



Managing the Risk of Suicide

A SUICIDE PREVENTION STRATEGY FOR THE ACT 2009–2014



The vision for mental health in the ACT

For the people of the ACT to achieve and maintain mental health and wellbeing.

Contents

Foreword	3
1. Introduction	4
2. A Strategy for <i>Managing the Risk of Suicide</i>	6
2.1 Purpose	6
2.2 Goals	6
2.3 Scope	6
2.4 Objectives	7
2.5 A Whole of Community Responsibility – Working Together	7
2.6 The Policy Context	7
2.7 Action Areas	9
3. Background	10
3.1 International Trends	10
3.2 Australian and Local Figures	10
3.3 Evaluation of the 2005–2008 Strategy	10
4. A Framework for <i>Managing the Risk of Suicide</i>	13
4.1 Towards an Understanding of Suicidal Behaviour – The Ecological Model	13
4.2 The Spectrum of interventions for mental health problems and mental disorders	14
5. Factors Influencing Suicide	16
5.1 Protective Factors	16
5.2 Risk Factors	17
5.3 At Risk Population Groups	18
6. Action areas and implementation plan	25
7. Governance, Implementation and Evaluation	36
7.1 Evaluation of <i>Managing the Risk of Suicide</i>	36
8. Consultation	37
Appendix One: Membership of Suicide Prevention Working Group	38
Appendix Two: Relevant National and ACT Policies and Plans	39
Appendix Three: Suicide Prevention Activities Undertaken 2005–2008	42
Appendix Four: Consultation Participants	43
Appendix Five: Suicide Prevention services in the ACT	44
Appendix Six: Suicide Prevention and Mental Health Literacy Programs Delivered in the ACT	48
Appendix Seven: Abbreviations and Glossary	49
References	55

Foreword

Suicide has profound emotional, social and economic effects on families, friends and the whole community. The factors influencing suicide rates are complex. Current research indicates that an understanding of risk factors is the most effective approach to suicide prevention.

Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014 builds on the work and learnings of the 2005–2008 suicide prevention strategy and provides a collaborative and co-operative whole of government approach to preventing suicide across the lifespan.

Many of the interventions to prevent suicide involve promoting mental health and wellbeing. As such, *Managing the Risk of Suicide and Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014*¹⁶ are closely related and embed an integrated, whole of government and whole of community approach to enhancing mental health and wellbeing in the ACT.

Managing the Risk of Suicide recognises at risk populations in the ACT and identifies specific actions to prevent suicide in these groups. Acknowledging the recent opening of the ACT's first prison, the Alexander Maconochie Centre (AMC), and recognising the high incidence of suicide after release from detention, *Managing the Risk of Suicide* highlights the importance of developing a comprehensive management plan for individuals identified with a mental illness prior to their release.

Providing timely and sensitive support to those bereaved by suicide and supporting those who work in the field of suicide prevention are two strategic areas that will be strengthened over the life of *Managing the Risk of Suicide*.

I am confident that *Managing the Risk of Suicide* will guide a coordinated approach to suicide prevention and will enhance the delivery of early interventions for those experiencing mental illness.



~~Katy Gallagher~~

Katy Gallagher, MLA
Deputy Chief Minister
Minister for Health

1. Introduction

Suicide leaves profound emotional, social and economic effects for families and friends and communities. The impact of suicide challenges human services and the community to do as much as possible to prevent these events, and reduce the consequent harm. Within the ACT, individuals, the general community and Government and community sector agencies, all play vital roles in reducing the risks associated with suicide. Extensive consultation with the ACT community and a review of suicide prevention literature informed the development of *Managing the Risk of Suicide 2005–2008: A Suicide Prevention Strategy for the ACT (the 2005–2008 Strategy)*¹.

The ACT Suicide Prevention Working Group (SPWG) was established in 2004 to increase awareness of suicide prevention and promote suicide prevention initiatives within the ACT. The SPWG provided valuable oversight and input for the implementation and evaluation of the original strategy and in developing the extension strategy *Managing the Risk of Suicide: A Suicide Prevention Strategy 2009–2014 (Managing the Risk of Suicide)*.

Managing the Risk of Suicide builds on the work and learning of its predecessor and provides a collaborative and co-operative whole of community approach to preventing suicide in the ACT.

Managing the Risk of Suicide sits within a broader mental health policy environment. Two documents of particulate note are *The ACT Health Mental Health Services Plan 2009–2014 (the ACT MHSP)*⁷⁶ and *Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT (Building a Strong Foundation)*.¹⁶

The ACT MHSP identifies the vision and the strategic directions for the development of the ACT mental health sector as it moves towards 2020. *Managing the Risk of Suicide* articulates the specific strategies and activities that will be implemented in delivering a collaborative and co-operative whole of community approach to preventing suicide in the ACT as directed by the objectives of the ACT MHSP.

The ACT MHSP envisages that in 2020, the mental health system of the ACT will be consumer orientated, consumer driven and will focus on recovery and rehabilitation. Consumers and carers will have seamless access to a coordinated and inter connected network of services provided by the consumer, community, public and private sectors that is designed to meet the mental health and psychological needs for individual health and wellbeing.⁷⁶

*Building a Strong Foundation*¹⁶ is also a sub-plan of the ACT MHSP and is a companion document to *Managing the Risk of Suicide*.

Building a Strong Foundation sets out the ACT Government's commitment to:

- Promoting mental health and wellbeing;
- Preventing mental illness;
- Intervening early in the course of an episode of mental illness; and
- Providing timely early intervention for those experiencing mental illness.

This document begins by providing an outline of the statistical incidence of suicide and a summary of findings from the evaluation of the 2005–2008 Strategy. Feedback from community consultations, findings from contemporary literature and directives from recent national policies relating to suicide prevention and mental health all contribute to the development of *Managing the Risk of Suicide*. Focus areas of service and sector development are identified, with specific strategies and actions for implementation. Finally, an evaluation strategy is also provided.

ACT Health would like to thank everyone, including members of the SPWG (Appendix One), members of the community, consumers and carers, clinicians and support workers, sector representatives and members of emergency and counselling services who freely gave their time to assist in the evaluation of the 2005–2008 Strategy and the development of *Managing the Risk of Suicide*.

2. *A Strategy for Managing the Risk of Suicide*

2.1 Purpose

As a sub-plan of the ACT MHSP⁶, *Managing the Risk of Suicide* provides a service development framework to guide an integrated, whole of community approach to suicide prevention across the lifespan in the ACT.

2.2 Goals

Individuals

- Reduce rates of suicide and self-harm in the ACT; and
- Increase resilience, coping skills and connectedness.

Community

- Improve awareness of and access to suicide prevention training, education and information.

Sectoral

- Increase collaboration and partnerships between organisations providing suicide prevention and postvention services in the ACT.

2.3 Scope

As a sub-plan to the ACT MHSP and companion document to the PPEI strategy, *Building a Strong Foundation*, this strategy seeks to fulfil the objectives specific to suicide prevention as outlined in these two documents.

Managing the Risk of Suicide takes a comprehensive and wide-ranging approach to the prevention of suicide in the ACT. *Managing the Risk of Suicide* considers biological, psychological, social and environmental factors influencing suicide and is concerned with preventing suicide across the life span. Reflecting the main themes from reports and strategies on suicide prevention in Australia³ the comprehensive approach adopted by this strategy seeks to:

- Address multiple risk and protective factors;
- Involve sustained action over a long period;
- Involve local and national action;

- Take a wide view of prevention as requiring interventions at a range of levels including the environment, whole of community, specific population groups and individuals at risk; and
- Include a focus on improving data, research and evaluation.

2.4 Objectives

The specific objective of *Managing the Risk of Suicide* is to reduce the rates of suicide and self-harm in the ACT through:

- Access to a timely and integrated service response;
- Increased community awareness of and access to suicide prevention training, education, information, networking and postvention;
- Identification of specific at risk groups, risk and protective factors and interventions to support at risk groups;
- The development of future suicide prevention initiatives; and
- Improving the general well-being, resilience and connectedness of the ACT community by supporting the implementation of the *Building a Strong Foundation*¹⁶ as appropriate.

2.5 A Whole of community responsibility – working together

Suicide prevention is everybody's responsibility. Building a fair and safe community requires involvement from all sectors of a community including individuals, health professional groups and service providers.³ The collaborative approach fostered by *Managing the Risk of Suicide* aligns with the principles of the *ACT Social Compact*,² which provides a positive basis for partnership and constructive working relationships between the community sector and ACT Government.

2.6 The Policy Context

Managing the Risk of Suicide is implemented within a policy context composed of National and ACT initiatives. As illustrated in figure 1, *Managing the Risk of Suicide* sits within a broader mental health policy environment. Two documents of particulate note are *The ACT Health Mental Health Services Plan 2009–2014 (the ACT MHSP)*⁷⁶ and *Building A Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT*.¹⁶

The national framework for the prevention of suicide, the *LIFE Framework*,³ provides strategic direction for suicide prevention activities across Australia. To maintain uniform objectives with national policy and to effectively capitalise on the public response to any national campaigns and promotions *Managing the Risk of Suicide* is strongly aligned with the *LIFE Framework*.

The goal of the *LIFE Framework*³ is to 'reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour in Australia'. Six action areas are identified:

1. Improving the evidence base and understanding of suicide prevention;
2. Building individual resilience and the capacity for self-help;
3. Improving community strength, resilience and capacity in suicide prevention;
4. Taking a coordinated approach to suicide prevention;
5. Providing targeted suicide prevention activities; and
6. Implementing standards and quality in suicide prevention.

Figure 1 summarises the relationships between key National and ACT policies and plans relevant to suicide prevention in the ACT. Further details of these policies and plans can be found at Appendix Two.

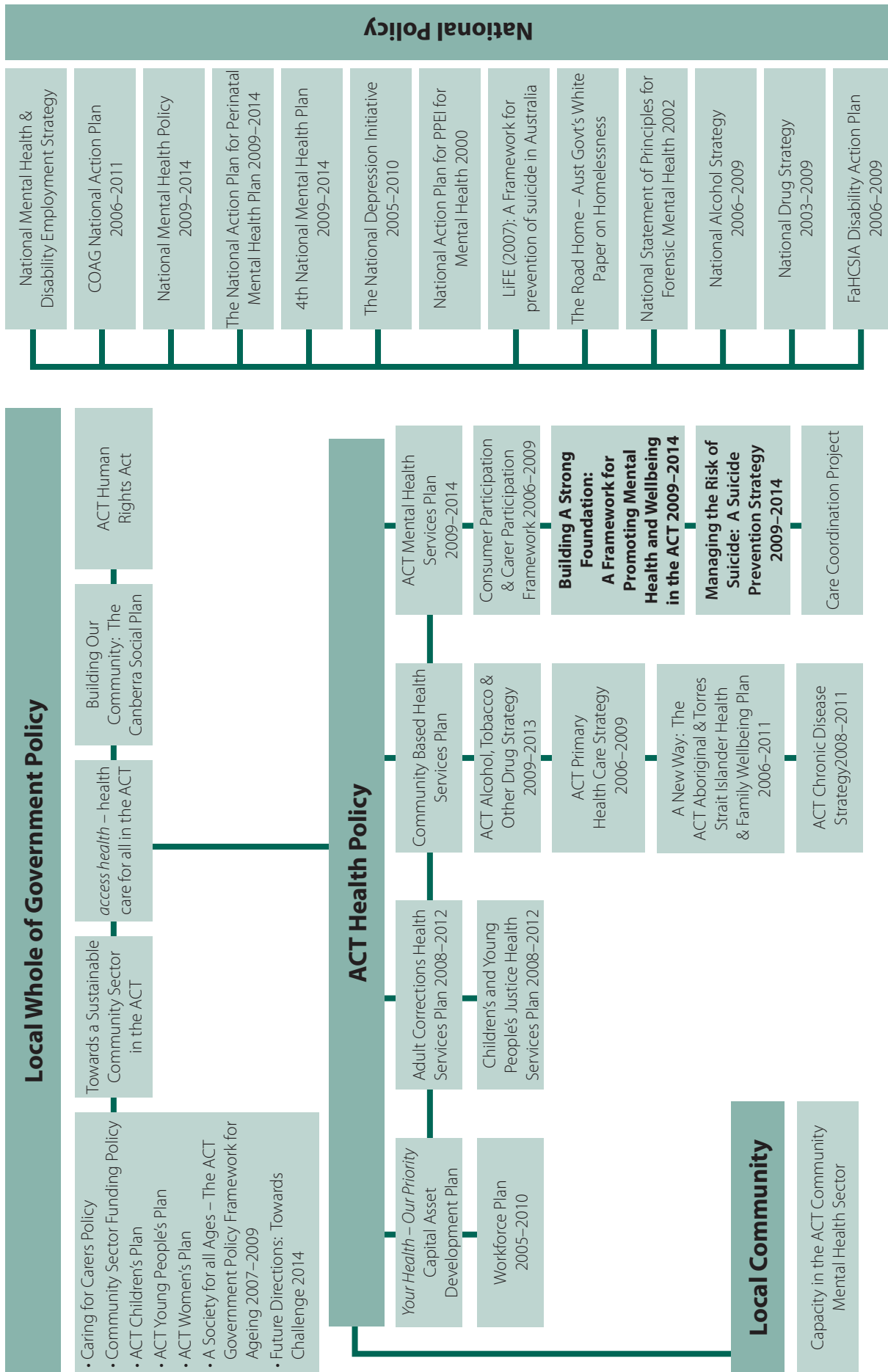


Figure 1 : Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014

2.7 Action Areas

Six key action areas provide the direction and framework for *Managing the Risk of Suicide*:

Action Area 1: Improving the evidence base and understanding for suicide prevention

Action Area 2: Building individual resilience and wellbeing

Action Area 3: Building community strength, resilience and capacity in suicide prevention

Action Area 4: Taking a coordinated approach to suicide prevention

Action Area 5: Providing targeted suicide prevention activities

Action Area 6: Implementing standards and quality in suicide prevention

Chapter Seven discusses further details of the rationale and evidence supporting these focus areas.

