Submission to:

Select Committee on Youth Suicide in the Northern Territory

Submission by:

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The following area of inquiry is addressed in this submission:

> *(c) the role, responsibility, co-operative co-ordination and effectiveness in the response and policies of agencies such as Police, Emergency Departments and general Health Services (Government and non-Government) in assisting/responding to young people at risk of suicide*

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1. SUMMARY

In 2007 the Northern Territory Suicide Prevention Coordinating Committee (NTSPCC or the Committee) was convened to establish a whole of government approach to suicide prevention. Lead by Mental Health Branch from the Northern Territory Department of Health and Families (DHF), the Committee's membership included 12 Northern Territory (NT) Government agencies and two Australian Government agencies. I observed the Committee for 3½ years and interviewed 22 participants as part of a process evaluation for the Mental Health Branch and for my PhD research on the whole of government process. The findings are useful for understanding how cooperative coordination amongst government agencies worked for suicide prevention from 2007 to 2011.

The conditions at the outset were unfavourable for such an initiative. It was largely unfunded and member agencies were overstretched with concerns from their core business as well as other intersectoral obligations. The Committee members from the Executive Director and Director level generally identified caring about suicide and suicide prevention but did not prioritise this process inline with their other responsibilities and often delegated responsibility to a subordinate.

The major focus and outcome of the process was the development of the NT Suicide Prevention Action Plan 2009-2011, despite the broader objectives of the Committee's Terms of Reference. Given that the Committee had no additional funds at their disposal initiatives contributed to the Action Plan came from within existing departmental capacity. The Suicide Prevention Coordinator (the Coordinator) drove the process with passion and commitment. She contacted and met members one-on-one. She sought to educate the member agencies about suicide in the NT and about the role their agency played in suicide prevention. The process did raise awareness amongst the Committee representatives about their role in suicide prevention however this was not translated to the member agencies at large. For attendees, the Committee was a good networking and information sharing opportunity.

The bulk of the action items in the Action Plan are unaltered departmental activities that have relevance to suicide prevention but it also contains some new activities related to increased mental health and suicide prevention training. It highlights a range of activities across the NT Government that contribute to suicide prevention. All action items have been categorised into the priority Action Areas of the Australian and NT suicide prevention policy frameworks. Its launch in March 2009 was well attended.

However, although the development of the Action Plan required member agencies to notify the Coordinator of their contributions it did not have an impact on the agencies. It did not alter the way they worked. Furthermore, despite stipulating that there would be annual reports, and despite considerable efforts by the lead agency to compile one, none has been released to date.

Joint initiatives, although popular and the accepted approach in suicide prevention policy, have not been shown to produce better outcomes. In this instance the whole of government initiatives struggled to get active engagement from the member agencies. This was in spite of strong bilateral relationships between Mental Health Branch and the member agencies, herculean efforts by the Coordinator and general goodwill that senior members felt towards suicide prevention. In considering the future policy directions for the NT government I

believe that public servants outside of the Mental Health Branch will remain passive on the issue of suicide prevention until it is a recognised political priority. Furthermore, I advise building on both the suicide prevention knowledge base and the strong bilateral relationships of the Mental Health Branch.

2. ABBREVIATIONS

ASIST	Applied Suicide Intervention Skills Training
CEO	Chief Executive Officer
DHF	Department of Health and Families
NGO	Non-government organisation
NT	Northern Territory
NTSPCC	Northern Territory Suicide Prevention Coordinating Committee
p.a.	per annum

3. INTRODUCING MYSELF AND MY RESEARCH

I am a final year PhD student at Menzies School of Health Research. My PhD research examines the whole of government process for suicide prevention addressing the questions of how it operates and what purposes it is adopted for. I have followed the NT whole of government approach to suicide prevention since 2007. I was invited to observe the process by Bronwyn Hendry (Director, Mental Health Branch) and Sarah O'Regan (up until recently the Suicide Prevention Coordinator). As well as my PhD research I have been conducting a evaluation of the same process for which Bronwyn and Sarah formed the Reference Group.

This research and evaluation has been approved by the Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research (reference number 08/65). All quotes are used with the permission of the owner. This submission doubles as a final evaluation report for the Mental Health Branch and is submitted with Bronwyn Hendry's knowledge and consent.

