

The Secretary,
Select Committee on Youth Suicides in the NT,
G.P.O. Box 3721,
Darwin, 0801.
Northern Territory

Re: Submission to the Senate Inquiry into Youth Suicides in Northern Territory.

Dear Sir / Madam,

I applaud the Northern Territory Government for taking a bipartisan approach to Youth Suicide Prevention, putting aside party politics, to address this crucial issue to safeguard future generations of Territorians.

Below is a summary of my submission and my full submission in response to the terms of reference. My recommendations are at the end of each TOR and my publications and other material are included as attachments.

Summary Response to the Terms of Reference

(a) Proposals to access Commonwealth funding programs including The National Partnership Agreement on Mental Health targeting suicide prevention, intervention and youth mental health, with a particular emphasis on Youth between 17-25 years of age;

Suicide prevention programs, past and present which have received or are receiving Commonwealth funding in the Northern Territory require evaluation for their efficacy and appropriateness. Programs which have proved effective in other jurisdictions which can be translated into Northern Territory's unique conditions, should be given a substantial trial period of 5 years to make a difference. More research needs to be supported by the NT Government and conducted into the suicide prevention across the life span, impact on families and the cohort effect of suicide within Indigenous settings. Evaluation needs to be built into new programs and existing programs for continuous quality improvement and monitoring of effectiveness. Quality Improvement Program Planning System provides a platform for planning and evaluation that can be accessed on the internet from any location in the NT that all partners in the project can have access to at any time.

(b) programs and services targeted at Youth aged 17-25 years of age with particular emphasis on Suicide Prevention education and awareness in Schools;

The existing program Mind Matters requires evaluation of its reach to rural and remote community education centres and secondary schools, and for its effectiveness in that setting. "headspace Outreach Teams for Schools should be supported by Commonwealth funding because of its clinical expertise and youth specific mental health promotion. In Indigenous settings "headspace" outreach team clinicians will need to work in tandem with Aboriginal Mental Health Workers. The current Indigenous youth specific programs in each major centre require outreach services to support rural and remote communities.

(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;

A transparent, streamlined, cooperative and coordinated approach is required between each of the players in the trajectory of a young person's risk for suicide. Roles and responsibilities for individuals and agencies often ends, leaving gaps in service and safety, when they should continue providing a safe, seamless service for young people at risk.

(d) the roles of targeted programs and services that address particular circumstances of high-risk groups, and identification of the strengths and weaknesses of existing suicide prevention responses;

Contagion and imitation resulting in cluster suicides are key factors in suicide among children, adolescents and young adults with most taking their own lives after the suicide or attempted suicide of a friend, relative or a community member. Postvention support and information needs to be provided within 24 hours to those affected by the death of a loved one to suicide to reduce the vulnerability of individuals, family and the community.

(e) the adequacy and appropriateness of suicide prevention programs aimed at 17-25 year olds; and

A comprehensive and coordinated evaluation of the efficacy of programs large or small, within a realistic and culturally relevant framework is conducted so that the programs / services / initiatives which have had some success, can be supported by Commonwealth Funding. New innovative programs be trialled within an adequate time-frame of 5 years with evaluation frameworks built into the design of the programs.

(f) the accuracy of suicide reporting in the NT, the factors that may impede accurate identification and recording of suicides and attempted suicide rates (and the consequences of any under reporting on understanding risk factors and provision of services to those at risk)

Access to the National Coroners Information System is imperative for data tracking and research analysis. Cooperation with the NT Coroner for contact tracing and immediate postvention response is necessary. The consequences of any under-reporting of suicidality either attempted or completed is clear, as it often results in further deaths from contagion and imitation. The consequences of not understanding risk factors can be poorly targeted and inappropriate interventions. The poor provision of services can either manifest in exclusive services to a small portion of the community which does not reach those at risk of suicide.

Response to the Terms of Reference

- **(a) Proposals to access Commonwealth funding programs including the National Partnership Agreement on Mental Health targeting suicide prevention, intervention and youth mental health, with a particular emphasis on Youth between 17-25 years of age;**

My proposal to access Commonwealth funding is to conduct further research and complete my PhD into the changing trends of attempted and completed suicide and the emerging issues associated with the social determinants of suicide in the Northern Territory (NT). I commenced my PhD with Charles Darwin University (CDU) in 2006 investigating Indigenous suicide in the NT under the guidance of an Indigenous Reference Group and my PhD supervisor at CDU. On the recommendation of NT Suicide Prevention Inter-Departmental Committee 2007 - 2010 and the Deputy Coroner, DOJ, I lost ethics approval and the full fee paying scholarship with CDU in 2008. I then withdrew from CDU just prior to completing my dissertation and gaining my PhD. I have published my findings in the Aboriginal & Islander Health Worker Journal but I have been unable to resubmit my PhD by publication to CDU because my ethics application was disallowed as a result of my research not being supported by the SPI-DC committee. I believe this has had unfortunate repercussions on building the evidence base for suicide prevention in the NT and has affected the lives of many Territorians. I request that this current NT Youth Suicide Prevention Committee reassess my research and recommend that my ethics approval is reinstated so that I can submit my PhD dissertation / publications to Charles Darwin University in 2012. (Attachment 1. Banks 2007)

My research was quoted extensively in Parliament on 17th August 2011 and is the only current evidence on suicide in the NT. It was referred to in Parliament by both the Independent Mr Gerry Wood and our Chief Minister Mr Paul Henderson. Both members of parliament quoted my current research statistics and publications, and Gerry Wood MLA has since circulated my research papers to members of the Select Committee on Youth Suicide. In 2006 I applied for access to the National Coroners Information System data, through the Victorian Institute of Forensic Medicine and was granted an Access Agreement 2006 – 2009 through Charles Darwin University to capture data and analysis it to investigate Indigenous suicide in the Northern Territory. I was the first and to date the only researcher in the Northern Territory to have been granted an Access Agreement.

Unfortunately once losing ethics approval from the Charles Darwin University, I lost ethics approval from Victorian Institute of Forensic Medicine and therefore lost access to the National Coroners Information System (NCIS). Without access to NCIS it impossible to conduct adequate and timely data analysis on demographic trends and anomalies relating to suicide in the Northern Territory. With the data that I captured I was able to produce several publications on suicide in the Northern Territory which are attached, but unfortunately much of this data is of the past two decades. We need current baseline data to track and evaluate our program effectiveness.