3. Background

3.1 International Trends

Close to a million people each year die by suicide worldwide,³ making suicide among the most prominent of international health issues. The number of people dying through suicide is significantly higher in most countries than the number of people dying through motor vehicle accidents.⁴ In Australia in 2007, 1881 deaths occurred by suicide, compared with 1 588 land and transport deaths.⁵

The factors influencing suicide rates are complex and are influenced by cultural, religious and environmental factors. These factors, combined with differences in data collection methods make international comparison of suicide rates difficult. A more comprehensive discussion comparing Australian and international statistics can be found in *Living is for Everyone: Research and Evidence in Suicide Prevention*.⁶

3.2 Australian and Local Figures

In Australia in 2007, 9.0 deaths per 100,000 head of population were registered as being attributable to suicide.⁴ ACT trends were similar although slightly higher with 9.5 deaths being registered as attributable to suicide per 100,000 head of population in 2007.⁷

Concerned communities are looking for better ways to manage the risk of suicide. The ACT Government and other agencies are already providing a range of suicide prevention programs and activities across the ACT. *Managing the Risk of Suicide* will strengthen and build on these activities.

Managing the Risk of Suicide will ensure a more coordinated response to suicide prevention by providing an agreed framework and implementation plan for suicide prevention activities within the ACT.

3.3 Evaluation of the 2005–2008 Strategy

The 2005–2008 Strategy was developed to guide suicide prevention activity in the ACT. Towards the plan's expiry, the SPWG recommended a two-part evaluation process:

- a. A review of the 2005–2008 Strategy, conducted by the SPWG; and
- b. Consultation with stakeholders and the community about the draft extension Strategy *Managing the Risk of Suicide*.

Noting the short duration of the 2005–2008 Strategy and the need for further time to elapse before meaningful outcomes can be measured, the SPWG advised that a separate evaluation report would not be sufficiently informative. The SPWG recommended that feedback from the review be used to inform an extension strategy that builds on the objectives of the 2005–2008 Strategy and ensures that any new or modified directives are based on current evidence.

During the review process, the SPWG decided that a more focused strategy which specifically and only targeted suicide prevention activities was appropriate for the ACT. Therefore, actions relating to mental health promotion, prevention and early intervention more generally are not included in this document, as they are more appropriately included in *Building a Strong Foundation*.¹⁶

The following sections report on the key findings from the SPWG’s review of the 2005–2008 Strategy. The public consultation process is discussed in Chapter 5 in the context of understanding the factors that influence suicidal thoughts and behaviour.

3.3.1 Progress in implementing priorities from the 2005–2008 Strategy

Significant progress was made in implementing the 2005–2008 Strategy over the past three years. A summary highlighting implemented activities is provided below. A more detailed list can be found at Appendix Three.

1. Over the life of the 2005–2008 Strategy, the ACT Government funded the following agencies for suicide prevention activities:
 - i. Mental Illness Education ACT for Skilling up in Suicide Prevention; and
 - ii. OzHelp to provide community education in suicide prevention and to facilitate community awareness about self-harm.
2. Over \$77 000 was expended in health promotion grants to organisations engaged in activities that included a suicide prevention component during the life of the 2005–2008 Strategy. This included funding for schools to provide peer support programs, training in the *Mental Health First Aid program*, and skills training in suicide prevention.
3. A range of programs were developed and/or delivered to:
 - i. Promote mental health wellbeing;
 - ii. Educate the community about suicide and suicide prevention;
 - iii. Provide support and skills for members of the community wishing to support others;
 - iv. Work towards strengthening continuity of care arrangements for individuals at high risk, including the development of formal agreements between Mental Health ACT and community agencies and the development of protocols and practices to improve consistency of care for those at risk is ongoing; and
 - v. To provide support for both individuals at risk of suicide and family and friends bereaved by suicide.

3.3.2 Strategic priorities for future action

The following areas were identified as priorities for future action:

- Investigation of mechanisms to provide suicide prevention training across relevant ACT Government Departments and health and human services agencies;
- Strengthening links with the Department of Justice and Community Safety to provide training in suicide prevention for corrections staff and detainees;
- Increased support for those transitioning from detention into the community; and
- Greater emphasis on postvention and, in particular, support for family and friends of those bereaved by suicide.

Actions to address these priority areas are reflected throughout *Managing the Risk of Suicide*.

3.3.3 Factors impacting on implementation

Evaluation of the 2005–2008 Strategy identified a number of factors that impacted on implementation. These included:

1. The short time period of the Strategy – The 2005–2008 Strategy only covered a period of three years. Recognising that many of the actions and interventions implemented to prevent suicide often have long-term effects on mental health and wellbeing, the short time frame did not allow sufficient time to evaluate outcome measures. However, outputs could be measured.
2. Methodological and implementation issues – The imprecise wording used for the actions within the 2005–2008 Strategy in combination with the absence of an implementation plan or evaluation strategy, have hampered the measurement of progress in implementing the 2005–2008 Strategy.

These issues have been addressed in *Managing the Risk of Suicide* by:

- Extending the time frame of *Managing the Risk of Suicide* to a five year period;
- Using more precise language to allow for the meaningful measurement of outcomes; and by the
- Development of an implementation strategy, agreed outcome measures and an evaluation plan which, as far as possible, have been endorsed by agencies external to ACT Health who have agreed to assume responsibility for the implementation of specific activities.

4. A Framework for Managing the Risk of Suicide

Many theories have been developed in an attempt to answer the question of why people die by suicide. Despite these, there is no single or definitive answer, and no simple answer to this question.³ However, it is known that suicide attempts or death by suicide is usually the result of an accumulation of risk factors that intersect with a number of social influences.

These risk factors and influences can include gender, age, mental illness, drug and alcohol misuse, family disharmony, bereavement, unemployment, cultural identity, legal issues (including incarceration), low educational attainment, homelessness, poverty and access to means. Given the complex interplay between the biological, psychological, cultural and social aspects which lead to suicidal behaviour, a multi-dimensional response is necessary.

4.1 Towards an understanding of suicidal behaviour – The ecological model

The World Health Organization's (WHO) World Report on Violence and Health⁸ provides an ecological framework for understanding and preventing suicide. The ecological model (figure 2) locates the individual and individual factors at the centre of a series of relationships, community and societal influences that interact.

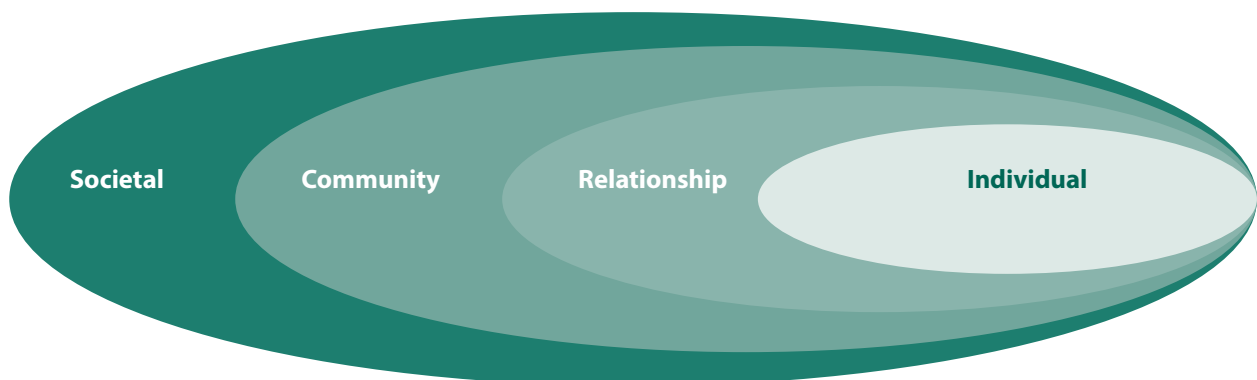


Figure 2: Ecological Model of potential factors affecting suicide³

Individual

The individual level is at the centre of the Ecological Model and considers the biological and personal history factors that affect a person's coping abilities. These factors may include mental health, educational attainment, substance abuse, biological traits or individual personality characteristics.

Relationship

Social relationships impact on an individual and may increase the risk for suicide. Relationships with peers, partners and family members all have an impact on a person's behaviour. They may be supportive or may include adverse experiences and contribute to social isolation.

Community

Considers the contexts in which social relationships are embedded, such as school, workplace and neighbourhood. Factors that are important may include duration of residence and degree of involvement in the local community, security of accommodation, income and financial security, as well as the functionality and connectedness of the community itself.

Societal

The outer level of the ecological model considers broader societal influences. These factors may include cultural norms, attitudes, health, education, and economic or social policies.

The ecological model is useful in understanding the complex and multi-factorial nature of the influences on social and emotional wellbeing and illness. Partnerships between government departments and the community are needed to provide the capacity to address these multiple factors. Immediate risk management needs to be present as an acute response, but it is only one element in a range of strategies that also focus on early intervention, prevention, and on addressing the social determinants that lead to mental wellbeing or illness. The ecological model makes the promotion of wellbeing and addressing factors that support wellbeing, part of and not distinct from suicide prevention.

4.2 The Spectrum of interventions for mental health problems and mental disorders

The spectrum of interventions for mental health problems and mental disorders shown below, adapted from Mrazek and Haggerty, is also useful in understanding the range of possible mental health interventions.

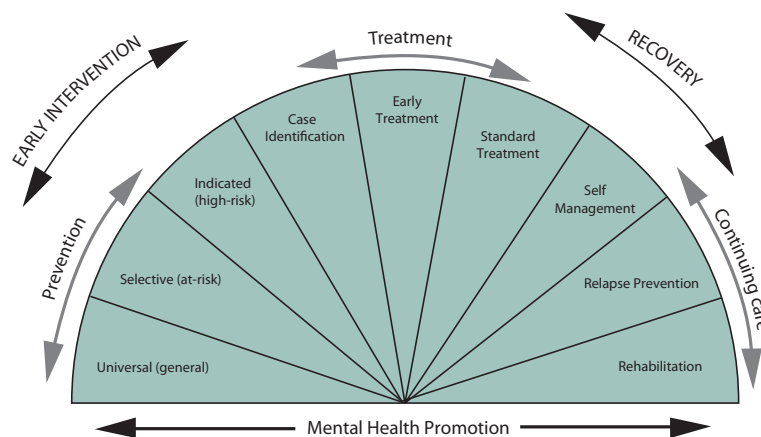


Figure 3: Mrazek and Haggerty Spectrum of interventions for mental health problems and mental disorders (adapted by Rickwood, 2006)⁹

Universal activities

These activities involve the whole population and may be aimed at improving mental health and wellbeing, resilience and awareness of factors that may influence suicide risk.

Mental health and wellbeing can be defined as:

The capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of equity, social justice, interconnections and personal dignity.¹⁰

Universal activities may include community education and measures to strengthen community connectedness.

Selective activities

These activities are targeted at population groups identified as being at greater risk compared to the general population. The type of interventions directed at specific individuals and groups are intended to diminish this higher risk. Different types of interventions may be required to deliver suicide prevention initiatives to specific population groups.

Indicated activities

Indicated activities aim to improve the mental health and wellbeing of individuals who are identified as having minimal but detectable signs of mental illness and may include programs for children showing signs of behavioural problems.¹⁷

Case identification and early treatment

Case identification refers to assessment, diagnosis and commencement of a treatment.

Standard treatment

Standard treatment involves the application of effective clinical and/or psychosocial treatment with the aim of providing the most effective intervention, to achieve the fullest possible recovery.

Engagement with longer-term treatment including relapse prevention

This treatment type involves the support of people whose needs are chronic or recurrent. The aim is to provide optimal clinical treatment and necessary social rehabilitation and support to prevent relapse or recurrence of symptoms or illness and to support optimal functioning.

Long-Term Care

Long-term care involves long-term support, treatment and care for individuals with chronic and disabling conditions. Rehabilitation and support to enhance functioning and quality of life are key components.

The *LIFE Framework* has further modified the Mrazek and Haggerty's model to include 'community-based safety networks'.³ Research examining health systems and errors occurring in systems, shows that failures in complex systems occur most frequently at transition or handover points.¹¹ This finding is supported by literature on suicide, which shows that the risk of suicide is greatly increased after leaving psychiatric care¹² and on release from prison.¹³

Within the *LIFE Framework*,³ community-based safety nets aim to bridge the gaps in care and support that people who feel suicidal experience as they transition between stages of professional care and support. These safety nets may include:

- Community-based services to support and foster recovery after discharge from clinical care;
- Effective client handover between services and back into the community; and
- Effective cooperation and communication between health professionals, community support services, schools, families, workplaces and community groups.⁵

5. Factors Influencing Suicide

Many factors may influence an individual's decision to take their own life. These can be grouped into the two broad categories of risk factors and protective factors. Risk and protective factors exist at the broader community level, at the relationship level and at the individual or personal level.

5.1 Protective Factors

Protective factors are factors that may reduce or mediate the possibility that a particular individual or group of individuals will become suicidal. These factors protect individuals, giving them the resilience to 'bounce back' when faced with adversity. Protective factors include:

- Good physical and mental health;
- Economic security;
- Self-esteem;
- A spiritual or religious belief;
- A personal sense of meaning or purpose to life;
- Personal resilience and problem-solving skills;
- Connectedness to family and school;
- Responsibility for children;
- Functional family communication patterns;
- The presence of a significant other person in an individual's life;
- Community and social integration; and
- Non-stigmatised community attitudes to mental health.

Protective factors can be strengthened by programs and activities that promote mental health and wellbeing and prevent mental illness.^{14 15} It is therefore reasonable to expect a long term reduction in suicide rates in communities with strong mental health and wellbeing promotion and prevention programs.

The ACT Government Promotion Prevention and Early Intervention (PPEI) Framework *Building a Strong Foundation*¹⁶ is a companion document to *Managing the Risk of Suicide* and promotes the development of protective factors. *Building a Strong Foundation* operates at three levels:

Promotion

Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals.¹⁷ Activities that promote mental health include public campaigns to reduce stigma, community education about mental health and wellbeing and development of policies and resilience programs in schools and parenting skills programs.

Prevention

Mental health prevention activities occur before the initial onset of a disorder to prevent the development of the disorder and focus on reducing risk factors and enhancing protective factors associated with mental ill-health.^{15 18} Prevention activities include programs which encourage help-seeking in men, programs to enhance the resilience of those from disadvantaged groups, including culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander peoples.

Early Intervention

Early intervention involves actions targeting people who display the early signs of a mental health problem or disorder and actions taken at the earliest onset of a mental health problem or disorder (e.g. early in life, early in course, early in episode).¹⁵ Early intervention activities include early assessment and diagnosis of individuals displaying signs and symptoms of mental illness and early treatment for people experiencing an episode of illness.

