Most deaths by suicide are among people of working age. Suicide is the leading cause of death for males aged 25–44 years and females aged 25–34 years. The proportion of suicides that are work-related is unclear. One Australian study found that 17% of suicides in Victoria from 2000–2007 were work-related. Applying this estimate to deaths across Australia, approximately 3,800 suicides over the decade to 2011 may be work-related.

Adults spend about a third of their waking hours at work. The workplace provides a unique opportunity to provide key health information and intervention. Suicide Prevention Australia (SPA) sees the workplace as playing a vital role in the creation of a suicide safe community.

The World Health Organisation suggests worker suicide is a result of a complex interaction between individual vulnerabilities and work-related environmental factors that trigger stress reactions and contribute to poor mental wellbeing. Employers have a legal responsibility to provide a safe and healthy workplace, including managing psychosocial stressors.

Understanding of the cost of workplace stress is continuously building and includes productivity losses due to presenteeism and absenteeism as well as workers compensation claims. No detailed and independent costing exists on the cost of suicide and suicidal behaviour to the Australian economy. A plausible estimate was calculated to be $17.5 billion per year, including productivity costs. Death claims paid out by Group Life Insurers in Superannuation for suicide exceeds $100 million per year.

Monetary value aside, suicide cuts lives short and leaves scars. Suicide is mostly preventable yet significant gaps exist in our understanding of the relationship between work and suicide, limiting prevention efforts. SPA has reviewed the existing evidence and summarised key issues in this document. We believe urgent action is required to address a range of systemic issues including managing unemployment, workers compensation and coronial processes. In addition, we call on organisations of all sizes to implement workplace policies and programs that promote a mentally healthy workforce and prevent suicide behaviours.

We ask employers to draw on the information provided in this document and call on them to:

- Promote a workplace culture that is inclusive, destigmatises mental health problems and encourages help-seeking. Sharing stories about personal experiences with suicide and mental health problems can be a powerful way to address stigma. In appropriate settings and with support and informed consent of all parties involved, leaders are encouraged to share their own stories, highlighting positive coping strategies and sources of help.

- Prioritise psychosocial workplace safety. This includes identifying ways to reduce work-related stressors.

- Understand and value the person as a human being rather than a resource. This includes understanding the interactions between what happens within the workplace and other aspects of life including family, relationships, cultural background, health, etc. This will help facilitate an
understanding of the meaning of work for people and the impact of stress, loss or failure of work on their lives.

- Promote mental health and suicide awareness within the workplace, paired with clear and communicated pathways to support for those in need.

- Establish mechanisms for the recognition and early detection of mental health and emotional difficulties in the workplace.

- Provide employees with access to appropriate self-help or professional interventions and treatment, for example via employee assistance programs linked to external community health resources. Pathways to care should be well promoted within the workplace, making sure employees feel encouraged to draw on these supports and understand the confidential nature of services. This will help overcome potential fear of breach of privacy.

- Frame suicide prevention programs in a manner which respects the cultural backgrounds and needs of the target audience, taking into account factors such as cultural and linguistic diversity, Indigenous status and diverse sexualities and genders.

- Be prepared for suicide to touch the lives of your employees and to respond appropriately. Lived experience of suicide can include having thoughts about taking one’s own life, making a suicide attempt, caring for someone who is suicidal, being bereaved by suicide, witnessing a suicide, or being exposed to suicide in some other way. These experiences will take on different meaning and importance for every person and can have lasting impacts.

To assist individual employers to achieve this, we ask that industry and employer groups:

- Establish relationships with key suicide prevention and mental health organisations.

- Develop industry wide guidelines for suicide prevention.

- Invest in the development of multifaceted suicide prevention programs tailored for the industry. This is especially urgent for industries characterised by relatively ready access to suicide means, elevated risk of suicide or a high proportion of male workers.

Government plays a vital role in suicide prevention. Action is required by government to address systemic issues that contribute to work-related suicide. We call on government to:

- Promote policies and practices that encourage employment, as this will give more people protection against one of the more significant risk factors for suicide.
• Invest in both labour market programs and suicide prevention programs (including mental health promotion) during times of economic downturn.

• Provide access to counselling services (via employment pathway services) for individuals unemployed for more than four weeks.

• Provide suicide intervention skills training for frontline staff working with the long-term unemployed.

• Fund research into the relationship between work and suicide to inform suicide prevention activities.

• Review the role of the workers compensation system in suicide prevention, minimising harm and maximising opportunities for intervention with those vulnerable to suicide. To achieve this, workers compensation claims databases require improvement and research is required to better understand the relationship between workers compensation and suicide.

• Resource coroners adequately to ensure coronial investigations include the role of work in suicide deaths.


• The proposed harmonised workplace health and safety regime increases focus on duty of care including mental health. We call on State and Territory governments to implement recommendations under the proposed regime.

• Invest in mental health and suicide prevention in the workplace.

With regards to work and suicide, SPA sees its role as:

• Engaging key influencers in the employment and workplace arena and promoting suicide prevention. Key influencers include Safe Work Australia, national organisations of employers (such as the Business Council of Australia and COSBOA) and employees (such as the Australian Council of Trade Unions), and national organisations which deal regularly with people who are unemployed or otherwise not in the workforce (such as the Australian Council of Social Services, the Job Network and Centrelink).

• Keeping abreast of developments among organisations providing suicide prevention services, programs and training, and responding to enquiries from employers and industries with appropriate information and referrals.

• Advocating for government policy that promotes employment opportunities, assists the unemployed find work quickly, and provides appropriate mental health support for the long-term unemployed and those accessing workers compensation.

• Advocating for research funding that gives priority to filling gaps in knowledge about suicide and its prevention including the relationship between work and suicide.

• Pursuing the development of a minimum data set in coronial records of suicide and for the inclusion of work factors as standard in psychosocial autopsy.

In addition, SPA looks to facilitate the participation of the business sector in the National Coalition for Suicide Prevention. Currently involving 25 of Australia’s leading organisations working in suicide prevention, this National Coalition is implementing the collective impact framework. Collective impact is a structured and sophisticated approach that has shown great promise in US communities in shifting intractable social problems.

The National Coalition, with SPA as the backbone organisation, is working towards the ambitious goal of halving suicide over the next decade. Contact the SPA office for more information or to join the National Coalition.

• Advocating for the development and maintenance of a best practice registry that helps employers choose evidence-based and appropriate workplace suicide prevention programs and training.
While no detailed and independent costing exists on the cost of suicide and suicidal behaviour to the Australian economy, every death does have a financial impact. A cost estimate produced by Mendoza and Rosenberg in 2010 proposed a plausible estimate to the Australian economy of $17.5 billion per year\(^\text{13}\). This figure included estimated productivity costs.

Research conducted by SuperFriend and IFS Insurance Solutions estimated that in 2012 death claims paid out in Australia by Group Life Insurers in Superannuation where suicide was the ‘known’ cause of death, amounted to more than $100 million\(^\text{14}\). For some SuperFriend Partner Funds, suicide death claims account for over 20 percent of their total death claims administered\(^\text{15}\).

