 24.1 suicides per 100,000 for males, 6.2 per 100,000 for females and 15.2 per 100,000 for all persons.

The data reported by the Queensland Suicide Register showed initial consistency with ABS. However, from 2002 onward the discrepancy between the two systems has been increasing, reaching a difference of almost 200 suicide deaths for 2006. The substantial difference between the ABS and Queensland Suicide Register data sets is attributable in part to differences in timing of the data collection processes. Annual ABS suicide reports contain only those suicide deaths that have been finalised by the cut off point, usually September of the collation year, with no later revision of data occurring. In contrast the Queensland Suicide Register is continually updated with the first report coming almost two years after the latest incident to allow for more comprehensive data to be included.

Coding of suicide cases also influence the data differences between the Queensland Suicide Register and the ABS. The Queensland Suicide Register, like the ABS, uses information obtained through the Coroners' offices and cross-checks them with the data available on the National Coronial Information System (NCIS). Causes of death are then scrutinised in the Queensland Suicide Register following the Suicide Classification Flow Chart, developed by the AISRAP and, and categorised into 'Beyond reasonable doubt', 'Probable', or 'Possible'. Since 2006, the NCIS has been the only source of data used by the ABS for coroner certified deaths, resulting in an increase in numbers of deaths assigned to unspecified causes of mortality, particularly for New South Wales and Queensland (ABS, 2009).

It would be difficult to completely avoid underreporting in suicide statistics. The Queensland Government is committed to ensuring as accurate as possible picture of suicide in the state to inform effective planning and implementation of strategies to reduce and prevent suicide risk. Integral to this is ongoing funding for the Queensland Suicide Register with strengthened integration of the findings into policy and planning. The State Coroner's office in Queensland has contributed to enhancing state and national data collection and reporting, including initial police

reports to the Coroner, and is participating in the National Committee for the Standardisation of Reporting of Suicide.

Presentation and interpretation of suicide data

It is more useful to look at long term trends than focus on year to year changes. The data may fluctuate from year to year for a range of reasons including the extent to which these deaths are registered in the same years as they occurred, delays in finalising coronial processes, and actual fluctuations in the number of deaths from external causes.

Indigenous identification

Identification of Aboriginal and Torres Strait Islander people in population, death and hospital data is known to be imperfect. Care needs to be taken when interpreting data for Indigenous people. Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The published rates are generally not adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions.

Other key populations

The ABS does not report on the number of suicides of children occurring in Queensland or nationally. Therefore, suicide in Australia and its impacts on children, young people and families is likely to be underreported. Similarly identification of ethnicity is also imperfect impacting on knowledge regarding suicide in culturally and linguistically diverse populations.

Queensland Government Actions to Improve Understanding of Suicide

Queensland Suicide Register is a comprehensive database of suicide mortality data, managed by the AISRAP and funded by Queensland Health since 1990. It provides an independent assessment of the incidence of suicide in Queensland.

Psychological Autopsy Study (AISRAP) was undertaken by AISRAP with funding by Queensland Health. This involved a detailed analysis to determine whether there are characteristic patterns of care and/or particular risk factors which would enable a targeted approach to be developed to assist clinicians in detecting and managing high risk patients.

Suicide in Indigenous Populations – Queensland: A Psychological Autopsy Study (AISRAP) was undertaken by AISRAP with funding by Queensland Health to undertake the Suicide in Indigenous Populations Psychological Autopsy Study. The study analysed data from the Queensland Suicide Register to profile the incidence and characteristics of suicide among the Queensland Indigenous population during the period 1994-2006.

Reducing Youth Suicide in Queensland

The Commission for Children and Young People and Child Guardian (CCYPCG) plays an important role in identifying, reporting, and advocating regarding issues affecting the rights, interests and wellbeing of children and young people in Queensland. In 2009, the CCYPCG undertook the *Reducing Youth Suicide in Queensland* project which provided a detailed review of the lives and deaths of children and young people who died by suicide between 2004-2007. The *Discussion Paper: Reducing Youth Suicide in Queensland* containing the findings of the project has been broadly disseminated with a call for submissions. The findings of the research and the response to the discussion paper will help inform future Queensland Government suicide prevention planning.

Office of the Public Advocate Queensland: Preventing suicide deaths of Queenslanders with a mental illness - An Issues Paper Report

The Office of the Public Advocate in Queensland undertook a review of a small number of suicide deaths based on coronial inquest data with a view to examining the systems of care which can help prevent the suicide of people who live with a mental illness. A series of recommendations were made in regard to mental health assessment; assessment of suicide risk; carer and support network involvement; liaison with general practitioners; discharge planning and community supports.

(c) The Appropriate Role and Effectiveness of Agencies, such as Police, Emergency Departments, Law Enforcement and General Health Services in Assisting People at Risk of Suicide.

People at risk of suicide frequently have contact with service providers such as general practitioners, health services or community agencies in the period prior to their death. However suicidal risk is frequently undetected. Mechanisms are required which boost the capacity of key service providers to contribute to the detection and appropriate management of risk. Establishment of effective systems is required across agencies to coordinate detection and response to those at risk. This involves community-based government agencies including housing, employment, law enforcement, disability, general health and mental health to provide services/supports in a coordinated and collaborative manner. A cornerstone of the Queensland Government approach has been increasing the engagement of all sectors in effective suicide prevention, and planning actions to build the capacity of service providers for detecting and managing individuals at risk, as well as broader suicide prevention.

The independent evaluation of the QGSPS concluded that the strategy had been successful in improving coordination of responses to suicide across Queensland Government agencies and increasing internal capacity for ongoing suicide prevention efforts by participating agencies. The evaluation clearly confirmed the QGSPS's effectiveness in broadening the engagement of agencies and the community in suicide prevention actions. In particular it was concluded that Queensland Government departments outside the health sector have been assisted to better understand their important role in suicide prevention and follow this with actions. Numerous instances of interdepartmental and interagency collaboration in program development and delivery occurred under the strategy.

