NORTHERN TERRITORY STRATEGIC FRAMEWORK FOR SUICIDE PREVENTION

A framework for the prevention of suicide and self-harm in the Northern Territory 2003

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FOREWORD

This Northern Territory Strategic Framework for Suicide Prevention acknowledges and builds on existing initiatives responding to suicide and self-harm, as well as confirming key directions and pathways for future activities supported by government and non-government sectors, communities and individuals across the Territory. It responds to widespread concern about the high rates of suicide and self-harming behaviour among some age groups and populations, and presents the evidence on actions that can help address this tragedy.

The Framework reflects Government's priorities, including a commitment to improving mental health care and is linked to a number of related national initiatives, including the National Suicide Prevention Strategy and the National Mental Health Strategy.

I would like to take this opportunity to thank all those people who contributed to the development of the Framework. It has been informed by consultation with community groups and individuals through intersectoral and public forums across the Northern Territory (NT). It has been developed with considerable assistance from the Suicide Prevention Interdepartmental Committee (SPIDC) and members are thanked for their valuable contribution in ensuring the document reflects key concerns and directions. The Committee comprised senior representatives from the Departments of Health and Community Services (Chair); Employment, Education and Training; Chief Minister (Office of Youth Affairs); Community Development, Sport and Cultural Affairs; Justice; Police, Fire and Emergency Services; and the Commonwealth Department of Health and Ageing.

I also want to specifically acknowledge the valuable contribution and support provided by the NT Coroner's Office in compiling this Framework.
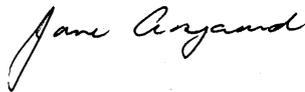
The Hon. Jane Aagaard MLA
Minister for Health and Community Services

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EXECUTIVE SUMMARY

Background

Suicide is a tragedy that affects many Australian families and communities each year. There is nation-wide concern, with action being undertaken across all levels of government and the community. Suicide is complex and related to an accumulation of risk and protective factors. It intersects with a range of problems across society including mental health, drugs and alcohol, family issues, employment, cultural identity, law enforcement, criminal justice, education and poverty.

This Strategic Framework for Suicide Prevention 2003 provides a platform to guide planning and development of initiatives with a focus on life promotion and the prevention of suicide and self-harm in the Northern Territory (NT). It is based on a whole-of-government and community approach that supports action across all levels of government, covers the entire lifespan, includes a spectrum of interventions and builds on existing services and supports. It provides key directions and pathways for future activities undertaken by sectors and communities with an interest in suicide prevention. It is a significant effort that is consistent with Government's priorities and good practice across a spectrum of approaches.

Key related initiatives include: Living is for Everyone (LIFE): A framework for prevention of suicide and self-harm in Australia (Commonwealth Department of Health and Aged Care CDHAC 2000a), the cornerstone of the National Suicide Prevention Strategy (NSPS); the National Mental Health Strategy; National Drug Strategic Framework 1998–99 to 2002–03; and National Anti-Crime Strategic Framework; the NT Government's Supporting Families and Building A Safer Community: Tough on Drugs policies and Domestic and Aboriginal Family Violence Strategies; and the NT Aboriginal Emotional and Social Wellbeing Strategic Plan (under development).

Trends in suicide rates

Extra care needs to be taken when interpreting suicide rates in the NT because of the relatively small number of suicide deaths and yearly fluctuations. However, it is clear that there are some significant differences between NT and national suicide rates and trends. The suicide rate for the NT has been higher than the national rate for the past decade and continues to rise. Whilst the national suicide rate has remained relatively constant, suicide deaths in the Northern Territory have increased over the past decade. In 2000, the NT rate was approximately 45–50% higher than the national rate (20 per 100,000 compared to 13 per 100,000) (ABS Information Paper: Suicides 2001).

Indigenous suicide rates have increased significantly. Until the early 1990s, reported suicide rates amongst Indigenous people in the Territory were significantly lower than for non-Indigenous Territorians. In 1990, no suicide deaths were recorded amongst Indigenous people. Whilst the relatively small numbers overall make it difficult to identify significant trend changes, 18 Indigenous people were recorded as having completed suicide in 1999 (ABS 2000), reflecting a substantial increase over a relatively short period of time. The suicide rate for NT Indigenous males has significantly increased in the 15–24 year age group since 1995, whilst there was a slight increase in suicide rates in the same non-Indigenous cohort over this period (ABS Death Registration Data).

The high and increasing national suicide rate for men aged 25–44 years is consistent with NT trends. There has been an increase in suicide rates for both Indigenous and non-Indigenous NT males in this age group over the past decade (ABS 2000). The rate amongst non-Indigenous NT males is comparable to the national average. Indigenous males in the NT within this age cohort experience significantly higher rates of suicide than the national average (ABS 2000).

What influences suicide?

While there is debate about the relative importance of different risk and protective factors related to suicide, some studies indicate that the most significant risk factors are: a history of mental illness; mental illness combined with harmful drug use; prior suicide attempt or deliberate self harm; and a family history of suicide or suicidal behaviour (CDHAC 2000b; Hilman et al 2000).

While comparatively little research has been conducted on the relationship between individual protective factors and suicide, the available evidence suggests that connectedness to family and community, relationships, personal resilience and economic security all play a part (CDHAC 2000b).

Effective responses to suicide

There is no single route to a reduction in suicide rates. It is nationally and internationally recognised that effective suicide prevention should combine population strategies with those aimed at high-risk groups. Prevention efforts need to minimise risk and enhance protective factors using a range of approaches targeting the whole population, specific groups and individuals 'at risk'. This means responsibility and ownership of suicide prevention initiatives is broad and must involve all levels of government, the non-government sector, local communities and individuals.

Areas for Action

The six areas for action in this Strategic Framework are based on the LIFE framework and include supporting rationales, evidence base and strategies for each action area:

Rationale	Sets out the reasons which support the choice of action.
Evidence	Presents the available evidence for the most effective approaches in each action area. Examples of existing approaches and projects, which have demonstrated effectiveness, are also provided.
Suggested Strategies	Identifies a broad range of tasks that will make a difference when implemented.
Assessing Progress	Provides a check list to track progress toward the anticipated outcomes and benefits arising from the implementation of each strategy.

Action Area 1 — Promoting wellbeing, resilience and community capacity across the NT. Enhance protection against suicide by strengthening wellbeing, optimism, connectedness, resilience, health and capacity across the entire community, with a particular focus on young people and their families.

Action Area 2 — Enhancing protective factors and reducing risk factors for suicide and self-harm across the NT. Support initiatives that reduce risk factors and promote protective factors for suicide and self-harm, giving increasing attention to 'critical periods' or transition points through the life course where interventions have the potential to be most effective.

Action Area 3 — Services and support within the community for groups at increased risk. Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of suicide and self-harm, through prevention, recognition and response.

Action Area 4 — Services for individuals at high risk. Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal behaviour.

Action Area 5 — Partnerships with Indigenous people. Provide culturally appropriate programs that support community responses to high rates of suicide in Indigenous communities.

Action Area 6 — Progressing the evidence base for suicide prevention and good practice. Ensure that programs have the greatest chance of benefit and minimum risk of harm by building the evidence base, sharing good practice and providing education and training.