There is a relationship between stress and work-related suicide\(^\text{14}\). While suicidal behaviour is an extreme outcome of stress, significant productivity gains are to be had by managing workplace stress. Medibank Private-commissioned research found that stress-related presenteeism and absenteeism cost the Australian economy $14.81 billion a year with 3.2 days per worker lost each year due to stress\(^\text{17}\).

Work-related mental stress claims are the most expensive form of workers’ compensation claim as they are often associated with long periods of absence from work\(^\text{18}\). Given that only 70% of workers who report that they have experienced work-related mental stress actually apply for workers compensation\(^\text{19}\), the potential cost of worker stress is much higher.

Measures taken to reduce or eliminate work stressors will contribute to preventing work-related suicide.

Monetary value aside, suicide cuts lives short and leaves scars.

Workplaces will be impacted by suicide. The World Health Organisation estimates that in a company of 1,000 employees, one worker will die by suicide every ten years\(^\text{10}\). For every employee who dies by suicide, another 10–20 will make a suicide attempt\(^\text{11}\). In addition, between 200–300 workers will suffer from a serious mental health problem\(^\text{12}\).

Making the business case: Why invest in suicide prevention?

As stated in the report of the 2010 Senate Inquiry into Suicide in Australia, ‘The Hidden Toll: Suicide in Australia’:

‘The personal and social impacts of suicide and attempted suicide on those affected cannot be quantified but are clearly enormous … No matter what the economic cost of suicide is calculated to be, a moral or a human obligation exists to assist those at risk of suicide and those who have been bereaved by suicide.’ \(^\text{20}\)
Suicide in Australia
Suicide is a substantial and ongoing problem for Australian society. Official figures put the lives lost from suicide at about 2,300 people in Australia each year\(^2\), but this is believed to be an under-estimate with the true figure being around 3,000 deaths each year\(^2\). About 75 per cent of these deaths are among males\(^2\). Each death gravely affects families, friends and communities.

Suicide becomes more prevalent in adolescence and rises with age, peaking around 45 years in men and 40 years in women, then declines, before becoming more prevalent again in those over 80 years\(^2\). Most deaths by suicide in Australia are in people of working age although it is noted that data is not routinely collected on employment status at the time of death.

It is estimated that approximately 2.1 million adults in Australia have had serious thoughts about ending their own life, and 500,000 adults have made a suicide attempt during their lifetime\(^2\). Approximately 65,000 suicide attempts occur every year\(^2\).

Work and mental health
Nationally, about 12.3 million people are in the labour force, with 11.6 million employed at December 2012\(^2\). Roughly speaking, a third of these will be self-employed or working in small businesses of fewer than 20 people, a third will be working in medium-sized businesses of 20–199 people and a third will be working in large businesses of 200 people or more.

The World Health Organisation (WHO) estimates that adults spend a third of their waking hours at work\(^2\). The workplace provides a unique opportunity to reach working age adults and provide key health information and intervention\(^2\).

The impact of mental health problems on work functioning and performance is at least comparable to the impact of physical injury\(^2\).

Mental health problems in the workplace typically manifest themselves as performance issues such as:

- Increased absenteeism
- Reduced productivity
- Increased employee turnover
- Increase in short and long-term disability days; and
- Increased disability claims\(^2\).

Employers are increasingly recognising that mentally healthy staff are more productive and that there are cost benefits to addressing mental health issues in the workplace\(^2\).

The provision of a safe and healthy work environment for all workers is an obligation under work health and safety (WHS) legislation\(^2\). Failure to provide a fair and safe workplace may breach disability discrimination legislation and human rights\(^2\).

Background
The workplace provides a unique opportunity to reach working age adults and provide key health information and intervention.

- 2,300 suicides every year
- Most suicides are working age males
- 1/3 of an adults waking hours are spent at work
Defining work-related suicide

Suicide is complex and there are usually multiple factors which contribute to someone taking their own life. There is very limited information available to identify how many attempted suicides or suicide deaths involve work-related factors.

The Victorian Work-Related Fatality Database (VWRFD) defines work-related suicide very broadly. It sees suicide as work-related if it involves:

- A work agent such as pharmaceuticals obtained by health staff, chemicals obtained by cleaners or firearms used by farmers
- Work stressors such as harassment or bullying; ongoing difficulties finding work; business-related financial difficulties; pain, depression or mobility limitations after workplace injury; recent redundancy; work-related compensation claims; involvement in work-related court proceedings; work-related interpersonal conflict or relationship breakdown; or stressful working conditions such as excessive hours
- Work location
- Commercial vehicles, including cars, trucks and trains.

Prevalence of work-related suicide

There is limited research focused specifically on the relationship between work and suicide.

A key 2002 report commissioned by the Creative Ministries Network provided insights into the role of work in Victorian suicides between 1989–2000. It was identified that work factors contributed to suicide in 109 cases. Acknowledging methodological limitations, the authors of the report suggest that this is an underestimation.

Key findings from this study are summarised in the box below.

In 31% of cases a work injury or work-related mental illness was reportedly related to the person’s suicide.

Among these deaths it was identified that the following issues played a role (percentage of suicides involving the factor provided in purple):

- 21% Work stress
- 19% Unspecified work problems
- 13% An argument or disagreement with a work colleague or supervisor
- 12% Fear of retrenchment
- 9% Performance pressures
- 7% Job dissatisfaction
- 6% Long hours
- 6% Being investigated over a work matter
- 5% Retrenchment

The World Health Organisation suggests worker suicide is a result of complex interaction between individual vulnerabilities and work-related environmental factors that trigger stress reactions and contribute to poor mental wellbeing.
TrackSAFE: An industry-wide response to suicide risks in the workplace

TrackSAFE was established by the Australian Rail Industry in 2012 with the aim of preventing suicide and reckless behaviour on the rail network and in doing so, creating a better workplace for rail employees. This industry-wide approach to suicide prevention is expected to be more effective than worthy, but unconnected, local efforts. TrackSAFE estimates that there are around 150 suicides annually on the rail network and a further 1000 attempts, many resulting in serious injury. Rail staff are exposed to trauma in every one of these situations. Train drivers and rail employees who experience an incident are often the last to see that person alive, and for them, severe mental, physical and emotional trauma can result from witnessing such an event. The trauma can be long-lasting, deeply felt and costly for these employees as well as their families.

In addition to projects which seek to prevent suicides from occurring (e.g. installing barriers, displaying posters promoting crisis services), TrackSAFE works to provide best practice trauma support for rail employees. In 2012 TrackSAFE developed the Rail Industry Trauma Management Framework, working with the Australian Centre for Posttraumatic Health (ACPMH) at Melbourne University to ensure the framework was evidence-based and international best practice. A general staff trauma awareness video has been developed along with training courses addressing coping skills and how to provide support.

In addition, TrackSAFE is working with Lifeline and beyondblue to continuously improve outcomes for employees as well as the general public.

www.tracksafefoundation.com.au
General risk factors

The causes of suicide are complex, and vary from person to person. The presence of risk factors increases the likelihood of suicidal behaviour and people who take their own life usually have many risk factors (and few protective factors). An absence of risk factors or only a couple of risk factors does not equate to no or low risk. Awareness of risk factors is useful to help consider the needs of a group or workforce in general.

