

Acknowledgments

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In recognition of the significantly high rates of suicide among Indigenous people, the strategy specifically identifies a way forward for impacting on the complex issues associated with suicide in Indigenous communities. Thanks and appreciation is given to staff of the Department of Aboriginal and Torres Strait Islander Policy Development, the Aboriginal and Torres Strait Islander Health Unit and other Indigenous community leaders and groups in Queensland for their invaluable contribution to these strategic directions.

The efforts of all involved have enriched the Queensland Government's direction for suicide prevention in many important ways. It is hoped that the partnerships forged will continue to work collaboratively and impact positively on reducing suicide in Queensland.

Foreword

Message from the Premier

The prevention of suicide is of the highest priority for the Queensland Government.

We are determined to reduce the unacceptably high rates of suicide in this State.

While our youth suicide rates show some signs of falling, the suicide rate for Indigenous Queenslanders is around double that of the wider population and rates for other at-risk groups have increased in recent years.

The Queensland Government has endorsed this five-year Strategy which builds on the achievements of the Youth Suicide Prevention Strategy and broadens the focus. It recognises the multitude of factors that make people of all ages vulnerable to suicide. The Strategy will direct this knowledge into effective prevention measures.

It provides a whole of Government approach and recognises that suicide is the responsibility of the entire community.

My fervent hope is that our combined efforts and community partnerships will have a positive and meaningful impact on reducing suicide in this State.

Peter Beattie MP

Premier and Minister for Trade

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Executive Summary

Any discussion about suicide must include the impact on individuals, their families and the broader community. Quantitative data cannot encapsulate the huge unquantifiable personal and community cost associated with an act of suicide or suicide attempt. Effective preventive action needs to be based on current evidence and quality information, and, importantly, an understanding of the broad context for acts of suicide and suicidal behaviour in Queensland. Such an understanding of these issues deepens our appreciation of the urgent need to take action.

Reducing Suicide: *The Queensland Government Suicide Prevention Strategy 2003–2008* has been developed as a whole-of-population collaborative effort by key Government Departments, recognising that suicide is an issue that is the responsibility of the whole community. The development of appropriate strategies requires coordinated and collaborative actions across Government and across sectors, to lower the morbidity and mortality associated with suicide and suicidal behaviour.

Whilst the rates of suicide and attempted suicide in Australia are of some concern, Queensland has a significantly higher rate than nationally. The highest rates are evident in young people, particularly young men; Indigenous populations; older people, particularly older males and older people from culturally and linguistically diverse populations; people with a mental illness; people in custody, including those in the youth justice system and same sex attracted people. In addition, it is recognised that there are specific issues in relation to an individual's ease of access to the service system that affect outcomes. These priority populations form the focus of this Strategy. It should also be acknowledged that behaviours are influenced by the broader determinants of health that influence social and emotional well-being. Population-based interventions using universal prevention strategies have also been identified in the Strategy, acknowledging their longer-term impact.

This document describes the strategic intent of the Strategy, drawing from input provided across Government and externally and taking into account contemporary evidence from Australia and internationally. Separate documents outline responses to the key strategies by individual Departments in the form of Action Plans.

The goal of this Strategy is to provide a framework for action in order to reduce rates of suicide and attempted suicide in Queensland. The Strategy comprises four sections.

Section One:

An Overview including the rationale and policy context

Section Two:

The Issues describes the context for the Plan and its implementation based on the current evidence

Section Three:

The Way Forward describes key principles and outcomes to drive the way forward

Section Four:

Suicide and suicide prevention in Aboriginal and Torres Strait Islander communities describes the unique issues relating to Indigenous suicide and an appropriate framework to respond to these issues.

It is also recognised that there is a critical role in the Strategy for ongoing and robust evaluation and monitoring of program development initiatives to ensure progress towards achieving the goal of the Strategy. To influence health outcomes in this area effectively, partnership development needs to progress within a practical framework across Government and across sectors, to minimise barriers and promote a whole-of-community and whole-of-life approach to suicide to achieve a sustainable change in health outcomes in Queensland.

Section 1: An Overview

Introduction

Suicide in Australia has been of considerable public concern for some time, particularly in Queensland, which, over the past 15 years, has experienced higher rates of suicide than the national average (De Leo & Evans, 2002). Consequently, suicide is recognised in Queensland as a significant public health issue that needs to be addressed as a priority. From a quantitative perspective, the significance of suicide is measured by rates of suicide and suicidal behaviour. However, the human impact of suicide is far-reaching and not easily quantifiable, extending beyond the individual to family, friends and the broader community.

The Queensland Government is committed to a sustained reduction in the rates of suicide and attempted suicide across the State, while still recognising that suicide prevention is a whole-of-community issue. A significant reduction in the rates of suicide and attempted suicide will occur only with a comprehensive and collaborative approach across Government in Queensland, incorporating strategies to meet identified needs across the lifespan. Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008 is underpinned by the current evidence and the latest national and international research.

Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008 comprises two parts:

- Part One** Strategic intent of a focused and collaborative Government approach to suicide prevention;
- Part Two** Department Action Plans detailing strategies, activities and milestones to be achieved across key Government Departments.

This document, **Part One**, is divided into four sections:

- Section One:** An Overview includes the rationale and policy context.
- Section Two:** The Issues describes the context for the Plan and its implementation based on current evidence.
- Section Three:** The Way Forward describes key principles and outcomes to drive the way forward.
- Section Four:** Suicide and suicide prevention in Aboriginal and Torres Strait Islander communities describes the unique issues relating to Indigenous suicide and an appropriate framework to respond to these issues.

Part Two is Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008 Action Plan 2003. This document represents the Action Plans developed by the relevant Government agencies to implement the strategies outlined in *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008*. The Action Plans enable comprehensive coverage of strategies within each of *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008* outcome areas, enhancement of cross agency partnerships in suicide prevention activities and the coordination and enhancement of evaluation mechanisms.

Outcomes of the Queensland Government Suicide Prevention Action Plan will form the basis for an annual report to Cabinet on actions implemented under Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008. This will include impact or outcomes of the action, proposed future action, emerging issues in suicide prevention and possible policy responses and the extent of delivery against the Strategy.

Development of the Strategy

Coordinated by Queensland Health, *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008* has been developed with input from a project team. This included representation from:

- Department of Aboriginal and Torres Strait Islander Policy
- Department of Employment and Training
- Department of the Premier and Cabinet
- Education Queensland.

Input was also sought from the Department of Corrective Services, Department of Families, Queensland Police, Primary Industries and Department of Emergency Services as well as peak non-Government organisations focusing on suicide prevention. Key discussion papers were disseminated to inform the consultation process with key stakeholder Departments and the broader community Statewide. The Strategy has been based on an analysis of the recent trends in the incidence of suicide and suicidal behaviour, the 6 Way Consultation with Young people carried out by the Office of Youth Affairs, along with Australian and international developments in research and prevention programs.

The strategic direction identified in the Strategy is consistent with the Commonwealth Strategy, *Living is for Everyone: A framework for prevention of suicide and self-harm in Australia* (Commonwealth, 2000), and articulates complementary strategies. The Strategy should therefore be read in conjunction with this national document, which provides a

comprehensive strategic overview of suicide in Australia.

The Strategy will assist Government and the community to work effectively towards suicide prevention in Queensland across the lifespan through:

- Providing a better understanding of suicide and suicidal behaviour
- Identifying priorities for program development
- Implementing these priorities in responsive programs which achieve clear outcomes, and
- Building frameworks for robust evaluation and monitoring.

Suicide in Queensland, 1996-1998 (De Leo & Evans, 2002), based on the most recent Queensland suicide data, provides an analysis of data from the Queensland Suicide Register and should be read in conjunction with this Plan.

Purpose

The goal of this Strategy is to reduce rates of suicide and attempted suicide in the Queensland population. The Strategy is consistent with the Queensland Government’s goal of “*Safer and More Supportive Communities*”, and its mission to achieve a better quality of life and safer and more supportive communities for all Queenslanders. “*Smart State Health 2020: Strategic Directions Statement*” (Queensland Government, 2002a) outlines the Queensland Government’s vision for the health system into the future. Suicide is established as a key health improvement issue. Furthermore, Health 2020 emphasises a whole of Government approach for health; a strong focus upon prevention, health promotion and early detection; health service delivery systems that are integrated, responsive and comprehensive; and continued development of a research culture and capability. *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008* reflects and supports these strategic objectives.

A set of targets has been identified below that will lead to changes in key indicators contributing to suicide incidence. These targets will need to be accompanied by appropriate strategies and linked to actions outlined in Section Three to ensure progress towards their achievement.

Targets

Queensland has consistently higher rates of suicide than the national average and rates for Indigenous peoples are consistently higher than those for the non-Indigenous population. The targets set out below are therefore designed, as a minimum, to bring the rate of suicide in Queensland to equal or lower than the national average, and in regard to Indigenous rates, to remove the suicide rate inequalities between Indigenous and non-Indigenous populations. Thus the targets are:

1. Sustained reduction in the rate of suicide in Queensland by 2008, particularly in known priority populations.
2. Sustained reduction in the rate of suicide attempts in Queensland by 2008, particularly in known priority populations.
3. Improve professional and community knowledge and awareness of risk factors and system responses to suicide prevention and management.
4. Improve links between research and knowledge management to inform policy and program development.

To reduce the rate of suicide for Indigenous peoples to a level that is commensurate with the rate of the general population in Queensland, Government reform around priority setting, service provision and resource allocation that reflects the specific needs of Indigenous communities must occur. It is also important to recognise that this target cannot be considered in isolation. For reductions to occur in the rates of suicide and suicide attempts in Indigenous peoples there needs to be improvements in the underlying social determinants of well-being. Section Four of this Strategy provides direction for Government Departments in developing a coordinated and integrated approach to

reduce the rate of suicide within the Indigenous population.

The approach

Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008 has been developed as a joint effort between key Government agencies, and this developmental phase has resulted in enhanced partnerships between these agencies. It is recognised that this is an initial step and further partnerships need to be developed and maintained across Government and across sectors into the community, to effectively impact on suicide rates in Queensland. Improved partnerships will result in an integrated approach to the development of Government policy and services, through to program development and implementation at the local level. Furthermore, a collaborative and whole of Government approach recognises that suicide is the responsibility of the whole community. Achieving reductions in the morbidity and mortality associated with suicide and suicidal behaviour is outside the capacity of any one Department or sector. Strong Government leadership combined with unequivocal commitment to shared Departments responsibility and action is therefore essential.

