
Dr John Barletta & Vince Dundas

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28th May 2012

Mr John Brady  
*Operations Manager*  
**Mates in Construction**  
PO Box 1001  
SPRING HILL QLD 4004

Dear Mr Brady:

It is with pleasure we present this project document for the Life Skills Program (LSP) initiative: *A Report on the Development of a Life Skills Program for Construction Apprentices*.

The document is the outcome of a project conducted pursuant to the following scope:
Create a program document that includes;

- Alignment with AISREP report, MIC vision, mission and values, LIFE framework and the principles of LivingWorks,
- Review of current literature including reference to reports and evaluations into the Life Skills courses conducted in the construction industry,
- A context for delivery as well the designated audience,
- A curriculum with objectives and content,
- Evaluative tools to be used to measure the effectiveness of the program, as well as gathering other useful data,
- Prerequisites for trainers to deliver the program,
- Suggested resources, and
- External validation of the program’s relevance.

We hope that this document meets with your expectations and needs, and that it is additive to your professional initiatives. Best wishes.

Regards,

JOHN BARLETTA, Ph.D.  
*Psychologist – Consultant*

VINCE DUNDAS, M.Ed.Admin.  
*Counsellor - Consultant*

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Fax: 07 3356 4600

**Mates in Construction (MIC)**

**Life Skills Program (LSP)**

**Introduction**

*Mates in Construction* (MIC) aims to be Queensland’s leading industry suicide prevention organisation focusing on raising awareness, capacity building, providing help, and engaging in research (see Appendix 6). The Life Skills Program (LSP) has been developed in alignment with MIC’s vision and mission, and in direct response to the Australian Institute of Suicide Research and Prevention (AISRAP) report (2006) into suicides in the Queensland construction industry.

The AISRAP report notes that:
*The most striking feature of these SMR (Standardised Mortality Ratios) calculations is the more than two-fold elevated risk of suicide by 15-24 year old CBCI (Commercial Building and Construction Industry) employees against young Australians, with the rate being almost double compared to Queensland youth. This clearly demonstrates that the elevated risk for suicide in the CBCI is due to the very high suicide rates in those younger employees* (p. 23).

The AISRAP report made a number of specific recommendations with regards younger workers/apprentices (see Appendix 7). These recommendations can be condensed into two key directives; provide easy to access help and support within the construction culture, and to teach young workers life skills as these are proven to build resilience and protection, particularly as it relates to suicide.

The AISRAP recommendations have been supported by a number of independent research reports from around Australia, including: *ArkAeon*, QLD, 2010/2011; *Hunter Institute of Mental Health*, NSW, 2005/2006; *Martin Harris Consulting*, TAS, 2010. demonstrating that the teaching of life skills to apprentices in the construction industry is a very effective way to build resilience providing the teaching is matched with an easy to access, cultural appropriate support structure. Where both of these conditions existed, there was clear evidence of increased help seeking amongst young workers.
Program Reviews

In response to the AISRAP recommendations, the MIC LSP was developed. The documents listed below outline the process and content of the development of the program:

- Our Core Beliefs about Suicide and Its Prevention, *LivingWorks* (2007)

Findings from Program Reviews

The abovementioned reports and documents have made the following recommendations:

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<th>Needs and/or recommendations</th>
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<td>• Resilience and wellbeing</td>
<td>Suicide Intervention Skills</td>
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<td>• Educational seminars</td>
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<td>• Aligned with government policy</td>
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<td>Report</td>
<td>Needs and/or recommendations</td>
<td>MIC structure/process to address need and/or recommendation</td>
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| Hunter Institute Appendix 8| • Promote support  
• Post apprenticeship support  
• Across other industries  
• Marketing  
• Annual feedback to stakeholders | • Induction presentations / GAT  
• Site MIC programs  
• Expansion into other industries project  
• MIC communications and marketing officer  
• Community Forums and evaluation reports |
| Dr Martin Harris Appendix 1 | Adopt the thriving and transition cycle  
• Transition without changes  
• Developmental approach  
• Complete restructure | • Not recommended by the report  
• Most likely option  
• Individual focus rather than group |
| LivingWorks Beliefs Appendix 11 | • Suicide is a community health problem.  
• Thoughts of suicide are understandable, complex and personal.  
• Suicide can be prevented.  
• Help-seeking is encouraged by open, direct and honest talk about suicide.  
• Relationships are the context of suicide intervention.  
• Intervention should be the main suicide prevention focus.  
• Cooperation is the essence of intervention.  
• Intervention skills are known and can be learned.  
• Large numbers of people can be taught intervention skills.  
• Evidence of effectiveness should be broadly defined | • GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• GAT / Connector / ASIST  
• MIC database / case management / research |

**Literature Review (see Appendix 12)**

Research has identified some of the human challenges for workers in the construction industry and closely related sectors. Additionally, research has highlighted the various benefits of adopting a comprehensive and coordinated approach to the provision of quality life skills training, including positive health outcomes for employees and the productivity benefits for employers. Whilst traditionally there was little training focused on the psychological and social needs of employees (including the construction industry), there appears a need to include such a focus if preparing and supporting employees in the workplace is to be considered truly important as research would suggest. Therefore,
employers need to acknowledge that catering to their employee’s psychological needs, in the workplace, is an integral part of employee care and responsibility.
Mates In Construction: Life Skills Program

Introduction to Framework and Program

It is evident from the review of the literature that the MIC program presently addresses a number of the recommendations and findings on site within the Queensland Building and Construction Industry (QBCI). The MIC LSP was developed following extensive research and consultation. Its primary purpose was to address the needs of apprentices, trainees, cadetships, young workers, and new entrants into the QBCI that are not presently being met by current industry programs, MIC programs, or specific issues raised within the literature review. With due regard to the findings of key reports, research and evidence reviewed in the literature, MIC have developed a responsive framework for predominantly addressing suicide and self-harm prevention in the QBCI. Additionally, general problem solving and coping strategies are integrated as too are specialty areas such as financial literacy and substance abuse issues.

Objectives of the Program

The primary objective of the MIC LSP is to develop participants’ awareness, knowledge and skills in suicide prevention. Specifically, it is expected that participants will develop a common set of understandings and skills as members of the industry who are concerned with suicide prevention, problem solving and the promotion of employee well-being, resilience and coping ability.

This will be achieved by:

- Increasing awareness about suicide and its prevention,
- Assisting workers build capacity to deal with life issues including work stressors,
- Providing effective pathways to heal and support, including appropriate referral pathways and services,
- Encouraging help-seeking behaviours by young workers by providing knowledge and skills to support peers (i.e., mates) in the workplace.

Characteristics and Context of the Program

The distinctive nature of adolescents and young adults is the foundation upon which the LSP is built. It is now recognized that to meaningfully impact the mental health of young people, programs must go beyond increasing knowledge. They must equip young people with not only factual information, but also with the skills to implement behaviours that enable them to reduce risk factors and enhance mental health. Programs must shape personal values and beliefs that support healthy behaviours. They should also develop essential skills necessary to adapt, practice and maintain a health-enhancing lifestyle. Programs must address the individual’s values, attitudes and beliefs whilst maintaining a focus on reinforcing resilience-
building behaviours. To ensure quality outcomes are achieved in the MIC LSP, the following characteristics are seen as essential:

1. **Delivered by Accredited Trainers**

   **Prerequisite qualifications:**
   - TAE40110 Certificate IV in Training and Assessment
   - Training with *The 7 Habits of Highly Effective People* (Covey) approach
   - Trained in ASIST (LivingWorks)
   - Orientation and pre-training of the MIC LSP framework
   - Trained in the *Stages of Change* (Prochaska) model (learners moving through Pre-contemplation, Contemplation, Preparation, Action, to Maintenance)
   - Internal accreditation process.

   **Ongoing review of trainers:**
   - Participant feedback data
   - Peer supervision, consultation and mentoring
   - Direct supervision and auditing of trainers to ensure a consistent standard and for quality control
   - Professional development in relation to group management processes and adult learning styles.

2. **Program Delivery Model**

   - Each of the three days could be delivered in a one-day format (non-consecutively), with up to three months between each of the three days
   - Flexible delivery that encompasses local needs and conditions but in a mandated curriculum
   - Small group teaching that allows for maximum participant experiential participation
   - Incorporates a variety of teaching strategies to encompass the variety of learning styles of the participants
   - The proposed delivery model framework includes *The Thriving Transition Cycle* by Dr Martin Harris (see Appendix 1) and *Seven Habits Maturity Continuum* by FranklinCovey (see Appendix 2).

3. **Teaching Methodology**

   - Focus on being process-driven rather than content-driven
   - Training and ongoing support are essential for program support and development (ideally delivered in MIC-accredited organisations)
   - The learning agenda is aimed at the needs of the participant
   - Days are structured and use informal processes
   - Activities cater to the various learning styles and levels

• Participants are considered to be goal-oriented and future-focused
• Measuring outcomes is integral to the program.

4. *Specific Content is Relevant*
   • The modules are industry-focused
   • Content reflects research findings
   • All modules are mapped against the national employability skills set.

5. *Evaluation and Recording of Participants is Integrated within the Program*
   Pre-test and post-test evaluations will occur at each day
   Development of the MIC database to record attendance, enrolment details, evaluation results, feedback, and any specific support given to apprentices (see Appendix 5).

**Evaluation Process**

The MIC LSP’s implementation will be systematically reviewed and evaluated on an annual basis. This is in response to recommendations of the ArkAeon report, and in alignment with current best practices. This review will be conducted both internally and externally to ensure objectivity and critical reflection on practice.
Life Skills Program: Overview of Curriculum

Day One

Objectives

Apprentices will;
1. Know about the MATES in Construction organisation and support network
2. Have an opportunity to connect to psychological help
3. Have the 1300MIC111 helpline number in their telephones and understand how the number works
4. Be aware of the invitations when they, or one of their mates, are struggling with issues, and what to do when they notice someone else is struggling emotionally
5. Do a current needs analysis with apprentices to ensure their issues are incorporated into the learning process
6. Develop a mind-frame for apprentices to understand their own behaviour and why they act in certain ways (to satisfy basic psychological needs)
7. Learn about the Emotional Bank Account as a useful tool for building trust in relationships
8. Construct a financial budget relevant to their needs
9. Use evaluative tools to gather data in relation to attitudes and knowledge of support systems and help-seeking behaviours.