INTRODUCTION

Suicide is complex. It results from an accumulation of risk factors and intersects with problems across society that include mental health, drugs and alcohol, family issues, employment, cultural identity, law enforcement, criminal justice, education and poverty. Cross-government and community partnerships are critical to strengthen the ability of individuals, communities and agencies to tackle the high rates of suicide and self-harm in the Territory.

There is increasing evidence about interventions which help to prevent suicide and self-harm, and provide alternative life-affirming choices for individuals and communities impacted by the loss and grief that accompanies a suicide. This Strategic Framework aims to provide a conceptual and policy platform for effective suicide prevention in the NT. It explores the size and scope of the problem; including who is affected, which groups are at higher risk and what factors influence suicide risk. It also recognises that whilst mental health problems and disorders are a risk factor for suicide, and the health sector is a crucial player, effective suicide prevention approaches are dependent on a collaborative effort across all levels of government and the community. Responsibility and ownership of initiatives rests with all sectors where risk and protective factors are present.

POLICY CONTEXT

Suicide prevention activities in Australia are taking place in the context of worldwide concern about increasing rates of suicide, particularly among young males. Australia is recognised as one of the first countries to have developed a comprehensive approach to suicide prevention: Living is for Everyone (LIFE): A framework for prevention of suicide and self-harm in Australia is the cornerstone of the National Suicide Prevention Strategy (NSPS).

In line with the LIFE framework, the NT Strategic Framework identifies six areas for action with correlating strategies and indicators for assessing progress. It builds on existing services and supports that promote life and respond to suicide and self-harm, as well as confirming key directions and pathways for future activities supported by government and non-government sectors and communities across the Territory. Strategies are underpinned by a whole-of-government and community approach that supports action across all levels of government, covers the entire lifespan, and includes a spectrum of interventions. It is a significant effort that is consistent with Government's priorities and evidence based practice.

Key related initiatives include: the National Mental Health Strategy; National Drug Strategic Framework 1998–99 to 2002–03; and National Anti-Crime Strategic Framework which forms the empirical and policy basis for crime prevention in all jurisdictions; the NT Government's Supporting Families and Building A Safer Community: Tough on Drugs policies and Domestic and Aboriginal Family Violence Strategies; and the NT Aboriginal Emotional and Social Wellbeing Strategic Plan (under development).

PREVALENCE OF SUICIDE IN THE NT

Several sources of data informed the development of this Strategic Framework including the Australian Bureau of Statistics (ABS), Northern Territory hospital and Coroner's records and the National Coroner's Information System (NCIS). Other sources included national and international studies, evidence-based reviews and reports. An analysis of the most recent published ABS data up to 1999, and evidence from unpublished sources indicates a number of significant trends.

The Northern Territory has high rates of suicide. Whilst the national suicide rates have remained relatively constant, suicide deaths in the Northern Territory have

increased over the past decade. In 1999, the NT rate was 28% higher than the national rate (16.6 per 100,000 compared to 13.0 per 100,000).

Indigenous suicide has significantly increased. Until the early 1990s, reported suicide rates amongst Indigenous people in the Territory were significantly lower than for non-Indigenous Territorians. In 1990, no suicide deaths were recorded amongst Indigenous people. Whilst the relatively small numbers overall make it difficult to identify significant trend changes, 18 Indigenous people were recorded as having completed suicide in 1999, reflecting a substantial increase over a relatively short period of time. The adjusted suicide death rate of Indigenous people in the NT of 32 per 100,000 population in 1999 (Figure 1).


Figure 1: Suicide, age-adjusted death rate, Northern Territory and Australia, 1992-1999
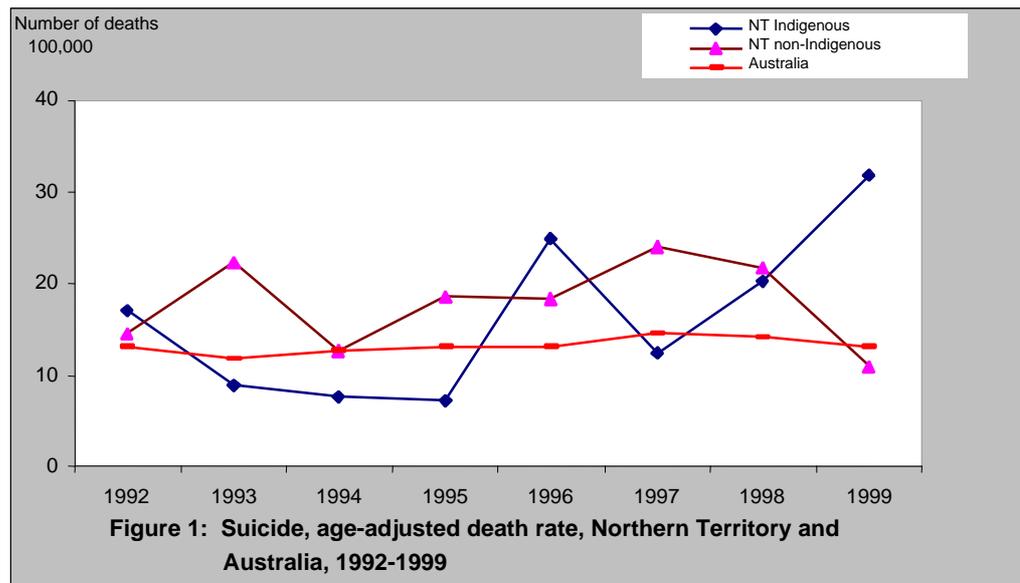
Data source: ABS Death Registration Data.

Indigenous men have increasing rates of suicide. NT Indigenous males had much lower suicide death rates in the early 1990s but have experienced a significant increase over the last ten years. The suicide death rate amongst Indigenous men in the NT has increased rapidly since 1997 to a point where in 1999, it was substantially higher than both the NT non-Indigenous male rate and the overall national rate (Figure 2).


Figure 2: Suicide, age-adjusted death rate, NT males and Australian males, 1992-1999
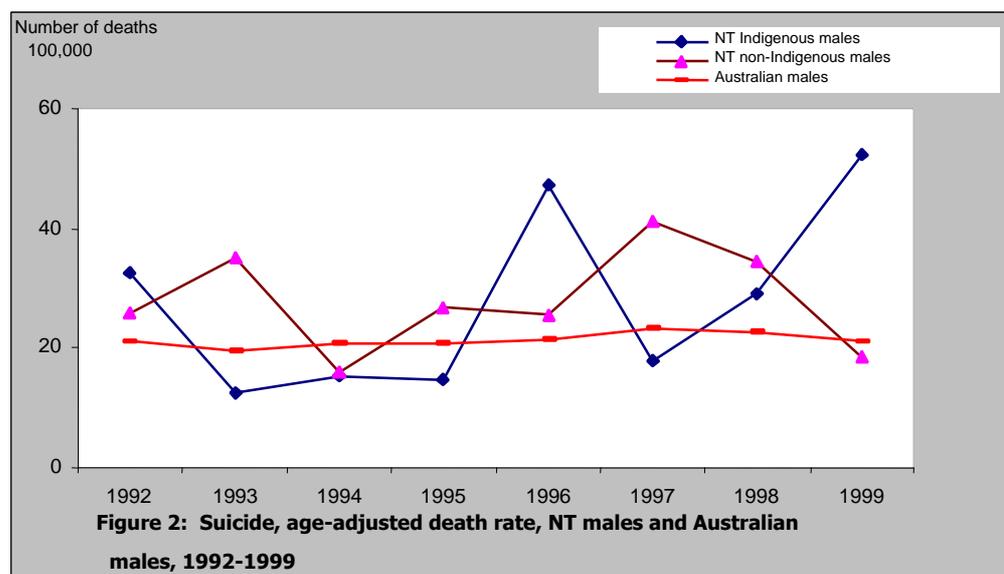
Data Source: ABS Death Registration Data