Taking a whole-of-life approach, this Strategy recognises that there are different rates of suicide and attempted suicide across age groups, and some specific populations are at higher risk than the general population, as outlined in Section Two. For high-risk priority populations, strategies must be developed and integrated across the spectrum of interventions, to ensure relevance to the specific population and effective impact leading to change. Furthermore Strategy development will take account of specific contextual priorities as well as settings identified as of either high need or efficacious in terms of achieving desired outcomes. For example, rural and regional areas have recorded higher suicide rates for certain age groups and genders (De Leo & Evans, 2002), and information of this nature will inform targeting of programs.

Whilst identified priority populations form the primary focus of this five-year Strategy for targeted interventions, outcomes focused on more general social determinants of health and well-being and universal preventive strategies have also been identified. It is accepted that changes to health status due to changes in social determinants of health and well-being, and some universal prevention measures, will take place beyond the five-year life of this Strategy. However, actions targeting these areas should continue to be undertaken across the Government and non-Government sector.

Rationale

Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008 builds on the work commenced as part of the Queensland Government Youth Suicide Prevention Strategy and related suicide prevention initiatives. The cornerstone of the QGYSPS has been the establishment of local community networks to strengthen the capacity of young people, their families and communities to take action at the local level. This Plan builds on the work and experience of local communities and the networks established under the QGYSPS. In the evaluation of the QGYSPS (Moller & Elkington, 1999), it was recommended that a five-year Strategic Plan be developed to ensure progress on a number of recommendations. These recommendations are outlined in Appendix 1.

The Strategy outlines the Queensland Government agenda to reduce suicide mortality and morbidity, particularly in priority populations, and identifies the need to develop and implement strategies for universal prevention and strategies to target the social determinants of health. This Strategy builds on the significant work already undertaken in this area to date. However, suicide prevention policy and program development cannot be seen in isolation. The Strategy links with a number of other relevant existing policy and program initiatives that promote well-being and respond to people who are at risk of suicide and suicidal behaviour.

Section 2: The Issues

The context

Whilst values and attitudes to suicide and our understanding of it has changed over time, the pathways to suicide are not well understood. We know that suicide has been consistently part of human history and as a behaviour is heavily influenced by societal beliefs. Contemporary research indicates that there are a number of factors putting people at greater risk of suicide and suicidal behaviour which may be countered by the development of protective factors described later in this Plan. An understanding of the interaction between risk and protective factors offers some explanation for the fact that suicide is not necessarily driven solely by exposure to risk, as people with the same level of risk will respond differently.

The complex interplay of a variety of risk factors including cultural, genetic, environmental and biological factors, as well as family characteristics, personality, beliefs, childhood experiences and determinants of health is further described by Beautrais (1998) in Appendix Three (Commonwealth, 2000). One way of understanding this interaction has been described by Bonner and Rich (1987). They describe the intersection of these risk factors with possible pathways to suicide to further our understanding of the interplay of these factors on an individual with key predisposing factors (Appendix 3).

Data

Issues

In interpreting statistics for suicide, it should be noted there is possible under-reporting due to misclassification of deaths, as some deaths which have occurred due to suicide may be reported as accidental or the cause not determined. De Leo & Evans (2002) discuss the classification of suicide in further detail and describe the basis of the suicide determination. In reviewing the suicide data it is also important to consider data focusing on risk indicators for people who self-harm or attempt suicide.

Reliable and accessible information on suicide is essential for planning of appropriate suicide prevention approaches. Data collection for fatal and non-fatal suicidal behaviour needs to be improved to ensure its validity and currency. Hospitals and other sociomedical services need to collect and maintain such data utilising uniform criteria and definitions. This will permit long-term monitoring and a subsequent better understanding of risk factors and pathways to suicide. Data sets of major social indicators should also be available in parallel to suicide data, to enable the design of multidisciplinary research to verify the impact of any intervention made. De Leo, 2002. The National Coroners Information System (NCIS), an initiative of the Australian Coroners' Society, is an important addition to existing data sources on suicide deaths, providing more timely, accurate and comprehensive data. Queensland will work with the NCIS in regard to continued development of data monitoring systems consistent with national frameworks.

In regard to suicide in Indigenous communities, it is important to note that suicide deaths are not distributed evenly. Across Indigenous communities rates are much higher in some areas with suicide rates among Aboriginal males in remote communities over six times higher than that of Queensland's population overall (Queensland Government, 2002b). In Cape York, suicides account for about 20% of hospital separations for mental illness and suicide, compared with about 5% in Queensland (Queensland Government, 2001a). Besides the Cape, metropolitan Brisbane has the highest recorded rates of suicide (De Leo & Evans, 2002).

As indicated above, accurate and meaningful data is essential to determine the success of this Strategy, and therefore the particular issues relating to identification of Indigenous status continue to impact on the quality of data collected. For instance, data collections on suicide do not distinguish between Aboriginal and Torres Strait Islander status and therefore most statistics are prepared and presented for Aboriginal and Torres Strait Islander peoples as a single entity. Therefore, in implementing this Strategy, effort must focus on developing and maintaining consistency across agencies in regard to collection of Indigenous identifiers.

Whilst statistics provide important quantitative information about suicide and suicidal behaviour, they do not convey the human dimension of profound loss experienced by family and friends or the broader social, economic or health costs.

Suicidal behaviour and self-harm

Limited consensus exists regarding definitions for suicidal behaviour with vigorous debate notable within the literature over appropriate terminology for behaviour within the self-harm spectrum. For the purposes of this document suicidal behaviour includes thinking about suicide (suicidal ideation), suicidal threats or suicidal acts. A suicidal act involves self-inflicted injury that is accompanied by the intention of the individual to die from the result of the action taken. Attempted suicide

entails a suicidal act causing injury but not leading to death. It is acknowledged that "attempted suicide" is problematic as a term, as it infers the self-harming behaviour was intended to cause death – yet it is known that intent is more complex and variable than this term implies (Beautrais, 1998). Even the most skilled clinician can find it difficult to differentiate between benign and ominous suicidal behaviour (Shaffer et al. 2001).

Self-harm is defined as any form of self-harmful behaviour or action causing injury or damage which may or may not be accompanied by clear suicide intent. Self-harm includes the various methods and degrees by which people may harm themselves, including self-laceration, self-battering, taking overdoses or deliberate recklessness, and is a serious health problem in itself (Commonwealth, 2000). The intent of self-harm is not in every instance to kill oneself but can be a response to emotional pain and distress, and, for some, is a means of coping with life. Due to the complex psychodynamics of self-harm and the associated data limitations, self-harm per se is not included as a particular focus of this Strategy.

Any analysis of the data to identify the prevalence of suicidal behaviour is confounded by issues of data collection and reporting, resulting in gaps in knowledge about self-harm behaviour. Studies often rely on self-reported data or the use of hospital statistics for admissions due to self-harm. These sources may result in an under-representation of the data as not all people who have been injured as a result of a suicide attempt will present at a hospital setting or be identified in the hospital setting. In addition, although acts of self-injury are not always accompanied by suicidal intent, they may have been identified as such in the hospital setting. Consequently, there are significant gaps in knowledge of self-harm prevalence and behaviour. However, emerging evidence indicates that people who are unemployed, those who are gay, lesbian or bisexual and young women are at substantially increased risk of self-harm behaviour (Commonwealth, 1999).

Unlike suicide, suicidal behaviour and attempted suicide are more prevalent for females than males, with the pattern of occurrence differing across the lifespan compared with suicide. Hospitalisations in 1996/97 due to suicidal behaviours peak in the 15 to 19 year age group for women and the 30 to 34 year age group for men, and drop until rates appear similar in men and women from the 65 to 69 year age group onwards (Commonwealth, 2000). The rates of hospital admission for attempted suicide remain higher for females than males until the 65 to 69 age group (Commonwealth, 2000).

Raphael et al. (2000) conducted a study of pathways of care for young people who presented for non-fatal deliberate self-harm. The study reported:

- 61% experiencing prior suicidal ideation
- Conflict with their partner as the most common precipitating event
- Approximately 90% of the young people did not seek help before self-harming
- One in four reported a family history of psychological/psychiatric illness
- Over half had a personal history of psychological/psychiatric illness.

Although suicidal behaviours including ideation are acknowledged as being strong risk factors at all ages, it has been shown that older people who die by suicide are less likely to have a history of suicidal behaviours and thoughts than younger people (Commonwealth, 2000). Acts of suicide in older people include less impulsive actions, use of more lethal and violent methods and less opportunity for rescue compared to younger age groups. This highlights the importance of age, appropriate strategies (De Leo et al. 1999). Given that at any age suicidal thinking indicates a high risk for suicide it is an important issue in regard to prevention and early intervention strategies.

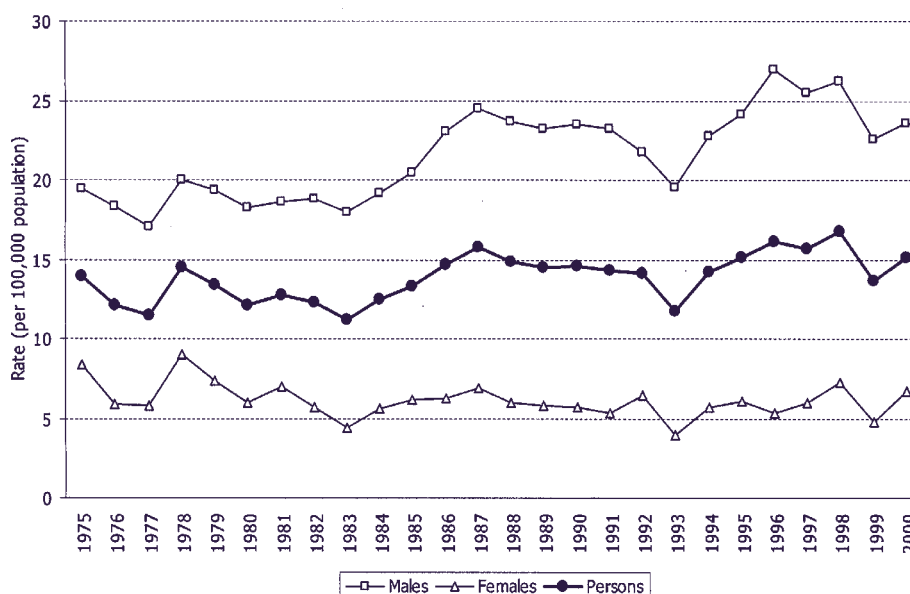
Suicide

Australia's overall rate of suicide has remained relatively stable at 10 to 14 suicides per 100,000 people since the 1920s (ABS, 2000),

with rates for men being consistently higher than women since data collection commenced in Australia (Commonwealth, 2000). A recently published report (De Leo & Evans, 2002) provides a comprehensive overview of Queensland data:

- The rate of suicide from 1996 to 1998 is 16.6 per 100,000 compared with the national average of 13.1 per 100,000 from 1985 to 1999;
- Suicide from 1975 to 1999 has increased, due to an increase in suicide in younger men;
- In Queensland, men are four times more likely to suicide than women;
- 45% of all suicides were of people under 35 years of age;
- The highest rate of suicide for males was in the 25 to 34 year age group, compared with females where the highest rate was in the 34 to 44 year age group;
- Indigenous peoples suicide at twice the rate of the Queensland population.