Content

- Pre-test component of Evaluation
- Introduction to MATES in Construction / Enrolment process
- Needs analysis – what do you hope for and need to get out of this course?
- Getting to know you (shield activity)
- General Awareness Training (extended version)
- Values and Beliefs – Shelter activity;
  - Where do we get our values and beliefs - are they true?
  - Are they useful in meeting my needs?
  - Am I prepared to change my values and beliefs if they are not useful? How do I do this?
• Framework – Feelings follow Thoughts, and Behaviour follows Feelings;
  ➢ What was I thinking when I did something (specific examples)?
  ➢ Is what I am thinking true and helpful?
  ➢ From where am I gaining my knowledge?
  ➢ How do I increase my knowledge?
  ➢ How do I review my thinking in a positive way?
• Use the framework to explore understandings, thoughts, values and practices on;
  ➢ Nutrition, Diet and Healthy Eating (see Appendix 4)
  ➢ Harm Minimisation with Alcohol and Other Drugs (see Appendix 4)
  ➢ Physical Activity and Wellbeing (see Appendix 4)
  ➢ Depression and Anxiety (see Appendix 4)
  ➢ Apprenticeship / Career
  ➢ Relationships with opposite gender
  ➢ Bullying (see Prevention of Workplace Harassment, Code of Practice, 2004)
  ➢ Workplace and Responsibilities (see Work Health and Safety Act, 2011)
  ➢ Conflict Management
  ➢ Money and Financial Planning
• Teach Emotional Bank Account as a way of understanding trust in personal and workplace relationships
• Use a budgeting tool to teach financial management
• Review of the day – ensure 1300MIC111 phone number is in their telephones
• Post-test component of Evaluation
Day Two

Objectives

Apprentices will;
1. Review progress with regards the effectiveness of the tools taught in the first day
2. Develop an understanding of maturity as taught through Covey’s Maturity Continuum
3. Explore the concept of Proactivity and the idea of the circle of concern/circle of influence
4. Examine the concept of Proactivity as it relates to determinism, and being a transition person to negative family trends
5. Develop a vision statement - tradesperson, partner, parent, finances
6. Learn about goal-setting as it relates to their vision statement
7. Examine Quadrant Two (Covey) time management – develop daily/weekly routines
8. Explore the advantages/disadvantages of competition versus cooperation, and how this relates to their work teams

Content

• Pre-test component of Evaluation
• Review life since last day, especially in terms of content of Day One
• Explain the concept of Maturity Continuum – we move in our mature responses depending on the situation/environment/relationships – When have you been mature / immature – what do you notice?
• Introduce the concept of maturity;
  ➢ Dependence / independence / interdependence.
  ➢ Apply to our own development as children, then as apprentices.
  ➢ What do we need to do to be considered important in our trade?
  ➢ What about our relationships?
  ➢ What can we do to help the process of growth – at work?
  ➢ What can we do to help the process of growth – at home?
• Describe the first three habits needed to achieve independence – be proactive, begin with the end in mind, first things first – do this in a general way connecting one concept in an applied way with the subsequent one
• Explore each habit individually
• Habit One – proactive/reactive – proactive language/ what situations draw a reactive response – when is this good/ when not? Teach circle of influence/circle of concern – get each apprentice to draw their own circle; focus on one or two areas that concern them at the moment – what is one proactive response you can do in this area – role-play some work scenarios; how can this be a powerful tool in our families?

• Habit Two – Vision – what sort of tradesperson do I want to be? Write/draw/talk about this vision in practical terms; be specific – what is your vision for your trade/the construction industry? (have fun with this one) Elevator speech to minister for Infrastructure and Construction; What is your vision for the type of person/partner/son/daughter/mate – what is your vision for the type of partner you would like to attract? What is your vision for your finances? What is your vision for your business?

• Habit Three – Begin with the end in mind – habit of personal management – teach the skill of goal-setting – break down the vision into bite size practical chunks; schedule them on a daily/weekly basis – how to use a diary/outlook/smartphone to help; Who can help/support me with this - how? Introduce the concept of Quadrant Two time management – draw charts for each quadrant based on typical site/daily tasks – how do you prioritize/what is the difference between urgent and important? How can this knowledge help? View video clip – Big Rocks (or similar)

• History walk 1901–2012 – highlight the move to compulsory superannuation, tax changes, population changes and implications for current workforce

• Teach Robert Kiyosaki's CASHFLOW Quadrant
  Employee/self-employed (work for money) – tax implications
  Business owner with a system/investor (money works for you) – tax implications.
  ➢ Where are we in the quadrant?
  ➢ How do we move through the quadrant?
  ➢ How does this help us work our financial goals?
  ➢ Do you have a financial plan?
  ➢ Where do we go for financial assistance?

• Post-test component of Evaluation
Day Three

Objectives

Apprentices will;
1. Learn to identify people with thoughts of suicide and know how to connect them to suicide first aid resources, via Connector training and SafeTALK
2. Learn the role of a Connector as a resource to mates (in work and out of work) who are struggling with significant life-issues
3. Gain a thorough understanding of the MATES in Construction program and how they can use it to support themselves and their mates
4. Revise the tools learnt in the tool box and then explore applying them to a current difficulty/challenge in the workplace or private life
5. Discuss personal support networks and their support accessibility
6. Describe the concept of a mentor and how to identify and engage one in their life
7. Learn the principles of self-care through the Dr Jack Groppel Energy Buckets concept
8. Engage an evaluative tool to assess changes in attitude from the commencement of the course and gather data about the relevance of the program.

Content

- Pre-test component of Evaluation
- Review life since last day especially in terms of content of Day One and Day Two
- Put apprentices through the MIC Connector and SafeTALK programs – ensure all key referral telephone numbers are in their mobile phones
- Teach the Energy Buckets concept as a method of understanding self-care
- Use template to help analyse their own energy management
- Revise the tools from the tool box;
  - Take a current life or workplace issue
  - Use a life skill tool to apply to the problem and see how a plan can be developed to bring it closer to a successful resolution
- Conclusion – review and feedback
- Post-test component of Evaluation.
1. What did you find helpful or interesting in this session?

2. What did you find least or not helpful in this session?

3. How will this session change your behaviour at work? Outside of work?

4. On this 5-point scale, how valuable was this session to you? (circle a number)

   5  4  3  2  1
   extremely valuable medium value not very valuable

   Comments:

5. How valuable do you think this session was to other participants? (circle a number)

   5  4  3  2  1
   extremely valuable medium value not very valuable

   Comments:

6. What would you most like to change about this session if it was offered again? (e.g., content, format, presenter, venue, time)

7. Would you recommend this session to others? Yes / No

8. Any other comments? (e.g., content, format, presenter, venue, time)

9. If you would you like a follow-up call from a MIC Field Officer, please talk with the trainer today.

   Thank you for taking a few minutes to provide this useful feedback.
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<th>How do you rate your knowledge about: (Day One)</th>
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<td>Very Low</td>
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<tr>
<td>The Mates in Construction organisation</td>
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<td>The help and support Mates in Construction can provide to you and others (including the telephone helpline)</td>
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<td>The behaviours a mate might show when they are at-risk of suicide</td>
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<td>What to do if you thought or felt a mate was at-risk of suicide</td>
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<td>The reasons for behaving the way you do</td>
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<td>The Emotional Bank Account in building trust with others</td>
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<td>Preparing a budget or using a budgeting tool</td>
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<td>Personal support systems available and ways of getting help</td>
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<td>General health and wellness</td>
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<td>The range of effects of alcohol and drug use on wellbeing</td>
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<td>Dealing with workplace bullying</td>
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<td>Managing feelings and conflict situations</td>
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<td>Building and maintaining close relationships</td>
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<td>Career planning, and work opportunities/responsibilities</td>
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<td>Current workplace policies and supports</td>
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1. What did you find **helpful** or **interesting** in this session?

2. What did you find **least** or **not helpful** in this session?

3. How will this session **change** your behaviour at work? Outside of work?

4. On this 5-point scale, how valuable was this session to you? (circle a number)

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<td>medium value</td>
<td>not very valuable</td>
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   **Comments:**

5. How valuable do you think this session was to **other participants**? (circle a number)

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   **Comments:**

6. What would you most like to **change** about this session if it was offered again? (e.g., content, format, presenter, venue, time)

7. Would you **recommend** this session to others? **Yes / No**

8. Any other **comments**? (e.g., content, format, presenter, venue, time)

9. If you would you like a follow-up call from a **MIC** Field Officer, please talk with the trainer today.

   **Thank you for taking a few minutes to provide this useful feedback.**
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<td>The difference between relying on others, and cooperating with others</td>
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<td>What people actually do to get what they need and want in their lives</td>
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<td>How people influence others in positive ways</td>
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<td>Developing a practical vision for yourself in your trade and personal life</td>
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<td>Setting specific short-term and long-term goals</td>
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<td>Using practical ways to organise your time and job priorities</td>
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<td>Cooperation in work teams</td>
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<td>Routines that will improve self care and wellbeing</td>
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<td>Financial budgeting and planning, and money management</td>
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<td>Where to get financial help when needed</td>
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1. What did you find **helpful** or **interesting** in this session?

2. What did you find **least** or **not helpful** in this session?

3. How will this session **change** your behaviour at work? Outside of work?

4. On this 5-point scale, how valuable was this session to **you**? (circle a number)

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   **Comments:**

5. How valuable do you think this session was to **other participants**? (circle a number)

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   **Comments:**

6. What would you most like to **change** about this session if it was offered again? (e.g., content, format, presenter, venue, time)

7. Would you **recommend** this session to others? **Yes / No**

8. Any other **comments**? (e.g., content, format, presenter, venue, time)

9. If you would you like a follow-up call from a **MIC Field Officer**, please talk with the trainer today.

   **Thank you for taking a few minutes to provide this useful feedback**
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<td>The warning signs of suicide</td>
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<td>Identifying mates who are at-risk of self-harm and/or suicide</td>
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<td>How to talk to someone if they are thinking of suicide</td>
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<td>Convincing someone to get help when you think they need help</td>
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<td>The role of the Connector to help mates at-risk</td>
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<td>How Mates in Construction can help you and others</td>
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<td>Ways to look at life situations, and have the skills to deal with challenges or problems</td>
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<td>Your personal support networks and how available they are to you</td>
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<td>What a mentor is and how to get one</td>
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Appendix 1

The Thriving Transition Cycle (A New concept of Thriving, Martin Harris)
Appendix 2

The Maturity Continuum (7 habits, FranklinCovey see: www.franklincovey.com.au)
Appendix 3
Integration of Thriving Transition Cycle and Maturity Continuum

1 & 5. Preparation
- Readiness for the challenge;
- Motivation;
- Positive planning; and
- Comprehensibility.

Habit 1: Be proactive

Habit 2: Begin with the end in mind

Habit 6: Synergise

2. Encounter
- Gaining confidence;
- Sense-making;
- Meaningfulness; and
- Engagement.

Habit 3: Put first things first

Habit 7: Sharpen the Saw

3. Adjustment
- Role development;
- Personal development;
- Manageability; and
- Support systems.

Habit 4: Think win-win

Habit 5: seek first to understand

Appendix 4

Tip Sheet: Nutrition, Diet and Healthy Eating

Eating a variety of healthy foods is vital to achieving a well-balanced diet, optimal nutrition and wellbeing. Diet is important in the prevention, incidence and prevalence of lifestyle diseases such as obesity, diabetes type 2, high blood pressure, stroke, high cholesterol, constipation, diverticulosis and coronary artery disease.

The following combinations of food have been put forward as considerations on which to model diets. The food combinations are parameters on what possible combinations of food will best meet recommended dietary intakes. The considerations are based on current research evidence for promoting optimal health and nutrition, and what is culturally acceptable and affordable.