Specific activities in *Building a Strong Foundation*¹⁶ will support *Managing the Risk of Suicide* by increasing social connectedness and resilience, and increasing community understanding, knowledge and skills in the area of mental health and wellbeing.

5.2 Risk Factors

Risk factors are factors that may increase the possibility that a person or group of people will become suicidal. The presence of risk factors in a person's life make it more difficult for them to 'bounce back' when they experience negative life events or experience adversity. Potential risk factors include:

- Premature birth;
- Poor physical or mental health;
- A history of deliberate self-harm;
- Socio-economic disadvantage;
- Discrimination;
- Low educational achievement;
- Legal problems;
- Imprisonment;
- Lack of parental bonding;
- Family violence or disharmony;
- Lack of friends;
- Experiences of bullying;
- Experiences of harassment;
- Experiences of abuse; and
- Social isolation.

Factors that have been identified as possibly precipitating suicide include relationship breakdown, trauma within the family, financial problems, military service, marital separation or divorce, interpersonal problems and disputes or personal illness. Recently, physical abuse and anxiety have also been identified as indicators of suicide risk.

A developmental history of physical, emotional or sexual abuse or neglect is thought to underlie a less resilient sense of self that can lead a person to being more readily overwhelmed by adverse events. Exposure to these types of experiences is a significant factor among several 'at risk' population groups (see section 5.3). Traumatic experiences at any time in life, and subsequent post-traumatic stress disorder (PTSD) can have a similar and sometimes compounding effect.

5.3 At Risk Population Groups

The most recent research suggests that an understanding of risk factors in suicide is best used to identify populations or specific groups that might be at risk, rather than attempting to identify individuals at risk.³ It should be noted that the risk factors for suicide are complex. Belonging to one of the identified 'at risk' groups is just one factor that might contribute to suicide risk but is not a predictive factor on its own.

Specific population groups have been identified as being at higher risk than others and have been identified as priorities for action and future development of suicide prevention activities in both *Managing the Risk of Suicide* and the *LIFE Framework*.³

5.3.1 People Experiencing a Mental illness

Having a mental illness has been shown to have a strong relationship with suicide-related behaviours.¹⁹

In this document, the term 'mental illness' is used to describe a group of illnesses where people may show disturbed mood, poor judgement, abnormal perceptions or thoughts, disturbed emotions and ability to relate to others, and inability to cope with life events.^{20,21}

Disorders identified in the Diagnostic and Statistical Manual, Fourth Edition Revised (DSM-IVR)²² will be considered under this category, including people with a mental illness, those who self-harm, those experiencing dementia, those who use alcohol or other drugs in a problematic manner and those experiencing post traumatic stress disorder or an acute stress disorder. In grouping these conditions together, it is recognised that the term 'mental illness' refers to a spectrum of illness and that not all individuals experiencing symptoms may themselves identify as having an 'illness'.

Estimates of the percentage of people whose suicide is related to a mental illness vary considerably from study to study, ranging from 30 per cent to 90 per cent of all suicides.²³ However, while having a mental illness is linked to suicide, this does not mean that everyone who takes their own life has a mental illness.

The disorders having the strongest links with suicide are depression, bipolar disorder, schizophrenia, alcohol and other drug abuse, borderline personality disorder, and behavioural disorders (e.g. conduct and oppositional disorders in children and adolescents).²³ Rates of death by suicide of 10 per cent for schizophrenia and 15 per cent for bipolar disorder are commonly quoted.²⁴ The risk of suicide is particularly increased where an individual has multiple disorders, is involved in harmful drug use or has a co-morbid disorder.²⁵

A previous episode of deliberate self-harm is a major predictor of suicide. While the intent of self-harm is not always suicide, the risk of accidental death is very high. The risk of suicide for people with a history of attempted suicide or deliberate self-harm persists and remains a potent risk factor for subsequent suicide, even if it occurred many years previously.

Groups who are prone to self-harm include young people aged 12–25, people with a developmental or intellectual disability, people with borderline personality disorder, and people with a psychosis.³ A study of young people who self-harm found that 61 per cent experienced prior suicidal ideation, and that 90 per cent of these did not seek help before self-harming.²⁶

Effective treatment of a mental illness through medication, counselling or other methods may reduce suicide rates within these groups. One study estimated that if the three disorders most frequently associated with suicide-related behaviours (i.e. depression, alcohol/drug/substance abuse disorders and schizophrenia) were treated in 50 per cent of all people with these conditions, suicides would be reduced by approximately 20 per cent.²³

The effective treatment of mental illness is not the only preventative measure needed to reduce suicide-related behaviours. Providing a sense of caring, better social connectedness and creating a secure, safe and empathetic environment for those who have a mental illness may reduce the risk of suicide.²³

Stigma and discrimination associated with having a mental illness may contribute to suicide risk, specifically in relation with the associated isolation, loneliness, unemployment and homelessness.²⁷ *Managing the Risk of Suicide* and *Building a Strong Foundation*¹⁶ both support better community understanding of mental illness, along with efforts to increase the wellbeing and resilience of the whole ACT community (including people with mental illness).

5.3.2 People Bereaved by Suicide

Suicide impacts on family and close friends and an estimated 7–10 people are bereaved by each act of suicide.³ This equates to approximately 20,000 Australians nationally or 450 Canberrans bereaved by a suicide every year.²⁸ This estimate considers close friends and families, but does not take into account the impact on other community members such as neighbours, school-mates or work colleagues who relied on or were otherwise connected with the person. Therefore, it is likely to be a conservative estimate, with the number of people affected by any one suicide likely to be significantly higher.

Research indicates that the impact of suicide may span several years and that a family history of suicide or suicidal behaviour may be associated with an increased risk of suicide. This distinct risk factor may arise from a contagion effect where the individual is exposed to the person and the issues he or she experienced before taking their life.³

5.3.3 Youth

Youth is usually defined as aged 12–25 years. While suicide is rare in children younger than 15, in the later teenage years the rates of suicide tend to climb and peak in young to mid adulthood.³

Suicide rates for young males in Australia peaked in the late 1990's, with rates fluctuating between 23 and 31 deaths per 100,000. Since then, the death rate from suicide among young males has declined by almost 50 per cent from 31 deaths per 100,000 in 1997 to 12.5 per 100,000 in 2007. Female suicide death rates have remained relatively stable over the same period, at 7 per 100,000 in 1997 and 4 per 100,000 in 2007.⁷

While overall suicide rates have dropped in this age group, the incidence of self-harm and psychological distress has increased. In the periods 1996 to 1997 and 2005 to 2006, the hospitalisation rate for intentional self-harm among young people increased by 43 per cent, from 138 per 100 000 to 197 per 100 000. The increase was greater among females than males, with the female rate being consistently at least twice as high as that for males over this period.²⁹ Similarly, the proportions of young males and females reporting high or very high levels of distress increased from 7 per cent and 13 per cent respectively in 1997 to 12 per cent and 19 per cent respectively in 2004–2005, an increase from 1997.³⁰

A number of factors have been associated with an increased risk of suicide among young people. These factors include: parental loss through separation or divorce; physical or sexual abuse; interpersonal problems; problematic use of drugs or alcohol; problems involving violence; experiencing a suicide within the family or having a parent with a mental illness.³¹

Disadvantage from low socio-economic status, limited educational achievement, low income or poverty are other potential factors that have also been identified with an increased risk for youth.² Unemployment is an issue with 6.7 per cent of Canberran's aged 15–24 experiencing unemployment in 2002–2003.³²

Homelessness is also an identified issue for youth in the ACT and a risk factor for suicide. Recent figures of young Canberrans experiencing homelessness are not available. However, the 2006 Australian Bureau of Statistics survey of homelessness found that, nationally, 21 per cent of the homeless people were teenagers aged 12–18 and 10 per cent were young adults aged 19–24.³³ Given that the same survey found that 1364 of Canberrans were homeless, it is possible to estimate that 286 of Canberrans aged 12–18 and 136 young people aged 19–24 are likely to be homeless at any one time.

5.3.4 Older People

Isolation, especially living alone, has been indicated as an important variable in suicidal behaviour in old age. Research reports between 24 per cent and 60 per cent of elderly people who suicide live alone and that the percentage of elderly suicide attempters who live alone increases with age.³ Declining physical health and interpersonal losses are serious factors for suicidal behaviour. It is believed that the frequency and timing of the losses experienced and the inability to resolve grief before experiencing another loss differentiates a suicidal reaction from a non-suicidal reaction. Research suggests that gender differences in coping with problems such as living with a physical disorder or illness and under-employment for those in their 60's may contribute to the higher suicide rate for men in comparison with women.³⁴

In 2007, 178 Australians aged 70 and over died by suicide. The number of men who died by suicide was significantly higher than women, with 138 men dying by suicide compared to 40 women.⁴

Social influences including widespread ageism may also impact negatively on older people. New attitudes and social attributes that portray positive images of ageing and promote community inclusiveness and opportunities for older people are likely to assist in modifying traditional cultural stereotypes leading to increasing the general wellbeing of this population group.³

*A Society for All Ages: The ACT Government Policy Framework for Ageing 2007–2009*³⁵ outlines the ACT Government's commitment to promoting positive images of ageing, community inclusiveness, and enhancing the health and wellbeing of older Canberran's. A number of programs have been set up to facilitate this, including community based allied health teams, the Still Ticking Men's Group; the Older Persons Mental Health Service and a number of options for psycho geriatric rehabilitation.

5.3.5 Men

Suicide is four times more common in men than women, and in 2005, 1657 men took their own lives. Contemporary literature indicates that specific populations of men are at greater risk of suicide than others. These groups include:

- Young men and those aged 20–44 – suicide accounts for more than one quarter of all deaths among men aged 20–44 years in Australia.³⁶ Life events such as depression, unemployment, financial difficulties, relationship problems, work stress and alcohol and drug abuse play a significant role in determining the risk of suicide in this age group;³⁷
- Men over the age of 75 years;

- Men undergoing traumatic life events, including relationship breakdown, separation from children, unemployment, financial stress and social isolation;
- Men in prison or custody – an Australian study found a sharp rise in suicide rates rose to 507 per 100,000 among adult men two weeks after discharge from prison, and remained high at 118 per 100,000 six months after discharge;³⁸ and
- Men from Aboriginal and Torres Strait Islander communities, with Aboriginal and Torres Strait Islander males aged 17–23 being the most at risk.³

A number of reasons have been suggested to explain the relatively high rate of suicide in men in Australia. They include:

- Lack of awareness of available support services in their area or a feeling that these services do not adequately cater for their needs and would not help in their situation;
- A tendency among men not to recognise or respond to their own negative emotions or distress, which may result in more chronic and severe emotional responses to adverse life events;³⁹
- A tendency among men not to seek help for emotional difficulties or communicate their feelings of despair or hopelessness to others;⁴⁰
- A feeling that help-seeking displays weakness or failure and a preference to solve problems on their own, without being a burden on others;⁴¹ and
- The higher likelihood in men to choose more lethal methods of suicide.

Recent studies propose that effective suicide prevention programs for men should promote physical and mental health, drawing on men's skills and strengths, rather than on perceived 'failings' or shortcomings.⁴² Men respond well to services that encourage problem-solving and enhance their ability to gain control over their emotions and circumstances.⁴¹ It is also valuable to introduce suicide prevention programs that target the family and friends of suicidal men who do not seek help themselves.⁴³ It is important that professional carers, such as general practitioners, actively ask men about their mental and emotional state, as men rarely initiate conversations about these topics.^{44,45}

5.3.6 Aboriginal and Torres Strait Islander Peoples

Suicide among Australia's Aboriginal and Torres Strait Islander peoples is substantially higher than in the general Australian population, by as much as 40 per cent in some years. Over the past 30 years, suicide rates have risen dramatically among Aboriginal and Torres Strait Islander peoples, with males aged 17–23 being the most at risk.³ In 2007, suicide was the sixth leading cause of death among Aboriginal and Torres Strait Islander peoples, with 89 deaths recorded. This comprised 72 men and 17 women.⁵

Factors commonly attributed to higher suicide rates among Aboriginal and Torres Strait Islander peoples include poverty, lack of education, poor employment prospects, the influence of suicide by a family member, imprisonment, loss and ongoing traumatisation from past dislocation and mistreatment, loss of cultural identity, lack of access to culturally appropriate services to assist those at risk of suicide and increased alcohol and other drug use.

Effective suicide prevention strategies in Indigenous communities need to:

- Reflect how Indigenous people view health, mental health and suicidal behaviours. Indigenous people have a holistic understanding of health and wellbeing that not only affects the individual, but the community as a whole. Wellbeing includes all aspects of health, including mental, physical, social, cultural and spiritual health;
- Reflect a focus on wellbeing and mental health promotion, rather than focussing on mental illness and suicide;

- Encourage ownership and involvement from local communities; and
- Show respect for cultural beliefs and attitudes surrounding suicide and mental health, and employ culturally appropriate techniques and methods.⁶

5.3.7 Culturally and Linguistically Diverse Groups

The phenomenon of suicide and suicidal thinking among people who move from one culture to another varies from country to country. Suicide rates among immigrants to Western countries appear, overall, to be higher than those found in the country of birth.³ This is also the case in Australia but the relative contributions of pre- and post-immigration factors to suicide rates and mental illness are unclear.⁴⁶

Data concerning suicide rates for culturally and linguistically diverse communities are difficult to obtain. A recent study found that suicide rates for culturally and linguistically diverse groups were similar to the Australian-born population with 25 per cent of all suicides nationally, occurring by people born in another country.⁴⁷ Some variation is evident among different migrant groups and the available data suggest that social attitudes along with cultural and traditional experiences in the country of birth are important influences.⁴⁸

Risk factors most commonly found to increase the likelihood of suicide among refugees and immigrants include exposure to violence and trauma, lack of family support, living with a mentally ill family member, family stress, being alone or unaccompanied, prolonged incarceration in immigration detention centres, poor coping skills and resettlement stress.³

5.3.8 People exposed to repeated trauma

People exposed to repeated trauma are at greater risk of developing disorders such as post traumatic stress disorder (PTSD), anxiety and depression and are at greater risk of suicide.