The evaluation question was to assess the extent that member departments of the Committee have developed a cross-government approach to suicide prevention in the NT with reference to attendance, contribution and motivation. However, in an effort to use the Select Committee as an opportunity for research transfer, my focus became area 3c of the inquiry from the Select Committee's Terms of Reference.

> the role, responsibility, co-operative co-ordination and effectiveness in the response and policies of agencies such as Police, Emergency Departments and general Health Services (Government and non-Government) in assisting/responding to young people at risk of suicide

The purpose of this report is to provide a concise snapshot of the whole of government process. Further details can be provided on request. Departmental and agency names and structures are accurate as of 30 June 2010 when the Committee was last active.

My research and evaluation have provided me with insights about what is working and what is not at the policy level for suicide prevention in the NT,

particularly the roles a range of government agencies have taken in suicide prevention policy. Although not youth specific my work has value when considering future policy directions in suicide prevention. I am willing to meet with the Select Committee to discuss my findings further.

4. Policy Approach to Suicide Prevention

The risk factors for suicide include substance abuse, homelessness, a history of abuse, unemployment and relationship breakdown. Suicide prevention can be framed by any of its risk factors. For example, appropriate medical management of a person with serious mental illness is one form of suicide prevention. Quite differently, schools and sporting clubs fostering resilience in young people can also be framed as a valid form of suicide prevention. For a police officer putting someone in custody, it might be ensuring that the person's belt is removed, restricting access to a means of hanging. Suicide is a not a problem where a holistic policy solution can be generated solely within the health department. It is known as a cross-cutting problem. Furthermore, many of the risk factors are complex social problems themselves. It is conceivable that actions in other social policy domains, such as welfare support, will impact on suicide.

These characteristics of suicide have lead to the belief that suicide prevention approaches should be multi-sectoral, coordinated or aligned across the sectors and involve the community. These sentiments have been voiced by the World Health Organization (World Health Organization 2011) and the Australian Government (Department of Health and Ageing 2007). Accordingly, interdepartmental and intergovernmental activities, or joint working, are the commonly advocated approaches to suicide prevention.

The rationale is that the diverse risk and protective factors and overlap with other complex problems mean that suicide can only be adequately addressed by joint working. Despite the logic there is no evidence that joint working for complex problems, or indeed suicide specifically, provides better outcomes (Mulgan 2002; Schulman 2010). Joint working is difficult and slow to implement as well as being resource intensive (Bakvis & Juillet 2004; Page 2005). Over the past decade there has been a significant increase in the number of joint initiatives in government. By example the NT Department of the Chief Minister, with an executive of only 13 members, lists membership of over 200 committees and forums in its latest annual report. Joint working has been found to be more effective when there is adequate funding, a time-limited problem and clearly defined objectives. Regardless, all Australian States and Territories have adopted a joint approach for suicide prevention.

5. BACKGROUND: WHOLE OF GOVERNMENT 2007-2011

The NT has around double the national rate of suicide. This discrepancy has existed since the beginning of this century (Australian Bureau of Statistics 2009; Jones et al. 2005; Measey, Li & Parker 2005). Analysis of NT suicides from 1981 to 2002 demonstrated that against the national trend, suicide rates in the NT had continued to increase (Measey, Li & Parker 2005). More recently, Pridmore and Fujiyama (2009) found that in the NT non-Indigenous and Indigenous suicide rates between 2001 and 2006 had fallen. However, they acknowledge that their findings may be partly attributable to the unusually high and low figures for Indigenous suicide in 2002 and 2006 respectively. Similar to the situation nationally, Indigenous suicide in the NT has increased significantly. Between the 1980s and 1990s the rate of suicide for NT Indigenous men compared to NT non-Indigenous men increased eight-fold (Jones et al. 2005).

In 2003 the NT released the Strategic Framework for Suicide Prevention: A framework for the prevention of suicide and self harm in the NT. Then in 2005 $250,000 was allocated for suicide prevention in the NT. This created for the first time a suicide prevention coordinator position. The Coordinator was charged with re-invigorating the whole of government approach to suicide prevention. The quote below outlines the objectives of the funding.