- Increase your **fruit and vegetable** intake.
- Eat at least 2 fruit serves daily (a serve is 150g) depending on energy needs.
- Eat a variety of vegetables (a serve is 75g) including starchy vegetables (e.g., potato, sweet potato, parsnip, sweet corn, peas), green and brassica vegetables (e.g., broccoli, cauliflower, cabbage, brussel sprouts, Chinese cabbage, bok choy, turnip, radish), orange vegetables (e.g., pumpkin, red capsicum, carrots, sweet potato), legumes (e.g., lima and kidney beans, lentils, soy beans, chickpeas, baked beans, tofu), and other vegetables (e.g., tomatoes, lettuce, celery). Eat at least 5 serves daily.
- Eat **nuts and seeds** (e.g., almonds, pistachios, walnuts, sesame and pumpkin seeds). They are high in energy so limit from once to twice daily, to twice a week, depending on your energy and protein requirements (a serve is 30g).
- Eat **wholegrain cereals** (e.g., wholegrain breads, cereals, rice, pastas, muffins and crisp-breads). Eat twice as many wholegrain food serves as refined cereal serves.
- Eat **lean red meats** (e.g., lamb, beef, pork, veal, pork, venison, kangaroo). People should not eat more than 455g of red meat per week, or 65g a day.
- Eat **other meat and alternatives** (e.g., poultry, fish, shellfish, eggs, legumes) to meet your protein intake from sources other than red meat.
- Eat a minimum of 2 to 2.5 serves of **dairy foods** (a serve is 250g) daily, a rich source of protein and calcium. Choose lower fat options (e.g., <4% fat-reduced or skim milk and yoghurt) or medium fat options (e.g., 4 to 10% fat regular milk and yoghurts). If eating higher fat options such as cheese (e.g., >10% fat) limit it to 20g daily.
- Choose **polyunsaturated and monounsaturated fats and oils** (e.g., olive oils and polyunsaturated margarine). Around 0 to 2 serves a day (serve is 10g) is sufficient based on current research evidence.

*Caution:*

Limit foods that have a low nutrient density and are higher in energy, saturated fat, or added sugars. Examples include soft drinks, alcohol, cakes, biscuits, confectionary and takeaway food like battered fish/chips and pizza.

It is recommended that men and women drink no more than two standard drinks (100ml of wine or 30ml of spirits is one standard drink) per day to reduce health risks over a lifetime.

*For more specific dietary advice consult a Nutritionist or Dietitian.*
Tip Sheet: Harm Minimisation in using Alcohol and Other Drugs

Are you one of the 90% of the population who have ever consumed alcohol or another drug that can be abused? While most illegal substances, including alcohol, present little risk to health with only occasional use, for some people their use gets out of control. Prolonged use of alcohol and other drugs becomes tolerance. This means that you have to take more of the drug to achieve the same effect. You may also find that although you used to use alcohol and other drugs for recreation, more of your daily activity is becoming more drug-focused. You are not the only person who turns to alcohol and other drugs when times get tough because there are short-term rewards to using such as feeling good or feeling better, or both. The info below will assist you minimise the harm.

Plan your use - less use means less harm to your health, work, and social relationships. Plan to use only on the weekends. It’s better to use on a Friday or Saturday, which will give your body and mind some chance to recover on Sunday. Put aside how much you are going to use and only use that much. It’s better to tell yourself that, This is as good as it gets, rather than taking too much and dealing with the consequences later.

Choose carefully whom you will use with - This is by far the most important aspect of using safely. It is important that you trust the people you are using with and where you will consume alcohol or other drugs. Ask yourself if you can trust the people you’re using with to help you if you get into trouble.

Eat before you use - No matter what substance you’re taking, extra demands are put on your body when you use. This is especially the case with stimulants such as Speed or Ice. Your body needs more energy reserves from food when you use.

Important Tips for Reducing Harm from alcohol and other drugs:

- While you may well be aware that alcohol affects your ability to drive or operate machinery safely, however consuming Cocaine and alcohol together you produce a chemical (Cocaethylene) in your body. This chemical is toxic to your heart. It is better to restrict your alcohol consumption if you plan to use Cocaine.
- If you’re going to use MDMA, sometimes called Ecstasy, being with people you trust, avoiding alcohol, drinking plenty of water, and taking breaks from dancing or other rigorous activity is important. This keeps your core body temperature down. Also it’s often difficult to know what’s contained in a pill so it’s safer to take a ¼ or ½ a pill first to see how you will react before taking more.
- Prolonged Methamphetamine use, (Speed or Ice) is associated with malnutrition. It’s important to consume healthy food beforehand, and also afterwards when you regain your appetite. It’s also better to eat while you’re taking. While you are using, make a milkshake with fruit, milk, yoghurt and healthy ingredients that are easy to palate.
- There is debate as to how much alcohol consumption harms or promotes good health. It depends on gender, age, weight, metabolism, and physical activity. For men it’s best to consume no more than 2-4 standard drinks a day & have 1 or 2 alcohol free days a week. Women, 1-2 standard drinks per day with 1 or 2 alcohol free days.
- Opiates such as Codeine (an over-the-counter medication), and Heroin are substances that cause physical as well as psychological dependence. When you stop using substances such as these after a long period of use, your body experiences symptoms such as nausea, vomiting, and diarrhea. This is called physical withdrawal and can be life threatening if the main substance you’ve been using is alcohol or Benzodiazepines (e.g., Valium).

Seek help from a GP or counsellor if concerned about any aspect of alcohol or drug use.

Tip Sheet: Physical Activity and Wellbeing

Most people know that regular physical activity (or exercise) provides many benefits for physical health, and as such, is an important part of a healthy lifestyle. Physical activity is also an important part of a psychologically healthy lifestyle.

There are many scientific reasons to link physical activity and wellbeing:

People who are physically active tend to have better wellbeing than those who are inactive. Similarly, people with poor wellbeing tend to be less active than those with good wellbeing.

Feeling stressed, anxious or depressed can be an inevitable part of life, because of having to deal with life events, illness, relationships and other challenges. Not everyone needs or chooses to seek professional help for these difficulties. Physical activity is an important part of self-care in these situations, and can be a useful coping strategy. People who are physically active are more resilient than inactive people, and can more easily bounce back from hard times.

Some physical health conditions (e.g., heart disease, diabetes, arthritis) can increase vulnerability to stress, anxiety and depression. Physical activity can help manage physical difficulties, and thereby reduce the risk of psychological difficulties.

Many of the physical benefits of activity (e.g., physiological changes, changes in brain transmitters, reduced blood pressure, increased blood flow to the brain, increased oxygen use, improved musculoskeletal functioning, and endocrine responses) also provide psychological benefits.

Physical activity can help manage some of the side effects (e.g., weight gain, lethargy) produced by various drug treatments.

Physical activity can provide specific psychological benefits that improve wellbeing, such as personal time-out, improved self-image and self-esteem, opportunities for positive emotions, social interactions, and a sense of accomplishment.

Specific types of physical activity, such as walking, are easily affordable, need few resources, can be done without supervision or professional advice, and can be done by almost everyone.

There are three different roles for physical activity in the context of wellbeing:

1. Physical activity can help maintain and improve wellbeing and resilience. Physical activity can provide positive emotions, self-esteem, confidence, energy, stamina, satisfaction, a sense of mastery and control, social connections, quality of life and better sleep, as well as reduce fatigue, tension, stress, and negative emotions. People who do physical activity can also improve their levels of vitality and emotional and social wellbeing over time. People who stop doing physical activity can experience a significant decline in wellbeing over time.

2. Physical activity can prevent psychological difficulties. Regular physical activity can limit the onset of depression, poor mental health, anxiety, stress and burnout over time.

3. Physical activity can be a useful adjunct to treatment for psychological difficulties. Physical activity can be as effective as other treatments for mild to moderate levels of depression, anxiety and stress. For serious conditions such as schizophrenia, physical activity, in combination with other psychological/psychiatric treatment, can help reduce symptoms and manage some of the side effects of the drugs used.
**What sort of physical activity should you do?**

The best type of physical activity to do is one that you enjoy. Physical activity does not have to be vigorous, at the gym, or *huff and puff* exercise like jogging. You may enjoy other types of activity such as dancing, yoga, or bushwalking. Either moderate intensity or vigorous intensity activity can provide psychological benefits. Moderate intensity activity, such as brisk walking, is when you breathe more heavily than usual, but can still carry on a conversation. In some cases, even light intensity physical activity is helpful.

However, not everyone enjoys physical activity. If this is the case for you, then choose a physical activity that you can and will do. You might like to think about the style of activities that suit you e.g., scheduled sessions -vs- flexible timing, individual -vs- group -vs- team-based, supervised/led -vs- unsupervised, with people the same age and sex as you or not, competitive or social, varied -vs- routine, or needing skill and practice or not. The more convenient it is for you, the more likely you are to do it. You may use other strategies to help your commitment, such as listening to music, or going with a friend. Physical activity that is done as part of your leisure time may provide more wellbeing benefits than other types of activity e.g., activity done at work, activities to get to and from places (e.g., walking, cycling), or housework.

*Green exercise* is physical activity that is done outdoors, and this may provide more wellbeing benefits than activity done indoors. Outdoor activity, including gardening, can improve mood, revitalisation, energy, satisfaction, enjoyment, and reduce tension, anger and depression. These effects may be greater for women than for men.

**How much physical activity should you do?**

For *physical* health benefits, it is recommended that people do approximately 30 minutes of moderate activity on most days of the week. Similarly, *psychological* benefits can be obtained from 30-minute bouts of activity, and it may take 4-16 weeks to experience the benefits. People with depressive symptoms may benefit from doing bouts of 45-60 minutes, and it may take 10-16 weeks to experience improvement. People with anxiety symptoms may benefit from doing longer bouts of 60-90 minutes.

However, *some activity is always better than none!* Doing even an hour a week can provide psychological benefits, especially if you are currently physically inactive. If you are doing some physical activity, it is important to maintain this where physically possible, even if at a lower level, as stopping physical activity altogether can result in a decline in wellbeing.

**Can physical activity create problems for wellbeing?**

A very small number of people may have psychological difficulties with physical activity. People with eating disorders, such as anorexia, may overuse exercise as a method to lose weight. Exercise dependency is an obsessive behaviour where people do extreme levels and continue to exercise despite injury, illness, fatigue, or other personal demands. Elite athletes may overtrain beyond their capacity to recover and can stop making progress and lose strength and fitness. These situations would require professional assistance.
Tip Sheet: Depression

Depression is a serious condition that is marked by continual low mood, sadness, and physical symptoms such as low energy and poor concentration. Depression is twice as commonly diagnosed in females compared to males and up to 7% of the population suffers from depression at any one time, and everyone has a 20% chance of having at least one episode of depression over their lifetime. Depression can reoccur even after effective treatment. If a person has had one episode of depression they have a 50% chance of having a second episode, if they have a second episode they have a 70% chance of a third episode and if they have a third, the chance of more episodes is 90%. Depression affects children, adolescents and adults. Depression typically is not a constant state and can improve over time and people may find themselves becoming depressed again after a period of remission. Depression is also the strongest predictor of suicide; this means if someone is depressed the suicide risk is automatically higher than a non-depressed person. If we think someone is depressed we should always ask them if they are feeling suicidal. There are some myths about suicide e.g., if you talk about it, they might do it; if the person suddenly appears improved they are no longer at risk, or suicide attempts or suicide talk is just attention seeking. None of these are true and if people say these things they are still at risk. People rarely are successful the first attempt, typically a successful suicide is preceded by two or more attempts. Talking to someone about suicide reduces the risk, however, it does not eliminate risk. Some people may be so suicidal that they need emergency assistance or specialist care.