Queensland Government also utilise whole-of-government planning and implementation for mental health reform. The Queensland COAG Mental Health Group and the Mental Health Interdepartmental Committee provide important forums and mechanisms for progressing a well integrated and comprehensive response. Governance of Queensland Government suicide prevention actions are being integrated through the Queensland COAG Mental Health Group.

Recent changes to the structure of Queensland Government agencies have contributed to improved service effectiveness for people at risk. In 2009 amalgamation of the various social services agencies occurred forming the new Department of Communities (Housing, Communities, Disability Services Queensland, Child Safety, Youth and Families, Sport and Recreation, Aboriginal and Torres Strait Islander Partnerships). This positions the department to enhance service delivery particularly to vulnerable clients, through the 'no wrong door policy'.

Examples of strategies to enhance effectiveness of sectors contributing to suicide detection and management in Queensland are outlined below.

Primary Care and General Health

Queensland Government's approach to suicide prevention recognises the key role in frontline mental health service delivery that general practitioners and other primary health care providers play. Queensland Health has allocated $2.2 million to support the implementation of the Queensland Framework for Primary Mental Health Care (the Framework) as part of the Partners in Mind (PIM) initiative. The Framework guides system reform and identifies a range of strategies at the local and state level to support a more integrated and effective primary mental health care system. The PIM initiative aligns with and supports the uptake of several Commonwealth Government initiatives including Access to Allied Psychological Services (ATAPS), MBS Better Access item numbers and Mental Health Nurse Incentive Program (MHNIP), along with Queensland Health initiatives including the Connecting Healthcare in Communities (CHIC)

initiative and Activate: Mind and Body (Improving the Physical and Oral Health of Individuals with Severe Mental Illness).

The PIM initiative will be further supported with the establishment of 10 new Primary Care Liaison Officer (PCLO) positions, funded as part of the *Queensland Plan for Mental Health 2007-2017*. The PCLOs are responsible for leading the implementation of the PIM initiative within their local area and increasing the capacity of private mental health care service providers, in particular, General Practitioners, to manage consumers with mental health problems.

Emergency Departments

People with suicidal behaviour or elevated risk frequently present to public hospital Emergency Departments. A history of previous suicidal ideation or behaviour has been shown to substantially elevate the risk of future suicidal behaviour or suicidal death. A major focus of the QGSPS was the Queensland Health *Early Intervention Project Officer (EIPO) Suicide Prevention Program*. The EIPO program was designed to target service gaps and enhance early detection, comprehensive assessment, management and follow-up of suicide risk in priority groups. EIPOs targeted Queensland Health emergency departments, acute mental health facilities and community mental health facilities with particular attention paid to transitional care following discharge from the health care setting.

Queensland Health is currently developing and implementing a post discharge care program in partnership with the Department of Health and Ageing and General Practice Queensland. The post discharge care program is to monitor suicide risk, provide outreach support and assertive referral for people presenting to and being discharged from the emergency department for self-injury and a suicide attempt.

In 2009, an *Emergency Department Liaison* project will be established as a Queensland Health initiative under the National Partnership Agreement on Homelessness (NPAH) between the Queensland Government and the Australian Government. This initiative will provide funding to establish a position in the four busiest Emergency Departments in Queensland. The positions will support people who are homeless or at risk of homelessness, who present to the Emergency Department, to access appropriate housing and support services.

Developing a patient safety culture

Queensland Health emphasises a patient safety culture including initiatives for safer systems; incident reporting and analysis; and clinician / staff open disclosure.

Reducing suicide and deliberate self-harm in mental health and related health care settings is one of four identified priorities in the *National Safety Priorities in Mental Health: A national plan for reducing harm (200*5). The Queensland Health Patient Safety Centre (PSC) has a dedicated Mental Health Safety and Quality program that implements National Safety Priorities actions within Queensland. These include promotion of good practice in suicide risk assessment and management; incident monitoring and management system; a system of investigation using a Root Cause Analysis for all inpatient suicides; collection and distribution of suicide data for greater learning; and consideration of Coroner's findings and recommendations for greater learning. Outside of the national strategies, the PSC Mental Health Safety and Quality program contributes to discrete initiatives at District and State level aimed at reducing suicide and deliberate self harm in health care settings. The PSC has developed a Queensland Health Mental Health Patient Safety Plan.

The PSC reviews clinical incident analysis and management processes for (suspected) suicide of consumers of mental health services (inpatient and community episodes of care). The reporting

and mandatory analysis of suspected suicide of consumers of inpatient services has been in effect since mid 2004.

The Queensland Health report *Achieving Balance: A review of systemic issues within Queensland Mental Health Services 2002-2003* was endorsed in 2005 and highlights issues facing mental health services in Queensland particularly around suicide. The report made nine key recommendations, all of which have either been implemented or are currently in the process of being implemented within Queensland Health. Recommendations included improvements to:

- assessment, leave and discharge planning, and inpatient observations;
- communication and information management;
- management of people with drug, alcohol problems and mental health issues;
- management of mental health presentations in emergency departments;
- support of general practitioners in managing patients with mental illness;
- immediate response to the investigation of sentinel events;
- administration of the *Mental Health Act 2000*; and
- staffing and bed resources, and education and training.

Police Services

The Queensland Police Service has statutory responsibility for the delivery of first response services in any crisis situation. The Queensland Police Service has high rates of involvement with people who suicide and those exhibiting suicidal behaviours. In response to the increasing number of mental health crisis situations, the Queensland Police Service, Queensland Ambulance Service and Queensland Health have developed a model for safe resolution of mental health emergencies. Part of the continuous improvement has been the development of a comprehensive training strategy for police which includes training in mental health issues (with a focus on suicide risk assessment and management) at a number of levels - recruitment, first year constable program, the constable development program, Operational Skills and Tactics, the Mental Health Competency Acquisition Program and the Mental Health Situational Online Support. This strategy provides a platform for ongoing training interactions in the form of First Officer Response training between Health and Police at the district level.