The Federal Government released its response to the Senate Committee's report "The Hidden Toll: Suicide In Australia" with its commitment to establish a "National Aboriginal and Torres Strait Islander Suicide Prevention Strategy" as recommended in the report. This is a critical step to reducing the significant risk and community impact of suicide around Australia. It found that the proportion of Indigenous people taking their own lives is around three times higher than the general population, with that proportion even higher again among young men. It also found that there was

widespread concern that the actual rate may be even higher than this figure, with attempted suicide believed to be significantly under-reported in Indigenous communities.

The report also cited that mainstream approaches to suicide prevention and identifying those at risk often don't work well in Indigenous settings because the risk factors are different, the stresses are different. They suggest that we need to use other methods to get the message out and other strategies to reduce vulnerability and increase individual, family and community resilience. A whole of community postvention response to suicide would tackle community-wide risk factors and build on the protective capacity of community, family, cultural and spiritual resilience. Concern was expressed over the prevalence of suicide clusters and contagion effects with the shock, grief, despair and hopelessness of one tragic death leading to another and to a series of suicides and attempted suicides.

The report also emphasised that it is really important that a comprehensive and coordinated approach be taken and that any strategies developed not be limited by the kind of short-term, siloed, on-and-off project funding that has constrained and overburdened the Aboriginal community-controlled health and community sector.

In the Northern Territory 70% of the population is non-Indigenous and accounts for approximately 55% of completed suicide, whereas 30% of the population is Indigenous but accounts for 45% of completed suicide, therefore there is an immediate inequity apparent. Most of the Territory's population is centred in Darwin and Palmerston and non-Indigenous people make up 85% of the urban population of Darwin and Palmerston and Indigenous people make up 15% of the urban population. Of the 85% of Indigenous people who live outside of Darwin and Palmerston, they are less educated, less likely to be employed or participating in the workforce, more likely to be in lower skilled occupations, and more likely to be earning very little, have more dependants, and far more likely to be living in overcrowded dwellings.

There is a complex and entrenched relationship between health, housing, education, and employment in remote areas of the NT. Most of the low income earners live in rural and remote areas of the NT, and of those earning less than \$250.00 per week, 37% are living in Darwin, and 63% are living in rural and remote areas of the NT. Young Indigenous adults in the poorest areas of the NT aged 15 – 35 years are almost four times more likely to complete suicide than those in the least deprived areas, and it is suggested that this can be partly explained by the high levels of deprivation in these areas.

Suicide rates in Indigenous communities of the Northern Territory are high, with dramatic increases in the past two decades. Research by Measey in 2006 found that there was an 800% increase in male suicide in the period from 1981 – 2002. The dramatic increase was attributed to the rapid increase in Indigenous male suicide. My research corroborates this finding having identified that Indigenous suicide increased from 5% of total suicides in 1991, reaching 55% of total suicides in 2002 and 2006, and 45% in 2010. I began my research investigating the reasons behind that rapid increase. I identified a contagion effect operating within groups of young men already clustered by association, mostly unemployed, young, married Indigenous men.

My research found that suicide contagion and imitation are key factors in suicide clusters. Suicides occurring within clusters of two or more suicides, accounted for three quarters of Indigenous suicide (77%) in the Northern Territory in a ten year period 1996 - 2005. Suicides clusters are two or more completed suicides occurring in close temporal and geographic proximity. They often occur in Indigenous settings in the context of intense clustering of attempted suicide, imitative suicidal behaviour,

and contagion effect. Imitation occurs when a victim copies the suicide of a previous victim and can lead to the geographic patterning of suicide. Contagion is a process whereby exposure to suicidal behaviour influences others to attempt or complete suicide.

A unique phenomenon I refer to as “Echo clusters” has emerged in some settings in the Northern Territory which have become “hotspots” for suicide. “Echo clusters” are defined as subsequent but distinct clusters of completed suicide, occurring after the initial or index suicide cluster, with subsequent clusters repeating or ‘echoing’ over time. Highly significant space – time – method clustering was found in 230 Indigenous suicides within a twelve year period 1996 – 2007. Using space – time – method Knox analysis, imitation rises to about 21% with a time window 360 days providing persuasive evidence of suicide clustering and hence imitation. That it is still rising to 27% at 540 days suggests evidence of the “Echo Cluster” phenomenon, with imitative suicide occurring well into the second year after the index suicide, providing indirect evidence of “Echo Clusters”.

“Echo clusters” also represent a cohort effect in the life of Indigenous communities bonded by two decades (1991 – 2010) of intense suicidal activity. The cohort has shared experiences of being young, male, unemployed, with excessive alcohol consumption, drug abuse, and the common experience of hanging. The cohort is predominantly male and aged 15 – 35 years and those who survive now have a lifetime risk for suicide.

The “young person at risk” lives in a “community at risk” of suicide and the young person at risk is not receiving adequate feedback or warnings from family and friends that their actions are leading them on a pathway to suicide. The consequences of their behaviour are not realised by the young person at risk, because there is a changed social structure within their community, where their risk taking and suicidal behaviour has become the accepted norm.

There is a younger cohort emerging, imitating the suicidal activity of the older cohort, but with changing demographics; young female Indigenous suicide is increasing, and is five times the rate of non-Indigenous females. The younger cohort is also mostly male, being driven by substance abuse, truancy, pathways to unemployment and perpetuated by family destabilisation and breakdown, violence and abuse. In 1996, Indigenous youth made up 40% of the total youth suicide and non-Indigenous youth made up 60% of youth suicide in the Northern Territory, but by 2006 Indigenous youth made up 80% of total youth suicide and this trend has continued.

The historical events of the past two decades in these Indigenous communities may be repeated unless the suicide contagion cycle is broken. The impact of the experience on the cohort needs to be reconciled, the contagion and clusters of attempted and completed suicide contained, and a new pathway for life provided.

The social determinants of suicide, particularly poor education and skill development of the “at risk” population, unemployment in young males, increasing young female suicide, and truancy as a risk factor for youth suicide, are some of the emerging issues which my research has revealed. Further research is required to adequately investigate this phenomenon and the links between unemployment, substance abuse and suicide, particularly as it relates to impulsivity and the method of hanging.