Depression is not the same as dealing with loss and grief, or reacting to a crisis or life problems or major changes, although people may feel like they are depressed at these times. These are considered normal reactions signalling a period of psychological adaption to changes, which is referred to as Adjustment. A person going through Adjustment would be expected to make steady progress working through their thoughts and feelings and eventually return to normal mood. However, they can also get stuck in this process and in some cases Adjustment might later turn into depression.

Causes of depression can be, genetic (i.e., family history or predisposing genes), some health problems can also cause depression, issues from our past such as abuse, trauma, rejection, learning negative beliefs about our self-worth and boundaries with others; and the current problems we are dealing with in our lives. We can see that all these things can provide stressors or triggers for depression, our health or genes can create problems for us, we might be struggling with past hurts or traumas and negative beliefs about ourselves and the world or we are overwhelmed by problems in our lives.

There are some common things to look for to identify if someone might be depressed. These are called symptoms: A. Has the person felt down or depressed for most days or most of the time for a minimum of two weeks? B. Have they lost pleasure in the activities that would normally make them happy?

If the person answers yes to at least one of these questions, and there has not been a previous loss or change in their life (Adjustment) we want to know some more things. If they have answered no to both questions they are probably not depressed. Some more questions are: 1. Has there been a change in appetite or body weight up or down? 2. Experiencing trouble sleeping? 3. Slowing down or becoming fidgety? 4. Low energy or tiredness nearly every
day? 5. Feeling guilty or not liking themselves? 6. Difficulty concentrating or making decisions? 7. Is the way they feel causing them distress or affecting their role e.g., employment, study, and relationships? 8. Do they think about hurting or killing themselves?

If a person answers yes to a minimum of five of the above questions they might be depressed. If a person is young they may have trouble understanding or answering these questions; it is still possible to discuss what we can with them and consider whether their behaviour fits any of these symptoms. For example, children may have more behavioural problems, and adolescents more withdraw or acting out behaviours, which are as important to consider as well as anything they might say to us. The same approach might apply to people from different cultural backgrounds and/or where English is a second language.

The good news is that depression responds well to treatment which includes counselling and medication. Cognitive therapy explores how our negative thoughts and beliefs reinforce our depressed feelings. If we learn to change our depressed thoughts we will no longer experience depressed mood. For example, if a person had an all or nothing belief or thought that they are failure as part of the series of thoughts that make them depressed, they can be taught to challenge and replace this thought. The first step is to be objective; how true is this really? Clearly a person is not a failure in every area of life and there are many successes. This rational-mind middle ground challenge to this thinking counters the extreme distorted thinking of depression and often improves mood. Another common error is to catastrophise which is to see the worst possible outcome in every situation, once again using rational-mind to challenge this is good i.e., what is the evidence that our catastrophic prediction will come true, has it ever in the past, what is the more realistic outcome in this situation? Behavioural therapy explores the things that are worrying us or are going wrong, and these are typically real problems in our life and they can feel very overwhelming. However if we set about working on these problems we will feel some control over our lives again. Underlying issues are another area a counsellor may work on, as things from our past that trouble us, or the need to understand ourselves and our reactions to others better. Does counselling really work? Yes. It has been show to work as well if not better than medication for most people. Research shows that counselling may improve areas of brain function similar to the way medication does. Medication can be very effective but there are also problems with side effects. For some people medication might be their preferred approach.

While you can do a lot to manage your own depression, or help others with depression, don’t forget the risks. It is often better to get professional help from a therapist or GP than go it alone.
Tip Sheet: Anxiety

Anxiety is a normal part of life. In fact we need anxiety to motivate us to do things and it can be a signal to adapt as it tells us something is wrong so we can do something to avoid consequences or protect ourselves e.g., getting off the road quickly if a car comes speeding along or getting an assignment done in time to avoid a fail grade. We may feel our physiology change, tension in our bodies, faster breathing and heart beat. The experience of crossing the road, the cars, or fear of failing then become encoded in our brain as a part of a library of triggers that can then produce anxiety simply by thinking about them. This has a clear adaptive advantage as it helps keep us safe from danger as we learn what to avoid. Our anxiety thoughts cause our brains to activate our sympathetic nervous system increasing stress hormones in our blood, which may increase blood pressure, heart rate, respiration, and clotting factors and alter our normal metabolism and hormone profile. This response is getting our bodies ready to either fight off a threat or to take flight to get away from a threat. In the short term, this is not a problem if we can reduce our anxiety back to normal levels. But in the long term chronic anxiety keeps this fight-flight mechanism switched on, can affect our physical health, and increases our chance of major disease. In more extreme cases, the anxiety threat coding system in our brain will start to react to normal things in our environment as threats, and we will worry about things, avoid things, or develop rituals to try to control anxiety, this can lead to mental health difficulties. Anxiety disorders can affect children as well as adults. The rate of anxiety disorders has been reported as being 2–9% across the lifespan, with a lifetime chance of 10% of developing an anxiety disorder.

While the capacity to become anxious is part of our design as humans, anxiety disorders are not. Probable causes are: 1. Genetic (higher rates for children with family members with anxiety disorders), 2. Family history, abuse, trauma, learned fear behaviours, poor family coping skills, poor self-image and poor sense of personal control, 3. Current stressors, such as major life problems or responsibilities. The interaction of internal cues from our threat coding system and stressors in the environment are probably the most important in creating anxiety disorders.

The most common is Generalized Anxiety Disorder (GAD) - worries and anxiety are present most of the time on most days for at least six months. The person might have difficulty controlling the worries, and the worries interfere with focusing on normal life roles and tasks, as well as feeling restless or tense, tired, poor concentration, irritable and having sleep problems. If you, or someone you know, would answer yes to having three or more of these symptoms, then there is a possible generalized anxiety problem. Anxiety can represent itself as other disorders as well. For example Obsessive Compulsive Disorder (OCD), where for a period of at least a month, people are trouble by recurrent thoughts, impulses, images that they find troubling but can’t get out of their minds e.g., the idea that they are dirty, contaminated, or fear of harming or contaminating others. They can also be troubled by compulsive behaviours such as doing something repeatedly without being able to resist, like washing or cleaning, counting or checking or arranging things over and over. Anxiety disorders can also be expressed as Phobias such as fear of social situations where for at least a month a person has become fearful or embarrassed about being watched or being subject to attention such as speaking in public, eating in public with others, or being at social gatherings. They then worry continuously about these situations and may avoid social contact to reduce anxiety. Specific Phobias are the same except they focus on one thing, such as a fear of spiders or snakes, heights or enclosed spaces. Panic Attacks are another class of
anxiety disorder where people suddenly feel anxious, frightened, uncomfortable or shaky or dizzy in situations where most people would not feel this way. The attack typically peaks in around 10 minutes of starting and is unpredictable. Sometimes people think they have a physical health problem as a result of their symptoms. Agoraphobia is a type of anxiety disorder where people feel very anxious or uneasy about places or situations where they might have panic like symptoms or even a panic attack e.g., being in crowd or on a bridge, at a busy shopping centre, travelling on a plane or train. The difference to panic attacks is that the person can endure these situations, if they must, even though they are very anxious or they more typically avoid the situations all together by not going out.

For such a debilitating disorder as anxiety, it is surprising how quickly psychological treatment can help most people. There are three levels of treatment. Cognitive: As our minds tell us how to feel and our bodies how to react, challenging the anxiety based thoughts can reduce our levels of anxiety. For example, I may worry about people making fun of me if I go to a party and tell myself that they will think I am a looser and don’t belong there. This is catastrophic thinking where I am projecting a worst case scenario without any evidence. I can challenge this thinking; What is my evidence for this belief, is it possible that other people there will be just like me and hoping to make some friends? My negative belief can’t be strongly maintained with counter positions. Cognitive interventions for anxiety are more sophisticated in psychological treatment than this example, but trying self-talk is powerful and can work well for some people and we all can do it. Behavioural: Because we experience so much physical arousal with anxiety we can learn to reduce it through behavioural techniques. For example, if I fear a situation I can gradually expose myself to the situation in small steps that I can manage. After repeated practice anxiety is often eliminated. This is called exposure and scientists think it works because of habituation; our nervous system gets used to the anxiety provoking situation and no longer reacts. The key is to do it in small manageable steps and don’t give up as it can be hard work. Popular alternatives to exposure are relaxation training; anxiety is incompatible with a relaxation state and relaxation training is enjoyable to practice. Practice is critical in dealing with anxiety. Treatment feels like hard work, but the more we practice the better the result. While we can do some of these things ourselves, often a psychological therapist is required as they are trained in the required cognitive and behavioural techniques.

The final approach to dealing with anxiety is medication. Medication can be very effective but there can be problems with tolerance, addiction and side effects depending on the type of drugs prescribed. For some people medication might be their preferred approach. Your GP can assist you with this option.
Appendix 5

MIC database to record attendance, enrolment, evaluations, feedback, and support

**Student Information:**
- Course ID (as per course entry page): Click here to enter text.
- Student name: Click here to enter text.
- Address: Click here to enter text.
- Contact phone number: Click here to enter text.
- Site: Click here to enter text.
- Gender: Choose an item.
- Date of birth: Click here to enter a date.
- Trade: Choose an item.
- Union: Choose an item.
- Union number: Click here to enter text.
- Stage of course completed: Choose an item.
- Were there any identifiable issues for the student: Choose an item.
- What actions were taken by the trainer: Choose an item.
- Comments: Click here to enter text.

**Student assessment and feedback:**
- Has today’s training increased your knowledge about suicide: Choose an item.
- Do you now feel confident to recognise the signs of suicide: Choose an item.
- With the knowledge you have gained from today do you feel: Choose an item.
- My trainer today was: Choose an item.

**Note:** There is currently no LSP on the MIC database for course entry. Course ID list on this page should link to the course entry page so that data entered on this page auto populates participants against the course ID on the course entry page.
Appendix 6

*Mates in Construction*

**Our Vision**
Queensland’s leading industry suicide prevention organisation focusing on raising awareness, building capacity, help, and research.

**Our Mission**
Using industry structures and networks, we achieve our vision by focusing on:

1. **Raising Awareness** – Communications, Newsletters, Training, Mates Events, Toolbox Talks
2. **Capacity Building** – Life Skills Tool Box, Mates in Construction program, SafeTALK, ASIST, Staying Connected, Building networks and links, Community building
3. **Providing Help** – Case management that connects workers to help by using existing services; and ensuring the help is both practical and useful
4. **Research** – Gathering data, partnering with research institutions to provide useful, insightful, and practical information back to the industry through the Mates in Construction Board.

**Our Values**
❖ **Honest and Reliable** – We deliver what we say we will do
❖ **Proactive** – Responding creatively to needs and emerging issues
❖ **Relationship based** – Building trust by being confidential, respectful, non-judgmental, positive and supportive.
Appendix 7

AISRAP Report Findings

- In the Queensland Commercial Building Construction Industry (CBCI), young employees (15-24 years) had very high suicide rates (58.6 deaths per 100,000 population). This was 2.39 and 1.93 times greater than the working-aged male population in Australia and Queensland, respectively.
- Young CBCI employees (15-24 years) were at elevated risk of suicide. Half had communicated their suicidal intent in the 12 months leading up to the suicide. Three-quarters had experienced relationship problems in the three months preceding their death, and they were more likely to be separated/divorced than other young Queensland males who died by suicide. Illicit drug use was common (41.7%), with 25% described as regular users.