It has long been recognised that defence personnel returning from combat, individuals involved in a traumatic accident and those experiencing repeated child sexual abuse are at greater risk of developing PTSD. Contemporary research indicates that other groups exposed to repeated trauma, such as emergency service workers, those on peace-keeping duties and humanitarian aid workers, are also at greater risk.

Common symptoms experienced by individuals exposed to repeated trauma include:

- Increased irritability;
- Difficulties concentrating;
- Memory problems;
- Insomnia;
- Depression;
- Anxiety; and
- Nightmares or periods during the day when a person feels like they are re-experiencing the trauma (flashbacks).

Research indicates that rates of PTSD in the general population range from 1 to 3 per cent.⁴⁹ However, studies of emergency service populations suggest rates of PTSD between 10 and 21 per cent.^{36 50}

Humanitarian aid workers may also be at risk of PTSD and/or Secondary Traumatic Stress (STS), which can develop as a result of repeatedly hearing first-hand accounts or narratives of traumatic events.⁵¹ A study of four groups of humanitarian organisations providing psychosocial aid to traumatised people in India found that all 76 workers reported STS as a result of their work and 8 per cent met the DSM-IVR criteria for PTSD.

Preventative measures and actions to minimise ongoing problems for individuals facing these types of situations include:

- Peer support;
- Access to counselling and support services such as Employee Assistance Programs (EAP); and
- Resilience building and reminding people of their strengths. For example, within an emergency services context, this may include reminding personnel that they are providing a vital service to the community and highlighting the positive aspects of their role.

Research suggests organisational variables can also have a significant impact on the trauma outcomes of emergency service workers. Issues such as poor communication, lack of consultation and other organisational hassles have been positively correlated with negative post-trauma symptoms in police officers.⁵² Conversely, positive post-trauma responses are related to positive perceptions of the organisation, such as feeling recognised for a job well done, being given responsibility and being valued.

Various employer groups are increasingly recognising the effects of exposure to repeated trauma on employees and are implementing promotion and prevention programs.

The Department of Veterans Affairs Operation Life provides a framework for action to prevent suicide and promote mental health and resilience across the veteran community. Similarly, the Australian Defence Force KYMS – Keep your Mates Safe program aims to strengthen approaches to reduce the risk of suicide within defence force communities.

Non-government aid and welfare agencies have a range of pre- and post-deployment activities to brief workers on issues relating to physical and emotional wellbeing. Emergency services organisations also have protocols and practices to address staff and volunteer wellbeing.

5.3.9 People receiving care in closed settings and those being discharged from closed settings

People who have experienced a period of care in a closed setting, including those who have been in an inpatient psychiatric unit, those in prison and those who have been detained in an immigration detention facility are at greater risk of suicide.

For those being discharged from psychiatric care, the risk of suicide is greater after leaving inpatient care than before a person enters care. The risk is elevated in the first day,⁵³ week,⁵⁴ month,⁵⁵ and year⁵⁶ after leaving treatment. For men, the rate of suicide in the first 28 days after discharge has been found to be 213 times greater than would be expected in the general population.⁵⁷ Moreover, at 12 months post discharge, suicide rates were found to be 27 times higher among men and 40 times higher in women, compared to the general male and female populations respectively.⁵⁸ The *National Survey of Mental Health and Wellbeing, 2008* found that, of respondents who reported previously being incarcerated, 41 per cent had experienced a mental illness in the past 12 months.⁵⁹

Several international studies have found an over-representation of the mentally ill in prisons. A recent review of 62 prison based mental health surveys found that prisoners were more likely to have a psychotic illness, major depression, or a personality disorder than the general population.⁶⁰ Within Australian prisons, a NSW study found the incidence of mental illness was 30 times higher in a prison population than in the general community.⁶¹

Similarly to those discharged from a psychiatric inpatient unit, those exiting prison are at significantly greater risk of suicide immediately following discharge.

In response to these findings, the *LIFE Framework*³ places greater emphasis on points of transition between stages of professional care and support.

5.3.10 Homeless People

The relationship between homelessness and mental illness is bi-directional: mental health problems can influence a person's ability to maintain stable housing⁶² and stable housing can influence mental health and wellbeing. The National Survey of Mental Health and Wellbeing found that, of respondents who reported previously being homeless, 54 per cent had experienced a mental illness in the past 12 months.⁵⁹ This is almost three times that for individuals who have never been homeless. Similarly, estimates suggest that between 15 per cent and 20 per cent of people who have a mental illness and are at risk of homelessness will be readmitted to a psychiatric inpatient unit within 28 days of discharge.³⁶

Under the National Partnership on Homelessness,⁶³ State and Territory governments will implement a policy of 'no exits into homelessness' from statutory, custodial care and hospital, mental health and drug and alcohol services for those at risk of homelessness. Priority groups will include:

- Young people leaving child protection and juvenile justice systems;
- People leaving hospital and other health care facilities, particularly mental health facilities and drug and alcohol services; and
- People leaving prison after serving sentences of 12 months or more.

The 2006 Homelessness Survey⁶⁴ found that 1364 Canberrans were homeless. *Breaking the Cycle: the ACT Homelessness Strategy*⁶⁵ acknowledges the impact of homelessness on mental health and sets out strategies to secure housing for people with mental illness in the ACT specifically and people in the Territory generally.

6. Action areas and implementation plan

This section sets out the areas that will be the focus of *Managing the Risk of Suicide*, provides the rationale and evidence-base to support the actions identified, and identifies the participants responsible for implementation of actions and the outputs anticipated.

After considering the results from the review of the 2005–2008 Strategy, feedback from consultations, and the action areas identified within the *LIFE Framework*³ the following action areas are a focus of *Managing the Risk of Suicide*:

1. Improving the evidence base and understanding for suicide prevention;
2. Building individual resilience and wellbeing;
3. Building community strength, resilience and capacity in suicide prevention;
4. Taking a coordinated approach to suicide prevention;
5. Providing targeted suicide prevention activities; and
6. Implementing standards and quality in suicide prevention.

In reading this document, it should be recognised that many of the strategies and activities identified could fall under two or more of the action areas. The approach adopted in developing *Managing the Risk of Suicide* has been to locate strategies and activities under the area which most closely aligns to the literature regarding evidence-based interventions for the groups being targeted.

Action Area 1: Improving the evidence base and understanding for suicide prevention

Rationale:

Despite a large amount of research and literature in the area, suicide prevention remains an inexact process based on limited scientific evidence.⁶⁵ There is an urgent need for continued development of well planned, evidence-based programs and research evaluating the effectiveness of suicide prevention interventions both internationally and in Australia.

Evaluation of local projects and initiatives will provide the sector with further information about suicide prevention strategies and interventions that are effective within the ACT context and will also add to the national and international knowledge base concerning suicide and suicide prevention.

It is recommended that all suicide prevention initiatives be guided by current evidence and include an evaluation component.

Outcome	Objectives	Activities	Outputs	Agencies Responsible
<p>1.1: Consistent collection and analysis of data on feelings of suicidality, suicide attempts, death by suicide and self-harm across the ACT.</p>	<ul style="list-style-type: none"> Work with the ACT Population Health Research Division Epidemiology Branch and other suitable agencies to develop improved data collection to provide reliable data to the community about suicide and suicide prevention and to increase understanding of risk factors and successful interventions in the ACT. Improve the quality and consistency of data reported from hospital emergency department and other services presentations involving attempted suicide and self-harm. Promote a culture of evaluation and reflective learning within organisations involved in suicide prevention and postvention. 	<p>1.1.1: Embed questions measuring suicidal ideation into the ACT General Health Survey.</p> <p>1.1.2: Investigate possibilities for streamlining collection of suicide data within ACT Health and MH ACT and between ACT Health, MHACT and the Commonwealth.</p>	<p>Annual report to the Suicide Prevention Implementation and Evaluation Group (SPIEG) summarising data from ACT General Health Questionnaire</p> <p>ACT Health to report to SPIEG on data collected consistency and scope for improved consistency by June 2010.</p>	<p>ACT Health</p> <p>ACT Health, MHACT</p>
<p>1.2: Improved capacity and skill in evaluation and reporting of suicide prevention programs in the ACT.</p>	<ul style="list-style-type: none"> Promote a culture of evaluation and reflective learning within organisations involved in suicide prevention and postvention. 	<p>1.2.1: ACT Health to distribute information about available education and training programs on evaluation relevant to community service organisations and organisations working in the area of suicide prevention.</p>	<p>Education and training programs regarding evaluation to relevant organisations.</p>	<p>ACT Health</p>

Action Area 2: Building individual resilience and wellbeing

Rationale:

Many factors influence a person's decision to take their own life, including individual, environmental and social factors.

Individual factors that may influence a person's mental wellbeing and suicide risk include social variables such as a feeling of being connected to and valued by society; biological variables such as mental and physical wellbeing; and individual characteristics including personality, personal history such as educational attainment and employment status. Individuals respond and cope differently to various life experiences. Providing people with the skills, knowledge and resources to enhance their own wellbeing and their awareness of protective and risk factors is important in reducing suicidal behaviour.

This section focuses on actions to build individual resilience and wellbeing specific to the area of suicide prevention. Further details concerning the ACT Government's commitment to enhancing social and emotional wellbeing for all Canberrans can be found in *Building a Strong Foundation*.¹⁶

Outcome	Objectives	Activities	Outputs	Agencies Responsible
2.1: Enhance individual awareness of suicide prevention/intervention, reduce stigma, and promote mental health literacy, help-seeking and support skills.	<ul style="list-style-type: none"> Support and strengthen universal programs targeting promotion of mental wellbeing, knowledge of suicide protective and risk factors and reduction of stigma. 	2.1.1: Map existing universal programs, including program content, availability and evidence base.	Report to SPIEG detailing available universal programs; completed by OzHelp by December 2009. Advertising material providing details of available programs posted on relevant organisation web sites.	ACT Health, OzHelp Foundation
		2.1.2: Promote web-based information about available suicide prevention programs and referral pathways on the ACT Health web site and other relevant organisation web sites.	Number of web site hits reported six monthly by relevant organisations	ACT Health OzHelp Foundation Lifeline Canberra SupportLink
		2.1.3: Distribute headspaces' mythbuster on talking to young people about suicide to GP's.	Number of mythbuster packages distributed to GP's. Feedback from GP's on usefulness of resource.	headspace ACT Consortium
		2.1.4: Promote 24 hour crisis counselling line to members of the community.	Number of organisations promoting the 24 hour counselling line.	Lifeline Canberra, ACT Health
		2.1.5: Develop and distribute culturally appropriate information on suicide prevention, protective factors, coping strategies and postvention, including a list of contact/crisis contact numbers.	Number and type of culturally appropriate resources available in a variety of formats.	ACT Health, ACT Transcultural Mental Health Network, ACT Multicultural Office

Outcome	Objectives	Activities	Outputs	Agencies Responsible
<p>2.2: Increased support for individuals working in the field of suicide prevention and those responding to incidents of suicide, attempted suicide and self-harm.</p>	<ul style="list-style-type: none"> Develop and implement strategies to support individuals with a key role in suicide prevention or trauma response, to safeguard mental health and wellbeing, enhance service delivery, improve staff retention and minimise the likelihood of suicide (eg health professionals, law enforcement officers, emergency services personnel, education and 	<p>2.2.1: Ensure that all MHACT clinicians have a professional clinical supervisor and are receiving regular supervision.</p> <p>2.2.2: Agencies encourage all individuals working in the field of suicide prevention and those responding to incidence of suicide, attempted suicide and self-harm to meet regularly with a supervisor or mentor.</p> <p>2.2.3: Promote the availability of workplace EAP services to MHACT and community sector organisation employees.</p>	<p>100 per cent of MHACT clinicians have a professional supervisor.</p> <p>100 per cent of MHACT clinicians are receiving regular clinical supervision.</p> <p>Percentage of individuals working in the field of suicide prevention and/or responding to incidence of suicide, attempted suicide and self-harm who meet regularly with a clinical supervisor or mentor; and/or</p> <p>Agencies report how staff are supported and debriefed within their roles.</p> <p>Awareness of EAP services in organisations.</p> <p>Utilisation rates of EAP services, when relevant.</p>	<p>MHACT</p> <p>Relevant community sector organisations, ACTDGP</p> <p>MHACT, relevant community sector organisations</p>

Action Area 3: Building community strength, resilience and capacity in suicide prevention

Rationale:

It is recognised that suicide is less likely to occur when people have good mental health, good interpersonal relationships, and family and community support.⁶⁷ Traditional mental health services and supports mainly focus on targeted interventions for those identified as being at greater risk. However, there is increasing emphasis that strengthening cohesion and supporting groups and communities⁶⁸ improves mental health and wellbeing. Providing universal interventions through actions and activities that support families, schools and whole communities before problems arise, and/or providing early intervention when a problem first arises, has been shown to reduce a range of behaviours associated with suicide risk, such as harmful drug use, mental health problems, delinquency and leaving school early.²

Building community strength and resilience requires involvement from all sectors of the community. Many activities to build community strength and resilience are outlined in *Building a Strong Foundation*.¹⁶ The activities outlined in this section relate specifically to build community knowledge about suicide prevention and build community capacity to provide effective suicide prevention interventions.

Actions to support groups of individuals known to be at increased risk, including those experiencing mental illness, those who have problematic drug and alcohol use, Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse backgrounds can be found in Action Area 5: Providing targeted suicide prevention activities.