Indigenous females have increasing rates of suicide. NT Indigenous females had much lower suicide death rates in the early 1990s. There has been a consistent increase in the suicide rate over the last decade. There has been a rapid increase in suicide rates among Indigenous females in the NT since 1995 to a point where in 1999 the rate was substantially higher than both the NT non-Indigenous female rate and the national rate (Figure 3).


Figure 3: Suicide, age-adjusted death rate, NT females and Australian females,1992-1999
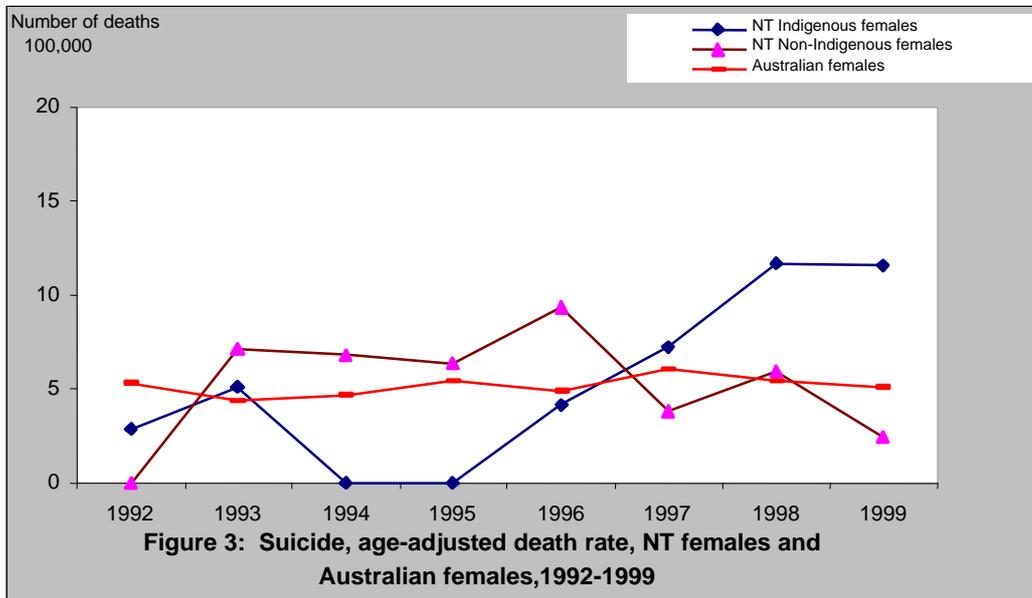
Data Source: ABS Death Registration Data

Young men have high and increasing rates of suicide death. Of particular concern is the trend in suicide rates amongst NT males, which have increased over the past decade. Young Indigenous males have recorded a rapid increase since 1997. The suicide rate for NT Indigenous males significantly increased in the 15–24 year age group from zero per 100,000 in 1992 to approximately 120 per 100,000 in 1999. There has also been an increase in the suicide rate for non-Indigenous males in the 15–24 year age group from 20 per 100,000 in 1992 to approximately 40 per 100,000 in 1999 (Figure 4).

Figure 4: Suicide, age-specific death rate, 15-24 years, males, 1992-1999
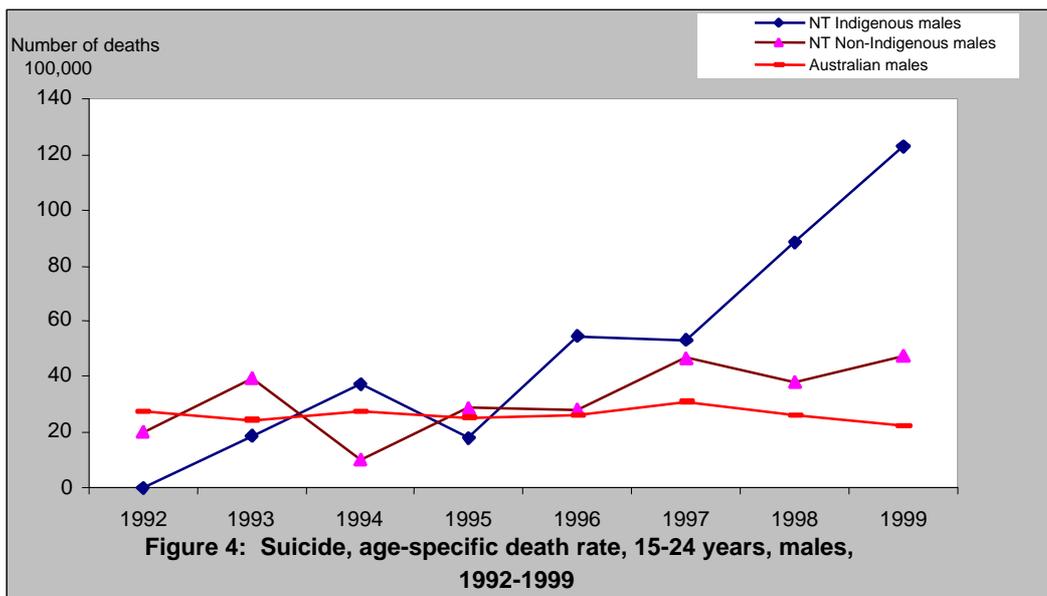
Data Source: ABS Death Registration Data

High rates of suicide by men aged 25–44 years. The high and increasing national suicide rate for men aged 25–44 years is consistent with NT trends. There has been an increase in suicide rates for both Indigenous and non-Indigenous NT males in this age group over the past decade (ABS 2000). The rate amongst non-Indigenous NT males is comparable to the national average, however, Indigenous males in the NT within this age cohort experience significantly higher rates of suicide than the national average (ABS 2000) (Figure 5).