Selected AISRAP Report Recommendations:

2. Promote awareness that suicide is a preventable problem within the industry.
   a. Use of informative and factual flyers on the problem of suicide, as well as the associated contributing factors indicated in this report.
   b. Use of educational seminars or training incorporated into the Blue Card Training, or TAFE/Apprenticeship course modules. Content should address:
      i. The prevalence of problems which are associated with suicidal behaviour (such as depression, substance use, relationship problems etc).
      ii. Knowledge of warning signs.
      iii. Ways to identify and respond to these problems before they become contributing factors to suicidal behaviour.
      iv. How to seek help for self and for peers who display these signs.
      v. Where to get support.

3. Reduce the stigma associated with help-seeking, mental illness, and suicide.
   a. Instigate environmental changes across all learning environments and building sites via use of simple factual posters, flyers and course materials which dispel myths about mental illness and suicide, and which clearly convey that ‘it’s okay to ask for help’.
   b. Use of educational seminars or training incorporated into the Blue Card Training, or TAFE/Apprenticeship course modules which directly address the issue of masculinity and the associated traditional culture of unacceptability of help-seeking (in order to positively influence attitudes towards help-seeking).
4. **Promote well-being, resilience and coping:**
   a. Use of educational seminars or training incorporated into the Blue Card Training, or TAFE/Apprenticeship course modules which focus on very key understandings and skills for problem-solving and coping particularly with regards to:
      i. Work-related stressors
      ii. Individual problems, and
      iii. Work-home interface stressors (e.g., relationship and family problems resulting for work related stressors such as work-load etc).

7. **Provide career and financial advice to young males (aged 15-24 years):**
   a. Implement educational seminars or workshops tailored specifically for encouraging and motivating career development pathways for young males.
   b. Implement educational workshops/seminars on gaining financial security (long term planning and investment), specifically with options for short and long term gains related to current incomes, etc.

8. **Improving work conditions for vulnerable workers:**
   a. Examine the feasibility of reducing weekly working hours for identified or ‘at risk’ employees (e.g., younger workers)

10. **Provide ‘mentoring’ services for ‘new employees’ to the industry:**
    a. Develop and offer peer mentoring systems whereby an apprentice/new employee is partnered with an experienced industry worker
    b. Peer mentor should be trained to provide information, orientation, social support, etc in an effort to reduce bullying and increase resilience (suggestion that mentors receive a financial inducement to maintain contact and sustainability of the program).
Appendix 8

ArkAeon Report Findings and Recommendations

1. Plan for expansion of the program
   • The majority of interviewees believe that the program needs to be expanded to reach a wider range of people. This may include, but is not limited to:
     - other apprentices
     - qualified tradespeople
     - other industries and professions
     - the general public.
   • A number of respondents proposed making the program compulsory to all apprentices.
   • Respondents favoured extending training into later years of apprenticeship.
   • Complete the Pilot Project, formally review effectiveness, and make any enhancements in response to learnings.
   • Consider mechanisms to expand the program audience (as part of the Program plan).
   • Consider options for expansion and develop a strategic plan for the future of the Program.

2. Establish capability to measure results
   • Some participants believe that regularly collecting feedback from parents and employer’s is a quantifiable way of gauging and measuring the success of the Program.
   • Funders have indicated that they value quantifiable evidence of the benefits of the Program.
   • Establish Key Performance Indicators to measure the Program implementation.
   • Establish Key Performance Indicators to measure the Program outcomes.
   • Collect data on the above, regularly report and review (such as the number of apprentices approaching OzHelp for assistance).

3. Increase visibility of, profile of and focus on the program
   • Encourage employers by providing them with more information about the program and demonstrating the benefits of the Tool Box.
• Achieve a wider government endorsement.
• Develop measures (quantitative and qualitative) of the value provided by the Program in consultation with relevant stakeholders.
• Report frequently to employers on both the progress of the Program implementation and the results attributed to the Program.
• Maintain relationships with relevant government bodies and continue to demonstrate the success and relevance of the Program.

4. Consider the extent to which the Program can be integrated into education as well as mental health
• The Tool Box should become an integral part of an apprentice’s training and it definitely has a future within the industry (this was supported by all interviewees).
• It was suggested that the course become a requisite of Apprenticeship Schemes.
• In order to facilitate the large scale growth of the project it was generally agreed that integration with learning institutions such as TAFE and group schemes would be beneficial.
• Continue to influence apprentice training programs to include Life Skills Toolbox Training.
• Lobby to have the course become a compulsory part of Apprentice Schemes.
• Continue to investigate potential of integrating with learning institutions such as TAFE and group schemes (initiatives currently underway by OzHelp Queensland).

5. Investigate extended delivery options
• Life Skills should be introduced as an important concept to apprentice’s during their induction process.
• Participants saw some potential value in the possibility of delivering courses outside standard working hours. However, there is a high risk that providing an out of hours option will result in:
  - Diminished value of the Tool Box
  - Greater demand on apprentices time
  - Higher likelihood that the apprentices will be tired and therefore will not gain as much benefit
  - Participants saw value in providing supplementary self-help readings online.
• Investigate opportunities to have Life Skills Tool Box Training introduced in apprentice induction processes.
• Investigate the value against the potential risks of presenting courses outside standard working hours.
• Investigate the provision of supplementary readings and support online.
• Investigate providing singular vacancies to employers.

6. Investigate alternative/additional recurring funding options
• Respondents suggested some funding of the Life Skills Tool Box Program by the Department of Education and Training would be appropriate.
• Investigate alternative funding sources (one-off and recurrent) for the Program.
• Investigate “user-pays” funding of courses where employers fund training (wholly or in part).

7. Complimentary training provided to staff involved with apprentices
• Provide training for staff involved with apprentices in various fields (such as administrative staff) to know how to effectively apply the principles of the Program particularly identification, referral and prevention.
• It would be particularly helpful to be able to effectively raise employer awareness of the issues relating to suicide, the life skills materials and the benefits of the Program.
• Raise awareness with other potential funders and supporters (such as Government departments).
• Develop and deliver supplementary awareness and training other stakeholder groups.

8. Maintain passion, connectivity, earthy quality, smartness of delivery
• Delivery quality by OzHelp was reported as exceptional in terms of the way that the facilitators relate to the course participants.
• It was suggested that course should continue to be delivered by facilitators who are external to any involved education body to maintain passion.
• Others suggested additional facilitators be accredited to expand delivery capacity whilst maintaining current approach, style and formats of delivery.
• Understand and document the current factors critical to the Program’s success.
• Develop guidelines for the course presentation.
• Develop a training program for the education of additional facilitators (including examinations).
• Develop a screening process for potential facilitators.
Appendix 9

**Hunter Report Recommendations**

1. That further efforts be made to promote the counselling and support services throughout the industry, particularly to older members among the employer group.

2. Those efforts are made to ensure that apprentices are aware that counselling and support services are available to them after their apprenticeship is over.

3. That priority is given to expand on the extent to which apprentices outside of the two Group Training Schemes receive the Life-Skills Toolbox training.

4. As key personnel in the Group Training Schemes are likely to change, that efforts be made to ensure the service is adequately marketed to all new stakeholders.

5. That feedback is provided to members of the industry in summary form, on an annual basis, to inform the sector about the nature and extent of the support and counselling services provided.

6. That further efforts be made to explain the objectives and content of the Life-Skills Toolbox to teachers and trainers in the Group Training Schemes.

7. That priority is given to reviewing the existing draft strategic plan, and developing a new plan in which the organisation’s key values and operating principles are clearly articulated.
Appendix 10

Harris Report

• While thriving shares the principal characteristic of resilience (i.e., the adaptive recovery from a de-stabilising experience), there are subtle differences. In particular, thriving is a response to challenging circumstance rather than adversity, and has a focus on learning and growth, rather than recovery (Spreitzer et al., 2005).

• The current three-day program provides the template for this review and the application of the ‘transition cycle’ model.

• The three blocks of offerings are grouped to provide information and activities to appeal to the apprentices and provide pathways of information.

• Specifically, the course objectives are to:
  - Assist participants in their transition into the workforce.
  - Assist participants to develop resilience and well-being by learning to understand and thus to value themselves and others.
  - Assist participants to develop strategies which will help them communicate more effectively.
  - Encourage participants to seek help when they need it and to discuss problems with a mate or to contact a resource such as OzHelp.

• The current program targets the transition as a linear process with information intended to assist the transition to the workforce by an accumulation of information. A more productive process would be to identify those aspects of the transition that are likely to provide assistance at the stages of the process and, where possible, to provide for the individual’s readiness at those stages. The current program does not target the identified needs of the individual; rather it provides a collection of valuable resources that are variously useful to their needs. A more productive process would be to more clearly identify the needs of the individuals and to provide for group and individual progress.

• The current program assumes that by delivering the messages contained in the suite of offerings, that these messages will be heard and understood. Clearly from the data the readiness of individuals to receive and understand the information in the program will vary. The program could provide a stepped program that allows for the range of entry levels.

• Clearly from the data, this information is absorbed and used by those who are able to access and process the message. Those that are ‘thriving’ are able to integrate this information in a meaningful and useful manner, but those ‘surviving’ or ‘languishing’ have little opportunity to integrate the information
in a meaningful way. The program could provide a stepped program that builds the skills of communication in a way that recognises the various levels of readiness and capacity to use the information.

• The OzHelp program achieves its objectives to the limited extent that they can be measured effectively. Prior to this exploration of an evidence base the program was limited to broad outcome measures and testimonial evidence of client satisfaction.

• The thriving apprentices were able to action these by the processes of:
  ➢ Purposeful and selective mastery (readiness for the challenge);
  ➢ Confident and proactive activity (motivation);
  ➢ Being self-assured and positively detached (positive planning);
  ➢ A clear and ordered, forward focus (comprehensibility);
  ➢ Positive self-concepts and a willingness to learn (confidence);
  ➢ Clarity of purpose and a commitment to process (sense-making);
  ➢ Awareness of the transition process and engagement (meaningfulness);
  ➢ Linking with others and accessing resources (engagement);
  ➢ Awareness of the transition and challenges (role development);
  ➢ Responsiveness and attentiveness (manageability);
  ➢ Identification and access to support systems (support systems);
  ➢ Identification of pathways and learning from experience (personal development);
  ➢ Demonstrating independence and sociability (relationship building);
  ➢ Mastering new and complex skills (environmental mastery);
  ➢ Willingness to be open and receptive to future challenges (trust and commitment);
  ➢ Autonomous planning and strategic insight (discretion).

Option 2:

The sequential/developmental connection through the stages allows for the OzHelp themes to be selectively developed to account for the stages of the transition. This provides a more comprehensive template for the OzHelp offerings and a point of reference for the review of content. As with Option 1, the OzHelp material has been positioned to better reflect the stage of the transition (and therefore the timing of the delivery of the material). In Option 2 the potential of this material is mapped through the stages of the transition. The OzHelp offerings in the Option 2 Table are those which are most suited to the stages of the transition cycle and, if well resolved, provide a positive trajectory. The advantages of adopting this option include:

• The placement of OzHelp offerings in a way that accounts for the Transition Cycle and provides an more

• The focus of the content can be reviewed to provide the continuity of contribution to the model; particularly to the stage of the transition.