Outcome	Objectives	Activities	Outputs	Agencies Responsible
3.1: Increased level of knowledge of suicide prevention activities and increased capacity to respond to the signs of suicidal behaviour.	<ul style="list-style-type: none"> Increase community participation in evidence based suicide prevention via suicide prevention awareness and training programs. 	<p>3.1.1: Continue delivery of evidence based suicide prevention community education programs.</p>	<p>Organisations delivering training report six monthly on: Number and type of program delivered to various groups, settings and organisations, eg school counsellors. Number of participants attending. Outcome data on learning from training programs.</p>	<p>ACT Health, OzHelp Foundation, Lifeline Canberra, headspace ACT Consortium</p>
		<p>3.1.2: Increased provision of evidence based mental health and suicide prevention workplace programs.</p>	<p>Organisations delivering programs report six monthly on: Number and type of courses delivered. Number of participants attending. Outcome data on learning from programs.</p>	<p>ACT Health, OzHelp Foundation, Lifeline Canberra</p>
3.2: Increased media compliance with the MindFrame national media guidelines.	<ul style="list-style-type: none"> Increase community knowledge and understanding of suicide and suicide prevention. Develop and maintain links with local media to encourage appropriate reporting and distribution of suicide prevention information. 	<p>3.1.3: Development of a workplace suicide awareness program, eg OzHelp's Mates in Construction.</p>	<p>Workplace suicide awareness program developed by 2010. Lifeline Canberra and OzHelp Foundation report six monthly on: Number of workplace suicide awareness programs delivered. Number of participants attending workplace training programs.</p>	<p>Lifeline Canberra and OzHelp Foundation</p>
		<p>3.1.4: Review existing local brochures and fact sheets aimed at increasing community understanding of suicide, suicide prevention strategies and factors that contribute to suicide behaviour and develop a distribution strategy.</p> <p>3.2.1: Support national level initiatives through the MindFrame media and mental health program http://www.mindframe-media.info/</p> <p>3.2.2: Write to media outlets annually reminding them of MindFrame and issues surrounding the responsible reporting of suicide.</p>	<p>Fact sheets and other resources reviewed by SPIEG by June 2010. Distribution strategy developed. Fact sheets and other resources distributed. Regular reporting on and identification of media response to suicide prevention, as relevant. Annual letter to all ACT media outlets signed by agencies represented on SPIEG.</p>	<p>SPIEG, ACT Health</p> <p>ACT Health, SPIEG, OzHelp Foundation, Lifeline Canberra</p> <p>ACT Health, SPIEG</p>

Action Area 4: Taking a coordinated approach to suicide prevention

<p>Rationale: Effective suicide prevention is everybody's responsibility and relies on all sectors of the community working together using sound evidence, with a careful assessment of outcomes. Because many different aspects of life can influence an individual's mental health and wellbeing, it is important that all human service, health and welfare agencies have knowledge of the factors that can protect individuals against and increase the risk of suicide, and feel confident to provide appropriate intervention. This does not imply that all organisations have the skills to provide clinical intervention but rather, that those who have direct contact with people who may be experiencing stress and distress, eg those experiencing financial, employment or housing stress have an awareness of the signs and symptoms that indicate that individuals may require further assistance and know where to refer them for additional support. These actions reflect the concept of 'no door is the wrong door', which describes a model of service delivery where each organisation in the service system is supported to assist all those who seek help, either by providing services directly or referring the individual on to another organisation to assist them.⁶⁹</p> <p>Individuals who engage with health and welfare services need to experience seamless care from services that work collaboratively and cooperatively to ensure that consumers receive the right care at the right time.</p>				
Outcome	Objectives	Activities	Outputs	Agencies Responsible
<p>4.1: Increased collaboration, including sharing of experience, collaborative service delivery and program implementation between organisations providing suicide prevention and postvention services in the ACT.</p>	<ul style="list-style-type: none"> Maintain an active SPIEG which guides development and implementation of suicide prevention policy in the ACT. Facilitate program and policy coordination and cooperation through partnerships between governments, peak and professional bodies and non-government organisations. 	<p>4.1.1: Hold regular meetings of the SPIEG.</p>	SPIEG meetings held bimonthly.	ACT Health, SPIEG
		<p>4.1.2: Regularly revise the membership of the SPIEG to ensure comprehensive representation from all relevant sectors in the ACT.</p> <p>4.1.3: Ensure that discharge and referral information is provided to other agencies in a timely manner when people are discharged from specialist mental health services.</p> <p>4.1.4: Monitor and evaluate the use of referral pathways to assist access to immediate bereavement counselling for family members after a suicide and connect the family with other services.</p>	<p>Annual review on SPIEG membership documented in minutes.</p> <p>Data reported by MHACT on a six monthly basis:</p> <p>Discharge summaries completed and sent to the consumers GP on the day of discharge for 100 per cent of clients.</p> <p>SupportLink to report number of referrals and organisations referred to on a six monthly basis.</p>	<p>ACT Health, SPIEG</p> <p>MHACT</p>
<p>4.2: Improve support to the carers, families and friends of people at risk of suicide.</p>	<ul style="list-style-type: none"> By collaboration between relevant agencies increase responsiveness of service providers to requests for grief and loss counselling and support for those affected by suicide. 	<p>4.2.1: Bring identified gaps in referral pathways and shared care arrangements specific to suicide prevention and postvention to the attention of service providers.</p> <p>4.2.2: SPIEG working group to make recommendation to service providers regarding identified perceived service gaps.</p> <p>4.2.3: Distribute the reprinted information and Support Pack for those bereaved by suicide or other sudden death to services likely to encounter bereaved clients.</p> <p>4.2.4: In partnership with the community sector, investigate options for the establishment of support groups for people bereaved by suicide and those working with people affected by suicide in the ACT.</p> <p>4.2.5: Collect a sample of stories from consumers concerning their journey to access care.</p>	<p>SPIEG to write to service providers outlining identified gaps in referral pathways and shared care arrangements.</p> <p>Recommendations made by SPIEG.</p> <p>Follow-up on actions taken on a six monthly basis.</p> <p>Number of kits distributed</p> <p>Feedback on usefulness of kit.</p> <p>Annual report to SPIEG by SupportLink and Lifeline Canberra on progress.</p> <p>Collection of a sample of consumer stories.</p>	<p>SPIEG, ACT Health, ACTDGP</p> <p>ACT Health, ACT, SPIEG</p> <p>SupportLink</p> <p>SPIEG, ACT Health, ACTDGP</p> <p>ACT Health, ACT, SPIEG</p> <p>SupportLink</p> <p>SupportLink, Lifeline Canberra, OzHelp Foundation</p> <p>SupportLink, Lifeline Canberra, Carers ACT</p> <p>ACT Health, SPIEG, MIEACT</p>
		<ul style="list-style-type: none"> Develop an understanding of people's journey to access services, to inform and improve services. 		

Outcome	Objectives	Activities	Outputs	Agencies Responsible
<p>4.3: Improve access to and coordination of support and follow-up services for families, friends and carers of those who have attempted to or have taken their life by suicide.</p>	<ul style="list-style-type: none"> Enhance the capacity of emergency personnel to respond to family and friends traumatised by the impact of a suicide. 	<p>4.3.1: Liaise with the AFP, ACT Ambulance regarding appropriate referral services available to clients and family affected by suicide.</p> <p>4.3.2: Ensure that suicide prevention training provided to front-line workers includes information about postvention support services and strategies.</p> <p>4.3.3: Ensure that emergency response workers are provided with training in mental health.</p> <p>4.3.4: Develop and monitor postvention procedures for families and carers of registered MHACT clients who complete suicide.</p> <p>4.3.5: Continue to support families and friends bereaved by suicide.</p>	<p>SupportLink to maintain ongoing contact with emergency service providers, in line with the current MOU's, to ensure appropriate referral making protocols are followed.</p> <p>Number of regular meetings with emergency services personnel, including all new members, to ensure seamless referral processes.</p> <p>By 2010 100 per cent of suicide prevention training programs for front-line workers contain a postvention component.</p> <p>Number and type of training sessions offered 6 monthly.</p> <p>Number of staff attending training sessions 6 monthly</p> <p>Number of condolence letters sent.</p> <p>Number of families requesting follow up.</p> <p>Number of families engaging in counselling.</p> <p>Number of families and friends bereaved by suicide supported.</p> <p>Types of support provided.</p>	<p>SupportLink, AFP, ACT Ambulance Service</p> <p>ACT Health, OzHelp Foundation, Lifeline Canberra, SupportLink</p> <p>JACS, ACT Health</p> <p>MHACT</p> <p>SupportLink</p>
<ul style="list-style-type: none"> Reduced number of suicide attempts in families, friends and carers of those affected by suicide. 				

Action Area 5: Providing targeted suicide prevention activities

Rationale:

Many factors influence an individual's ability to cope under pressure or when faced by life-changing circumstances. These factors include genetic make-up, previous life and family experiences, current and past physical and mental health, a range of cultural and gender-related factors, and a person's social support systems. Research indicates that being exposed to a number of these factors in a negative way can impact on a person's ability to cope with life stresses and may place some people at greater risk of experiencing suicidal thoughts. On the basis of these findings, a number of 'at risk' groups have been identified (See section 5.3 'At risk population groups'). A number of interventions have been identified to reduce the risk people in these groups face and/or to minimise the negative experiences people from these groups have:

Outcome	Objectives	Activities	Outputs	Agencies Responsible
5.1: Front-line workers, families, carers and gatekeepers have a greater capacity to support those experiencing suicidal feelings.	<ul style="list-style-type: none"> Provide evidence based education and information for consumers and carers involved with at-risk individuals and groups to enable them to identify and respond rapidly to people at risk. 	<p>5.1.1: Promote and facilitate evidence based mental health and suicide prevention skills training programs eg ASIST, Safe Talk, RE-FRESH, Mental Health Ambassadors Program, RESPOND, Suicide Prevention for the Elderly, Mental Health First Aid Training.</p> <p>5.1.2: Provide all schools counsellors in high schools and colleges with suicide prevention training.</p>	<p>Number and type of courses delivered, number of attendees 6 monthly.</p> <p>Feedback from trainings reported</p> <p>MHACT training data.</p>	<p>ACT Health, OzHelp Foundation, Lifeline Canberra, Carers ACT, Headspace ACT Consortium</p>
	<ul style="list-style-type: none"> Enhance capacity of schools counsellors to identify and respond to young people at risk. Increase capacity of service providers to engage with men. 	<p>5.1.3: Promote education and training programs aimed at increasing service providers awareness of issues affecting men's ability to access services and their skills in engaging men.</p> <p>5.1.4: Explore possibilities for hosting a biannual workshop on engaging and working with men, with a particular emphasis on suicide prevention.</p>	<p>Percentage of schools counsellors in high schools and colleges who have undertaken suicide prevention training.</p> <p>Number of training programs conducted.</p> <p>Outcomes of training programs.</p>	<p>DET</p> <p>OzHelp Foundation, Menslink</p>
5.2: Reduced incidence of suicide and suicidal behaviour in groups at highest risk.	<ul style="list-style-type: none"> Increase confidence among Corrections Officers in their ability to recognise individuals who may be at high risk of suicide and to engage with those individuals 	<p>5.1.5: Provide training in suicide prevention and mental health literacy and stigma reduction programs for corrections staff.</p>	<p>Progress towards hosting a biannual workshop on engaging and working with men.</p> <p>Type and number of programs delivered.</p> <p>Outcome measures from training programs.</p>	<p>ACT Health, Menslink</p> <p>JACS, Corrections Health, OzHelp Foundation</p>
	<ul style="list-style-type: none"> Increase access to evidence-based early interventions for group identified as at risk of suicide, eg men. 	<p>5.2.1: Promote evidence based workplace programs for at risk men, such as the Staying Connected program.</p>	<p>Number and type of other programs delivered.</p> <p>Feedback on other program.</p> <p>Number of Staying Connected programs delivered.</p> <p>Feedback on Staying Connected program.</p>	<p>OzHelp Foundation</p>

Outcome	Objectives	Activities	Outputs	Agencies Responsible
<p>5.3: People in the criminal justice and juvenile justice systems receive assessment, treatment and care as appropriate to their level of suicide risk.</p>	<ul style="list-style-type: none"> Increase access to evidence-based early interventions for people in the justice system at risk of suicide. 	<p>5.3.1: All individuals at <i>Bimberi Youth Justice Centre</i> and the Alexander Maconochie Centre (AMC) receive a mental health and risk assessment upon entry.</p> <p>5.3.2: Develop protocols and referral pathways to ensure follow-up of individuals assessed as having a mental health problem requiring ongoing care by a tertiary MH service will be provided a recovery plan during their stay and upon exiting the facility.</p> <p>5.3.3: Form a working group comprising groups delivering health and mental health care in ACT correction facilities to develop and implement mental health promotion, prevention and early intervention strategies.</p> <p>5.3.4: In partnership with key stakeholders, explore mechanisms to provide training in suicide prevention and mental health literacy and stigma reduction for detainees of all ACT corrections facilities.</p>	<p>100 per cent of individuals receive a mental health and risk assessment upon entering AMC or Bimberi.</p> <p>100 per cent of individuals assessed as requiring ongoing care by a tertiary MH service will be provided a recovery plan during their stay and upon exiting the facility.</p> <p>Implementation of working group.</p> <p>Strategies and plans developed and implemented.</p> <p>Type and number of programs delivered.</p> <p>Outcome measures from training programs.</p>	<p>MHACT (Forensic), Corrections Health</p> <p>MHACT (Forensic)</p> <p>MHACT (Forensic), Corrections Health</p> <p>JACS, OzHelp Foundation, Lifeline Canberra</p>
<p>5.4: Increase supports for people identified as 'at risk', who are transitioning between services.</p>	<ul style="list-style-type: none"> Improve procedures and protocols for the follow-up of people at key service transition points, including people being discharged from inpatient services, people presenting at ED after a suicide or intentional self-harm attempt, those entering or leaving the criminal justice system, and those recently released from other detention facilities. 	<p>5.4.1: Develop protocols and referral pathways to ensure that people who have attempted suicide or are assessed as being at high risk of suicide, receive appropriate community based care and support following discharge and during at risk periods.</p> <p>5.4.2: Housing ACT, through the Housing for Young People Program (HYPP) to work with young people transitioning to independent Housing ACT tenancies to ensure increased supports are available during transition periods.</p> <p>5.4.3: Individuals assessed as having mental health problem requiring ongoing care by a tertiary MH service will be provided a recovery plan during their stay and upon exiting the facility.</p> <p>5.4.4: Individuals requiring medication as part of their recovery plan will be supplied with a script for their medication upon exiting the facility.</p> <p>5.4.5: Case summaries will be sent to primary clinicians for all sentenced prisoners upon exit.</p>	<p>On discharge, 80 per cent of consumers have an appointment made to see their regular health care professional within 7 days of discharge.</p> <p>80 per cent of consumers received follow-up from MHACT within 7 days of discharge.</p> <p>Discharge summaries sent to primary clinicians on the day of discharge for 100 per cent of consumers discharged from an inpatient unit.</p> <p>Number of HYPP clients exiting Bimberi Juvenile Justice Centre and/or other settings providing closed care.</p> <p>100 per cent of individuals assessed as requiring ongoing care by a tertiary MH service will be provided a recovery plan during their stay and upon exiting the facility.</p> <p>100 per cent of individuals requiring medication as part of their recovery plan will be supplied with a script for their medication upon exiting the facility.</p> <p>Case summaries are sent to primary clinicians for 100 per cent of sentenced prisoners upon exit.</p>	<p>ACTDGP, MHACT, clinical managers, psychiatrists</p> <p>Housing ACT</p> <p>MHACT (Forensic), Corrections Health, ACT Corrective Services, Public Advocate.</p> <p>MHACT (Forensic), Corrections Health</p> <p>MHACT (Forensic), Corrections Health</p>

