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Northern Territory Inquiry into Youth Suicide

Suicide Prevention Australia Submission

October 2011

Suicide Prevention Australia welcomes the opportunity to make this submission and commends the Committee for investigating this incredibly important issue.

Please find attached with this submission Suicide Prevention Australia's position statements on *Suicide Prevention and Capacity Building in Australian Indigenous Communities*, *Responding to Suicide in Rural Australia* and *Youth Suicide Prevention*.

Also attached is an article from the Medical Journal of Australia: De Leo, D., Dudley, M., Aebersold, C., Mendoza, J., Barnes, M, Harrison, J and Ranson, D (2010) Achieving Standardised Reporting of Suicide in Australia: Rationale and Program for Change. *Medical Journal of Australia* 192, 8, 452 – 456.

Introduction

The most recent figures show a rate of suicide in the Northern Territory of 20.1 per 100,000. This is over twice the national average and close to three times the lowest state rate. Men account for the largest proportion of all suicide deaths and in the Northern Territory 33 out of every 100,000 men may die by suicide.

Statistics

Official suicide statistics are widely accepted to be underestimated by as much as 20-30% (Harrison, Pointer, & Elnour, 2009, Lifeline Australia et al. 2010). A variety of issues contribute to this data problem. These range from inconsistencies with the collection of information for Coroners to use, to the difficulty in determining the intent of a deceased person, to data entry inconsistencies at later stages of statistical collection. Please see the attached article from members of the Suicide Prevention Australia coordinated National Committee for the Standardised Reporting of Suicide (NCSRS) for further information on the national state of suicide statistics. Suicide data is not consistent in recording Indigenous status or other demographic variables, leading to difficulty in generating clear understandings of at risk groups. In addition, data on suicide attempts and self harm are difficult to collect and analyse due to the lack of priority given to this information in health service data and the tendency for the majority of suicide attempt and self harm cases to not present

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to health or social services.

The committee is called upon to recommend that the Northern Territory Government work with the Federal government and the National Committee for the Standardised Reporting of Suicide to overcome the challenges to suicide statistical collection. There is a clear requirement for the production of accurate statistics which can identify and address need. The National Committee for the Standardised Reporting of Suicide would welcome further discussions with the Inquiry. Please contact Suicide Prevention Australia for more information.

Suicide in the Northern Territory

The disproportionate rate of suicide in the Northern Territory is partly explained by the geographic and demographic composition of the territory, with rural dwellers and Indigenous communities overrepresented; these groups experience higher rates of suicide than metro dwellers and non-Indigenous communities.

Indigenous suicide

The Indigenous suicide rate in the Northern Territory is 36.7 per 100,000, while the non-Indigenous NT community also experience higher rates than their counterparts in other states (Pridmore & Fujiyama 2009).

Although not always the case Indigenous communities have been shown to have a significantly higher rate of suicide than the non-Indigenous population. The risks of suicide and self-harm among Indigenous communities are complex and are compounded by historical and socio-cultural issues.

For Indigenous males aged 0–24 years and 25–34 years, suicide rates are approximately three and four times the corresponding age specific rates for non-Indigenous males respectively and the suicide rates for young Indigenous women are approximately five times that of non-Indigenous young women (ABS & Australian Institute for Health and Welfare (AIHW) 2008). Suicide rates per 100,000 in the NT are highest for both Indigenous and non-Indigenous people in the 65-74 age group, followed by the 25-44 year age groups. However Indigenous communities experience over twice the rate of suicide as their non-Indigenous counterparts in the 15-24 year age group (Pridmore & Fujiyama 2009). The suicide rate among young Indigenous people has increased over the last 30 years (Cantor et al. 1998).

The risk factors for suicide in Indigenous communities cannot be assumed to be the same or have the same correlations as non-Indigenous communities. For example the link between mental illness

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and suicide is less evident in Indigenous communities than in the general population, with other factors such as alienation, grief, social disadvantage, sexual assault, family violence, unemployment, lack of meaningful engagement and substance abuse compounded by social, cultural and historical factors contributing to increased risk (SPA 2008).

Indigenous Australians experience a higher burden of disease attributable to mental disorders than the rest of the population, with alcohol and substance abuse being the largest contributors to this burden (Vos et al. 2003). Indigenous males suffer four and a half times the rate of alcohol dependence compared to the general population (Vos et al. 2003). Similarly the habitual inhalation of noxious substances is more prevalent among Indigenous communities. The risk of suicide is greatly increased in those with alcohol and substance disorders and is a major contributor to suicide in the NT. Alcohol and substance abuse can generate risk independently or exacerbate pre-existing risk, it also contributes to other social problems such as domestic violence and economic deprivation.

According to survey data, psychological distress impacts on 27% of Indigenous Australians (AIHW 2009). Suicide risk is further exacerbated in conditions of economic deprivation, low education and employment opportunities and physical health problems. All of which are disproportionately present in Indigenous communities in the NT although at variable rates across communities.