In Queensland, between 1975 and 2000, increases and decreases in the suicide rates for males and females have occurred almost simultaneously, as portrayed in the below graph. The data shows that the male suicide rate has increased by approximately five deaths per 100,000 (to approximately 25 per 100,000) over the period while female rates have remained stable at around 6 per 100,000.



Suicide rates by gender, Queensland, 1975-2000.
 Source: Australian Bureau of Statistics (by request)

Significant concern regarding rural suicide rates has occurred in the context of reports of consistently higher rates in small rural towns compared to metropolitan and regional areas (Dudley et al 1998). However, other studies have indicated no significant difference between rural and metropolitan suicide rates for Australian-born males (Morrell et al. 1999) or portrayed a highly variable picture of suicide rates between different rural communities and regions (Cantor et al. 1998).

In analysing urban and rural differences for Queensland suicide data, De Leo & Evans (2002) use the Accessibility and Remoteness Index of Australia (ARIA). This Index assigns one of five categories (Highly Accessible, Accessible, Moderately Accessible, Remote and Very Remote), which represents that location accessibility and remoteness from services. For the purpose of De Leo & Evan analysis, urban locations are those with an ARIA category of Highly Accessible and rural area are those with an ARIA category other than Highly Accessible. For example, urban areas included most inner and outer suburbs of Brisbane, and suburban areas of Toowoomba, Gladstone, Rockhampton, Townsville, the Sunshine Coast, and the Gold Coast. Rural areas included the remaining areas of Queensland.

The recent Queensland suicide data analysed by De Leo & Evans (2002) does not demonstrate any significant differences between rates of suicide in urban and rural areas for either gender or for persons. However, analysis of age groups reveals young males (15–24 years) and older males (75 years plus) in rural areas had significantly elevated suicide rates compared to their urban counterparts. Conversely rates of suicide among middle-aged people in rural areas (45-54 years) were comparable or slightly lower than middle-aged people in urban areas. De Leo & Evans (2002) posit that middle-aged people may be less affected by isolation and paucity of services in rural areas due to greater mobility. Methods used differed according to rural and urban areas in the De Leo & Evans analysis of Queensland suicide data (2002).

An alternative method is considering the State data according to actual geographical region. Analysis of Queensland suicide data on this basis demonstrated that different regions had differing profiles of suicide rates (De Leo & Evans, 2002). Queensland suicide data was divided into seven regions – North and Far North, Mackay–Fitzroy, Western, Darling Downs and Wide Bay, Coastal, Brisbane City, and Outer Brisbane. Considerable heterogeneity in the relative risk across regions was

highlighted in the De Leo & Evans report, with relative risk in most regions being dependent on age and gender. The development and targeting of suicide prevention programs and activities under this Strategy will therefore take account of important contextual factors such as rural, urban and regional differences and needs. Rather than a blanket approach to suicide prevention across the State, careful consideration will be given to individual regional profiles and rural and urban differences. This permits a targeted and locally responsive approach to be taken.

Population Priority Groups

Overview

A number of groups have been identified as having elevated rates of suicide from the data and from Statewide consultations in the development of this Strategy. These groups are a priority for selective interventions under the key outcomes outlined in Section Three: The Way Forward. Further discussion of the unique issues contributing to Aboriginal and Torres Strait Islander people's rates of suicide is contained in Section Four.

Young people

Despite recent decreases in the incidence of youth suicide in Queensland, young people in Queensland have the highest rates of youth suicide in Australia (ABS, 2001). Males from 15 to 44 years of age have a significantly higher suicide rate than the overall male rate (De Leo & Evans, 2002). De Leo & Evans (2002) suggest that recent suicide data draw attention to the suicide mortality rates for males and females in the younger age groups (15–24 & 25–34 years) as of particular concern. Young males living in rural areas within Queensland was associated with a significantly elevated rate of suicide compared to their urban male counterparts (De Leo & Evans, 2002). The higher rate of suicidal behaviour for young females has been described earlier in this document.

In a Victorian study of those who died by suicide, 43% of males aged 15 to 19, and 27% of males aged 20 to 24 had contact with the police in relation to theft and property crimes (Tiller et al. 1997). This suggests young people who offend or are in custody may be a particular group at risk.

There is overwhelming evidence to suggest that mental illness (particularly affective disorders and substance abuse disorders) plays a major role in youth suicidal behaviour (Beautrais, 1998). Marttunen et al. (1993) found that rates of mental illness among young people who died by suicide were uniformly high, ranging from 67 to 95%.

Help seeking and service utilisation trends among young people also reflect gender differences significant to suicide prevention programming. Whilst a comprehensive Queensland study has confirmed previous findings that the vast majority of young people are most likely to approach family and friends for help when feeling unhappy or distressed, almost a third of males reported that they do not seek help (Donald et al. 2000). Furthermore males were twice as likely as females to indicate they would never use a formal service when feeling unhappy or distressed. The importance of a focus upon access to services and ensuring appropriate and responsive care is available is highlighted by Donald et al's findings. The study showed that 71% of the young people surveyed who had attempted suicide did not receive medical assistance following a recent suicide attempt and 67% did not access a mental health professional following the attempt (2000).

Indigenous¹ people

It is believed that Aboriginal and Torres Strait Islander peoples as two distinct population groups experience very different realities in relation to suicide and self-harm (Commonwealth, 2000); Tatz, 1999. However, due to a lack of systematic coding for Indigenous status in regard to suicide data

¹ This Plan uses the term, *Indigenous and Aboriginal*. The term *Indigenous* is inclusive and is used to encompass *Aboriginal and Torres Strait Islanders*.

collection, difficulties exist in calculating accurate rates for Aboriginal and Torres Strait Islander peoples as distinct groups as well as a single category. Despite these gaps the available evidence clearly indicates that suicide has become a social issue of increasing importance and magnitude for Aboriginal communities. However, it can also be recognised that Aboriginal and Torres Strait Islander communities have shown enormous resilience and strength during a long period of sustained change and upheaval. The cultural diversity and integrity that exists within Aboriginal and Torres Strait Islander communities should be acknowledged and utilised in the development of local solutions for local problems.

Suicide in Indigenous communities needs to be examined in the context of the historical impacts of colonisation, racism and discrimination experienced by Aboriginal and Torres Strait Islander peoples. The effects of these experiences are manifested in intergenerational stress and anxiety and, in some cases, suicidal and violent behaviour. Furthermore Aboriginal and Torres Strait Islander peoples hold a holistic view of health encompassing physical, emotional, spiritual and mental health and the importance of connections to family, community and land (Commonwealth, 2000). Therefore, in developing suicide prevention strategies and actions, consideration of these issues and cultural needs must be taken into account. De Leo & Evans (2002) in their analysis of Queensland data indicate that:

- Indigenous peoples suicide at twice the rate of the total Queensland population;
- Young Indigenous males in the 15–24 year age group are four times more likely to suicide than other young people in Queensland, and in the 25–34 year age group the rate is three times greater than the State average;
- These younger age groups, 15–24 and 25–34 years, record the highest rates of Indigenous suicide;
- The average age at which Indigenous peoples suicide is 26 years, significantly

younger than the State average of 40 years;

- The rate of suicide amongst Aboriginal and Torres Strait Islander females is consistent with the State average in Queensland, although suicide for Indigenous women is concentrated in the younger age groups.

The Strategy aims to reduce rates of Indigenous suicide and attempted suicide across the State. This supports the recognition that suicide occurs in all geographical situations, as well as in discrete Aboriginal and Torres Strait Islander communities. However, through implementation of the Plan and other research activity, an assessment will be undertaken to determine the priority regions and sites for efforts in responding to Indigenous suicide in Queensland. In making this assessment consideration will be made of existing programs and initiatives by Governments and communities and the major areas of concern that can be addressed with the available resources. The strategic implications and actions stemming from these issues are further elaborated in Section Four of this document.

Older people

With the Australian population ageing, a greater number of older Australians will find themselves physically and economically dependent on others, and affected by mental and physical ill health for the first time. Depression is strongly linked to suicidal thoughts and acts amongst this population group, particularly older men. Available data indicates that suicide rates decrease with age. However, according to Goldney & Harrison (1998), rates peak again for older people aged 75 years and over, especially for older men. In an analysis of recent suicide data, De Leo & Evans (2002) confirmed this older age group as of specific concern, reporting males aged 75 years and over as having unstable but particularly high suicide rates. Furthermore, elderly males living in rural areas had significantly elevated rates compared to their urban counterparts (De Leo & Evans, 2002).

People from culturally and linguistically diverse backgrounds

Studies of the rates of suicide in culturally and linguistically diverse (CALD) communities have found those males born outside Australia have lower rates of suicide than the Australian born population. However, for females, the reverse pattern is evident (Morrell et al. 1999). CALD populations have similar suicide rates to their country of origin, but by the second generation the rates are consistent with those of the general population in Australia. Dudley, 1997. There are significantly higher suicide rates for CALD populations (both men and women) over the age of 65 with rates for CALD males and females being 65% and 177% higher respectively than the general population. (McDonald & Steel, 1997).

Feedback from Statewide consultations for this Strategy indicates that self-harming behaviour is a major issue in some migrant refugee communities, particularly refugees on Temporary Protection Visas.

People in custody

In analysing suicides in custody, De Leo & Evans (2002) suggest the accuracy of the data may be affected by other variables including the length of time spent in custody, the small number of deaths occurring and the duration of imprisonment. They report that in Queensland:

- Suicide rates for people in custody are 10 times higher than the general population
- Indigenous rates are twice that of non-Indigenous peoples in custody
- The average age of suicide in custody is 28 years of age
- The rate of suicide for Indigenous peoples in custody is 20 times the general population.

