



LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

11th Assembly

Select Committee on  
Youth Suicides in the NT

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**Gone Too Soon:  
A Report into Youth Suicide in  
the Northern Territory**

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**COMMITTEE REPORT**

**March 2012**

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## Chair's Preface

Suicide is a tragedy for the individual and devastating for their family, friends and community. The pain for loved ones is immeasurable and enduring. When it is a young person with their whole life ahead of them, the tragedy is heightened. In the Northern Territory, with our many tight-knit communities, the sense of loss and failure can carry across regions.

Our youth suicide rate is 3.5 times the national average, and the overall rate is twice the national rate. The rates for men have always been relatively high. This alone is cause of great concern, however the Committee heard that the rate for young women, particularly young Indigenous women, has increased in recent years. Girls now comprise up to 40% of all suicides of children under the age of 17. The suicide rate for Indigenous Territorians is particularly disturbing, with 75% of suicides of children from 2007 to 11 in the Territory being Aboriginal and around 50% of all suicides.

It was heartening to hear of the excellent work being done around the Territory to respond to youth in crisis, such as the initiatives in Nguiu and Ski Beach where the community rallied to turn around some of the highest suicide rates in the world; the work of the Darwin Region Indigenous Suicide Prevention Network, which took the initiative to fill the gaps in suicide support in the region; and the work of the Mt Theo Program, where the elders of Yuendumu developed diversionary programs to help those of their youth in crisis, to name but a few. The Committee was also impressed by people around the Territory working to build and maintain strong communities, both as professionals and as volunteers.

Nonetheless, more needs to be done to address youth suicide. Too many of our youth are falling through the gaps and not getting the help they need. For too many of our youth, there is not enough hope to protect them from the impulse to end their lives. Clearly things need to change if we are to stop losing our young people at their own hands at such a high rate.

The greatest priority is to work better with what we have got. The need for greater coordination and collaboration was raised with the Committee wherever it went. It does not make sense to hear that there are too many service providers in places where some people cannot access services. Nor does it make sense to hear of successful and vital programs closing or losing staff because a grant program has ceased or changed its priorities. It is therefore essential that the Government take up the Committee's recommendations 19, and 23 regarding mapping services and funding across the Territory and establishing a new Suicide Prevention Coordination Committee with the authority and resources to ensure agencies and organisations are working together and providing services where they are needed. Recommendations 20 and 22 are also targeted at improving the way we deliver services and are a high priority for the Committee.

The second priority is to ensure that there are people for our youth to turn to in times of crisis and to help them through the transition from childhood to mature adults. This includes adequate psychological, social and other counselling services for clinical needs,

and youth workers, friends and other mentors in their day to day lives. The Committee therefore calls on the Government to give close and favourable consideration to recommendations 1, 4, 7, 9, 12, 13, 14, 18 to improve access to psychological services and 6, 10, 11 to improve access to positive role models and life promoting opportunities.

The lack of infrastructure to provide community building activities or to enable the provision of services was another theme that what raised with the Committee in a number of contexts. The Committee therefore considers that recommendations 2 and 3 must be addressed to facilitate the development of strong and healthy communities.

The important role that schools play in the lives of young people was another issue that arose repeatedly. Schools make a significant contribution in building resilience in children and giving them skills to deal with many of life's challenges. They are also on the front line when dealing with many crises. The Committee commends recommendations 4, 5, 9, 10 and 15 as a means of assisting schools with these tasks.

The response to a suicide can make a significant difference to the lives of the bereaved and can reduce the chance of further suicides in imitation. To improve our response we need to better equip those who deal with the bereaved and provide the bereaved with access to services to help them through this difficult time. Recommendations 16, 17 and 21 are aimed improving the help we provide to those who have lost loved ones to suicide.

Suicide is a multidimensional problem that requires many different responses. Some of the key issues identified by the Committee are already the subject of significant policy initiatives and were beyond the capacity of the Committee to address. These include issues such as alcohol and substance abuse, domestic violence and local economic development. Continued action is required on these high level issues, as well as the recommendations put forward by the Committee, to reduce youth suicide in the Territory.

The Committee is very grateful to all those who provided submissions to the Committee or attended its hearings and forums. It was both humbling and inspiring to hear of the dedication of many across the Territory to provide help to those in need, and of the time and initiative many have taken to strengthen their communities. The Committee also thanks those who shared personal and often painful stories to enable the Committee to better understand the issues around youth suicide. In particular, the Committee thanks the young people who generously shared their personal stories with us and the challenges they have faced. It was wonderful to hear how they are turning their struggles and experiences into success. Finally, I thank the other Members of the Committee for their commitment to understanding and finding solutions to the problem of youth suicide.

**Marion Scrymgour MLA**  
**Chair**

## Committee Members



**Ms. Marion SCRYMGOUR, MLA**

Member for Arafura

**Party:** Australian Labor Party

**Committee Membership:**

**Standing:** House; Public Accounts, Estimates, Subordinate Legislation and Publications, Legal and Constitutional Affairs;

**Sessional:** Environment and Sustainable Development; Council of Territory Co-operation

**Select:** Youth Suicides in the NT

**Chair:** Legal and Constitutional Affairs Committee, Environment and Sustainable Development, Youth Suicides in the NT



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**Ms. Kezia PURICK, MLA**

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**Parliamentary Position:** Deputy Leader of the Opposition; Shadow Minister for Primary Industry, Fisheries and Resources, Statehood, Women's Policy

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**Sessional:** Council of Territory Co-operation-Animal Welfare Sub-committee

**Select:** Youth Suicides in the NT



**Mr. Peter STYLES, MLA**

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**Standing:** Standing Orders, Members' Interests

**Sessional:** Environment & Sustainable Development

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## **Acknowledgements**

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## Acronyms and Abbreviations

ABS	Australian Bureau of Statistics
AFL	Australian Football League
AIHW	Australian Institute of Health and Welfare
AISRP	Australian Institute of Suicide Research and Prevention
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AOD	Alcohol and Other Drugs
ARDS	Aboriginal Resource Development Service
ASIST	Allied Suicide Intervention Skills Training
ASPAC	Australian Suicide Prevention Advisory Council
ATAPS	Allied Psychological Services Project
BDR	Banned Drinker Register
BOiMHC	Better Outcomes in Mental Health Care
CAAC	Central Australia Aboriginal Congress
CAYLUS	Central Australian Youth Link Up Service
CCIS	Client Care Information System
COAG	Council of Australian Governments
CRC	Co-operative Research Centre
DCF	Department of Children and Families
DRISPN	Darwin Region Indigenous Suicide Prevention Network
EPPIC	Early Psychosis Prevention and Intervention Centres
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GAT	General Awareness Training
GMSPN	Galupa Marngarr Suicide Prevention Network
GPNT	General Practice Network Northern Territory
HSK	Healthy School-Age Kids
IASRTG	Inter-Agency Suicide Response Task Group
LIFE	Living is for Everyone
MCH	Maternal, Child and Youth Health
MHACA	Mental Health Association of Central Australia
MST	Multisystemic Therapy
NAAJA	North Australian Aboriginal Justice Agency
NALAS	North Australian Legal Aid Service
NCIS	National Coroner's Information System
NCSRS	National Committee for Standardised Reporting on Suicide
NHMRC	National Health and Medical Research Council
NPARIH	National Partnership Agreement on Remote Indigenous Housing
NSPP	National Suicide Prevention Program
NSPS	National Suicide Prevention Strategy
NSPSAF	National Suicide Prevention Strategy Action Framework
NT ADIS	Northern Territory Alcohol and Drug Information Service
NTCOSS	Northern Territory Council of Social Services
NTEIPP	Northern Territory Early Intervention Pilot Program
NTSFSP	Strategic Framework for Suicide Prevention
NTSPCC	Northern Territory Suicide Prevention Coordinating Committee

PuP	Parenting Under Pressure Program
QPR	Question Persuade Refer
RGSC	Roper Gulf Shire Council
SAAP	Supported Accommodation Assistance Program
SAM	Save a Mate
SPP	Specific Purpose Payment
TEABBA	Top End Aboriginal Bush Broadcasting Association
TESPN	Top End Suicide Prevention Network
WHO	World Health Organisation
WWK	Warra-Warra Kanyi
WYDAC	Warlpiri Youth Development Aboriginal Corporation
YARN	Youth At Risk Network
YAW-CRC	Cooperative Research Centre for Young People, Technology and Wellbeing

## Terms of Reference

Resolved by the Legislative Assembly 17 & 18 August 2011

1. A Committee to be known as a Select (or Sessional) Committee on Youth Suicides in the NT be appointed comprising, three (3) members nominated by the Chief Minister, two (2) members to be nominated by the Leader of the Opposition and one (1) Independent;
2. The Committee to be empowered to inquire into and report on the current and emerging issues of Youth Suicide in the Northern Territory.
3. The Committee to inquire into and report on:
  - (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;
  - (b) programs and services targeted at Youth aged 17-25 years of age with particular emphasis on Suicide Prevention education and awareness in Schools;
  - (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;
  - (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;
  - (e) the adequacy and appropriateness of suicide prevention programs aimed at 17-25 year olds; and
  - (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).
4. The Independent Member of the Committee shall be the Member for Macdonnell.
5. The Committee shall elect a Government member as Chair.
6. The Chair of the Committee may, from time to time, appoint a member of the Committee to be the Deputy Chair of the Committee and the Member so appointed shall act as Chair of the Committee at any time when there is no Chair or when the Chair is not present at a meeting of the Committee.
7. Three Members of the Committee shall form a quorum.
8. The Committee may proceed to the dispatch of business notwithstanding that not all Members have been appointed and notwithstanding any vacancy.
9. The Committee is to report by the first sitting date after February 2012.

10. The Committee may present to the Assembly, from time to time, progress reports of its proceedings with or without the evidence received.
11. The foregoing provisions of this resolution have effect notwithstanding anything contained in the Standing Orders.

## Executive Summary

The rate of youth suicide in the Northern Territory is unacceptable. For 2009, 11 deaths of 15 to 24 year olds have been determined to be suicide. In the period 2002-06, the suicide rate of 15 to 24 year olds was over twice that of other Australian jurisdictions. This high rate of loss of young lives demands action. The Committee is also concerned that the high suicide rate signifies underlying social problems that need to be addressed.

Suicide is an issue that affects all sectors of society. However, there are some particularly concerning trends that require special attention. Comparison of suicide data of 10 to 17 year olds in the Territory from 2001-05 and 2006-10 indicate that the rate of Aboriginal youth suicides has increased (from 18.8 to 30.1 per 100,000) while the rate for non-Aboriginal youth has decreased (from 4.1 to 2.6 per 100,000). The Committee was also informed of a disturbing increase in the rate of suicide among Aboriginal girls aged 10 to 17 years.

While each suicide has unique causes, a range of factors have been identified that increase the risk of suicide. These include mental health problems, drug and alcohol misuse, sexual and physical abuse, lack of employment, social and economic disadvantage, educational disadvantage, cultural and sexual identity issues, and problems with family and the law. With a number of the suicides in the Territory it was also evident that they resulted from impulsive behaviour; usually accompanied by alcohol or substance abuse.

To respond to the suicide in the Territory, the committee identified four areas for further action:

1. Building Strong, Healthy and Resilient Communities.
2. Identifying and Helping those at Risk.
3. Helping the bereaved and stopping the contagion.
4. Smarter Service Delivery.

The foundation of lasting suicide prevention is building stronger and more resilient communities. In this regard, there were some major contributing factors that are already well recognised priorities for Government and, while central to reducing the suicide rate, were too great an issue to be adequately addressed by the Committee. These include alcohol and substance abuse, domestic violence, and economic development and governance of rural and remote communities. In addition to these high level issues, the Committee identified a number of areas where action could be taken to build stronger communities.

The first priority for stronger communities is the development of infrastructure for community activity and for service delivery, including sporting and youth facilities, staff and respite accommodation. Many witnesses outlined that places for community activity, such as sporting facilities and youth and recreation centres, facilitated the development of positive behaviours and relationships that contributed to resilience. Investment in

housing was also identified as an ongoing need, as many communities were unable to attract or retain staff for various services due to the lack of accommodation. A number of witnesses also noted that youth in crisis often needed a safe place to stay for a while, especially those suffering from domestic violence, and the Committee has recommended graded accommodation options and mental health facilities for young people in a number of regional centres.

The Committee also recognises the critical part played by schools and families in developing young people to be better able to manage and navigate the difficulties and challenges of life. Strategies to improve the capacity of schools to help students in this regard include teaching on mental wellbeing, adequate provision of school counsellors, and policies and teaching on the positive use of communications technology and the prevention of cyber-bullying.

To help those at risk, the Committee found the need for more counselling and mental wellbeing services across the Territory, including, but not limited to, mental health services. In particular, the Committee recommends:

- There be a minimum ratio of counsellors to students in all schools;
- The provision of mental health specialist staff for court and detention settings;
- Promotion of youth friendly and culturally appropriate counselling and mental health services, including the establishment of headspace services in Katherine, Tennant Creek and Nhulunbuy;
- Promotion of the use of on-line and telephone crisis support services; and
- Maintaining at least one staff member with mental health training in all accident and emergency departments

The Committee also noted the valuable role Youth Engagement Police Officers can provide to youth at risk and recommends they be assigned to all growth towns and other remote communities with high needs.

The response to a completed suicide can have a significant impact on the bereaved and the community at large. In particular, action can help prevent the contagion effect where other family, friends or community members follow a suicide with their own suicidal ideation and attempts. The Committee has recommended that this be addressed through:

- Review of Department of Education and Training Emergency Preparedness Policy and Emergency Management Kit and incorporation of procedures for responding to suicides; and
- Provision of suicide bereavement training for frontline staff of Police, Health and Education.

The most consistent theme to emerge from the Committee's evidence was the need to improve how services are coordinated and funded throughout the Territory and between all levels of government and service providers. The Committee was informed of

instances where the number of service providers made it confusing for those in need, and other instances where the lack of services was a critical issue. The scarcity of resources in remote and regional communities means that a high level of collaboration is needed to make the most of what is available.

Related to the need for greater coordination and collaboration was the need for improved funding processes. The Committee encountered a number of very effective locally developed programs, particular in regards to youth diversion. The Committee considers that such programs are key to addressing many of the issues around suicide as locally developed programs will be attuned to local needs and, more fundamentally, lasting benefit can only be obtained as communities develop within themselves the capacity to deal with such issues. However, this presents a number of funding issues. Work is required to better enable:

- Effective local initiatives to access resources to allow them to develop;
- Consistency of funding over time to allow the development of programs and the skills of their staff;
- Accountability and evaluation so money is not wasted on less effective programs;
- Collaboration and cooperation between providers;
- Coordination of the funding and development of services to avoid duplication and ensure equity of access.

To better coordinate the provision of services throughout the Territory, the Committee has recommended that the Northern Territory maintain and make available a database that maps all youth and community related services provided by all three tiers of government and the non government sector. The Committee has also recommended the establishment of a high level Suicide Prevention Coordination Committee with an ongoing secretariat within the Chief Minister's Department to drive coordination at the policy level. Further, to help ensure coordination on the ground within communities and regions, and to facilitate the development of local responses to local needs, the Committee has also recommended the establishment of youth development officers and community development officers within each shire.

## Recommendations

### Recommendation 1

The Committee recommends that the Northern Territory Government, in conjunction with the Australian Government, urgently:

- a) provide extensive and effective community based professional development and training of existing local staff in relation to facilitating access to mental health assessments and counselling services (including grief counselling) in regional, rural and remote communities; and
- b) include mental health care specialists and counselling services (including grief counselling) as locally based or regularly and frequently visiting staff in all health clinics across the Northern Territory.

### Recommendation 2

The Committee recommends that the Northern Territory Government:

- a) review the status of visiting officers quarters in terms of:
  - the extent to which current facilities meet the needs of visiting services;
  - maintenance and upgrade requirements; and
  - options for funding and development of required infrastructure to facilitate visiting service requirements.
- b) conduct a staff housing audit in Katherine, Tennant Creek, Jabiru, Nhulunbuy and Growth Towns to identify:
  - staff housing requirements of the Shires, Northern Territory and Australian Government departments for the delivery of community based services including those provided by non-government organisations on behalf of the Northern Territory and Australian Governments; and
  - strategies and funding options for the additional staffing housing requirements;
- c) table a report on the progress of the audit and review of service infrastructure in the Legislative Assembly by 30 June 2013.

### Recommendation 3

The Committee recommends that the Northern Territory Government, and the Australian Government, prioritise Youth specific infrastructure funding for:

- a) graded accommodation options and mental health facilities for young people at risk of suicide, young people with severe substance abuse or mental health issues, and those requiring respite from adverse family circumstances, in Palmerston, Katherine, Tennant Creek, Alice Springs and Nhulunbuy;
- b) youth, sport and recreation facilities and youth drop in centres in regional towns such as Katherine, Tennant Creek and Nhulunbuy, and remote communities; and
- c) construction of a Litchfield Activity Hub as a 'one-stop' youth wellbeing facility in the outer Darwin region.

#### **Recommendation 4**

The Committee recommends that the Department of Education and Training increase the professional development opportunities for all teachers in relation to mental health and wellbeing, and recognising and assisting young people at risk of suicide.

#### **Recommendation 5**

The Committee recommends that the Department of Education and Training:

- a) review its anti-bullying policy guidelines and incorporate a policy regarding cyber bullying and the use of mobile phones during school hours and direct all schools to implement this policy as a matter of priority; and
- b) actively encourage the uptake of educational resources and training available through the Australian Communication Media Authority's *cybersmart* website.

#### **Recommendation 6**

The Committee recommends that the Department of Children and Families' Office of Youth Affairs establish a substantial funding program to facilitate the introduction of positive youth development programs and that this funding stream be open to both Local Government Authorities and Non-government Organisations.

#### **Recommendation 7**

The Committee recommends that the Department of Health, in conjunction with Aboriginal Medical Services Alliance Northern Territory (AMSANT), introduce the Integrated Service Delivery Model into Aboriginal Primary Health Care Services over the course of the next five years; with a particular emphasis on the regional centres of Katherine, Tennant Creek and Nhulunbuy and all remote area communities with a population of more than 200.

#### **Recommendation 8**

The Committee recommends that the Department of Children and Families' Domestic and Family Violence Policy Unit review community attitudes, public awareness and cultural applicability in remote communities of the current *Stop the Hurting Campaign*.

#### **Recommendation 9**

The Committee recommends that the Department of Education and Training determine an optimum ratio of students per school counsellor for primary schools, middle schools and high schools and allocate counsellors on that basis.

#### **Recommendation 10**

The Committee recommends that the NT Police Service assign Youth Engagement Police Officers to all Growth Towns, and other remote communities that NT Police have identified as having particularly high levels of youth offending, substance abuse, and family or community violence in the past 12 months.

#### **Recommendation 11**

The Committee recommends that the Northern Territory Government urge the Australian Government to continue the Youth in Communities program, and:

- a) Expand the program to provide greater equity of access;
- b) Ensure service providers have the capacity to provide outreach services as required; and
- c) Ensure that service providers effectively liaise with providers of complimentary youth, sport and recreation services funded by the Northern Territory and Australian Governments.

### **Recommendation 12**

The Committee recommends that the Department of Justice, in conjunction with the Department of Health, Aboriginal Medical Services Alliance Northern Territory (AMSANT) and the North Australian Aboriginal Justice Agency (NAAJA):

- a) ensure that dedicated specialist mental health staff are placed on call in court and detention settings for assessment and acute interventions as required and as a link to ongoing community based care following release; and
- b) trial the use of Multi Systemic Therapy treatment for young offenders with repeat arrest histories.

### **Recommendation 13**

The Committee recommends that, in accordance with the Australian Government's support of Recommendation 23 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), and in light of evidence regarding the incidence of suicide in young people under the age of 25 in the Northern Territory, the Northern Territory Government:

- a) calls upon Telstra, in the interests of corporate citizenship, to drop call charges for mobile phone calls made to the *Kids Helpline* as a matter of priority; and
- b) promote and encourage the use of telephone counselling and on-line crisis support services in media campaigns and relevant departmental information brochures.

### **Recommendation 14**

The Committee recommends that the Northern Territory Government actively lobby the Australian Government to:

- a) establish and fund *headspace* centres in Katherine, Tenant Creek and Nhulunbuy; and
- b) provide *headspace* outreach services to remote Northern Territory communities.

### **Recommendation 15**

The Committee recommends that the Department of Education and Training review its *Emergency Preparedness Policy and Emergency Management Kit* and incorporate requirements for the development of specific procedures to respond to suicide, and direct schools to implement this policy as a matter of priority.

### **Recommendation 16**

The Committee recommends that the Northern Territory Government:

- a) provide *Suicide Bereavement Training* for all frontline staff required to respond to those bereaved by suicide; and

- b) resource the Office of the Coroner to provide fully qualified grief counselling.

### **Recommendation 17**

The Committee recommends that, in accordance with the Australian Government's support of Recommendation 11 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), the Northern Territory Government review debriefing procedures and counselling support available to frontline workers regularly exposed to suicide and attempted suicide related incidents; including Northern Territory Government, Local Government and Non-government service providers.

### **Recommendation 18**

The Committee recommends that, in accordance with the Australian Government's support of Recommendations 9 and 11 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), the Northern Territory Government:

- a) mandate that hospital accident and emergency departments maintain at least one person with mental health training and capacity to conduct suicide risk assessments at all times; and
- b) establish mandatory procedures to provide follow up support to young people that have been in psychiatric care, have been treated following an attempted suicide or who are assessed as being at risk of suicide.

### **Recommendation 19**

The Committee recommends that, as a matter of the utmost priority, the Northern Territory Treasury, in conjunction with the Australian Government establish and maintain:

- a) The comprehensive mapping of all youth and community related services (including, but not limited to, primary health, mental and allied health services, alcohol and other drug services, youth diversion, youth, sport and recreation, school counsellors, NT Police Officers and Youth Engagement Police Officers, child care) provided by all three tiers of government (Local, Northern Territory, Commonwealth) and the non-government sector in the outlying rural districts of Darwin (ie Humpty Doo, Noonamah, Batchelor), Jabiru, Katherine, Tennant Creek, Alice Springs, Nhulunbuy and remote Indigenous communities.
- b) The development of a data base which clearly identifies the aims and objectives of programs, funding sources, funding amount, funding term and status (ie recurrent vs non recurrent), physical location of service, service delivery area, service provider and, where applicable, outreach service arrangements.
- c) The use of this data to inform:
  - development of funding programs and allocation of grant funding at the Australian Government (in terms of funding programs related to the Stronger Futures policy), Northern Territory Government and Local Government level; and
  - priorities for remote service delivery;
- d) Access to the data base by Local Government Authorities, all Australian Government and Northern Territory Government Departments, service providers, and grant applicants on request.

### **Recommendation 20**

The Committee recommends that, in accordance with the Australian Government's support of Recommendation 12 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), the Northern Territory Government provide funding for a project to identify and link agencies and services involved in the care of young people at risk of suicide. This project should aim to implement agreements and protocols between police, correctional facilities, hospitals, mental health services, telephone crisis support services and community organisations to improve:

- a) awareness by different personnel of suicide prevention roles;
- b) expectations; and
- c) handover procedures and continuity of care for young people at risk of suicide.

### **Recommendation 21**

The Committee recommends that the Northern Territory Government:

- a) fund the Coroner's Office to maintain and provide access to a suicide register.
- b) fund the Department of Health to investigate establishing a regulatory and administrative framework to enable serious incidences of child self-harm to be reported to the Department of Health and the Department to initiate appropriate responses;
- c) table a report on the findings of this investigation in the Legislative Assembly by 30 June 2013.

### **Recommendation 22**

The Committee recommends that the Government establish youth development and community development officer positions within each Shire throughout the Northern Territory to:

- a) Liaise with communities, non-government service providers, and Local, Territory, and Australian Government agencies;
- b) Liaise with and assist the Coordinator of the NT Suicide Prevention Coordination Committee in the monitoring of regional issues relating to self-harm and suicide;
- c) Facilitate regional coordination of youth and community services; and
- d) Facilitate the engagement of communities in the development of community based strategies to build community resilience, address issues relating to youth disengagement, familial and community dysfunction.

### **Recommendation 23**

The Committee recommends that a new Northern Territory Suicide Prevention Coordination Committee be established as a matter of priority and sit within the Department of the Chief Minister, and that:

- a) The Suicide Prevention Coordination Committee must include high level representation from Mental Health, Children and Families, Education and Training, the Office of the Children's Commissioner, NT Police, the Coroners Officer, Australian Government and Non-government Sector.
- b) The Government provide funding for:

- employment of a full time Suicide Prevention Coordinator, a full time Suicide Prevention Research Officer, and a full time Suicide Prevention Administration Officer; and
  - an operational budget to facilitate the work of the Committee.
- c) The Northern Territory Suicide Prevention Coordination Committee incorporate a suicide information clearinghouse function and be responsible for disseminating information to Shires, member agencies and relevant community organisations regarding:
- Suicide prevention, intervention and postvention strategies and training programs;
  - Funding available for suicide prevention, intervention and postvention strategies and training programs;
  - Statistical data relating to the incidence of suicide across the Northern Territory; and
  - Research into suicide in the Northern Territory.
- d) The Northern Territory Suicide Prevention Coordination Committee formulate a 2013-2016 Action Plan as a matter of priority and that:
- Development of the Action Plan utilise a *Working Backwards* approach whereby the desired outcomes are defined at the outset and strategies then developed to achieve these outcomes which clearly identify responsible agencies, resources required, milestones and evaluation methods;
  - The Plan takes into consideration the themes, suggestions and recommendations of this report;
  - The Plan incorporate specific strategies for Indigenous communities, including initiatives to rapidly implement postvention services to Indigenous communities following a suicide to reduce the risk of contagion, and the development of culturally appropriate resources;
  - The Plan incorporate prioritised and costed funding proposals for a mix of suicide prevention, intervention and postvention strategies to be implemented in the first twelve month period of the Action Plan; and
  - The Chief Minister table the Plan in the Legislative Assembly before the 2013 budget sittings.

# 1. CONDUCT OF THE INQUIRY

The Legislative Assembly resolved to establish the Committee on 17 August 2011 and the Committee first met on 29 August 2011, at which time it called for submissions by 30 September 2011.

The call for submissions was advertised in the *Arafura Times*, *Centralian Advocate*, *Darwin Sun*, *Katherine Times*, *NT News*, *Palmerston Sun*, *Tennant & District Times*, *Territory Weekly Regional* and *The Australian*, placed on the Committee's website, and forwarded to the Shires. Radio announcements were broadcast between 9 and 23 September 2011 on CAAMA Radio, Larrakia Radio, PAW Radio, Top End Aboriginal Bush Broadcasting Association (TEABBA) and Aboriginal Resource Development Service (ARDS). The Committee also directly contacted a number of organisations and individuals to advise them of the call for submissions.