> [To] enable the coordinator to help implement the *NT Strategic Framework for Suicide Prevention*, and … also help enhance life promotion and suicide prevention activities in the Territory….The coordinator will help develop programs and policies across Government departments and community organisations that focus on life promotion and suicide prevention.
>
> (Northern Territory Government 2005)

However, the bulk of the funding was consumed by the suicide prevention coordinator position salary and on-costs. The small remaining portion was used to keep the Applied Suicide Intervention Skills Training (ASIST) program running. Therefore at the outset the activities of the intersectoral committee that would be formed were unfunded. Consequently the initiatives of this whole of government approach were required to come from existing capacity of the member departments.

This whole of government process was initiated out of the Mental Health Branch of the then Department of Health and Community Services. A significant contributing factor in the decision to adopt a whole of government approach for suicide in the NT was that it was (and still is) the predominant and accepted approach in suicide prevention policy.

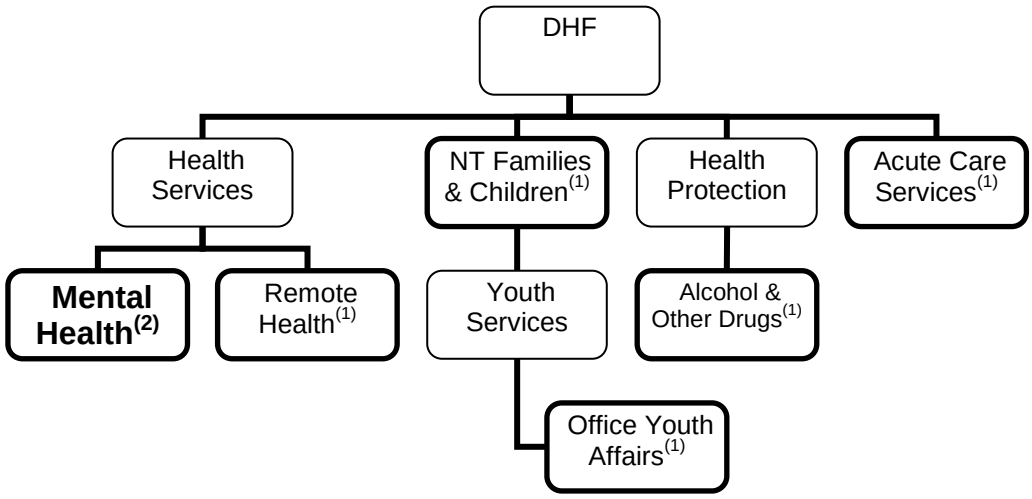
The Mental Health Branch was the lead agency of the Committee. The Director was the Chair and the Coordinator, for the most part, provided the secretariat support. The Committee met for the first time in March 2007. The members represented departments, divisions and branches from within the NT Government as well as representatives from the Darwin offices of two Australian Government departments. For this reason I have used the generic term ‘agency’ throughout this submission. In some instances there was departmental representation as well as branch or division representation from the same department. Member agencies are listed in bold in Box 1. Membership also included two clinical experts and a representative from the National Advisory Council on Suicide Prevention.

Box 1: Member Agencies

NT Government

Department of Health and Families

Abbreviated DHF organisational chart, member agencies outlined in bold



Other NT Government member departments and divisions

Department of Education and Training(1)

Department Local Government Housing, and Sport

Sport and Recreation(2)

Office of Indigenous Policy(1)

NT Police Fire and Emergency Services

Police(2)

Department of Justice(2)

Court Support Services - **Coroner's Office***(1)

Australian Government

Department of Health and Ageing

Darwin Office(2)

Department of Families, Community Services and Indigenous Affairs

Darwin Office(1)

Departmental names and structures are accurate up to 30 June 2010 (when the Committee was last active) but due to restructures and renaming may not be the appropriate names and structures for the duration of the Committee. Numbers in parentheses indicate the number of individuals interviewed from each agency

* The Coroner's Office acted in their independent judicial role, not as a departmental representative

The Committee's Terms of Reference outlined their objectives and key tasks (Box 2).