Figure 5: Suicide, age-specific death rate, 25-44 years, males, 1992-1999
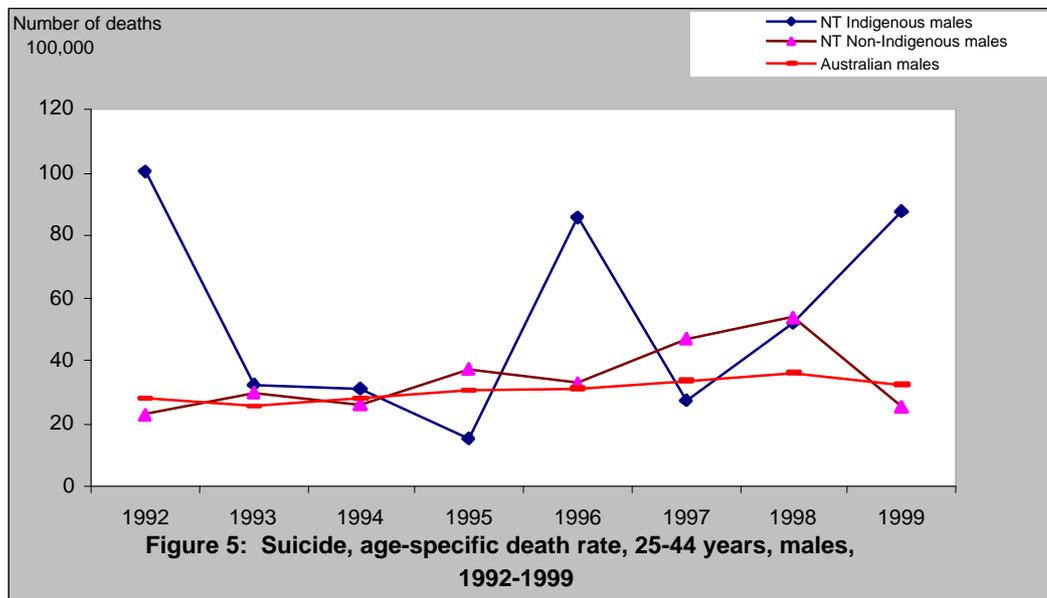
Data Source: ABS Death Registration Data

Attempted suicide and deliberate self-harm is a serious problem. Evidence from international studies suggest that the ratio of attempted suicide to suicide ranges from 4:1 to around 200:1. Women are also thought to be more likely to attempt suicide than men (CDHAC 2000b).

Data regarding intentional self-harm and attempted suicide is collected in NT public hospital records but needs to be treated with caution as:

- not all people who attempt suicide present at hospital or places where this data could be registered;
- not all attempts are recognisable and may lead to misclassification eg single motor vehicle accidents; and
- self reporting measures for suicide attempts may not be reliable.

In addition, many incidents of intentional self-harm may not feature deliberate intent to commit suicide. Self-inflicted injury may occur in the context of cultural practices or risk-taking behaviours where there is no suicidal intent. Nevertheless, available data indicates the incidence of these behaviours presents a serious problem in the NT.

WHAT INFLUENCES SUICIDE?

A number of researchers have developed models on pathways to suicide and the complex interplay of factors involved. A model of risk factors for suicide and suicide attempts developed by Beautrais (1998) has been adapted for inclusion in the LIFE framework and is presented in Figure 1.

Figure 6: Risk pathway for suicide and suicide attempts
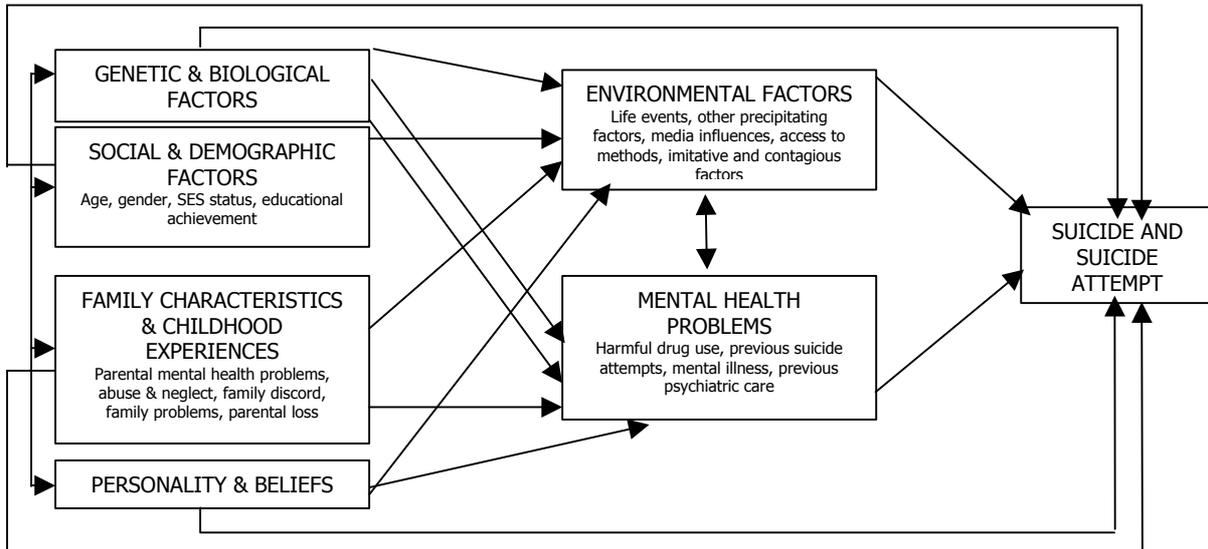
Source: Commonwealth Department of Health and Aged Care 2000 - Learnings About Suicide, p39.

Risk factors

The LIFE framework provides a detailed analysis of the available evidence on factors that influence suicidal behaviour. Most notable risk factors are: a history of mental illness; mental illness combined with harmful drug use; prior suicide attempt or deliberate self-harm; and a family history of suicide or suicidal behaviour (CDHAC 2000b; Hilman et al 2000). Other important factors include:

- socio-economic disadvantage, including low educational achievement and unemployment;
- legal problems, imprisonment or behaviour that brings the person into conflict with the law or society;
- sexual orientation, with studies showing gay, lesbian and bisexual people, particularly adolescents and young adults are at increased risk of suicidal behaviours and thinking;
- family adversity and child abuse and neglect;
- availability of means of suicide;
- stress, crises and losses, including loss of employment or physical health, relationship breakdown, death and other interpersonal loss; and
- cultural and social factors, including in particular those related to grief, loss and trauma experienced by Aboriginal people and community (CDHAC 2000b).

Limited research on suicide has been undertaken in the NT, however, a recent study of factors related to suicide by Parker and Ben-Tovim (2002) in the Top End found:

- mental illness prior to suicide;
- the most common stresses experienced by individuals prior to their death were relationship breakdown, trouble with family and friends and medical illness

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(ranging from upper respiratory infections and mild diarrhoea to terminal cancer and HIV); significant alcohol abuse prior to suicide, particularly amongst males;

- in 60% of cases, families and friends described the victim as showing signs of a and
- 65% of people who died by suicide did not seek help prior to their death.