The Committee received 46 submissions, which are at Appendix A

The Committee held 10 public hearings in Darwin (6), Alice Springs, Nhulunbuy, Ski Beach, Katherine and four public forums in Tennant Creek, Yirrkala, Bees Creek, and Katherine and a youth forum with the assistance of headspace in Palmerston. Details of the hearings are at Appendix B

Arrangement were made for hearings and a public forum on the Tiwi Islands, first on 25 January and then on 1 and 2 February 2012, but these could not be held due to severe weather and a community funeral. However, the Committee met with the Tiwi Island Shire Council on 3 February 2012.

## 2. BACKGROUND

### 2.1 Introduction

#### 2.1.1 Definitions

##### **Suicide**

**Suicide** is the intentional taking of one's own life. Suicidal behaviour includes suicidal thinking (ideation), planning, attempts and completed suicides. To be classified as a suicide, a death must be recognised as being due to other than natural causes. It must also be established by coronial inquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life.<sup>1</sup>

**Completed suicides** is a term used to refer to deaths by suicide to distinguish from attempted suicides and parasuicides.

**Attempted suicide** is an act of self-inflicted self-harm where the intention was for a fatal outcome but death did not occur.<sup>2</sup> It is often difficult to determine whether an act of self-injury intended death. Intentional self-harm is a phrase often used in association with suicide. Despite the differences, 'people who self-harm are more likely to feel suicidal and are more likely to attempt and complete suicide than people who don't self-harm.'<sup>3</sup> Self-harming behaviour is therefore a serious risk factor for suicide.

**Parasuicides** are attempted suicides where there is no apparent intent to end life.

**Postvention** refers to care, interventions and other support services for individuals, families and communities after a suicide to limit the distress and future negative outcomes that can result from a death by suicide.

##### **Youth**

The Committee's terms of reference were to look at current and emerging issues with youth suicide, with a particular emphasis on youth aged 17 to 25 years of age.

The Macquarie Dictionary defines youth as:

The time of being young; early life; the period of life from puberty to the attainment of full growth; adolescence, the first or early period of anything.<sup>4</sup>

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<sup>1</sup> Australian Bureau of Statistics, 3309.0 - Suicides, Australia, 2005, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3309.0/>, at 11 October 2011

<sup>2</sup> Australian Government Department of Health and Ageing and the Hunter Institute of Mental Health, 'Response Ability', *Attempted Suicides*, <http://www.responseability.org/site/index.cfm?display=134569#ratesage>, at 25 January 2012

<sup>3</sup> Lifeline Australia, The Inspire Foundation, OzHelp Foundation, Centre for Mental Health Research Australian National University, Suicide Prevention Australia, The Salvation Army and Brain and Mind Research Institute, 2010, 'Breaking the Silence', [www.lifeline.org.au/.../Breaking%20the%20Silence\\_Secured.pdf.asp](http://www.lifeline.org.au/.../Breaking%20the%20Silence_Secured.pdf.asp), at 14 December 2011, p 21

<sup>4</sup> Macquarie Dictionary, 4th ed, 2005, Macquarie Library Pty Ltd, p1643

Operational definitions include people 15 to 24 years of age (United Nations<sup>5</sup> and Australian Bureau of Statistics (ABS)<sup>6</sup>) and 12 to 25 (the Department of Children and Families (DCF) and many other agencies and much of the literature on youth development).

The Committee understands that the emphasis on the 17 to 25 age range was put within the terms of reference in response to the existing research already underway into children's deaths and to ensure that older youths were given adequate consideration. While the Committee has maintained this emphasis, it was concerned with issues relating to the suicide of any young people in the Northern Territory. Except where specified, 'youth' is given its general meaning and not delineated by any precise age range.

### 2.1.2 Reason for Inquiry

Suicide is a significant issue for the Northern Territory, occurring across all demographics and locations. The Northern Territory has consistently recorded the highest rate of suicides in Australia since the 1990s.<sup>7</sup> The Northern Territory rate of deaths by suicide is still double the national average despite a slight decrease in the suicide rate in the 2005-09 period.<sup>8</sup> Over that period, the Northern Territory had the highest standardised rate of deaths by suicide, followed by Tasmania, South Australia and New South Wales.<sup>9</sup>

Debate in the Legislative Assembly to establish the Committee and inquiry concentrated on the alarming rate of suicides in the Northern Territory compared to the rest of Australia and the high rate in comparison to other causes of death such as road accidents.<sup>10</sup> Debate centred on the alarming rate of youth suicide, the observed and recorded contagion that can spread through some Aboriginal communities and the need to reduce these statistics using effective intervention and prevention solutions. The importance of more open positive public discourse about the issues was also cited as an important reason for establishing the inquiry.

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<sup>5</sup> United Nations, 'United Nations Report on Global Situation of Youth Shows Changing Trends' <http://www.un.org/events/youth98/backinfo/yreport.htm>, at 6 October 2011

<sup>6</sup> Australian Bureau of Statistics, 'Using Children and Youth Statistics, Defining Children and Youth', <http://www.abs.gov.au/websitedbs/c311215.nsf/22b99697d1e47ad8ca2568e30008e1bc/c04c0f363a929bcfa256fc60025e847!OpenDocument>, at 6 October 2011

<sup>7</sup> Australian Bureau of Statistics, 3303.0, Causes of Death, Australia, 2009. Australian Bureau of Statistics, cited in Submission No. 29, Mental Health Association, Central Australia, 14 October 2011

<sup>8</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>9</sup> Submission No. 18, Department of Health, Attachment A, 4 October 2011,

<sup>10</sup> Hansard Debates, Eleventh Assembly, First Session - 08/08/2011 - Parliamentary Record No: 21, Extract from Daily Hansard, 17 August 2011 (At Appendix B)

### 2.1.3 Overview of Findings

The Committee found that the high rate of youth suicide in the Northern Territory was unacceptable. Young Indigenous men are the highest risk group.<sup>11</sup> The increasing rate of suicides by young girls and women is a worrying emerging trend that needs close attention.<sup>12</sup> Action is required to address the risk factors that lead to this terrible human toll, to help those in crisis, and to assist those who live with the consequences of completed suicides.

The Committee explored the risk factors associated with youth suicides to assist with developing strategies to reduce its incidence. The Committee found that many risk factors can interact with one another to result in a person deciding to take their own life. Major risk factors identified during the inquiry include familial dysfunction, violence and domestic violence, mental health problems, drug and alcohol misuse, social and economic disadvantage, educational disadvantage, lack of employment, cultural and sexual identity issues.

In considering the effectiveness of service delivery towards suicide prevention, the Committee found that a shortage of essential physical infrastructure was limiting the range of programs and services that could be offered to young people in need and the level of training and support for professionals on the ground. This includes crisis and safe accommodation suitable for young people, particularly those suffering from a mental illness, housing for staff in remote and very remote communities and sporting and recreational facilities for young people for social interaction and re-enforcement of positive community values. Improved telecommunications infrastructure to support reliable internet connectivity to allow remote and very remote communities to receive at call outreach support from regional and urban centres would also assist.

The Committee looked at the role of education and training in preventing youth suicide and helping those at risk. The Committee found that young people want mental health awareness and suicide prevention training for their own awareness and to be able to support their peers and direct them to the best help. There is a range of suicide prevention training packages known to be effective for young people in schools, such as MindMatters and KidsMatter, but these have only been delivered in a limited number of schools.

The challenges faced by people working on the frontline of service delivery and support were considered and the Committee found that identifying those at risk as early as possible is a key challenge for frontline professionals. Getting those at risk to the right services was acknowledged as equally challenging. These challenges are exacerbated by access issues such as distance preventing people reaching services, and the availability of appropriate services such as youth specific and culturally appropriate services for high risk groups. Mental Health First Aid and suicide prevention training for

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<sup>11</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Dr Howard Bath, Convenor of Child Deaths Review Committee, p2

<sup>12</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Dr Howard Bath, Convenor of Child Deaths Review Committee, p2

gatekeeper positions such as teachers, nurses, doctors and counsellors are needed across the Territory. The Committee also found that there is a need for professional development and support for staff who deliver suicide prevention programs and services such as through mentoring and incident debriefing.

In considering the level of access to Federal Government support for suicide prevention in the Northern Territory, the Committee found that the Northern Territory is aligned with the relevant Federal Government policies on suicide prevention. This is achieved through projects and programs delivered and funded under the National Strategy for Suicide Prevention, agreements and partnerships through the COAG as well as Federal Government health, infrastructure, education and Indigenous affairs policies and funding packages. Despite the co-operative approach between the two jurisdictions, the Committee found that a complete picture of the availability, uptake and effective use of Commonwealth funding available to the Northern Territory for suicide prevention and related activities, as well as alignment with national and Territory objectives, must be ascertained as soon as possible to ensure efficient resource allocation and effective service delivery.

In looking at the programs and services available in the Northern Territory targeting youth aged 17-25 years, the Committee found a range of service providers delivering effective programs. However, there were some areas such, as the Alice Springs region, where there were a number of programs with similar aims, while at the same time there were gaps in service delivery, particularly in regional, rural, remote and very remote areas. The absence of regular psychological services in remote and very remote areas was found to be a major gap. The lack of youth specific services and culturally appropriate services, as well as training and professional support for staff on the frontline were other major gaps identified. The model of youth mental health service provided by headspace was found to be exemplary and the Committee highlighted the desirability of having this model supported to increase its outreach capacity to remote and very remote areas and replicated in as many regions of the Northern Territory as possible.

The Northern Territory has in place a number measures to support suicide prevention. This includes the delivery of health services, education, policing, community development, infrastructure development and youth justice. However, the Committee found a lack of co-ordination of services across the Northern Territory and on regional bases was a major obstacle to better delivery of appropriate suicide prevention, protection and postvention services. The Committee found that although past attempts by the Northern Territory Government to provide co-ordination for the delivery of suicide prevention programs and services achieved some success, such as the development of the NT Suicide Prevention Action Plan 2009-11, this co-ordination did not succeed into the longer term. The Committee is of the view that a key to improving coordination is mapping the provision of services and funding across the Territory across all levels of government.

The Committee considered key data sources, data collection, reporting and research to better understand the factors that may impede accurate identification and recording of suicides and attempts. The Committee noted that a precise level of deaths by suicide may not be known due to the applicability of definitions to varying circumstances, the

difficulties of knowing or proving a person's intent, and the time required to finally determine cause of death in some cases. The Committee found that recording self-harm injuries and suicide attempts is also very difficult. There are a range of sources of such information, including communities, police and hospitals, but this data is not brought together in any one repository. Lack of reliable and accessible information about levels of self harm hinders our understanding of, and ability to respond to, the problem and the evaluation of such responses.

A number of research priorities must be realised to better support suicide prevention, particularly research focussed on Northern Territory conditions. The first priority was better research into and evaluation of the effectiveness of programs and service delivery models in the Territory so we have a clearer understanding of which programs work and which do not. Further understanding is also needed regarding the benefits and risks of greater awareness and discussion of suicide. The use of electronic social networking and the control of cyber-bullying is a developing area where research needs to catch up with new technologies. Further research has also been called for into the causes of the rising incidence of suicide in Aboriginal communities in recent decades, and more recently in Aboriginal youth and girls. Related to this are understanding the role of violence, substance abuse, mental illness. The means of limiting imitation and contagion could also benefit from further study.

The Committee also considered that a better understanding of the economic cost of suicide and self harm is required to enable policymakers to better prioritise resources in this area.

The Committee found that a youth suicide rate over three times the national average is an issue that must be addressed. While there has been much effort put into addressing this issue, the results to date indicate it has not been enough. Such a complex problem requires multilayered solutions, so the Committee has explored options for reducing the risk factors for suicide, assisting those in need, and responding to completed suicides. In looking at all these options, the overriding theme to emerge has been the need to improve the coordination of service delivery throughout the Territory.

## 2.2 Statistical Overview of Youth Suicide in the NT

### NT youth suicide rates

The rates of youth suicides in the Territory are disturbingly high. The Menzies School of Health Research informed the Committee that for the period 2001-06, the suicide rate for young Territorians aged 15-24 years was 3.5 times the Australian rate.<sup>13</sup> ABS death registration data provided to the Committee by the Department of Health shows that for the period 2002-06, 37 per 100,000 15 to 24 year olds died from suicide. The jurisdiction with the next highest rate was South Australia with 13 per 100,000. For 2009, 11 deaths of 15 to 24 year olds have been determined to be suicide. Approximately 30% of all suicides in the Northern Territory in 2009 were people aged 15 to 24.<sup>14</sup>

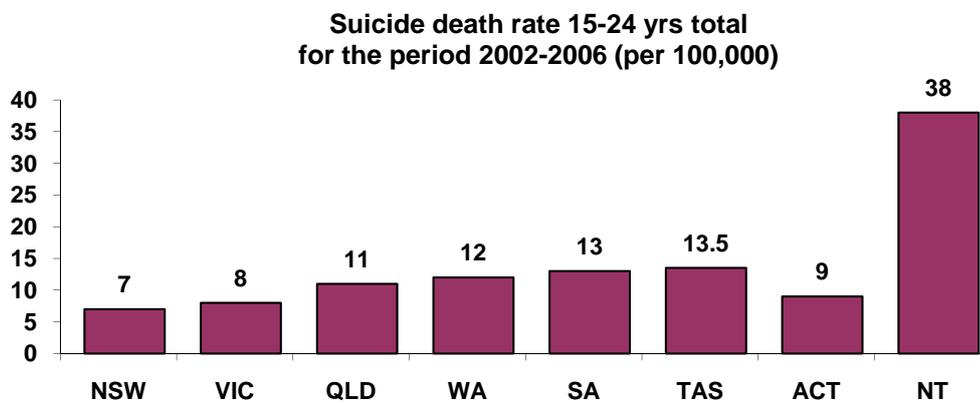


Figure 1 - **Source:** ABS Death Registration Data, reproduced from Submission No. 18, Section A, Attachment 1, p 5

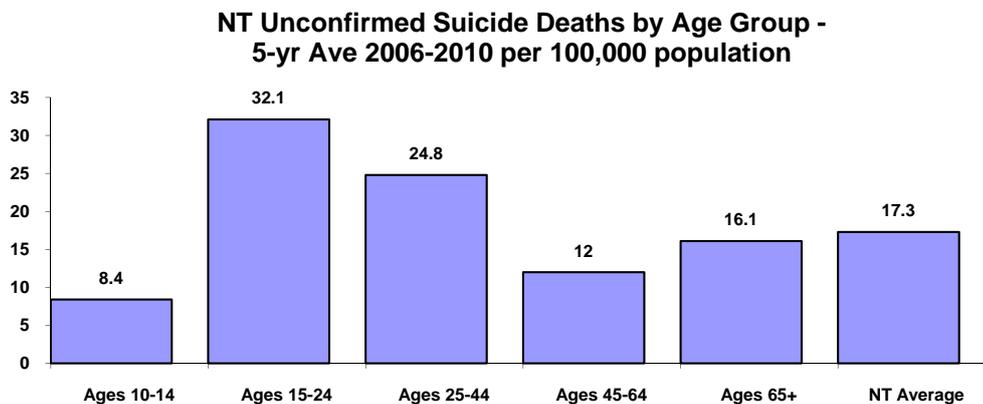


Figure 2 - **Source:** Notifications Territory Coroner's Office, 2005-11 (August year-to-date), reproduced from Submission No. 18, Section A, Attachment 2, p 10

<sup>13</sup> Pridmore, S. and H. Fujiyama (2009) 'Suicide in the Northern Territory, 2001-2006', cited in Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011, p4

<sup>14</sup> Australian Bureau of Statistics, 2011, Cat No. 3303.0, Causes of Death Data 2009, cited in Submission No. 23, headspace, 7 October 2011

Figures supplied by the Territory Coroner on 14 March 2012 showing deaths initially assessed as suicides indicate relative overall stability in numbers in the Territory over the past five years. The clearest trend is a decrease in the rate of non-Indigenous adult suicides. This decrease is largely offset by an increase in Indigenous adult suicides over the same period. With child suicides, there is a decrease in both Indigenous and non-Indigenous suicides around 2009. However, this decrease is not sustained and 2011 levels are close to those of 2007. These figures may differ from the final determinations for suicides for these years but do give an indication of trends in deaths from self harm.

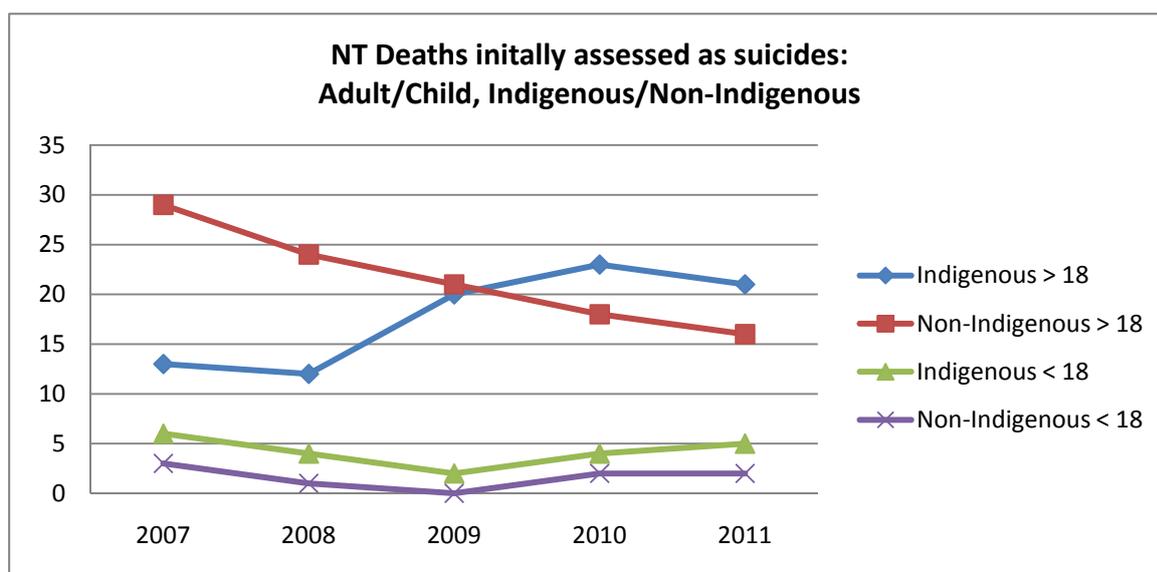


Figure 3 - Source: Territory Coroner's Office, 'Suicide Deaths NT 2007-11', Tabled Paper, Darwin Public Hearing, 14 March 2012

### NT Suicide rate by sex

Males account for the largest proportion of all suicides in the Northern Territory, with a standardised death rate by suicide of 33 per 100,000 for males and 6.3 for females for 2005-09.<sup>15</sup> This is the highest standardised death rate by suicide for males in any Australian jurisdiction for that period, with Tasmania having a rate of 23.2, South Australia 19.1, and Western Australia 18.5. The Territories suicide rate for males is also over twice the national average of 15.6. For Northern Territory women during 2005-09, the rate of 6.3 is the second highest after Western Australia (7.5) and about a third higher than the national rate of 4.4.<sup>16</sup>

<sup>15</sup> Australian Bureau of Statistics, 2011, 3303.0 Causes of Death, Australia, 2009, 'Table 11.5 Suicide(a), State and territory(b), Number of deaths, Age-standardised death rate(c), Rate ratio(d), Sex, 2000–2009(e)(f)(g)(h), [http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/D4B355BE67928750CA25788400129F8A/\\$File/3303.0\\_11%20suicide%20\(australia\).xls#11.5!A1](http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/D4B355BE67928750CA25788400129F8A/$File/3303.0_11%20suicide%20(australia).xls#11.5!A1), at 8 March 2012

<sup>16</sup> Australian Bureau of Statistics, 2011, 3303.0 Causes of Death, Australia, 2009, 'Table 11.5 Suicide(a), State and territory(b), Number of deaths, Age-standardised death rate(c), Rate ratio(d), Sex, 2000–2009(e)(f)(g)(h), [http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/D4B355BE67928750CA25788400129F8A/\\$File/3303.0\\_11%20suicide%20\(australia\).xls#11.5!A1](http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/D4B355BE67928750CA25788400129F8A/$File/3303.0_11%20suicide%20(australia).xls#11.5!A1), at 8 March 2012

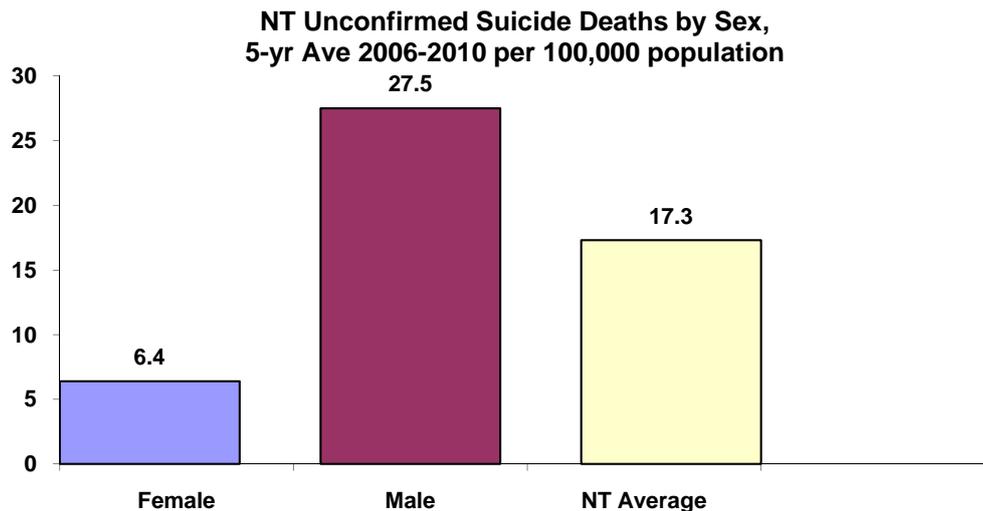


Figure 4 - **Source:** Notifications Territory Coroner's Office, 2005-11 (August year-to-date), reproduced from Submission No. 18, Section A, Attachment 2, p8

There has been a recent worrying increase in the number of girls completing suicide. Forty per cent of the 20 people aged 10 to 17 completing suicide during 2006-09 were female.<sup>17</sup> This contrasts with the slightly older age range of 15 to 24 year olds, of whom 1 of the 11 suicides in 2009 were females.<sup>18</sup>

### NT Indigenous suicide rates

Youth suicide is most acute in the indigenous population in the Northern Territory. For Northern Territory Indigenous children under 15 years of age between 2001 and 2006, the suicide rate was five times the Australian rate.<sup>19</sup> In that same period, for the same age range, there were no cases of suicide of non-Indigenous children in the Northern Territory.<sup>20</sup>

In the 1980s, there was no difference in the suicide rates between Indigenous and non-Indigenous people in the Northern Territory, but since then, rates for Indigenous people have overtaken figures for non-Indigenous.<sup>21</sup>

There is evidence of suicide occurring at an earlier age among Northern Territory Indigenous people compared to non-Indigenous.<sup>22</sup> Comparisons of data between 2001-05 and 2006-10 indicate an increasing rate of suicide deaths of 10 to 17 year old Aboriginal children in the Northern Territory (2001-05 18.8 per 100,000; 2006-10 30.1

<sup>17</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Dr Howard Bath, Convenor of Child Deaths Review Committee, p3

<sup>18</sup> Australian Bureau of Statistics, 2011, cited in Submission No. 20, Suicide Prevention Australia, 6 October 2011, p5

<sup>19</sup> Pridmore, S. and Fujiyama, H., 2009 'Suicide in the Northern Territory, 2001-2006', cited in Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011, p4

<sup>20</sup> Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011, p4

<sup>21</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Dr Howard Bath, Convenor of Child Deaths Review Committee, p36-37

<sup>22</sup> Submission No. 7, Professor Saxby Pridmore and Associate Professor Pim Kuipers, 29 September 2011

per 100,000), whereas the rate for non-Aboriginal 10 to 17 year olds appears to be decreasing (2001-05 4.1 per 100,000; 2006-10 – 2.6 per 100,000).<sup>23</sup> Of the 20 suicide deaths of 10 to 17 year olds during 2006-09, 95 per cent were Aboriginal.<sup>24</sup>

Another concerning aspect of the high rate of Indigenous child suicide is the number of girls taking their lives. Around 40 percent of the 10 to 17 year old Aboriginal people completing suicide during 2006-09 were female.<sup>25</sup>

**Unconfirmed Suicide Deaths by Indigenous indicator,  
5-yr Ave 2006-2010 per 100,000 population**

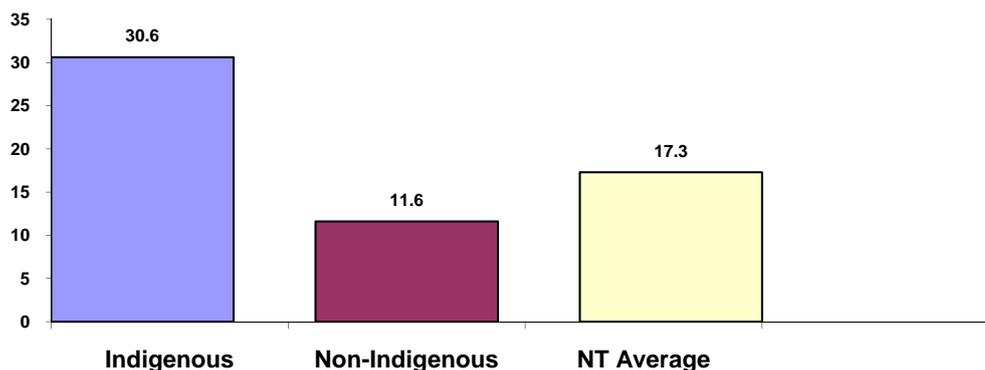


Figure 5 - **Source:** Notifications Territory Coroner's Office, 2005-11 (August year-to-date), reproduced from Submission No. 18, Section A, Attachment 2, p 9

### NT suicide rates by region

Figures supplied by the Department of Health show that, during the period 2006 to 2010, the Health Region with the greatest number of suicides was Darwin Urban, with around 50% of all suicides in the Territory. However, the health Regions with the greatest rate per 100,000 people were Darwin Rural, Barkly and East Arnhem, all of which had a rate over two thirds higher than Darwin Urban.