General risk factors include:

- Mental health problems
- Being male
- Family discord, violence or abuse
- A family history of suicide
- Being Indigenous
- Identifying as gay, lesbian, bisexual or transgender
- Poverty and low income
- Social or geographical isolation
- Bereavement

Additionally, there are suicide risk factors that are particularly useful when considering the relationship between work and suicide. These factors, such as occupation, work conditions and unemployment, will be covered on the following pages.

Occupational risk

Suicide rates vary across occupational groups. Key influences on occupational suicide rates include the unique day-to-day psychosocial stresses of the workplace; greater exposure to harrowing or violent incidents that give rise to post-traumatic stress disorder; and ready access to lethal means of suicide such as firearms, lethal doses of medications or pesticides.

A recent comprehensive review of international research on suicide and occupation mapped suicide rates against the major codes used in the International Standard Classification of Occupations (ISCO), allowing comparison of groups by skill level and against the general working-age population. The following groups were found to have elevated suicide risk:

- Labourers, cleaners and elementary occupations (ISCO major category 9)
- Machine operators and ship’s deck crew (ISCO major group 8)
- Farmers and agricultural workers (ISCO major group 6)
- Service workers such as police (ISCO major group 5)
- Skilled trades such as builders and electricians (ISCO major group 7)

Lower rates of suicide were identified in:

- Managers (ISCO major group 1) and
- Clerical workers (ISCO major group 4)

It was concluded that in general lower skilled occupations tend to have higher risk of suicide than highly skilled occupations. Analysis of Australian suicides supports these findings. Investigations of suicides in Queensland found elevated suicide rates among male workers in agricultural, cleaning, construction and transport industries and female nurses and artists. This same study found the suicide rate was lowest among education professionals. In Victoria, elevated suicide rates have been identified among managers, technicians and trades workers and professionals [e.g. engineers and accountants].
Industry-wide approaches to suicide prevention

The following two examples highlight the key role industry groups can play in suicide prevention:

1. **SuperFriend** is a national mental health promotion foundation that helps ‘all profit to member’ superannuation funds to promote and support improved mental health and wellbeing for their members, through the workplace. Created by the Industry Funds Forum, an association whose members are the CEOs of Australia’s largest industry super funds, SuperFriend collaborates with industry funds, group insurers and the mental health sector to facilitate targeted workplace mental health programs, initiatives and research to benefit members and member workplaces. Through its Partner Funds, SuperFriend has potential reach to 7.1 million Australians and 680,000 employers.

   A key project of SuperFriend, SuperMIND is an initiative to collect, analyse and understand superannuation claims relating to mental illness and suicide. The project aims to influence and affect industry changes in the way member and claims data is collected, maintained and reported. In turn, targeted programs aimed at reducing the incidence of suicide and the severity and length of mental health related disability claims can be developed. Data collected will inform best practice for funds and insurers so they can use the available information to achieve a meaningful reduction in the incidence of mental illness and suicide within their membership base.

   www.superfriend.com.au

2. **MATES in Construction** is a charity set up in 2008 to reduce the high level of suicide among Australian construction workers. It is owned and controlled by the Australian Building and Construction Industry. The organisation was established to implement the recommendations of a major report on suicide within the Queensland Commercial Building and Construction Industry. The report found that suicide rates in the industry were higher than the Australian average for men, and that youth suicide within the industry was more than double the rate of the working-age male population in Australia49. Workers in the Queensland Construction industry, according to these statistics, are six times more likely to suicide than to die from an industrial accident49.

   MATES in Construction is based on the simple idea that “suicide is everyone’s business” and that if the building and construction industry in Australia is to improve the mental health and wellbeing of workers and to reduce suicide, everyone in the industry must play their part.

   www.matesinconstruction.com.au
**Working conditions**

WHO states that stressful work environments are characterised by a lack of time, uncontrollable work schedules, background distractions, strife (caused by poor employee relations, bullying or harassment), lack of space, general uncertainty and a push to do more with less.\(^50\)

As previously stated, a review of Victorian suicides between 2000–2007 attributed 55 per cent of work-related suicides to work stressors.\(^51\) In these cases, the most common work-related stressors identified were:

- General/other work stress (21%)
- Business-related financial problems (21%)
- Recent retrenchment or fear of this or resignation (19%)
- Unable to find employment (9%)\(^52\).

Many of these deaths also involved non-work stressors such as depression, anxiety or other mental illness, relationship problems or substance abuse issues, however, work-related stressors were the sole stressor in 45 per cent of these suicides.\(^53\)

Adverse conditions here included very repetitive monotonous work, increased responsibility felt as a burden, and pronounced mental strain due to contact with work clients.

It is worth noting that in this study, more than half of all suicides deemed work-related also had other stressors noted including a history of anxiety and depression or other mental illness, relationship problems, drug and alcohol abuse or other health problems.

It is a reminder that work does not function in isolation—it interacts with many other aspects of the individual’s life.

**Models that predict stress in the workplace may offer some insight into the relationship between work conditions and suicide. For example, under the job demand/control model\(^55\), people who work in roles that are highly demanding, and in which they have little control over the workload, are likely to feel greater stress.\(^56\) It has been hypothesised that the same combination of high demand and low control may contribute to suicidality\(^57\), although this model has not been tested in the Australian context.

Overall there is limited research looking at the specific relationship between working conditions and suicide. However, given the established relationship between poor mental health and suicide, employers should actively work to ensure the workplace promotes positive mental health.

**Clusters & contagion in workplaces**

A suicide cluster may be identified when a group of suicides or suicide attempts occur closer together in time and space than would normally be expected on the basis of statistical prediction and/or community expectation.\(^58\)

It is thought that some clusters may be due to contagion, the process where one person’s suicide influences another person to engage in suicidal behaviour, although the mechanisms for contagion are not well understood.\(^59\)

Clusters in the workplace may also be indicative of an underlying workplace culture or work conditions that cause psychosocial harm.

There has been a number of high profile cases of multiple suicides in a workplace, or within an organisation. The best known recent occurrence involves France Telecom, which in 2008 and 2009 went through a period of significant restricting, downsizing and cost-cutting. Between 35 and 60 employees died by suicide, some of whom left notes which blamed harassment and bullying by management. The CEO accountable has been indicted in what will be a test case in France.\(^60\) Another involved Foxconn, a manufacturing company in Zhengzhao, China, which contracts to Apple and HP, among others. Media reports suggested 14 people died by suicide in 2010, with harsh working conditions and low pay blamed.\(^61\)

In addition to promoting a workplace conducive to mental health and wellbeing, action can be taken to minimise the likelihood of contagion after a suicide has occurred in a workplace. Postvention programs provide bereavement support, assisting employers and staff in their grief and loss responses.

Where there is a suggestion of a potential emerging cluster in a workplace it is recommended that assistance is sought via programs such as the StandBy Critical Postvention Response program which will assist workplaces take steps to reduce risk of further suicides.\(^62\)
Unemployment

Unemployment is a risk factor for suicide attempt and suicide, with higher rates of suicide occurring during periods of higher unemployment.