The experience of confinement in correctional facilities involves profound changes to a prisoner's life with major implications for the psychological well-being and adjustment of inmates. The physical context and structure of prison, the interpersonal and cultural context

and isolation from existing networks interact in varying ways with individual prisoners' personality and coping style. Furthermore prisons are often scenes of brutality, violence and stress. Other stressors that exist for prisoners relate to the nature of the offence committed (given the social hierarchy is largely determined by the type of crime committed), as well as factors such as mental disorder, pressures from the outside environment and feelings of guilt over the offence.

Furthermore, formulating action in regard to Indigenous suicide in custody requires particular consideration be given to the historical, economic and social context of Aboriginal and Torres Strait Islander peoples so that culturally appropriate strategies are developed and sensitively implemented. The findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991) made 339 recommendations, of which 163 are applicable to corrective service organisations. The RCIADIC recommendations provide a framework for Indigenous suicide prevention action for custodial settings specifically, as well as informing Government activities aimed at improving Indigenous well-being across all sections of the community.

People with a mental illness

Mental health problems, particularly depression, are major contributing factors to suicidal behaviour in people of all ages (Beautrais, 1998). A recent report produced by the research group Access Economics highlights the significant suicide risk for people living with schizophrenia with the highest risk usually within a year or two of symptoms starting (Access Economics, 2002). The World Health Organisation calculates the lifetime risk of suicide globally for people with schizophrenia as 10–13%, which is 12 times the population risk (Barbato, 1997).

People who are not receiving treatment or whose current treatment needs to be enhanced have high rates of suicide (Chippis et al. 1995). This may include people who present at accident and emergency department in general hospitals, general

practitioners or other counselling and support services. In 25% of suicides, people had contact with a mental health service in the previous 12 months (Appleby et al. 1999), with 39% of males and 76% of females having contact with services within the last month of life (Vassilas and Morgan, 1997). Inpatient suicides in psychiatric facilities have been identified as 25% higher than suicides reported in custodial settings (De Leo & Evans, 2002). Suicide of inpatients occurs most commonly in the week following discharge (Appleby et al. 1999).

People who are gay, lesbian or bisexual

Recent studies have demonstrated that gay, lesbian and bisexual people-particularly adolescents and young adults-are at substantially increased risk of suicidal behaviour and suicidal thinking. A recent Australian study by Nicholas and Howard (1998) found that gay identified young men (aged 18-24 years) were 3.7 times more likely to attempt suicide. Most of these attempts occurred after the person had self-identified as gay, but before having a same-sex experience and before publicly identifying themselves as gay. Statewide consultations undertaken as part of the development of this Strategy also identified self-harming as a major issue for this group.

Spectrum of Interventions

Overview

Mrazek and Haggerty's (1994) framework offers a model to consider the broad spectrum of mental health interventions from prevention through to treatment, rehabilitation and longer-term care. Whilst these areas are referred to as separate concepts, they should not be seen as discrete, as there is overlap between each area of intervention. However, this framework offers an opportunity for the analysis of the different components of the spectrum, developing a broader understanding of the range of interventions for suicide prevention, at an individual and population level (Figure 1). Each of these areas is described in further detail below. This model, which underpins the National Suicide

Prevention Strategy, *Living is for Everyone* (Commonwealth, 2000), can be used as a tool to assist agencies, service providers and communities to identify and plan the scope of their interventions. The types of intervention employed will depend on contextual issues, for example whether people are in rural and remote communities or in custody.

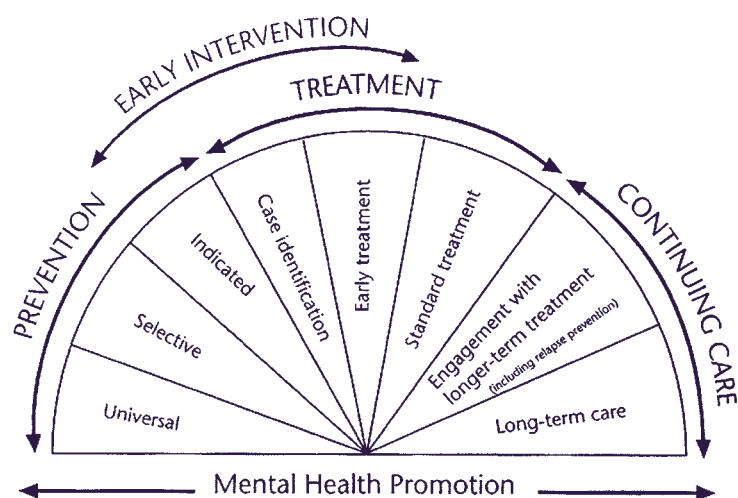
Available data indicates that there is a range of activities and responses required to reduce the incidence of suicide and suicidal behaviour across the spectrum of interventions. This includes strategies to address the needs of priority population groups at higher risk of suicide and self-harm, universal prevention strategies and measures to address social determinants of health more broadly. Effective suicide prevention activities require collaboration and linkages between people, their families, services, communities, across the Government, non-Government and the private sector as reflected in this Strategy. Activity should be multidisciplinary and implemented across the spectrum of interventions. The Strategy identifies key outcomes to support a comprehensive suite of actions in each of these areas to enhance suicide prevention activity in Queensland.

It is widely recognised that key social determinants influence health inequities between different population groups. The evidence consistently indicates that economic disadvantage, a shorter lifespan, and higher levels of illness, distress and disability are inherently linked. The key social determinants of health include:

- Living and working conditions (including employment and education levels)
- Physical environment
- Personal health practices/individual capacity
- Culture and ethnicity
- Discriminatory practices
- Age and gender, Queensland Government, 2001.

Activities aimed at the promotion of social and emotional well-being and preventative actions assist at redressing these inequities.

Figure 1 Spectrum of Interventions for Mental Health Promotion (Commonwealth, 2000)



Source: adapted from Mrazek and Haggerty (1994)

Promotion of social and emotional well-being

Well-being encompasses social, emotional, physical, economic, cultural and spiritual health. Well-being is enhanced through safe, nurturing family environments, supportive social networks, personal skills to manage life's challenges, communities and systems of governance that are just and facilitate opportunities for participation, cultural expression, healing, education and training, employment, recreation and sport.

Activities promoting social and emotional well-being require a population-based approach targeting all members of the community. Promoting of social and emotional well-being involves the development of personal and family resilience, supportive communities, connectedness within schools, development of recreational opportunities at the local level, promotion of physical activity and building social networks. These activities assist towards building healthy environments for individuals, their families and the community across urban and rural areas. Promoting social and emotional well-being is the responsibility of the whole community and provides benefits across the wider community. Improving the mental health literacy of the population is a critical strategy to promote better understanding of mental health in the community, as well as reducing misconceptions and stigma in regard to mental illness.

Well-being is a positive outcome of a person's resilience and is enhanced by identified protective factors which include good family, social and community support (Commonwealth, 2000). The sense of well-being that arises due to a person's resilience protects them from or reduces their risk of suicide. A person's resilience is defined by their individual communication, cognitive and emotional skills and ability to seek help, protecting them from the risk factors associated with suicide and suicidal behaviour (Commonwealth, 2000). A better understanding of the factors that foster resilience to mental illness and suicide will enhance health outcomes. Table 1 provides an overview of risk and protective factors across the lifespan based on the current evidence and indicating their relationship to one another. Many of these factors are not limited to one group or stage of life, and are not intended to be used as a checklist for the prediction of suicide and suicidal behaviour.

Risk factors, while mentioned individually here, have a cumulative burden on an individual and, in the context of an insurmountable crisis such as loss, sadness and anger, may result in suicidal acts. The effects of risk factors are balanced by protective factors which, amongst others, include connections to family and community, economic security and religion (Resnick et al. 1997; De Leo et al. 1999). The presence of

protective factors builds individual resilience against risk factors and promotes social and emotional well-being.

As indicated above the promotion of social and emotional well-being is not the responsibility of the health sector alone and requires cohesive action from a wide range of agencies. Promotion of social and emotional well being incorporates individual, family and community level action and takes place in a variety of settings including home, schools, work and social environments. Interventions include the promotion of positive social environments in the home, education and work settings as well as promotion of positive life skills to increase resilience and connectedness. Improving the capacity of communities to enhance the social and emotional well-being of their members requires a whole-of-Government, whole-of-community approach.

The current social and economic issues faced by Indigenous peoples are major factors in suicide and suicidal behaviour in Aboriginal and Torres Strait Islander communities. Much has been said about the levels of dysfunction of Indigenous communities. For instance, the Aboriginal and Torres Strait Islander Women's Task Force on Violence Report states that:

Indigenous communities have endured, and continue to endure, substandard and overcrowded housing, poor health, poor education and welfare dependency. Many live in environments similar to those in the poorest developing countries, and lack access to the resources required to alter their impoverished State. (Queensland Government, 1999:xii).

Aboriginal and Torres Strait Islander peoples have been affected by colonisation to varying degrees, but the impact has been borne more severely by Aboriginal people. Consultations across Queensland have found that the colonial experience has been the direct cause of emotional health problems in communities and that dysfunction manifesting itself as self-harming and suicidal behaviour is the result of many issues that have not been resolved (Queensland Government, 1999).

Research linking social and emotional well-being directly to suicide prevention is limited. However, it is generally accepted that given the strong association between suicide and mental illness or risk factors at an individual, family and community level, the enhancement of social and emotional well being provides reduced vulnerability to suicide.

The accumulated evidence around these interventions suggests the importance of a longer-term commitment to change health outcomes, resulting in benefits beyond the life of this Plan.

Prevention

Universal prevention refers to those activities targeted to the general population, taking a public health or population health approach. These activities have the potential to improve the overall social and emotional well-being of the population, but may also target national risk factors, and specifically reduce suicide rates. For example, limiting the availability of lethal means or creating safe environments has historically reduced suicide rates (Beautrais, 1998).

Local and international evidence indicates that access to the means of suicide results in a greater likelihood that these means will be used for suicide (Beautrais, 1998, Cantor et al. 1996). Measures to reduce access to means include maintaining control on firearms, reducing the lethal potential of motor vehicle exhaust, limiting access to prescription drugs and medicines and conducting environmental safety audits. Evidence suggests that suicide increases in response to media reports of suicide (Commonwealth, 2000; Commonwealth 2002). Therefore, there is a need for work to be undertaken with the media to ensure responsible reporting of suicide. Interventions in the area of universal prevention can have an immediate effect and promote shorter-term changes in the community but, when targeting outcomes of increased well-being or improved health, the impact may be over a longer time frame.