• Allowing for the sequential/developmental offering of information and training;
• Engaging with Stage Four of the transition cycle. However:
• It will require a review of content and the pacing of the program across the delivery opportunities;
• It does not account for the variety of delivery platforms;
• It does not allow for the use of pro-active identification of the individual needs of the apprentices.
<table>
<thead>
<tr>
<th>OzHelp Themes</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication theory</td>
<td>Comprehensibility</td>
<td>Engagement</td>
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<tr>
<td>Inter-gender comm...</td>
<td>Comprehensibility</td>
<td>Engagement</td>
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<tr>
<td>Non-verbal comm...</td>
<td>Comprehensibility</td>
<td>Gaining confidence</td>
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<tr>
<td>Values and beliefs</td>
<td>Positive planning</td>
<td>Meaningfulness</td>
<td>Personal development</td>
<td>Trust and commitment</td>
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<tr>
<td>Needs and wants</td>
<td>Readiness</td>
<td>Gaining confidence</td>
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<tr>
<td>Behaviour is chosen</td>
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<tr>
<td>Magnificent seven</td>
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<tr>
<td>Financial literacy-budget</td>
<td>Sense making</td>
<td>Manageability</td>
<td>Environmental mastery</td>
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<tr>
<td>Depression/mental illness</td>
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<tr>
<td>Suicide awareness</td>
<td>Support systems</td>
<td>Relationship building</td>
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<tr>
<td>Leadership &amp; team-building</td>
<td>Role development</td>
<td>Environmental mastery</td>
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<tr>
<td>Stereotyping</td>
<td>Role development</td>
<td>Discretion</td>
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<tr>
<td>Beliefs</td>
<td>Motivation</td>
<td>Meaningfulness</td>
<td>Personal development</td>
<td>Discretion</td>
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<tr>
<td>Financial literacy-credit</td>
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<td>SMART goals &amp; money</td>
<td>Personal development</td>
<td>Environmental mastery</td>
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<td>Emotions</td>
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<td>Anger management</td>
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<td>Decision making</td>
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<td>Conflict resolution</td>
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<tr>
<td>Addictions</td>
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<tr>
<td>Learning styles</td>
<td>Comprehensibility</td>
<td>Engagement</td>
<td>Personal development</td>
<td>Relationship building</td>
</tr>
</tbody>
</table>
Appendix 11

LivingWorks Beliefs

- Suicide is a community health problem.
  - Everyone can help.

- Thoughts of suicide are understandable, complex and personal.
  - Approach people at risk with an open mind.

- Suicide can be prevented.
  - It is possible to save lives and prevent injuries—now.

- Help-seeking is encouraged by open, direct and honest talk about suicide.
  - If you are approachable, people at risk will seek you out.

- Relationships are the context of suicide intervention.
  - Helping either relies upon or builds a relationship.

- Intervention should be the main suicide prevention focus.
  - The emphasis should be on preventing suicidal behaviours.

- Cooperation is the essence of intervention.
  - The helper and person at risk need to work together to prevent suicide.

- Intervention skills are known and can be learned.
  - Helpful skills are known and most everyone can learn them.

- Large numbers of people can be taught intervention skills.
  - The means to teach intervention skills on a large scale exist now.

- Evidence of effectiveness should be broadly defined.
  - These means are effective.
# Appendix 12

## Literature Review:
**People At-Risk by Vocational Sector and Life Skills: Findings and Implications**

<table>
<thead>
<tr>
<th>Author/Date (only 1st author listed)</th>
<th>Review of Findings</th>
<th>Recommendations for Preventative Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agerbo (2007)</td>
<td>Most of the considerable variation in suicide risk across occupations is explained by socio-economic factors, except for doctors and nurses. Apart from doctors, the risk of suicide has little association with occupation among people who suffer from a psychiatric illness.</td>
<td>Restriction of access to lethal means is an important strategy in suicide prevention.</td>
</tr>
<tr>
<td>Agervold (2004)</td>
<td>The results of this study bring into question the assumption that a generally poor work environment contributes to bullying. The results suggest that management style may directly or indirectly contribute to a higher level of bullying. Bullied employees report significantly more symptoms of psychological stress and mental fatigue than non-bullied employees.</td>
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<tr>
<td>Amagasa (2005)</td>
<td>This work related suicide study suggests that long work hours, heavy workloads and low social support may contribute to depression and suicide.</td>
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<tr>
<td>Andersen (2010)</td>
<td>Qld State Suicide Register was analysed to reveal a significantly higher risk of suicide for male subjects in the agricultural, transport and construction sectors. High suicide rates were also found in female nurses, artists, agricultural workers and cleaners, while education professionals (of both genders) appear to be at lower risk.</td>
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<tr>
<td>Berkman (2004)</td>
<td>In age-adjusted survival analyses for all causes of death, men who were least socially integrated were 4.42 times as likely to die during follow-up as those with the highest social integration.</td>
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</table>
level of integration. The results suggest that in this employed cohort of middle-aged men and women, social integration is an important predictor of mortality.

**Bertolote (2004)**

Since suicide is affected by socio-cultural factors, there is no safe indication that what has worked somewhere will work elsewhere. In order to acquire any public health importance, suicide prevention programs must clearly spell out their objectives and targets. Isolated actions have a much lesser probability of yielding significant results.


There was no significant difference between farmers and controls for numbers in contact with their general practitioner or mental health services in the three months before death. There may be some differences in help seeking behaviour between farmers and the general population as over 30% of farmers presented with exclusively physical symptoms.

| GP's should consider depressive and suicidal intention in farmers presenting with physical problems. Removal of firearms should be considered with depression diagnosis. |

**Bottomley (2002)**

Victorian coronial inquiry found work related factors linked to suicides: work stress, disagreement with colleagues, fear of retrenchment, performance pressure, long hours, injury or work related mental illness.

**Boxer (1995)**

Suicide is the eighth leading cause of death in the US. Suicide rates have been reported to be particularly high in professional, managerial, and executive groups. Some studies suggest that workers in a number of occupations, including chemistry, farming, and law enforcement, may have elevated suicide rates. Current evidence supports the conclusion that both male and female physicians have elevated rates of suicide, with females at particularly high risk.

| |

**Burnley (1995)**

NSW: Not currently married male manual workers were particularly at risk although marital status variations were significant with both genders and at different ages. While there were no significant variations by marital status in the means of committing suicide there were variations between genders, and there were regional and social class variations.
in the use of guns with males. The use of guns was a factor in the elevated suicide mortality levels among inland rural youth and men, and among farmers and transport workers while the use of poisons was also significant with these occupational groups. The use of poisons was greater among persons committing suicide in the areas of elevated mortality in inner Sydney and the use of guns much lower. There were significant variations in suicide mortality by marital status with both genders in each age group >25 and with never married and divorced men of low occupational status, mortality was particularly high.

| Carlton (2000) | Few adolescents who experience significant psychological distress seek professional psychological help. Contrary to expectations, higher levels of suicidal ideation led to lower levels of help-seeking intentions for suicidal thoughts. Help-negation has been identified in clinical suicidal samples. The implications of these findings for interventions that increase appropriate professional psychological help-seeking in adolescents are also discussed. |
| Mental health promotion and education programmes aimed at improving adolescents' appropriate professional psychological help-seeking should aim to modify help-seeking attitudes and explicitly identify the help-negation process in an effort to short-circuit it in times of crisis. |

| Corney (2010) | A study of male apprentices working in the building and construction industry examined mentoring relationships. The results indicate apprentices identify a range of mentors in their lives, predominantly in their personal lives, and the majority of these relationships develop organically. Apprentices value the psychosocial support that mentoring relationships provide. Findings support an expanded definition of mentoring to include significant others. |
| Recommendations include encouraging the development of young working men’s social networks as a key factor in promoting social support and increasing apprentice retention. |

<p>| Deane (2001) | Undergraduate university students show higher levels of suicide ideation negatively correlated with help seeking intentions. This study found that help-negation is not merely a result of hopelessness or prior help-seeking experiences. |
| Make professional mental health services more acceptable and accessible. Educate people about help-negation before it is exacerbated by acute suicidal states and provide positive examples of appropriate help-seeking, particularly in the context of suicide. |</p>
<table>
<thead>
<tr>
<th>Reference</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>De Leo (2004)</td>
<td>This paper reviews the psychological autopsy method used in suicide and concludes the method would benefit from standardisation in its application.</td>
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<tr>
<td>Fraser (2005)</td>
<td>Whilst suicide rates in some groups of farmers are higher than the general population, conclusive data do not exist to indicate whether farmers and farming families experience higher rates of mental health problems compared with the non-farming community. It is clear, however, that farming is associated with a unique set of characteristics that is potentially hazardous to mental health and requires further research.</td>
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<tr>
<td>Gullestrup (2011)</td>
<td>A large-scale workplace-based suicide prevention and early intervention program was delivered to over 9,000 construction workers on building sites across Queensland. Intervention components included: universal General Awareness Training (GAT; general mental health with a focus on suicide prevention); gatekeeper training provided to construction worker volunteer ‘Connectors’; Suicide First Aid (ASIST) training offered to key workers; outreach support provided by trained and supervised MIC staff; state-wide suicide prevention hotline; case management service; and postvention support provided in the event of a suicide. Findings from over 7,000 workers are reported, indicating strong construction industry support, with 67% building sites and employers approached agreeing to participate in MIC. GAT participants demonstrated significantly increased suicide prevention awareness compared with a comparison group. Connector training participants rated MIC as helpful and effective, felt prepared to intervene with a suicidal person and knew where to seek help for a suicidal individual following the training. Workers engaged positively with the after-hours crisis support phone line and case management. MIC provided postvention support to non-MIC.</td>
<td>Further implementation of Mates in Construction program for preventing suicide in construction workers.</td>
</tr>
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<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td><strong>Hawton (1998)</strong></td>
<td>Farmers who commit suicide tend to use methods to which they have easy access.</td>
<td>Restriction of the readily available methods, particularly in farmers known to be depressed or otherwise at risk, might prevent some suicides.</td>
</tr>
<tr>
<td><strong>Heller (2007)</strong></td>
<td>The incidence of suicide in the construction industry: total of 64 male suicides occurred over the seven-year period, representing a crude suicide rate of 40.3 per 100,000, significantly greater than the working age Australian male rate. Young employees were at excessive risk (double) with separation, divorce, relationship problems, and untreated psychiatric conditions the major contributors. Focus groups emphasized the importance of work-home interface factors and industry-specific factors preceding suicide. It appears that work-related factors (e.g., long working hours, pressure), interpersonal factors (e.g., relationship problems), and individual factors (e.g., alcohol and substance abuse) interact to contribute to suicide risk in this male-dominated, blue collar industry. Strong cultural themes evolve around the industry itself, such as being ‘masculine,’ and having a frequent association with alcohol and drug use, with more emphasis on ‘toughing it out’ than on communicating problems. That such themes are encountered by young males upon immediately entering the industry may contribute to perpetuating existing attitudes and behaviours, and may prove resistant to change once ingrained.</td>
<td>Prevention programs may need to incorporate wholesale changes to industry culture, before any specific interventions may be rendered viable.</td>
</tr>
<tr>
<td><strong>Jacoba van der Wal (2003)</strong></td>
<td>The life skills learning program was presented to artisans employed in industry. The selected materials (collage and stimulus instruments) depicted life skills and reflected the learning outcomes of the program.</td>
<td></td>
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<tr>
<td><strong>Jarvholm (2002)</strong></td>
<td>Contrary to other international studies, the risk of suicide was not higher for electricians in the construction industry in Sweden.</td>
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<tr>
<td>Author (Year)</td>
<td>Description</td>
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<tr>
<td>Judd (2005)</td>
<td>The elevated rate of suicide amongst farmers does not seem to be simply explained by an elevated rate of mental health problems. Individual personality, gender and community attitudes that limit a person's ability to acknowledge or express mental health problems and seek help for these may be significant risk factors. Five key findings emerged from the study: no support for the proposition that farmers experience higher rates of mental health problems than non-farmer rural residents; potentially important personality differences between farmers and non-farmers were identified; levels of conscientiousness were significantly higher amongst farmers and levels of neuroticism were significantly lower. A strong association between maleness and farming was found. In the qualitative study, participants indicated that farming is an environment in which individuals experienced a range of stressors but have limited capacity to acknowledge or express these. In addition, there appeared to be significant attitudinal barriers to seeking help for those who may have mental health problems, particularly males.</td>
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<tr>
<td>Kivimaki (2003)</td>
<td>A strong association between workplace bullying and subsequent depression suggests that bullying is an aetiological factor for mental health problems.</td>
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</tr>
<tr>
<td>Kposowa (1999)</td>
<td>There are differentials in the risk of suicide among industrial groups, and the industry with the highest risk is mining. While significant differences in suicide risk were found among industrial groups, less significant differences were found among occupational groups. Only labourers and the unemployed were found to have significantly higher risks of suicide than farmers and farm managers.</td>
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<tr>
<td>Lampert (1984)</td>
<td>Findings show an inverse relationship between occupational status and suicide for all age groups over the past 30 years. Over time, male suicide rates have increased particularly for employed males over 65, employed males aged 14 to 24, and males in low-status occupations. General economic</td>
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</table>
insecurity among workers of low socioeconomic status, particularly the elderly, is suggested as a contributing factor to these trends.