<sup>23</sup> National Coroners Information System; Shu Qin Li, Health Gains Planning Branch, NT Department of Health, cited in Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011, p4

<sup>24</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Dr Howard Bath, Convenor of Child Deaths Review Committee, p3

<sup>25</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee

### Unconfirmed Suicide Deaths by Health Region, 5-yr Ave 2006-2010

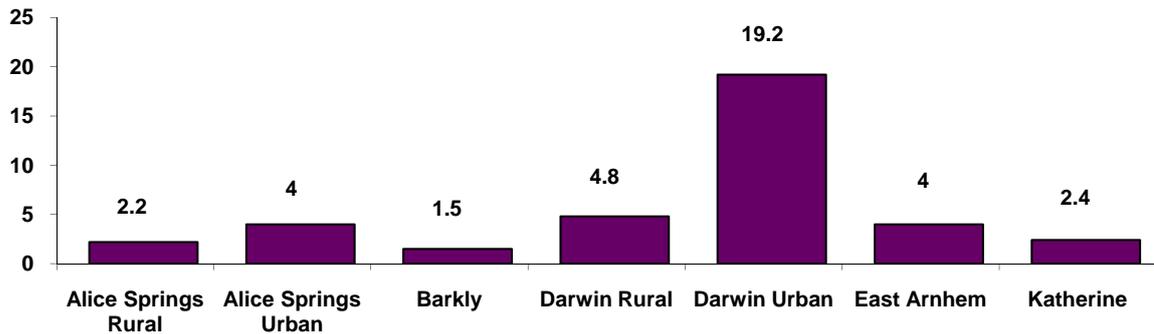


Figure 6 - **Source:** Notifications Territory Coroner's Office, 2005-11 (August year-to-date), reproduced from Submission No. 18, Section A, Attachment 2, p 6

### Unconfirmed Suicide Deaths by Health Region, 5-yr Ave 2006-2010 per 100,000 population

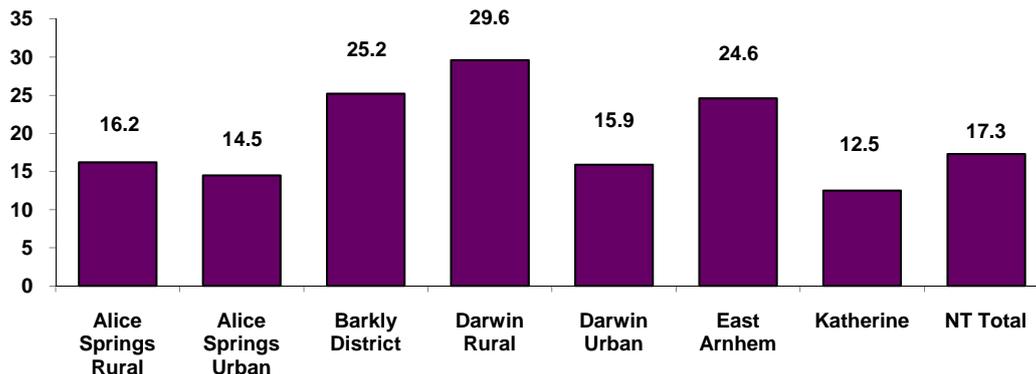


Figure 7 - **Source:** Notifications Territory Coroner's Office, 2005-11 (August year-to-date), reproduced from Submission No. 18, Section A, Attachment 2, p 7

## Australia's suicide rates

In Australia, suicide is the second leading cause of death among young people after motor vehicle accidents.<sup>26</sup> In 2009, 259 Australians aged between 15 and 24 years of age took their own lives.<sup>27</sup>

Rates of youth suicide in Australia have been declining since 1997.<sup>28</sup> Despite the decline, suicide is still the leading cause of death for young men in the 15-24 year age

<sup>26</sup> Royal Children's Hospital Melbourne, 'Youth Suicide in Australia', [http://www.rch.org.au/cah/research.cfm?doc\\_id=11036](http://www.rch.org.au/cah/research.cfm?doc_id=11036), at 9 March 2012

<sup>27</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

group.<sup>29</sup> A comparison of preliminary 2009 Australian data for suicides to previous years indicate a slight decline in numbers for males in the 15-19, 20-24 and 25-29 year age groups and consistency in rates for females in the same age ranges except the 25-29 year age group where an increase is noted.<sup>30</sup>

Suicide rates for young people aged 15-24 years increases with remoteness. For 2003-05, the age-standardised suicide rate in remote and very remote areas was three times higher than in major cities (31 per 100,000 compared to 9 per 100,000 young people).<sup>31</sup> Rates for young males in rural and remote Australia are almost twice the rate of young males living in capital cities.<sup>32</sup>

A comparison of age standardised suicide rates for young people 15 and 24 years of age between 2003 and 2005, showed that the rates were higher for those in the most socioeconomically disadvantaged areas of Australia (13 per 100,000) compared to the least socioeconomically disadvantaged young people (9 per 100,000).<sup>33</sup>

The rates of suicide in Indigenous communities have been increasing since the 1970s.<sup>34</sup> The majority of Indigenous Australians who suicide are under 29 years of age.<sup>35</sup> The rate of suicide in Indigenous communities in Australia may be 40% higher than in non-Indigenous.<sup>36</sup>

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<sup>28</sup> National Suicide Prevention Strategy, Living is for Everyone, 'Youth: Statistics and Trends', <http://www.livingisforeveryone.com.au/Youth.html>, at 9 March 2012

<sup>29</sup> Australian Bureau of Statistics cited in Submission No. 29, Mental Health Association, Central Australia, 14 October 2011 and Submission No. 7, Professor Saxby Pridmore and Associate Professor Pim Kuipers, 29 September 2011

<sup>30</sup> Australian Bureau of Statistics, 2011, 3303.0 Causes of Death, Australia, 2009, Table 11.1 Suicide(a), Number of deaths, 5 year age groups by sex, 2000–2009(b)(c)(d)(e), [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/D4B355BE67928750CA25788400129F8A/\\$File/3303.0\\_11%20suicide%20\(australia\).xls#11.1!A1](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/D4B355BE67928750CA25788400129F8A/$File/3303.0_11%20suicide%20(australia).xls#11.1!A1), at 7 March 2012

<sup>31</sup> National Suicide Prevention Strategy, Living is for Everyone, 'Youth: Statistics and Trends', <http://www.livingisforeveryone.com.au/Youth.html>, at 9 March 2012

<sup>32</sup> Royal Children's Hospital Melbourne, 'Youth Suicide in Australia', [http://www.rch.org.au/cah/research.cfm?doc\\_id=11036](http://www.rch.org.au/cah/research.cfm?doc_id=11036), at 9 March 2012

<sup>33</sup> National Suicide Prevention Strategy, Living is for Everyone, 'Youth: Statistics and Trends', <http://www.livingisforeveryone.com.au/Youth.html>, at 9 March 2012

<sup>34</sup> Royal Children's Hospital Melbourne, 'Youth Suicide in Australia', [http://www.rch.org.au/cah/research.cfm?doc\\_id=11036](http://www.rch.org.au/cah/research.cfm?doc_id=11036), at 9 March 2012

<sup>35</sup> Royal Children's Hospital Melbourne, 'Youth Suicide in Australia', [http://www.rch.org.au/cah/research.cfm?doc\\_id=11036](http://www.rch.org.au/cah/research.cfm?doc_id=11036), at 9 March 2012

<sup>36</sup> Royal Children's Hospital Melbourne, 'Youth Suicide in Australia', [http://www.rch.org.au/cah/research.cfm?doc\\_id=11036](http://www.rch.org.au/cah/research.cfm?doc_id=11036), at 9 March 2012

Suicide death rate 15-24 yrs total for the period 2002-2006 (per 100,000)



Figure 8 - Source: ABS Death Registration Date, reproduced from Submission No. 18, Section A, Attachment 1, p 5

## International comparisons

Youth suicide rates in Australia are higher than many other countries.<sup>37</sup> In a 1992 World Health Organisation (WHO) report on the suicide rates of 24 countries, Australia had the fourth highest rate for 15-24 year olds.<sup>38</sup> For all WHO member countries<sup>39</sup>, suicide is one of three leading causes of death among 15 to 34 year olds.<sup>40</sup> Comparing suicide rates with those of other countries can be misleading due to variances in reporting, collection practices and analysis.<sup>41</sup> In broad terms, Australia's rate of suicide is similar to the United States of America and Canada, higher than the United Kingdom and lower than New Zealand.<sup>42</sup>

<sup>37</sup> Australian Bureau of Statistics, '4102.0 - Australian Social Trends, 1994, Mortality and Morbidity: Youth suicide, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/C8B4C69EC061ACDDCA2570EC00785DC2?opendocument>, at 9 March 2012

<sup>38</sup> Australian Bureau of Statistics, 4102.0 - Australian Social Trends, 1994, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/C8B4C69EC061ACDDCA2570EC00785DC2?opendocument>, at 9 March 2012

<sup>39</sup> Australia is a member of the World Health Organisation

<sup>40</sup> World Health Organisation, Suicide Prevention and Special Programmes, Mental Health, Introduction, [http://www.who.int/mental\\_health/prevention/suicide/country\\_reports/en/index.html](http://www.who.int/mental_health/prevention/suicide/country_reports/en/index.html), at 9 March 2012

<sup>41</sup> Australian Government Department of Health and Ageing and the Hunter Institute of Mental Health, 'Response Ability', *Comparisons with other Countries*, <http://www.responseability.org/site/index.cfm?display=134569#comparison>, at 11 March 2012

<sup>42</sup> Australian Government Department of Health and Ageing and the Hunter Institute of Mental Health, 'Response Ability', *Comparisons with other Countries*, <http://www.responseability.org/site/index.cfm?display=134569#comparison>, at 11 March 2012

## Self Harm & Attempted Suicide

Self-harm and suicide attempts are indicators for risk of completed suicide. Self-harm and suicide attempts are relatively more common among young people.<sup>43</sup> The peak age for youth suicide attempts is between 16 and 18 years.<sup>44</sup> Australian figures for 2005-06 of hospitalisations of young people from intentional self-harm were 196 per 100,000 young people. Between 1996-97 and 2005-06, the hospitalisation rate for intentional self-harm for young people increased by 43%. The proportional increase was greater for females than males and the rate for females was consistently twice as high as males during this period.<sup>45</sup> However, available recorded data on self-harm and suicide attempts may not be showing the complete picture because cases that don't receive a police, medical or hospital response may not be reported or recorded.<sup>46</sup>

In the period 2005-06, self harm hospitalisation rates were almost twice as high among young Aboriginal and Torres Strait Islanders compared to other young Australians. Anecdotal evidence suggests that currently, attempted suicide and threats of suicide, especially in remote Indigenous communities are exceptionally high however there is limited data to confirm this.<sup>47</sup>

For 2005-06, the age standardised rate of young people aged 15 to 24 years living in very remote areas hospitalised for intentional self-harm was twice the rate of young people living in major cities. The age standardised hospitalisation rate was higher for young people who live in the most socioeconomically disadvantaged areas (260 per 100,000) than those living in the least socioeconomically disadvantaged (203 per 100,000).

Northern Territory Police told the Committee that in the period July 2006 to June 2011, police officers responded to 419 attempted suicides of which 196 were young men aged 18 to 25; 153 were young women in the same age bracket and 189 were Aboriginal youth.<sup>48</sup> Data from Northern Territory Police also indicates a higher rate of suicide attempts in regional, rural, and remote areas. Police recorded 239 suicide attempts made by young people aged between 15 and 25 years in rural, regional and remote areas in the period between July 2006 and June 2011. This accounts for over 57% of the number of suicide attempts attended by Police in that period.<sup>49</sup> Of the 239 Police

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<sup>43</sup> Submission No. 20, 'Suicide Prevention Australia', 6 October 2011

<sup>44</sup> Steele, M. M. and Doey, T., 2007 'Suicidal Behaviour in Children and Adolescents. Part 1: Etiology and Risk Factors', cited in Submission No. 12, Menzies School of Health Research, 30 September 2012, p9

<sup>45</sup> National Suicide Prevention Strategy, Living is for Everyone, 'Youth: Statistics and Trends', <http://www.livingisforeveryone.com.au/Youth.html>, at 9 March 2012

<sup>46</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>47</sup> Submission No. 11, Centre for Remote Health, A joint centre of Flinders University and Charles Darwin University, 30 September 2011

<sup>48</sup> Committee Hansard, Darwin Public Hearing, 4 November 2011, Northern Territory Police, Fire and Emergency Services, 4 November 2011

<sup>49</sup> Submission No. 34, 'Northern Territory Police, 18 October 2011, Attachment 1, 'Attempted Suicides from 1 July 2006'

records of suicide attempts in regional, rural and remote areas of the Northern Territory by young people, 218 were Indigenous, 110 were females, and 129 were males.<sup>50</sup>

### **A comment on statistics**

The collection of suicide statistics is a complex matter that is discussed further at section 2.5. Differences of definition and method and purpose of collection make simple comparison problematic. The Senate Committee inquiry recommended reforms to improve the accuracy of suicide statistics including the standardisation of collection practices.<sup>51</sup> Revisions and studies have suggested error margins between around 10 and 30 per cent.<sup>52</sup> With a jurisdiction as small as the Northern Territory, there can also be problems with comparing figures from individual years or regions as they may not reflect trends over time.

While further work is required on improving the data on suicides in Australia and any figure needs to be understood within its context and the potential for errors, a clear picture remains that the youth suicide rates in the Northern Territory are very high compared to the rest of Australia.

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<sup>50</sup> Submission No. 34, 'Northern Territory Police, 18 October 2011, Attachment 1, 'Attempted Suicides from 1 July 2006'

<sup>51</sup> Commonwealth Parliament, Senate Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Canberra, p xvii, Recommendation 2

<sup>52</sup> Commonwealth Parliament, Senate Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Canberra (p17 - ABS revision for 2007 resulted in a 9.2% change. p 16 - Queensland suicide register figures were higher than the ABS. Submission No. 20, Suicide Prevention Australia, 6 October 2011 (p1 – "Official suicide statistics are widely accepted to be underestimated by as much as 20-30%.")

## 2.3 Issues Current and Emerging

The primary issue for the Committee in examining the current and emerging issues with youth suicide was to understand the factors that increased or decreased the likelihood of suicides occurring; the risk and protective factors for suicide. These are examined in 2.3.1 below. The current government policies and funding to address youth suicide are set out in 2.4 and the programs and services being delivered are set out in 2.5. The question of how to decrease these risk factors and increase the protective is addressed in Chapter 3.

Another issue frequently raised in submissions and hearings was the need for better physical infrastructure to both sustain functional communities and enable better service provision. Although it was not seen as a direct risk or protective factor for suicide, it was major theme that arose when discussing suicide prevention. This is outlined at 2.3.2.

The importance of the public understanding of, and attitudes towards, suicide, and education on how to deal with suicidal behaviour, was also a theme consistently raised in evidence. This is examined at 2.3.3.

### 2.3.1 Risk and Protective Factors

Risk factors are the factors that influence the likelihood of an individual becoming suicidal. Risk factors can also be referred to as vulnerability factors. Protective factors reduce the likelihood of suicidal behaviour by improving a person's ability to cope with difficulties and choose positive options instead of suicide.<sup>53</sup> It is understood that people who suicide often have many risk factors and few protective ones.<sup>54</sup> However, risk and protective factors do not explain why many people affected by multiple risk factors do not attempt suicide and why some people with few risk factors and many protective factors take their own life.<sup>55</sup> Nevertheless, understanding the risk and protective factors associated with suicide overall and for risk groups in particular is necessary for developing more effective and long lasting preventative interventions.

Suicide prevention requires activities that promote health and wellbeing at an individual, family and community level.<sup>56</sup> It involves a range of strategies to target the whole population, risk groups and individuals.<sup>57</sup> A person's decision to suicide can be influenced by one or more factors in combination and occurring in a specific and

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<sup>53</sup> Living is for Everyone, Fact sheet 4 Risk and protective factors in suicide prevention, <http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%204.pdf>, at 12 March 2012, p1

<sup>54</sup> Living is for Everyone, Fact sheet 4 Risk and protective factors in suicide prevention, <http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%204.pdf>, at 12 March 2012, p1

<sup>55</sup> Living is for Everyone, Fact sheet 4 Risk and protective factors in suicide prevention, <http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%204.pdf>, at 12 March 2012, p1

<sup>56</sup> Committee Hansard, Darwin Public Hearing, 4 November 2011, Witness: Department of Health

<sup>57</sup> Committee Hansard, Darwin Public Hearing, 4 November 2011, Witness: Department of Health

individual context. Therefore, there is no simple, single or guaranteed solution or approach that can be taken to prevent suicide.

Risk factors can be grouped in a number of ways for better understanding. Certain risk factors are more applicable to some groups but not to other groups, for example, the risk factors for suicide for a young man are generally different to those for a retired older man.<sup>58</sup> Risk factors can be modifiable or non-modifiable; modifiable being those risk factors that can be changed such as a person's perception or reaction to a situation; non modifiable being those risk factors that cannot be changed such as genetic factors, gender and age. The Department of Health divides suicide risk factors into those that are static (non-modifiable), dynamic (changing and changeable) and situational (dependent on the situation).<sup>59</sup> Some risk factors such as substance abuse can be considered static or dynamic depending on the individual and circumstances. The impact of some risk factors can be reduced by interventions such as strengthened social support. Those risk factors that cannot be changed, such as previous attempt at suicide, provide an alert to a heightened risk of suicide when other risk factors come into play, such as a stressful life event.<sup>60</sup>

**Static risk factors** include family violence, sexual abuse, physical health issues, low educational attainment, mental illness, history of substance abuse, history of family suicide, previous self harming behaviour, consequences of inadequate housing and cultural issues.<sup>61</sup>

**Dynamic risk factors** include current suicidal thinking, feelings of depression, abandonment, or hopelessness, current substance abuse, current diagnosis of depression or other mood disorders and other psychiatric illness.

**Situational risk factors** include isolation and loneliness, recent suicide of family or friend, recent loss, bereavement, relationship difficulties and recent stressful events.

## Major Risk Factors Considered During the Inquiry

### *Mental Illness*

There is strong evidence that mental illness is prevalent in many completed suicides.<sup>62</sup> Untreated mental health problems have been associated with many youth suicides.<sup>63</sup> Experiences of mental health issues such as depression can lead to other serious problems including substance abuse, withdrawal from social contact, relationship breakdowns with family, friends and other peers, and poor performance in school and

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<sup>58</sup> Living is for Everyone, Fact sheet 4, Risk and Protective Factors in Suicide Prevention, <http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%204.pdf>, at 14 March 2012

<sup>59</sup> Submission No. 18, Department of Health, 4 October 2011, Section A, Attachment 3

<sup>60</sup> Suicide Prevention Resource Centre, Risk and Protective Factors for Suicide, Massachusetts

<sup>61</sup> Submission No. 18, Department of Health, 4 October 2011, Section A, Attachment 3

<sup>62</sup> The Royal Australian and New Zealand College of Psychiatrists RANZCP, 2010, cited in Submission No. 23, headspace, 7 October 2011, p4

<sup>63</sup> Submission No. 17, Inspire Foundation, 30 September 2011

work.<sup>64</sup> The Committee heard that 26.5% of young Australians between 18 and 24 years of age currently live with anxiety and substance abuse disorders.<sup>65</sup> In 2008, an estimated 31% of Indigenous young people aged 16–24 had high or very high levels of psychological distress.<sup>66</sup> Females were more likely to report high or very high levels (35%) compared to males (26%).<sup>67</sup> Statistics from 2007 showed that 9% of young people aged between 16 and 24 experience high or very high levels of psychological distress and 25% experience at least one mental health disorder.<sup>68</sup> There are higher rates of depression, substance abuse, co-morbidity and post-traumatic stress disorder in Aboriginal and Torres Strait Islander communities especially in rural and remote regions.<sup>69</sup>

The National Survey of Mental Health and Wellbeing 2007 found higher rates of mental health issues in young people. The survey also found that 25% of young people experience a mental health disorder, however less than 10% accessed a service for help.<sup>70</sup> Not seeking help increases the level of risk for these young people. Not only does this statistic indicate the level of help-seeking by young people, it also reflects the challenges for the community and service providers to encourage and engage young people to seek help when they are struggling. The peak age of onset of mental illness is adolescence.<sup>71</sup> Therefore early intervention in mental illness provides the best opportunity for a young person to recover quickly.<sup>72</sup>

### ***Family History of Suicide***

Suicidal behaviour and suicides of parents and siblings have been associated with suicide attempts made by children. Suicidal behaviour by parents, early trauma including maltreatment and sexual abuse are associated with early onset of suicide attempts and with repeated attempts among young people. Children who experience early trauma and abuse as well as parents who have experienced the same, are at a high risk of suicide.<sup>73</sup> Extensive familial studies have shown that suicidal behaviour runs in families.<sup>74</sup> The need for prevention to focus on family suicidal behaviour and early childhood indicators of suicide risk among families at high risk of impaired parenting, identified at the community level and through the child protection system was highlighted

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<sup>64</sup> Submission No. 17, Inspire Foundation, 30 September 2011

<sup>65</sup> Submission No. 17, Inspire Foundation, 30 September 2011

<sup>66</sup> Australian Institute of Health and Welfare, 2011, 'Young Australians Their Health and Wellbeing', Canberra

<sup>67</sup> Australian Institute of Health and Welfare, 2011, 'Young Australians Their Health and Wellbeing', Canberra

<sup>68</sup> Submission No. 14, Alira Capararo, Clinical Psychologist and Lyn Byers, Remote Nurse Practitioner, 30 September 2011

<sup>69</sup> Submission No. 23, headspace, 7 October 2011, p6

<sup>70</sup> Submission No. 23, headspace, 7 October 2011, p4

<sup>71</sup> Kelly, C., 2010, 'Youth Mental Health First Aid: A course for adults who live with, work with or care for adolescents', Psychiatric Disability Services of Victoria, p6

<sup>72</sup> Kelly, C., 2010, 'Youth Mental Health First Aid: A course for adults who live with, work with or care for adolescents', Psychiatric Disability Services of Victoria, p6

<sup>73</sup> For example, Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>74</sup> Menzies School of Health Research, Centre for Child Development and Education, 2011, 'Suicide of Children and Youth in the NT, 2006-2010, Summary of Final Report to the Child Death Review and Prevention Committee'

during the inquiry.<sup>75</sup> Suicide prevention programs also need to address the underlying factors that can influence a person's risk to mental health including housing, alcohol and other drug problems and child safety and protection.<sup>76</sup>

### ***Family Violence, Abuse and Neglect***

There is strong evidence that a background of childhood neglect and abuse is a major contributor to suicide risk.<sup>77</sup> The Children's Commissioner spoke about the devastating long-term effects on children of exposure to violence including its impact on the ability to trust, cognitive flexibility, emotional and behavioural impulse regulation, and self-confidence, as well as interest and engagement in education and other life affirming activities.<sup>78</sup> Further, children with limited social support and limited personal strategies to survive are at high risk of suicide.<sup>79</sup> Positive attributes such as resilience, self-esteem, having a sense of belonging and supportive environments can protect an individual and community from the risk of suicide.<sup>80</sup>

The Convenor of the Child Deaths Review Committee told the Committee that family violence and general family conflict is involved in many of the cases they have looked at. This is reflected in hospitalisation rates, particularly for Indigenous women. In the four year period 2004-05 to 2007-08, the hospitalisation rate in Northern Territory public hospitals of Indigenous women for assault related causes was 82 times greater than for non-Indigenous women.<sup>81</sup> This is echoed in Australian Institute of Health and Welfare (AIHW) figures for the period 2006-08, which show that for every one non-Indigenous female hospitalised for assault, 69 Indigenous women are hospitalised for causes related to assault.<sup>82</sup>

### ***Demographic Risk Factors***

Age, gender, education, income and occupation and other demographics can be risk factors for suicide. The occurrence of high rates of suicide is during the adolescent to early adult years.<sup>83</sup> The Northern Territory has the youngest population in Australia, with 20% aged between 12 and 24 years.<sup>84</sup> Approximately 38% of the Territory's Aboriginal

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<sup>75</sup> For example, Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>76</sup> Submission No. 14, Alira Capararo, Clinical Psychologist and Lyn Byers, Remote Nurse Practitioner, 30 September 2011

<sup>77</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>78</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee, p5

<sup>79</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee, p2

<sup>80</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>81</sup> Department of Health, 2011, 'Hospital Admissions in the Northern Territory, 1976 to 2008', p59; referred to in Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Convenor of Child Death Review Committee

<sup>82</sup> Aboriginal and Torres Strait Islander Health Performance Framework 2010 Report Northern Territory referred to in Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Convenor of Child Death Review Committee, p7

<sup>83</sup> Australian Institute of Health and Welfare, 2011, 'Young Australians Their Health and Wellbeing', Canberra

<sup>84</sup> Australian Institute of Health and Welfare, 2011, 'Young Australians Their Health and Wellbeing', Canberra

population is children under the age of 15.<sup>85</sup> More than 45% of the Territory's Aboriginal population is under 19 years of age compared with 26% of the non-Indigenous Territory population. Forty percent of the population of Central Australia is under 25 years of age.

Adolescents were identified as particularly vulnerable to suicide for reasons including emotional fragility due to identity formation issues associated with growing up. The Children's Commissioner told the Committee that girls and boys between the ages of 10 and 17 are at equal risk of suicide. In addition, pre-existing vulnerabilities can be aggravated by other issues including:

- Media images presenting desirable images which are unattainable by vulnerable adolescents;
- Misuse of electronic media such as mobile phones and social networking sites as vehicles for bullying;
- death of family member or close friend;
- overcrowding at home;
- untreated and unresolved effects of trauma;
- alcohol or drug related problems;
- serious illness or disability; and
- the effects of unemployment of members of the family on children.<sup>86</sup>

The Northern Territory is the most sparsely populated jurisdiction in Australia, having the smallest population spread across the third largest land mass. In 2008, the population of the Northern Territory was approximately 220,000.<sup>87</sup> More than 50% of its population live in the Darwin region and more than 33% live in remote and very remote areas.<sup>88</sup> Seventy percent of the Central Australian population live in remote areas and 24% live in very remote areas.