Emergency Services

The Queensland Ambulance Service has a key responsibility for supporting and improving the health and well-being of individuals and the community including those who self harm and are suicidal. This is achieved through the provision of emergency and non-emergency ambulance based primary health care and specialised health transport services.

Due to the vast geographical nature of Queensland, the Queensland Ambulance Service can be the primary source of contact for suicidal people and be expected to provide after hours crisis services due to reduced access to medical services and/or dedicated mental health services. The Queensland Ambulance Service also provides Inter-facility Transfers by road of patients with mental illness requiring specialised care or in cases where admission is not available locally. The geographical isolation of many Queensland communities provides additional challenges in safe transportation of people. Retrieval from rural and remote areas of the State is facilitated by a number of agencies including Queensland Ambulance Services, Royal Flying Doctor Services and the Queensland Police Service. Queensland Health has recently initiated a collaborative project to develop an operational policy and associated interagency guidelines for the emergency transport of mentally ill and suicidal persons from rural and remote areas.

Queensland Ambulance Service is improving paramedics' assessment and management of presenting issues including suicidality through their involvement in the *Mental Health Intervention*

Project (see below) as well as the *Vulnerable Clients Project* (VCP). The VCP is being developed to enhance and broaden professional development of personnel.

Mental Health Intervention Project

The *Queensland Health Mental Health Intervention Project* (MHIP) is a three agency collaborative arrangement between Queensland Police Service, Queensland Ambulance Service and Queensland Health. It develops a common approach between all agencies that are likely to have initial contact with people experiencing a crisis in the community. This project is based on the successful Memphis model.

The MHIP recognises the need to develop agreed responses to individuals who are existing clients of district mental health services, experiencing a mental health crisis; improved safety for individuals, mental health staff, police, ambulance and the community; improved continuity in communication and liaison, and clarity regarding roles and responsibilities across all situations; meaningful information sharing between the three services; adequate and timely responses informed by risk assessment; and improved access to a range of services for individuals who are experiencing a mental health crisis.

A core component of the MHIP is that the agencies come together to share expertise and resources to more effectively respond to mental health crisis situations. MHIP training is ongoing across the three partner agencies (Queensland Police Service, Queensland Ambulance Service and Queensland Health) and continues to exceed training targets. Mental Health Intervention Coordinators are in the process of developing local tri agency protocols and procedures to support collaborative responses across the three agencies.

Amendments have been made to the *Health Services Act 1991* to allow for greater information sharing between the Queensland Police Service and Queensland Health. Further, in 2004 Queensland Health and Queensland Police endorsed a Memorandum of Understanding which formalised arrangements to review the collaborative processes established.

At the time of writing this submission, approximate numbers of staff trained were:

- Queensland Health – more than 787 staff trained;
- Queensland Police Service – more than 6,885 staff trained;
- Queensland Ambulance Service – more than 1,860 staff trained.

Education Queensland

The education sectors within Queensland are committed to working in a coordinated way to support the mental health and wellbeing of Queensland students, in collaboration with relevant clinical service providers. Actions have targeted improving knowledge and capacity in early detection and school management of students at risk of suicide and mental health problems and disorders. Department of Education and Training (DET) has developed the *Supporting Students' Mental Health and Wellbeing policy*, and a set of suicide prevention guidelines for school based staff across the state. *Regional Mental Health Contact Officers* have been established in each of the ten DET regions to facilitate effective systemic response to mental health issues. A range of comprehensive professional development strategies have recently targeted suicide prevention and mental health including the training of over 1400 front line school personnel in suicide awareness and management including ASSIST. In order to respond to the heightened risk associated with Indigenous populations, DET has designed a professional development resource to enable access for rural and remote communities. DET have also engaged the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) to provide professional

development to schools with significant enrolment of culturally and linguistically diverse students, including those from a refugee background.

To enhance the ability of school personnel to detect and manage suicide risk further professional development activities are being planned. These include *Mental Health First Aid* Train the Trainer courses, which will involve participation by the Catholic and Independent sectors. There will also be a further rollout of the suite of *Living Works* training particularly targeting school based support staff including Chaplains and Youth Support Coordinators.

Queensland Ed-LinQ is a state-wide initiative under the *Queensland Plan for Mental Health 2007-2017* (QPMH) to support child and youth mental health services, the education sectors and primary health care to work collaboratively to improve the understanding, recognition, treatment, support and prevention of mental health problems and disorders affecting school-aged children and young people in Queensland.

Disability, HACC and Community Mental Health Services

Disability Service Plans, a requirement for all Queensland Government departments under the *Disability Service Act 2006*, are a key mechanism for promoting social inclusion and the quality of life of people with a disability, including people who are frail aged, by ensuring access to mainstream government services. Through the plans, departments are working to provide increased responsiveness and gradual improvement of government services, including suicide prevention programs, to people with a disability including more coordinated whole-of-government responses.

Disability, HACC and Community Mental Health Services have an active role in supporting clients identified as experiencing mental health issues including access of relevant clinical and non-clinical support and services. All Queensland Department of Communities, community mental health programs, include elements of suicide risk assessment and prevention activities. The Community Mental Health Program provides funding to Harmony Place and the QPASST to support culturally specific mental health promotion and prevention strategies for people from CALD backgrounds. The Home and Community Care (HACC) service in collaboration with the Community Mental Health program is establishing an initiative that targets mental health literacy and healthy ageing activities for HACC eligible clients.

(d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide.

Queensland Government has taken a multifaceted and long term approach to improving public awareness of mental illness and suicide and encouraging help-seeking. The QPMH identifies mental health promotion, prevention, and early intervention (MHPPEI) as one of five priority areas for action. The Queensland Centre for Mental Health Promotion Prevention and Early Intervention (QC MHPPEI) is in the early stages of establishment with the aim of providing leadership, coordination and innovation in MHPPEI through an integrated program of policy development and analysis, research, implementation, communication and dissemination that aligns with identified State MHPPEI priorities.