Selective prevention refers to interventions targeted towards individuals or groups

Age	Protective Factors	Rick Factors
0-2	<ul style="list-style-type: none"> • Successful parent - child bonding • Positive social and family relations • Healthy public policy • Quality child care • Early recognition and support of developmental problems • Early identification of risk of child abuse and family violence 	<ul style="list-style-type: none"> • Perinatal, physical and mental health problems • Poor attachment and neglect • Abuse and exposure to family violence
2-4	<p>As above plus:</p> <ul style="list-style-type: none"> • Supportive community contact and networks • Successful cognitive development 	<ul style="list-style-type: none"> • Parents with a mental illness • Children who are showing signs of disruptive behaviour
5-11	<ul style="list-style-type: none"> • Awareness and acceptance of diversity • Positive connections with family, school and teachers¹ • Early recognition and support for developmental problems • Successful cognitive and emotional development and peer socialisation • Early support for depression and anxiety • Social inclusion 	<ul style="list-style-type: none"> • Children showing early signs and symptoms of depression • Physical and sexual abuse, family violence² • Poor coping strategies such as self-harming • Young people living with a carer or parent with a mental illness • Lack of access to quality support services and information • Racism, bullying and discrimination³
12-25	<ul style="list-style-type: none"> • Positive connection with family, education, employment² • Belief that suicide is wrong¹ • Early intervention and appropriate treatment for depression, anxiety, addiction and serious psychiatric illness such as schizophrenia⁴ • Comprehensive information about alcohol and drugs 	<ul style="list-style-type: none"> • Signs and symptoms of mental illness, antisocial behaviour, offending, substance abuse, and self-harm⁵ • Family breakdown, family violence, conflict and legal problems^{2, 5} • Lack of access to information and appropriate treatment • Bullying and discrimination including sexuality⁶ • Socioeconomic disadvantage, including low educational achievement, unemployment²
25-60	<ul style="list-style-type: none"> • Presence of a significant other⁷ • Responsibility for children⁸ • Community and social integration⁹ • Good physical and mental health • Early intervention and support for depression, anxiety, addiction 	<p>25 to 40</p> <p>As above plus:</p> <ul style="list-style-type: none"> • Legal problems, imprisonment or conflict with the law¹⁰ • Ease of access to guns¹ <p>40 to 60</p> <p>As above plus:</p> <ul style="list-style-type: none"> • Loss, including relationship breakdown employment and health⁹ • Lack of access to support services and information
60+	<ul style="list-style-type: none"> • Participation within the community and connection to family, friends, community networks • Good physical and mental health⁹ • Income security⁹ • Early intervention for depression, and anxiety 	<p>As above plus:</p> <ul style="list-style-type: none"> • Loss of former functioning/wellness • Unaddressed bereavement • Lack of financial support⁹

Table 1: Summary of risk and protective factors across ages as identified in the literature

(Adapted from Life 2000 and Queensland Government Child and Youth Health Policy Statement 2001)

¹ Resnick et al. 1997, ² Beautrais, 1998, ³ Blum & Rinehart, 1997, ⁴ Goldney, 1998, ⁵ Tiller et al. 1997, ⁶ Bagley and Tromblay 1997, ⁷ Hassan 1995, ⁸ Smith et al. 1998, ⁹ De Leo et al. 1999, ¹⁰ Royal Commission into Aboriginal Deaths in Custody, 1991

identified as at elevated risk of suicide or suicidal behaviour. The following groups, based on the most recent data, form the highest priority areas for the Queensland Government in this Plan:

- Young people, especially young males
- Indigenous peoples, especially males aged 15–24
- Older people, especially older men, and those over 75 years
- People in custody, including those in the youth justice system and particularly Indigenous peoples
- Older people from culturally and linguistically diverse communities
- Current inpatients and people recently discharged from a mental health inpatient facility
- Gay, lesbian and bisexual people, and young women, specifically in relation to suicidal behaviour.

Early intervention

There are a number of factors associated with an increased risk of suicide and suicidal behaviour, including depression, anxiety, hopelessness and helplessness. Through the existing community networks, the Strategy aims to enhance the capacity of communities to respond to problems such as depression, as well as encourage the development of local partnerships and alliances across services and agencies. Improving the capacity of services will include knowledge and skill development as well as improving referral systems and processes and community-based options for support.

Early intervention activities targeting high-risk individuals displaying early warning signs and symptoms include case identification and early treatment activities. Early intervention activities can make significant gains in reducing the impacts of suicide and suicidal behaviour. There is therefore the need to enhance community capacity to recognise and respond to early signs and symptoms, as many people do not access health services. In addition to increasing the mental health

literacy of the Queensland community, early intervention requires a continued focus on ensuring access to appropriate and responsive services.

Interventions early in life can also effectively impact on the developmental trajectory of health, the development of resilience and other psychosocial outcomes. This approach recognises the primary role of families and communities in providing safe, supportive and nurturing environments for the healthy growth and development of our children and young people. Effective interventions early in life have the potential for significant and lasting effects on health and well-being in later life.

Treatment and support

Suicide prevention is also a fundamental part of treatment maintenance and relapse prevention for those within the community who have a mental illness (Commonwealth, 2000). It has been estimated that the majority of people who suicide suffer from a diagnosable mental illness at the time of their death, particularly disorders such as depression, substance abuse disorders and antisocial behaviours. These estimates range from 28% to 98% (Eisele et al. 1987; Goldney, 1991). While most people with a mental illness go on to live a productive life, their psychiatric care is a marker of suicide risk (Commonwealth, 2000).

There is the need to develop strategies to improve the mental health literacy of the population and health workers at all levels of the service system to build capacity. There is also the need to develop specific strategies that identify the skill development needs of service providers to improve the treatment and management for a range of mental health problems. These strategies will support the development of protocols and referral systems between health services and community organisations to ensure continuity of care and integrated approaches to management and follow-up post-discharge. These enhanced systems and processes will ensure support for people at risk, those who do have a serious mental illness, as well as ensure appropriate follow-up for people who have recovered from

a mental illness and are unsupported. This integrated approach across the service system into the community will be critical to improving outcomes and will be enhanced by partnership development across disciplines, agencies and sectors.

Historically Indigenous peoples have been marginalised and have not been able to access services that are appropriate or sensitive. This may be due to perceived and/or realised institutionalised racism and discrimination or because of the general lack of services. Services that make up the pathways to suicide prevention may not be culturally sensitive to Aboriginal and Torres Strait Islander concepts of holistic physical, emotional, spiritual and mental health and the importance of connections to family, community and land (Iker 1996). Ensuring culturally appropriate services are accessible and responsive to the needs of Indigenous peoples are key components of a comprehensive approach to suicide prevention.

Service delivery gaps are also identified in regard to appropriate and accessible care and support for individuals displaying suicidal behaviour or at risk of suicide who fall outside the entry criteria for mental health services. People presenting with issues that do not meet the classification requirements for a major mental illness or groups often referred from one service to another (e.g. dual diagnosis, people experiencing adverse life events, people identified as having emotionally unstable personalities) require a system of care development.

Continuing care

The importance of follow-up and continuing care is demonstrated in a study which identified that 41% of people who complete suicide have been discharged from psychiatric in-patient care within the preceding 12 months (Pirkis and Burgess, 1998). There is a need for improved continuity of care across a range of systems and settings, and, in particular, follow-up and support over the first 12 months following discharge. Gunnell and Frankel (1994) call for the targeting of those

recently discharged from psychiatric care and strategies to improve the education of general practitioners to reduce suicides due to the number occurring in people immediately post-discharge. Zametkin et al (2001) identify the importance in suicide prevention of the physician's ongoing role in the follow-up of people with depression, as it is a chronic and recurring health issue.

Postvention

Postvention encompasses the immediate support provided to individuals, families and communities after a suicide or a suicide attempt and any ongoing support provided to help people integrate their responses. Postvention recognises that individuals recently bereaved by suicide may be at greater risk of suicide behaviour (Commonwealth, 2000). Although the survivors of suicide have been a relatively neglected population in terms of research, there is consistent evidence which suggests that family members and friends of people who die by suicide show increased rates of depression, post-traumatic stress disorder and anxiety disorders (Beautrais, 1999). Furthermore, the experience of having a family member or a close friend who has died by suicide has been associated with an increased risk of suicide behaviour (Beautrais, 1999).

The provision of a comprehensive, coordinated and collaborative system of care to people and communities affected by suicide is therefore an important component in reducing the mortality and morbidity associated with suicide. Effective interventions require working with individuals and agencies in partnership to build capacity to respond and to provide the appropriate level of community-based support. This will also include addressing need across settings and ensuring that appropriate systems are in place to support those bereaved by suicide. Management and coordination of postvention activities are also critical in ensuring positive outcomes from the postvention interventions undertaken.

Section 3: The Way Forward

Overview

This Strategy has identified a number of fields of influence where Government, non-Government and intersectoral activity has the potential to make a significant difference based on the current data. It also spans areas for partnership activity between Government and other sectors building on the significant suicide prevention activity currently being undertaken across the State.

As the causes of suicide are multifaceted, any prevention program should be multimodal and multi-strategic. Interventions to prevent suicide should include strategies targeting the individual, family and community in a multidisciplinary approach. Interventions will span the spectrum from health promotion and prevention actions through to early intervention, support, treatment and postvention strategies. Partnerships built between Government, communities, families, individuals and agencies will be pivotal in making a difference to rates of suicide and suicidal behaviour across Queensland. A positive interrelationship between Government agencies and other key stakeholders is critical to the successful implementation of this Plan, as different stakeholders employ their areas of expertise to initiate interventions across the spectrum.

Program Principles

The following eight guiding principles underpin the Strategy and are integral to its successful implementation. These include:

- A focused and collaborative Government approach
- Active partnership development across sectors
- A range of interventions and responses from a focus on well-being and prevention, through to improved access to care and relevant services, to postvention
- Continuous learning, implementation of agreed best practice and further development of the body of evidence
- Sustainable outcomes that build on existing infrastructure
- Culturally appropriate actions responsive to the needs of local communities
- Contextually sensitive and targeted actions that respond to the particular needs of urban and rural areas and regional profiles
- Do no harm

Outcomes and Strategies

The following outcomes and strategies specify how the Strategy will contribute towards reducing the incidence of suicide and suicide attempts. The outcomes are based on the strategic themes across the spectrum of interventions and different settings, as well as focusing on specific program elements. The development and implementation of strategies for all outcome areas must be cognisant of the population groups identified as requiring priority focus.