My research shows that 82% of Indigenous suicide in the NT was aged 15 – 34 years 2000 – 2005, with suicide currently being the main cause of death for Australians aged 15 to 34. In NT Indigenous population, 86% of suicides were completed by hanging in the period from 2000 – 2005 but has increased to 91% completing suicide by hanging in the period 2006 – 2010. This has serious implications for intervention because hanging as a method involves high lethality and impulsivity, with little

window of opportunity for intervention and rescue. In young people aged 10 – 14 years this figure is 100% complete suicide by hanging, 15 – 19 years 90% complete suicide by hanging, and 20 – 25 years 86% complete suicide by hanging.

Some Indigenous communities in the Northern Territory are protected from suicide, for example, Wadeye; whereas other communities have been ravaged by suicide, for example, Tiwi Islands, and these differences require investigation. Both communities have high potential risk factors for suicide, particularly substance abuse and violence, but one has a low suicide rate and the other has high suicide rate.

What are the protective factors which are supporting resilience within the community with low suicide rates? Some preliminary findings of my research suggest that Wadeye has protective factors such as, the presence of elders who still maintain respect and autonomy within the community because of their spiritual and cultural integrity, the absence of an alcohol outlet located within the community, a strong police presence, and access to (mental) health services. Whereas the suicide rates dramatically increased on the Tiwi Islands where there was an almost unlimited supply of alcohol and heavy substance use (mainly cannabis), very little respect for and autonomy of the elders, a very limited police presence and limited (mental) health services. How the community of Wadeye will fair in the future when the elders pass on, or if a liquor outlet is allowed into the community, remains to be seen? These factors are upstream social determinants which have an impact now, but also determine the future of a community's safety from suicide.

Evaluation needs to be built into new programs and existing programs for continuous quality improvement and monitoring of effectiveness. Quality Improvement Program Planning System provides a platform for planning and evaluation that can be accessed on the internet from any location in the NT that all partners in the project can have access to at any time.

My research proposal and funding submission attached

Recommendations:

Firstly, I recommend that a Suicide Prevention Strategy and / or Life Promotion Strategy Unit be set up within the Chief Ministers' Department to ensure interdepartmental cooperation and transparency of program deliverables.

Second, I recommend that a First Response Unit for Suicide Postvention be set up within the Coroner's Office, DOJ to provide critical incident debriefing and bereavement support to individuals, families and communities. This response service could be offered either by "Standby Response Service" Qld or Salvation Army Suicide Prevention Service NSW.

Third, it is my recommendation that the Standby Response Service (Qld) or the Salvation Army Suicide Prevention & Bereavement Support Services work with the Coroner's Office in the Northern Territory to provide a First Response Bereavement Support Service. This service it is envisioned would accompany the Coroner to urban, rural and remote settings where suicides have occurred.

Fourth, I recommend that Salvation Army Suicide Prevention & Bereavement Support Services provide postvention bereavement training to Salvation Army personnel, all emergency services staff, Coroner's constables, prison guards at the juvenile detention centre, and volunteers of established networks who wish to access training to support the bereaved.

Fifth, I recommend that investment into research relating to the antecedents and the social determinants of suicide, monitoring the demographic trends and the evaluation of effective models of prevention, intervention, postvention is vital in the prevention of youth suicide in the Northern Territory and funded.

Sixth, I recommend that LifeForce Networks which currently established in Darwin, Palmerston and Nhulunbuy, are funded to expand and support further network development in Katherine, Batchelor, Jabiru, Borroloola, Tennant Creek, Alice Springs, and with network hubs on the Tiwi Islands, Maningrida, Daly River, Hermannsburg, Santa Theresa, Pintjinjarra Lands.

Seventh, I recommend that Northern Territory "headspace" youth mental health units in Palmerston and in Alice Springs and receive funding to implement the recently developed "headspace" Outreach Teams to Schools Service in urban and regional centres in the Northern Territory.

Eight, I recommend that Indigenous Psychological Services training be targeted to individuals and agencies from more rural and remote locations in the Northern Territory so that a critical mass of Indigenous people have attended Workshops on "Mental Health Assessment of Aboriginal Clients" and "Suicide Prevention in Aboriginal Communities"

Ninth, I recommend that Ozhelp be provided with further Commonwealth funding to continue their work in the building industry workplaces of the Northern Territory, particularly supporting young apprentices as they enter the workplace.

- **(b) programs and services targeted at Youth aged 17-25 years of age with particular emphasis on Suicide Prevention education and awareness in Schools;**

Below is a short description of program and services which target or have targeted youth aged 17-25 years of age. The target suicide prevention education and awareness in schools but also target youth who have left the school system prematurely. The antecedents for truancy is also discussed.

The Life Promotion Program, Mental Health Program, Department of Health 1999 – 2006 developed "Youth At Risk Network" which successfully brought together stakeholders from the various youth related organisations in Darwin. "YARN" which met monthly, provided an example of an innovative model for further networks to be developed in Darwin, Palmerston and the Top End.

Danila Dilba Youth Services Program is a youth program which has supported youth in the city of Palmerston for almost 10 years with one of its young staff members winning the "Northern Territory Inaugural Life Award" in 2007. The award was presented by the then Minister Mr Matthew Bonson, at an awards ceremony held at Danila Dilba Palmerston on the 10th September, 2007. Danila Dilba has continued its excellent track record in supporting youth at risk in Palmerston and outer Darwin region with many innovative programs.

Talc Head Indigenous Youth Program is a youth program developed by local Indigenous men and women to address the youth at risk population in the Top End.

Roper Gulf Shire Council Youth Services Programs are being rolled out into the community around Katherine. They are building links to specialist youth services both in Katherine - General Practice Network and Darwin, "headspace" and Menzies Health to support the Youth Regional camps being run in Katherine.