Protective factors

Comparatively little research has been conducted on the relationship between protective factors for individuals and suicide, however, the available evidence suggests they may include:

- connectedness to family and school;
- responsibility for children, family communication patterns;
- the presence of a significant other, an adult for a young person, a spouse or partner;
- personal resilience and problem-solving skills;
- good physical and mental health;
- economic security in older age;
- strong spiritual or religious faith;
- community and social integration; and
- early identification and treatment of mental disorders (CDHAC 2000b).
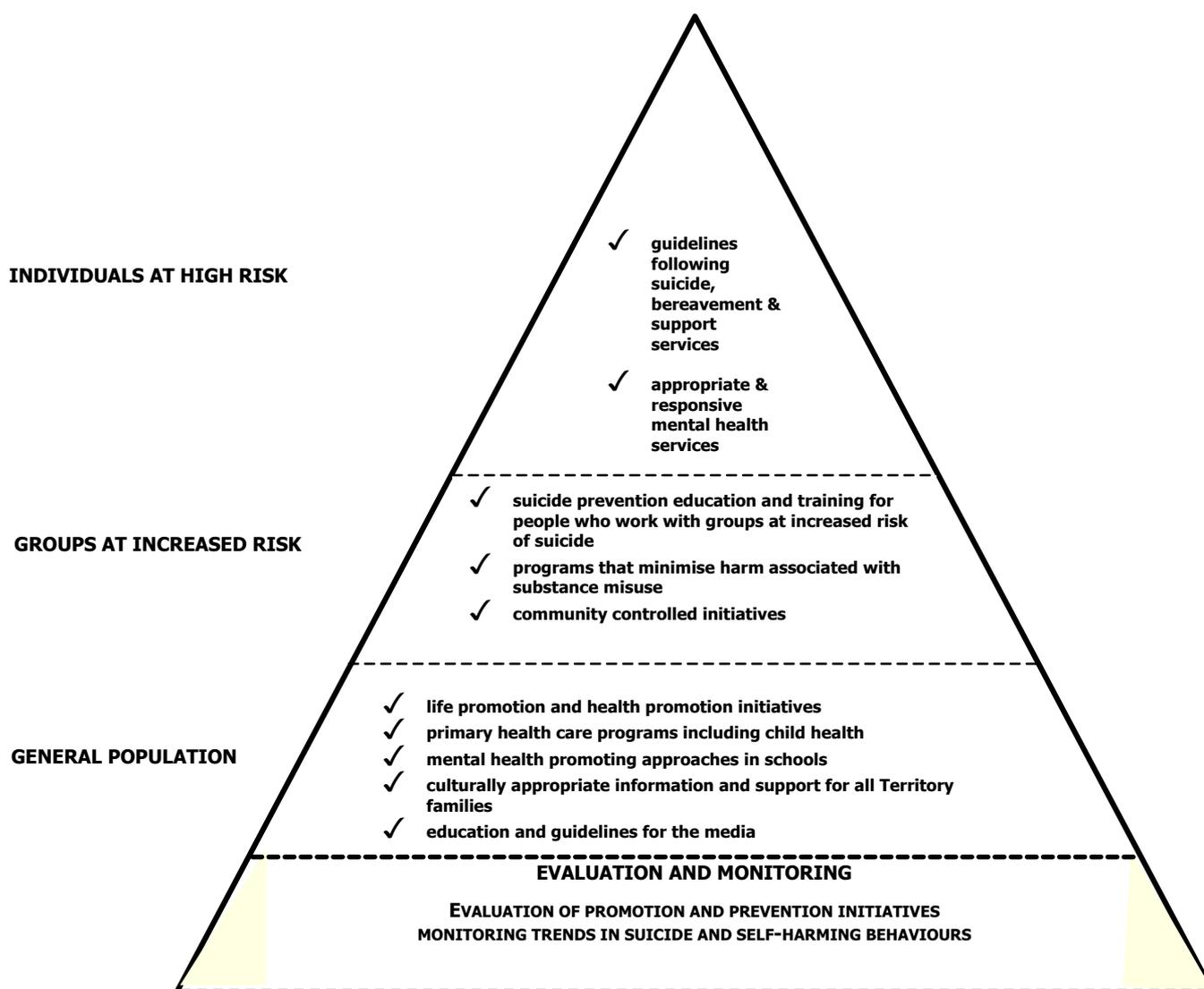
A FRAMEWORK FOR ACTION

Whilst mental disorders and substance abuse are key factors that make the health sector a crucial player, many risk and protective factors for suicide also operate across other social outcomes, including violence, crime and school achievement (Resnick et al 1997). Broad preventive strategies need to be built upon what is known about the shared determinants and interventions across these domains, to harness synergies across programs, sectors and government portfolios including education, employment, family and community welfare, health, crime prevention and substance misuse. Responsibility and ownership of suicide prevention initiatives is broad and must involve all levels of government, the non-government sector, and include action by local communities and individuals.

It is nationally and internationally recognised that effective suicide prevention should combine population strategies with those aimed at high risk groups. Prevention efforts need to minimise risk and enhance protective factors with a diversity of approaches targeting the whole population, specific groups and individuals 'at risk' (See Figure 7).

The six areas for action described in this Strategic Framework address these different levels of suicide prevention, including:

1. Promoting wellbeing, resilience and community capacity across the Northern Territory.
2. Enhancing protective factors and reducing risk factors for suicide and self-harm across the Northern Territory.
3. Services and support within the community for groups at increased risk.
4. Services for individuals at high risk.
5. Partnerships with Aboriginal and Torres Strait Islander people.
6. Progressing the evidence base for suicide prevention and good practice.

Figure 7: Three levels of suicide prevention interventions

INDIVIDUALS AT HIGH RISK

✓ guidelines following suicide, bereavement & support services

✓ appropriate & responsive mental health services

GROUPS AT INCREASED RISK

✓ suicide prevention education and training for people who work with groups at increased risk of suicide

✓ programs that minimise harm associated with substance misuse

✓ community controlled initiatives

GENERAL POPULATION

✓ life promotion and health promotion initiatives
✓ primary health care programs including child health
✓ mental health promoting approaches in schools
✓ culturally appropriate information and support for all Territory families
✓ education and guidelines for the media

EVALUATION AND MONITORING

EVALUATION OF PROMOTION AND PREVENTION INITIATIVES
MONITORING TRENDS IN SUICIDE AND SELF-HARMING BEHAVIOURS

The six action areas cover the following aspects:

Rationale	Sets out the reasons, which support the choice of action.
Evidence	Sets out the available evidence for the most effective actions in the area. Examples of existing approaches and projects, which have demonstrated effectiveness, are provided.
Suggested Strategies	Identifies a broad range of tasks that will make a difference when implemented.
Assessing Progress	Intended to provide a check list of the anticipated outcomes and benefits resulting from the implementation of strategies.

Responsibility for Action and Evaluation

Evaluation is critical to increasing the evidence base for future planning, monitoring trends and measuring the impact of action. As a lead agency, the Department of Health and Community Services will assume responsibility for coordinating a final review of the Framework that will include major achievements and progress by all relevant Departments.

Rationale

Increased personal resources such as resilience, self esteem and life skills as well as a sense of connectedness to others and belonging within family and the community may mediate life stresses or events and protect at risk groups from suicide. These strengths are best applied universally across the population and are most achievable through shifts in public policy which prioritises them as fundamental to the delivery of services to the community.

Evidence

'Happy, healthy, successful individuals with good social supports don't suicide, do they?' (Martin 2002, p.250). Traditionally, suicide prevention programs have largely focused on the prevention or reduction of risk factors and are yet to fully encompass the concept of enhancing health, particularly mental health. There is widespread belief that suicide does not occur in those who have good mental health, good interpersonal relationships, and family and community support. Martin (2002) suggests that to prevent suicide 'our best opportunity may be to increase the level of mental health in Australia, so that suicide never crosses anyone's mind'.