Analysis of economic conditions and mortality rates across 26 European countries from 1970-2007 found that every 1% increase in unemployment was associated with a 0.79% increase in suicides among working age adults, with the effect even larger when unemployment rates rose rapidly by 3% or more. The effect was not consistent across sex and age groups with the strongest significant effect found among males aged 24–35 and 55–64 years. Conversely, during periods of rising unemployment the same study found that longer unemployment was associated with a reduction in suicide rates.

One interpretation of these findings is that during rising periods of unemployment job-loss is a normative experience, while the jobless during more prosperous times may experience greater hopelessness and stigma. Long-term unemployment is associated with reduced financial security and status, family tensions and loss of self-esteem which may contribute to suicidality.

Looking at long-term unemployment, a review of the limited number of existing pieces of international research available found that the long-term unemployed carried increased risk of both suicide attempt and suicide compared to the short-term unemployed and the general population. Further, this risk is greatest in the first five years, and persists at a lower but elevated level up to 16 years after unemployment.

Length of unemployment

Australian research comparing the country’s suicide rates against unemployment rates during the period 1985–2006 found that during periods of declining unemployment rates, longer periods of unemployment (over four weeks) were associated with higher suicide rates for men but not for women. This effect was most prevalent among males aged 24–35 and 55–64 years. Conversely, during periods of rising unemployment the same study found that longer unemployment was associated with a reduction in suicide rates.

Every 1% increase in unemployment was associated with a 0.79% increase in suicides among working age adults.

Mental illness

Mental disorders are a major risk for suicide. Specific mental disorders that have been linked to suicide include depression, substance abuse (both alcohol and drugs), personality disorders and schizophrenia. Co-occurring conditions are particularly common among those who take their own life.

Given that most people work it follows that the majority of people who experience mental health problems will be in the workforce. Mental health problems are leading cause of occupational disability, while depression is expected to be the leading cause of disability in developed countries by 2020.

The influence of unemployment on suicide rates remains present even after controlling for mental illnesses such as depression or anxiety and other variables. Similarly, the impact of adverse psychosocial working conditions on suicide is independent of mental illness.

Workplace bullying

Bullying can have a serious impact on an individual’s health and wellbeing, and there is some evidence linking bullying to suicidal behaviour.

Over the past few years in Australia, there have been a number of high profile cases where suicide was linked to...
workplace bullying. One such case was the suicide of 19 year old Brodie Panlock, a waitress working in Victoria, who took her own life after experiencing prolonged and vicious bullying at work. Five of Brodie’s work colleagues were convicted and fined a combined $335,000 for their roles in the bullying. As a result of this tragic case, the Victorian Crimes Act was amended to include ten year prison sentences for bullying under what is commonly known as ‘Brodie’s law’.

In 2012, a Commonwealth Inquiry into workplace bullying was conducted to review the issue and identify how responses across the country could be improved. The report of the Inquiry Workplace Bullying “We just want it to stop” identifies a range of systemic improvements to respond to bullying as well as measures to enhance prevention and early intervention efforts.

In response to the report recommendations, Safe Work Australia have published a Guide for preventing and responding to workplace bullying to assist employers address issues around bullying.

Everyone at the workplace has a duty under work health and safety laws and can help to ensure workplace bullying does not occur.

Suicide and workers compensation

There is limited research addressing suicides or suicide attempts and the workers compensation system. A Safe Work Australia report identified 50 claims for suicide or suicide attempt between 2008–09 and 2010–11, with 59.4% of these claims being made by males (includes claims from all states/territories except Victoria).

Suicide and suicide attempt represented only 0.2% of all mental stress claims during this period. The report sheds no light on the circumstances of these claims.

In a report for the Creative Ministries Network in 2010, Bottomley and Neith looked at the Victorian WorkCover Authority’s compensation claims database to identify claims involving suicidal behaviour. Between 1985 and 2007 there were 21 claims for death by suicide and 36 claims for attempted suicide. It was noted that this is likely to be a significant underrepresentation of the actual number of work-related and/or workers compensation-related suicides or suicide attempts.

Three key risks were identified in the study. First, there was a tendency for some people to enter the workers compensation system due to a physical injury but later experience psychological deterioration prior to death. Second, length of time on compensation was correlated with greater suicidal behaviour. Those who had previously made a claim and went on to die by suicide were on workers compensation for almost three times as long as those who attempted suicide. Third, younger workers on workers compensation appeared to be more vulnerable than older workers.

It is not possible from the available data to make causal links between the workers compensation system and suicide however, the relationships identified in this study warrant further investigation. It is especially concerning that workers compensation claims database and the Victorian Coronial database. The coronial database identified work factors as contributing to suicide in only 9 of the 21 workers compensation cases. While these two databases serve different purposes and were not designed for comparison, this situation highlights the need for coronial processes to consider the work environment in all cases of suicide. SPA agrees with Bottomley and Neith that coronial processes should include work factors including workers compensation claims, when conducting psychosocial autopsies of those who died by suicide. This will assist future research investigating the relationship between work, workers compensation and suicide.

For more information on the relationship between chronic pain and suicide download SPA’s Chronic Illness, Chronic Pain and Suicide Prevention Position Statement from www.suicidepreventionaust.org.
Protective factors reduce the likelihood of suicidal behaviour and give some indication of a person’s ability to cope with difficult circumstances. Protective factors often sit at the opposite end of a continuum to risk factors (e.g., strong connections to family, friends and community are a protective factor whereas social isolation is a risk factor).

General protective factors include:
- Mental health and wellbeing
- Being female
- Strong social connections with family, friends and community
- Physical and emotional security
- Safe and affordable housing
- Mid to high socioeconomic status
- Access to support services.

In addition, protective factors that are highly relevant to work and suicide are:
- Being employed
- Having a sense of meaning and identity
- Job security
- Limited exposure to environmental stressors including work stress
- Low levels of stigma and a positive attitude to help-seeking.

Despite much research, there is a lack of high quality evidence regarding what interventions are effective in preventing suicide. This paper must be viewed within this context.

A recent approach by van der Feltz-Cornelis and colleagues provides a structure based on best practice and suggests there are six levels at which there is evidence that suicide prevention efforts can be effective:

- Cooperation with General Practitioners (GPs) to improve their knowledge and abilities in detecting and managing suicide risk
- Public awareness campaigns and cooperation with local media to improve public attitudes on depression
- Training sessions for gatekeepers, healthcare professionals, geriatric care providers, counsellors, religious leaders and other community facilitators on management of depression and suicide risk
- Services and self-help activities for high risk groups to facilitate access to professional help
- Restriction of access to potential lethal means
- Improvement of access to care.

This paper will focus on suicide prevention activities most suitable for the workplace—increasing access to care and gatekeeper training. In addition, other approaches with promising but less substantial evidence will be identified including mental health and suicide literacy and skills training.

Increasing access to care

Access to care is an important issue in workplace suicide prevention. For many workers, working hours can make help seeking very difficult. For example, the length of normal working days in the construction industry can be ten hours with eight-hour days on the weekend. Visiting a GP or psychologist when working these hours can be a major logistical challenge.