A *Statewide Plan for Mental Health Literacy* is being developed to identify actions to improve community awareness, understanding and attitudes towards mental health problems and disorders. Current focus is on activities to improve the mental health literacy of key front-line workers across government and non-government agencies, including access to mental health first aid training. Work is also underway developing and disseminating occupationally specific mental health literacy resources. A partnership with the Hunter Institute of Mental Health, NSW, will result in mental health literacy resources for the Queensland context for emergency services personnel and nurses in generalist hospital settings. Funding has been provided to the Queensland Transcultural Mental Health Centre to establish sustainable mechanisms and capacity to support the building of cultural and linguistic knowledge and skills at the community level for culturally specific mental health promotion and prevention strategies. The Queensland Government has made a substantial investment in *beyondblue: the national depression initiative* and is targeting improved utilisation of the *beyondblue* suite of resources as well as those of other national and specialist programs.

The Queensland Government is actively working to ensure appropriate public reporting of suicide through engagement with National strategies. The National Media and Mental Health Group has guided the Australian Government Department of Health and Ageing in producing the *Mindframe National Mental Health Initiative*, which is managed by the HIMH. The Queensland Government supports this initiative and continues to work with the HIMH. The *Mindframe* initiative is a comprehensive strategy that aims to influence media representation of issues related to mental illness and suicide, encouraging responsible, accurate and sensitive portrayals. The strategy includes a number of projects which are focussed on providing resources and education opportunities for media professionals. Within Queensland this area requires continued focus and greater engagement particularly by print media.

(e) The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk.

The provision of training to front-line workers has been central to national and state suicide prevention strategies. As in other jurisdictions programs such as *Applied Suicide Interactive Skills Training (ASIST)* have been widely implemented across Queensland. Increasingly *Mental Health First Aid* and more intensive suicide prevention training programs are being incorporated into Queensland Government workforce development strategies. This recognises the importance in ensuring service providers have adequate understanding of mental illness as well as suicide risk. Staff turnover is being addressed through integration of suicide and mental illness training into orientation and ongoing training programs.

Queensland has developed and implemented a comprehensive and multifaceted approach to the training and support of key front-line workers within health and mental health as well as non-health services.

Mental Health Training

Since April 2007, the Queensland Centre for Mental Health Learning (QCMHL) has delivered a range of accredited and non-accredited training to mental health staff, government and non-government workers that provide knowledge and skills in relation to suicide risk assessment and management. QCMHL's standardised training packages include training facilitation guides, participant guides, slides and pre and post training evaluations.

Assess and respond to individuals at risk of self-harm or suicide

This one day accredited training unit is part of the Certificate IV in Mental Health Work (non-clinical) training package. It has been delivered to a wide audience including Queensland Health staff, non-government staff and other government department staff. This training program aims to up-skill participants in identifying and estimating the level and immediacy of current self-harm/suicide risk; knowing the necessary actions required to promote safety; ability to facilitate and strengthen the individual's links to further care; and to provide on-going support once it is assessed that there is no imminent risk. Thorough assessment is undertaken of participant's knowledge, confidence, and training satisfaction. Statistically significant increases between pre and post-test have been achieved in each of these areas.

Suicide risk assessment and management (1/2 day workshop)

The Suicide Risk Assessment and Management half day training program was developed by QCMHL to assist new mental health workers in assessing and responding to individuals who are at risk of self-harm or suicide. Pre- and post-training evaluation assesses knowledge, clinicians' level of confidence in a range of skills required for suicide risk assessment and management, understanding of the suicide risk assessment and management guidelines, and training satisfaction. Statistically significant increases between pre and post-test have been achieved in these areas.

Suicide risk assessment and management (1 day workshop)

This one day workshop aims to provide Queensland Health mental health staff with appropriate skills and knowledge to assess and respond to individuals who are at risk of self-harm or suicide. It incorporates the Queensland Health *Guidelines for the Management of People with Suicidal Behaviour or Risk*. At the completion of the training it is expected that staff will have a greater understanding of suicide risk and protective factors, increased understanding of the risk intervention process and an understanding of the guidelines for assessing and managing suicide risk.

Critical Components of Risk Assessment and Management for the Mental Health Practitioner (1 day workshop)

The *Promoting balance in the forensic mental health system - Final Report - Review of the Queensland Mental Health Act 2000* contained a number of recommendations directed at legislative and administrative reform to improve the forensic mental health system. A number of these recommendations were related to managing risk associated with patients under the *Mental Health Act 2000.* Ensuring clinicians' understanding of assessment and management practices across a continuum of clinical risk was outlined as a priority.

To contribute to these recommendations the Queensland Centre for Mental Health Learning (QCMHL) designed and delivered a comprehensive clinical risk management training program for specialist and mainstream mental health clinicians in Queensland Health. This one day competency based training workshop provides participants with the core knowledge and skills required in clinical risk assessment and management. Key topics include: principles of risk assessment and management, risk and protective factors, the range of risks in clinical practice, cultural issues in risk management, the use of the *Mental Health Act 2000* in risk management, clinical management strategies to reduce risk, and linking the risk management plan to risk assessment.

Department of Communities: Child Safety Training

The Department of Communities provides suicide prevention training and support for front-line staff providing services to children and young people at risk. As children in the child protection and youth justice systems are considered to have an elevated risk of suicide, the Department of Communities has embedded suicide prevention related initiatives into core departmental processes. For example suicide prevention and critical incident reporting (including suicide and/or self-harm risk assessment) has been included in Child Safety and Youth Justice Officer mandatory training. Workforce training is supported through suicide risk policy and procedures that include criteria for recording a child or young person at risk of self-harm or suicide; procedural requirements for children and young people who are not subject to ongoing departmental intervention; risk factors and warning signs to consider, including general principles in relation to Indigenous self-harm and suicide; and review and closure requirements for self-harm and suicide risk alerts.

Systematic mechanisms also promote detection and response. The Integrated Client Management System has the capacity to record details of incidents which indicate that a young person may be at risk of suiciding. Case workers must complete a Suicide Risk Alert (SR1) within 24 hours of the risk being identified. The SR1 has a clear and immediate risk-management plan documented, and a medium to long term risk management plan must also be developed within two weeks of the creation of the SR1.