Outcome Six specifically focuses on the development and implementation of strategies for the Aboriginal and Torres Strait Islander peoples. However, the strategies relating to Outcome Area Six cannot be viewed in isolation and are cross-referenced to the other outcome areas. Outcome Area Six is not intended as an encompassing plan for Aboriginal and Torres Strait Islander peoples in relation to suicide prevention and it is vital that the needs of Aboriginal and Torres Strait Islander peoples are also identified and addressed in and through the other outcome areas.

Outcome 1

Enhanced community capacity to promote and maintain social, emotional, cultural and spiritual well-being across the lifespan.

Strategies

- Pursue a focused and collaborative approach to suicide and related prevention programs that builds partnerships between key Government Departments.
- Facilitate intersectoral linkages and action to promote well-being.
- Develop approaches to promote well-being at the individual, family, community and organisational levels through enhancing factors that protect against adverse social conditions and reducing risk factors associated with suicide and suicidal behaviour.
- Facilitate community participation and ownership in planning for sustainable well-being at the local level.
- Build healthy public policy including responsive communities, strong family units, self-efficacy and safe reporting of suicidal behaviour and intentional self-harm.

Outcome 2

A more knowledgeable community, able to take responsibility and implement risk reduction strategies.

Strategies

- Establish priorities for suicide prevention activities including identification of key settings, target groups and issues to be addressed based on literature and expert advice in alignment with the Queensland context.
- Build the capacity across sectors to undertake contemporary and evidence-based strategies to promote mental health and prevent mental illness including delineation of appropriate roles, infrastructure and linkages.
- Increase skill and knowledge to promote well-being and mental health literacy through mechanisms with demonstrated efficacy and suitability.
- Develop approaches to reduce stigma and discrimination to foster acceptance and support of marginalised and high-risk groups within the community.
- Engage with relevant agencies and individuals working with each priority group and develop District action plans (with objectives and time lines) to address the needs of priority groups.
- Reduce access by the population to the means to complete suicide.
- Develop a comprehensive strategy and partnership approach with the media in regard to mental health prevention and risk reduction.

Outcome 3

Greater system-wide knowledge, capacity and skills to ensure services are able to intervene early and respond effectively to suicide and suicidal behaviour.

Strategies

- Increase knowledge and skills of agencies and groups in regard to early identification of suicidal and self-harming behaviour, early signs of mental illness, and appropriate responses, including:
 - Mental health and other key service providers;
 - Primary health care providers and key response agencies such as police and

- emergency service personnel; and,
- Individuals and agencies in the broader community sector who are regularly in contact with people at high risk of suicidal behaviour and suicide.
- Develop actions in conjunction with key service providers, agencies and representatives from key high-risk groups/ areas for appropriate early intervention options, including strategies to reduce stigma and discrimination.
- Develop enhanced referral systems and care pathways across agencies and into the community, to provide diverse and appropriate options for early intervention, continuity of care and ongoing support.
- Improve access to, and ensure a diversity of approaches for early interventions, at a service delivery level and within a population-based approach.
- Improve support options for people experiencing adverse life events including family and relationship breakdown, trauma and grief and loss.

Outcome 4

Enhanced treatment and support services that are responsive to people who are at high risk of suicide and suicidal behaviour.

Strategies

- Ensure provision of comprehensive, timely and evidence-based treatment and support to people at risk of suicide and suicidal behaviour.
- Enhance education and training across key sectors, in the identification, diagnosis and treatment of suicidal behaviours and associated mental health problems.
- Enhance evidence-based options for early and continuing treatment for people identified at risk.
- Enhance community, professional and emergency responses to people in crisis with suicidal ideation or behaviour.
- Increase the accessibility, relevance and cultural appropriateness of mainstream services.

- Undertake continuous quality improvement of services.
- Enhance local infrastructure and capacity to access specialist support.

Outcome 5

A coordinated system of care across sectors, between Departments, services and individual providers.

Strategies

- Promote community knowledge of, and access to, a coordinated system of care.
- Ensure consumer and carer engagement in the delivery of a coordinated system of care.
- Improve follow-up of people at risk of suicide and suicidal behaviour, particularly targeting those discharged from hospitals or mental health facilities, and individuals who have engaged in previous self-harm and suicidal behaviour.
- Provide coordinated and quality care across sectors, programs, practitioners, and organisations to meet the diverse needs of clients.
- Develop integrated and comprehensive postvention systems.
- Enhance awareness and acceptance of the needs of people bereaved by suicide and develop better support systems to meet their needs.
- Address the difficulties in transferring relevant information between systems.

Outcome 6

Service responses across the spectrum of interventions that are culturally sensitive and consider the needs of Aboriginal and Torres Strait Islander peoples.

Strategies

- Engage Indigenous communities in identifying the cultural, historical and spiritual factors which may influence suicide and suicidal behaviour. (Outcome Area One).
- Promote approaches to enhance self-esteem and capacity to enable individuals

and communities to connect with a value system based on identity, place, people and land. (Outcome Area One).

- Develop partnership approaches with communities to strengthen local responses to address complex issues including drug and alcohol use, interpersonal conflict, violence, and grief and loss. (Outcome Areas Two, Three and Four).
- Enhance primary health and mental health services for Indigenous peoples to promote mental health and prevent mental illness. (Outcome Areas Two and Three).
- Improve access to specialist mental health services. (Outcome Areas Four and Five).
- Enhance the capacity of communities and front line workers to recognise and respond to risk at the individual and community level. (Outcome Areas Two, Three and Four).
- Develop partnerships with Indigenous peoples to improve data collection, research and evaluation and sharing of best practice approaches across communities and sectors (Outcome Area Seven).

This outcome and associated strategies are further elaborated within Section Four of this document.

Outcome 7

Evidence-based policy, program and service development.

Strategies

- Facilitate greater alignment, coordination and integration of State, Commonwealth and local suicide prevention activities and initiatives at the policy development and implementation levels, through formal partnership agreements and network development.
- Develop and implement suicide prevention policies, programs and services underpinned by the current evidence base.
- Ensure evaluation and reporting

requirements are a core component of suicide prevention programs.

- Develop partnerships and collaboration with key researchers, academics and expert advisers in the field of suicide prevention to enhance planning, program development, implementation and evaluation.
- Disseminate best practice approaches and emerging issues relating to suicide prevention activities across all sectors of the community to enhance the transfer and uptake of current evidence into practice at all levels of activity.
- Ensure availability and access to appropriate and quality workforce training and development across sectors.
- Establish data collection and surveillance mechanisms to monitor and document all suicides, suicidal behaviour and undetermined deaths related to accidental injury occurring in Queensland to inform and refine interventions across the spectrum.
- Support ongoing research into key and emerging suicide prevention issues.

Implementation

Implementation of this Strategy requires the cooperation and contribution of a broad range of Government, non-Government and community stakeholders. Given the scope of participants, sectors and activities involved, a clear framework for action is required that translates the strategic intent of this document into transparent and measurable actions. Documentation of roles and responsibilities, program activities, outcome indicators, evaluation, and reporting requirements are all essential to ensure the necessary coverage of key issues, priority groups and settings, and coordination of activities across the spectrum of interventions. The implementation process will therefore involve:

- Engagement of relevant Departments, agencies, groups and individuals in a collaborative and focused approach to suicide prevention planning and

implementation through formal partnership agreements;

- Implementation of suicide prevention action plans targeting priority activities across the spectrum of interventions relevant to each Departments scope and role;
- Development of suicide prevention action plans within collaborative and representative processes with the active input of stakeholders relevant to the specific priority issue(s) and/or target group(s) being addressed at District and local level; and
- Execution of a comprehensive governance and advisory structure and process that oversees, coordinates, monitors, and refines as appropriate the implementation of *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003–2008*.

Facilitation of greater alignment, integration and coordination between State and Commonwealth Government suicide prevention activities will be pursued and monitored under this Strategy. Development of networks, formal partnership agreements and other coordinating mechanisms will be utilised for this purpose. Similarly, coordination with suicide prevention initiatives undertaken within the non-Government sector will be further developed.

Research and Evaluation

Suicide prevention needs to be based on a clear understanding of the issue and grounded in the best available evidence of what constitutes effective approaches. It is acknowledged however that gaps exist in regard to the understanding of the phenomenon, access to timely and reliable information and the veracity of research and evaluation of past and current suicide prevention initiatives. Activities aimed at extending the evidence base for understanding, preventing and responding to suicide are therefore critical components of a comprehensive strategic approach to suicide.

Reducing Suicide: The Queensland Government

Suicide Prevention Strategy 2003–2008 provides for a continuous and robust evaluation process. The development of the QGSPS evaluation framework will facilitate evaluation of all projects and suicide prevention activities undertaken. Furthermore strategic, level evaluation of cross-agency coordination mechanisms, progress against targets, particularly for the priority populations, and performance of Government within each of the Outcome Areas is pursued under the Strategy. Promoting continued learning through partnerships and collaboration with research bodies and expert advisers is a key feature of the Strategy.

Section 4: Suicide and suicide prevention in Aboriginal and Torres Strait Islander communities

Section Four aims to present further context about specific issues facing Indigenous communities and provide direction to Government Departments in developing targeted strategies to reduce the rate of suicide in Indigenous populations.

The factors affecting Indigenous communities today, and which have contributed to the high rates of suicide, particularly in Indigenous men, include “breakdown of social structure and kinship, loss of religious practices, loss of spirituality, loss of hope and extermination of cultural heritage” (Memmott et al. 2001). It is these social and political realities that need to be taken into consideration in understanding and addressing suicide and self-harm within Aboriginal and Torres Strait Islander communities effectively (Tatz 2001).

In addition to the risk factors shared by the general community (see Table 1 – Section 2) Aboriginal and Torres Strait Islander peoples experience risk factors unique to their communities, as well as at a magnitude and scale that increases their vulnerability to suicide and suicidal behaviour. The Yarrabah Family Life Promotion project found during the first year of the project’s operation that major contributing factors to suicide and self-harm included:

- Alcohol and drugs
- Unresolved grief
- Depression
- Family violence
- Unemployment
- Parental neglect
- Low self-esteem.

Tatz (2001) supports this and suggests that contributing factors to Indigenous suicide include having no sense of purpose in life, few role models and mentors, ineffective parenting, sexual assaults, alcohol and drugs, grief cycles and illiteracy.

Possible approaches:

Overview

It must be acknowledged that positive community-based projects that ensure community engagement and participation are making a difference in Aboriginal and Torres Strait Islander communities. Indigenous communities have demonstrated their willingness to address suicide and to working in partnership with Government and non-Government agencies to ensure services and projects address the needs of their communities. There are a number of current Government initiatives that provide a framework for working with Indigenous communities that address issues of individual and community well-being. A common theme in these initiatives is the recognition that Indigenous communities know what works for their

communities, an effective partnership as a base for moving forward and a holistic approach to community well-being.