Outcome	Objectives	Activities	Outputs	Agencies Responsible
<p>5.5: Reduced incidence of stress-related health problems, incidence of vicarious trauma and suicide or suicidal behaviour among clinicians, community support workers and emergency service works.</p> <p>5.6: There are no suicides in ACT detention facilities.</p>	<ul style="list-style-type: none"> Provide support to the caring professions to minimise the likelihood of suicide among carers and clinical professionals. 	<p>5.5.1: Develop and promote mental health and wellbeing programs in occupational groups whose members are subject to frequent traumatic events (e.g. Police, ACT Ambulance Service, Emergency Services, General Practitioners).</p> <p>5.5.2: Investigate ways of addressing issues raised from report provided for action 5.5.1.</p> <p>5.6.1: Create MOU amongst ACTCS, AFP, Mental Health ACT and Court Administration, focusing on communication and responsibilities of staff.</p>	<p>SupportLink report six monthly on supports provided to ACT Ambulance Service.</p> <p>Number and type of issues raised and addressed from report.</p> <p>Reduction in the number of deaths in ACT detention facilities.</p>	<p>MHACT, Carers ACT, SupportLink, ACTDGP</p> <p>All Sectors</p> <p>ACTCS, AFP, MHACT, Court Administration</p>

Action Area 6: Implementing standards and quality in suicide prevention

Rationale: In order to provide consistent, evidence based services and interventions, all services and agencies require a clear understanding of what is expected of them. This requires the development and adherence to clear practices and protocols; ensuring that those working in the field of suicide prevention have access to evidence based training and that systems are in place to monitor issues of quality and safety and to implement improvement as necessary.				
Outcome	Objectives	Activities	Outputs	Agencies Responsible
6.1: Increased knowledge, skills and capacity among front-line workers, gatekeepers, families and carers in effective suicide prevention practices.	<ul style="list-style-type: none"> Provide access to support and ongoing professional development and training to improve the understanding and skills of all working in the area of suicide prevention and postvention. 	6.1.1: Map the training programs available and existing gaps in training available for professionals and para-professionals working in the field of suicide prevention and postvention.	Report to SPIEG mapping training programs available and existing gaps in training available for professionals and para-professionals working in the field of suicide prevention and postvention by ACT Health and OzHelp by December 2010.	ACT Health, OzHelp Foundation, headspace ACT Consortium
		6.1.2: Promote and deliver a suite of training programs to ensure that all professionals and para-professionals working in the field of suicide prevention and postvention have the opportunity to gain the necessary skills in an appropriate time frame.	Number and range of courses offered.	ACT Health, OzHelp Foundation, Lifeline Canberra
<ul style="list-style-type: none"> Increase the knowledge and skills of professionals and para-professionals about the specific issues and problems experienced by men who may be at risk. Ensure that training provided in the ACT continues to be evidence based and reflects best practice. 	6.1.3: SPIEG Secretariat to disseminate information to medical, clinical and allied health professional peak bodies on suicide prevention awareness and training opportunities on a quarterly basis.	6.1.4: Host regular forums for professionals and para-professionals to promote learning and sharing of information and resources available to those working with at risk men.	Information disseminated to appropriate professional bodies by ACT Health.	ACT Health, ACTDGP
		6.1.5: Biannual evaluation of Lifeline Canberra and OZHELP's ASIST and Safe Talk training programs.	Number of events held. Number of participants attending. Feedback on forum content.	Menslink, ACT Health
6.2: Enhance the capacity of Government Departments and non-government service providers to recognise and respond to signs of suicidal behaviour.	<ul style="list-style-type: none"> Increased delivery of accredited training and professional development in suicide prevention related topics to service providers across a wide range of sectors. 	6.2.1: Investigate the feasibility of including suicide prevention training as part of training for OH&S representatives within the ACT Government.	Report to SPIEG from Lifeline Canberra and OZHELP biannually.	Lifeline Canberra, OzHelp Foundation
		6.2.2: Annually review training needs in relation to suicide prevention across relevant ACT Government and human service agencies and recommend actions to address identified gaps.	MOU's/agreements include requirements to regularly run suicide awareness/prevention programs in Government Departments and non-government service provider organisations developed with appropriate training organisations. Annual report to SPIEG on outcomes from survey of training needs in relation to suicide prevention across relevant ACT Government and human service agencies. Communication of recommended actions to address identified gaps. Responses to identification of identified gaps monitored by ACT Health on a six monthly basis	ACT Health OzHelp Foundation, Lifeline Canberra

7. Governance, Implementation and Evaluation

The implementation of *Managing the Risk of Suicide* will be monitored and evaluated through the oversight of the Suicide Prevention Implementation and Evaluation Group (SPIEG)—a group comprised of both community and Government representatives. The SPIEG will comprise of representatives from key stakeholder groups and will report to the Strategic Oversight Group of the ACT MHSP.

The SPIEG will have the responsibility for coordinating the implementation and monitoring of actions identified in *Managing the Risk of Suicide*.

7.1 Evaluation of *Managing the Risk of Suicide*

Measuring the outcomes of the strategies and activities used to meet these goals will not be straightforward for a number of reasons:

1. Change in patterns of suicide behaviour and self-harm will be long-term. Therefore, a comprehensive longitudinal evaluation design is necessary to capture change over an extended period. This will need to include the collection of pre- and post-intervention data on factors that may influence suicide and self-harm.
2. It is not possible to attribute any observed change as a direct result of activities initiated under *Managing the Risk of Suicide*. This is because there are often confounding factors that cannot be controlled for when trying to measure the specific influence(s) of intervention activities on suicidal behaviour.
3. Those working in the field of suicide prevention already face significant reporting requirements. Therefore, every effort will be made to identify data measures that are already collected and reported. This will include, but not be limited to:
 - The Australia Bureau of Statistics *National Survey of Mental Health and Wellbeing*, which collects national data on a range of mental health related issues including suicide rates, rates of mental illness, access to mental health services etc;
 - The Australia Bureau of Statistics Suicide Australia, which collects national data on deaths registered in Australia where the underlying cause of death was deemed to be suicide;
 - The National Coroners Database;
 - The ACT General Health Questionnaire, which collects Territory level data about a range of health issues, including psychological distress; and
 - Information from the Mental Health ACT *Mental Health Assessment Generation and Information Collection* system (MHAGIC) data base.

Specific data concerning the outcome(s) of programs and activities undertaken by local organisations to promote issues around suicide and suicide prevention will be collected on a six monthly basis by ACT Health through a specifically designed survey distributed to relevant services and service providers. A report summarising this data will be provided to the Strategic Oversight Group on a six monthly basis and tabled in the Legislative Assembly annually.

A mid-term progress report providing a detailed analysis of progress in implementing *Managing the Risk of Suicide* to the end of June 2011 and identifying modifications required in order to continue meeting the changing needs of the local environment will be published in the second half of 2011.

8. Consultation

A draft of *Managing the Risk of Suicide* was distributed to the whole of the ACT Government, community agencies identified as either contributing to suicide prevention activities or agencies identified as being exposed to people at risk of suicide or self harm for comment in June 2009. The consultation process included:

- Focus groups;
- Individual consultations;
- Public submissions; and
- Public forums.

See Appendix Four for a list of consultation participants.

Appendix 1

Membership of Suicide Prevention Working Group

ACT Division of General Practice:	Dr Karl Richardson Kelly Gourlay
ACT Health General Practitioner Representative:	Dr Clare Willington
Policy Division, ACT Health:	Mr Richard Bromhead (Chair) Dr Johann Sheehan (Secretariat)
ACT Mental Health Consumer Network:	Mr Edward Wallace
Carers ACT:	Ms Jill Pierce
Centre for Mental Health Research (ANU):	Prof Kathy Griffiths
Department of Health and Ageing (ACT Branch):	Ms Peta Nelson Mr Paul Henson
Lifeline Canberra:	Ms Marie Bennett
Menslink:	Mr Glenn Cullen
Mental Health ACT, ACT Health	Ms Amber Shuhyta
OzHelp Foundation:	Ms Irmgard Reid
Suicide Prevention Australia:	Ms Dagmar Ceramidas
SupportLink Australia:	Ms Donna Evans

Appendix 2

Relevant National and ACT Policies and Plans

Managing the Risk of Suicide: A suicide prevention strategy for the ACT 2009–2014 is informed by national and local plans and policies.

*The National Action Plan for Mental Health 2006–2011*⁷⁰ recognises the importance of promotion, prevention and early intervention in enabling the community to better manage its mental health and wellbeing. The National Plan identifies specific policy directions necessary to achieve effective promotion, prevention and early intervention, including:

- Building resilience and coping skills of children, young people and families;
- Raising community awareness;
- Improving capacity for early identification and referral to appropriate services;
- Improving treatment services to better respond to the early onset of mental illness, particularly for children and young people; and
- Investing in mental health research to better understand the onset and treatment of mental illnesses.

The *National Mental Health Policy 2008*⁷¹ embeds a whole of government approach to mental health, first agreed to by the Council of Australian Governments in July 2006, within the National Mental Health Strategy. The policy provides a context for the development of national and state plans relating to mental health and wellbeing.

The *4th National Mental Health Plan* builds on the previous three plans and has a strong focus on a whole of government approach to future developments. The plan has five priority areas:

- Social inclusion and recovery;
- Prevention and early intervention;
- Services, access, coordination and continuity of care;
- Quality improvement and innovation; and
- Accountability—monitoring, reporting and evaluation.

The *National Depression Initiative*⁷³ aims to increase the capacity of the broader Australian community to prevent depression and respond effectively to it.

The *National Action Plan for Perinatal Mental Health 2008–2010*⁷⁴ provides a population approach to improving the perinatal mental health and wellbeing of women and their relationship with their infant.

The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*¹⁷ outlines a strategic framework and plan for action to address promotion, prevention and early intervention priorities and outcomes in the Second National Mental Health Plan.⁷⁵

The *National Living is for Everyone (LIFE) Framework*³ is a framework for prevention of suicide in Australia provides the strategic direction for suicide prevention activities in Australia for the next five years.

The goal of the *LIFE Framework* is to 'reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour in Australia'. Six action areas are identified in the *LIFE Framework*:

- Improving the evidence base and understanding of suicide prevention;
- Building individual resilience and the capacity for self-help;
- Improving community strength, resilience and capacity in suicide prevention;
- Taking a coordinated approach to suicide prevention;
- Providing targeted suicide prevention activities; and
- Implementing standards and quality in suicide prevention.

*The ACT Mental Health Services Plan 2008–2014*⁷⁶ sets the vision and strategic direction for the mental health sector in the ACT to the year 2020. The Plan acknowledges that a strong emphasis on promotion, prevention and early intervention is required to optimise the mental wellbeing of all Canberrans.

*Building a Strong Foundation Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014*¹⁶ sets the overall priorities for the promotion of mental health and wellbeing and the prevention and early intervention for those experiencing symptoms of mental illness in the ACT.

*The ACT Health Action Plan 2002*⁷⁷ sets the directions for public health services in the ACT. It highlights the need to 'strengthen the health of the community by leading whole of government action addressing the social determinants of health'.

*The Social Compact*² recognises that the best way to achieve such a community is for the Government and community organisations to work in partnership.

*Building Our Community: The Canberra Social Plan*⁹³ identifies the social, economic and environmental improvements needed to support a stronger community and greater wellbeing for people of the ACT. *Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009–2014*¹⁶ extends two of the main themes of the Social Plan: 'Quality in health care' and 'A fair and safe community'.

*The ACT Human Rights Act 2004*⁷⁸ sets out human rights legislation in the ACT.

*The ACT Alcohol, Tobacco and Other Drug Strategy 2009–2013*⁷⁹ sets out the ACT Government's strategy to address the problematic use of alcohol, tobacco and other drugs.

The ACT Alcohol and Other Drug and Mental Health Comorbidity Strategy (in preparation). Bringing together priorities from all stakeholders, the Comorbidity Strategy will draw together service options from the diverse range of services and support options available. It will develop cross sectoral entry and discharge options to improve the identification, treatment and support options for individuals with comorbidity.

*The ACT Children's Plan 2004–2014*⁸⁰ sets out a whole of government approach to support the development of children in the ACT.

*The ACT Primary Health Care Strategy 2006–2009*⁸¹ provides direction for the efficient and effective delivery of primary health care services in the ACT.

*The ACT Women's Plan*⁸² identifies factors pivotal to the development of effective and responsive policies, programs and services to meet the needs of women and girls in the ACT.

*A New Way: The ACT Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011*⁸³ outlines a commitment by all parties to work collaboratively to develop and implement innovative solutions that deliver measurable and meaningful change in the health status of Aboriginal and Torres Strait Islander communities in the ACT.

*The National Partnership Agreement of Closing the Gap in Indigenous Health Outcomes*⁸⁴ has been established to address targets set by COAG for closing the gap in health outcomes between Indigenous and non-Indigenous Australians. Six targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas are identified:

To close the gap in life expectancy within a generation;

- To halve the gap in mortality rates for Indigenous children under five within a decade;
- To ensure all Indigenous four years olds in remote communities have access to early childhood education within five years;
- To halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
- To halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
- To halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

To address these issues, a package of health reforms have been developed centred on five priority areas:

- Tackling smoking;
- Providing a healthy transition to adulthood;
- Making Indigenous health everyone's business;
- Delivering effective primary health care services; and
- Better coordinating the patient journey through the health system.

*Consumer Participation and Carer Participation across Mental Health ACT*⁸⁵ is a Framework acknowledges the rights of consumers and carers to participate in decision making processes regarding mental health care.

*Caring for Carers Policy*⁸⁶ embodies the ACT Government's commitment to better acknowledge carers and address their needs.

*Adult Corrections Health Services Plan 2008–2012*⁶⁰ identifies a framework for the management of the health of remandees and prisoners in detention within the ACT correctional system.