The concept of 'connectedness' as a protective factor against a range of ill health outcomes, including suicide and mental health problems, has received much literary attention in recent years. Research into the social determinants of health has convincingly demonstrated that social support and good social relations make an important contribution to health (Wilkinson and Marmot 1998).

Childhood and adolescence are particularly important periods for strengthening wellbeing and resilience. Evidence suggests that young people who are emotionally connected to their families, schools and community are less likely than their peers to suffer emotional distress, have suicidal thoughts and behaviours, be violent, drunk, smoke cigarettes or use cannabis (Roche 1999).

Examples of existing broad based strategies in the NT include expanded recreation and sporting programs sponsored by the Department of Community Development, Sport and Cultural Affairs, a range of programs promoting self-esteem by recognising and celebrating achievements of young people, recreational and developmental activities including National Youth Week funded by the Office of Youth Affairs, community based crime prevention initiatives, the Juvenile Diversion Program, universal parenting programs and family support services funded through the Department of Health and Community Services, and an

A Mental Health Promotion Resource for Secondary Schools

MindMatters is an innovative national mental health promotion program, which is being implemented in NT secondary schools following a successful professional development program for principals and teachers. MindMatters endeavours to strengthen young people's life skills and resilience whilst fostering a supportive school environment and a culture which encourages partnerships between school, family and the community.

increased focus on prevention and early intervention in the Mental Health and Alcohol and Other Drugs Programs.

Strategies	Assessing Progress
• Implement and evaluate evidence based population approaches to improve mental health in settings and across the lifespan eg programs in childhood, schools, families, workplaces and community organisations. • Cross program resourcing for the implementation and evaluation of mental health promotion programs in primary and secondary schools. • Identify, review and adapt safe, accurate and appropriate community education materials that address stigma and discrimination. • Establish partnerships in mental health promotion and suicide prevention across government and community organisations including Health, Education, Justice, Sport and Recreation and Local Government.	• Increased number of programs based on primary prevention approaches to mental health (see National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000). • Increased number of schools adopting a health-promoting schools approach. • Increased number of community education materials disseminated and extent of dissemination. • Increased number of formal and informal partnerships that support population approaches across sectors eg MoUs and Agreements.

ACTION AREA TWO
Enhancing protective factors and reducing risk factors for suicide and self-harm across the NT.

Support initiatives that reduce risk factors and promote protective factors for suicide and self-harm, giving increasing attention to 'critical periods' or transition points through the life course where interventions have the potential to be most effective.

Rationale

International and national data highlight key social and individual factors that are known to be associated, in a cumulative way, with higher rates of suicide. These include mental disorders, drug and alcohol problems, family adversity, child abuse and neglect and involvement in the justice system. These factors do not cause suicide, however, it has been suggested that they culminate in a constellation of stresses which undermine a person's capacity to cope. A coordinated whole-of-government and community approach is required to address these factors and develop personal skills and social structures to mediate their impact.

There is accumulating evidence and support for introducing strategies at particular developmental transitional points or 'critical periods' throughout the lifecourse when individuals tend to be more receptive to advice, support and learning opportunities that will help them successfully move into the next phase of life. Transitional periods include changing from primary to secondary school, leaving the family home, job insecurity, the transition to parenthood and events involving major change or loss.

Evidence

Given the strong association between mental health disorders and suicidal behaviour, suicide risk could potentially be reduced by increasing the general population's understanding of early signs of mental health problems and disorders and the availability of advice and effective treatment.

The use of peer support and peer based models can provide interventions at timely points and in settings where many services and professionals have limited opportunities to intervene. Research shows that peers are often the first points of contact when young people are seeking support, help and advice. Research also shows that peer models can stem the flow of inaccurate and inappropriate information being shared amongst peers and peer groups.

There is evidence to suggest that media and public presentations of suicide can increase rates of suicide. Similarly, the negative portrayal of mental illness further marginalises population subgroups and potentially affects help-seeking behaviour, particularly amongst young people. The Commonwealth Department of Health and Ageing has funded the development of a media resource kit, 'MindFrame', to encourage the responsible reporting and portrayal of suicide and mental disorders.

There is also growing consensus that school-based suicide awareness programs may encourage, rather than prevent, suicidal behaviour amongst young people. It is therefore recommended that general mental health issues are incorporated into school curricula and not suicide specific programs. 'MindMatters', a mental health promotion resource for secondary schools, and the 'Peer Skills Program' are examples of initiatives operating in some NT secondary schools.

Strong parental attachment, effective parenting skills and positive role modelling have consistently been identified as protective factors against a range of social problems. Roche (1999) argues that a strong relationship with a caring, capable adult (usually a parent) is the single most important protective influence on normal psychosocial development. This supports a focus on parents but also suggests that mentoring and extended family involvement should be fostered where parental participation is not possible.

Strategies	Assessing Progress
• Work in partnership with other government departments and non-government agencies to address issues, which can increase risk of child abuse and neglect, drug and alcohol problems and involvement with the criminal justice system. • Develop and introduce a range of initiatives to support Territory families eg Triple P parenting program. • Disseminate information throughout the community about early signs and symptoms of mental health problems and help-seeking behaviour. • Implement early intervention initiatives targeting groups at risk of suicide identified in the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 eg education and training activities for young people, families and service providers on recognising depression. • Disseminate and support the 'MindFrame' project and media guidelines for reporting suicide and mental illness. • Identify and promote good practice in reporting suicide and mental illness.	• Increased number of joint initiatives and intersectoral action plans that address drug and alcohol problems, child abuse, criminal and juvenile justice issues. • Increased number of programs that address protective factors, eg increased number of programs that foster positive parenting skills. • Increased availability of information on the early signs and symptoms of mental health problems and disorders with particular reference to young people, eg range of appropriate materials, education and training that provide information on mental health problems and where to get help. • Increased opportunities for mental health practitioners and other frontline workers to improve their skills in assessment of young people who have or are at risk of developing mental health problems. • Decreased number of inappropriate portrayals of suicide and mental disorders in the media. • Increased availability of information to support media when reporting suicide and mental illness.

ACTION AREA THREE
Services and support within the community for groups at increased risk.

Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of suicide and self-harm, through prevention, recognition and response.

Rationale

Stand alone services for suicide prevention are neither practical nor effective in the Northern Territory context. Prevention is best achieved by reorienting and focusing existing services and by enhancing the effectiveness of services that support individuals who are most at risk.

Mainstream services and agencies need to have an awareness of suicide issues, self-harm and associated risk factors and be equipped to act and refer appropriately. Primary health care and community based service providers are important contact points for people in crisis. It is therefore important to provide accessible and effective support, care and referral through these services.

Remote and rural communities face particular challenges. Suicide rates are often higher in these regions and access to services is limited.