Housing and Homelessness

The Australian Housing Institute provides a two day Mental Health First Aid workshop that assists staff in the social housing sector working with clients experiencing mental health issues to understand such clients' needs and appropriate responses. This training focuses on understanding how to assist people at risk of suicide, risk factors and how to link people to services.

Department of Education and Training (DET): Professional Development

DET has engaged LivingWorks to provide safeTALK and ASSIST workshops to school based staff across Queensland. The department is developing a model for delivery of this material that will ensure ongoing provision to DET staff.

(f) The role of targeted programs and services that address the particular circumstances of high risk groups.

The Queensland Government has developed programs for high risk groups, and continues to build effective linkages between services and sectors to facilitate improved responsiveness.

Housing & Homelessness

The Department of Communities (Housing and Homelessness Services) is working with Queensland Health to improve access to appropriate accommodation and/or support for clients with mental health issues whose housing needs have been assessed as high or very high. In 2005, under the Queensland Government's Responding to Homelessness Strategy, Queensland Health was funded to develop *Homeless Health Outreach Teams* (HHOT) to provide health outreach services to people who are homeless or at risk of homelessness. This program is to be expanded to seven sites across Queensland in 2010 under the *National Partnership Agreement on Homelessness (NPAH)* between the Queensland Government and the Australian Government. HHOT provide comprehensive assessment, case management, and intervention for homeless persons who are experiencing mental illness. Specialist alcohol and drug positions have also been funded to provide assessment, treatment and prevention programs for homeless persons with substance use concerns. Co-occurring mental health and alcohol and other drug problems (dual diagnosis) require a collaborative response between the HHOT and local District Alcohol, Tobacco and Other Drugs Services.

Housing and Support Program

The Department of Communities (Housing and Homelessness Services and Disability Services), in collaboration with Queensland Health, delivers the *Housing and Support Program* (HASP), an initiative under the *COAG National Action Plan for Mental Health 2006-2011* (NAP). The HASP program utilises a recovery oriented model providing social housing, clinical support and tailored non-clinical support to enable people with a psychiatric disability to live in their own homes in the community. This approach promotes social inclusion, community connectedness and enhanced quality of life. A total of 193 supported social housing places have been provided to people with a psychiatric disability through HASP to 30 June 2009.

Employment

As part of the commitment to people with a disability, Department of Employment, Economic Development and Innovation (DEEDI) committed $5 million over five years under the *Skilling Queenslanders for Work initiative* to the NAP. This funding is used to assist 100 people with a mental illness each year to prepare for the workforce and aligns to the NAP.

Care Coordination

When the NAP was agreed in July 2006, Care Coordination was identified as one of the two flagships. In September 2006, Queensland agreed to a model of care coordination that relied on the cooperation of all departments responsible for human service provision. This would ensure the group of people with mental illness most at risk of "slipping through the gaps" would have better coordinated services. These people have a very high level of suicide risk.

Queensland's commitment to this flagship has been the appointment of 20 *Service Integration Coordinators* (SIC). The SICs engage local service providers in the government, non-government and private sectors to actively participate in the Care Coordination model. They ensure integration with primary health care providers and engage housing, employment, disability support, income support and other agencies to ensure the delivery of a more seamless and connected system of care for people with severe mental illness and complex care needs.

Alternatives to Admission

The *Alternatives to Admission* (A2A) program provides intensive community treatment that assists with early discharge and prevention of admissions. A2A provides mental health care using an integrated partnership model, ensuring provision of clinical and non-clinical mental health care to consumers. A2A programs have been established in Townsville; Brisbane (Prince Charles Hospital and Royal Brisbane and Women's Hospital); Central Queensland; and Redcliffe-Caboolture.

Dual Diagnosis Positions

Queensland Health has funded 21 *Mental Health Dual Diagnosis Coordinator* positions across Queensland. In November 2008, Queensland convened the Alcohol, Other Drugs and Mental Health Collaborative, a joint partnership between Mental Health Branch and Alcohol, Tobacco and Other Drugs Service Branch. The Collaborative will guide District implementation of the new Queensland Health policy: *Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems) 2008* and other dual diagnosis initiatives in Queensland.

Forensic Mental Health Services

Queensland Health has invested in *Forensic Mental Health Service Coordinators*, substantially increasing capacity in these services. The Transitional Care Coordination program, which operates as a partnership between Richmond Fellowship Queensland and the South East Queensland Prison Mental Health Service, continues to develop as a valued adjunct to clinical care.

Transcultural Mental Health Positions

Queensland Health has employed 12 *Multicultural Mental Health Coordinator* positions to focus on the provision of clinical support to clinicians in regard to people with Culturally and Linguistically Diverse (CALD) backgrounds. The Queensland Transcultural Mental Health Centre has progressively formulated a multifaceted approach to suicide risk reduction and prevention for culturally and linguistically diverse communities (CALD) throughout Queensland. Underlying the approach is the understanding that as some risk and protective factors in CALD communities are outside the influence of mental health services, implementation strategies will require strong partnerships with multicultural services and community leaders in ethnic communities. In particular settlement experiences such as breakdown of traditional and family support structures, unemployment, racism & discrimination, isolation and barriers to service access may become risk factors for mental health problems or situational crisis which in turn become risk factors for suicidality. A cultural brokerage approach is therefore fundamental, that is purchasing cultural and linguistic knowledge and skills in order to deliver culture specific strategies as the most effective way to ensure culturally inclusive programs and services. Elements of the Queensland approach to CALD suicide prevention include outreach through bilingual workers; a focus on reducing stigma and increasing mental health literacy of key people such as community and spiritual leaders; partnerships with multicultural non-government sector organisations; capacity building in key settings with high numbers of migrants e.g. with English as Second Language teachers, settlement workers, bilingual General Practitioners etc; and the development of targeted programs that focus on enhancing modifiable protective factors and reduction of risk factors. One such example is a group program developed by the Queensland Transcultural Mental Health Centre called BRiTA Futures, a group resiliency program for CALD children and young people focusing on life skills in relation to the particular issues that children of migrants face and bicultural identity issues.