LifeForce Wesley Mission, since the beginning of 2010 in the Northern Territory, have taken on the capacity building task of developing Networks in the Top End with Darwin Regional Indigenous Suicide Prevention Network, Top End Suicide Prevention Network and Nhulunbuy Suicide Prevention Network. These LifeForce Networks raise public awareness about the issue of suicide, strengthen community relationships, capitalise on community knowledge, focus on your local community, and encourage individual and organisational participation. They are essential in providing a core group of caring members of the community actively supporting suicide prevention, intervention and postventions efforts within the community

Mind Matters Program is embedded into the high school curriculum and there is a project officer who has carriage of the program within Northern Territory Education Department. Depending on the teachers familiarity with the program and the competing pressures of the curriculum it can be incorporated into the young person's education. I understand that the urban schools use the program and the critical incident protocols well in responding to youth suicide or suicidal activity. Life matters provides schools with protocols to youth suicide attempts and completed suicide. Currently Mind Matters is implemented in most Northern Territory urban schools and has been established for more than 10 years in the NT.

Orygen Centre for Youth Mental Health have established "headspace" youth mental health units in the Northern Territory, in Palmerston and in Alice Springs. The Commonwealth government has provided a commitment to establishing a nationwide network of "headspace" Outreach Teams to schools to deliver mental health promotion and provide direct clinical services and other supports to school communities affected by suicide. "headspace" in Palmerston and Alice Springs and are well placed to receive funding to implement the recently developed "headspace" Outreach Teams to Schools Service. More recently "headspace" has provided services in Palmerston and Alice Springs and currently is developing a program to address the issues of self-harm and suicide for Australian schools.

The "headspace" project proposes to work closely with middle schools and high schools around Australia to provide early intervention to address the reasons for poor mental health, substance abuse and self-harm, particularly those issues which lead to truancy. Attendance at school at school is necessary to provide a pathway to employment and my research has found that particularly in Indigenous populations that unemployment is a high risk for suicide. Truancy from school can be a marker of problems in a young person's life. All truancy is a reportable and there is legislation which requires children to attend school. In the limited research conducted into youth suicide which this research has undertaken, truancy is a major risk factor or a marker, that children and adolescence are on a pathway to self-harm and suicide or other sudden death.

There is an emerging issue of suicide in the very young, 10 – 17 years of age, with truancy as a marker for substance abuse, physical and / or sexual abuse, risk taking and suicidal behaviour in the young needs to be explored. Service agencies need to be provided with the information to adequately these issues and provide appropriate interventions to the young at risk of, or who are truant from school.

In the school system, some young people are not picked up as being suicidal until they abscond from school, become truant and which builds into a vicious cycle. They then become easy prey to drug dealers and become involved in compromising situations, involved in crime, often with threats made to their safety. Many young people in this situation become depressed, then morbidly depressed, which can lead to psychosis and suicide. Where in this trajectory does the intervention which saves the young person's life take place? Often it doesn't.

Indigenous Psychological Services aims to provide the highest quality, culturally appropriate, mental health services to Aboriginal (Australian) people. It is achieved through the provision of training, community based interventions, research and consultancy services in culturally appropriate and sensitive workshops. Workshops are conducted by Dr Tracy Westerman on "Mental Health Assessment of Aboriginal Clients" and "Suicide Prevention in Aboriginal Communities" in Darwin and most major centres.

Applied Suicide Intervention Skills Training (ASIST) provides professionals and the community members with the skills to provide a brief intervention which can save the life of a suicidal young person. Lifeline Alice Springs and Anglicare Darwin are currently running workshops in the NT to train from line workers.

Mental Health First Aid provides training for professionals of providing interventions to people with mental health problems and suicidal thoughts.

- (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;

The Life Promotion Program, Mental Health Program, Department of Health 1999 – 2006 developed the "Inter-Agency suicide Response Task Group" (I-ASRTG) in collaboration with the Northern Territory Coroners Office which provided a model of response to provide bereavement support and postvention to individuals, families and communities at risk. The Coordinator Life Promotion Program contributed to the development of the Northern Territory version of the "Information & Support Pack for those bereaved by suicide or other sudden death" which was originally developed in Perth (2001) by the Ministerial Council for Suicide Prevention with support from people bereaved by suicide. The Bereavement Pack was adopted nationally in 2003 and updated in 2007 with a current hard copy version 2010.

<http://www.ichr.uwa.edu.au/preventingsuicide/resources/bereavementpack>

The Life Promotion Program, Mental Health Program, Department of Health 1999 – 2006 also developed "Crisis Intervention Committees" within large communities to respond to recurrent suicidal activity. These committees met and monitored the "at risk" behaviour, self-harm and suicidal behaviour among the risk populations, and all were trained in ASIST to provide suicide intervention.

The role of agencies in responding and assisting people at risk of suicide or in the aftermath of suicide requires a seamless and systematic approach. Roles and responsibilities for individuals and agencies often ends, leaving gaps in service and safety, just when they should continue providing a safe, seamless service for young people at risk.

The Indigenous Postvention Response and Containment Model is a model of response that links all tiers of response from high level government to coal face interventions. (Hanssens 2011)

The policies of agencies such as Police, Emergency Departments and General Health Services in assisting and or responding to young people at risk of suicide are set in place. Unfortunately, their implementation at the coal face is questionable. I suggest it is not a reflection on individual, agencies or departments, but the lack of

coordination and cooperation between each of the players in the trajectory of a young person's tragic suicide.

If one works on the premise that no young person should be left alone when they have thoughts or plans to suicide, then a seamless service must be provided from identification of suicide risk, entry into a service, and safe discharge into the care of a person who understands the risks of suicide and agrees not to leave the person alone. The support person must be aware of the risks associated with suicidal ideation (thoughts) the impulsivity of suicide along the risk continuum of attempts, through to the act of suicide completion, and that the level of risk can fluctuate for the young person. Just when it appears the young person is recovering can be the highest risk period for the young person; therefore extreme caution must be exercised throughout the course of the young persons' recovery.

A first response unit within the Coroner's Office, Department of Justice, providing critical bereavement support to individuals, families and communities is required. Bereavement support is the best prevention of subsequent suicides and begins the response to contain suicide clusters and contagion. From the research evidence it suggests that any prevention and intervention efforts need to be incorporated into a comprehensive postvention response for the bereaved.

A 'Memorandum of Understanding' between police, health and education at all levels – urban, rural and remote, to incorporate Inter-Agency Suicide Response Task Group Protocols, First Response Protocols and Critical Incident Response Protocols. The protocols for attempted and completed suicide need to be incorporated into a clear and streamlined pathway of notification of a suicide death from Coroner's Office to Police in each jurisdiction including Mental Health Program to Emergency Departments & Health Centres in each jurisdiction.