*Children's and Young People's Justice Services Health Plan 2008*⁸⁷ identifies a framework for the management of the health of children and young people in detention within the youth justice system. The Plan defines the role of ACT Health in providing for the health needs of residents; identifies key health needs of the current and expected populations of Bimberi, the services required to appropriately meet these needs, best practice strategies for providing health care to residents, and linkages between government agencies and community services to assist in providing services for residents.

Appendix 3

Suicide Prevention Activities Undertaken 2005–2008

Themes	Activities
Increasing community resilience and wellbeing	Training for the whole community: Mental Health First Aid Youth Mental Health First Aid SafeTALK ASIST Peer skills programs in schools and workplaces: MIEACT Mental Illness Education ACT FR-ESH Mental Health Ambassadors SafeTALK LifeSkills Toolbox Staying Connected Tradies Tune-Up Project Orientated School Mentoring (POSM) Moodgym MindMatters KidsMatter Community education events: Heads-Up
Strengthening the capacity of service providers to respond to people at risk	Training for service providers, including ACT public servants and non-government agencies: Mental Health First Aid Youth Mental Health First Aid SafeTALK ASIST Respond Accredited mental health training programs for General Practitioners Self-harm training for Lifeline counsellors and community agencies Service development: Development of treatment and intervention policies and protocols Service agreements between ACT Government Departments Strengthening of planning when consumers leave hospital Increased service provision: Increased access of the Australian Government Better Access Initiative through General Practice; ACT StandBy Suicide Bereavement Service Launch of the youth and adult Step-Up/Step Down facilities.
Improve the continuity of care for individuals at high risk	Activities to strengthen care: Development of formal agreements between Mental Health ACT and community agencies Development of self-harm and suicide protocols Development of a post-attempt support group
Support for families bereaved by suicide	Services and supports: Lifeline telephone counselling ACT StandBy Suicide Bereavement Service Reprint of the Information and Support Pack for those bereaved by suicide.
Advancing the field of suicide prevention	Regular meetings of the SPWG

Appendix 4

Consultation Participants

ACT Mental Health Consumer Network
ACT Council for Social Service (ACTCOSS) – G. Wilson
ACT Division of General Practice
ACT Health Aboriginal and Torres Strait Island Health Policy Unit
ACT Health Drug and Alcohol Policy Unit
ACT Health GP Advisor
ACT Human Rights Commissioner
C. Allatt
A. Marie
Australian Red Cross
R. & B. Booth
P. Boyer
D. Briggs
G. Buckford
Carers ACT
Chief Ministers Department
Conflict Resolution Service – F. McLroy
Director, Corrections Health
Department of Disability, Housing and Community Services
Department of Education and Training
Department of Justice and Community Safety
Department of Territory and Municipal Services
The Elected Elders Body
C. & G. Gerrity
Gugan Gulwan Youth Aboriginal Incorporation
B. Hausia
Headspace – Lisa Kelly
B. Hitchcock
Housing ACT
C. King
Menslink
Mental Health ACT
Mental Health Community Coalition ACT
Mental Illness Education ACT
OzHelp – Irmgard Reid
J. Phillips
The Public Advocate
Transcultural Mental Health Network
Vietnam Veterans Federation ACT Branch - Gerald Mapstone
K. Wells
G. Willson
Winnunga Nimmityjah Aboriginal Health Service
Women’s Centre for Health Matters

Appendix 5

Suicide Prevention services in the ACT

A range of health and well-being services are available in the ACT through the provision of services by the ACT Government and by community organisations. Government agencies and the primary care system such as General Practitioners tend to provide more specialised clinical services. Community agencies such as youth centres are more focussed on support, health promotion and illness prevention programs and rehabilitation services. Schools, sporting, cultural and recreational groups also have a role in providing support and promoting healthy behaviours and activities. Many organisations have in place referral and information sharing systems that facilitate service provision to consumers where possible.

Immediate help contact list

Health First 6207 7777

Canberra Connect 132 281

The intake points for government services are:

Mental Health Crisis Assessment and Treatment Team 1800 629 354

Child and Adolescent Mental Health Intake 6205 1971

ACT Ambulance Service 000 or 6207 9900

Community Health Intake 6207 9977

The Canberra Hospital 6244 2222

Aged Care Assessment Team 6244 3815

NAME	DESCRIPTION	CONTACT
ACT Health Intake and Assessment/ Aged Care Assessment Team	Intake and assessment unit for aged care services, physiotherapy, community nursing, occupational therapy, social work, diabetes services, nutrition services, stoma therapy, continence clinic, wound clinic, palliative care and aged day care centres in the ACT.	PO Box 11, Woden ACT 2606 Ph: 6207 9977 Ph: 6244 3815 or 624422 22 Fax: 62052611 Web: www.health.act.gov.au
Alcohol & Drug Foundation ACT Inc	The Foundation administers a range of residential and community based education and treatment programs for addictions.	GPO Box 2230, Tuggeranong ACT 2901 Ph: 6292 2733 Fax: 6292 7073 Web: www.adfact.org
Alcohol & Drug Program, ACT Health	Provides a 24-hour information service on alcohol and other drugs. Support, referral and initial phone assessment is also offered to clients and families wanting to access ADP services 24 hours per day.	GPO Box 825, Canberra City ACT 2601 Ph: 6207 9977 Fax: 6205 0951 Web: www.health.act.gov
ACT Mental Health Consumer Network	Provides information and referral and represents the interests of people who have been treated for a psychiatric illness.	PO Box 469, Civic Square ACT 2608 Ph: 6230 5796 Fax: 6230 5790 Web: www.communityact.org/actmentalhealth Email: mhcninc@ozemail.com.au
ACT Suicide Prevention Working Group	The ACT Suicide Prevention Working Group comprises key professionals who represent both government and non-government organisations with an interest in suicide prevention.	GPO BOX 825, Canberra City ACT 2601 Ph: 6205 5142 Fax: 6205 5148

Belconnen Community Service – Bungee Program	The Bungee program aims to promote social and emotional wellbeing; resilience of young people and their families; community acceptance and aims to reduce the stigma associated with people affected by mental illness.	PO Box 679, Belconnen ACT 2617 Ph: 6264 0232 Fax: 6251 9952 Web: www.belcomserv.com.au Email: bungee@belcomserv.com.au
Beyond Blue: the national depression initiative	Beyond Blue is a national independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance used disorders in Australia	The beyondblue info line on 1300 22 4636 www.beyondblue.org.au
Calvary Public & Private Hospital	Public hospital with 24 hour accident and emergency services and private hospital wing.	PO Box 254, Jamison Centre ACT 2614 Ph: 6201 6111 Fax: 6201 6210 Web: www.calvary.act.com.au
Canberra Connect	Provides a single point of contact for ACT Government information and services. Access to Canberra Connect is through five shopfronts, a call centre on 13 22 81 and the internet.	Level 3 Macarthur House 12 Wattle Street, Lyneham ACT 2602 Shopfronts: Belconnen – Swanson Plaza Civic – 197 London Circuit Dickson – Challis St Tuggeranong – Homeworld Centre Woden – Cnr Corinna & Furzer Sts Ph: 13 22 81 Web: www.canberraconnect.act.gov.au Email: canberraconnect@act.gov.au
Child & Adolescent Mental Health Service (CAMHS)	Counselling and assessment service for children and adolescents aged up to eighteen years of age with emotional, behavioural or psychiatric problems. Family therapy and outreach service for homeless adolescents is available. After hours triage and crisis assessment is available	Building A Level 2, Callum Offices, Callum & Launceston Street, Woden Phone 6205 1469 Fax 6207 5266
Children of Parents with a Mental Illness (COPMI)	This project aims to increase the awareness of the needs of children with parent(s) affected by a mental illness within Mental Health ACT and across the community sector. Its focus is to promote the early identification of children of parents affected by a mental illness that are vulnerable; to support services to provide assessments sensitive to the specific needs of this population; and to deliver services to meet those needs.	GPO Box 825, Canberra City ACT 2601 Ph: 13 22 81 6205 1469 Fax: 6207 5266 Web site: www.copmi.net.au
Community Education Mental Health Services	Education programs are available for consumers and carers, health professionals, service providers and the broader community to improve understanding of mental health and illness.	GPO Box 825, Canberra City ACT 2601 Ph: 6205 1178 Fax: 6205 5148 Email: jane.pepper@act.gov.au
Connections Volunteers	Mental Health ACT funds Volunteering ACT to operate the Connections Volunteers program. This program assists in developing links between clients of Mental Health ACT and volunteers with the aim of reducing social isolation and increasing community involvement.	Labor Club Community Chambers, Chandler Street, Belconnen ACT 2617 Ph: 6251 4060 Fax: 6251 4161 Web: www.volunteeract.com.au Email: connections@volunteeract.com.au
Crisis Assessment Treatment Team (CATT) – Mental Health Triage, Mental Health ACT	The Crisis Assessment Treatment Team offers a range of services from 24 hour access through triage, to treatment for moderate to severe psychiatric illness (including suicidal behaviour), through to the Psychiatric Services Unit (offering inpatient treatment and care), to the Community Mental Health Teams operating in each regional centre which offers longer-term, case management support.	PO Box 11, Woden ACT 2606 Ph: 1800 629 354 Fax: 6205 1978

Health First	24 hours a day, 7 days a week health telephone advice line staffed by registered nurses to answer health questions from the general public.	Ph: 6207 7777 Web: www.healthfirst.net.au Email: healthfirst@hph.com.au
Kids Help Line	Kids Help Line is a national telephone and web based counselling service for young people aged 5 to 18 years. Offers 24 hour telephone counselling. The service is free, anonymous and confidential.	PO Box 376, Red Hill QLD 4059 Ph: 1800 551 800 Fax: 07 3367 1266 Web: www.kidshelp.com.au Email: admin@kidshelp.com.au
KidsMatter	KidsMatter is the first national mental health promotion, prevention and early intervention initiative specifically developed for primary schools. Currently being trialled in 101 schools across Australia, KidsMatter involves the people who have a significant influence on children's lives – parents, families, care-givers, teachers and community groups – in making a positive difference for children's mental health during this important developmental period.	Web: http://www.kidsmatter.edu.au/
Lifeline ACT	Provides a free, anonymous confidential 24-hour phone service for people under stress, in crisis or with any problem.	GPO Box 583, Canberra City ACT 2601 Ph: 13 11 14 Fax: 6257 4290 Email: office@act.lifeline.org.au
Menslink	Menslink is a non-profit, charitable association promoting the value, well-being and social participation of young men by providing appropriate and professional services with outreach activities. Activities include counselling, community education, advocacy, and research and identification of gaps in services.	PO Box 4147, Manuka ACT 2603 Australia Ph: 6239 4699 Email: info@menslink.org.au
Mental Health First Aid	A first aid course that covers helping people in mental health crisis situations or the early stages of developing a mental health problem. Participants learn the signs and symptoms of mental health problems, where and how to get help, and what sort of help has been shown to be effective.	Locked Bag 10, Parkville Vic 3052 AUSTRALIA Fax: (03) 9342 3745 Email: mhfa@mhfa.com.au
Mental Illness Education ACT (MIEACT)	MIEACT provides information to secondary school and college students, community mainstream and youth agencies about principal mental illnesses, their symptoms and maintenance of mental health with the view of improving mental health literacy	PO Box 74, Ainslie ACT 2602 Ph: 6257 1195 Fax: 6257 1195 Web: www.mieact.com.au Email: mieact@mieact.com.au
MindMatters	MindMatters is a mental health promotion program for secondary schools. It aims to build the capacity of school communities to enhance resilience of students and staff through creating an environment where students feel connected to others and are engaged in relevant and challenging learning	GPO Box 158, Canberra City ACT 2601 Ph: 6205 1469 Fax: 6207 5266 Email: libby.porter@act.gov.au
National Coroner's Information Scheme (NCIS)	Canberra has had very strong involvement in the NCIS. In 1998 this database was piloted in the ACT with other states joining in 2000 and 2001. The database contributes to the nationwide effort to prevent suicide by providing reliable data and coverage of core information about each event, including the coronial determination as to intent of the deceased, enabling early identification of cases, particularly suicide clusters.	Web: www.ncis.org.au Email: ncis@vifm.org
OzHelp Foundation	The OzHelp Foundation is an early intervention, suicide prevention and social capacity building program targeting industry and community. It is built on a vision to enhance the resilience of industry apprentices, workers and broader community through training and support.	PO Box 162, Belconnen ACT 2616 Ph: 6251 4166 Web: www.ozhelp.org.au Email: keith@ozhelp.org.au

Poisons Information Service	24 Hour phone service offering advice and information on poisonous substances, bites and stings.	The Canberra Hospital, Yamba Drive, Garren ACT 2605 Ph: 13 11 26 Fax: 6244 3334
Police (Australian Federal Police)	Responsible for law enforcement in the ACT including Juvenile Aid Bureau and the Sexual Assault Unit. Involved with the Neighbourhood Watch committees throughout the ACT.	London Circuit, Canberra ACT 2601 Ph: 13 14 44 Fax: 6245 7303 Web: www.afp.gov.au
Post & Ante Natal Depression Support & Information Group	This program provides support groups, telephone information, referral and support to women with post and antenatal depression. Childcare is also provided to enable clients to attend support group meetings.	PO Box 137, Red Hill ACT 2603 Ph: 6207 1343 Fax: 6207 1490 Web: www.pandsi.org.au Email: pandsi@austarmetro.com.au
SANE Australia	SANE provides and help online service to ask questions about Mental Health and related topics. Enquiries are usually answered within 3 working days.	Sane Helpline:1800 18 SANE (7263) Available 9am to 5pm week days Email: www.sane.org
StandBy	StandBy is a Suicide Bereavement Response Service that provides a 24-hour coordinated community crisis response to families, friends and associates who have been bereaved through suicide.	PO Box 400, Calwell ACT 2905 Ph: 0432 063 839 or 6243 3663 Fax: 1300 656 200 Web: www.supportlink.com.au Email: admin@supportlink.com.au
St Johns Care – Community Grief Support Program	Provides information, referral, education and training on a wide range of grief and loss issues, and free individual support sessions to bereaved people in the community.	GPO Box 219, Canberra ACT 2601 Ph: 6248 7771 Fax: 6262 6665
The Canberra Hospital	Full range of public hospital services provided, including 24-hour accident and emergency	PO Box 11, Woden ACT 2606 Ph: 6244 2222 Fax: 6281 3935 Web: www.canberrahospital.act.gov.au Email: public.affairs@act.gov.au
Vietnam Veterans Federation Australia	The prime service of Vietnam Veterans Federation Australia is lodging claims for veterans to the Department of Veterans Affairs. A crisis support officer is on call 24 hours a day.	3 Burkitt Street, Page ACT 2614 Ph: 6255 1599 Fax: 6255 1577 Email: vvfact.tpg.com.au
White Wreath Association Incorporated 'Action Against Suicide'	The White Wreath Association Inc is a national non-denominational, non-political and anti-discriminatory body supporting people who have been directly affected by suicide and those who are affected by mental illness/disorders. The aim of the organisation is to promote public awareness of the seriousness of mental illness, the risk of suicide and the need to support and educate families and carers.	PO Box 1078, Browns Plains QLD 4118 Ph: 07 3219 7279 Fax: 07 3219 8148 Web: www.whitewreath.com/ Email: whitewreath@bigpond.com