Aboriginal and Torres Strait Islander Suicide Prevention

The evaluation of the *National Suicide Prevention Strategy* (1999–2006) identified the issue of appropriateness of the approaches taken towards funding and supporting Indigenous suicide projects. Research has indicated important differences in the causes of suicidal behaviour not only between Indigenous and non-Indigenous people but also between different Aboriginal and Torres Strait Islander communities (Elliot-Farelly, 2004). A focus is required beyond individual circumstance to examine behaviours in societal contexts (social, historic, geographic, and political) particularly as a large proportion of Indigenous suicides occur in clusters (Tatz, 1999). The development of partnerships with Aboriginal and Torres Strait Islander communities is essential in addressing Indigenous suicide.

Evidence suggests that suicide prevention and postvention programs need to be localised and delivered by individuals who are accepted by Aboriginal and Torres Strait Islander communities. In addition to up skilling front-line health and emergency staff, a dedicated Aboriginal and Torres Strait Islander mental health workforce is important. The *Queensland Plan for Mental Health 2007-2017* (QPMH) is supporting expanded Aboriginal and Torres Strait Islander mental health service provision. The QPMH is providing $5.15 million to improve services by creating additional Indigenous mental health positions and establish a hub of specialist expertise to provide leadership and oversight of development of service models to support delivery of services to Aboriginal and Torres Strait Islander people.

Queensland research shows that the application of local solutions is particularly relevant given that location and its relation to history plays a significant part (Hunter, 2001) For example, in Queensland, suicide is much more common in communities which were once missions than in other communities, where the suicide rate is only marginally higher than the national average. Therefore a "one size fits all" problem and a "one size fits all" solution may not be appropriate.

The Yarrabah Family Life Promotion program is an example of a local initiative developed in response to three suicide clusters between the mid 1980s and mid 1990s. Established in 1995, it was facilitated by the local Council and community-controlled medical service. It included: training community members in crisis intervention and counselling; a crisis centre and crisis line; one-on-one grief and loss counselling and family and men's support groups; information for suicide survivors, families of suicide victims and people who self-harm; workshops on parenting and relationships; promotion of sport, recreation and cultural activities; development of networks across family and clan groups; and initiatives addressing alcohol misuse. Following implementation of the Yarrabah Family Life Promotion no suicides were reported for the period 1997-1999 and three between 2000-2004 compared to 12 from 1992-1996. Community ownership of the problem and the solution was key to the success of the program.

The Family Wellbeing (FWB) Program, piloted in Hope Vale, Wujul Wujul and Yarrabah, is a mental health promotion initiative that aims to empower participants and their families to strengthen their resilience and ability to cope with everyday challenges of life. In a two-step process, the program initially involves structured personal development workshops conducted in a safe group environment which focus on leadership, relationships and conflict resolution. The follow-up community development process is aimed at supporting groups to collectively address community issues identified through personal development training. The FWB program at Hope Vale and Yarrabah have been evaluated and indicate the program has significantly enhanced participants' feelings of self-worth, resilience, ability to reflect on the root causes of problems, and problem solving ability, as well as an improved sense of hope that their situation can change.

Other priority group response

Similar improvement in effective targeting of other key groups is called for. Children in the child protection and youth justice systems are considered to have an elevated risk of suicide and require particular consideration in regard to program development. Research reported by the Queensland Commission for Children and Young People and Child Guardian in the *Reducing Youth Suicide in Queensland* discussion paper (2009) highlighted areas that can inform both preventive and early intervention activities. In the review of child and young people suicide deaths between 2004–2007 strong associations were identified between suicide and contact with police or the youth justice system, childhood abuse and family conflict and violence. In addition transitions including into or out of care were associated with higher risk. Previous suicidal behaviours were also a key risk factor.

Settings based models effectively targeting specific groups can also be identified. The Queensland Government has supported OzHelp Queensland to implement the Mates in Construction program. The programme addresses mental health and wellbeing related issues including suicide and self harm in the construction industry. Using a model based on the work of OzHelp Foundation ACT, the Mates in Construction program takes a comprehensive approach to suicide prevention within the industry. Site based awareness training, peer-support, referral and case management services are provided. The Mates in Construction programs stands out in its capacity to provide essential coping and relationship skills as well as facilitate help-seeking in a population recognised as having levels of mental health problems and risky lifestyle issues as well as notoriously reluctant to seek health and mental health support.

(g) The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy.

The role of research in suicide prevention is critical if new and innovative approaches are to be developed that will contribute to a responsive service system and support evidence-based clinical practice. Queensland has consistently supported a broad program of research through important partnerships and expert engagement. The focus has been on building the evidence base for suicide prevention and improving the understanding of factors that contribute to risk and protection in the Queensland context. Queensland Health has worked closely with the AISRAP to identify and support areas of research including:

- The Queensland Suicide Register to collect, analyse and document quality suicide mortality and morbidity data to inform policy and program development and service improvement in suicide prevention for this state.
- The Psychological Autopsy Study by AISRAP to identify issues important to efforts to improve detection and engagement of people at risk;
- Suicide in Indigenous population – Queensland: A psychological Autopsy Study by the AISRAP to specially analyse information related to suicide of Indigenous people; and,
- Comprehensive mapping and assessment of quality of all suicide prevention services and programs across Queensland.

There are many areas relating to suicide risk and protection that require further empirical research that can then translate to practice. Despite an unparalleled level of research activity in areas of direct and indirect relevance to suicide prevention within Australia, there are pervasive problems with the transmission and dissemination of findings, and integration of this research with policy and clinical practice.

At a national level suicide prevention would be considerably assisted by the establishment of an independent national institute or clearinghouse for suicide research.