Fly-in-fly-out (FIFO) workers may find it even more difficult to access health care. Recent research commissioned by Lifeline WA identified a significant structural barrier to accessing care was poor communication coverage in remote work areas. In addition, one in five workers in the study claimed their industry did not
have on-site mental health or on-site counselling facilities.

Provision of Employee Assistance Programs (EAPs) which give employees access to confidential psychological and health care services can be useful in improving access to care.

**Gatekeeper training**

Gatekeeper training is seen as a highly promising suicide prevention strategy\(^94\), with good evidence of benefits such as increased knowledge about suicide prevention and improvements in self-rated efficacy to provide crisis intervention in workplace settings in the United States\(^95\), Scotland\(^96\) and Canada\(^97\).

**Mental health and suicide literacy**

Mental health literacy refers to knowledge and beliefs about mental disorders including how to recognise them, understanding of risk factors and what types of help are appropriate as well as where to find help\(^99\). Similarly, suicide awareness or literacy reflects an understanding of the risk factors and causes of suicide, signs that a person may be suicidal, appropriate help-seeking as well as combating harmful myths or stigma surrounding suicide\(^100\).

A range of training programs are available in Australia to build literacy.

Training is also available to teach crisis intervention skills, equipping people with a range of skills to provide appropriate support and referral to individuals in crisis.

Training courses are offered both to the general community and tailored to the specific needs of a workplace. Contact the SPA office for details of training organisations.

**Provision of Employee Assistance Programs (EAPs) which give employees access to confidential psychological and health care services can be useful in improving access to care.**

Gatekeeper training involves identifying a group of people who are in a natural position to carry out informal surveillance of a larger community of people. These ‘gatekeepers’ can be trained to detect individuals at risk and refer them to appropriate supports. Potential gatekeepers include clergy, police, sports officials, teachers, co-workers, shopkeepers and others who get to know a community of people well.

It has been suggested that gatekeeper training should contain the following elements:

- Theoretical aspects of depression and suicide, including symptoms and treatment
- Practical elements, such as how to talk about suicidality, how to detect suicidality and how to handle an acute suicidal crisis

**Multifaceted workplace suicide prevention programs**

Multifaceted suicide prevention programs combine gatekeeper training with mental health and suicide literacy as well as improved access to care. An international example of a successful multilevel workplace program is the *Together for Life* program which targeted the police force in Montreal, Quebec.

Under this program all police officers participated in a half day training course focused on building mental health and suicide literacy; supervisors and union representatives undertook a one day gatekeeper training course; access to care was facilitated by establishing a dedicated confidential telephone helpline for police; and the program was promoted to the workforce via articles in the internal newsletter and posters displayed in the workplace\(^101\).

Over the 12 years the *Together for Life* program ran the suicide rate among Montreal police decreased by 79% [from 30/100,000 to 6/100,000], while suicide rates among other Quebec police and the people of Quebec remained stable\(^102\). The program was also well received by staff.

A study on this program was unable to tease out which elements of the program contributed to its success, and it was suggested that the synergy between different elements may have been important. Key features of *Together for Life* were that it was authentic, multifaceted and designed with the specific workforce in mind\(^103\).
An exemplar multifaceted suicide prevention program in the Australian context is the MATES in Construction program. This program was developed in 2008 in response to findings that suicide rates among young (15–24 years), predominantly male, Queensland construction workers were approximately double that of working-age Australian males. MATES in Construction provides:

- General suicide awareness training to at least 80% of workers on participating construction sites
- Half day gatekeeper training for ‘connectors’ - volunteers on site who have basic suicide intervention skills and can connect a worker to referral pathways
- Two day Applied Suicide Intervention Skill Training (ASIST) for volunteers who are able to act as mental health first aid officers on site and provide more detailed help in crisis
- Centrally employed field officers who are able to provide supervision support for connectors and first aid officers as well as deliver training
- Clear referral pathways to help and case management processes to ensure workers in need are connected to appropriate care
- Access to 24-hour telephone crisis support as well as promotion of this service in the workplace
- Critical incident and postvention support to assist impacted workmates after a suicide attempt to has suicide occurred.

Central to MATES in Construction is cultural change ensuring mental health is given the same status as physical health. Involvement of peers in the workplace has been important in developing this safety culture.

As of January 2014, over 44,000 people have undertaken MATES in Construction training. While the impact of the program on suicide rates among the target workforce has not yet been assessed, suicide awareness levels and help-seeking has increased.

The Australian construction industry has prioritised mental health and suicide prevention with other targeted programs also available and an annual construction industry mental health conference.

Multifaceted suicide prevention programs combine gatekeeper training with mental health and suicide literacy as well as improved access to care.
MATES in Construction case example

Peter, a builder’s labourer and Connector [gatekeeper], called the MATES in Construction 24-hour helpline. He was with Andrew. Peter had noticed that Andrew had changed over the past few weeks. Andrew, a bricklayer, was normally a friendly, tidy and competent tradesperson but Peter had noticed he had become aggressive and withdrawn. The conversation went a bit like this: “It’s Peter here, I am sitting with Andrew he is not doing so well – actually he is pretty f….d” (laughing a little in the way we do when we deal with an uncomfortable truth).

Andrew was under financial and domestic pressure and in the preceding week he had had a fight with his wife who had left with the children. There was now a domestic violence order against him. Peter had asked Andrew about his aggressive behaviour in the week prior—“Mate, it is not like you, what’s up”—but Andrew had brushed him off.

The day after the fight with his wife, Andrew had made all the preparations for suicide and was about to complete the act when a friend came by. When Andrew returned to work he sought out Peter as he knew Peter was a Connector.

Peter was directed to the union delegate on site who was registered with the MATES in Construction program as an ASIST worker and could provide safety in the short term. Arrangements were made with Andrew’s employer to provide Andrew with low risk work with Peter until the MATES in Construction Case Manager came to site that afternoon.

Andrew was connected to crisis counselling, a criminal and family lawyer and was put in contact with the local hospital Alcohol, Tobacco and Other Drugs Service to deal with a severe alcohol abuse issue revealed in the process.

Six months later Andrew is doing well, he has regular contact with his children and is employed with the same employer. While he is still battling his alcohol abuse issue, the starting point in resolving any issue is to recognise it.

Case study kindly provided by MATES in Construction.
Policy can and must respond more effectively to challenges for labour market inclusion of people with mental illness and suicidal ideation, and for those returning to work after suicide attempt or bereavement.

Two elements stand out for policy makers:
1. To intervene at the right time; and
2. Coordinate interventions effectively.

The complexity of suicide demands that progress can only be made by thinking beyond silos and developing inter-sectoral policies and programs.

Taking an industry-based approach to the design and development of suicide prevention activities—as opposed to requiring individual employers to take action—may assist in overcoming such barriers.

Organisations of all sizes should, and can, have health and safety policies and programs that promote mentally healthy workforces and prevent psychosocial injury and suicidal behaviours. Employers have a duty under work health and safety legislation to ensure the workplace is safe, both in terms of physical health and safety as well as mental health.