The *Meeting Challenges, Making Choices* Queensland Government (2002) response to the Cape York Justice Study details the need for a new approach where Government and community develop partnerships and share responsibilities. The framework for change includes immediate interventions, community engagement and development, and Government reform.

It is important that all agencies acknowledge and take responsibility for their part in reducing Indigenous suicide through improving the well-being of Aboriginal and Torres Strait Islander communities. This equates to an inclusive framework that encompasses and integrates the full gamut of existing and prospective health, educational, economic, social, cultural and welfare policy directions and strategies. State, Commonwealth and community initiatives aimed at improving opportunities for Aboriginal and Torres Strait Islander peoples, including appropriate community infrastructure and ensuring access to generalist and specialist services, are essential components of Indigenous suicide prevention. As part of the implementation of the Strategy, agencies will be required to further develop their current and proposed activity to reduce suicide, including Indigenous suicide. Strategic leadership and coordination will be provided through the Department of Aboriginal and Torres Strait Islander Policy.

Strategies

In considering suicide prevention activities, Departments should identify any existing, relevant community plans or community planning processes already being undertaken. Examples include community renewal programs and community action planning processes. Every effort should be made, where appropriate, to link suicide prevention responses and actions to other relevant community activities. Opportunities should be explored for communities to take ownership of such responses. Partnerships between

communities and Departments should take into account local circumstances and plans.

Listed below are some examples of what is happening across Government, reflecting activity across the spectrum of interventions outlined in Section 2 of the Strategy. The examples presented are in no way exhaustive. However, the illustrations presented begin to demonstrate the range and diversity of activities, settings and key partners essential to, and possible within, a comprehensive and effective Indigenous suicide prevention approach.

Promote approaches to enhance self-esteem and capacity to enable individuals and communities to connect with a value system based on identity, place, people and land.

Corrective Services currently provides a range of programs that focus on enhancing Indigenous self-esteem based on connections with country and family. These programs include visits by Elders, cultural activities and celebrating cultural events. The Department of Families also provides these activities for young Indigenous men and women in youth detention centres.

As a way of promoting a sense of connectedness and future for the young men and women of Yarrabah, the Police Citizens Youth Club is providing a safe and appropriate space in the community where sports, discos, meals, vacation camps and driving lessons are provided. The club now employs former high school students. The centre was established in 1996 and between late 1996 and late 1999 there were no youth suicides in the community.

Education Queensland's *Partners for Success* program aims at developing a compact between schools and their local communities to facilitate greater community engagement, empowerment and self-determination in the learning and education process.

Engage Indigenous communities in determining the cultural, historical and spiritual factors which may influence suicide and suicidal behaviour.

The community action planning process to be undertaken as part of the *Meeting Challenges, Making Choices* implementation will engage Indigenous communities to ensure that the cultural, historical and spiritual factors that may influence suicide and suicidal behaviour are addressed through a whole-of-community approach.

The Vision Planning Process undertaken on Palm Island in 1998 started because the rate of young people dying from self-harm had been at least one a month. The community came together, initiated by the men, to discuss how life could be improved on the Island. The Community Council employed a project officer who worked with community people and Government agencies to develop a Vision Plan for the Island. This type of initiative is not-resource intensive and can be supported by Government and managed by the community.

Develop partnership approaches with communities to strengthen local responses to address complex issues including drug and alcohol use, interpersonal conflict, violence and grief and loss.

The Queensland Government, in conjunction with the Aboriginal and Torres Strait Islander Advisory Board, is currently developing the Queensland Aboriginal and Torres Strait Islander Family Violence Agreement. This Agreement commits the Government to working together and with Indigenous communities to reduce Indigenous family violence and improve community well-being. Regional action planning processes will provide community-based direction to the implementation of the Agreement.

Under the *Meeting Challenges, Making Choices* (2002) Strategy the Queensland Government will undertake an intensive strategy to reduce violence and harm from alcohol misuse. Part of this includes the development of whole of Government, whole-of-community Alcohol Management Plans for each Deed of Grant in Trust community.

Enhance primary health and mental health services for Indigenous peoples to promote

mental health and prevent mental illness.

Queensland Health is currently developing strategies and projects for working with Indigenous young people within local communities which aim to enhance primary health and mental health outcomes for community members. Queensland Health funds Life Promotion Officers in the Indigenous Communities of Yarrabah, Hope Vale and Wujal Wujal.

Community-based projects such as the Yarrabah Family Life Promotion Program work in collaboration with existing health services to enhance primary and mental health services for Indigenous peoples. The project uses a Community Development suicide prevention model to heal individuals and promote healthy family lifestyles. The goal of the project has been to develop a locally owned culturally relevant primary health care and treatment model that responds across the spectrum of interventions. The outcomes of the Program include families taking ownership of the problem and individuals are talking instead of self-harming.

Improve access to specialist mental health services.

The *Ten Year Mental Health Strategy for Queensland 1996* outlines clear planning guidelines for the establishment of Indigenous community mental health positions Statewide. The guidelines for Aboriginal and Torres Strait Islander Mental Health staffing numbers are based on the higher level of need and set at twice the staffing level applicable to general child and youth and adult mental health services. This includes 5 full-time equivalent positions per 10,000 of population for children and young people (1-18 years); 6 full-time equivalent positions per 10,000 of the total population; and 2 full-time equivalent positions per 10,000 population for older people (over 55 years).

To date Queensland Health has created 63 full-time equivalent Indigenous Mental Health Worker positions Statewide with an overall target to create approximately 65 by 2006. These staffing guidelines provide a model for

other sectors in planning services to address the needs of Aboriginal and Torres Strait Islander peoples in Queensland.

Furthermore, all Queensland Health employees, including those providing specialist mental health services, must participate in the *Aboriginal and Torres Strait Islander Cultural Awareness Program*. This will help to ensure that Aboriginal and Torres Strait Islander peoples feel comfortable accessing Queensland Health services.

Queensland Health, through its *Indigenous Allied Health Cadetship Program* is also able to sponsor Aboriginal and Torres Strait Islander students studying in fields such as psychology and social work.

Enhance the capacity of communities and front line workers to recognise and respond to risk at the individual and community level.

Projects such as the recently released Pine Rivers Shire suicide/self-harm risk assessment and referral pathway flowchart, which offers information to service providers about level of risk, referral to emergency and mental health services and referral to appropriate support services. The flowchart, which is aimed at those who come into contact with young people at risk, such as youth workers, doctors, health workers, educators, community organisations and Government agencies, could be adapted for use with Aboriginal and Torres Strait Islander clients and organisations.

Queensland Health, on behalf of the Queensland Government Youth Suicide Prevention Strategy and in partnership with the tertiary sector, is in the process of establishing an on-line suicide prevention service for workers and communities in rural, remote and regional Queensland. This service will provide general information and support to the broader community and professional advice and a clinical consultation service to a range of Government and non-Government workers Statewide. This service will also provide training for community members and front line workers to understand the contributing factors and the interrelationship

between the risk and protective factors for Indigenous suicide.

Develop partnerships with Indigenous peoples to improve data collection, research and evaluation and sharing of best practice approaches across communities and sectors.

It is important for Government agencies to share learnings from local, national and international projects with each other and Indigenous communities. Projects such as the Managing for Outcomes Evaluation Framework for Cape York and the evaluation methodology being developed to measure progress of the implementation of *Meeting Challenges, Making Choices* will start to develop a robust knowledge base which will inform future research, evaluation and good practice. These projects will be developed and implemented in partnership with Indigenous peoples and communities.

Appendix 1: QGYSPS Recommendations for the Development of a Five-year Strategic Plan

- Effectively manage the mix of Commonwealth, State and community initiatives
- Provide a framework to guide resource allocation and inform the coordination of prevention activities
- Provide a greater focus on the prevention of suicide in Indigenous communities
- Provide a greater focus on well-being
- Provide greater direction to local communities to respond to emerging issues
- Provide a greater focus on evaluation and the identification of best practice approaches

Appendix 2: National and State Suicide Prevention Strategies and Initiatives

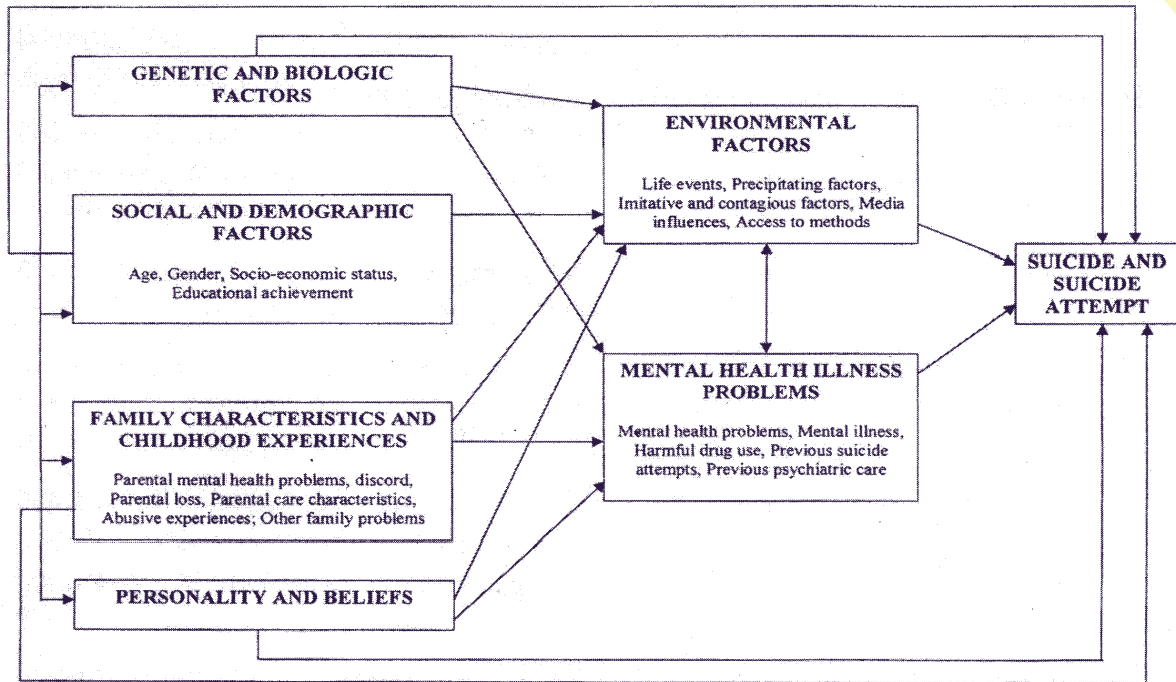
National

- *Living is for Everyone: A Framework for the Prevention of Suicide and Self-harm in Australia (2000)*
- *National Mental Health Strategy: First and Second National Health Plans (1992 and 1998)*
- *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000)*
- *National Action Plan for Depression (2000)*