Crisis Intervention Committees need to be established within large communities with recurrent suicidal activity which meets and monitors the "at risk" behaviour, self-harm and suicidal behaviour among the risk populations. The "Indigenous Postvention Response to Contain Suicide Clusters and Promote a Suicide Safe Community" is a model of response and containment which hinges on the cooperation of the Coroner's Office, Police, Mental Health Program and Hospital Emergency Departments, General Practitioners and Health Centres within legislative constraints.

One of the recommendations of the Commonwealth's response to the 'Hidden Toll: Suicide in Australia' report, was to support the timely distribution of suicide data to allow early notification of suicides for postvention responses and bereavement support. The first response is crucial in setting in motion bereavement support for family friends and relatives and early identification of those at risk of suicide after the event.

Cooperation between police in each jurisdiction and the local health agency to inform each other of an attempted or completed suicide thereby detecting emerging clusters of attempted or completed suicide within a community setting, which if not contained can result in suicide "hotspots" and "echo clusters".

The "Indigenous Suicide Postvention Response and Containment" model underpins the activities of response agencies and networks for the mobilisation of community postvention and intervention efforts after completed suicide or other suicidal behaviour or activity, identifying imitation, and thus preventing suicide contagion and suicide clusters.

Salvation Army Suicide Prevention & Bereavement Support Services have experience with Suicide First Response Units and have conducted Suicide Bereavement Support training in the Northern Territory for eight front line senior Salvation Army personnel in 2008. Participants of the workshop came from a wide variety of services and support agencies including a women's shelter in Darwin; a community outreach in Katherine; an alcohol rehabilitation in Alice Springs; prison ministry services in Darwin; a Flying Padre who covers the whole of the Northern Territory. Salvation Army Officers work in major urban towns, visit remote Indigenous communities, and work with young men and women at risk all over the Northern Territory.

The training and support for frontline workers is essential in any setting but particularly Indigenous settings. Intervention training particularly ASIST training is adequate in the Northern Territory, but training in prevention and postvention critical incident debriefing is inadequate and staff at the coal face are at real risk of vicarious trauma, suicidal ideation or completing suicide themselves. They have high levels of burnout, self blame and blame from family and community. They require critical incident debriefing regularly but as a rule rarely receive it. Yet they are constantly at the coal face, responding to threats of suicide on a daily basis because of the high rates of attempted suicides in Indigenous settings. Even when finishing their daily work, they can be called upon at any time of the day or night to respond to a cry for help. Therefore the risk for these frontline workers and their families is manifold as they often live in a "community at risk" and contagion is an ubiquitous factor. As frontline workers they are exposed to "sorry business" grief and loss in the most existential way, yet there is no systematic process for the postvention response and self care guidelines to safeguard them from burnout and vicarious suicide risk.

The Coronial Inquest into 22 suicide deaths in the Kimberley region resulted in the "Blank Page Summit" and may be a model of intervention for Indigenous communities in the Top End of Australia. Also the Family Life Promotion Program in Yarabah in North Queensland has virtually eliminated suicide from its community, which had the highest rate of suicide of any Indigenous setting in Australia. Their Family Life Promotion program is a wholistic program incorporating whole of life, whole family interventions which is now seeing an almost zero truancy rate in children with youth graduating from university and coming back to work in their community.

Recommendations

Firstly, I recommend that a Suicide Prevention Strategy and Life Promotion Program Unit be set up within the Chief Ministers' Department to ensure interdepartmental cooperation and transparency of program deliverables.

Second, that a First Response Unit for Suicide Postvention be set up within the Coroner's Office, DOJ to provide critical bereavement support to individuals, families and communities

Third, it is my recommendation that Salvation Army Suicide Prevention & Bereavement Support Services provide postvention bereavement training to Salvation Army personnel, all emergency services staff, Coroner's constables, prison guards at the juvenile detention centre, and volunteers of established networks who wish to access training to support the bereaved.

Fourth, it is my recommendation that the Standby Response Service (Qld) or the Salvation Army Suicide Prevention & Bereavement Support Services (NSW) work with the Coroner's Office in the Northern Territory to provide a First Response Bereavement Support Service. This service it is envisioned would accompany the Coroner to urban, rural and remote settings where suicides have occurred.

Fifth, it is my recommendation that the Family Life Promotion program model, which a wholistic program is incorporating whole of life, whole family interventions be investigated and incorporated into a suicide prevention strategy for Indigenous people of the Northern Territory.

- **(d) the roles of targeted programs and services that address particular circumstances of high-risk groups, and identification of the strengths and weaknesses of existing suicide prevention responses;**

Young Australians are more likely to complete suicide than die from an illness or accident, the Health (Department DoHA) has told the Senate inquiry, "The Hidden Toll – Suicide in Australia 2010". In the Northern Territory Suicide in males and aged 15 – 35 years of age make up 82% of completed suicide. Professor Deigo DeLeo from the Australian Institute Suicide Research and Prevention confirms that those who attempt suicide now have a lifetime risk for suicide.

In the Northern Territory there is also a younger cohort emerging 10 – 17 years of age imitating the suicidal behaviour of the older cohort, using the same method of hanging in almost 100% of suicides, with intense suicide contagion. Child and Youth suicide is becoming more prevalent in Indigenous settings and efforts need to be made to respond quickly to this tragedy.

Of primary concern following an Indigenous suicide is the potential for contagion which can lead to further suicides forming suicide clusters. When high rates of suicidal behaviour, attempted and completed suicide occur within discrete Indigenous settings, it immediately raises the possibility of imitative suicidal behaviour resulting from contagion.

Contagion is a key factor in suicide among children and adolescents with most taking their own lives after the suicide or attempted suicide of a friend, relative or a community member. Contagion also appears to be universal in Indigenous communities of the Northern Territory, even in urban settings. Information about support services needs to be provided quickly to those affected by the death of a loved one to suicide to reduce the vulnerability of individuals, families and communities to suicide contagion and imitation. Families and communities require spiritual and practical support in the aftermath of a young person taking their own life.