Box 2: Objectives and Key Tasks of the Committee

Objectives	Key Tasks
Provide leadership for suicide prevention activities for the Northern Territory Provide and promote a whole of government/whole of community approach to suicide prevention Support a sound evidenced based approach for the development of programs and future policy directions to address suicide and self-harming behaviours across the Northern Territory.	Develop an Action Plan for suicide prevention activity across government departments in line with the NT Strategic Framework for Suicide Prevention and the National LIFE Framework. Promote and support the collaborative development of suicide prevention activities in partnership with others with an interest and expertise in the area. Develop the evidence base by improving data collection on suicide and self-harming behaviour in the Northern Territory. Promote and support research activity that will contribute to suicide prevention and minimise the adverse effects of suicide and self harming behavior. Advise the Australian Government of specific Northern Territory issues relating to suicide and self harming behavior and its prevention. Work collaboratively with the National Advisory Council on Suicide Prevention Board as appropriate.

My data included interviews, observation and document review. I conducted 22 semi-structured interviews. Interviewees included government representatives and all three expert members, representative(s) from each member agency, Australian and NT Government representatives, Committee members and individuals sent as proxies and individuals who attended meetings and those who never attended. The breakdown of the agency representatives interviewed is shown in Box 1. I also made eight cold-calls to executive directors from five different member departments to gauge their awareness of this whole of government initiative. Observation of the Committee was carried out over 3½ years as an invited, non-participant evaluator and researcher. I observed for the routine and general mood as well as disturbances in these. I have reviewed documents related to the whole of government process that included policies, Committee documents and media articles.

Data analysis was conducted by immersing myself in the data and reflecting on it in light of other observations and the academic literature in the fields of public administration, organisational theory and joint working for complex problems. The themes discussed in this submission have been produced by a dynamic process of moving between the data and the developing categories.

6. WORKINGS OF THE COMMITTEE

Almost half of the Committee member agencies were health agencies. Furthermore, the initial NT Police Fire and Emergency Services representative and the Department of Education and Training representative were psychologists. Members from health agencies and health or allied health professionals were the dominant contributors in the Committee room.

> The Territory['s]… overriding temptation is still to lump [suicide] in with the … mental illness side of things. … I mean it's still being run by health bureaucrats. You've still got people like [the Darwin Clinical Expert] coming along who's got a particular set of views about the way the world should be. When you get that group that you've been observing together, they still defer to the health professionals, so even though you've got coppers there who know a lot more about it and Education does not take it seriously at all in terms of their position because they send exceptionally low level people to there.
>
> Expert Member

> …. you saw in those meetings that mostly it was health and the Australian Government … it is very health focused and that is fine, they have the Suicide Prevention Unit, but as for [my Division there was] minimal involvement. So it was a cruisy committee to be on….It was fine. I didn't mind it because it was not that intense and because, from our area, I did not have to do a lot of work so to sit on it you could see it as an inconvenience because you did not have that much of an impact but you also got to meet other people from other areas which you have formed relationships with as well so that is the added bonus to it.
>
> Committee proxy

The Coordinator was central to the process inside and outside of the Committee room. Her commitment and hard work were regularly praised. Indeed the process demonstrated a range of strong bilateral relationships that the Mental Health Branch has with the member agencies.

The Coordinator was required to spend a considerable amount of time explaining and contextualising suicide prevention and its relevance for the member agencies over the first year. The contextualising was to raise the awareness of members that they had a role in suicide prevention and that it was an issue worthy of their priority.

> I got the impression they were trying to … get people just interested. So it wasn't necessary what the committee achieved it was to motivate the individual departments to go off and do something about suicide in their individual departments, which I think is a reasonable purpose of the committee but … unless you make the committee actually do something it is not one designed to keep people coming to a committee meeting. They are not going to come and spend six hours being lobbied in there, but it's not an unreasonable thing to have. I mean awareness raising of things is important the trouble is everyone has got so many demands on their time. It's always a difficult question of how you raise awareness of a particular problem.
>
> Committee member

Individual members reported having an increased understanding of suicide and the role their agency plays in suicide prevention from their involvement in this whole of government initiative. However representatives, with the exception of the Mental Health Branch, did not report that suicide prevention was part of their core business. Executive Director or Director level representatives (referred to

as senior in this submission) and non-senior representatives described themselves as conduits between their agency and the Committee. Agencies, including health agencies, described themselves as add-ons to the whole of government process. They continued, despite the whole of government process, to see suicide prevention as separate to the existing priorities of their agencies.