Funding agencies and service providers should take into account the varying needs of industries and organisations as well as the potential reach and impact of workplace suicide prevention activities.

The World Health Organization states ‘the workplace directly influences the physical, mental, economic and social wellbeing of workers and in turn, the health of their families, communities and society. It offers an ideal setting and infrastructure to support the promotion of health to a large audience’.

The Australian Government’s Healthy Workers Initiative provides $294.3 million from 2009–10 to 2017–18, mainly through states and territories, to support workplace health programs that focus on decreasing rates of overweight and obesity, increasing levels of physical activity and intake of fruit and vegetables, smoking cessation and reducing harmful levels of alcohol consumption. Notably, mental health and suicide prevention were excluded from the Healthy Workers Initiative.

A portion of that funding could be directed towards mental health, of which suicide prevention could be an element, either explicitly or implicitly.

Experience shows that it is difficult to deliver health promotion programs to those who are self-employed or working in small organisations. Small business owners say they do not have the time to run...
health programs, and unions have lower membership rates among smaller businesses. For industries composed predominantly of self-employed or small employers an industry based approach helps overcome these barriers. Medium and large organisations may prefer to develop an organisation specific program.

**National Mental Health Commission**

The National Mental Health Commission (NMHC) has drawn attention to the significant role of workplaces in the promotion of mental health and in suicide prevention, as well as the importance of employment in a contributing life\(^{112}\).

In 2012, the NMHC joined with eleven partner organisations to form the Mentally Healthy Workplace Alliance\(^{113}\). The Alliance seeks to advance good workplace practices, drive cultural change among business leaders and end workplace discrimination against those with serious mental health concerns.

In 2014, the Alliance will launch a national kit of practical advice and tools for employers\(^{114}\).

**LIFE Framework: National Suicide Prevention Strategy**

The Living Is For Everyone (LIFE) Framework, published in 2007, guides Australia’s National Suicide Prevention Strategy (NSPS) and sets out priority target audiences, settings and interventions\(^{115}\). The workplace is explicitly identified as a domain impacted by suicide with ‘work colleagues’ a stated target audience. Access to support in the workplace in times of crisis is identified as an area for focus in the implementation of the LIFE Framework. Key workplace strategies to prevent suicide and help build both individual and community resilience are listed as de-stigmatisation of mental health problems and other factors that give rise to suicide risk [e.g. homelessness, mental illness] and help-seeking in the workplace.

The LIFE Framework calls for improvements in the capacity of workplaces to respond to those in imminent risk and encourages establishment of pathways to care drawing on local services to ensure a seamless service.

Six workplace focussed projects are currently funded under the NSPS and target apprentices, young workers and men working in the building, construction and mining industries as well as retail, hospitality and farming\(^{116}\). Together, these projects operate in the ACT, NSW, NT, TAS, VIC and WA.

Additional funding for work-related suicide prevention programs is provided under the Taking Action to Tackle Suicide (TATS) package\(^{117}\). Work-related projects funded under TATS include mental health and suicide awareness training for frontline community workers such as financial, legal and relationship counsellors, and healthcare workers; expansion of beyondblue’s National Workplace Program\(^{118}\) through the development of elearning resources for workplaces and provision of subsidised face-to-face workshops; targeting unemployed men with campaigns on depression and stigma reduction; and additional services targeting men in the building industry.

Targeted suicide prevention activities are also funded through various government departments [at state/territory or federal level] including veterans’ affairs, defence, justice, education, employment and immigration.

At the current time, funding for projects covered by the NSPS ends effective 30 June 2014. The government has not yet committed to continuation of funding attached to the NSPS. Funding for projects under the TATS package runs to the end of 2015.

Despite the Australian Government investing $127.1M in the NSPS between 2006–2012\(^{119}\), concerns have been raised that this has been ineffective in preventing suicide\(^{120},^{121}\).

On 4 February 2014, the terms of reference for the Mental Health Review, to be conducted by the NMHC, were announced by the Minister for Health\(^{122}\). This review will examine existing mental health services and programs across the government, private and non-government sectors. Programs and services which focus on suicide prevention are to be included in the review. The NMHC is due to report on the review by the end of November 2014.

It is expected that decisions about future government investment in suicide prevention activities, programs and services will be made after the review has been completed.
Almost all people who die by suicide have shown one or more warning signs before their death. These warning signs generally include:

- A feeling of hopelessness
- Feeling trapped with no options and no way out
- Seeing no reason to live and no sense of purpose to life
- Increasing alcohol and/or drug use
- Withdrawing from friends, family and/or society
- Self-harming and/or attempting suicide
- Showing impaired judgement and/or uncharacteristic behaviour

The following information, taken from the WHO resource *Preventing Suicide: A Resource at Work*, provides useful information to help identify and respond to someone who is suicidal in the workplace.

There are no firm rules to follow to recognise when a worker may be suicidal. People will vary in the extent to which they will share problems with others, particularly managers and work colleagues. The majority of those who do take their lives give definite warning signs of suicidal intentions.

Almost all people who die by suicide have shown one or more warning signs before their death.

These are not harmless bids for attention but important cries for help that should be taken seriously.

Warning signs may include:

- Being withdrawn and unable to relate to co-workers
- Talking about feeling isolated and lonely
- Expressing fears of failure, uselessness, lack of hope or loss of self-esteem
- Impulsivity or aggression
- Fragmented sleep
- Dwelling on problems with seemingly no solutions
- Speaking about tidying up affairs

There is greater risk if these signs are coupled with any of the following:

- Recent loss of close relationship
- Sudden change in work circumstances
- Serious or embarrassing work-related event
- Increased misuse of alcohol
- History of suicidal behaviour
- Current depression, burnout or unexplained fatigue

A colleague can help by:

- Expressing acceptance and concern
- Encouraging the person to talk. Asking someone if they are suicidal will not tip them over the edge but provide a starting point for a solution
- Gently letting the person know confidentiality will have to be broken in order to notify appropriate persons within the organisation
- Taking immediate action to refer the person to a specialist
- Identifying and arranging support among family members and close friends or colleagues
- Following company policy with respect to documentation
- Arrange to have the person supported to return to work as soon as possible making provision for as much flexibility as possible
- Creating a supportive environment for the person to return to work after a suicide attempt
- Eliminating or reducing job stress and other work-related psychosocial hazards.
Case study: Responding after a suicide

About five weeks before a medium sized business was to close the staff enjoyed a night out to celebrate the end of their working together. The team was mostly young and had worked together for some time. The day after the dinner, one young male employee did not turn up. Later that evening a call from his family to Sharon, the manager, told her that he had taken his own life. Needless to say, this was a great shock as Sharon was responsible for closure of the centre and the re-deployment of staff. She immediately did four things:

1. Offered condolences to the family and checked with them that she could inform the team the next day
2. She called the HR Manager who worked on a secondary location and who agreed to come to the site the following morning to assist in telling the team. The HR manager also told other key people including the CEO
3. She contacted the StandBy Response team for advice on how to best tell the staff this sad news
4. She also invited StandBy team to provide crisis responders at the workplace should any staff wish to be supported

The next day, Sharon and the HR Manager gathered the team together in a quiet place separate from their workspace. They delivered the news in a caring and concise way, telling the team they would keep them informed as information emerged.