Indigenous people are three times more likely than other Australians to complete suicide, Indigenous males are most at risk, and residents of remote or regional areas are twice as likely to complete suicide, as big-city residents. The same social issues that determine the health of a community appear to determine the rates of suicide a particular community.

The Northern Territory has alarming rates of Indigenous suicide with corresponding critical social and economic determinants of health. Michael Marmott (2011) suggests that there are six domains that are necessary to address these determinants:

1. early child development within healthy families
2. education and skills development
3. employment and working conditions
4. minimum income for healthy living
5. sustainable communities
6. social determinants approach to prevention, which includes suicide.

This research has identified vulnerabilities which link with the determinants of suicide in Indigenous communities. These vulnerabilities result in the breakdown of social connectedness, social cohesion, employment and economic stability, spiritual and emotional wellbeing, which are so vital in preventing suicide contagion and cluster suicides.

Suicide rates in Indigenous urban, rural and remote communities of the Northern Territory are high, with dramatic increases in the past two decades. Suicide clustering, contagion and imitation have been observed as possible reasons for this increase and a rare phenomenon “Echo Clusters” have been identified and is original research.

“Echo Clusters” represent a cohort effect in the life of Indigenous communities bonded by two decades of intense suicidal activity, the shared experiences of unemployment and excessive alcohol consumption, and the common experience of hanging. The cohort is predominantly male and aged 15 – 35 years of age who now have a lifetime risk for suicide. Since human behaviour is highly imitative the historical events of the past two decades may be repeated, unless the contagion cycle is broken, the impact of the cohort is diffused and the contagion contained.

I have analysed data from all jurisdictions in the Northern Territory and have identified “hotspots” for suicide in urban, rural and remote locations. Some settings are “hotspots” for suicide due to suicide contagion and imitation, resulting in suicide clusters. Suicide “hotspots” within Indigenous settings are locations for suicide where there is intense suicidal activity often occurring at the same site or similar sites within a community. A “hotspot” in an Indigenous setting can also be a whole community, with suicidal activity resulting in a “whole community at risk” of suicide. “Hotspots” for suicide can be self-limiting and burn out, or go on to develop into suicide “echo clusters”.

Recommendations

Firstly, I recommend that Northern Territory “headspace” youth mental health units in Palmerston and in Alice Springs and receive funding to implement the “headspace” schools program in urban and regional centres in the Northern Territory.

Secondly, I recommend that Palmerston Danila Dilba youth services be expanded for outreach services into rural and remote settings, and that youth services similar to the Danila Dilba youth services model be replicated in the major urban settings in the Northern Territory to promote wellbeing in Indigenous youth as a hedge against suicide.

- **(e) the adequacy and appropriateness of suicide prevention programs aimed at 17-25 year olds;**

The Life Promotion Program (Top End), Mental Health Program, Department of Health 1999 – 2006 developed the “Inter-Agency suicide Response Task Group” (I-ASRTG) in collaboration with the Northern Territory Coroners Office which provided a model of response to provide bereavement support and postvention to individuals, families and communities at risk.

The Life Promotion Program (Top End), Mental Health Program, Department of Health 1999 – 2006 also developed “Crisis Intervention Committees” within large communities to respond to recurrent suicidal activity. These committees met and monitored the “at risk” behaviour, self-harm and suicidal behaviour among the risk populations, and all were trained in ASIST to provide suicide intervention.

The Life Promotion Program (Top End), Mental Health Program, Department of Health 1999 – 2006 developed “Youth At Risk Network” which successfully brought together stakeholders from the various youth related organisations in Darwin. “YARN” which met monthly, provided an example of an innovative model for further networks to be developed in Darwin, Palmerston and the Top End.

The Life Promotion Program (Top End) also developed resources, for example, the Youth At Risk Card – “If Life Sux Ask for Help” card circulated within schools in the NT so that youth could have a list of people and agencies where they could access help. It was usually available with the “Toughin It Out” pamphlet which provided simple ways of dealing immediately with suicidal thoughts. The Life Promotion Program (Top End) also developed the Bereavement Support Contact Card which was handed out by the Coroner’s Constables DOJ when interviewing family members of the victims of suicide in the NT. The family could then ring the Life Promotion Program (Top End) for follow up bereavement support for individuals, families and communities.

The Coordinator Life Promotion Program (Top End) contributed to the development of the Northern Territory version of the “Information & Support Pack for those bereaved by suicide or other sudden death”. It was originally developed in Perth (2001) by the Ministerial Council for Suicide Prevention with support from people bereaved by suicide. The Bereavement Pack was adopted nationally in 2003 updated it in 2007 and there is a current hard copy version 2010.
<http://www.ichr.uwa.edu.au/preventingsuicide/resources/bereavementpack>

The following services can be accessed online, have conducted training or have been established in the Northern Territory. But no evaluation has been conducted on the efficacy of the ad hoc arrangement for service provision, therefore it is impossible to assess the adequacy or appropriateness of suicide prevention programs aimed at 17 – 25 year olds.

The Life Promotion Program (Top End) Department of Health 1999 - 2006 is one of the programs which was de-funded without an evaluation, whereas the Life Promotion Program Central Australia has been funded now for 12 years with great efficacy, but may now require formal evaluation. Where evaluations of programs do exist these evaluations should be formally assessed by the newly formed Parliamentary Select Committee on Youth Suicides in the NT, or by the proposed Suicide Prevention Strategy Unit / Life Promotion Strategy Unit, and formally approved as best practice for suicide prevention in the Northern Territory.

Evaluation needs to be built into new programs and existing programs for continuous quality improvement and monitoring of effectiveness. Quality Improvement Program Planning System (QIPPS) provides a platform for planning and evaluation that can be accessed on the internet from any location in the NT that all partners in the project can have access to at any time. Memorandum of Understanding or Access Agreements can be undertaken to safeguard the programs integrity.

Recommendations

Firstly, that a stocktake be undertaken of all programs which have provided suicide prevention programs, services or initiatives in the Northern Territory from the commencement of the National Youth Suicide Prevention Strategy 1998.