The geography, the size of towns and communities and the strong bonds between community members means that a suicide can have profound impacts across large areas and affect many residents.<sup>89</sup> The proportion of Territorians living remotely are at high risk of suicide from issues associated with isolation and loneliness, including difficulties accessing regular and appropriate programs and services including follow-up support after a self-harm incident, suicide attempt or completed suicide.<sup>90</sup>

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<sup>85</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011, Attachment 2

<sup>86</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>87</sup> Department of Health, 2011, 'Hospital Admissions in the Northern Territory, 1976 to 2008'

<sup>88</sup> Northern Territory Government, 2011-12 Budget, 'Northern Territory Economy', <http://www.budget.nt.gov.au/papers/econ/4.population.pdf>, at 27 January 2012

<sup>89</sup> Committee Hansard Transcript, Darwin Public Hearing, 24 November 2011, Police Commissioner, NT Police Fire and Emergency Services

<sup>90</sup> Submission No. 14, Alira Capararo, Clinical Psychologist and Lyn Byers, Remote Nurse Practitioner, 30 September 2011

Certain regions of the Northern Territory are thought to be more prone to suicide than other regions. Young people in Arnhemland for example, may have a greater propensity to develop mental illness and this may be further contributing to increased risk of suicide.<sup>91</sup> This may be particularly so within the context of the added risks for the development of severe mental illness associated with drug abuse. Aggressive behaviour associated with obtaining funds from family members to satisfy alcohol and other drug habits as well as distress from drug related debts may further increase vulnerability to suicide.<sup>92</sup>

Young people in regional and rural areas and Indigenous communities are over represented in the suicide statistics.<sup>93</sup> This is reflected in the proportion of Northern Territory Police attendance to suicide attempts made by young people aged between 15 and 25 years in regional, rural and remote communities from 2006 to 2011 (57%).<sup>94</sup> In rural areas, suicide rates have been linked with depression, especially in relation to agricultural productivity and economic difficulties, other psychological distress, issues associated with isolation, and cultural attitudes such as the stigma associated with mental health problems and the desire to be stoic.<sup>95</sup> The picture of suicide risk in rural and remote areas is likely to be underestimated.<sup>96</sup> Research has shown that rates may be 33% higher in rural areas compared to major cities and rising to 189% higher in very remote areas.<sup>97</sup> A Queensland study found that agricultural workers were more than twice as likely to suicide as other members of the general population.<sup>98</sup>

### ***Aboriginal and Torres Strait Islanders***

There is an immediate need to understand the risk and protective factors associated with suicides by Aboriginal and Torres Strait Islander people in order to reduce the extremely high rates. Indigenous Territorians make up 12.5% of the national Indigenous population<sup>99</sup> but comprise more than 30% of the Territory population, the largest proportion compared to other States and Territories.<sup>100</sup> Approximately 80% of Indigenous Territorians live in remote and very remote regions.<sup>101</sup> There are 641 discrete Aboriginal communities in the Northern Territory, 570 of which have populations of less than 200 people and 50 communities with populations ranging between 200 and 1,000 people.<sup>102</sup> In addition to increased risk from issues associated with isolation, high unemployment and low levels of education, these demographics have implications for service delivery.

<sup>91</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>92</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>93</sup> Submission No. 23, headspace, 7 October 2011

<sup>94</sup> Submission No. 34, 'Northern Territory Police, 18 October 2011, Attachment 1, 'Attempted Suicides from 1 July 2006'

<sup>95</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>96</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>97</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>98</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>99</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011, Attachment 2

<sup>100</sup> Northern Territory Government, 2011-12 Budget, 'Northern Territory Economy',

<http://www.budget.nt.gov.au/papers/econ/4.population.pdf>, at 27 January 2012

<sup>101</sup> Northern Territory Government, 2011-12 Budget, 'Northern Territory Economy',

<http://www.budget.nt.gov.au/papers/econ/4.population.pdf>, at 27 January 2012

<sup>102</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011, Attachment 2

This includes access to regular and appropriate allied health services such as psychological services, and inadequate infrastructure to support ongoing community based programs and long-term housing options for staff to deliver training and other programs to communities.<sup>103</sup>

The Committee received extensive evidence about the many significant indicators of the risks that underscore the suicide statistics for Indigenous Australians. From headspace for example these included that:

- Aboriginal and Torres Strait Islanders report higher levels of psychological distress compared with other Australians – 77% reported experiencing at least one major stressor in the past 12 months, most commonly the death of a family member or close friend (42%).
- Aboriginal and Torres Strait Islander communities especially in rural and remote area have higher rates of depression, substance abuse, co-morbidity and post traumatic stress disorder.
- The level of access of community and outpatient mental health services by Aboriginal and Torres Strait Islanders is not equivalent to need.
- The level of access of primary healthcare services and Medicare funded services by Indigenous Australians is lower than non-Indigenous Australians.
- Rates of hospitalisation for mental health related reasons requiring specialised psychiatric care is almost double the rate of other Australians.
- Rates of hospitalisation for mental health related reasons without requiring specialised psychiatric care are approximately three times higher, compared with other Australians.
- Death rates from mental and behavioural disorders for Aboriginal and Torres Strait Islanders are significantly higher than for non-Aboriginal and Torres Strait Islanders.
- Twenty four percent of parents of Aboriginal and Torres Strait Islander Australian children aged 4 to 17 years rated their children to be at risk of serious emotional and behavioural difficulties compared to 15% for other Australians.
- Mental health issues such as depression are more often co-morbid with substance abuse.<sup>104</sup>

In his consideration of suicides by Aboriginal and Torres Strait Islander people, Dr Robert Parker highlighted the destructive effects of unresolved trans-generational trauma (also referred to as Malignant Grief) on the wellbeing of a community and reduced personal resilience for already vulnerable adolescents. Dr Parker discussed the

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<sup>103</sup> For example Submission No. 14, Alira Capararo, Clinical Psychologist and Lyn Byers, 30 September 2011

<sup>104</sup> Submission No. 23, headspace, 7 October 2011

idea that the deceased have a psychological 'life in death' within a small community and along with background factors, may be relevant to reduced personal resilience and increased risk of suicide.<sup>105</sup> Grief, loss and trauma and cumulative effects of ongoing and recurring grief loss and trauma can also increase a person's vulnerability.<sup>106</sup>

Many submissions pointed out that suicide by Indigenous Australians is a relatively recent phenomenon. Prior to the 1960s, there were no references to suicide in historical, medical, or anthropological records, nor in fictional or artistic depictions.<sup>107</sup> Records of Indigenous suicides began in the 1980s.<sup>108</sup> The first reported suicide by an Aboriginal person was in 1981.<sup>109</sup> Aboriginal deaths by suicide increased throughout the 80s and 90s.<sup>110</sup> In the region from Elliot to the Queensland, South Australia and Western Australian borders, an average of 10 suicides are recorded each year and these rates have remained steady over recent years.<sup>111</sup> Suicide deaths by Aboriginal and Torres Strait Islanders currently represent 50% of all suicide deaths in the Northern Territory.<sup>112</sup> Now, the suicide rates for Indigenous males aged 0-24 and 25-34 years are approximately three and four times respectively that of other Australians for each corresponding age range.<sup>113</sup> The suicide rate for young Indigenous women is approximately five times that of non-Indigenous young women.<sup>114</sup> The Committee heard from a traditional healer in Central Australia:

Of course, not everything was perfect and people did have problems, and we know about that. But, we were always able to fix them because of our ability to see what was going on in people's heads and also to understand flow - flow obviously stemming from the brain is a big one and all those big veins and muscles and tendons, and so on that connect big parts of the body. We have always been able to see and understand and work on those strings, particularly if you have blockages, we are able to unblock, get people flowing and working better, and giving people an all-round general feeling of wellbeing, as well as counselling - cultural counselling.

But, when you have these brand new things that we have never really understood and are faced with now, which are problems generated by many other factors but also drug abuse like cannabis, alcohol, and other drugs affect people and affect the flow of people in a way that we have never ever been able to fix – we cannot fix it. Our ancient, traditional skills cannot allow us, or we cannot fix those things. We cannot stop them, we cannot heal them.

Part of my work is obviously to recommend that people see a doctor and we appreciate how well medication works and we encourage people to get on to correct

<sup>105</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>106</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>107</sup> Submission No. 4, Professor Colin Tatz, AO, 23 September 2011

<sup>108</sup> Submission No. 4, Professor Colin Tatz, AO, 23 September 2011

<sup>109</sup> Measey, M., Qin Li, S., Parker, R (2005), *Suicide in the Northern Territory 1981–2002*, Department of Health and Community Services, cited in Submission No. 29, Mental Health Association, Central Australia, 14 October 2011, p10

<sup>110</sup> Australian Bureau of Statistics, 2011, *3303.0- Causes of death, Australia, 2009*, cited in Submission No. 29, Mental Health Association, Central Australia, 14 October 2011, p10

<sup>111</sup> Australian Bureau of Statistics, 2011, *3303.0- Causes of death, Australia, 2009*, cited in Submission No. 29, Mental Health Association, Central Australia, 14 October 2011, p10

<sup>112</sup> Australian Bureau of Statistics, 2011, *3303.0- Causes of death, Australia, 2009*, cited in Submission No. 29, Mental Health Association, Central Australia, 14 October 2011, p10

<sup>113</sup> Australian Bureau of Statistics and Australian Institute for Health and Welfare, 2008, cited in Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>114</sup> Australian Bureau of Statistics and Australian Institute for Health and Welfare, 2008, cited in Submission No. 20, Suicide Prevention Australia, 6 October 2011

medication, because that helps us, but the problems that happen for people, there are many problems that we cannot solve.<sup>115</sup>

The Committee was advised that the high rates of suicide by Aboriginal and Torres Strait Islanders must be seen in the context of poverty and disadvantage that many Aboriginal people experience, particularly those in remote communities where there are barriers to better health from difficulty accessing services, language barriers, inappropriate services and systemic community control.<sup>116</sup> Investments in resourcing communities to lead and engage with their initiatives to build strength and wellness, including young people will result in positive effects on mental health and suicidal behaviour in Aboriginal communities.<sup>117</sup>

### ***Substance abuse as a risk factor***

Approximately 26.5% of Australians aged between 18 and 24 currently live with anxiety or substance abuse disorders.<sup>118</sup> Substance abuse is often co-morbid with mental health issues, such as depression.<sup>119</sup> A review of completed suicides in the Northern Territory found that common factors that were associated with those cases included alcohol and other substance abuse, as well as cyber bullying, recent loss or bereavement, relationship difficulties, mental illness and learned behaviour.<sup>120</sup> Cannabis can reduce metabolism capacity and alcohol also has counterproductive effects, including from excessive consumption, and is known to be linked with depression and suicide.<sup>121</sup>

Alcohol and substance disorders are major contributors to suicide in the NT. Alcohol and substance abuse on their own contribute to risk but in combination with mental illness and other risk factors such as domestic violence and economic deprivation exacerbates the risks.<sup>122</sup> The co-morbidity of alcohol and other drugs with mental health problems is common and elevates the risk of suicide.<sup>123</sup> The common association of alcohol and other drugs with cases of Aboriginal suicide has resulted in specific programs and services being developed to integrate alcohol and other drugs and mental health services into Aboriginal primary health care in the NT.<sup>124</sup>

### ***Recent suicide as a risk factor***

There is a great deal of evidence that suicides by young adults have led to other youth completing suicide, leading to clustering in some communities. Suicide contagion refers to suicides directly related and linked to one another through geography, relationship or

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<sup>115</sup> Committee Hansard, Alice Springs Public Hearing, 10 November 2011, WITNESS: Rubert Peter (spoken in traditional language and translated into English), Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Women's Council, p25

<sup>116</sup> Sub No. 25, Northern Territory Council of Social Services, 7 October 2011

<sup>117</sup> Sub No. 25, Northern Territory Council of Social Services, 7 October 2011

<sup>118</sup> Submission No. 17, Inspire Foundation, 30 September 2011

<sup>119</sup> Submission No. 23, headspace, 7 October 2011, p6

<sup>120</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>121</sup> Submission No. 16, Dr Yolande Lucire, 30 September 2011

<sup>122</sup> Submission No. 20, Suicide Prevention Australia, Part 1, 6 October 2011, p2

<sup>123</sup> Submission No. 28, Aboriginal Peak Organisations, 14 October 2011

<sup>124</sup> Submission No. 28, Aboriginal Peak Organisations, 14 October 2011

method. Imitation and contagion is more common in young people.<sup>125</sup> Contagion is known to be a significant contributor to suicides among children and adolescents, particularly in Aboriginal communities, including urban areas.<sup>126</sup>

The Committee was made aware of a number of suicide deaths of 10 to 17 year olds, especially Indigenous children, almost exclusively by hanging, associated with imitating the suicidal behaviour of older age groups, forming clusters within communities.<sup>127</sup> The Children's Commissioner told the Committee that clustering is a feature of Northern Territory child and adolescent suicides, resulting in complex after effects including feuds and payback responses which can destabilise cohesion within a community.<sup>128</sup> 'Hotspots' for suicide have been identified in urban, rural and remote area based clusters and echo clusters of suicides in the same area.<sup>129</sup>

Menzies School of Health Research believe that clustering in some communities is a reflection and consequence of many risk factors afflicting the community impacting together on vulnerable children.<sup>130</sup> The factors include high levels of alcohol or drug abuse and abuse or neglect.<sup>131</sup> The underlying mechanisms that lead to imitation and clustering of suicide risk need to be better understood.<sup>132</sup>

### **Cyber-bullying**

There is growing evidence of the harm of online or cyber bullying on young people and it has been associated with a number of youth suicides.<sup>133</sup> During the Committee's youth forum, cyber bullying, including through mobile phone technology, was identified as a serious and growing problem for young people.<sup>134</sup> Cyber-bully can be harmful to a person's mental and physical health.<sup>135</sup> Victims can feel isolated and unsafe, leading to loss of self-esteem, feelings of anxiety and shame, leading to depression and to suicide.<sup>136</sup> A case of suicide by a teenager in Victoria in 2009 was found by the Victims of Crime Assistance Tribunal to have resulted from an act of violence (cyber-bullying).<sup>137</sup> This reflects the growing acknowledgement of the risk of suicide from cyber-bullying and the act of bullying as a criminal act. The perpetrator of the bullying can also suffer from

<sup>125</sup> Submission No. 20, Suicide Prevention Australia, Part 1, 6 October 2011

<sup>126</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>127</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>128</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee, p3

<sup>129</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>130</sup> Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>131</sup> Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>132</sup> Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>133</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>134</sup> Committee Hansard, headspace Youth Public Forum, 2 December 2011

<sup>135</sup> Australian Human Rights Commission, 'Cyberbullying, Human rights and bystanders', <http://www.hreoc.gov.au/bullying/cyberbullying/impacts.html#fn11>, at 17 March 2012

<sup>136</sup> Australian Human Rights Commission, 'Cyberbullying, Human rights and bystanders', <http://www.hreoc.gov.au/bullying/cyberbullying/impacts.html#fn11>, at 17 March 2012

<sup>137</sup> ABC News, 30 May 2011, 'Act of violence caused cyber-bullied teen's suicide', <http://www.abc.net.au/news/2011-05-30/act-of-violence-caused-cyber-bullied-teens-suicide/2737266>, at 17 March 2012

his or her bullying through ongoing antisocial and criminal behaviour and further abuse giving in other contexts.<sup>138</sup>

## Protective Factors

To understand and respond appropriately to human weaknesses and illnesses, such as suicidal thoughts or mental illness, it is important to understand what makes people strong – ‘the factors that make life worth living and the factors that build individual health and wellbeing’.<sup>139</sup> In general, health and security and a sense of belonging and connection to the family, social groups and community are important protective factors for suicide prevention. Specific protective factors thought to reduce the likelihood of suicidal behaviour include the presence of a caring and supportive adult, having responsibilities for and care of others, personal resilience such as coping skills, spiritual beliefs, economic security, good physical and mental health, early and effective interventions and treatment, and restricted access to methods of suicide.<sup>140</sup> Protective factors can also include an individual’s attitude and behavioural characteristics as well as environmental factors and culture.<sup>141</sup>

The table below provides examples of risk factors and corresponding protective factors.

**Table 1:** Examples of risk and protective factors

	<b>Risk factors for suicide</b>	<b>Protective factors for suicide</b>
<b>Individual</b>	<ul style="list-style-type: none"> <li>• gender (male)</li> <li>• mental illness or disorder</li> <li>• chronic pain or illness</li> <li>• immobility</li> <li>• alcohol and other drug problems</li> <li>• low self-esteem</li> <li>• little sense of control over life circumstances</li> <li>• lack of meaning and purpose in life</li> <li>• poor coping skills</li> <li>• hopelessness</li> <li>• guilt and shame</li> </ul>	<ul style="list-style-type: none"> <li>• gender (female)</li> <li>• mental health and wellbeing</li> <li>• good physical health</li> <li>• physical ability to move about freely</li> <li>• no alcohol or other drug problems</li> <li>• positive sense of self</li> <li>• sense of control over life’s circumstances</li> <li>• sense of meaning and purpose in life</li> <li>• good coping skills</li> <li>• positive outlook and attitude to life</li> <li>• absence of guilt and shame</li> </ul>

<sup>138</sup> Australian Human Rights Commission, ‘Cyberbullying, Human rights and bystanders’, <http://www.hreoc.gov.au/bullying/cyberbullying/impacts.html#fn11>, at 17 March 2012

<sup>139</sup> Australian Government Department of Health and Ageing, ‘Living is for Everyone, ‘Research and Evidence in Suicide Prevention’, p15

<sup>140</sup> Australian Government Department of Health and Ageing and the Hunter Institute of Mental Health, ‘Response Ability’, ‘Risk and Protective Factors’,

<http://www.responseability.org/site/index.cfm?display=134912>, at 14 March 2012

<sup>141</sup> Suicide Prevention Resource Centre, Risk and Protective Factors for Suicide, Massachusetts

	<b>Risk factors for suicide</b>	<b>Protective factors for suicide</b>
<b>Social</b>	<ul style="list-style-type: none"> <li>● abuse and violence</li> <li>● family dispute, conflict and dysfunction</li> <li>● separation and loss</li> <li>● peer rejection</li> <li>● social isolation</li> <li>● imprisonment</li> <li>● poor communication skills</li> <li>● family history of suicide or mental illness</li> </ul>	<ul style="list-style-type: none"> <li>● physical and emotional security</li> <li>● family history</li> <li>● supportive and caring parents/ family</li> <li>● supportive social relationships</li> <li>● sense of social relationships</li> <li>● sense of social connection</li> <li>● sense of self-determination</li> <li>● good communication skills</li> <li>● no family history of suicide or mental illness</li> </ul>
<b>Contextual</b>	<ul style="list-style-type: none"> <li>● neighbourhood violence and crime</li> <li>● poverty</li> <li>● unemployment, economic insecurity</li> <li>● homelessness</li> <li>● school failure</li> <li>● social or cultural discrimination</li> <li>● exposure to environmental stressors</li> <li>● lack of support services</li> </ul>	<ul style="list-style-type: none"> <li>● safe and secure living environment</li> <li>● financial security</li> <li>● employment</li> <li>● safe and affordable housing</li> <li>● positive educational experience</li> <li>● fair and tolerant community</li> <li>● little exposure to environmental stressors</li> <li>● access to support services</li> </ul>

**Source:** Living is for Everyone, 'Research and Evidence in Suicide Prevention', p14

The relationship between reduced risk and the presence of a protective factor is not straight forward.<sup>142</sup> The same event can affect people differently, depending on their personal circumstances such as their sense of self, ability to cope, beliefs about life and their socio-economic factors and health.<sup>143</sup> Many submissions emphasised the need to build and enhance protective factors to counter risk factors including those associated with geographic, socio-economic and health conditions by focusing on improving education, employment possibilities, health and wellbeing.<sup>144</sup>

A resounding message during the inquiry was the need to establish and build resilience in young people as early as possible as an effective protective mechanism against suicide so they are empowered with the tools and skills to respond positively to difficult life situations and make positive life choices. The Committee believes that herein lies the best opportunities for suicide prevention before suicide has a chance to take seed, by instilling values and strengths in young people for their overall health and wellbeing that can ensure that suicide is not an option for consideration.

### 2.3.2 Infrastructure

Effective, adequate and appropriate levels of infrastructure to facilitate and support the provision of and access to services were identified as current issues associated with youth suicides in the Northern Territory. The Committee found that a shortage of physical infrastructure to support suicide prevention was significantly impeding the

<sup>142</sup> Suicide and Suicide Prevention in Australia: Breaking the Silence, p56

<sup>143</sup> Living is for Everyone, Fact sheet 4, Risk and Protective Factors in Suicide Prevention, <http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%204.pdf>, at 14 March 2012

<sup>144</sup> For example Submission No. 20, Suicide Prevention Australia, 6 October 2011

Northern Territory's ability to address risk factors for suicide and to provide programs and services for those in need. This included lack of youth specific accommodation for mental illness and crisis care, recreation and social facilities, and housing for community members, on the ground staff and visiting professionals to deliver on-going, regular programs and services.

A number of witnesses also identified the need for a safe place for those suffering a crisis to go to.<sup>145</sup> In 2010, the Senate Community Affairs References Committee recommended that Commonwealth, State and Territory Governments provide additional funding for accommodation options for people at risk of suicide and with severe mental illness.<sup>146</sup> This was reinforced by the Northern Territory Department of Health, which recommended expanding the scope of safe houses established in a number of communities to provide a safe environment for individuals at immediate suicide risk. This includes off-site mental health services and support such as 'freecall' 24 hour telephone triage and crisis service to support these safe houses.<sup>147</sup>

Some witnesses noted the lack of places for youth to go to for recreation and social interaction. The Committee found that infrastructure to support more activity-based programs such as sports is very much needed. Several submissions recommended that suicide prevention activities be sport, cultural and artistic based.<sup>148</sup> This includes activity-based programs that build ongoing relationships with mentors, provide opportunities for teamwork and encourage positive behavioural responses to difficulties such as problem solving skills and resilience building.<sup>149</sup> The submission from Prof. Colin Tatz focussed on the importance of sport as part of prevention strategies against youth suicide, arguing that sport can alleviate and defer suicidal ideas and actions, and even deflect or counter them. Sports operate within rules and boundaries that are easily understood and followed, and involve not only those who play but also coaches, umpires, those who contribute to the club and its management and also fans and spectators.<sup>150</sup> At the individual and community level, sport offers participative opportunities that give people a sense of pride and belonging, as well as offering a distraction that can act as a protector against suicide.<sup>151</sup> The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Australian Sports Commission are currently initiating sports based projects in five major Territory communities. Prof. Tatz suggests monitoring suicide and attempted suicide rates in these communities in conjunction with the implementation of these projects to gauge their effectiveness on rates.<sup>152</sup>

A significant constraint on service delivery in a number of locations was a lack of housing for staff to deliver those services. In remote communities, on-ground staff have the

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<sup>145</sup> Submission No. 18, Department of Health, 5 October 2011

<sup>146</sup> Commonwealth Parliament, Senate Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Canberra

<sup>147</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>148</sup> For example Submission No. 18, Department of Health, 4 October 2011

<sup>149</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>150</sup> Submission No. 4, Prof. Colin Tatz, 23 September 2011

<sup>151</sup> Submission No. 4, Prof. Colin Tatz, 23 September 2011

<sup>152</sup> Submission No. 4, Prof. Colin Tatz, 23 September 2011

immediate responsibility to respond to acute situations. Clinical on-ground staff often have limited professional training around mental health and suicide. More staff on the ground in remote communities trained in mental health and suicide response, including therapeutic and crisis intervention services, has been recommended by many submissions.<sup>153</sup> A major infrastructure barrier to achieving this important on-site training and support is the severe housing shortage in remote areas for permanent and visiting staff to be accommodated.<sup>154</sup>

The Central Australian Aboriginal Congress highlighted the following infrastructure challenges for Central Australia to include:

- a large geographic area with small populations scattered across isolated homelands;
- unsealed roads with implications for access and transport; and
- poor housing infrastructure within remote communities for resident population as well as staff.<sup>155</sup>

Transport was identified as a barrier to accessing services. **headspace** spoke about young people in rural and remote areas not being able to get to the services located in regional centres.<sup>156</sup> Batchelor for example, has services provided by the Batchelor Health Clinic, however, the clinic has limited capacity to provide regular support and monitoring. Batchelor is supported by services in Darwin and Palmerston but, due to transport, Batchelor residents have difficulty accessing these services.<sup>157</sup> The Tamarind Centre can only visit the area once a month and this is part of a return trip to provide outreach services to Katherine.<sup>158</sup> Even within urban centres, the availability and cost of travel affects young people getting to services.<sup>159</sup> **headspace** suggested service providers be supported to provide or subsidise transport to their services or consider health professionals going to a young person's space rather than asking the young person to attend the professional's domain.<sup>160</sup>

It has been shown that 90% of 16 to 29 year olds use the internet daily. The proportion of young people who use the internet as their primary source of advice and support grows every year. However, the rate of help seeking for mental health issues has largely remained the same. Seventy to 80% of 16 to 24 year olds who experience a mental disorder are unwilling or unable to receive clinical care. Young people in rural and remote areas are particularly at risk given the high suicide rates in these areas. New and emerging technologies including internet and mobile phone provide opportunities to

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<sup>153</sup> Submission No. 14, Alira Capararo, Clinical Psychologist and Lyn Byers, Remote Nurse Practitioner, 30 September 2011

<sup>154</sup> Submission No. 14, Alira Capararo, Clinical Psychologist and Lyn Byers, Remote Nurse Practitioner, 30 September 2011

<sup>155</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011, Attachment 2

<sup>156</sup> Submission No. 23, headspace – National Youth Mental Health Foundation, 7 October 2011

<sup>157</sup> Submission No. 27, Department of Education, 13 October 2011

<sup>158</sup> Submission No. 27, Department of Education, 13 October 2011

<sup>159</sup> Submission No. 23, headspace, National Youth Mental Health Foundation, 7 October 2011

<sup>160</sup> Submission No. 23, headspace, National Youth Mental Health Foundation, 7 October 2011

enable improvements in the mental health and wellbeing of young people. Information communication technology based services can compliment a range of mental health services from promotion, prevention and intervention.

Infrastructure to support increased online services that appeal to young people was considered during the inquiry. Online services can provide a pathway to appropriate care that is available 24 hours a day, is able to reach rural and remote areas and is able to absorb huge demand for little cost. The Inspire Foundation informed the Committee that with the rollout of the national broadband network further opportunities will emerge to develop and deliver new methods of service delivery including outreach to reach large numbers of people at low cost.<sup>161</sup> The Committee agrees with the Inspire Foundation that investment needs to be made into the kinds of services and programs that young people are willing and able to access, including internet help services.

### **2.3.3 Suicide and Mental Health Awareness Education**

The Committee found that through education and public awareness there are valuable opportunities for positive suicide prevention messages to reach young people and the wider community and to encourage help seeking and reduce stigma associated with mental illness and suicide. The potential for education and public awareness to influence choices and behaviours and the need to capitalise on and invest in this potential was identified by several submissions. Robert Parker of Top End Mental Health recommended that education and public awareness focus on influencing health behaviours and promoting good mental health and empower people with knowledge and information to increase protective factors against suicide.