Delegation of responsibility for the Committee was commonplace. At the outset senior representation was requested, and largely appointed, however over time these senior representatives delegated responsibility. Senior members often reported being overstretched with their departmental workload as well as intersectoral obligations. They also felt their decision making powers were not required by the Committee. The decision to delegate was not due to their lack of interest or concern about suicide but rather because they prioritised the whole of government process below their other work commitments. Delegation was to subordinates, many of whom had little whole of government experience. It was viewed as an opportunity for professional development for them.

> One of the …. general issues is that there are so many of these initiatives going on around government it is very hard to keep up with them. At one level or another every initiative is seeking a whole of government perspective, and for me it's really a matter of working out which ones that we can really add the most value to.
>
> Committee Member, Executive Director level

A Planning Forum was held in September 2007. It had participation from both the government and non-government organisations (NGOs). Initially, there were plans to have a Community Reference Group to provide regional and NGO input to the Committee. However at the Planning Forum the consensus was that community/NGO sector did not have capacity for another committee. Consequently the Coordinator garnered input from existing regional groups where possible by attending their meetings and/or receiving their minutes. The information gathered was not generally provided to the Committee.

The central focus of the process was the compilation of the Northern Territory Suicide Prevention Action Plan 2009-2011 and, subsequently, attempts to report on the Action Plan. The Action Plan was developed without additional resources. The Coordinator worked one-on-one with representatives from the member agencies educating them about the types of activities their department was responsible for that were pertinent to suicide prevention. In some instances the Coordinator suggested new actions that the agency could adopt that would assist with the NT's efforts to prevent suicide.

Action items in the Action Plan that are an outcome from this whole of government process relate to mental health and suicide prevention training for staff of the agencies of Police, Sport and Recreation and NT Families and Children. However, the Action Plan is largely a compilation of unaltered departmental activities. These include joint activities in the area of suicide prevention that were ongoing when the Committee was formed, members' departmental core business and activities that have come from initiatives funded by other policies. The Action Plan does not contain timelines or key performance indicators.

Committee members did not identify that the Action Plan had an impact on the work of their agency. It is also notable that due to the process of compilation and the lack of new initiatives spawned from this whole of government exercise the Action Areas did not strategically guide the member agencies' contributions but rather the activities of the member agencies were allocated into appropriate Action Areas.

The Committee was an information sharing forum. Committee meetings were used by the lead agency to emphasise the role and potential contributions of the member agencies to suicide prevention. There were regular updates from the Department of Health and Ageing about national developments in suicide prevention, particularly funding allocations and new funding rounds. The Coordinator, particularly in the first year, shared suicide statistics and presented on the risk and protective factors of suicide to the Committee. Although input from all member agencies was welcomed, information presented to the Committee was primarily from health agencies.

The lead agency had no jurisdiction over the member agencies nor did they have funds to entice participation and contribution. They had to rely instead on soft powers – the ability to call meetings, moral suasion and goodwill. The Coordinator's efforts to build an understanding of the relevance of the member agencies to suicide prevention were designed to establish and maintain engagement. Some interviewees thought that this was indicative of the early stages of this joint initiative. I am mindful, however, that there have been two earlier intersectoral committees formed in the NT to work on suicide prevention with similar member agencies (Permanent Interdepartmental Executive Committee on Youth Suicide Prevention in 1999 and Suicide Prevention Interdepartmental Committee 2001).

I cold-called Executive Directors to assess their knowledge of the initiative. About half were aware of it. A quirk of this process, however, is that most senior public servants were highly informed about suicide in the NT and about the role their agency plays in it. In spite of this the lead agency struggled to get active input into the process. The subordinates who were delegated responsibility for representing their agencies often did not have knowledge of the breadth of programs within their agencies. This contributed to the difficulties the Coordinator encountered in gaining member agencies' contributions to the Action Plan and also when there were attempts to report on the Action Plan.

Representatives' attempts to feedback the Committee's activities to member agencies at executive and management meetings were given low priority and little attention.