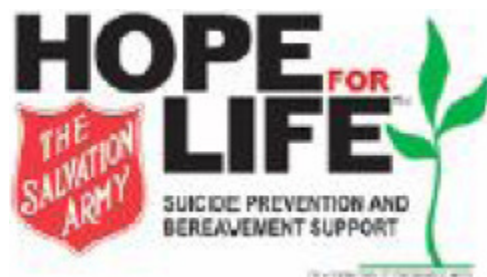
Second, that a comprehensive and coordinated evaluation of the efficacy of programs large or small, within a realistic and culturally relevant framework is conducted so that the programs / services / initiatives which have had some success, can be supported by Commonwealth Funding. New innovative programs be trialled within an adequate time-frame of 5 years with evaluation frameworks built into the design of the programs, planned and evaluated using QIPPS.

Below is a list of some but not all of the services which have had input into the NT.

PREVENTION / INTERVENTION / POSTVENTION



Lifeline Top End & Central Australia Phone: 131114 or <http://www.lifeline.org.au/> and provides Living Works - ASIST training and other support services.



Suicide Prevention Training & Bereavement Support Training Phone: 1300 467 354 or <http://suicideprevention.salvos.org.au/> ran a Postvention Bereavement Training program in the NT in 2008.



Dealing with Suicidal thoughts pamphlet: <http://www.toughinitout.org/> and was used extensively by the Life Promotion Program in the Northern Territory 1999 – 2006.



Top End Phone: 89315999 & Central Australia Phone: 89584544 <http://www.headspace.org.au/> and is entering a new phase with Outreach Teams into schools.



Beyond Blue: NT AMHW Program Phone: 1300 224 636 <http://www.beyondblue.org.au/index.aspx>? Raising awareness for the treatment of depression and other mental health conditions and reducing stigma.



OzhelP: <https://ozhelp.org.au/site/> Provides suicide awareness and training to the building industry.

AUSTRALIA WIDE NETWORKS



Wesley Mission LifeForce Networks (NT) Phone: 1800 100 024 <http://www.wesleymission.org.au/centres/lifeforce/>

POSTVENTION & BEREAVEMENT



Bereavement Packs NT version Phone Suicide Prevention Coordinator: 89992789 <http://www.ichr.uwa.edu.au/preventing-suicide/resources/bereavement-pack> <http://www.ichr.uwa.edu.au/preventing-suicide/arbor>



StandBy Response Service & Suicide Prevention Training

http://www.unitedsynergies.com.au/index.php?option=com_content&view=article&id=40



A.R.B.O.R – Active Response Bereavement OutReach:

<http://www.ichr.uwa.edu.au/preventingsuicide/arbor>

http://www.ichr.uwa.edu.au/files/user51/ARBOR_flyer_web_2010.pdf



LivingWorks

suicide-safer communities - seeing lives for tomorrow

LivingWorks - ASIST Training: Conducted by

Anglicare NT <http://www.livingworks.com.au/>

OTHER SUICIDE PREVENTION INFORMATION

Life Promotion Program Central Australia - Suicide Story:

<http://www.mhaca.org.au/LPP-suicide-story.html>

Indigenous Psychological Services: <http://www.indigenouspsychservices.com.au/>

Mental Health First Aid: <http://www.mhfa.com.au/cms/>

Mindframe Media: <http://www.mindframe-media.info/>

Mind Matters: <http://www.mindmatters.edu.au/default.asp>

Surviving Suicide Loss Toolkit: <http://www.afsp.org/!les/Surviving/toolkit.pdf>

The Blank Page Summit Kimberley Region WA Suicide Prevention:

<http://blankpagesummit.com/>

Family Life Promotion Program Yarabah Nth Qld:

http://gyhsac.org.au/index.php?option=com_content&view=article&id=120&Itemid=115

Grow NT: <http://www.grow.net.au/index.php/contact-us>

Suicide Prevention Foundation: www.1800HOLDON.com.au & www.aftersuicide.com.au

Suicide Call Back Service: www.suicidecallbackservice.org.au

Australian Psychological Society:
<http://www.psychology.org.au/FindaPsychologist/Default.aspx?ID=1204>

- **(f) the accuracy of suicide reporting in the NT, the factors that may impede accurate identification and recording of suicides and attempted suicide rates (and the consequences of any under-reporting on understanding risk factors and provision of services to those at risk)**

The Federal Government released its response to the Senate Committee's report "The Hidden Toll: Suicide In Australia" in 2010, finding that there was widespread concern that the actual suicide rate may be even higher than current figures, and with attempted suicide believed to be significantly under-reported in Indigenous communities.

The accuracy of suicide reporting in regional and remote Australia is fraught with difficulty and contributes to under-reporting of suicide deaths. Reporting of Indigenous suicide is particularly problematic as increasing Indigenous rates may be hidden with statistics of overall suicide rates in a jurisdiction which appears stable or even with diminishing rates. This has been the case in the Northern Territory where annual fluctuations can hide the increasing rates of Indigenous suicide and the decreasing rates of non-Indigenous suicide. Indigenous status is usually well recorded in the health system in the Northern Territory but is not always recorded accurately in the demographic data entered into the National Coroners Information System.

All jurisdictions in Australia are now using the Victorian Institute of Forensic Medicine's National Coroners' Information System (NCIS) electronic database but it requires manual examination of each electronic record to determine Indigenous status. Therefore it is a barrier to accurate research and reporting of Indigenous suicide in the Northern Territory. It is a grave disadvantage for rural and remote Territorians; particularly Indigenous people make up 60-80% of the rural and remote population. It has also disadvantaged the Northern Territory youth who have experienced a delayed youth suicide crisis, a decade after the youth suicide crisis of the 1990's in mainstream Australia, and which has occurred virtually unnoticed by government decision makers.

When a suicide occurs in any community, not just an Indigenous community the news of the suicide is spread quickly. Indigenous communities are close knit and the "reach of news" is widespread and is speedily communicated, which also spreads the contagion. The consequences of under-reporting of suicides can mean that postvention support services, if they exist, are not activated; contagion will spread, imitative suicide will ensue, and suicide clusters will occur.

The accuracy of forensic testing for alcohol and other drugs is vitally important in reviewing the antecedents of suicide and other sudden death in the Northern Territory. The accuracy of the data and timely reporting of the Coroners' Office, Department of Justice to the NTPF&ES Department of Justice can provide opportunities for immediate drug & alcohol interdiction.