The Committee learnt about a number of existing school-based mental health training programs that are known to be effective for young people. MindMatters and KidsMatter are two such programs. MindMatters is a national initiative for secondary schools funded by the Commonwealth Government. The program supports the promotion, prevention and early intervention for schools and is based on the WHO Global School Health initiative and National Health Promoting Schools framework. Over the last 10 years, the program has been successfully attended by more than 150,000 participants. The program has been recognised as a leading initiative in secondary schools in Australia. It supports a whole school approach to mental health of young people, including links with community agencies and services, support groups and promoting help seeking. A component of MindMatters involves professional development for staff taking in suicide prevention, self-harm and high risk taking behaviours. MindMatters has worked with Anangu Education Leaders from the Anangu Pitjantjatjara Yankunytjatjara Lands to adapt the MindMatters resources to be culturally appropriate and suitable for Anangu. This has resulted in a high level of local ownership of the program being delivered on the Lands. The direct involvement of the Anangu in identifying and leading delivery processes provides a good example of developing culturally appropriate programs.<sup>162</sup>

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<sup>161</sup> Submission No. 17, Inspire Foundation, 30 September 2011

<sup>162</sup> Submission No. 31, Principals Australia Inc, MindMatters, 14 October 2011

While MindMatters has been well known in urban Northern Territory schools since its introduction 10 years ago, there is no clear indication of its reach to rural and remote schools.<sup>163</sup>

In Northern Territory schools, the choice to deliver a program or service is a decision for each school.<sup>164</sup> For example the Committee was told that MindMatters has only been delivered in a small number of schools.<sup>165</sup> Each school decides if a program is run and which programs to run. Several submissions called for the health and wellbeing of adolescents and young adults to be the focus of expanded prevention programs in schools and to build resilience in young people to deal with the challenges of life, along with programs that strengthen the capacity of families and communities to respond appropriately and effectively to young people in distress.<sup>166</sup>

The Committee learnt about a number of examples of good programs for educational outcomes that could be adopted in the Northern Territory such as the Auruakun (Queensland) School Attendance promotion program and a program run by Professor George Patton with adolescent school students in Melbourne to enhance their ability to make ethical and personally empowering decisions.<sup>167</sup>

The important role that schools play in raising mental health awareness and building resilience highlights the difficulties for those young people who do not attend, or have limited attendance, and thereby do not receive the help and support that schools provide. This was also reflected in the House of Representatives Committee of Health and Ageing recommendation that Federal, State and Territory Governments in partnership with community-based service providers ensure continuity of care for school leavers through referral if necessary.<sup>168</sup>

The Children's Commissioner recommended that the link between school attendance and rates of youth suicide be explored.<sup>169</sup> Truancy can be an indicator of problems in a young person's life and a risk marker of a pathway to self-harm or suicide. One submission suggested that because truancy is reportable, there can be mechanisms in place to trigger responses from schools and service agencies to provide appropriate interventions that can avert passage into a vicious cycle that can lead to depression, self-harm or suicide.<sup>170</sup>

Predominantly, the help seeking behaviour of young people is to turn to friends and family. The Children's Commissioner told the Committee that it is not common for young

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<sup>163</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>164</sup> Committee Hansard, Darwin Public Hearing, 24 November 2011, WITNESS: Gary Barnes

<sup>165</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee

<sup>166</sup> Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>167</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>168</sup> Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, 2011,

'Before it's too late: Report on Early Intervention Programs Aimed at Preventing Youth Suicide', Canberra

<sup>169</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Convenor of Child Death Review Committee

<sup>170</sup> For example, Submission No. 15, Leonore Hanssens, 30 September 2011

people to have accessed or be known by mental health services before their suicide.<sup>171</sup> The Committee found that young people want the skills and knowledge to be able to recognise the signs of a friend or peer in distress and help direct them to appropriate support. One program the Committee learnt about which can provide this training is Save a Mate (SAM), an initiative of the Red Cross that provides education, training, and support to young people on health issues, particularly mental health and alcohol and other drug use. Other well regarded programs include Allied Suicide Intervention Skills Training (ASIST) which provides professionals and community members with the skills to intervene in ways that can save the life of a suicidal young person<sup>172</sup> and SAFEtalk, which is a training program for young people 15 years and over to identify persons with thoughts of suicide and connect them with first aid resources.<sup>173</sup>

The need for training for health support professionals and those in frontline gatekeeper positions such as teachers, doctors, nurses, counsellors and police officers was raised throughout the inquiry. This training includes how to identify those at risk, appropriate interventions including directing those at risk to appropriate help.

The Clontarf Foundation education programs were established in 2000 and commenced with adolescent Indigenous males in Western Australia. The programs aim to improve discipline, life skills and self esteem of young Aboriginal men so that they can participate meaningfully in society. The Foundation currently caters for over 2,500 boys in 45 schools across WA, NT and Victoria.<sup>174</sup> The participation of young Aboriginal men in Clontarf Football Academies has shown significant retention rates for the participants through to completion of secondary school and onto workforce participation. By the end of 2008, 76% of graduates from the 2007 program were employed.<sup>175</sup> In April 2009, 67% of graduates of the 2008 program were in full-time employment.<sup>176</sup> Clontarf Football Academies are now in Alice Springs, Palmerston, the Tiwi Island, Katherine, Tennant Creek, Jabiru, Gunbalanya, Yirrkala, Sanderson and Casuarina.<sup>177</sup> There are approximately 900 students involved in the Clontarf program for 2012, which represents approximately 40% of the eligible young Indigenous boys in the Territory.<sup>178</sup> The Committee heard a first-hand account from a young person who completed a Clontarf program:

They actually, even in Year 12, they help you finish Year 12, as well as continue it on. If you ever needed to talk to someone or need help with something, they will always be there to help the students. They need more programs like that to go into more communities [*inaudible*] to push Aboriginals as well as other people through school, as well as to help them get a job after school. ... It is not, basically, just for

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<sup>171</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee

<sup>172</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>173</sup> Submission No. 13, Megan Lawrance, PhD Student, Menzies School of Health Research, 30 September 2011

<sup>174</sup> Clontarf Foundation, <http://www.clontarffootball.com/>, at 3 October 2011

<sup>175</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>176</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>177</sup> Daily Hansard, Question Transcript, 15 February 2012, Response to Question from Member for Nhulunbuy to Chief Minister

<sup>178</sup> Daily Hansard, Question Transcript, 15 February 2012, Response to Question from Member for Nhulunbuy to Chief Minister

football no more; it is for pretty much most kids in schools which will help them study in school. If they need a hand with homework etcetera, they can always go there. They try and keep them out of trouble at recess and lunch. They give them a room where they can eat, have breakfast, pretty much hang out, make friends. Pretty much they will try and stop any discrimination and if they are mucking up in class and all that, they will go into the class physically and actually try and get them to stop mucking up, and help them with what they are having problems with. With the kids that are actually regularly behaving and all that, they reward them, take them to camps etcetera. Yeah, I finished Year 12 last year with them. If I was not with Clontarf or anything, I probably would have dropped out in Year 11.<sup>179</sup>

The expansion of the Clontarf model to include adolescent girls was recommended to the Committee.<sup>180</sup> The Department of Education told the Committee that similar academies for girls are being established throughout the Northern Territory.<sup>181</sup> Girls Academies have been established at Centralian Middle School and Senior School, Katherine, Palmerston, Rosebery, Jabiru, Gunbalanya, Nightcliff, Sanderson, Dripstone, Casuarina and Tennant Creek.<sup>182</sup> In 2011, 400 young women took part in Northern Territory Girls Academies.<sup>183</sup>

The 2010 Senate Committee inquiry into suicide in Australia acknowledged the need to increase public awareness through a long-term national awareness campaign via a range of media and the release of national estimates on suicide biannually to assist with public awareness on suicide.<sup>184</sup> The Senate Committee also recommended approaches targeting high risk groups, a review of Mindframe guidelines and current media practices for reporting on suicides.<sup>185</sup> The Mindframe National Media Initiative provides guidelines for media reporting on mental illness and suicide to influence and encourage responsible, accurate and sensitive representations for the community.<sup>186</sup> Through the initiative a range of resources are made available to the media, schools and universities, the mental health and suicide prevention sector, film, television and theatre industry, the Police and courts.<sup>187</sup>

Education and awareness programs and strategies targeting the whole community can build strength and resilience at the individual, family and community level and minimise risk factors through relationship building and good parenting. For these to succeed, leadership and mentoring from strong local role models as well as the willing involvement

<sup>179</sup> Committee Hansard, 'headspace Youth Forum', 2 December 2011, Witness: A Witness, p14

<sup>180</sup> For example Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

<sup>181</sup> Committee Hansard, Darwin Public Hearing, 24 November 2011, Witness: Chief Executive Officer, NT Department of Education

<sup>182</sup> Daily Hansard, Question Transcript, 15 February 2012, Response to Question from Member for Nhulunbuy to Chief Minister

<sup>183</sup> Daily Hansard, Question Transcript, 15 February 2012, Response to Question from Member for Nhulunbuy to Chief Minister

<sup>184</sup> Commonwealth Parliament, Senate Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Canberra

<sup>185</sup> Commonwealth Parliament, Senate Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Canberra

<sup>186</sup> Mindframe National Media Initiative, 'Mental Illness and Suicide in the Media', <http://www.mindframe-media.info/site/index.cfm?display=105836>, at 29 February 2012

<sup>187</sup> Mindframe National Media Initiative, 'Resources and Projects under the Mindframe Initiative', [http://www.mindframe-media.info/client\\_images/521027.pdf](http://www.mindframe-media.info/client_images/521027.pdf), a5 29 February 2012

of the community is needed.<sup>188</sup> The Blank Page Summit on Suicide held at the Billard Community Western Australia in 2009 came up with a number of solutions to deal with suicide vulnerability primarily to:

- create suicide-proof communities (e.g. leadership of mental health workers within a community, community education and care of vulnerable individuals);
- train Families to be Families (e.g. parenting skills); and
- encourage self-care through staged support.<sup>189</sup>

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<sup>188</sup> Submission No. 3, Central Australian Aboriginal Congress, Wednesday 21 September 2011

<sup>189</sup> Submission No. 8, Department of Health, Top End Mental Health Service, 29 September 2011

## 2.4 Government Policies and Funding

### 2.4.1 Federal Government Policies and Funding

The principal Federal Government policies and funding related to suicide prevention are outlined below.

#### National Suicide Prevention Strategy

The National Suicide Prevention Strategy (NSPS) is the guiding approach for national policy on suicide prevention in Australia, with emphasis on promotion, prevention and early intervention for mental health. The NSPS aims to:

- Improve the evidence base and understanding of suicide prevention;
- Build individual resilience and the capacity for self-help;
- Improve community strength, resilience and capacity in suicide prevention;
- Take a coordinated approach to suicide prevention;
- Provide targeted suicide prevention activities; [and]
- Implement standards and quality in suicide prevention.<sup>190</sup>

The NSPS is made up of the following four key components.

1. The overarching policy framework is the **Living is for Everyone (LIFE) Framework** which provides a strategic plan for national action on suicide prevention. The Australian Suicide Prevention Advisory Council (ASPAC) supports the framework by providing expert advice to inform national decisions and identify community needs and priorities for the NSPS.
2. The **National Suicide Prevention Strategy Action Framework (NSPSAF)** guides the Australian Government's strategic directions and priorities in suicide prevention for the period 2009-11. Leadership and implementation of the NSPSAF is provided collaboratively by the ASPAC and the Department of Health and Ageing.
3. The **National Suicide Prevention Program (NSPP)** is the Federal Government funding program for suicide prevention activities under the Strategy and covers community-based projects at the local level and national investment at the universal, selective and indicated level<sup>191</sup>, as well as support infrastructure and research. For the period 2009-10 to 2010-11 \$11.6 million has been provided

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<sup>190</sup> Australian Government, 'Mental Health & Well Being, National Suicide Prevention Strategy', <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/national-suicide-prevention-strategy-1>, at 16 February 2012

<sup>191</sup> Classification of programs and services according to target group 'universal'- population or community level, 'selective'- groups at high risk and 'indicated' individuals. Refer to section on Programs and Services for more information.

under the NSPP for targeted services for Aboriginal and Torres Strait Islander communities.

4. Mechanisms to support and promote alignment with and enhancement of State and Territory suicide prevention activities, such as through the COAG National Action Plan for Mental Health 2006-11 and National Mental Health Plan 2009-14.<sup>192</sup>

Total funding attached to the NSPS is \$134.4 million from 2007-08 to 2012-13.<sup>193</sup> The NSPS supports programs in States and Territories. Four projects in the Northern Territory are funded through the NSPS.

1. Access to ATAPS Additional Support for Patients as Risk of Suicide and Self-Harm Demonstration Projects – Additional funding since 2008 from the Department of Health and Ageing to Divisions of General Practice to be able to offer more intensive, prioritised service for people at risk of suicide, such as after clinical hours counselling and call back service. Further to the pilot, in 2010-11, Divisions of General Practice were provided with additional funding to develop infrastructure and referral pathways to specialised allied psychological services for people who have self-harmed, attempted suicide or have suicidal ideation.<sup>194</sup>
2. Mental health resources for Arnhem Land communities – the project through the General Practice Network Northern Territory (GPNNT) enabled the development of resources for Aboriginal Mental Health Workers and community members of north-east Arnhem Land communities. Resources developed included a culturally appropriate manual for mental health issues and a recording on DVD of a story about life choices and resilience building in men. The story is told in Yolngu language, subtitled in English.
3. OzHelp REAL4Mii Northern Territory – the project run through the OzHelp Foundation Ltd aims to build the capacity of workers in building, construction and mining industries in the Darwin region to recognise warning signs of suicide, know where to access support and provide mentoring to colleagues.
4. Suicide Story Training Project – the project run through the Mental Health Association of Central Australia (MHACA) is to deliver the Suicide Story training resource to eight remote Indigenous communities in the Northern Territory, to develop a Train the Trainer Program and deliver two ‘Train the Trainer’ workshops. Suicide Story is a DVD containing short films featuring voices of Aboriginal people

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<sup>192</sup> Australian Government, ‘Mental Health & Well Being, National Suicide Prevention Strategy’, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/national-suicide-prevention-strategy-1>, at 16 February 2012

<sup>193</sup> Australian Government, ‘Mental Health & Well Being, National Suicide Prevention Strategy’, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/national-suicide-prevention-strategy-1>, at 16 February 2012

<sup>194</sup> Living is For Everyone, Projects funded under the National Suicide Prevention Strategy - Northern Territory, <http://www.livingisforeveryone.com.au/ProjectDetails.aspx?pfiler=state&catID=151#>, at 17 February 2012

focussing on nine issues relevant to suicide prevention and which accompanies a three day indigenous specific training.<sup>195</sup>

In 2011, the House of Representatives Committee on Health and Ageing examined early intervention programs for reducing youth suicide and recommended that Federal, State and Territory Governments together with other key stakeholders engage and consult with young people to:

- develop appropriate approaches, strategies, initiatives and programs for youth suicide prevention to be incorporated into the NSPS to ensure an holistic approach;
- evaluate existing measures; and
- share information.<sup>196</sup>

The Select Committee on Youth Suicides in the Northern Territory supports that recommendation to engage and consult with young people and recommends its endorsement through action at the Territory level.

The 2010 Senate Community Affairs References Committee inquiry into suicide in Australia made a number of recommendations for the NSPS including formal commitment with appropriate funding allocation be made through the COAG, and independent evaluation of the NSPS be made with consideration for a new governance and accountability structure external to Government.<sup>197</sup> The Federal Government responded affirmatively to the recommendations. Commitment to consult with State and Territory Governments for formal agreement for funding was given. Funding under the NSPS - National Suicide Prevention Program doubled to \$23.8 million in 2010-11. Funding for suicide prevention was further increased with the introduction of the Mental Health: Taking Action to Tackle Suicide Package, announced in July 2010.<sup>198</sup>

### **Mental Health: Taking Action to Tackle Suicide Package**

The 'Taking Action to Tackle Suicide' is a funding package of \$274 million over four years from 2010-11 to 2013-14 announced by the Federal Government in 2010. The plan has four strategic action areas:

1. Increased frontline services and support for those at greatest risk, including those with severe mental illness and who have attempted suicide. It includes more

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<sup>195</sup> Living is for Everyone, 'Projects funded under the National Suicide Prevention Strategy - Northern Territory <http://www.livingisforeveryone.com.au/ProjectDetails.aspx?pfilter=state&catID=151#>, at 17 February 2012

<sup>196</sup> Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, 2011, 'Before it's too late: Report on Early Intervention Programs Aimed at Preventing Youth Suicide', Canberra

<sup>197</sup> Senate, Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Parliament of Australia, Recommendations 37, 38 and 39

<sup>198</sup> Commonwealth Government of Australia, 2010, 'Commonwealth Response to The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs Reference Committee', Canberra

psychology and psychiatry services, as well as non-clinical support such as assistance with day-to-day needs. (\$115 million)

2. Increased support to communities affected by suicide in the form of direct suicide prevention and crisis intervention, such as increasing the capacity of counselling services and improving safety for hotspots. (\$74.5 million);
3. Increased crisis support services, workplace programs, and campaigns to reduce stigma and encourage help-seeking, particularly targeting men at greatest risk but least likely to seek help. (\$23.2 million);
4. Promoting and building good mental health and resilience in young people to protect children from developing problems later in life that can lead to suicide, including increased services for children with mental health problems. (\$61.3 million).<sup>199</sup>

Further to this funding, in September 2011, the Federal Government announced \$6 million under the Taking Action to Tackle Suicide Package to support new community based suicide prevention services for Indigenous communities. This includes commitment to continuing and expanding the membership of the ASPAC until 2014, developing Australia's first Indigenous Suicide Prevention Strategy and establishing the Indigenous Suicide Prevention Advisory Group.<sup>200</sup>

### **Better Outcomes in Mental Health Care**

The Better Outcomes in Mental Health Care (BOiMHC) program aims to improve community access to quality primary mental health care. There are two parts to the program: the ATAPS program enabling general practitioners to refer patients to allied health professionals and access for general practitioners to patient management advice from psychiatrists.<sup>201</sup>

### **COAG Agreements and Partnerships**

There are three key types of agreements between the Australian, State and Territory Governments under COAG:

1. National Agreements;
2. National Partnership Agreements; and
3. Inter-governmental agreements.

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<sup>199</sup> Commonwealth Government of Australia, 2010, 'Commonwealth Response to The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs Reference Committee', Canberra

<sup>200</sup> The Hon. Jenny Macklin, The Hon Mark Butler MP, & The Hon Warren Snowdon MP, Joint Media Release, 10 September 2011, 'World Suicide Prevention Day - Bringing Experts Together to Tackle Suicide' [http://www.jennymacklin.fahcsia.gov.au/mediareleases/2011/Pages/world\\_suicide\\_prevention\\_100911.aspx](http://www.jennymacklin.fahcsia.gov.au/mediareleases/2011/Pages/world_suicide_prevention_100911.aspx), at 11 September 2011

<sup>201</sup> Australian Government, Department of Health and Ageing, 'Programs, Better Outcomes in Mental Health Care', <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-boimhc>, at 17 February 2012

There are six COAG National Agreements:

1. National Health Reform Agreement
2. National Education Agreement
3. National Agreement for Skills and Workforce Development
4. National Disability Agreement
5. National Affordable Housing Agreement
6. National Indigenous Reform Agreement

National Agreements are not funding agreements although a National Agreement can be associated with a National Specific Purpose Payment (SPP). National Agreements contain objectives, outcomes, outputs, performance indicators, roles and responsibilities for service delivery in the relevant sectors.

National Partnerships are a mechanism to support the delivery outputs or projects, facilitate reforms or provide incentives in the form of rewards for States and Territories that achieve nationally significant reforms. SPPs and project payments as well as investment from the Commonwealth National Building Fund for State and Territory infrastructure projects are National Partnership payments. National Partnerships can include Implementation Plans to achieve specific benchmarks which when reached, trigger payment from the Federal Government.<sup>202</sup> There are many Partnership Agreements for a range of areas including health, education, housing, Indigenous specific areas, infrastructure, environment, and community services.<sup>203</sup>

### ***The National Health Reform Agreement***

The National Health Reform Agreement was signed in August 2011. The Agreement sets out the intention of the Commonwealth, State and Territory Governments to work together to improve health outcomes for all Australians. The Agreement establishes structural changes to the Australian health system, particularly financial and governance arrangements for primary health and aged care. The Agreement recognises that States and Territories have primary carriage of managing the public hospital system but the Federal Government has lead responsibility for general practice and primary health care and program responsibility for aged care.<sup>204</sup>

The Federal Government will contribute at least an additional \$16.4 billion between 2014-15 and 2019-20 based on meeting 45% of efficient growth for 2014-15 and 50% from 2017-18. A proportion of the \$16.4 billion is guaranteed for each State and

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<sup>202</sup> Standing Council of Federal Financial Arrangements, 'National Partnerships', [http://www.federalfinancialrelations.gov.au/content/national\\_partnership\\_agreements/indigenous.aspx](http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous.aspx) at 21 February 2012

<sup>203</sup> Standing Council of Federal Financial Arrangements, 'National Partnerships', [http://www.federalfinancialrelations.gov.au/content/national\\_partnership\\_agreements/indigenous.aspx](http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous.aspx) at 21 February 2012

<sup>204</sup> Council of Australian Governments, 2011, 'National Health Reform Agreement' p23

Territory. If additional growth funding is below \$16.4 billion, the remainder will be provided to State and Territory Governments as top up.<sup>205</sup>

### ***National Partnership Agreement on Mental Health***

The Federal Government has committed \$201.3 million over the next five years under the National Partnership Agreement on Mental Health. Allocation will be through competition by States and Territories for funds from a common pool to ensure that funding targets known gaps in service delivery and improvements are measured against defined outputs and outcomes.<sup>206</sup> The Federal Government specific program responsibilities include prevention, promotion, primary care services, workforce development, employment, support for education, community based social support and targeted programs. The Federal Government will be encouraging States and Territories to improve their mental health systems and ensure better services for people suffering from severe mental illness. This includes accommodation support and presentation, admission and discharge planning with hospitals emergency departments. State and Territory Governments have agreed to fund 50% of the efficient growth in public hospital services from 2014-15, including public hospital services in the community.<sup>207</sup> Details are being negotiated with States and Territories through COAG. The intention of the funding is to provide incentives to States and Territories to address shortfalls and increase accountability. The measures are particularly targeted at people suffering from severe mental illness who frequently attend emergency departments and are in need of stable accommodation as part of the measures to assist their treatment.<sup>208</sup>

### ***10 Year National Roadmap for Mental Health***

A new draft 10 year Roadmap for mental health was released for public comment in January 2012. The draft was developed by all State and Territory Governments. When completed, the 10 year roadmap will replace the COAG National Action Plan on Mental Health 2006-11. The Federal Government has committed \$2.2 billion over five years to build a better mental health system. The Roadmap will provide a long-term national reform plan to guide the focus and funding for mental health for the next 10 years. Key focus areas under the Roadmap are getting to the most vulnerable and hard to reach people, reducing the stigma, discrimination and misunderstanding still surrounding

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<sup>205</sup> Council of Australian Governments, 2011, 'National Health Reform Agreement'

<sup>206</sup> Australian Government Department of Health and Ageing, 'National Mental Health Reform 2011-12, A National Partnership Agreement on Mental Health'  
<http://www.health.gov.au/internet/publications/publishing.nsf/Content/nmhr11-12~nmhr11-12-priorities~Partnership>, at 20 February 2012

<sup>207</sup> Australian Government Department of Health and Ageing, 'National Mental Health Reform 2011-12, A National Partnership Agreement on Mental Health'  
<http://www.health.gov.au/internet/publications/publishing.nsf/Content/nmhr11-12~nmhr11-12-priorities~Partnership>, at 20 February 2012

<sup>208</sup> Australian Government Department of Health and Ageing, 'National Mental Health Reform 2011-12, A National Partnership Agreement on Mental Health'  
<http://www.health.gov.au/internet/publications/publishing.nsf/Content/nmhr11-12~nmhr11-12-priorities~Partnership>, at 20 February 2012

mental illness and ensuring a system that provide all levels of care for people living with a mental illness.<sup>209</sup>

### ***National Partnership Agreement on Remote Service Delivery***

This National Partnership agreement is between the Commonwealth Government and the Governments of New South Wales, Queensland, Western Australia, South Australia and Northern Territory. The National Partnership commits these Governments to address the issues associated with social inclusion, including responses to address Indigenous disadvantage. The agreed objectives under the agreement for remote service delivery are:

- a) improve the access of Indigenous families to a full range of suitable and culturally inclusive services;
- b) raise the standard and range of services delivered to Indigenous families to be broadly consistent with those provided to other Australians in similar sized and located communities;
- c) improve the level of governance and leadership within Indigenous communities and Indigenous community organisations;
- d) provide simpler access and better coordinated government services for Indigenous people in identified communities;
- e) increase economic and social participation wherever possible, and promote personal responsibility, engagement and behaviours consistent with positive social norms.<sup>210</sup>

The 15 larger communities in the Northern Territory identified under the Strategic Indigenous Housing and Infrastructure Program are locations for initial investment under the agreement.<sup>211</sup>

### ***National Partnership Agreements: Closing the Gap on Indigenous Disadvantage***

There are seven Indigenous specific COAG National Partnership Agreements that provide a common framework for State and Territory Governments for outcomes, measures of progress and policy directions to guide Indigenous reform.<sup>212</sup>

1. National Partnership on Closing the Gap in Indigenous Health Outcomes
2. National Partnership on Remote Indigenous Housing

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<sup>209</sup> The Hon Mark Butler MP, and the Hon Jenny Macklin MP, 'Media Release, 17 January 2012, 'A New Ten Year Plan for Mental Health', <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb001.htm>, at 19 March 2012

<sup>210</sup> Council of Australian Governments, National Partnership Agreement On Remote Service Delivery, p5-6

<sup>211</sup> Council of Australian Governments, National Partnership Agreement On Remote Service Delivery

<sup>212</sup> Australian Government Department of Families, Housing, Community Services and Indigenous Affairs, 'Closing the Gap: National Partnership Agreements' [http://www.facs.gov.au/sa/indigenous/progserv/ctg/Pages/national\\_partnerships.aspx#g#g](http://www.facs.gov.au/sa/indigenous/progserv/ctg/Pages/national_partnerships.aspx#g#g), at 21 February 2012

3. Closing the Gap: National Partnership Agreement on Indigenous Early Childhood Development
4. National Partnership on Indigenous Economic Participation
5. National Partnership Agreement on Remote Service Delivery
6. Closing the Gap: National Partnership Agreement on Remote Indigenous Public Internet Access
7. Closing the Gap in the Northern Territory National Partnership Agreement

### ***Closing the Gap: Northern Territory National Partnership Agreement***

The Northern Territory National Partnership Agreement was signed by both Governments in July 2009 and continues until 2011-12. The Australian Government committed \$807.4 million for project areas such as remote policing, substance abuse, community safety, law and justice, support for families, education, language, literacy and numeracy, health, welfare reforms, employment; governance and leadership. The funding under this partnership agreement continued the Northern Territory Emergency Response which is to be superseded by the newly introduced Stronger Futures policy.<sup>213</sup>

### ***Overarching Bilateral Indigenous Plan - NT***

The first COAG Overarching Bilateral Agreement on Indigenous Affairs was signed in 2005 and was in place until 2010. The National Indigenous Reform Agreement was signed in November 2008 and is the basis for the Overarching Bilateral Indigenous Plan. The National Indigenous Reform Agreement covers the overarching objectives, outcomes, outputs, performance indicators and benchmarks committed to by all Governments to achieve through National Partnership Agreements and National Agreements.