The Committee was not a forum where different approaches to suicide prevention were contested nor were the impacts of different agencies' policies discussed. Indeed, two relevant developments in suicide prevention were not raised at the Committee (the 2009 coronial findings of the suicide of a girl in Mutitjulu which detailed the failure of agencies to work together and another cross-government initiative in the NT formed in relation to concerns about a spike in self-harm in an Aboriginal community).

In the Committee's second year the focus was on finalising the now draft Action Plan. Meeting discussions centred on procedural concerns - deciding on the action areas of the Plan, the timeframe of the Action Plan, reporting processes for the Action Plan, the layout of the Action Plan, processes for garnering regional input, agreeing to deadlines for input, and frequency of Committee meetings after the launch.

The Action Plan was launch in Alice Springs in March 2009. It was well attended and well received. At this time $330,000 in reallocated funds from the DHF was made available for the delivery of ASIST, the development and delivery of SAFEtalk for youth, to develop resources on suicide, self-harm and bereavement support, and to complete and trial the Life Promotion Program's 'Suicide Story'.

The annual reporting, as with the Committee meetings, was anticipated by the lead agency to reinforce the commitment of each agency to the Action Plan. Furthermore the reports were to go via the DHF Chief Executive Officer (CEO) to the CEO Coordinating Committee in an effort to raise awareness amongst the departmental executives. However there was significant turnover within the Committee after the launch of the Action Plan. Some representatives had identified developing the Action Plan as the major goal and did not identify a need for further meetings.

The atmosphere in the Committee room was, with few exceptions, overwhelmingly genial. This can be attributed to how the Mental Health Branch governed the exercise. However, key decisions, such as contributions to the Action Plan, were made in consultation with the Coordinator outside of the Committee room and member agencies did not actively engage in the process. The process was largely unilateral. The existence of the Committee and the Action Plan with contributions from a variety of agencies did not, in my assessment, amount to an integrated approach to suicide prevention.

7. Outcomes from the Process

Committee members and proxies reported that the whole of government process was a useful information sharing and networking opportunity. However it did not significantly impact on the activities of the agencies or the way they operated. Individuals within member agencies did develop a better understanding of their role in suicide prevention but this was not translated to the agencies at large.

The dedicated Coordinator became overstretched with the considerable work this process required as well as the other responsibilities of her position. After 3½ years she was burnt out.

There was significant pride in achieving the milestone of completing the Action Plan. The Action Plan and the whole of government process were identified as being important to raise awareness. This included not only raising the awareness of the roles the member agencies play in suicide prevention but also increasing awareness of the issue of suicide within the NT Government in a hope to increase it as a political priority. I think the pride in the Action Plan is reflective of producing a document that demonstrates that there is action related to suicide prevention across the government agencies. It has made visible actions that might previously have been overlooked when considering the NT Government's response to suicide. It has not, however, changed the way suicide prevention is addressed across the member agencies.

Suicide prevention attracted $330,000 in funding at the launch and a further $200,000 in 2010-11. The more recent funding was allocated largely to suicide intervention training. This funding, while welcome, is notably small in comparison to other jurisdictions and in comparison to the public health problem of suicide in the NT. Furthermore this funding was from DHF and not indicative of a cross-government effort to address suicide prevention. During the Committee process representatives were able to nominate initiatives they would like to see funded if more funding became available. However representatives were not, to the best of my knowledge, consulted on how these funds would be spent. (The $2.4 million allocated to suicide prevention in the latest budget is noted but separate to my discussion on this whole of government process.)

The Action Plan has not been reported on despite efforts from the Mental Health Branch. Although never formally disbanded, the Committee has not been convened for almost 18 months.

The first two objectives of the Committee (to provide leadership and promote a whole of government approach for suicide prevention activities in the NT) were not achieved by the Committee but rather by the lead agency and particularly the Coordinator. It is notable that this process was implemented with limited funding and at a time when there was a perception that suicide was not a political priority. These are known barriers to collaborative initiatives. A whole of community approach was not fulfilled due to the lack of capacity within the community sector to participate. The final objective was to support a sound evidenced based approach for the development of programs and future policy directions. Certainly the data presented by the Coordinator may have assisted in meeting this objective. However, I do not have data about how the allocation of the funding was determined and therefore if programs were developed and selected based on this evidence. Although the objectives have largely been met they have been achieved through the dedication and hard work of one individual and not through a joint interdepartmental process. The Committee as a unit did not fulfil the objectives stipulated in the Terms of Reference.