Appendix 6

Suicide Prevention and Mental Health Literacy Programs delivered in the ACT

NAME	DESCRIPTION	CONTACT
BluePages Depression information (developed by the Centre for Mental Health Research, ANU)	Depression information website for consumers. Randomised Control Trials (RCT) evidence that it improves knowledge of depression, decreases stigma and decreases depressive symptoms relative to control.	Ehub services project officer. Ph: 6125 0733 Ph: 6125 0733 Fax: 6125 0733 Web: www.bluepages.anu.edu.au
MoodGYM (developed by the Centre for Mental Health Research, ANU)	An automated cognitive behaviour therapy site developed by the Centre for Mental Health Research at the ANU. Evidence from RCT's that it decreases depressive symptoms. RCT evidence that it prevents depression in adolescent boys.	Ehub services project officer. Ph: 6125 0733 Ph: 6125 0733 Fax: 6125 0733 www.moodgym.anu.edu.au
e-couch (developed by the Centre for Mental Health Research, ANU)	Online automated program delivering mental health literacy and self help tools for depression, Generalised Anxiety Disorder, and Social Anxiety disorder.	Ehub services project officer. Ph: 6125 0733 Ph: 6125 0733 Fax: 6125 0733 www.ecouch.anu.edu.au
Carers ACT	Keeping Families Connected (KFC) A 5 week course run by Carers ACT for Carers of people with a mental illness and/or a substance dependence problem. KFC provides information and explores issues connected with: carer stress; mental illness (including common therapeutic approaches); listening skills; assertively working with mental health professionals; suicide prevention; drug and alcohol use; and community support services.	Churches Centre Level 1, suite 5, 54 Belconnen Way Belconnen ACT 2616 Ph: 6296 9900
OzHelp Foundation	Life Skills Toolbox 12 competencies based training modules delivered over a 48 hour timeframe, designed to develop resilience and well-being in apprentices entering the building and construction industry. Tradies Tune-Up A free health check service based on a pit stop model, for apprentices and workers. It provides seven brief screenings with each 'tune-up' taking approximately 15 minutes. Staying Connected A half day workplace program to help separated Dads take control of their lives and stay connected to their children. Depression in the Workplace A 1 hour to half day program aimed at increasing awareness and understanding about depression and its management in a workplace setting. Mental Health in the Workplace A 3 hour program to provide understanding of the most commonly occurring mental illnesses, and what can be done about these. ASIST A two day skills-based, suicide first aid workshop that equips people for an effective suicide intervention for someone at risk. The emphasis is on helping a person at risk stay safe and seek further help. SafeTALK A half day workshop for any member of the community to recognise people with thoughts of suicide and to connect them to suicide first aid resources.	OzHelp Foundation 40B Lathlain Street Belconnen ACT 2617 Ph: 6251 4166 Fax: 6251 4366 Web: www.ozhelp.org.au

Appendix 7

Abbreviations and Glossary

Definitions have been sourced from the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) Glossary. <http://auseinet.flinders.edu.au/> unless otherwise stated.

ABI	Acquired Brain Injury
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ACTCOSS	ACT Council of Social Service
AFP	Australian Federal Police
AIHW	Australian Institute of Health and Welfare
AMC	Alexander Maconochie Centre
AOD	Alcohol and Other Drug
ASIST	Applied Suicide Intervention Skills Training
Auseinet	Australian Network for Promotion, Prevention and Early Intervention for Mental Health
<i>Building a Strong Foundation</i>	<i>Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009-2014</i>
CALD	Culturally and Linguistically Diverse: Can refer to individual people, communities or populations who have a specific cultural or linguistic connection through birth, ancestry, or religion.
CAMHS	Child and Adolescent Mental Health Services
Capacity building	Involves enhancing the ability of individuals and groups to mobilise and develop resources, skills and commitments needed to accomplish shared goals. Capacity building for health promotion: the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organisations, and; the development of cohesiveness and partnerships for health in communities
Carer	A person who has a caring or supportive role in the life of a (mental health) consumer
CATT	Crisis Assessment and Treatment Team
COAG	Council of Australian Governments

Continuity of care:	When a person moves from one agency or treatment environment to another (say from a GP to a specialist mental health service, or from hospital to the community), ensuring that appropriate service is provided by the new agency, and that it happens on time ⁸⁸
Co-morbidity	The occurrence of more than one illnesses at the same time. Co-morbidity may refer to the co-occurrence of mental illnesses and the co-occurrence of mental illnesses and physical conditions. ⁵⁹ In this Strategy, the term co-morbidity generally refers to the occurrence of a mental illness and the problematic use of alcohol or other drugs
Connectedness	A person's sense of belonging with others. A sense of connectedness can be with family, school or community
Consumer	A person who has used (or is using) a mental health service
COPMI	Children of Parents with a Mental Illness
DET	Department of Education and Training
DHCS	Department of Disability, Housing and Community Services
DGP	Division of General Practice
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders Four
Early intervention	Intervention activities that focus on individuals and aim to prevent the progression to a diagnosable disorder for people experiencing signs or symptoms of mental health problems and to reduce the affects (shorten the duration and reduce the potential damage to the wellbeing of a person) of the illness on an individual experiencing an episode of mental illness
ED	Emergency Department
Evaluation	The process used to describe the process of measuring the value or worth of a program or service.
Evidence base	A summary of the research that informs current understanding of possible directions for promotion, prevention and early intervention initiatives
FR-ESH	First Responders – Effective Suicide Help
Gatekeeper	A person who holds an influential position in either an organisation or a community who coordinates or oversees the actions of others. This could be an informal local opinion leader or a specifically designated person, such as a primary-care provider, who coordinates patient care and provides referrals to specialists, hospitals, laboratories, and other medical services
GP	General Practitioner
HASI	Housing and Accommodation Support Initiative
Health outcome	A change in the health of an individual or population due wholly or partly to a preventive or clinical intervention.
Health promotion	The process of enabling people to increase control over, and to improve their health ⁸⁹
HYPP	Housing for Young People Program

Indicated intervention	aim to improve the mental health and wellbeing of individuals who are identified as having minimal but detectable signs of mental illness and may include programs for children showing signs of behavioural problems. ¹⁷
JaCS	Justice and Community Safety
MACH	Maternal and Child Health
<i>Managing the Risk of Suicide</i>	<i>Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014</i>
MHAGIC	Mental Health Assessment Generation and Information Collection
MHACT	Mental Health ACT
Mental health	A broad term that refers to how a person thinks, feels and acts in their day-to-day life. It is how people feel about themselves, their lives and the other people in their lives. It includes how a person handles stress, relates to other people, and makes decisions. It is increasingly being defined as a positive attribute, incorporating a state of emotional and social wellbeing that enables people to undertake productive activities, experience meaningful interpersonal relationships, adapt to change and cope with adversity (WHO, 1999). Mental health is not the absence of illness, but rather, the ability to cope and feel positive about people and events in life. The phrase mental health and wellbeing is used to refer to a positive state of mental health. ⁹
Mental health and wellbeing	Any action to maximise mental wellness in a population or for individuals through managing environmental conditions for those who are currently well, those at risk and those experiencing illness. Promotion is a process of enhancing the coping abilities of individuals, families and the wider community by providing power through knowledge, resources and skills ¹⁰
Mental health literacy	'The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking' ¹⁷
Mental health problems	A problem that interferes with a person's thoughts, feelings and social behaviour, but to a lesser extent than a mental illness. Mental health problems are more common and include the mental ill health that may be temporarily experienced as a reaction to the stresses of life. While mental health problems are less severe than mental illnesses, they still can have a significant impact on a person's future opportunities and sense of wellbeing, and may develop into a mental illness if not effectively treated. ⁹
Mental health promotion	any action to maximise mental wellness in a population or for individuals through managing environmental conditions for those who are currently well, those at risk and those experiencing illness. Promotion is a process of enhancing the coping abilities of individuals, families and the wider community by providing power through knowledge, resources and skills. ⁹⁰
Morbidity	The incidence rate of illness or disorder in a community or population.
MHFA	Mental Health First Aid

MHSP	ACT Mental Health Services Plan
MIEACT	Mental Illness Education ACT
MITT	Mobile Intensive Treatment Team
NGOs	Non-Government Organisations or Community Agencies
NSW	New South Wales
OCYFS	Office of Children, Youth and Family Support
OH&S	Occupational Health and Safety
Outcome	A measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions
OzHelp	Suicide prevention / life skills program for industry and community
PANDSI	Post and Antenatal Depression Support Incorporated
Perinatal	Relating to the periods shortly before and after the birth of a baby
Postvention	Interventions to support and assist the bereaved after a suicide has occurred.
PPEI	Promotion, Prevention and Early Intervention
Prevention	Interventions to reduce risk factors contributing to the development of a mental illness and enhance protective factors that promote mental health and wellbeing. ⁹ Prevention interventions may be classified according to their target group, as: Universal: provided to whole populations; Selective: targeting those population groups at increased risk of developing a disorder; and Indicated: targeting people showing minimal signs and symptoms of a disorder.
Primary care	In the health sector generally, 'primary care' services are provided in the community by generalist providers who are not specialists in a particular area of health intervention
Protective factors	Factors that give people resilience in the face of adversity and moderate the impact of stress and transient symptoms on the person's social and emotional wellbeing. Protective factors reduce the likelihood that a disorder will develop
PSU	Psychiatric Services Unit
Psychosocial rehabilitation	See: Rehabilitation (psychosocial)
PTSD	Post Traumatic Stress Disorder: A psychological disorder affecting individuals who have experienced or witnessed profoundly traumatic events, characterized by recurrent flashbacks of the traumatic event, nightmares, irritability, anxiety, fatigue, forgetfulness, and social withdrawal.
Public health	The science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society. Public health (has a) comprehensive understanding of the ways in which lifestyles and living conditions determine health status.
RCT	Randomised Control Trial

Recovery	Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential ⁹¹
Refugee	A person who is outside his or her country of nationality or habitual residence; has a well founded fear of persecution because of his or her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution (Article 1). ⁹²
Rehabilitation (psychosocial)	The process of facilitating an individual's restoration to an optimal level of independent functioning in the community.
Relapse prevention	A specific component of the recovery process. It entails maximising wellness for people with mental illness by reducing the likelihood and impact of relapse. It involves empowering people with mental illness to recognise early warning signs of relapse and develop appropriate response plans. It requires identifying risk and protective factors for mental health, and implementing interventions that enhance protective factors and eliminate or reduce the impact of risk factors.
Resilience	Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking, and help-seeking.
Risk factors	Factors that increase the likelihood that a disorder will develop, and exacerbate the burden of existing disorder. Risk factors indicate a person's vulnerability, and may include genetic, biological, behavioural, socio-cultural and demographic conditions and characteristics. Most risk (and protective factors) for mental health lie outside the domain of mental health and health services-they derive from conditions in the everyday lives of individuals and communities. Risk and protective factors occur through income and social status, physical environments, education and educational settings, working conditions, social environments, families, biology and genetics, personal health practices and coping skills, sport and recreation, the availability of opportunities, as well as through access to health services.
Risk-taking behaviours	Risk taking behaviours are behaviours in which there is some risk of immediate or later self-harm. Risk-taking behaviours might include activities such as dangerous driving, train surfing, and self-harming substance use.
Self-harm	Any behaviours causing destruction or alteration of body tissues, with or without the intent to die. It includes self-injury, attempted suicide and other forms of intentional injury to self.
SPWG	ACT Suicide Prevention Working Group
SPIEG	Suicide Prevention Implementation Working Group
Social determinants of health	The range of personal, social, economic and environmental factors which determine the health status of individuals or populations

Social support	Assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life. Social support may include emotional support, information sharing and the provision of material resources and services. Social support is now widely recognised as an important determinant of health, and an essential element of social capital.
SPIEG	Suicide Prevention Implementation and Evaluation Working Group
Stakeholders	Stakeholders include all individuals and groups who are affected by, or can affect, a given operation. Stakeholders can be individuals, interest groups or organisations.
STS	Secondary Traumatic Stress
Suicide	A death is classified as a 'suicide' by a coroner based on evidence that a person died as a result of a deliberate act to cause his or her own death. If there is contrary evidence, a coroner may classify the death as having been caused by someone else, or as accidental. If there is insufficient evidence, the coroner may not be able to reach a decision on the cause of death. ⁹³
Suicidal Ideation	Thoughts or behaviours that focus on suicide.
Suicide attempt	A deliberate or ambivalent act of self-destruction or other life-threatening behaviour, that does not result in death.
Suicide prevention	Concerned with preventing suicide by reducing the risk factors associated with suicide and increasing the protective factors, such as promoting mental health and resilience within the community.
Suicide-related behaviours	Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death, and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicide-related behaviours.
Transcultural mental health	Extends the definition of mental health to look at the interactions of individuals and groups within a culturally diverse environment, to identify specific risk and protective factors for those individuals and groups who may be marginalised within the dominant culture, and to address societal and structural issues within the environment in order to promote their mental health and wellbeing.
TCH	The Canberra Hospital
Vocational rehabilitation	Services with a primary focus on interventions to assist people who have experienced, or continue to experience, a mental illness to enter or re-enter the workforce.
WHO	World Health Organization: The United Nations specialised agency for health.

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