Evidence

The majority of young people enjoy good health and the very young rarely present with suicidal behaviour. However, adolescence and young adulthood is a time when the individual is engaged in developmental tasks involved in establishing an adult identity separate from their parents. During this period, individuals are particularly vulnerable to substance related harm, development of mental health problems, and involvement in the justice system. The individual may also find it difficult to ask for and accept protective support from family or other care-givers. Prevention efforts need to be considered in the context of the young person's developmental processes, their peer relations and respond to the broad range of causal and contributory factors, including the promotion of protective factors such as resiliency, life skills and feelings of belonging.

It is understood that the process leading to suicide is often not an impulsive act but rather a continuum, beginning with suicidal thinking, suicide attempts and ending with completed suicide. A recent national survey found that, while more than one in five adults meet the criteria for a mental health disorder, 62% do not seek professional help (Andrews et al 1999). A recent study conducted in the Top End of the Northern Territory, indicated that nearly two-thirds of individuals who died by suicide had not sought help prior to their death (Parker and Ben-Tovim 2002).

However, most people contemplating suicide do give some signs of their intention. The people most likely to observe indications of suicidal tendencies are those close to the individual, such as their family, friends, teachers and colleagues. These people are also likely to know about any precipitating events and adverse factors in the individual's local environment and be useful resources for responding to the situation.

> ### Applied Suicide Intervention Skills Training (ASIST)
>
> The Living Works – **Applied Suicide Intervention Skills Training (ASIST)** program is a two day intensive participatory course designed to help participants recognise and assess persons at risk of suicide and master a model for effective suicide intervention. A support network for trainers who complete a five day program has also been established in the NT.

The evidence indicates that building the capacity of workers and organisations is crucial. Training programs for workers to identify, refer and work effectively with individuals at risk of suicide, may improve care and reduce suicide rates. The Living Works – Applied Suicide Intervention Skills Training (ASIST) program has been implemented across the Territory, including a significant number of remote communities. ASIST is a two day intensive participatory course designed to help participants recognise and assess persons at risk of suicide and master a model for effective suicide intervention. Participants are employed in a wide range of government, non-government and private organisations. A support network for trainers who complete a five day program has also been established in the NT. The Department of Health and Community Services has funded training on co-occurring mental health and substance abuse problems for clinicians and remote community workers.

Strategies	Assessing Progress
• Implement and evaluate education and training, support materials and policies in issues relating to suicide that are culturally appropriate for people who work in a broad range of sectors including health, police, teachers, council workers and youth workers. • Develop systems for help seeking, advice and referral with a range of access points including local services (eg school counsellors, clergy, community health). • Ensure the availability of suicide prevention and mental health materials, support, resources and training that are culturally appropriate to workers in rural and remote communities.	• Increased training opportunities for workers to improve their capacity to recognise, respond to and refer individuals from a range of groups who are at increased risk of suicide, with particular reference to young people, Indigenous people and men. • Increased number of service providers who have received appropriate and quality suicide prevention training. • Increased number of rural and remote communities that have implemented suicide prevention initiatives.

ACTION AREA FOUR
Services for individuals at high risk.

Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal behaviour.

Rationale

Efforts to prevent suicide must focus on those identified as high risk through targeted strategies and coordinated responses to suicidal behaviour. Health care providers are one of the main contact points for people with suicidal or self-harming behaviour, with many individuals considered 'high risk' presenting at emergency services and others seeking assistance from the primary care sector including community controlled organizations and General Practitioners. People who have mental health problems or mental disorders, misuse alcohol and other drugs, or have been exposed to forms of abuse and neglect are at particular risk.

Action Area Four selectively targets improvements in suicide prevention and intervention toward those individuals demonstrating disproportionate increases in risk of death by suicide, specifically Indigenous people, young people and men.

Evidence

One of the strongest indicators of suicide risk is a previous suicide attempt or deliberate self-harm and a history of mental illness. There is accumulating evidence from clinical and population studies indicating that harmful levels of alcohol and other drug use is also over-represented among those who die by suicide (Hillman et al 2000). Harm minimisation strategies that target substance misuse may also help reduce the incidence of suicide and self harm. Examples of strategies in place in the NT include liquor restrictions, complementary measures that support individuals affected by substance abuse, and the development of alcohol plans in remote communities.

Government's Supporting Families and Building A Safer Community: Tough on Drugs policies and Domestic and Aboriginal Family Violence Strategies identify risk and protective factors that are also linked to suicide and self-harm. Implementation of these policies will, in addition to preventing violence, criminal and antisocial behaviour, also contribute to the prevention of suicide and self-harm in the NT.

The potentially contagious impact of suicide death, particularly on young people and Aboriginal communities, can be more effectively managed if workers have access to good practice guidelines, and bereavement and support services are available for family members and friends following a death by suicide. Postvention strategies for families, schools, workplaces and communities are also part of a suite of interventions required to respond to 'at risk' populations.

> The **Bereavement Support Contact Card** and **Care and Support Pack** offers a referral point for family, friends, peers, communities and other relevant people affected by suicide. It is a collaborative venture between the Life Promotion Program and the Coroner's Department of the Northern Territory. NT Coroner's Constables and Accident and Emergency Department staff distribute the card.

Life Promotion Officers have facilitated the establishment of suicide response task groups in some Top End and Central Australian communities. These groups work collaboratively with NT Coroner's Constables to provide follow-up support to people who attempt suicide, and postvention support and referral for bereavement counselling for those who have lost a loved one through suicide.

Strategies	Assessing Progress
• Build effective links between services responding to incidents of attempted suicide and self-harm including emergency departments, ambulance services, police, community mental health, GPs, community health, general hospital, drug and alcohol treatment and prevention services.	• Evidence of agreed protocols and guidelines in departments/agencies providing emergency response to suicide and self-harm.
	• Evidence of compliance with agreed protocols/guidelines on responding to suicide and self-harm.
• Provide appropriate training and support to staff responding to suicide, self-harm, drug harm or mental health crises.	• Evidence of links and collaborative practice approaches between key programs and agencies including mental health and alcohol and drugs services.
• Incorporate policies and practices that support suicide prevention initiatives and respond to attempted or completed suicides within emergency services, mental health services, schools, workplaces and juvenile and adult correctional facilities.	• Increased numbers of government and non-government service providers who have received training on effective interventions for people who are at high risk of suicide.
• Establish partnerships between police, ambulance, hospitals, schools and community organisations to improve support in the community for people bereaved or affected by suicide.	• Increased suicide prevention initiatives focusing on Indigenous people and men aged 25–44 years.
	• Evidence of protocols for responding to attempted and completed suicides within emergency services, mental health services, schools, workplaces and juvenile and adult correctional facilities.
	• Evidence of protocols in hospitals and community health settings for staff on the use of risk assessments and notification of persons who are considered at risk.
	• Increased initiatives to respond to, and support people bereaved or directly affected by suicide.

ACTION AREA FIVE
Partnerships with Indigenous people.

Provide culturally appropriate programs that support community responses to high rates of suicide in Indigenous communities.

Rationale

Although traditional culture protects against suicide in some communities, it is recognised that Aboriginal people may be at increased risk because they experience a greater burden of social problems and stresses which may be exacerbated by a lack of access to health and social support services. Despite such adversity, Aboriginal people have shown tremendous strength and resiliency. Connectedness to country, culture and community, and relationships with extended families are important sources of strength and offer some protection from the effects of racism.