(h) The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

It is difficult to accurately gauge effectiveness of the National Suicide Prevention Strategy (NSPS). The nature of the complex interactions involved in suicide risk and protection across individual, family, community, environmental and cultural domains require a sophisticated and longitudinal approach to evaluating outcomes and impact. The *Living Is For Everyone (LIFE)* Framework (2007) and the associated NAP that committed a significant increased investment in the NSPS are both relatively recent developments and require further time for implementation and review.

The commitment to align the Queensland Government suicide prevention actions with the LIFE Framework reflects the direction taken in other jurisdictions including NSW, Western Australia and Victoria. This is consistent with the *Fourth National Mental Health Plan* activity related to the coordination of state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework.

This level of state and national alignment of suicide prevention is unprecedented. In the past a major limitation in the implementation of national suicide prevention strategies has been the absence of coordination with state efforts. This has led to areas of duplication, inefficiency and limited sustainability of achievements when they have occurred. The combination of learning's from over a decade of national and state implementation, evidence of increased capacity across government at both state and national levels for suicide prevention, and the strengthened commitment to, and mechanisms for alignment provide the conditions for more effective implementation. It is important that these important advances in integration and coordination which optimise good outcomes be supported through the strongest possible continued commitment across all levels of government.

The Broader Social Policy Approach

To effectively reduce risk as well as vulnerability to risk across the diverse Australian population, mental health strategies should be complemented and supported by broader public health and social policy approaches. Of particular importance is the universal foundation that results from well formulated social policy and public health initiatives targeting structural determinants of health and wellbeing have been established (eg Friedli, 2009).

The harmful consequences of unemployment can result from combinations of poverty, stress, social isolation and deterioration of mental health. In young men, in particular, the effect of unemployment increases the risk of premature death from suicide. In New Zealand, research suggests that being unemployed was associated with a two-to threefold increased relative risk of death by suicide, compared to being employed (with the confounding effects of mental health attributing to around half, but not all of the association) (Blakely, 2003, p. 596). The World Health Organisation (WHO) lists unemployment and economic distress as one of a list of factors that increase the risk of suicide generally. Unemployment effects mental health and wellbeing, both because of its psychological consequences and the financial problems it brings, increasing both depression and anxiety. The risk is higher in regions where unemployment is widespread, and for marginalised groups who are more likely to experience unemployment, such as Indigenous Queenslanders or young people.

Responding to this important relationship is not possible through a mental health program approach that does not address employment. Employment programs that aim to encourage individuals and particularly those in high risk suicide groups into the workforce, and thus actively increase their level of engagement with society, can actively work to prevent suicide.

References

A Healthier Future for All Australians. Final Report of the National Health and Hospitals Reform Commission - June 2009. Commonwealth Government.

Access Economics (2002). An analysis of the burden of schizophrenia and related suicide in Australia. SANE Australia.

Achieving Balance: Report of the Queensland Review of Mental Health Sentinel Events – a review of system issues within Queensland Mental Health Services. (2002-2003). Queensland Government.

Ambulance Services Act 1991. Queensland Government.

Appleby L, Shaw J, Amos, McDonell R, Harris C, McCann K, Kiernan K, Davies S, Bickley H, Parsons R (1999). Suicide within 12 months of contact with mental health services: national clinical survey. British Journal, 318: 1235-1239.

Australian Bureau of Statistics (2009) Causes of Death, Australia, 2007, Cat: 3303.0, Canberra, ACT.

Australian Bureau of Statistics (ABS) 2001. Causes of Deaths, Australia. Cat.No 33303.0. Canberra.

Australian Bureau of Statistics (ABS) 2006. National Health Survey: Survey of results. ABS. Canberra.

Australian Bureau of Statistics (ABS) 2008. Causes of Deaths, Australia. 2006. Canberra.

Australian Health Ministers. *National Mental Health Plan 2003–2008*. Canberra: Australian Government, 2003.

Beautrais AL (1998). Risk Factors for Suicide and Attempted Suicide Amongst Young People. A literature review prepared for the National Health and Medical Research Council, Canberra.

Blakely, TA Collings SCD and Atkinson, J (2003) "Unemployment and Suicide. Evidence for a causal association?" Journal of Epidemiol Community Health, 57: 594-600.

Burgard et al, cited in Laplagne (2006).

Cai, L and Kalb, G 2006, "Health status and labour force participation: evidence from Australia", Health Economics, 15:3, 241-261.

Commonwealth of Australia (2004) National Strategic Framework for Aboriginal & Torres Strait Islander Health: Framework for Action by Governments.

Connecting Healthcare in Communities (2007): Queensland Government Initiative.

De Leo D, Evans R (2002). Suicide in Queensland, 1996-1998: Mortality rates and related data. Brisbane: Australian Institute for Suicide Research and Prevention.

De Leo, D & Heller, T.S. (2004) *Suicide in Queensland, 1999 – 2001: Mortality rates and related data*. Brisbane: Australian Institute for Suicide Research and Prevention.

Demsey, M. (1947). Decline in tuberculosis: The death rate fails to tell the entire story. American Review of Tuberculosis, 56, 157-164.

Department of Aboriginal and Torres Strait Islander Policy (2004). *Meeting the Challenges of Substance Misuse.*

Department of Aboriginal and Torres Strait Islander Policy *The Cape York Partnership:* Queensland Government.

Department of Aboriginal and Torres Strait Islander Policy. *Towards a Queensland Government and Aboriginal and Torres Strait Islander Ten Year Partnership.*

Department of Health and Ageing (2003) *National Mental Health Report 2004: Eighth Report.- Summary of changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002*. Commonwealth of Australia, Canberra.

Discussion Paper: Reducing Youth Suicide in Queensland. Commission for Children and Young People and Child Guardian. (2009): Queensland Government.

Doessel, D.P, Williams, R.F.G, Whiteford, H. (2009). A Reassessment of Suicide Measurement. Some comparative PYLL-based trends in Queensland, Australia, 1920-2005. Crisis. Vol. 30(1): 6-12.