The current Bilateral Indigenous Plan Between the Commonwealth of Australia and the Northern Territory of Australia To Close The Gap In Indigenous Disadvantage 2010 – 2015 builds on that first agreement to:

- Align existing Northern Territory Government and Australian Government Indigenous initiatives;
- Align the reporting requirements associated with these activities;
- Engage in joint strategic policy development and planning processes for future activity in the Northern Territory;
- Develop and share evidence and undertake joint planning and implementation of evaluations; and

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<sup>213</sup> Council of Australian Governments, Closing The Gap in The Northern Territory National Partnership Agreement Council of Australian Governments, [http://www.federalfinancialrelations.gov.au/content/national\\_partnership\\_agreements/indigenous/closing\\_the\\_gap\\_in\\_the\\_NT/national\\_partnership.pdf](http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous/closing_the_gap_in_the_NT/national_partnership.pdf), at 20 February 2012

- Make results of evaluations publicly available via the Closing the Gap Clearinghouse in order to build a cumulative body of evidence to inform and improve policy and service delivery for Indigenous Australians.<sup>214</sup>

The building blocks to achieve the Plan's objectives are early childhood, education, health, economic participation, healthy homes, safe communities, governance and leadership.<sup>215</sup> The Northern Territory policies and plans that align with the Bilateral Agreement include 'A Working Future' policy and the 'Northern Territory's Closing the Gap: A Generational Plan of Action.' Programs and services under the National Partnership Agreement will be evaluated in 2011-12 and inform commitments by both Governments in the future.<sup>216</sup>

### ***National Mental Health Commission***

The Federal Government has allocated \$34 million over five years, which includes \$12 million in new funding, to set up the National Mental Health Commission within the Prime Minister's portfolio. The function of the Commission is to monitor, assess and report on the performance and impact of Australia's mental health system for consumers and carers. The first task of the Commission is to produce a National Report Card on Mental Health and Suicide Prevention in 2012.<sup>217</sup>

### **Other Commonwealth Funding Opportunities**

A wide range of other relevant Commonwealth funding opportunities are available including:

- Attorney Generals Community Safety funding;
- Department of Health and Ageing, Indigenous Sport and Recreation Funding;
- Health Heroes Initiative – training for Indigenous health workers; and
- DEEWR: Vacation and After School Care and Indigenous Economic Development Strategy

### **Commonwealth Funding Accessed in the Northern Territory**

The Department of Health provided the Committee with a comprehensive list of current Commonwealth funded programs in the Northern Territory and identified a range of opportunities for further access from recent commitments made by the Commonwealth Government. Active Northern Territory programs funded by the Commonwealth are:

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<sup>214</sup> Australian Government and Northern Territory Government, *Overarching Bilateral Indigenous Plan Between the Commonwealth of Australia and the Northern Territory of Australia to Close the Gap in Indigenous Disadvantage 2010 – 2015*

<sup>215</sup> Australian Government and Northern Territory Government, *Overarching Bilateral Indigenous Plan Between the Commonwealth of Australia and the Northern Territory of Australia to Close the Gap in Indigenous Disadvantage 2010 – 2015*, p4

<sup>216</sup> Australian Government, Budget 2011-12, 'A new National Mental Health Commission [http://www.budget.gov.au/2011-12/content/glossy/health/html/health\\_overview\\_11.htm](http://www.budget.gov.au/2011-12/content/glossy/health/html/health_overview_11.htm), at 20 February 2012

- headspace Palmerston and Alice Springs – funded through the National Youth Mental Health Foundation. A new funding agreement of \$450,000 per site. headspace Top End will receive an additional \$174,000 in discretionary funding per year until 2014. Central Australia headspace will receive discretionary funding of \$144,000 per year until 2014.
- OzHelp and OzHelp Programs for 2010-11 – OzHelp Foundation is a non profit community based mental health support agency focusing on suicide prevention in industry workplaces. OzHelp programs include General Awareness Training (GAT), Safetalk, courses such as Mental Health in the Workplace. The Commonwealth Department of Health and Ageing is one of its major sponsors. The LIFE network and the MHACA are two of its support partners.<sup>218</sup>
- ATAPS Suicide Prevention Services in Darwin (GPNNT) – The Department of Health anticipates the service will be expanded to Central Australia.
- FAHCSIA Youth in Communities program – funded under Closing the Gap in the Northern Territory. Youth in Communities is designed to provide diversion programs for Indigenous youth in the Northern Territory aged between 10 and 20 years of age. Priority is for those at risk of substance misuse, suicide or intentional self-harm and entering or re-entering into the criminal justice system.<sup>219</sup> Twenty-one programs are listed under the Youth in Communities Program, with different durations. Combined funding for these programs is \$25,956,331.<sup>220</sup> Examples of programs include an Australian Football League (AFL) Regional Development Program Manager working in communities to develop programs and competitions around AFL (\$390,000) and Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) and Malaban Health Board Aboriginal Corporation to provide a youth service in Maningrida (\$875,000).<sup>221</sup>
- SAM – Under the program, young people mostly between 18 and 30 years of age are recruited to deliver the services to other young people, 12-25 years of age. The SAM 'our way' Indigenous youth program is funded by BeyondBlue and Red Cross and is currently being delivered in the Northern Territory by the Red Cross.

## **New Commonwealth Funding**

An additional \$1.5 billion over five years has been committed by the Commonwealth Government. The proportion that is available for the Northern Territory is still unclear. The Federal Government 2011-12 Budget includes the following initiatives:

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<sup>218</sup> OzHelp Foundation, 'Introduction', [https://ozhelp.org.au/site/about\\_introduction.php](https://ozhelp.org.au/site/about_introduction.php), at 22 February 2012

<sup>219</sup> Department of Families, Housing, Community Services and Indigenous Affairs, 'Youth in Communities' [http://www.fahcsia.gov.au/sa/indigenous/progserv/families/Pages/youth\\_in\\_communities.aspx](http://www.fahcsia.gov.au/sa/indigenous/progserv/families/Pages/youth_in_communities.aspx), at 1 March 2012

<sup>220</sup> Department of Families, Housing, Community Services and Indigenous Affairs, 'Youth in Communities' [http://www.fahcsia.gov.au/sa/indigenous/progserv/families/Pages/youth\\_in\\_communities.aspx](http://www.fahcsia.gov.au/sa/indigenous/progserv/families/Pages/youth_in_communities.aspx), at 1 March 2012

<sup>221</sup> Department of Families, Housing, Community Services and Indigenous Affairs, 'Youth in Communities' [http://www.fahcsia.gov.au/sa/indigenous/progserv/families/Pages/youth\\_in\\_communities.aspx](http://www.fahcsia.gov.au/sa/indigenous/progserv/families/Pages/youth_in_communities.aspx), at 1 March 2012

- \$571M over five years to expand services and improve coordination for people with severe mental illness;
- \$343.8 M for Coordinated Care for people with severe, persistent mental illness through employment of Care facilitators.
- \$492M over five years for prevention and early intervention mental health services for children and young people; and
- \$419.7M to expand mental health services for teenagers and young adults.<sup>222</sup>

Also part of the broader \$1.5 billion are allocations specifically for suicide prevention initiatives including:

- Boosting the capacity of crisis hotlines e.g Lifeline - \$18.1 million
- Mental Health First Aid training for frontline community workers - \$6.1 million
- Improving safety at 'hotspots' - \$9 million
- Outreach teams to schools - \$18.7 million
- Supporting communities to reduce risk of suicide - \$22.2 million
- Expanding the National Workplace Program - \$11 million
- Increasing the capacity of helplines for men - \$2.8 million
- Targeted campaigns for men's mental health - \$9 million
- Expansion of KidsMatter - \$19.6 million
- Services for children with mental health and developmental issues - \$24 million
- Expanding online mental health and counselling services - \$22.3 million
- Indigenous specific initiatives brought forward under the 'Taking Action to Tackle Suicide' package<sup>223</sup>

Also in 2011, eleven key areas of relevant Commonwealth funding allocation from were also announced. These are:

- \$197.3 million for additional 30 new headspace sites;
- \$222.4 million for 12 Early Psychosis Prevention and Intervention Centres (EPPIC) which focus on providing services to young people aged 16 and 25 years. These initiatives will require matched funds. States and Territories will be required to contribute a minimum of 50% of the operational costs and 100% of capital costs. A more flexible scaled down version is being considered for the Northern Territory.

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<sup>222</sup> Submission No. 18, Department of Health, 4 October 2011, p14

<sup>223</sup> Submission No. 18, Department of Health, 4 October 2011

- \$201.3 million over 5 years under a new National Partnership on Mental Health to address major service gaps in mental health including accommodation, emergency departments and community-based crisis support. Allocation will be through a competitive process. Co-investments from States and Territories will be required.
- \$11M over five years to help build resilience and identify emerging mental health problems early. This includes development of Mental Health and Wellbeing Check to be included in Healthy Kids Check for three to four year olds.
- \$1.5 million for Social Engagement and Emotional Development survey 8 to 14 year olds
- \$61 million to double the number of Family Mental Health Support Services that provide a way for families to get help for their children outside of the clinical mental health system if their child is showing early signs of problems or at risk of mental illness.
- \$220 million over 5 years to improve access to primary health care for people with mental illness.
- \$205 million to expand ATAPS
- \$14.4 million to establish a single mental health on-line portal to provide easy 'One Stop' access to evidence-based online psychological therapy.
- \$32 million to establish a National Mental Health Commission to increase accountability and transparency. This includes \$12 million in new funding. The Commission will fall within the Prime Minister's portfolio and report to Parliament.
- \$2.4 million to increase employment participation for people with a mental illness. This is in addition to funding under the Building Australia's future Workforce Package.<sup>224</sup>

## 2.3.2 NT Government Policies and Funding

### Strategic Framework for Suicide Prevention

The Northern Territory has in place a Strategic Framework for Suicide Prevention (NTSFSP) and the Northern Territory Suicide Prevention Action Plan 2009-2011. Both policies align with the national LIFE framework under the NSPS.

The Strategic Framework has been in place since 2003. The Framework outlines six action areas for suicide prevention.

1. Promoting wellbeing, resilience and community capacity across the Northern Territory

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<sup>224</sup> Submission No. 18, Department of Health, 4 October 2011

2. Enhancing protective factors and reducing risk factors for suicide and self-harm across the Northern Territory
3. Services and support within the community for groups at increased risk
4. Services for individuals at high risk
5. Partnerships with Aboriginal and Torres Strait Islander people
6. Progressing the evidence base for suicide prevention and good practice.<sup>225</sup>

The Action Plan was developed with the participation of the Commonwealth Government. The Action Plan is currently under review and an assessment report is currently being prepared. The Committee was advised by the Department of Health that following consultation, a revised Action Plan for 2012-2014 will be developed in the very near future.<sup>226</sup>

Initiatives under the Action Plan included intervention training targeting all population groups and young people over the age of 15, as well as training workshops to address self-harming behaviour amongst young people. The Northern Territory Government has allocated a further \$2.4 million over three years for suicide prevention. Initiatives include training for frontline workers, increased education in schools and targeted intervention for young people at risk. Strategies include improved data collection and research and targeting of 'hot spots'.<sup>227</sup>

An Interim Report on the Review of the Northern Territory Suicide Prevention Action Plan 2009-11 covered the first year of operation. The primary focus for the first year was on training particularly for workers to better identify and respond to those at risk, risk reduction and promotion of physical and mental health. Key highlights of the first year of implementation included:

- Expansion of mental health and suicide prevention components of the Northern Territory Police Cadet Training Program and development of online modules for serving police officers.
- Training for professionals working with young people who engage in self-harming behaviours.
- Training for staff of Department of Education and Training as part of Child Protection and Mandatory Reporting.
- Development of the 'Suicide Story' training resource.
- Multidisciplinary cross-agency training programs that provide staff with the opportunity to network, exchange skills and knowledge and develop awareness of risk from a broader perspective.

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<sup>225</sup> Northern Territory Government, 2003, 'Northern Territory Strategic Framework for Suicide Prevention', p12

<sup>226</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>227</sup> Submission No. 18, Department of Health, 4 October 2011, Attachment 8

- Strategies such as the development of new risk assessment tools and policy and referral pathways.<sup>228</sup>

## **Territory 2030**

The Northern Territory Government's broad overarching strategic plan contains a number of objectives relevant to young people and suicide prevention. Territory 2030 acknowledges that in order to meet the challenges of health and education, greater investment is required to achieve a greater mix of service providers including private, community controlled and non-government organisations as well as alliances to address the social factors that can contribute to ill health.<sup>229</sup> The strategic plan acknowledges that communities in regional and remote areas, whose populations are mostly Indigenous, are among the poorest in Australia and require a specific set of strategies and policies to address limited economic and employment opportunities, low literacy and numeracy rates and overall poor health.<sup>230</sup> Many of the objectives of Territory 2030 coincide with the steps towards reducing suicide, such as improving education, health and wellbeing, community safety and infrastructure development outcomes.

Each major policy area of Territory 2030 contains objectives and targets towards educational, social, health, economic and environmental outcomes at the population level. At this high strategic level, suicide prevention outcomes are important positive consequences of improved social, economic and environmental conditions.

The educational outcomes under objectives for life-long participation in education, such as the action item of closing the gap for Indigenous students attending government schools to be the same rate as for non-Indigenous students by 2018<sup>231</sup> will increase protective factors against suicide and increase young people's access to programs and services provided through schools for intervention and prevention. The action item to ensure that all Indigenous four-year-olds in remote communities have access to early childhood education within five years will ensure that resilience gets instilled from a very young age. Other actions under this educational objective such as improving Year 11 and 12 enrolments in Territory schools by 2020, to achieve proportional full-time equivalent of students to be at or above national levels, and to increase the proportion of young people aged 15 to 24 in post-school education, training and employment by 2020<sup>232</sup> all go to the heart of the evidence received by the Committee on the opportunities that education provides for suicide prevention including building strength and resilience and raising awareness, as well as preparing young people with the skills and tools to make positive choices for their lives.

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<sup>228</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>229</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p9

<sup>230</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p9

<sup>231</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p50

<sup>232</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p50

Relevant objectives under Territory 2030 for 'Society' include affordable and appropriate housing to meet the varying needs of Territorians, improving access to accommodation, ensuring public safety that includes the safety of children from all forms of abuse and investing in and valuing the people of the Territory, their cultures and communities. A key target under this objective is the development of an approach to social inclusion with a people-centred focus and linked-up Government response by 2012.<sup>233</sup> Another key target of relevance to suicide prevention is improving Indigenous employment rates.<sup>234</sup>

Under 'Economic Sustainability', a key objective is Investment and infrastructure, with a major target being the development of a rolling Infrastructure Plan for roads, power, water, sewerage and telecommunications. Release of a plan for high-speed broadband is planned for 2012. These objectives are relevant to the findings of the Committee on the need to ensure an appropriate level and quality of infrastructure to improve service delivery including telecommunications that can improve outreach to regional and remote communities.<sup>235</sup>

Under Health and Wellbeing in Territory 2030, the health of Territorians is acknowledged as representing the extremes to be found in Australia. On the extremes of poor health are chronic diseases, mental illnesses as well as conditions of poor lifestyle such as alcoholism, smoking related illnesses and heart disease. The appalling level of health outcomes for Indigenous Territorians is also acknowledged and linked to social disadvantage and poverty.

A major objective under the theme of 'Health and Wellbeing' is 'Reforming the Territory Health system' to ensure that all Territorians will have improved access to essential healthcare services by 2030 and all Territorians will have better understanding of their own health matters and the health system and be more engaged in the care of their own health.<sup>236</sup> This change in approach focuses on prevention and is relevant to the evidence considered by the Committee on the need to increase the levels of mental health literacy in the community so that young people and the community can recognise the warning signs and find help or direct a person in need to the get the right help as soon as possible.

Another major target under 'Health and Wellbeing' is to achieve excellence in the delivery of remote area health services including Indigenous health services through linking education, research and policy with service provision. A primary action under this target is the establishment of an institute for education and child development, a health research and training precinct in Darwin and linked to Alice Springs.

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<sup>233</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p28

<sup>234</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p28

<sup>235</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p35

<sup>236</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p46

For young people, under 'Health and Wellbeing', a key target is to achieve major gains in the health and wellbeing of young Territorians including reduced hospitalisation rates, decreased number of children being treated for acute, chronic and preventable conditions including from vaccination and reduced childhood obesity to below national levels.<sup>237</sup> Of direct relevance to suicide prevention, under this target reduce rates of youth suicide by implementing innovative programs and learning from recent successful local and national programs.<sup>238</sup>

### **Other Northern Territory Government Policies**

Policies that build stronger and healthier communities can contribute to suicide prevention. The primary policies that may impact on youth suicide in this regard include:

- A Working Future
- Every Child Every Day
- Housing the Territory National Partnership Agreement on Remote Indigenous Housing (NPARIH incorporating SIHIP)
- Enough is Enough Alcohol Reforms
- Initiatives under a Safe Territory
- A New Era in Corrections
- Review of Youth Justice
- 10 year Infrastructure Plan

#### ***A Working Future***

*A Working Future* is the Northern Territory Government's plan to strengthen services to remote communities, outstations and homelands through a hub and spoke service delivery model. The 21 Growth Towns are Ali Curung, Angurugu, Borroloola, Daguragu/Kalkarindji, Elliott, Galiwin'ku, Gapuwiyak, Gunbalanya, Lajamanu, Maningrida, Milingimbi, Ngukurr, Ntaria (Hermannsburg), Numbulwar, Papunya, Ramingining, Umbakumba, Wadeye, Wurrumiyanga (Nguui), Yirrkala and Yuendumu.. The key areas under the plan are:

- Early childhood outcomes of Indigenous children including access to quality early childhood education and services, including child and family centres.
- Schooling to ensure improved overall literacy and numeracy for Indigenous children and youth to meet basic literacy and numeracy standards, with a long-term

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<sup>237</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p50

<sup>238</sup> Northern Territory Government, 'Territory 2030: Strategic Plan 2009' [http://www.territory2030.nt.gov.au/doc/T2030\\_Strategic\\_Plan.pdf](http://www.territory2030.nt.gov.au/doc/T2030_Strategic_Plan.pdf), p50

view of increasing the number of Indigenous people successfully transitioning from school to further study and or work.

- Health outcomes for Indigenous Australians comparable to the standards of the broader population, including increasing access to suitable and culturally appropriate primary health and preventative services.
- Economic participation increased through increased depth and breath of skills and capabilities for the labour market.
- Healthy homes ensured through equality of opportunity to the same housing options as other Australians including improved amenity and reduced overcrowding, especially in remote areas.
- Safe communities that ensure Indigenous children and families are safe and protected from violence and neglect in their home and communities, including reduced alcohol and substance abuse in remote communities. Alcohol management plans are part of this objective and have been developed to reduce alcohol-related harm in all Territory communities not just Growth Towns. These plans are overseen by Alcohol Reference Groups with representatives from local government, service providers, relevant Northern Territory Government agencies such as Police, DOJ and DOH. Alcohol Management Plans currently exist in Alice Springs, Tennant Creek, Katherine, Palmerston, Groote Eylandt and the East Arnhem region. Plans are under development or consideration in Timber Creek, Borroloola, Jabiru and the West Arnhem region and Elliott.<sup>239</sup>
- Governance and leadership objectives to ensure that Indigenous communities are empowered to participate in policy making and program implementation.

The Territory Government has adopted the COAG national targets for *Closing the Gap on Indigenous Disadvantage*. The implementation of the *A Working Future* policy and the Remote Service Delivery National Partnership Agreement will be complementary.<sup>240</sup> Both Commonwealth and Territory Governments are working together to provide long-term funding. The Territory Government is working with local people to plan for the future of their local economy and support new enterprises. An Indigenous Economic Development Strategy has been developed by the Commonwealth Government which contains a number of strategies and targets relevant to the Northern Territory's implementation of *A Working Future* policy including essential services infrastructure, new or refurbished community stores and manager accommodation across the Northern Territory, increased dental follow-up services and increase the police presence in remote communities in the Northern Territory with five new permanent police stations.<sup>241</sup>

<sup>239</sup>Tackling Anti-Social Behaviour, 'Alcohol Management Plans', <http://www.asb.nt.gov.au/alcohol.html>, at 19 March 2012

<sup>240</sup> Australian Government and Northern Territory Government, *Overarching Bilateral Indigenous Plan Between the Commonwealth of Australia and the Northern Territory of Australia to Close the Gap in Indigenous Disadvantage 2010 – 2015*

<sup>241</sup> Australian Government, *Indigenous Economic Development Strategy 2011–2018*, [http://www.indigenous.gov.au/wp-content/uploads/2011/12/ieds\\_2011\\_2018.pdf](http://www.indigenous.gov.au/wp-content/uploads/2011/12/ieds_2011_2018.pdf), at 18 March 2012

The National Partnership Agreement on Closing the Gap also integrates a number of initiatives commenced under *Closing the Gap of Indigenous Disadvantage: A Generational Plan of Action*, developed by the Northern Territory Government in response to the *Inquiry into the Protection of Aboriginal Children from Sexual Abuse (Little Children are Sacred)* report into child abuse and neglect in the Northern Territory. Reporting against *Closing the Gap on Indigenous Disadvantage* targets in remote areas and an evaluation of remote service delivery is required yearly.

Another aspect of *A Working Future* is the development and implementation of a Regional Integrated Transport Strategy to ensure access to employment, services and programs. Regional passenger bus trials are currently underway in Katherine, Alice Springs and Gove. In terms of the Gove Peninsula Bus Service, the Committee notes that this has proven to be successful; with the service carrying over 12,700 passengers in the first year of operation. Feasibility studies have also been completed for bus services in the remote towns of Wadeye and Maningrida.

Under the Digital Regions Initiative National Partnership Agreement, \$6.6 million as a part of a three-year \$16.4 million funding package has been provided by the Northern Territory Government to enhance services in Territory Growth Towns including video conferencing, tele-health for clinicians and e-learning initiatives for students and employees.<sup>242</sup> These developments will support outreach and support services to remote communities as recommended by many submissions during the inquiry.