The Committee and the Action Plan from this whole of government approach suggest there was a joint process while the interview and observation data convey a different story. This separation between the day-to-day action and the formal organisational structures has been noted previously (Brunsson 2002; March & Olsen 1979), particularly when the formally stated goals are ambiguous and/or unrealistic.

8. Reflections for Future Policy Directions

Political Priority: Senior public servants across NT government agencies judged that developing an approach to suicide was a lower priority than other acute concerns within their department. The lack of strategic decision making required by the process as well as the lack of funding contributed to this prioritisation. Underlying these elements, I believe, was member agencies' perception that suicide prevention was not a priority for their Minister. For suicide to be given genuine cross-government status it needs to be a priority for the entire government, not just the Ministers for Health and Children and Families. Political priority and the resources that naturally follow bring bureaucratic attention. Suicide is currently something that individuals within the public service care about but that government agencies do not have the capacity to address due to issues of higher political priority.

Resourcing: Any effort to reduce suicide in the NT will need significant investment. The resourcing for the past four years has been woefully inadequate to the task at hand. Should a joint approach be selected again then it is essential that it is well funded. A cross-government process cannot be sustained without adequate resourcing. The funding must cover the administrative requirements (bearing in mind that collaborative initiatives are slow to establish) as well as program funding. Joint funding arrangements must also alleviate any concerns that one agency is subsidising another (Page 2005). In this case the expectations in the Committee's Terms of Reference were unrealistic given the context. Future approaches to address youth suicide will require adequate resourcing or there is the risk that the outputs will again be largely bureaucratic expressions of desire and hope and not substantive contributions to suicide prevention. The NT's latest suicide prevention funding of $2.4 million over three

years still lags significantly behind Western Australia, Queensland and NSW (based on annual funding per age-standardisd rate of suicide the funding allocations from Western Australia, Queensland and NSW are 10, 5 and 2.5 times higher respectively than the NT).

Suicide Prevention: This is an exceedingly broad field. By example consider how it encompasses mental health services, corrections, alcohol and other drugs, child welfare, alcohol policy, parenting, grief, remote service provision and primary health care just to name a few. Activities that foster physical and mental wellbeing, resilience and a sense of community are all contributing to suicide prevention. March and Olsen (1979) note that in the situations of choice that public servants face daily, individuals select activities that are immediate, specific, operational and doable. Conversely they are more likely to defer issues that are distant, general and difficult to translate into action. Unfortunately, (youth) suicide prevention falls into the later category. It requires long-term commitment and prevention activities often do not provide immediate outcomes. These elements need to be taken into account when considering suicide prevention funding and evaluation. Furthermore there needs to be a balance between having broad objectives that allow for flexibility but introduce considerable ambiguity and having clearly defined goals that allow suicide prevention to be broken into specific, operational and doable tasks for the agencies concerned.

Options for joint approaches: Alternatives to another intersectoral committee should capitalise on the strong bilateral relationships that the Mental Health Branch has across the NT Government departments and with the Darwin office of Australian Government Department of Health and Ageing. A model of working bilaterally, advocated by the United Nations and adopted in South Australia, is Health in All Polices (SA Health 2010). A different approach, developed by Dr Sarah Schulman, is 'Working Backwards' (InWithFor 2011). Here the desired changes in the community are defined at the outset. The exercise is then to decide how those outcomes can be achieved, what agencies/resources are required and set about working in a task specific manner. One response to the findings of this research is to say there should be a higher level committee. I would be wary about this choice because committees consume considerable human resources and this research indicates that the NT bureaucracy currently has little capacity for more committees. (This is particularly true for public servants in the higher echelons of the bureaucracy and a similar situation may exist in the NGO sector given their rejection of a Reference Group). In my opinion a higher level committee would only be appropriate if the tasks of the Committee were well defined, time-limited and agencies specifically selected for those tasks.

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