The team were provided with space and time to digest the information and offered access to the response team from StandBy that afternoon. StandBy assisted the Manager and HR Manager to develop a short term bereavement response plan for the workplace and media management. This included linking individual staff to support services from within the local community via prearranged care pathways.

As the week progressed, Sharon was able to provide staff with funeral details and together the group decided that a small number of people, with the CEO, would be appropriate to attend the funeral.

At the funeral, the parents of the young man requested to visit his workplace to meet some colleagues and retrieve his personal belongings. This was arranged and over a small informal lunch the parents and staff talked and others helped to clear his desk.

It was a difficult day but again Sharon organised for StandBy staff to attend. His parents were comforted and reassured by the compassionate welcome they received.

Literature was made available on how to access support outside the workplace after the call centre’s closure and re-deployments and StandBy’s follow up procedures.

Case study kindly provided by the National StandBy Response Service

How colleagues can help after a suicide attempt

Co-workers can be reluctant to intervene because they fear for the person or are anxious not to jeopardise close working relationships. However, not discussing or acknowledging the incident can create feelings of isolation and social distance. When people are recovering from a mental condition peer group support is very important and need to:

- Feel accepted and supported
- Speak openly about the circumstances; and
- Be reassured and re-integrated into the workplace environment

When a workplace suicide occurs

A timely response to a workplace suicide can reduce subsequent ill effects among surviving workmates and friends. Workplaces need to move swiftly and with consideration should a suicide or attempt occur.

- Enlist emergency personnel immediately
- Brief workers immediately in an open and honest manner without discussing the method of death
- Provide accurate information about suicide risk factors
- Organise an appropriate tribute for the person who died

Support workmates to manage their grief

Identify vulnerable or high risk individuals and ensure employee assistance programs are available

Conduct a critical incident review

Implement occupational health and prevention strategies.
Key websites for suicide prevention in Australia

**Suicide Prevention Australia (SPA)**
Phone: 02 9223 3333
www.suicidepreventionaust.org
SPA is the peak body for the suicide prevention sector in Australia. SPA brings together diverse interests across disciplines to promote collaboration and partnerships between communities, practitioners, research and industry. SPA works to develop a community that knows how to ask for help and how to give it. As the lead agency of the National Coalition for Suicide Prevention, SPA works in partnership to reduce the stigma around mental illness and suicide and to assist the healing for people with lived experience of suicide attempts and suicide.

**Conversations Matter**
www.conversationsmatter.com.au
Conversations Matter is a practical online resource to support safe and effective community discussions about suicide.

**LIFE Communications**
www.livingisforeveryone.com.au
Living Is For Everyone (LIFE) provides the available evidence and resources to guide activities aimed at reducing the rate at which people take their lives in Australia. The site is designed for people across the community who are involved in suicide and self-harm prevention activities. LIFE Communications is a National Suicide Prevention Strategy project.

**Lifeline**
Lifeline provides all Australians experiencing a personal crisis with access to online, phone and face-to-face crisis support and suicide prevention services. A range of services are also provided through local Lifeline Centres across Australia that meets the needs of local communities. In the ‘Get Help’ section of the website, access various information and self-help tools for suicide prevention as well as online crisis chat.

**National Mental Health Commission**
www.mentalhealthcommission.gov.au
The National Mental Health Commission focuses on three main things, to report, advise and collaborate with the aim of transforming systems and promoting change, so that all Australians achieve the best possible mental health and wellbeing.

Key workplace suicide prevention and mental health organisations

**beyondblue**
www.beyondblue.org.au
*beyondblue* is Australia’s national depression and anxiety initiative. *beyondblue* has a focus on the workplace setting and has a range of resources related to mentally healthy workplaces. This includes both online resources and face-to-face workshops focussing on raising awareness and reducing stigma, improving skills to manage issues related to mental health in the workplace and preventing workplace related mental health problems.

**Comcare**
www.comcare.gov.au
Comcare partners with workers, their employers and unions to keep workers healthy and safe, and reduce the incidence and cost of workplace injury and disease. Comcare has published a useful guide to empower managers and employees to work together to build inclusive workplace cultures and effective systems for promoting mental health in the Australian Public Service. The guide, *Working together: Promoting mental health and wellbeing at work*, is available on the Comcare website.
The Mentally Healthy Workplace Alliance is a new national approach by business, community and government to encourage Australian workplaces to become mentally healthy for the benefit of the whole community and businesses, big and small.

**SuperFriend**


SuperFriend is a national mental health promotion foundation that helps ‘all profit to member’ superannuation funds to promote and support improved mental health and wellbeing for their members, through the workplace. One initiative facilitated by SuperFriend is the provision of mental health and wellbeing training to staff across the financial services sector. The aim of the training is to build sector capacity, prevent suicide and minimise the impact of mental health problems for members and member workplaces.

**Crisis support services**

**Kids Helpline**

Phone: 1800 55 1800

Kids Helpline is a free, private and confidential, 24 hour counselling service for young people aged 5-25 years. Counselling is offered by phone, email and over the web.

**Lifeline**

Phone: 13 11 14


Lifeline provides all Australians experiencing a personal crisis with access to online, phone and face-to-face crisis support and suicide prevention services. A range of services are also provided through local Lifeline Centres across Australia that meets the needs of local communities. In the ‘Get Help’ section of the website, access various information and self-help tools for suicide prevention as well as online crisis chat.

**MensLine**

Phone: 1300 78 99 78

MensLine Australia is a professional telephone and online support, information and referral service, helping men to deal with relationship problems in a practical and effective way.

**Suicide Call Back Service**

Phone: 1300 659 447

[www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)

The Suicide Call Back Service is a 24-hour, nationwide service that provides telephone and online counselling to people 15 years and over who fit one of the following categories: people who are suicidal, people caring for someone who is suicidal, people who are bereaved by suicide, or a health professionals supporting a suicidal individual.

**State mental health crisis lines (available 24/7)**

Contact your state or territory mental health crisis line to ask about crisis support services in your local area including psychiatric crisis teams or Crisis Assessment and Treatment Teams (CATT).

**ACT**

Mental Health Triage Service
Phone: 1800 629 354

**NSW**

Mental Health Line
Phone: 1800 011 511

**NT**

Top End Mental Health Service
Phone: 08 8999 4988

**QLD**

13 HEALTH
Phone: 13 43 25 84

**SA**

Mental Health Assessment and Crisis Intervention Service
Phone: 13 14 65

**TAS**

Mental Health Services Helpline
Phone: 1800 332 388

**VIC**

Suicide Help Line
Phone: 1300 651 251

**WA**

Mental Health Emergency Response Line
Phone: 1800 676 822

**Specialist support after a suicide**

**National StandBy Response Service**

Phone: 07 5442 4277

Email: standbynational@unitedsynergies.com.au

The National StandBy Response Service provides a 24 hour coordinated community response to families, friends and communities who have been bereaved through suicide. StandBy offers tailored workplace responses to suicide including the Critical Postvention Response program to assist workplaces deal with emerging suicide clusters.