**Local Implementation Plans** are being developed Under the National Partnership Agreement on Remote Service Delivery for the 21 Growth Towns.<sup>243</sup> Local Reference Groups in each community in consultation with Territory and Commonwealth Governments are setting the priorities for their community under each of the key areas under *A Working Future* and their LIPs contain targets, actions measures of success and timelines to achieve these priorities. So far LIPs have been signed for 13 communities - Angurugu and Umbakumba, Yirrkala, Yuendumu, Ntaria (Hermansburg), Numbulwar, Galiwin'ku, Milingimbi, Gapuwiyak, Lajamanu, Ngukurr, Gunbalanya and Wadeye.<sup>244</sup>

### ***Every Child Every Day Strategy 2010 - 2012***

The Strategy aims to improve enrolment, attendance and participation of children and young Territorians in Northern Territory schools. The Strategy works from the approach that getting children to school every day is everyone's business. The five key priority areas are:

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<sup>242</sup> Computer World, Tech World, 6 May 2011, 'NT makes first e-health contributions' [http://www.techworld.com.au/article/385551/nt\\_makes\\_first\\_e-health\\_contributions/](http://www.techworld.com.au/article/385551/nt_makes_first_e-health_contributions/), at 21 March 2012

<sup>243</sup> Northern Territory Government, *A Working Future*, 'Local Implementation Plans' [http://www.workingfuture.nt.gov.au/Overview/Local\\_Implementation\\_Plans.html](http://www.workingfuture.nt.gov.au/Overview/Local_Implementation_Plans.html), at 19 March 2012

<sup>244</sup> Northern Territory Government, *A Working Future*, 'Local Implementation Plans' Which communities have signed a Local Implementation Plan?, [http://www.workingfuture.nt.gov.au/Territory\\_Growth\\_Towns/Which\\_communities\\_have\\_signed.html](http://www.workingfuture.nt.gov.au/Territory_Growth_Towns/Which_communities_have_signed.html), 19 March 2012

1. Ensuring that parents and communities share the same beliefs and understandings about the importance of school and regular attendance for the future of the education and future of the child and that in turn will help to encourage and establish good patterns of attendance from as early as possible.
2. Ensuring high quality leadership in schools and at the department level and involving parents to improve enrolment, attendance and participation. A key strategy under this priority area of relevance to suicide prevention is new processes for dealing with absenteeism including working closely with individuals and their families to address the issues and improve attendance as well as punitive measures if necessary.
3. Ensuring that schools are safe and welcoming places for children and young people to attend, through building strong relationships within the schools and ensuring that, if needed, children are referred to the appropriate help and support. This is of direct relevance to suicide prevention because children and young people need to feel that school is a safe, supportive and welcoming place and if they are struggling with any issues, they can access help through their school. One of the key strategies under this priority area of relevance to suicide prevention is the alignment of mental health and child protection resources through the creation of a dedicated Manager of Mental Health and Child Protection. Other relevant key strategies include teaching the ‘Keeping Safe’ child protection curriculum which involves a rigorous process of engaging with the community to allow families and schools to talk about the wellbeing of students and promote schools as safe places, the expansion of the Remote School Counsellor program, early intervention for students with special needs and partnerships with non-Government organisations such as Clontarf Academies.<sup>245</sup>
4. Building strong partnerships with parents, businesses and the community to promote and ensure that regular attendance at school is taken as everyone’s responsibility. Key strategies under this priority area of relevance to suicide prevention include schools working with parents, businesses and communities to create agreements to support and improve enrolment, attendance and participation; integrated child and family services to ensure that parents and communities can access support and help so their children have the best chance at succeeding in life.
5. Promoting and creating relevant and interesting learning pathways for students so that children and young people want to engage in learning and see the value and importance in their education for their future. Key strategies of relevance to suicide prevention include universal access to early childhood education where strength and resilience building can begin, incentives for attendance such as scholarships

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<sup>245</sup> Northern Territory Government, Every Child, Every Day, The Action Plan, 2010 – 2012, A Smart Territory

for high attendance and ensuring an understanding of pathways to work, further education or training for students through regular attendance.<sup>246</sup>

Although not bound by the Northern Territory Government policy, the 34 non-government schools are encouraged to take up the Every Child, Every Day action plan and strategy.<sup>247</sup>

### ***National Partnership Agreement on Remote Indigenous Housing (incorporating SIHIP)***

The NPARIH is a joint housing program between the Commonwealth Government, the States and the Northern Territory for the 'provision of housing for Indigenous people in remote communities and to address overcrowding, homelessness, poor housing condition and severe housing shortage in remote Indigenous communities.'<sup>248</sup> Although funding is from the Commonwealth Government, each State and the Northern Territory are to deliver the new houses, rebuilds and refurbishments. For the Northern Territory the aim of the program is to deliver 934 new houses, 415 rebuilds of existing houses and 2,500 refurbishments across 73 remote Aboriginal communities and a number of community living areas or town camps by 2013. The program focuses on the importance of better housing for healthier families, stronger communities and to enable other community development such as economic growth through employment and training.<sup>249</sup> Almost \$700 million is being spent across remote regions of the Territory in the joint program.<sup>250</sup>

### ***Enough is Enough Alcohol Reforms***

The reforms were introduced in 2011 to reduce the per capita consumption of alcohol in the Northern Territory to the National Average, reduce the negative impacts associated with alcohol misuse, provide sanctions by limiting access to known problem drinkers who commit alcohol-related crime and anti-social behaviour and provide pathways to treatment.<sup>251</sup> The reforms include:

- New and amended legislation to support the 'Enough is Enough' Alcohol Reform;
- Introduction of the Banned Drinker Register (BDR);
- Alcohol Court Reform and the establishment of the Alcohol and Other Drugs (AOD) Tribunal;

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<sup>246</sup> Northern Territory Government, 'Every child, every day, The Strategy, 2010 – 2012', A Smart Territory

<sup>247</sup> Northern Territory Government Department of Education and Training, 'Every Child, Every Day', <http://www.det.nt.gov.au/teachers-educators/school-management/enrolment-attendance/every-child-every-day>, at 19 March 2012

<sup>248</sup> Council of Australian Government, National Partnership Agreement On Remote Indigenous Housing, p1

<sup>249</sup> Northern Territory Government, 'National Partnership Agreement on Remote Indigenous Housing', [http://www.housing.nt.gov.au/remotehousing/strategic\\_indigenous\\_housing\\_and\\_infrastructure\\_program](http://www.housing.nt.gov.au/remotehousing/strategic_indigenous_housing_and_infrastructure_program), at 19 March 2012

<sup>250</sup> Northern Territory Government, Strategic Indigenous Housing Infrastructure Program, <http://www.housingnt.nt.gov.au/Public/Strategic%20Indigenous%20Housing%20and%20Infrastructure.html>, at 19 March 2012

<sup>251</sup> Northern Territory Government, 'Enough is Enough Alcohol Reform Report, July 2011 to December 2011', p1

- Training and resource provision for health care providers across the Territory; and
- Communication and awareness campaigns.<sup>252</sup>

The social harms from the misuse of alcohol cost the Northern Territory approximately \$642 million per year.<sup>253</sup> Based on Northern Territory Police statistics, in its first six months of implementation, reported alcohol related assaults were found to have reduced overall by 5.1%.<sup>254</sup> The reforms are part of a long-term strategy to reduce alcohol consumption so clearer results of improvements from these alcohol reforms can really only be gauged in the long-term.

### ***Other Initiatives under a Safe Territory***

A range of existing Northern Territory Government initiatives grouped under 'Safe Territory' are of relevance to suicide prevention. These include:

Safe Houses – as part of the Australian Government Family Support Package, the Northern Territory Government has committed funding to June 2012 to help establish and open 20 *Safe Places* and two urban houses in 15 remote communities across the Northern Territory. The aim is to provide increased safety options in remote communities for women and children to escape violence and places for men and young people to cool down. The function of safe houses within each community is also to provide education to help reduce family violence and intervention as well as promote individual and family wellbeing. *Safe Places* working closely with Police, Night Patrols and clinics in communities to deliver their programs and services.

### ***Domestic and Family Violence Reporting***

Mandatory reporting of domestic and family violence to Police came into effect in the Northern Territory in 2009, with \$15 million allocated over three years for a range of initiatives to support the introduction of the reform. This has included the establishment of a Domestic and Family Violence Policy Unit in the DCF, staged public awareness campaign firstly on the new mandatory reporting requirement and to encourage Territorians to help reduce the impacts of domestic and family violence through reporting and more recently targeting violent men's behaviour and attitudes, encouraging those men to stop and think about their actions to avoid resorting to violence. The Domestic and Family Violence Policy Unit also provides online resources and delivers information sessions throughout the Territory.

Funding under the initiative has included increased specialist crisis accommodation across the Territory, counselling and support services including hospital emergency department based domestic and family violence workers.

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<sup>252</sup> Northern Territory Government, 'Enough is Enough Alcohol Reform Report, July 2011 to December 2011', p1

<sup>253</sup> Northern Territory Government, 'Enough is Enough Alcohol Reform Report, July 2011 to December 2011', p1

<sup>254</sup> Northern Territory Government, 'Enough is Enough Alcohol Reform Report, July 2011 to December 2011', p5

The Northern Territory Government is a party to the COAG 12 year National Plan to Reduce Violence Against Women and their Children, 2010-2022. The DCF is involved in developing and implementing the Northern Territory's Implementation Plan.<sup>255</sup>

### ***Review of Northern Territory Youth Justice System***

The strategic review sought to:

- identify emerging issues and trends in youth justice that might affect the achievement of the *Territory 2030* and *A Working Future* goals and outcomes,
- evaluate the impact of existing legislation, policy and practice, recommend strategies for dealing effectively with young offenders;
- recommend ways to enhance the ability of Government agencies and communities to provide services to help reduce youth offending especially Indigenous offenders;
- and propose future policies, programs and practices for youth justice with particular focus on vulnerable groups, such as Indigenous youth, young people with a mental health issues, young women and culturally diverse groups.

The Review acknowledged that targets under the two strategic policies considered will affect youth justice in the Territory, encompassing education, training, health and wellbeing, early childhood development, reducing the rates of youth suicides, reducing alcohol consumption and other substance abuse, increasing Indigenous employment, social inclusion and road safety. The review also acknowledged the link between mental health and alcohol and other drugs, and associations with youth suicide.<sup>256</sup> The Review found that many young people in the criminal justice system have substance abuse issues, that these levels are increasing and many of these young people have never been treated or undergone rehabilitation for substance misuse.

Effective early intervention and preventive programs were found by the Review to reduce some young people's changes of offending. This included reconnection and healing programs for helping young Indigenous youth including for mental health and healing programs that reconnect young Indigenous people with their cultural identity.<sup>257</sup> Residential rehabilitation facilities, such as youth camps, were also found to offer help by providing therapeutic treatments and other services for young people as well as provide an alternative to being held in remand in a detention facility where they can receive a range of effective interventions they cannot receive while in detention. Youth rehabilitation camps can also be a place for transition from detention to post release and

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<sup>255</sup> Northern Territory Government, [http://www.safeterritory.nt.gov.au/stopping\\_violent\\_crime/domestic\\_violence\\_reporting.html](http://www.safeterritory.nt.gov.au/stopping_violent_crime/domestic_violence_reporting.html), 19 March 2012

<sup>256</sup> Northern Territory Government, 2011, 'Report of the Review of the Northern Territory Youth Justice System', p34

<sup>257</sup> Northern Territory Government, 2011, 'Report of the Review of the Northern Territory Youth Justice System', p40

help young people safely integrate back into the community and possibly reduce recidivism.<sup>258</sup>

### **10 year Infrastructure Plan**

The Northern Territory Government is developing a 10 year infrastructure strategy to help guide development and prioritise requirements for the Northern Territory. Linked to the Territory 2030, the strategy will help to support Government priority areas for investment. The Strategy will cover all infrastructure under the responsibility of the Northern Territory Government that is provided by local government, the Federal Government and the private sector. The Territory's 2011-12 Budget has allocated \$1.5 billion to infrastructure.

### **Safe Children, Bright Futures Strategic Framework 2011-15**

The Safe Children, Bright Futures Strategic Framework 2011-15 is Northern Territory Government's response to the board of inquiry into the child protection system in the Northern Territory. The Board of Inquiry found that the child protection system in the Northern Territory was under significant pressure and dealing with challenges relating to receiving and responding to notifications, assessing and investigating children at risk, recruiting and supporting foster carers and monitoring family-based and residential care services. The Northern Territory key reforms areas are:

- Keeping Kids Safe
- Supporting and Strengthening Families
- A Strong and Effective Legal Framework
- Working Together
- Our People
- Healing, Growing, Walking Together
- Building a Better, Stronger, More Accountable System.

The key reforms under the Strategic Framework are:

- Reducing the backlog of child protection investigations;
- A new Department and a new structure;
- A strong Aboriginal community sector;
- Supporting foster carers;
- New partnerships and ways of working together;

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<sup>258</sup> Northern Territory Government, 2011, 'Report of the Review of the Northern Territory Youth Justice System', piv

- Building community capacity;
- A stronger legal framework; and
- Caring for our people.

Each strategy under the Framework is for the protection of children and the delivery of programs and services that provide this protection. Therefore all the strategies under the Framework are directly relevant to suicide prevention and intervention through ensuring the safety, health and wellbeing of children. Support for the frontline professionals who provide help and support for children is also covered in the Framework and also relevant to suicide prevention. Important actions under the Framework that relate to suicide prevention include:

- Establishing Child Safety and Wellbeing Teams and localised child safety and wellbeing plans in all Territory Growth Towns and elsewhere.
- Increase the number and scope of the current and planned child and family centres in Territory Growth Towns.
- Trial the use of existing remote area infrastructure to promote child and family safety and wellbeing.
- Develop an investment framework for child and family services.

## 2.4 Programs and Services

### 2.4.1 Types of Services

Programs and services for suicide prevention can be divided into 'universal' - targeting the entire population or community, 'selective' - targeting groups at high risk and 'indicated' - aimed at identifying and treating individuals.<sup>259</sup> Programs and services may also be considered to be of more than one type. The approach behind universal programs and services is general improvement of the capacity of individuals in a population to recognise the signs and risks, seek help or help others.<sup>260</sup> Selective programs and services must be customised for the group and reflect the beliefs, needs, concerns and issues of the group. Indicated services are dependent on identifying individuals at risk. The continuity of care following a self-harm incident or suicide attempt was identified as another limitation of indicated programs and services.

### Universal Services and Programs

Universal services and programs available in the Northern Territory include:

- telephone support lines such as Lifeline, Kids Helpline, Mensline and Parentline;
- online websites such as reachout.com, headspace online;
- social networking sites such as Facebook where people have created networks for people affected by suicide to share stories and support one another e.g. Brothers-in-Arms for service members affected by suicide;
- organisational, professional and community networks linked by common goals for prevention such as Darwin Region Indigenous Suicide Prevention Network (DRISPN) and Top End Suicide Prevention Network (TESPN) and Galupa Marngarr Suicide Prevention Network (GMSPN);
- training programs, seminars and workshops for professionals and those in positions that may require them to respond to a cry for help or completed suicide such as ASIST, Wesley LifeForce programs, Salvation Army Hope for Life programs, and Mental Health First Aid courses;
- public awareness and education campaigns such as 'Too Many Too Soon' Youth Suicide Prevention Program, Are you OK Day?, World Suicide Prevention Day, International Safer Internet Day, motivational speakers such as celebrity and sporting personalities visiting communities and schools delivering positive messages about life.

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<sup>259</sup> Australian Government, National Suicide Prevention Strategy, <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/content/national-suicide-prevention-strategy-1>, at 16 February 2012

<sup>260</sup> Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, 2011, 'Before it's too late: Report on Early Intervention Programs Aimed at Preventing Youth Suicide', Canberra

The Committee received information from many service providers about the programs and services available. Some of the programs and services are described below.

**Wesley LifeForce** has delivered suicide prevention training seminars and workshops to the Australian community for the past 20 years. They have delivered four suicide prevention workshops in the Top End to 58 community members. Wesley LifeForce with the support of the community has helped to establish the three community networks DRISPN, TESPN and GMSPN. These networks bring together community services, professionals and individuals to promote and allow the co-ordination of community activity to address issues around suicide, tailored to local situations and needs.<sup>261</sup> Several submissions called for these networks to be expanded into other regional centres with hubs in remote areas such as Tiwi Islands, Maningrida, Ntaria (Hermannsburg) and Santa Teresa.

**The Salvation Army Hope for Life** deliver a number of programs for suicide prevention such as its Champions Program, where their officers visit communities and speak to people and leave leaflets in the community for people who don't want to speak to an officer but may want to know where to turn for support. Another program delivered by the Salvation Army is the Question Persuade Refer (QPR) Suicide Prevention program that teaches participants to recognise the warning signs of suicide and the skills to direct a person to the right help.<sup>262</sup> The Salvation Army is delivering its Living Hope Bereavement Support training service providers and community workers in the Northern Territory to provide bereavement support to individuals and families.<sup>263</sup>

**Mental Health First Aid** training provides training for professionals providing interventions to people with mental health problems and suicidal thoughts until an appropriate professional treatment is received or the situation is resolved.<sup>264</sup> The Mental Health First Aid training is recommended for frontline professionals such as police officers, prison officers, teachers, social, health, welfare and community workers including youth workers, nurses, counsellors and therapists, lawyers, security officers and anyone in a team leader/ management role.<sup>265</sup> The training program is delivered by the Mental Health First Aid Training and Research Program under the auspices of Orygen Youth Health Research Centre, University of Melbourne. By increasing knowledge, the program can also help to reduce stigma and increase supportive action.<sup>266</sup>

The **ASIST** program is widely regarded as an effective training program that provides professionals and care givers with the skills to recognise and intervene in ways that can

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<sup>261</sup> Submission No. 40, Wesley LifeForce Suicide Prevention Program, 7 December 2011

<sup>262</sup> Salvation Army, Hope for Life, 'QPR Suicide Prevention'

<http://suicideprevention.salvos.org.au/training/qpr-suicide-prevention>, at 7 February 2012

<sup>263</sup> Personal Communication, Envoy Alan Staines OAM, Director, The Salvation Army Suicide Prevention–Bereavement Support Services with Committee Chair, 5 October 2011

<sup>264</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>265</sup> Mental Health First Aid, 'What is Mental Health First Aid?', <http://www.mhfa.com.au/cms/>, at 18 March 2012

<sup>266</sup> Mental Health First Aid, 'What is Mental Health First Aid?', <http://www.mhfa.com.au/cms/>, at 18 March 2012

save the life of a young person contemplating suicide. The program is delivered by Mental Health Services, Lifeline, and Anglicare.<sup>267</sup>

**Accidental Counsellor, Central Australia** is a training workshop developed by Lifeline Central Australia for people who are not trained counsellors but might find themselves in situations where they are in the counselling role e.g reception staff<sup>268</sup>

**The Life Promotion Program** in Central Australia is based in Alice Springs and Tennant Creek and co-ordinated by MHACA. The program provides suicide prevention, education and training and a co-ordinated response to suicide in the region. This program also created 'Suicide Story' in collaboration with Aboriginal communities.<sup>269</sup>

The **Dulwich Centre Foundation** provides a narrative program trialled in South Australia (Port Augusta) and Northern Territory (Yirrkala and Gunyangara). The program is a community approach that engages at least two communities encountering similar problems to exchange stories and messages over a period of time. Each stage of the process was developed by each community in response to the conversations being shared.

**Safetalk**, Central Australia and Top End is a training program for frontline workers and community members focussing on teaching recognition and engagement with people who might be having thoughts of suicide and then connect them with community or professional help. The program can also be run for young people over 15. Anglicare are also funding an Indigenous trainer to deliver the program in language within communities that have been experiencing high rates of self-harm behaviour.<sup>270</sup>

### Selective Programs and Services

Selective programs and services available in the Northern Territory targeting risk groups such as youth and Indigenous youth include:

- Youth friendly and specific programs and services such as headspace and reachout.com;
- Youth programs delivered in the community including diversionary programs and sport and cultural programs;
- School-based youth specific awareness and training programs such as MindMatters and KidsMatter; and
- School focused academies such as Clontarf for young men and the soon to be established academies in Darwin for young women that encourage sporting endeavour with academic achievement.

<sup>267</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>268</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>269</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>270</sup> Submission No. 18, Department of Health, 4 October 2011

- Social services and programs such as assistance for unemployed e.g. job centres and homeless people e.g. Supported Accommodation Assistance Program (SAAP);
- Children's programs and services such as the Maternal, Child and Youth Health (MCYH) Program and the Healthy School-Age Kids (HSAK) program;
- Youth justice and diversionary programs such as restorative justice approaches like youth justice conferences which are an alternative to the more formal court processes;<sup>271</sup>
- Parenting programs such as Strong Women, Strong Babies, Strong Culture Program<sup>272</sup>;

Brief descriptions of some of the programs and services that are available follow. **headspace** youth mental health units are established in Palmerston and Alice Springs. headspace provides early intervention mental health services for young people aged between 12 and 25 years. headspace was established in 2006 and has provided services to more than 45,000 young people through their 30 metropolitan, regional or remote centres in Australia.<sup>273</sup> The work of headspace focuses on community engagement, raising awareness, providing training and education, policy advocacy and contributing to building knowledge through evidence based treatment.<sup>274</sup> Specific services provided by headspace include assistance and advice on physical health, drug and alcohol counselling and vocational assistance with an overall aim of empowering young people to seek help as early as possible.<sup>275</sup>

The Inspire Foundation established the **reachout.com online program** in 2007 to provide an early intervention and prevention service to young people 14 to 25 years of age. The online service has approximately 1.3 million hits per year. In the last 12 months, 1,500 young people in the Northern Territory accessed the services of reachout.com. The Foundation's user surveys show that its online services are making a positive impact on mental health literacy. The Foundation works with young people to develop its programs and services.<sup>276</sup> In 2010, the Foundation along with a number of partners including Orygen Youth Health Research Centre, Brain and Mind Research Institute and Australian National University established the Co-operative Research Centre for Young People, Technology and Wellbeing (the CRC) and a number of international partners. The CRC is driven by young people, academic, youth organisation and services, business and government with a shared vision for a society in which all young Australians grow up in healthy and safe communities. The research program of the CRC is founded on evidenced based research and knowledge to support

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<sup>271</sup> Relationships Australia, 'Youth Diversion Program' <http://www.nt.relationships.org.au/services/services-for-youth>, at 1 March 2012

<sup>272</sup> Australian Indigenous InfoNet, 'Strong Women, Strong Babies, Strong Culture', <http://www.healthinonet.ecu.edu.au/key-resources/programs-projects?pid=357>, at 9 February 2012

<sup>273</sup> Submission No. 23, headspace – National Youth Mental Health Foundation, 7 October 2011

<sup>274</sup> Submission No. 23, headspace – National Youth Mental Health Foundation, 7 October 2011

<sup>275</sup> Submission No. 23, headspace – National Youth Mental Health Foundation, 7 October 2011

<sup>276</sup> Submission No. 17, Inspire Foundation, 30 September 2011

the development of accessible products, services and policies that will benefit young people. The research program explores the potential of technologies, the role they play in young people's lives and how they can be used to help young people deal with the challenges they face.<sup>277</sup>

**Suicide Story** is an indigenous specific training tool to help Indigenous communities and families create safe communities and homes. It is a DVD containing short films featuring voices of Aboriginal people focussing on nine issues relevant to suicide prevention and which accompanies three days of specific training. The DVD also aims to increase understanding about suicide and provide the skills necessary for intervention.<sup>278</sup>

The **Danila Dilba Youth Services Program** has supported Indigenous youth in Palmerston for almost 10 years.<sup>279</sup> The Youth Services Program provides advice and support to young Indigenous people on any matters or issues of concern including medical and emotional and social wellbeing. This is achieved through one-on-one support and group activities designed to help develop skills, confidence and leadership skills. Referrals to other appropriate services is also provided. The Youth Services Program also provides a drop-in centre where young people can feel safe, meet and interact and seek advice and support.<sup>280</sup> Danila Dilba also offers specific programs for young Indigenous girls and women in the Palmerston area.

**Talc Head Indigenous Youth Healing Program** is a youth program developed by local Indigenous men and women through the Balunu Foundation to address the youth at risk population in the Top End.<sup>281</sup> The program targets young people aged 14 to 17 years with consideration given to 11 to 13 year olds in exceptional circumstances. The target group is disadvantaged indigenous youth at risk, typically those demonstrating anti-social and extreme behavioural difficulties resulting from problems in their personal or family life such as problems with alcohol and other drugs, domestic violence, criminal activity and identity issues. The program is based on healing through traditional Aboriginal culture through the wisdom and guidance of traditional elders. The program works on building the confidence and pride of individuals through strengthening identity. The program also aims to provide the tools for young people to address and deal with the challenges they face, including personal trauma.<sup>282</sup>

The **Roper Gulf Shire Council (RGSC) Youth Services Programs** provides regional youth camps with links to specialist youth services in Katherine through the GPNNT, Palmerston "headspace" and Menzies School of Health Research.<sup>283</sup> The camps bring together young people at risk to participate in activities that promote and encourage good life choices by exposing the participants to and raising their awareness of pathways

<sup>277</sup> Submission No. 17, Inspire Foundation, 30 September 2011

<sup>278</sup> Mental Health Association of Central Australia, 'Suicide Prevention and Intervention Training, Suicide Story - Training Tool', <http://www.mhaca.org.au/LPP-suicide-story.html>, at 8 February 2012

<sup>279</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>280</sup> Danila Dilba Youth Service, <http://www.bebo.com/Profile.jsp?MemberId=4884151075>, at 18 March 2012

<sup>281</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>282</sup> Balunu Foundation, 'Indigenous Youth Healing Program' <http://www.balunu.org.au/programs.html>, at 8 February 2012

<sup>283</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

and options for training and employment e.g developing skills for work in agriculture. In 2010-11, Youth Regional Camps were held in Edith Falls, Mataranka Station, Katherine and Darwin

Other initiatives of the RGSC Youth Services Programs include a current project to establish a dedicated youth centre or space in three of the Shire's communities and another to hold a Youth Festival or Carnival. The RGSC Youth Services Programs focus on staff training and development for their Youth Workers in their communities and this is reflected in high staff retention rates.<sup>284</sup> Other Shires such as Victoria Daly Shire Council have moved towards a youth development and engagement model which for Victoria Daly Shire Council commenced in November 2011 and is being developed with the involvement of its communities.<sup>285</sup>

The Committee was impressed by an example that is both universal, selective and community driven. The program used theatre to reach young people and the community to open up discussion about youth suicide in a community in Wales following a two year spike in youth suicides. Young people were not encouraged to speak openly about what was happening in their community. A play was adapted from a popular contemporary novel with suicide as a major theme. Young people from the community performed the play. The performance was followed by a facilitated discussion on the topics raised in the play and the situation in the community. The play and discussion were greatly praised by the community and the Arts Council of Wales for the way it opened discussion about issues related to suicide and the situation in the community.<sup>286</sup>

Between 2005-07 there were a three suicide deaths of young men in Yuendumu. As part of the community response, the Warlpiri Youth Development Aboriginal Corporation (WYDAC) focussed its attention on suicide prevention. Between July 2006 and June 2007, there were 28 separate suicide attempts made by young people in Yuendumu. Since July 2007, there have been no completed suicides at Yuendumu but there continues to be suicidal behaviour, ideation, threats and suicide attempts. Between July 2007 and June 2008 following the concerted efforts of the community and the program, suicide attempts reduced to 14. Out of that community response emerged the **Warra-Warra Kanyi** (WWK) program as part of the community refocusing from general youth work, diversionary and youth development activities to a specific suicide prevention and response. The WWK is a counselling and mentoring project which combines formal counselling skills with a local Warlpiri approach based on peer mentoring. With the community behind it, WYDAC secured federal government support from the Personal Helpers and Mentors project (Mental Health branch, FAHCSIA) to formally establish WWK in December 2008.<sup>287</sup>

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<sup>284</sup> The Roper Gulf Shire Council, Annual Report 2010-11

<sup>285</sup> Committee Hansard, Katherine Public Forum, 6 February 2012, Witness: Katherine Harris, Regional Youth Engagement Program Coordinator, Victoria Daly Shire Council

<sup>286</sup> Submission No. 6, Alyson Evans, Project Officer, Darwin Community Arts, 28 September 2011

<sup>287</sup> Submission No. 30, Warlpiri Youth Development Aboriginal Corporation (WYDAC) Mt Theo Program, 14 October 2011

**CounterPunch** is a new initiative called funded by the Northern Territory Government through the Mental Health Program from 2011-12 combining amateur boxing with psychological intervention and a life skills program to target the physical and mental wellbeing of young people aged 10 to 25. Referrals to the program can be made through schools and organisations that service youth e.g Mission Australia and headspace. Self referrals can also made. Initially, the program is being delivered in Darwin. A number of remote communities have expressed interest in the program. CounterPunch will complement programs such as Clontarf and target young people who may be disengaged from school and those would benefit from more intensive individual or group organisations. Services have commenced on a part-time basis but these will increase by November 2011.<sup>288</sup>

The **Northern Territory Early Intervention Pilot Program (NTEIPP)** is an initiative under the Australian Government's National Binge Drinking Strategy launched in Katherine in December 2010 and run until 2012.<sup>289</sup> The program aims to reduce underage binge drinking and the harm it causes young people and the community. Early intervention is provided by Youth Outreach Workers based in the pilot areas of Alice Springs and Katherine and supported by a Resource Development Officer in Darwin. Part of the initiative is a training kit used to train police and community services staff on engaging with young people to deliver messages about the harms of binge drinking. Youth workshops targeting identified at-risk youth are also held as part of the initiative. Television advertisements have also been produced featuring young Territorians discussing how binge drinking affects them and their communities.<sup>290</sup> Menzies School of Health Research are helping to monitor the effectiveness of the pilot program.