But the accuracy of suicide reporting is not just a Coronial issue but is a whole of Government issue which requires legislative change if it is to be addressed adequately. There are two issues at hand firstly, suicide deaths which are reportable deaths to the Coroner and secondly, attempted suicides which are often recorded haphazardly and ad hoc depending on the services in each jurisdiction. For example, police in Nhulunbuy keep excellent records for a small jurisdiction which are a valuable asset when estimating the size of the suicide problem in East Arnhem, and other demographic data. The Aboriginal Mental Health Worker Program on the Tiwi Islands record accurately every attempt which comes to their attention but Mental Health Services in each jurisdiction rarely hear of all attempted suicides, only if they are serious enough to require evacuation.

The National Coroners Information System should be utilised more effectively to provide timely analysis of suicide data particularly for Indigenous settings. NCIS data should be accessible to researcher with or without the approval and / or support of the Coroner in each jurisdiction. Only then can there be transparency and timely reporting of the changing trends and impact of suicide particularly on the young in each jurisdiction. The impact can be immediate on policy decisions, for example, to reduce alcohol availability in certain situations (during funerals “sorry business” related to suicide or sudden unexpected deaths). The impact of a police presence in certain jurisdictions, increased mental health personnel, suicide interventions activated, increased grief and trauma counsellors and critical incident debriefing within a comprehensive postvention response.

The consequences of any under-reporting of suicidality either attempted or completed is clear, as it often results in further deaths from contagion and imitation. The consequences of not understanding risk factors can be poorly targeted and inappropriate interventions. The poor provision of services can either manifest in exclusive services to a small portion of the community which does not reach those at risk of suicide.

Please accept my submission in good faith and in the hope that this excellent opportunity to work with the community at large, the health services sector, General Practitioners, Ministers of Religion, Coroners, Indigenous psychologists, Aboriginal Health (Mental) Workers and non-government agencies will reduce the toll of suicide on our most disadvantaged and vulnerable citizens, our youth.

Yours sincerely,

Leonore Hanssens

PUBLICATIONS RELATING TO RESEARCH:

2007 ORIGIN CDU

Banks R. Suicide Contagion. *Origins Magazine* Charles Darwin University. Edition 1, 2007: 24-25. <http://www.cdu.edu.au/newsroom/origins/edition1-2007/origins1-2007-suicide-contagion.pdf>

2007 AIHWJ

Hanssens L & Hanssens P. Research into the Clustering Effect of Suicide within Indigenous communities, Northern Territory, Australia. *Aboriginal & Islander Health Worker Journal* May / June 2007; 31(3) 3–11.

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Hanssens L. Indigenous Dreaming: how suicide in the context of substance abuse has impacted on and shattered the dreams and reality of Indigenous communities in Northern Territory, Australia. *Aboriginal & Islander Health Worker Journal*. November / December 2007(b); 31 (6) 5 – 12.

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Bridge S. Hanssens L & Santhanam R. Dealing with Suicidal thoughts in schools: Information and education directed at secondary schools. *Australasian Psychiatry*. 2007 vol. 15 supplement. 58 – 62.

2008 AIHWJ

Hanssens L. Clusters of Suicide. The need for a comprehensive postvention response to sorrow in Indigenous communities in the Northern Territory. *Aboriginal & Islander Health Worker Journal*. March / April 2008(a); 32. (2) 25 – 33.

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2008 PHC RIS

Eckermann S. "Understanding Suicide" Snapshot of Australian Primary Health Care Research. 2008: 12 – 13.
http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/phcris_pub_6417.pdf

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Schultz R. & Hanssens L. Health Promotion in Australian General Practice. Letter to the Editor. <http://www.racgp.org.au/afp/200912/200912letters.pdf>

2010 AIHWJ

Hanssens L. "Echo Clusters" – Are they a Unique Phenomenon of Indigenous Attempted and Completed Suicide? *Aboriginal & Islander Health Worker Journal*. January / February 2010. 34. (1) 3 – 12.

2011 AIHWJ

Hanssens L. "Suicide (Echo) Clusters" – Are They Socially determined, the Result of a Pre-existing Vulnerability in Indigenous Communities in the Northern Territory and How Can We Contain Cluster Suicides? *Aboriginal & Islander Health Worker Journal*. January / February 2011. 35. (1) 14 – 19.

CONFERENCE PRESENTATIONS, WORKSHOPS & MEDIA

2006 SBS

Bates A. "Suicide In Aboriginal Communities". Living Black SBS 17th May 2006
Series 5: Episode 11. www.livingblack.com

2006 Suicide Prevention Australia National Conference

Hanssens L "Suicide Contagion in Indigenous Communities" Paper presented at the
Suicide Prevention Australia - National Conference. Adelaide October 2007.

2007 Inaugural Postvention Conference Salvation Army

Hanssens L. "The Search to Identify Contagion Operating within Suicide Clusters in
Indigenous Communities, Northern Territory, Australia". Paper presented at the
Salvation Army Inaugural Postvention Conference - Living Hope. Sydney. May 21st –
24th, 2007.

2007 IASP CONFERENCE - Killarney Ireland

Hanssens L. "Indigenous Dreaming: how suicide in the context of substance abuse
has impacted on and shattered the dreams and reality of Indigenous communities in
Northern Territory, Australia". Paper presented at the International Association for
Suicide Prevention Conference. Killarney, Ireland. September 1st -5th 2007.

2008 Salvation Army Bereavement Training

Attended 'Living Hope' Train the Trainer Salvation Army. Suicide Bereavement
Support Workshop. Perth, Western Australia. April 2008. **WEBSITE**
Conducted 'Living Hope' Suicide Bereavement Support Training Workshop, Darwin
Northern Territory. May 2008.

2009 2nd National Postvention Conference Salvation Army

Hanssens L. "Echo clusters"– the unique story of Indigenous Suicide. Paper
presented at the Salvation Army Inaugural Postvention Conference - Living Hope.
Melbourne. May 20th – 22nd, 2009.

2010 4th ASIA PACIFIC IASP CONFERENCE – Brisbane Australia

Hanssens L. "Echo clusters"– the unique story of Indigenous Suicide. Paper
presented at the International Association for Suicide Prevention Conference.
Brisbane, Australia. November 2010.

OTHER USEFUL PUBLICATIONS

<http://www.livingisforeveryone.com.au/>

<http://www.suicidepreventionaust.org/>