Silburn et al. (2010) propose that the characteristics of suicide rates in Indigenous communities suggest that Indigenous suicide cannot be viewed as an individual psychological issue, but rather must be considered a community level risk. Hunter and Milroy (2006) argue that historical forces have negatively shaped the collective family environments of Indigenous communities and have created vulnerabilities and weakened traditional resilience. Aside from specific suicide prevention measures for Indigenous communities, initiatives which aim to address the social determinants of distress and bridge health gaps between Indigenous and non-Indigenous communities are necessary.

Suicide contagion occurs when one suicide directly contributes to another and may be linked by geography, relationship or method. Contagion has been identified as a significant contributor to Indigenous suicides, particularly suicides by hanging (Hanssens 2007). Imitation or contagion is more common in younger people and may be impacted by cultural grief practices in Indigenous communities (Hanssens 2008). Preventing suicide contagion in Indigenous communities can be assisted by culturally appropriate postvention models. Postvention refers to care after a suicide and aims to limit the distress and future negative outcomes that can result from a suicide death. Examples of these are occurring in the Kimberley in WA and in Northern Queensland through Standby Response services.

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Any approach to Indigenous suicide prevention cannot operate effectively without respect to the historical and cultural context of the particular heterogeneous community it serves. Empowerment, self determination and capacity building are important to any community initiative but given historical tensions and cultural distinctions, are paramount for suicide prevention in Indigenous communities. Examples of laudable Indigenous suicide prevention programs already operating in the NT include the Mental Health Association of Central Australia's Suicide Story training project. Local communities have also developed their own initiatives, for example Galupa Marngarr Suicide Prevention Group in Arnhem Land.

Rural and remote suicide

Suicide in a rural context in the Northern Territory is not clearly delineated from that of Indigenous suicide, but additional and compounding factors associated with rural and remote areas impact on both Indigenous and non-Indigenous suicide risk.

Due to the relative inaccuracy of suicide statistics and the possibility that rural and remote areas are disproportionately underestimated (due to infrastructure issues and high levels of suicide stigma), it is hard to get an exact picture of suicide risk in rural and remote areas in Australia. Nonetheless, research has shown that suicide rates may be 33% higher in rural areas then in major cities, rising to 189% higher in very remote areas (Australian Institute of Health and Welfare, 2010). Similarly a Queensland study by Andersen et al. (2010) found that agricultural workers were over twice as likely to die by suicide as members of the general employed population.

The high rate of rural and remote suicide has been linked to depression, especially that related to agricultural productivity and economic difficulties. For example drought (Speldewinde et al., 2009), a lack of employment opportunities (Fragar et al. 2010) and financial insecurity (De Leo et al., 2005) have all been linked with psychological distress and suicide in rural areas.

The isolation experienced by those in rural and remote areas is compounded by the lack of public infrastructure, especially health and social service access. Rural communities generally have a lack of quality services and the population are often required to travel long distances to access care. Also rural community members may be personally acquainted with their GP, which combined with a stoic cultural attitude to mental health problems decreases willingness to reveal psychological problems.

Youth suicide

Youth suicide is a rare but tragic event. In 2009, suicide claimed the lives of at least 259 Australians

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aged 15 – 24 years, and was the leading cause of death for this cohort (ABS 2011). There were 11 intentional self harm deaths among the 15-24 year age group in the Northern Territory in 2009, 10 of whom were young men (ABS 2011). This is a rate of 48.4 per 100,000 young men and would be expected to be revised upwards as more Coronial cases from that year become finalised.

The impact of youth suicide deaths radiate through communities causing immeasurable personal, social and financial costs. Self harm and suicide attempts are relatively more common among young people, with long term physical and psychological implications for their health and welfare. A recent report by Mission Australia (2009) indicated that 26.3% of youth considered suicide to be a major concern for them; second only to drugs (26.8%).

The causes of suicide are complex and vary across the lifespan. Biological, social and environmental conditions generate distal vulnerabilities and predispose an individual to risk; while additional events or proximal factors can generate tipping points to suicidality. Mental illness, drug and alcohol issues, social isolation, educational and economic disadvantage, sexual minority issues, child sex abuse and physical health problems can contribute to risk, while traumatic life events and loss can generate immediate crises.

Resilience, self-esteem, connectedness, belongingness, supportive environments and positive life events can be valuable safeguards against the effects of distal risk factors and can prepare a person to deal with a proximal event. Prevention efforts which target these and other similar protective factors are most often applied at the universal level and target the whole population without differentiating between levels of risk. These are the most common prevention programs and often fall under the banner of mental health promotion or social and emotional wellbeing programs.

Positive youth mental health programs at the school level fit into this category and include existing projects such as Mindmatters and Kidsmatter. The evaluation and evidence base of these and other school based programs is generally positive in many regards. However their impact on suicide rates is hard to measure. Additionally within current resourcing levels the ability of these programs to successfully reach all young people or teachers in the NT is limited.

Universal programs hold many benefits for protecting youth against suicide as they target the upstream determinants of suicidality and have numerous other positive outcomes. However regardless of the effectiveness of universal programs, biological, social and environmental conditions will inevitably leave a proportion of individuals immune to these benefits and requiring targeted interventions.