**Events & national days for suicide prevention**

**R U OK? Day**


R U OK? Day is a national day of action on the second Thursday of September and dedicated to reminding people to regularly check in with family and friends.
**World Mental Health Day**  
www.1010.org.au  
World Mental Health Day is held every year on 10th October and coincides with National Mental Health Week. This is a time to encourage the community to learn more about mental health and wellbeing, with many events and campaigns run across the country.

**World Suicide Prevention Day (WSPD)**  
www.wspd.org.au  
World Suicide Prevention Day is held every year on the 10th September. On this day, numerous events, conferences, campaigns and local activities call to public attention one of the world’s largest causes of premature and unnecessary death – suicide.

**Research centres**

Research centres can provide access to the latest evidence base about what works in suicide prevention. Key research centres for suicide prevention are:

- **Australian Institute for Suicide Research and Prevention (AISRAP)**  

- **National Centre of Excellence in Suicide Prevention (CRESP)**  
  www.cresp.edu.au

**Training**

Suicide awareness training is offered by a range of organisations across the country including the following:

- **Australian Institute for Suicide Research and Prevention (AISRAP)**  

- **Community Response to Eliminating Suicide (CORES)**  
  www.cores.org.au

- **Farm-Link (Centre for Rural and Remote Mental Health)**  
  www.crrmh.com.au

- **Hope for Life Suicide Prevention & Bereavement Support (Salvation Army)**  
  www.suicideprevention.salvos.org.au

- **Lifeline**  
  www.lifeline.org.au

- **LivingWorks Australia**  
  www.livingworks.com.au

- **Mental Health First Aid**  
  www.mhfa.com.au

- **MindOut! The National LGBTI Mental Health & Suicide Prevention Project**  
  www.lgbtihealth.org.au/mindout

- **On the Line**  
  www.ontheline.org.au

- **QPR Suicide Prevention online training program**  

- **Suicide Story (Indigenous suicide prevention)**  
  www.mhaca.org.au

- **Wesley LifeForce**  
  www.wesleylifeforce.org
**Glossary**

**Absenteeism:** Unavailability of an employee to work.

**Gatekeeper:** A person who holds an influential position in either an organisation or a community who coordinates or oversees the actions of others. This could be an informal local opinion leader or a specifically designated person, such as a primary-care provider, who coordinates patient care and provides referrals to specialists, hospitals, laboratories, and other medical services.

**Mental health:** The World Health Organization defines mental health as “a state of well-being in which the individual realises his or her own abilities, can manage the normal stresses of life, work productively and fruitfully and is able to make a contribution to his or her community.”

**Mental disorder:** A recognised, medically diagnosable illness or disorder that results in significant impairment of an individual’s thinking and emotional abilities and may require intervention. There are many different mental disorders.

**Mental health problem:** A situation in which a person experiences some disturbance or impairment of normal emotions and/or thinking.

**Presenteeism:** The productivity that is lost when employees come to work but, as a consequence of illness or other medical conditions, are not fully productive.

**Prevention, Intervention and Postvention:**

a) **Prevention:** Preventing conditions of ill health from arising.

b) **Intervention:** To take action or provide a service so as to produce an outcome or modify a situation. Any action taken to improve health, or change the course of, or treat a disease or dysfunctional behaviour.

c) **Postvention:** the provision of crisis support and assistance for those affected by a suicide death.

**Suicidal behaviour:** Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

**Suicide prevention:** Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

**Wellbeing:** A state characterised by health, happiness, and prosperity.
References

3. ABS (2013a)
5. WHO (2006)
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12. Ibid.
21. ABS (2013a)
23. ABS (2013a)
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29. Ibid.
30. Ibid.
33. See the Work Health and Safety Act in each state or territory
35. WHO (2006)
36. Routley & Ozanne-Smith (2012)
38. Routley & Ozanne-Smith (2012)
39. Ibid.
41. Mendoza & Rosenberg (2010)
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91. Ibid.


98. van der Feltz-Cornelis et al. (2011)


101. Mishara & Martin (2012)

102. Ibid.

103. Ibid.


105. See www.matesinconstruction.com.au

106. See www.matesinconstruction.com.au

See, for example, OzHelp Foundation [www.ozhelp.org.au] and Incolink [www.incolink.org.au]

See Commonwealth, state and territory legislation such as Work Health and Safety Act 2011 [Cth]


See www.workplacementalhealth.com.au


The LIFE Framework is available at www.livingisforeveryone.com.au

Organisations funded are Incolink (VIC), OzHelp (WA), OzHelp Tasmania (TAS), OzHelp NT (NT), Farm-Link/ Centre for Rural and Remote Mental Health (NSW). More information available at http://livingisforeveryone.com.au/Projects.html


For more information see http://www.beyondblue.org.au/workplace. The National Workplace Program is developed and managed by beyondblue and delivered by Davidson Trahaire Corpsych


Mendoza & Rosenberg (2010)

Available for download in various languages at http://www.who.int/mental_health/resources/preventingsuicide/en/
Listed below is a summary of key crisis support services available across Australia.

<table>
<thead>
<tr>
<th>Service</th>
<th>Who?</th>
<th>Telephone counselling</th>
<th>Online crisis counselling</th>
<th>Other details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifeline</strong></td>
<td>Anyone experiencing a personal crisis or thinking about suicide</td>
<td>Available 24/7</td>
<td>Available at set times - see website for details</td>
<td></td>
</tr>
<tr>
<td>Phone: 13 11 14 <a href="http://www.lifeline.org.au">www.lifeline.org.au</a></td>
<td></td>
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</tr>
<tr>
<td><strong>Suicide Call Back Service</strong></td>
<td>Anyone aged 15+ yrs who is suicidal, caring for someone who is suicidal, bereaved by suicide, or a health professional supporting a suicidal individual</td>
<td>Available 24/7</td>
<td>Available at set times - see website for details</td>
<td>Access up to 6 x 1 hr telephone counselling sessions</td>
</tr>
<tr>
<td>Phone: 1300 659 467 <a href="http://www.suicidecallbackservice.org.au">www.suicidecallbackservice.org.au</a></td>
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<td></td>
</tr>
<tr>
<td><strong>Kids Helpline</strong></td>
<td>Young people aged 5-25 yrs</td>
<td>Available 24/7</td>
<td>Web &amp; email counselling</td>
<td></td>
</tr>
<tr>
<td>Phone: 1800 55 1800 <a href="http://www.kidshelp.com.au">www.kidshelp.com.au</a></td>
<td></td>
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</tr>
<tr>
<td><strong>MensLine Australia</strong></td>
<td>Men, all ages</td>
<td>Available 24/7</td>
<td>Online &amp; video counselling at set times - see website for details</td>
<td>Access up to 6 x 1 hr telephone counselling sessions. Services also available in Arabic</td>
</tr>
<tr>
<td>Phone: 1300 78 99 78 <a href="http://www.menslineaus.org.au">www.menslineaus.org.au</a></td>
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</table>

If life is in danger call 000.