Community involvement and control is essential in any efforts that aim to break the cycle of suicide, self-harm, grief, loss and trauma. The National Aboriginal Community Controlled Health Organisation (NACCHO) defines Aboriginal community control as 'a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the community' (NACCHO 1997).

Specific prevention strategies for Indigenous people need to be integrated with culturally effective health services and community capacity building to facilitate action on a range of social issues including self-harm. This approach acknowledges the relationship between suicide risk and other health and social issues and is consistent with a community development approach.

Evidence

Renowned for his contribution to an increased understanding of Aboriginal suicide, Colin Tatz (2001) identified a number of risk factors specifically relevant for Aboriginal populations, including:

- no sense of purpose in life;
- few role models and mentors;
- ineffective parenting;
- sexual assault;
- alcohol and other drugs;
- animosity and jealously;
- grief cycles; and
- illiteracy.

The Ways Forward report highlighted the critical importance of Aboriginal community control and community participation in the development, implementation and evaluation of programs (Swan and Raphael 1995). Examples of successful community initiated action includes 'Strong Men's' and 'Strong Women's' groups established in many remote communities.

Based on community development principles, **Crisis Intervention Committees** promote physical, emotional, spiritual and cultural well being of people, families and communities by facilitating community responsibility through community owned and developed initiatives. It aims to heal and empower Indigenous communities to reduce self-harm and suicide by providing options to move to a healthier lifestyle through culturally relevant initiatives. Committees have been established in some Top End and Central Australian communities. In communities with existing structures and processes, for example, preventable chronic disease networks and the night patrol networks, the Life Promotion Team build the capacity of these committees to address suicide prevention and related issues. Committees are coordinated by local government community councils and include representatives from different language and skin groups, and service providers.

The groups facilitate community discussion on issues of concern and identify local solutions to problems. Some communities have also established a Crisis Intervention Committee based on community development principles, to provide a coordinated, community response to crisis events. These Committees are often coordinated by local government community councils and include representatives from different language and skin groups and service providers. Many people in remote communities have also participated in the Applied Suicide Intervention Skills Training (ASIST), which has increased their ability to respond to crisis situations.

International and national evidence indicates that Indigenous health and welfare services are most effective when delivered by Indigenous professionals. Greater emphasis needs be placed on the unique expertise and understanding of Aboriginal emotional and social wellbeing that Aboriginal health and mental health workers, traditional healers and other community members possess (RANZCP 2002).

The Top End Division of General Practice (TEDGP) manages a program that enables remote communities to engage, train and support Aboriginal Mental Health Workers (AMHWs) to work in partnership with General Practitioners (GPs). A Partnership Agreement has been developed to formalise cooperative arrangements between the TEDGP, Top End Mental Health Service, Batchelor Institute of Tertiary Indigenous Education and Charles Darwin University to support AMHWs, GPs and visiting teams in addressing mental health needs in remote communities in a culturally appropriate service delivery model.

Strategies	Assessing Progress
• Ensure information and training support is available to mainstream and Indigenous health and community agencies on suicide prevention throughout the NT. • Increase the input of Indigenous people into policy, program and service development. • Support the implementation of linked initiatives including the NT Emotional and Social Wellbeing Strategic Plan and the NT Domestic and Aboriginal Family Violence Strategies. • Increase access to effective life promotion and suicide prevention initiatives and activities that are culturally appropriate and relevant for Indigenous people's wishes, stage in life, education background and state of health.	• Increased number of initiatives that effectively address issues such as substance abuse, violence and relationship breakdown as social issues contributing to self-harm and suicide in Aboriginal communities. • Increased opportunities for remote community members to participate in training on suicide prevention eg ASIST. • Evidence of Indigenous organisations and communities' involvement in the design, implementation and evaluation of policies, planning and service development. • Evidence of the implementation and monitoring of the NT Emotional and Social Wellbeing Strategic Plan and the NT Domestic and Aboriginal Family Violence Strategies. • Continued resourcing for life promotion and suicide prevention programs grounded in the culture of Indigenous people.

ACTION AREA SIX
Progressing the evidence base for suicide prevention and good practice.

Ensure that programs have the greatest chance of benefit and minimum risk of harm by building the evidence base, sharing good practice and providing education and training.

Rationale

A strong evidence base is needed to guide planning and funding for effective interventions in resource challenged environments. The complexity of suicide as a social problem and the considerable investment in prevention efforts across Australia, require a commitment to continued development, implementation and evaluation of best practice models as well as a skilled workforce. This process is integral to ensuring the effectiveness of programs and developing a knowledge base about what works.

Evidence

Data on suicide and suicidal behaviour is available from several sources and is important to determine the size and scope of suicide and associated problems. Ensuring this information is presented in an accurate, timely and useful manner presents a significant challenge. There are lengthy delays in the release of official data from the Australian Bureau of Statistics (ABS) due to a range of factors including complex validation processes. However, enhancements to the National Coronial Information System (NCIS) will enable more accurate, timely and comprehensive data on suicides. Effective links between key agencies such as the Department of Health and Community Services and the Coroner's Office will also improve the quality of data collection and analysis.

Suicide prevention programs need to be based on good practice and the best available evidence. This requires systematic and appropriate evaluation of intervention and prevention programs, research into a range of issues related to suicidal behaviour and suicide prevention and regular reviews of literature to determine effective suicide prevention programs. Research and evaluation results need to be widely disseminated to inform future action.

> The Department of Health and Community Services has commissioned the Cooperative Research Centre for Aboriginal Health to undertake **a review of health promotion strategies that are effective in improving Indigenous mental health** to guide future planning.
>
> This authoritative evidence based document will be a key resource to inform action across a range of sectors, including workers and planners with an interest in violence, suicide prevention, crime prevention and social development.

Strategies	Assessing Progress
• Establish and support partnerships between coronial and health information systems, and population and mental health surveillance systems, including mental health services, GPs, private psychiatrists and Aboriginal medical services. • Investigate the development of data systems to underpin suicide prevention activities across health, welfare, justice and education sectors.	• Evidence of up-to-date information being maintained on suicide and self-harm data, trends and emerging issues to inform research, policy and service delivery. • Evidence of formal partnerships and agreements between key agencies with an interest in research, information and evidence-based practice in suicide prevention.

• Support research that builds the evidence on what helps reduce risk factors for suicide and self-harm, and enhances protective factors for good mental health. • Support development and dissemination of good practice guidelines for responding to suicide, self-harm and mental health problems and disorders. • Support evaluation of suicide prevention initiatives through publication, dissemination of evaluation resources and, where appropriate, education and training**.**	• Evidence of research that builds the evidence base for good practice in preventive approaches in the NT. • Evidence and implementation of guidelines and protocols consistent with good practice identified through research, evaluation, consumer consultation and expert consensus. • Increased numbers of workers participating in suicide prevention training in urban, rural and remote areas. • Dissemination of evaluation resources to service providers and community agencies. • Evidence of suicide prevention related programs being evaluated.

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LIST OF FIGURES

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