<table>
<thead>
<tr>
<th><strong>Leiter (1996)</strong></th>
<th>Longitudinal study of health care workers found spill-over relationships from work to home and, to a lesser extent home to work. The results are discussed in terms of an integrative model of work and family stress.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Liu (1994)</strong></td>
<td>Suicide rates among industrial groups were examined systematically. Marked differences in suicide rates were found among industrial groups. People employed in public administration had the lowest rate, and the construction and mining industries had the highest. The differences of suicide rates may be related to socio-demographic differences, self-selection for occupation, ease of access to lethal agents, or job stress.</td>
</tr>
<tr>
<td><strong>Malmberg (1997)</strong></td>
<td>The proportional mortality ratio for suicide is higher in farmers than in the general population. (England and Wales).</td>
</tr>
<tr>
<td><strong>Malmberg (1999)</strong></td>
<td>Autopsy study of suicide in farmers in UK: problems faced by working and retired farmers in the year before death included mental illness, occupational problems, relationship problems, and physical illness. The most frequent single problem and the one which was most often judged to be important in the death was mental illness (46%). Preventative measures are flagged in abstract as being discussed in full text (unable to access on-line).</td>
</tr>
<tr>
<td><strong>Mandell (1992)</strong></td>
<td>The prevalence of alcohol dependence and abuse in two high risk industries, construction and transportation, is confirmed. More than one in four construction labourers and one in five skilled construction trades workers received a DSM diagnosis related to alcohol abuse. The findings support the view that occupation may be associated with Alcohol Dependence and Alcohol Abuse, independent of demographic variations.</td>
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<tr>
<td><strong>Mann (2005)</strong></td>
<td>Evidence examined the effectiveness of specific suicide-preventive interventions and recommendations made for future prevention programs and research. Ascertaining which Physician education in depression recognition and treatment and restricting access to lethal methods</td>
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<table>
<thead>
<tr>
<th>Source</th>
<th>Summary</th>
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<tbody>
<tr>
<td>Barletta, J., &amp; Dundas, V. (2012).</td>
<td>Some components of suicide prevention programs are effective in reducing rates of suicide and suicide attempt is essential in order to optimize use of limited resources.</td>
</tr>
<tr>
<td>Miller (2010)</td>
<td>Construction workers at Ground Zero after 9/11 were exposed to stressful and traumatic conditions. Clinicians, trade union leaders and the Cornell School of Industrial and Labor Relations designed a psychosocial capacity-building project which helped workers recognize, understand and respond to their reactions through interventions including peer training, psychosocial workshops, brochures, and outreach and referral services. The project emphasized the use of mutual aid and social support through groups facilitated by clinicians and offered by unions. The article describes planning and implementation of the project, and evaluations of the effectiveness of the project. Results of this evaluation are positive and encouraging of a psychosocial capacity-building model for construction workers engaged in dangerous, stressful, and psychologically risky work.</td>
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<tr>
<td>Notkola (1993)</td>
<td>Both suicide and accidental death rates were high in semiskilled construction workers and forestry workers. Socio-economic factors such as marital status and housing conditions do not explain this trend.</td>
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<tr>
<td>Olafsson (2004)</td>
<td>A factor analysis of bullying items identified two factors: general bullying and work-related bullying. Males score higher on both factors, but when asked directly if they have been bullied or not, no significant gender difference appears. Victims resort to more passive coping strategies as the bullying becomes more serious.</td>
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<tr>
<td>Page (2002)</td>
<td>Male farm manager and agricultural labourer suicide rates are higher than male national rates and rates in the wider rural population, particularly in the later years of the period investigated. Access to means of suicide has been demonstrated to be successful.</td>
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<td>Author</td>
<td>Description</td>
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<tr>
<td>Rayner (1998)</td>
<td>Individuals being bullied revealed a difficulty in finding support and resolving the issue. A case is made that respondents report a culture of acceptance of bullying within their workplaces. It is suggested that a lack of overt action by those in supportive roles such as trade union representatives, personnel managers and OHS professionals can contribute to sustaining this culture.</td>
</tr>
<tr>
<td>Renberg (2003)</td>
<td>An instrument measuring attitude to suicide was developed through postal questionnaires.</td>
</tr>
<tr>
<td>Robinson (1999)</td>
<td>Study of electrical workers in 1980’s USA: The finding of statistically significant excess deaths due to prostate cancer, musculoskeletal disease, suicide, and disorders of the blood-forming organs was unexpected.</td>
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<tr>
<td>Rodgers (2010)</td>
<td>ASIST skills training program document.</td>
</tr>
<tr>
<td>Sarchiapone (2011)</td>
<td>Restriction to means of suicide may be particularly effective in contexts where the method is popular, highly lethal, widely available, and/or not easily substituted by other similar methods.</td>
</tr>
<tr>
<td>Spurgeon (1997)</td>
<td>It is concluded that there is currently sufficient evidence to raise concerns about the risks to worker health and safety with long working hours.</td>
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<tr>
<td>Stack (1995)</td>
<td>An analysis of gender differences in suicide among labourers confirms female labourers had a suicide rate of 7.6 times that of females in general. Overrepresentation of males in the ranks of labourers does not, however, decrease their suicide risk.</td>
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<tr>
<td>Stack (2000)</td>
<td>84 studies, over 15 years, reviewed to conclude social integration is negatively related to suicide. Migration lowers social integration.</td>
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<td>Study (Year)</td>
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<td>Stack (2001)</td>
<td>Study found 15 occupations with either significantly higher (e.g., dentists, artists, machinists, auto mechanics, carpenters) or lower (e.g., clerks, elementary school teachers, cooks) suicide risk than the rest of the working-age population.</td>
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<tr>
<td>Steenland (1999)</td>
<td>Mortality patterns for painters were identified. Moderate risk was identified with cancers. Suicide rates and neuropsychiatric diseases have been associated with painters in earlier studies.</td>
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<tr>
<td>Stern (1997) AJIM 31</td>
<td>Suicide is not a focus of this study. It is listed with injuries. The most notable risk documented in the study was fatal falls.</td>
</tr>
<tr>
<td>Stern (1997) AJIM 32</td>
<td>This report presents the results of proportionate mortality ratios among members of the International Union of Operating Engineers. Suicide rates were noted as statistically significant in this group.</td>
</tr>
<tr>
<td>Stern (2000)</td>
<td>This report presents the results of proportionate mortality ratios for members of the United Union of Roofers and Water Proofers. Suicide is not examined. Injuries, including falls were noted as statistically significant.</td>
</tr>
<tr>
<td>Taylor (2005)</td>
<td>The skills shortage pervades the rhetoric and calls for Australia to become a skilled nation, and is implicitly associated with conceptions of youth as attitudinally deficient and inadequately prepared to meet the needs of the economy. A lack of clarity exists regarding the term ‘skills’, and the distinction between ‘soft’ and ‘hard’ skills. While the new employability skills framework identifies the attributes and dispositional skills considered an employment-oriented soft skills regime, it leaves questions unanswered. With reference to a group of trade-oriented youths, the skills debate is critiqued to show the promotion of soft skills as measurable competencies has compounded an ambiguous and imprecise field.</td>
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<td>Author</td>
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<td>Tennant (2001)</td>
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<td>Torre (2005)</td>
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<td>Warr (1992)</td>
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<td>Wilhelm (2004)</td>
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<td>Van (2000)</td>
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<td>Zhang (2003)</td>
<td></td>
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</tbody>
</table>
References: Literature Review


Renberg, E. & Jacobsson, L. (2003). Development of a questionnaire on attitudes towards suicide (ATTS) and its application in a Swedish population. *Suicide and Life Threatening Behavior, 33*(1), 52-64.


Appendix 13

Resource List

The following are a range of resources available to the apprentices and trainers in the area of suicide prevention, personal development, resilience-building and coping strategies. These include structured programs, web sites, tip sheets, on-line help, and phone help-lines.

OZHELP
This Life Skills Tool Box Program has been developed by Oz Help specifically for apprentices entering the construction industry, to help develop resilience and well-being, and to enable them to take more effective control of their lives. It builds upon long-standing traditions of mateship and mutual support within the industry.
www.ozhelp.org.au

SANE Australia
SANE Australia is a national charity working for a better life for people affected by mental illness through campaigning, education and research. It conducts innovative programs and campaigns to improve the lives of people living with mental illness, their family and friends. It also operates a helpline and website, which have thousands of contacts each year from around Australia.
www.sane.org

ASIST
LivingWorks ASIST is an interactive workshop that equips people for a more active role in suicide intervention. The program takes participants beyond suicide awareness by enhancing their confidence and ability to recognise and respond to a person at risk of suicide or self-harm. It is designed to help all caregivers become more comfortable, competent and confident when dealing with persons at risk. ASIST aims to highlight participant attitudes towards suicide and provide participants with the knowledge and skills to recognise and estimate suicide risk. The training presents a model for effective intervention and generates information about resources in the local community.
www.livingworks.net

LIFE (Living Is For Everyone)
The LIFE Framework aims to:
- Improve understanding of suicide,
- Raise awareness of ways of responding to people considering taking their own life,
- Raise awareness of the role people can play in reducing loss of life to suicide.
The LIFE Framework also provides a summary of current understandings in suicide such as risk and protective factors, vulnerability and risk, tipping points and warning signs.
www.livingisforeveryone.com.au

Mind Matters
MindMatters aims to:
- Embed promotion, prevention and early intervention activities for mental health and wellbeing,
- Enhance the development of environments where young people feel safe, valued, engaged and purposeful,
- Develop the social and emotional skills required to meet life’s challenges,
- Help education communities create a climate of positive mental health and wellbeing,
- Develop strategies to enable a continuum of support for participants with additional needs in relation to mental health and wellbeing,
- Enable education communities to better collaborate with families and the health sector.

www.mindmatters.edu.au

**MoodGym**

MoodGYM is an innovative, interactive web program designed to prevent depression. It consists of five modules, an interactive game, anxiety and depression assessments, downloadable relaxation audio, a workbook and feedback assessment.