Relevant Queensland Government initiatives include:

- *Smart State: Health 2020 – a vision for the future, Queensland Health (2002)*
- *Ten-Year Mental Health Strategy for Queensland (1996)*
- *Beyond A Quick Fix – Queensland Drug Strategic Framework (1999)*
- *Putting Families First – Policy Statement (2000)*
- *Queensland Families: Future Directions (2002)*
- *2010 – A Future Strategy, Education Queensland*
- *Our Shared Future: Queensland's Framework for Ageing 2000-2004 (2000)*
- *Towards a Queensland Government and Aboriginal and Torres Strait Islander Ten Year Partnership (2001)*
- *Aboriginal and Torres Strait Islander People: Queensland Mental Health Policy Statement (1996)*
- *Non-English Speaking Background Mental Health Policy Statement (1995)*
- *Future Directions for Child and Youth Mental Health Services (1996)*

Appendix 3: Risk Factors for Suicide and Suicide Attempts (Commonwealth, 2000)

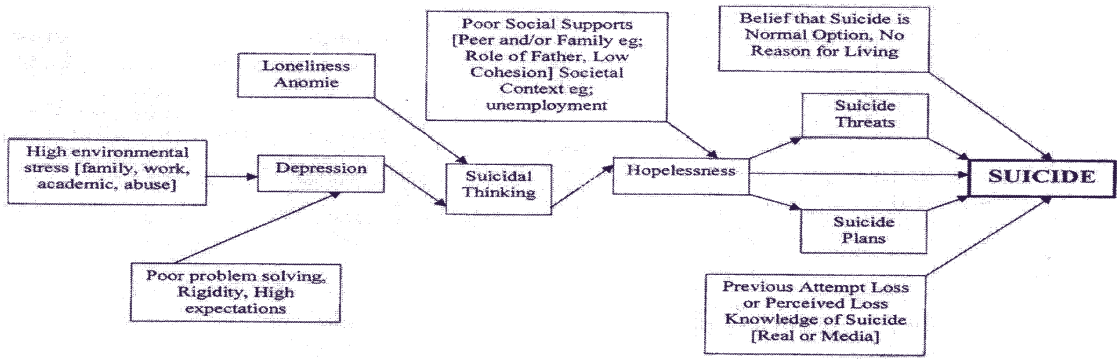


Source: Adapted with permission from Beautris (1998)

Appendix 4: Pathways to Suicide (Commonwealth, 2000)

Table 3: Pathways to Suicide

Table 3: Pathways to Suicide



Source: Adapted from Bonner and Rich 1987

References

- Access Economics (2002). *An analysis of the burden of schizophrenia and related suicide in Australia*, SANE Australia.
- Appleby L, Shaw J, Amos T, McDonnell R, Harris C, McCann K, Kiernan K, Davies S, Bickley H, Parsons R (1999). Suicide within 12 months of contact with mental health services: national clinical survey. *British Medical Journal*, 318: 1235-1239.
- Australian Bureau of Statistics (2001). *Causes of Deaths, Australia*, cat. No 33303.0, Canberra.
- Australian Bureau of Statistics (2000). *Suicides Australia, 1921-1998*. ABS, Canberra.
- Bagley C, Tremblay P (1997). Suicidal behaviours in homosexual and bisexual males. *Crisis*, 18: 24-34.
- Barbato A (1997). *Schizophrenia and public health*, World Health Organisation Division of Mental Health and Prevention of Substance Abuse, WHO/MSA/NAM/97.6, Geneva, 1997.
- Beautrais AL (1998). *Risk factors for suicide and attempted suicide amongst young people*. A literature review prepared for the National Health and Medical Research Council, Canberra.
- Blum R, Rinehart PM (1997). Reducing the risk: Connections that make a difference in the lives of youth. *Youth Studies Australia*, 16: 37-50.
- Bonner RL, Rich AR (1987). Toward a predictive model of suicidal ideation and behaviour: some preliminary data in college students. *Suicide and Life Threatening Behaviour*, 17:50-63.
- Cantor CH, Leenars AA, Lester D, Slater PJ, Wolanowski AM, Toole B (1996). Suicide trends in eight predominantly English speaking countries, 1960-1989. *Journal of Social Psychiatry and Psychiatric Epidemiology*, 31:364-373.
- Cantor CH, Neulinger K, Roth J, Spinks D (1998) *The epidemiology of suicide and attempted suicide among young Australians*. A literature review prepared for National Health and Medical Research Council, Canberra.
- Chippis J, Stewart, G, Sayer, G (1995). Suicide mortality in NSW: clients of mental health services. *New South Wales Public Health Bulletin*, 6: 75-81.
- Commonwealth Department of Health and Aged Care (2002). *Reporting Suicide and Mental Illness: A Resource for Media Professionals*. Commonwealth of Australia, Canberra.
- Commonwealth Department of Health and Aged Care (2000). *Life, A framework for prevention of suicide and self-harm in Australia*. 2000. Commonwealth of Australia, Canberra.
- Commonwealth Department of Health & Aged Care (1999). *National Youth Suicide Prevention Strategy, Setting the evidence-based research agenda for Australia: (A literature review)*, Commonwealth of Australia, Canberra.
- De Leo D, Evans R (2002). *Suicide in Queensland, 1996-1998: Mortality*

rates and related data. Brisbane: Australian Institute for Suicide Research and Prevention.

De Leo D, Hickey PA, Neulinger K, Cantor CH (1999). *Ageing and Suicide: A report to the Commonwealth Department of Health and Aged Care*. Brisbane: Australian Institute for Suicide Research and Prevention, Griffith University.

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

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

Eisele JW, Frisino J, Haglund W, Reay DT (1987). Teenage suicide in King County, Washington. II. Comparison with adult suicide. *American Journal of Forensic Medical Pathology*, 8: 210-216.

Goldney RD (1998). Suicide prevention is possible: a review of recent studies. *Archives of Suicide Research*, 4: 329-339.

Goldney RD (1991). Suicidal behaviour. In R Kosky, HS Eshkevari, V Carr (eds). *Mental Health and Illness*, Butterworth-Heinemann, Sydney.

Gunnell D, Frankel S (1994). Prevention of suicide: aspirations and evidence. *British Medical Journal*, 308: 1227- 1233.

Hassan R (1995). *Suicide Explained: The Australian Experience*. Melbourne: Melbourne University Press.

Iker P (1996). Law, psychiatry and psychology: an Aboriginal women's perspective. 16th Annual Congress, Australian and New Zealand Association of Psychiatry, Psychology and Law, Gold Coast, Queensland, cited in Commonwealth 2000.

Marttunen MJ, Aro HM, Lonnquist JK (1993). Adolescence and suicide: A review of psychological autopsy studies. *European Child and Adolescent Psychiatry* 2: 10-18.

McDonald B, Steel S (1997). *Immigrants and mental health: an epidemiological analysis*, New South Wales Transcultural Mental Health Centre, Sydney.

Melish L (2001). *6 Way Consultation with Young People: Input into the Prevention of Youth Suicide 5 Year Strategic Plan*. Office of Youth Affairs, Department of Employment and Training, Queensland.

Memmott P, Stacy R, Chambers C, & Keys C (2001). *Violence in Indigenous Communities*. National Crime Prevention.

Moller J & Elkington J (1999). Final Report: *An Evaluation of the Queensland Government Youth Suicide Prevention Strategy*, Prepared for the Queensland Department of Health, Mental Health Unit.

Morrell S, Taylor R, Slaytor E, Ford P (1999). Urban and rural suicide differentials in migrants and the Australian-born. New South Wales, Australia 1985-1994. *Social Science and Medicine*, 49(1): 81-91.

Mrazek PJ, Haggerty RJ (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, National Academy Press, Washington DC.

Pirkis JE, Burgess PM, Meadows GN, Dunt DR (2001). Suicidal Ideation and suicide attempts as predictors of mental health service use. *Medical Journal of Australia*, 175: 542-545

Pirkis JE, Burgess PM (1998). Suicide and recency of contact with health care: a systematic review. *British Journal of Psychiatry*, 173: 462-474.

Queensland Government (2002a). *Smart State Health 2020: Strategic Directions Statement*, Queensland Health, Queensland.

Queensland Government. (2002b). *Meeting Challenges, Making Choices – the Queensland Government Response to the Cape York Justice Study*, Department of the Premier and Cabinet, Queensland.

Queensland Government (2001a). *Cape York Justice Study*, Department of the Premier and Cabinet. Queensland.

Queensland Government (2001b). *Social determinants of health - the role of public health services*. Queensland Health, Queensland.

Queensland Government (1999). *The Aboriginal and Torres Strait Islander Women's Task Force on Violence*, Department of Aboriginal and Torres Strait Islander Policy and Development.

Raphael B, Dower J, Donald M, Kelly B (2000). *Pathways of care for young people who present for non-fatal deliberate self-harm*. University of Queensland.

Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, Tabor J, Beuhring T, Sieving RE, Shew M, Ireland M, Bearinger LH, Udry JR (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*, 278:823-832.

Royal Commission into Aboriginal Deaths in Custody (1991). *Overview and Recommendations*. Australian Government Publishing Service, Canberra.

Shaffer D, Pfeffer, CR, & the Work Group On Quality Issues (2001). Summary of the practice parameters for the Assessment and Treatment of Children and Adolescents With Suicidal Behaviour. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40 (4): 495-499.

Smith J, Mercy J, Conn J (1998). Marital status and the risk of suicide. *American Journal of Public Health*, 78: 78-80.

Tatz, C (2001). *Aboriginal Suicide is Different – A Portrait of Self-Destruction*. Aboriginal Studies Press: Canberra.

Tiller J, Krupinski J, Burrows G, Mackenzie A, Hallenstein H, Johnstone G (1997). *A Prospective Study of Completed and Attempted Suicides in Victoria*. University of Melbourne and Australian Rotary Health Research, Melbourne.

Vassilas CA, Morgan HG (1997). *Suicide in Avon. Life stress, alcohol misuse and use of*

services. British Journal of Psychiatry, 170: 435-455.

Zametkin AJ, Alter MR, Yemini BA (2001). Suicide in Teenagers. *Journal of the American Medical Association*, 286: 3120-3125.