Donald, M, Dower, J, Lucke, J & Raphael, B. (2000). The Queensland Young people's Mental Health Survey Report, Centre for Primary Health Care. School of Population Health and Department of Psychiatry, University of Queensland.

Dudley MJ, Kelk NJ, Florio TM, Howard JP, Waters BGH (1998). Suicide among young Australians, 1964 – 1993. Medical Journal of Australia. 169: 77-80.

Elliot-Farrelly, T. (2004) Australian Aboriginal suicide: the need for an Aboriginal suicidology? Australian e-Journal for the Advancement of Mental Health. 3(3):1-8.

Fourth National Mental Health Plan. An Agenda for Collaborative Government Action in Mental Health 2009-2014.

A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009.

Framework for the Development of the Future Mental Health Workforce in Queensland 2000: Queensland Government.

Jané-Llopis, E and Anderson, Peter (2007) "A Policy Framework for the Promotion of Mental Health and the Prevention of Mental Disorders", in Mental Health Policy And Practice Across Europe: The Future Direction of Mental Health care, Martin Knapp, David McDaid, Elias Mossialos and Graham Thornicroft (eds), European Observatory on Health Systems and Policies Series: McGraw Hill.

Kitchener, B. Jorm, T. (2000) Orygen Research Centre. University of Melbourne, Dept of Psychiatry. Mental Health First Aid.

Laplagne, P Glover, M and Shomos, A (2007) Effects of Health and Education on Labour Force Participation, Productivity Commission Staff Working paper, Productivity Commission: Melbourne.

Lawerence, D., Almeida, O.P., Hulse, G.K., Jablensky, A.V., & Holman, D., (2000). Suicide and attempted Suicide among Older Adults in Western Australia, Psychological medicine, 30 (4) July , 813-821.

Mathers C. (1994) "Health differentials among adult Australians aged 25–64 years". AIHW Health Monitoring Series No. 1. Canberra: AGPS.

Mental Health Service Needs of Indigenous Children and Youth in Queensland (1999): Queensland Government.

MindMatters: A Mental Health Promotion Resource for Secondary Schools. Commonwealth of Australia 2000

Morrell et al 1993; 2007 Morrell, S, Taylor, R, Quine, S and Kerr, C (1993) "Suicide and Unemployment in Australia 1907-1990", Social Science and Medicine, 36:6,749-756.

Morrell, S, Page, A and Taylor, R, (2007) "The Decline in Australian Young Male Suicide", Social Science and Medicine, 64,747-754.

National Standards for Mental Health Services. Commonwealth Department of Health & Aged Care 2006

National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009. Australian Health Ministers' Advisory Council endorsed 2004

National Strategic Framework for Aboriginal and Torres Strait Islander Health; context (2003-2013).

National Strategic Framework for Aboriginal and Torres Strait Islander Health; Framework for Action (2003-2013).

National Suicide Prevention Strategy: Living is For Everyone Framework. (Revised 2007). Commonwealth Government.

National Youth Suicide Prevention Strategy (1995-1999): Commonwealth Government.

Non-English Speaking Background Queensland Mental Health Policy Statement 1996.

O'Kane & Tsey, 1999, Hunter & Tsey 2003, Rosen 2003, leaving a wide gap in mental health communication (Hunter 1993, 1997, 2002).

O'Kane, A. & Tsey, K. (1999) Shifting the balance – services for people with mental illness in central Australia. Darwin: Menzies School of Health Research.

Partnerships for Healthy Communities: Promotion, Prevention and Early Intervention – Improving the Mental Health and Well-Being of Queenslanders (2000).

Pirkis, J. Williamson, M. Harris M, Robinson, J, Gladman, B. (2009). Evaluation of the Queensland Government Suicide Prevention Strategy 2003-2008. Centre for Health Policy, Programs and Economics. University of Melbourne.

Police Based Intervention: Crisis Intervention Team, 2003, Dupont R., Policing and Best Practice conference, Gold Coast 2003.

Position Paper: Recovery Oriented Service Provision: Queensland Health: Queensland Government.

Preventing Suicide Deaths of Queenslanders with a Mental Illness. (2008). Office of Public Advocate Queensland: Queensland Government.

Psychiatric Disability Strategic Plan 2000-2005 : Queensland Government.

Queensland Forensic Mental Health Policy 2002 : Queensland Government.

Queensland Government Strategic Framework for Disability 2000-2005.

Queensland Government Youth Suicide Prevention Strategy 1998-2003.

Queensland Health (2000). The Smart State: Health 2020: Queensland Government.

Queensland Health Action Plan for Consumer and Carer Consumer Participation in Mental Health: Towards Consumer-Centred Service: Queensland Government.

Queensland Health and Queensland Police Service: Crisis Intervention Protocols: Queensland Government.

Queensland Health and Queensland Police Service: Local Protocol Agreements: Queensland Government.

Queensland Health and Queensland Police Service: Memorandum of Understanding: Queensland Government.

Queensland Health. Ed-LinQ (linking schools and mental health). Queensland Centre for Mental Health Promotion, Prevention and Early Intervention. The Queensland Government.

Queensland Health. Meeting Challenges Making Choices. Department of Aboriginal and Torres Strait Islander Policy.

Queensland Health's Directions for Aged Care 2004-2011: Queensland Government.

Queensland *Mental Health Act 2000*.

Queensland Mental Health Information Development Strategy 2005-2008. Queensland Government.

Queensland Mental Health Policy Statement: Aboriginal and Torres Strait Islander People June 1996: Queensland Government.

Queensland Plan for Mental Health 2007 -2017: Queensland Government.

Reducing Suicide: Queensland Government Suicide Prevention Strategy 2003-2008: Queensland Government.

Responding to the mental health and well-being needs of people in rural and remote communities: Queensland Government.

Schubert, K. (2009) Working well Guide: reflections on providing suicide prevention projects in remote Aboriginal Communities in Central Australia. Funded by: Commonwealth of Australia: National Suicide Prevention Strategy.

Tatz C. (1999) Aboriginal Suicide is Different: a report to the Criminology Research Council.