MoodGYM aims to:
- Help you identify and overcome problem emotions,
- Show you how to develop coping skills for the future so you can enjoy good mental health.

www.moodgym.anu.edu.au

**Helping Friends**

Helping Friends is a training and peer support program for young people in education communities. It is based on the premise that young people initially seek out their peers for help and support, and that every education communities has many informal helping networks. The program identifies *helpers* and offers them training in specific skills for helping and supporting their peers. An anonymous opinion survey determines the most important issues for young people in the targeted year level.

www.aicafmhna.net.au

** Headspace**

Support Teams *Suicide Postvention Toolkit* and associated resources and fact sheets, including how to talk to young people about suicide.

www.headspace.org.au

**Responding to people at risk of suicide**

Service providers develop relationships and contacts with large numbers of families and individuals in the community, providing them with an important opportunity to identify and respond to the signs of suicide risk. This resource is aimed at agencies that do not have a primary role in supporting people at risk of suicide but may have contact with people at risk of suicide as part of their core business. While suicide risk is higher among some demographics than others, suicide affects everyone in our society. Everyone is responsible for identifying and responding to people at risk of suicide.


**Principles for providing postvention responses to individuals, families and communities following a suicide death**

The principles are divided into three key areas to:
- assist organisations and service providers to ensure their responses following a suicide death are consistent with good practice,
• assist communities with the longer term goal of establishing coordinated postvention responses in accordance with good practice,
• provide information about further postvention resources available for bereaved people, service providers and the media.

**Principles for developing organisational policies and protocols for responding to clients at risk of suicide and self-harm**

While having broad application to a range of agencies in the human services field, the principles are intended to specifically support those agencies to meet standard 6 of the Standards for Community Services in Queensland. This standard requires agencies to develop, implement and review policies and procedures for preventing harm (including suicide and self-harm), and to respond to potential or actual harm that may occur to clients. The principles include an overview of a range of issues which should be considered in the development of written policies and protocols, good practice suggestions and additional resources and reference materials.

More specifically, the principles are structured to assist agencies to consider:
• overarching principles and organisational roles,
• practice issues in working with people at risk of suicide and self-harm, such as assessment, intervention, referral, confidentiality, needs of specific population groups and postvention and bereavement,
• organisational practices which underpin effective responses to people at risk of suicide and self-harm, such as professional development and training, professional support and supervision, record keeping and review and evaluation.

**Youth Suicide Prevention**

The Department of Communities contributes towards Youth Suicide Prevention through supporting Gallang Place, Aboriginal and Torres Strait Islander Corporation to provide services to young Indigenous people in the Brisbane area who are identified as being at risk of suicide or engaging in self-harming behaviours. Resources and other initiatives which promote good practice in suicide and self-harm prevention include three online suicide prevention resources, to assist organisations and service providers to identify and respond to people at risk of suicide.

**The Time Out House Initiative (TOHI)**

This is a pilot of two programs for young people aged 18-25 years who are showing early signs and symptoms of mental health problems. More information:

A strategy to provide greater access to suicide prevention and mental health training for those working in the sector. This will involve training in identified Queensland locations for delivery of suicide prevention initiatives. More information:

The department maintains a strong partnership with the Queensland Alliance and other key stakeholders in the government and non-government sectors.
Youth Mental Health First Aid Training
Provides a basic understanding around identifying suicidal risk among young people and responding.
www.mhfa.com.au

Resilience for Life (Adult Resilience Program)
Just like the developmental milestones children face, adults equally continue to experience many life changes. This could range from common challenges such as transitioning into the workplace, entering and ending relationships, and starting a family, to unforeseen and unplanned events such as the loss of a loved one, natural disasters, or financial difficulties. Feeling overwhelmed and/or anxious is a natural by-product of such experiences or situations. Resilience for Life is an interactive program developed to provide adults with positive coping skills to better navigate these experiences, effectively manage the associated feelings, and to be resilient for life.
www.pathwayshrc.com.au

Websites and Other Resources
Queensland Health has a range of information about suicide and suicide prevention that can be accessed at:

National Suicide Prevention Strategies

Support after Suicide – Australian online service provided by the Jesuits
www.supportaftersuicide.org.au/

Australian Psychological Society
www.psychology.org.au/publications/inpsych/suicide_industry
(contains links to further resources)

Education Queensland

The Center for Mental Health in Schools (UCLA) Suicide Prevention
www.smhp.psych.ucla.edu/qf/p3002_02.htm

National Institute for Mental Health

Self-injury and Suicide
www.tpronline.org/bundle.cfm/Self_Injury_and_Suicide_Bundle

SPEAK (Office of Mental Health NY)
www.omh.ny.gov/omhweb/speak
University of Washington, Reconnecting Youth Prevention Research Program
www.son.washington.edu/departments/pch/ry

National Center for Suicide Prevention Training
www.ncspt.org/default.asp

State Plans for Suicide Prevention
www.ac.wwu.edu/~hayden/spsp

US Air Force Medical Service Suicide Prevention Program
www.osophs.dhhs.gov/ophs/BestPractice/usaf.htm

**Additional Websites**

General educational advice, information sheets, and in some cases, on-line assessment and help can be accessed on a range of psychological, emotional and relationships issues from the following websites. (e.g., Anxiety, Depression, Health, Mental illness, Relationships, Substance abuse)

Alcoholics Anonymous
www.aa.org.au

Anxiety Treatment Australia
www.anxietyaustralia.com.au

Australian Bipolar Website
www.members.iinet.net.au/~fractal1

Australian Drug Foundation
www.adf.org.au

Australian Government Alcohol Information
www.alcohol.gov.au

Australian National Tobacco Campaign
www.quitnow.info.au

Australian Psychological Society
www.psychology.org.au/publications/tip_sheets

Beyond Blue: National Depression Initiative
www.beyondblue.org.au

Black Dog Institute
www.blackdoginstitute.org.au

Blue Pages: Depression info
www.bluepages.anu.edu.au
Clinical Research Unit for Anxiety & Depression  
www.crufad.unsw.edu.au

Depression Net  
www.depressionnet.com.au

Drug Information  
www.druginfo.nsw.gov.au

Early Psychosis Prevention & Intervention Centre  
www.eppic.org.au

Family Drug Support  
www.fds.org.au

Kids Help Line  
www.kidshelp.com.au

Legal Aid Office  
www.nla.aust.net.au

Lifeline Australia  
www.lifeline.org.au

Macquarie Psychology Clinic: Anxiety Information  
www.psy.mq.edu.au/MUARU

Mayo Clinic  
www.mayoclinic.com

Mensline Australia  
www.menslineaus.org.au

Narcotics Anonymous  
www.na.org.au

National Drug & Alcohol Research Centre  
www.med.unsw.edu.au/ndarc

National Institute of Mental Health  
www.nimh.nih.gov

ParentLink  
www.parentlink.act.gov.au

Pregnancy Counselling Link  
www pcl.org.au
Queensland Cancer Fund
www.qldcancer.com.au

SIDS & KIDS
www.sidsandkids.org

Stepfamily Zone
www.stepfamily.asn.au

Support Group Information

**Telephone Help Lines**

Alcohol & Drug Information Services
1800 422 599

Alcoholics Anonymous
07 3255 9162

Alcoholics Tobacco & Other Drugs
07 3837 5989

Family Drug Support
1300 368 186

Cancer Helpline
13 11 20

Domestic Violence Hotline
1800 811 811

Family Relationship Advice Line
1800 050 321

Family Services Australia
1300 365 859

Kids Help Line (24 hrs)
1800 55 1800

Legal Aid Queensland
1300 65 11 88

Lifeline Telephone Counselling (24 hrs)
13 11 14
Mensline Australia  
1300 78 99 78

Narcotics Anonymous  
1300 652 820

Pregnancy Counselling Link  
1800 777 690

Quitline  
13 78 48

Sexual Assault Help Line  
1800 010 120

Salvo Care Line  
07 3831 9016

SIDS & KIDS  
1800 628 648
Appendix 14

External Validation for the MIC Life Skills Program

Business Owners and Employers in the Construction Industry:

Peter De Felicis, MetroTiles
I have been in the industry for nearly 20 years, and the industry definitely needs to be informed about these issues. We had our own experience with an apprentice who I felt was going to top himself. We took some drastic measures to help him. I do believe you are on the right track with introducing this information within a training course. I would almost introduce a compulsory meeting with a social worker during their training time so that problems can be identified early. Maybe even a psychometric test. I would try to shy away from introducing additional time and costs to business, as it most likely would be ignored. Agree 100% with the blake mentality. I also think that their schooling life has not prepared them for the real world. They leave in Year 10 or 12 and are expected to man-up straight away with no life skills.

Joe D’Ercole, Hercules Developments
I have read over the programme that you have put together and think it is a valuable tool that can be useful. I was originally an apprentice mechanic who has now moved into the building industry, and many of my friends who are also in building were once in carpentry, electrical and plumbing apprenticeships. I believe any life skills assistance provided to an apprentice is invaluable in furthering their knowledge and experience. If my boss didn’t give me and my friends opportunities and support, we would be struggling today. Good luck and I support the programme 100%.

Mental Heath and Education professionals in Academia and Clinical Practice:

Dr Matthew Bambling, Lecturer, School of Medicine, University of Queensland
A well-constructed document, impressive. I think that it might be good to note in the program overview some mention of substances, depression and anxiety and why this is a problem with regards suicide, given the impact on risk. It might be worth including tip sheets on depression and anxiety along with the others. You have done a good job here of providing educative concepts around risk and also increasing participants’ personal awareness and self development.

Prof. Paul Burnett, Dean of Research and Training, Queensland University of Technology
The incidence of young people suiciding in our community is a serious one that needs to addressed. The Life Skills Program report by Barletta and Dundas covers the key information, skills and behaviours that are believed to assist people in general (and apprentices in this case) to learn about themselves and to develop resilience strategies. The content of the three day program is grounded in the literature and will provide apprentices with an appropriate toolbox to be more resilient and to cope better with life circumstances. The evaluation and feedback strategies accompanying this program are a real strength.
Dr Jason Dixon, Clinical Counsellor and Consultant, Private Practice, Brisbane
This program addresses the needs of a section of the workforce often overlooked in terms of promoting wellness. The program provides participants with the skills they need to be mindful of the potential risks to their mental health, and also provides them with the knowledge to promote a healthy workplace environment for their colleagues. The content of this program is based on current research and delivered in a way that is meaningful for participants to consider their own wellness. There are numerous benefits not only for participants, but also for their employers.

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