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Traditionally Australian schools have been reluctant to incorporate specific suicide prevention programs into their remit due to concerns of discussing suicide with young people and the lack of training teachers have to respond to suicide. The value and safety of targeting specific suicide prevention programs to youth, which include measures to increase awareness of suicide risk and how to seek help for suicidality is contentious (Mazza 1997). Fears that irresponsible programs may create imitative behaviours and inappropriate content may restrict help-seeking underpin much of the caution for school-based suicide awareness programs (Gould 2003b). Yet, these fears have limited basis in evidence and have been suggested to be out of date and contributing to a lack of understanding of suicide prevention and fear of open discussion (Bridge et al. 2007, Kalafat 2003, Gould et al. 2005, Joiner 2009, Miller & Eckert 2009).

The strong rationale behind implementing suicide prevention programs in schools includes the proximity of teaching staff to young people who may be at risk and the tendency for young people to seek help from peers rather than adults (Kalafat 2003). Thus trained gatekeepers, including teachers, are primly placed to respond to risk, while young people who are approached by or who recognise risk in a peer can be equipped to respond effectively. Please refer to Suicide Prevention Australia's Position Statement on Youth Suicide Prevention for much more details on school based suicide prevention: http://www.suicidepreventionaust.org/?statement=youth-suicide-prevention-in-australia .

Policy and service delivery context

The Northern Territory Suicide Prevention Action Plan 2009-2011 is based on the LiFE Framework but retains elements specifically relevant to the NT such as partnerships with Indigenous people. The NT strategy sits across the whole of Territory Government, with responsibilities aligned with the Department of Health and Families, the Department of Education and Training, the Department of Justice, the Department of National Resources, Environment, The Arts and Sport, the Department of the Chief Minister and the NT Police, Fire and Emergency Services. This approach is a strength of the strategy which extends suicide prevention responsibility across government and across community, an often lauded but rarely achieved concept.

Projects funding under the National Suicide Prevention Strategy in the NT (according to www.livingisforeveryone.com.au) include Suicide Story Training Project, OzHelp, ATAPS Additional Support for Patients at Risk Of Suicide and Self Harm Projects and Mental Health Resources for Arnhem Land Communities. None of these focus explicitly on young people, however Mindmatters and Kidsmatter educational programs are also active in the NT.

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Online programs such as Reachout.com are providing young people with support during tough times and overcome many of the traditional barriers to young people accessing services. The potential for online and new media suicide prevention initiatives are great and should be considered but to complement rather than as an alternative to investment in face to face services.

To determine the effectiveness of current suicide prevention activities and programs in the NT a comprehensive evaluation would be required. However anecdotal evidence and the observable suicide trends would suggest that current programs at their existing level of funding are not meeting the full level of need in the NT.

Apart from youth primary prevention programs such as Mindmatters, Kidsmatter and the many other laudable programs and secondary measures such as Headspace and ATAPS, a focus on the social determinants of Northern Territory suicide is necessary. In this regard, Indigenous inequalities, unemployment and socio-economic deprivation, educational gaps, drug and alcohol issues, physical health problems, and rural and remote health infrastructure must be urgently addressed.

When considering recommendations for the implementation of programs and services the Inquiry must consider the practical challenges and unique context of service delivery in the Northern Territory. Firstly geographic isolation necessitates a certain level of self sufficiency in remote communities but this does not mitigate the need for additional and regular input and sharing from across the Territory. The NT Government must overcome this obstacle with careful consideration of each community's needs and available resources and create a balance between encouraging autonomy whilst not assuming capability.

Additionally language and cultural barriers restrict the ability to roll out initiatives across the Territory, requiring tailored packages for each community. While custom may dictate hierarchical community structures, suicide prevention initiatives must carefully consider whether these are appropriate or sufficient for the purposes of each project and work with the community to develop the most effective projects. Regular monitoring should allow for changes and adjustments as a project develops.

To compliment these social and suicide prevention measures, a comprehensive territory wide educational and awareness raising initiative could increase the numbers of people equipped to respond to suicidality, increase help seeking behaviours and reduce the stigma of suicidality and mental illness. Gatekeeper training of medical and social professionals is a key suicide prevention measure that deserves increased policy and funding attention. Without widespread suicide prevention knowledge in communities, people at risk are less likely to be recognised, treated or

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recover.

To summarise, some key points for the committee to consider:

- Addressing the mental health needs of Indigenous Australian.
- Investing in postvention to reduce contagion suicides and community distress.
- Considering schools as a prime site of prevention.
- Adapting programs to fit cultural and geographic contexts.
- Overcoming the tyranny of distance in NT communities.
- Evaluating and as appropriate increasing the funding given to existing programs.
- Working with the federal government and the NCSRS to improve the quality of suicide statistics.
- Increasing community and professional awareness of suicide prevention

Suicide Prevention Australia would welcome an opportunity to discuss these important issues in more detail with the committee.

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