'**Watch My Space**', a cyber program designed, developed and driven by young people working with Corrugated Iron Youth Arts and Northern Territory Police to stop cyber bullying. The aim of the program is to raise awareness about cyber bullying, provide young people, parents and the wider community with information and ideas about how to respond positively to cyber bullying and to build resilience in young people through greater understanding and knowledge about their rights and responsibilities. A competition is currently being run through 'Watch My Space' for entrants to produce a creative representation through mediums such as video, photography, poetry, music or visual art of their ideas about cyber bullying and how to combat it in positive ways.<sup>291</sup>

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<sup>288</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>289</sup> Northern Territory Police, Fire and Emergency Services, Media Release, 8 December 2010, 'NT Early Intervention Pilot Program Launch in Katherine Tomorrow', <http://www.pfes.nt.gov.au/Media-Centre/Media-releases/2010/December/08/NT-Early-Intervention-Pilot-Program-Launch-in-Katherine-Tomorrow.aspx>, at 1 March 2012

<sup>290</sup> Youth Minister's Round Table of Young Territorians, 2011, 'Round About the NT', Vol 16: Issue 2 (June)

<sup>291</sup> Watch My Space, <http://www.watchmyspace.com.au/about-watch-my-space>, at 1 March 2012

## Indicated Programs and Services

Indicated programs and services although aimed at the individual are not restricted to the individual and can extend to family, friends, peers and others.<sup>292</sup> A range of indicated programs and services for individuals and groups such as families are available in the Northern Territory. These include:

- Mental health services from general practitioners and specialists such as psychologists;
- Allied health services and programs including from specialists, community, health and social workers;
- Counselling services, including school, vocational, relationship and critical trauma response counselling provided by organisations such as Mission Australia, Red Cross and EASA Northern Territory;

### 2.4.2 Service Delivery Issues

The Committee found that while there is a range of services and programs available in the Northern Territory, large gaps in service delivery are present. At the same time, the Committee heard that in some communities there are many service providers offering programs and services with similar aims.<sup>293</sup> The Committee found that the overall system of service delivery in the Northern Territory faces a number of significant challenges from lack of co-ordination across agencies and service providers, infrastructure needs of communities including housing, roads and telecommunications, barriers to accessing funding, limited funding cycles, obstacles to identifying those at risk and getting those at risk to the right help, and lack of youth specific services and programs.

### Gaps in Service Delivery

Gaps in service delivery and safety were highlighted, especially for postvention services immediately after a suicide and in the following days to reduce the risk of imitation and contagion. Acknowledging that the bereaved can be at high risk of suicide, it was recommended to the Committee that a first response unit for suicide postvention be established that would accompany Police or the Coroner to provide critical bereavement support services.<sup>294</sup> The Territory Coroner expressed the view that his office required a counsellor in order to properly assist the bereaved it dealt with, as is the practice in all other Australian coroner's offices.<sup>295</sup> In addition, it was recommended that postvention bereavement training be provided to frontline staff such as Police, emergency services staff and prison guards who may be required to provide bereavement support in the first

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<sup>292</sup> Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, 2011, 'Before it's too late: Report on Early Intervention Programs Aimed at Preventing Youth Suicide', Canberra

<sup>293</sup> Committee Hansard, Alice Springs Public Hearing, 10 November 2011, Witness: Dr Boffa, Central Australian Aboriginal Congress, p9

<sup>294</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>295</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Territory Coroner

instance.<sup>296</sup> More targeted bereavement support services were also called for, especially bereavement support specifically for young people. Jesuits Social Services believes that current research and their own experience have highlighted the need for bereavement support interventions for different grieving styles, including cultural variations.<sup>297</sup> These recommendations correspond with the 2010 Senate Community Affairs and Reference Committee recommendation that Federal, State and Territory Governments together with community service providers develop and implement a national suicide bereavement strategy.<sup>298</sup>

### **Approach to Service Delivery**

Several submissions called for a shift in the approach to service delivery. Central Australian Youth Link Up Service (CAYLUS) and Northern Territory Council of Social Services (NTCOSS) spoke about the need for youth programs to be treated as essential services.<sup>299</sup> CAYLUS also asked for more support for young people who don't attend school and therefore cannot access the support from schools. Blair McFarland gave the example of Ipolera outstation:

There is a building at the school, and the school principal at the time was really supportive and very happy to send this person out there. When the head teacher was out there that gave Mavis a structure. Mavis would take the kids and was accessing welfare referrals and that sort of thing. Because she had the infrastructure of the school and the teacher could occupy the kids with educational activities, they were there, they were fed, they were getting support and getting an education.

That was working really well but the Education Department decided the numbers did not add up, partly because kids would go there for a few months then go away, then other kids would come. It was a pretty well-used facility whilst it was operating, particularly for girls and was a crucial piece of the jigsaw at that stage.

However, the Education Department further up from the principal said: 'No, you cannot send that teacher there any more'. That teacher was not allowed to go any more and the kids had nothing to do and became unruly. That became a little more a management issue and the people at the outstation started complaining so Mavis closed the program down. If that school had continued there would have been enough structure to not have had all those implications and Ipolera might still be going.<sup>300</sup>

A few submissions identified a need not to habitually attribute completed suicides to mental disorder. Professors Pridmore and Kuipers see such an approach as an impediment to better understanding and prevention of suicide. The submission cites recent studies in non-western settings that have found mental disorder in less than 50% of completed suicides. Professors Pridmore and Kuipers recommend further

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<sup>296</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>297</sup> Submission No. 26, Jesuit Social Services, 7 October 2011

<sup>298</sup> Senate, Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Parliament of Australia, Recommendation 33

<sup>299</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Blair McFarland, Manager, Central Australia Youth Link-up Service (CAYLUS)

<sup>300</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Blair McFarland, Manager, Central Australia Youth Link-up Service (CAYLUS), p16

investigation of the sociological context in suicide to develop any long lasting holistic response suicide.<sup>301</sup>

The Committee received examples of collaborative programs which provide models worth considering in the future including:

- The Life Promotion Program, Mental Health Program, and the Department of Health developed the Youth At Risk Network (YARN) which met monthly from 1999 to 2006. YARN brought together stakeholders from the various youth related organisations in Darwin.<sup>302</sup>
- The Inter-Agency Suicide Response Task Group (IASRTG) developed by the Department of Health and the Territory Coroner's Office, 1999 – 2006, provided a model of bereavement support and postvention to individuals, families and communities at risk. A Northern Territory version of the Information and Support Pack for those bereaved by suicide or other sudden death was developed with the input of the Life Promotion Program co-ordinator (Department of Health).<sup>303</sup>
- From 1999 – 2006, Crisis Intervention Committees existed within large communities to respond to suicides and monitor 'at risk' behaviour, self harm and suicidal behaviour among risk populations. All members were trained through ASIST to provide suicide intervention. The re-establishment of these intervention committees within large communities with high rates of suicide was recommended by Leonore Hanssens.<sup>304</sup>
- The Blank Page Summit held in response to 22 suicide deaths in the Kimberley region which provides a community driven model of intervention for Indigenous communities.
- The Family Life Promotion Program in Yarabah in North Queensland has had great success in reducing the numbers of suicides in their community, reduced school truancy rates and increased number of young people graduating from university and returning to the community to work. The program incorporates whole of life and whole family interventions.<sup>305</sup>

## Co-ordination and Collaboration

The Committee heard from many witnesses that suicide prevention and response services in the Northern Territory through both Government and non-government agencies, lack co-ordination. The Department of Health also referred to a lack of collaboration between agencies and programs despite the strong willingness of agencies to engage with one another.<sup>306</sup>

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<sup>301</sup> Submission No. 7, Professor Saxby Pridmore and Associate Professor Pim Kuipers, 29 September 2011

<sup>302</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

<sup>303</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>304</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>305</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>306</sup> Submission No. 18, Department of Health, 4 October 2011

The Committee found that there are some co-ordination through associations and networks and at the regional level. For example the primary health care network in the Northern Territory is led and co-ordinated by the GPNNT. The GPNNT has an objective to improve health service delivery and health outcomes in the Northern Territory and provides a range of health services to support general practitioners and primary health carers including mental health services.<sup>307</sup> In Central Australia, a good level of co-ordination is provided through the MHACA. The Top End Association of Mental Health promotes good mental health in the community through its programs and services but does not fulfil a co-ordination role across the region in a similar way. More effective co-ordination is required for program delivery and policy development.<sup>308</sup> This includes identification of risk, entry into service and safe release into the care of the most appropriate trained support person.<sup>309</sup> Levels of co-ordination are required across the Northern Territory; at the regional and local level as well as at the service type or at-risk group level similar to the existing co-ordination for general practice and allied medical services. The service type or at-risk level of co-ordination would apply to groups such as mental health services, youth specific programs and services and programs and services for Aboriginal and Torres Strait Islanders.<sup>310</sup>

The Department of Health identified some key barriers to coordination to be the large number of small programs that exist owing to short-term, fragmented funding, impediments due to confidentiality and incompatible information systems. Compiling individual risk profiles could be assisted by better information sharing but the risk factors are often of a sensitive nature. A lead agency working with a young person with access to collated data would be better able to develop a comprehensive support plan.<sup>311</sup>

The DCF acknowledged that fragmentation of a health system, including mental health service provision affects effective delivery. The DCF told the Committee that it works with other Government agencies through a shared Client Care Information System (CCIS) to eliminate gaps in services to clients at risk. A function in the database establishes a mechanism by which the DCF and Department of Health can cross reference multiple services for individuals at risk.<sup>312</sup> However, agencies also maintain their own databases and client management systems without cross reference such as the Department of Justice, the Child Protection Database and Police data systems.<sup>313</sup>

A previous attempt at a whole-of-government process for suicide prevention through the Northern Territory Suicide Prevention Coordinating Committee (NTSPCC) developing and implementing the NT Suicide Prevention Action Plan 2009-2011 had little ongoing success. An independent assessment of the process found a number of weaknesses which inevitably led to the current abeyance of the NTSPCC, including:

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<sup>307</sup> General Practice Network NT, <http://www.gpnnt.org.au/site/index.cfm>, at 8 February 2012

<sup>308</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>309</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>310</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>311</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>312</sup> Submission No. 35, Department of Children and Families, 3 November 2011

<sup>313</sup> Submission No. 35, Department of Children and Families, 3 November 2011

- the majority of action items were departmental activities that were already part of the department's work or in train;
- the Action did not drill down to the level of timelines or key performance indicators;
- the process was too reliant on the Co-ordinator to do the bulk of the work;
- the lack of a community/non-government reference group;
- Health served as the lead agency but did not have the jurisdiction or funds to encourage or entice agency participation or contribution; and
- the lack of reporting.<sup>314</sup>

## Training

Another area identified for improvement is training in prevention and postvention critical incident debriefing to protect staff on the ground from the risks and effects of responding to loss, traumas and threats including burnout and self blame. In remote communities, support workers can be called any time of the day or night. Self care guidelines to protect front line support workers would also assist frontline workers.<sup>315</sup>

The NTCOSS raised the issue of youth workers in communities being in the best position to identify those at risk but not being equipped to provide a more intensive response, although this may be the expectation of their employer, funding body and community. The focus of youth workers is to provide a relationship based approach with a broader case management framework. NTCOSS believes that there are few appropriately qualified outreach youth support workers who can provide a tailored response to a young person identified as at risk. Youth workers especially in remote areas are challenged by cultural factors, distance, difficulties accessing services and personal isolation. NTCOSS recommends training, professional development, regular structured networking opportunities with peers and appropriate mentors and professional supervision to increase the capacity of youth workers to support suicide prevention in the community<sup>316</sup>.

The Salvation Army spoke about the scene of a suicide attended by police as an accident or crime scene until police and other assessments are made.<sup>317</sup> In addition to the incident itself, the attendance of police can have an affect on the individuals and families. Police therefore have a great responsibility to respond appropriately to ensure the emotional wellbeing of the bereaved and help eliminate any possibility of imitation and contagion. The Committee received some evidence about assisting police when responding to self-harm, suicide attempts and completed suicides. The Salvation Army

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<sup>314</sup> Submission No. 13, Megan Lawrance, PhD Student, Menzies School of Health Research, 30 September 2011

<sup>315</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>316</sup> Submission No. 25, Northern Territory Council of Social Services, 7 October 2011

<sup>317</sup> Submission No. 21, Salvation Army, Hope for Life, 6 October 2011

recommends training to all police such as through its Hopefirst approach, so that responses and support from police are consistent and appropriate for grieving families.<sup>318</sup>

### Appropriate Services

The unique characteristics of Territory remote communities affect the level of service delivery to these communities. Relatively small populations scattered across large geographic areas provide challenges for access to services due to isolation and distance.<sup>319</sup> Another key challenge for service delivery is the number of language groups of people for whom English is not a first or even second or third language. In Central Australia for example, there are more than 10 language groups.<sup>320</sup>

Based on the success of the Mount Theo program, the Warlpiri Youth Development Aboriginal Corporation (WYDAC) recommended the following elements as critical to an effective preventative and therapeutic model of care to address youth suicide in Central Australia:

1. A permanent, locally-based qualified counsellor with significant time and relevant experience in the community, and ideally, adequate resources to ensure appropriate relief by a second qualified professional.
2. Peer mentoring - particularly critical in raising awareness during crisis situations.
3. Programs that are locally developed, preferably based in a non-government organisation or community-oriented/outreach clinic
4. Rapid, consistent, accessible, local and informed crisis response to address suicide attempts, and preventing attempts from becoming completed suicides
5. Ongoing suicide prevention incorporating a holistic view, involving a youth development type model (or solid link with an appropriate youth development service) focusing upon education, development, wellbeing, and diversion<sup>321</sup>

Efforts to address suicidal behaviour in Central Australia must also seek to address cannabis misuse as a significant underlying factor in suicide risk.<sup>322</sup>

The Committee heard from Drs Ruth and John Rudge that there is no regular psychological service in remote communities in the Northern Territory.<sup>323</sup> This is despite the opportunities under the Commonwealth Government assistance offered through the ATAPS program. Under ATAPS, a general practitioner can refer a patient at risk to a private sector allied health professional. A person can receive up to 12 sessions in a calendar year, six of which are time limited and a further six following review by a

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<sup>318</sup> Submission No. 21, Salvation Army, Hope for Life, 6 October 2011

<sup>319</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011, Attachment 2

<sup>320</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011, Attachment 2

<sup>321</sup> Submission No. 30, Warlpiri Youth Development Aboriginal Corporation (WYDAC) Mt Theo Program, p24

<sup>322</sup> Submission No. 30, Warlpiri Youth Development Aboriginal Corporation (WYDAC) Mt Theo Program, 14 October 2011

<sup>323</sup> Committee Hansard, Darwin Public Hearing, 31 January 2012, Witnesses: Drs Ruth and John Rudge, Psychologists

general practitioner. ATAPS is a short-term intervention but if a person needs more long term support, a program will be devised.<sup>324</sup>

Indigenous Psychological Services was recommended by one submission for its model of culturally specific, appropriate and sensitive mental health services that it delivers, including training, community based intervention and research consultancy.<sup>325</sup> Indigenous Psychological Services runs programs throughout Australia including the Northern Territory.<sup>326</sup> Similar culturally appropriate services need to be developed throughout the Northern Territory.

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<sup>324</sup> Commonwealth Government Department of Health and Ageing, 'Access to Allied Psychological Services (ATAPS)', <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-boimhc-ataps>, at 13 February 2012

<sup>325</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>326</sup> Submission No. 15, Leonore Hanssens, Part 1, 30 September 2011

## 2.5 Data Collection and Research

### 2.5.1 Data Collection

Quality statistics on suicides is essential for understanding the dimensions of the problem, variations in trends by time and place and any correlations with possible causal factors. It is only through quality data that policy makers can determine where further action to address the problem is needed and which actions are effective.

The Committee found that a number of factors are impeding access to quality and current information regarding incidents of suicide and self harm. While the Coroner provides an expert and highly regulated system for assessing the cause of deaths, the time required to determine difficult cases and process the data means that it takes years to get reliable figures for confirmed suicides. Collecting information on rates of self harm is made more difficult by the lack of a single comprehensive reporting regime in addition to the difficulties with both identifying harm and determining the cause. Nevertheless, information collected by police, hospitals and other sources can give an indication of the scope of the problem and changes in trends over time and between locations.

The focus on suicide rather than all deaths from self harm can disguise the extent of the problem. The tragedy is no less when the person who kills themselves through deliberate self harm did not intend that result. In Australia, the definition of suicide is a common law definition referring to the deliberate taking of one's life.<sup>327</sup> Dr Roseby recommended changing the legal definition of suicide or introducing a diagnostic test for coronial processes with a higher degree of sensitivity to demonstrating intent that would allow the Coroner to distinguish in his or her findings between a death by suicide and by deliberate self-harm.<sup>328</sup> This would allow deaths where intent could not be conclusively determined by the Coroner to be recorded as due to self-harm. A better understanding of self-harm deaths could also be obtained through more detailed reporting of such deaths through a suicide register. The Committee encourages further work to improve the reporting of death by self-harm through such bodies as the National Committee for Standardised Reporting on Suicide (NCSRS).

### Coronial Investigations

Deaths that appear to be unexpected, unnatural or violent, or that directly or indirectly resulted from an accident or injury, or a death of a person whose identity is unknown or in care or custody must be reported to the Coroner for investigation.<sup>329</sup> The Territory Coroner told the Committee that his office investigates between 350-374 reportable deaths.<sup>330</sup> Although all reportable deaths must be investigated, not all result in an

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<sup>327</sup> Butterworths Concise Australian Legal Dictionary, 3rd Edition, p417 and Mindframe, 'Mental Illness and Suicide in the Media', <http://www.mindframe-media.info/site/index.cfm?display=105557>, at 21 March 2012

<sup>328</sup> Submission No. 46, Dr Rob Roseby, 1 March 2012, p3

<sup>329</sup> *Coroners Act*, s12

<sup>330</sup> Committee Hansard, Darwin Public Hearing, p2

Inquest (a public judicial inquiry). Approximately 15 reportable deaths per year result in an Inquest.<sup>331</sup>

For a death to be classified as a suicide, the death must be:

- due to unnatural causes (not due to illness);
- a result of self-inflicted actions; and
- the person had an intention to die.<sup>332</sup>

If the Coroner is not satisfied all the criteria for a suicide are met beyond reasonable doubt, the death may be declared as accidental. Physical and forensic evidence including autopsy results, toxicology and histology results, medically determined cause of death as well as testimony from family and friends may be used to determine intent. All relevant circumstances of the death must be considered in the Coroner's investigations.<sup>333</sup>

When the Coroner holds an inquest into the death of a person in custody or caused or contributed to by injuries received while in custody, the Coroner must make recommendations towards preventing future deaths in similar circumstances.<sup>334</sup> A copy of the report and recommendations must be provided to the Attorney-General.<sup>335</sup> If a coroner's report to the Attorney-General comments on an agency or the Police, the CEO or the Police Commissioner must respond to the Attorney-General within three months of receiving the report. The response must contain a statement of action that will be taken by the agency in response to the Coroner's report and recommendations. The Attorney-General must then report on the Coroner's report or recommendations to the Legislative Assembly.<sup>336</sup> There is no provision under the Act for monitoring or reporting on the actions that an agency CEO or the Police Commissioner reported to the Auditor-General will be undertaken to address the findings and recommendations of the Coroner. A mechanism for public reporting of this follow-up would ensure greater accountability for the process and ensure necessary improvements are implemented.

Difficulties and delays in the processes for determining a death as suicide affect the data on suicides. This can include delays in receiving toxicology and histology results.<sup>337</sup> Practices in determining intent vary between jurisdictions and can affect coroner's determinations of intent.<sup>338</sup> This may include legislative or regulatory barriers, sympathy with feelings of the family, age of the deceased person, sensitivity to cultural and

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<sup>331</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Territory Coroner, p2

<sup>332</sup> Australian Government Department of Health and Ageing and the Hunter Institute of Mental Health, 'Response Ability', 'Investigation of suicide deaths in Australia', <http://www.responseability.org/site/index.cfm?display=134569>, at 8 March 2012

<sup>333</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Territory Coroner, p2

<sup>334</sup> *Coroners Act*, s12, 26(2)

<sup>335</sup> *Coroners Act*, s12, 27

<sup>336</sup> *Coroners Act*, s46B (3)

<sup>337</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>338</sup> Australian Bureau of Statistics, 2011, 3303.0 - Causes of Death, Australia, 2009, 'Method of Suicide', <http://abs.gov.au/ausstats/abs@.nsf/Latestproducts/EBA9606492CEFC61CA25788400127CEB?opendocument>, 9 March 2012

religious beliefs and practices of the deceased or family.<sup>339</sup> The mechanism of death may make it difficult to conclusively determine intent, such as a motor vehicle accident or drowning. The burden of proof required of the Coroner to establish beyond a reasonable doubt that suicide was intended may reduce the likelihood of suicide being determined.<sup>340</sup> The Territory Coroner told the Committee:

We get about 40 or 50 a year. I have no doubt there are probably another half dozen of single vehicle road accidents where people have ended their life intentionally. But, you cannot be sure. Our law system is you do not call it an intentional death unless you are fairly sure. But, I reckon there are probably another half dozen at least.

Then of the ones we call it suicide the ones where the kid has put the noose around his neck I have a feeling in some of those they are more a call for attention; they do not really intend to kill themselves, they just do not wake up. Or, 'Please, someone stop me doing this. I am unloved. No one pays attention to me'.

Of the 40 or 50, you could add another half dozen and then subtract two or three.<sup>341</sup>

### Data Collection on Suicide Deaths

A coroner is the only entity that can legally determine intent and certify a death as a suicide, therefore the primary source of data on suicide deaths are Coroners' offices. Medical practitioners can provide evidence on self-inflicted nature of injuries that might support the Coroner's determination and classification.<sup>342</sup> The ABS is the primary source of statistics on suicides in Australia. Since 2006, the primary source of ABS statistics on suicides is the National Coroners Information System (NCIS) which contains data on every death reported to a coroner in Australia since 1 July 2000.<sup>343</sup> Data in the NCIS is input from the office of each State and Territory Coroner.<sup>344</sup> Due the need to protect the confidentiality of individuals and families, access to the NCIS is restricted, requiring ethics clearance from each jurisdiction.<sup>345</sup>

The NCIS is an initiative of the Australian Coroners Society and jointly funded by Commonwealth, State and Territory agencies.<sup>346</sup> The data in the system can assist coroners with their investigations by allowing them to review previous coronial cases that may be similar to current cases. Other important functions of the NCIS are to co-ordinate national data collection and provide valuable information to assist with the

<sup>339</sup> Australian Bureau of Statistics, 2011, 3303.0 - Causes of Death, Australia, 2009, 'Method of Suicide', <http://abs.gov.au/ausstats/abs@.nsf/Latestproducts/EBA9606492CEFC61CA25788400127CEB?opendocument>, 9 March 2012

<sup>340</sup> Australian Bureau of Statistics, 2011, 3303.0 - Causes of Death, Australia, 2009, 'Method of Suicide', <http://abs.gov.au/ausstats/abs@.nsf/Latestproducts/EBA9606492CEFC61CA25788400127CEB?opendocument>, 9 March 2012

<sup>341</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Territory Coroner, p2

<sup>342</sup> Senate, Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Parliament of Australia, p18

<sup>343</sup> Senate, Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Parliament of Australia, p18

<sup>344</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Territory Coroner

<sup>345</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Territory Coroner

<sup>346</sup> National Coroners Information System, <http://www.ncis.org.au/>, at 23 December 2011

development of health and safety strategies.<sup>347</sup> The Committee learnt that Australian Coroners are currently working towards uniform reporting but that differences remain between jurisdictions.<sup>348</sup> The NCSRS has found that throughout Australia suicide data is currently recorded through a range of agencies and often with different reporting processes. The NCSRS acknowledges that while co-ordinated and consistent data collection is critical, it can be difficult to meet the needs and requirements of all stakeholders, including coroners, policy makers and researchers.<sup>349</sup>

There is ongoing debate about including deaths caused by risk taking such as single vehicle motor accidents, however, coroners cannot make findings of suicide when there is reasonable doubt about a person's intent.<sup>350</sup>

### **Data Collection on Suicide Attempts and Self-Harm Incidents**

There is no comprehensive system for recording attempted suicides and other self-harm injuries. Police records of their responses to attempted suicides and hospital records of patients attending for injuries due to self-harm provide two systematic sources of data. Data recorded by communities of self-harm incidents that don't result in hospitalisation could be used to can provide further information but these are often not reported and the methods for recording are inconsistent. However a high level of co-ordination and standardisation of recording is required to ensure quality of data. The reporting and recording of attempted suicide is not conducted in a co-ordinated way in most Australian jurisdictions with the possible exception of Western Australia.<sup>351</sup>

Reports of attempted suicides from multiple sources can easily result in multiple counts of one event unless the identity of the person is recorded accurately and protected by confidentiality. For example information from a police call-out would overlap with information provided by hospital emergency departments.<sup>352</sup> A further difficulty is distinguishing between attempted suicide, suicide threats, and 'self inflicted' accidents resulting in hospitalisation.

The Department of Health informed the Committee that initial inter-agency discussion has taken place about the potential benefit of sharing information and collating attempted suicide data for identification of elevated risk and target intervention as well as to enhance research and service planning.<sup>353</sup> A feasibility study will be conducted in 2012-13 to consider current recording of suicide attempts with a view to co-ordinating a

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<sup>347</sup> Suicide Prevention Australia, Projects, 'National Committee for Standardised Reporting on Suicide', <http://suicidepreventionaust.org/project/national-committee-for-standardised-reporting-on-suicide-ncsrs/>, at 18 March 2012

<sup>348</sup> Suicide Prevention Australia, Projects, 'National Committee for Standardised Reporting on Suicide', <http://suicidepreventionaust.org/project/national-committee-for-standardised-reporting-on-suicide-ncsrs/>, at 18 March 2012

<sup>349</sup> Suicide Prevention Australia, Projects, 'National Committee for Standardised Reporting on Suicide', <http://suicidepreventionaust.org/project/national-committee-for-standardised-reporting-on-suicide-ncsrs/>, at 18 March 2012

<sup>350</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>351</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>352</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>353</sup> Submission No. 18, Department of Health, 4 October 2011, p21

framework for suicide related information management towards better suicide prevention. The Department of Health recommends that the feasibility study consider a cost-benefit analysis of relaxing confidentiality requirements for the purposes of better suicide prevention.<sup>354</sup>

### The Quality of Available Data

Quality data is required to ensure that services are provided to people and places where they can have the greatest benefit and equitably address needs.

The Committee heard from the Central Australia Aboriginal Congress (CAAC) that many communities do not have resident police and therefore there can be delays in reporting suspicious deaths. Also from CAAC the Committee heard that deaths associated with motor vehicles could be from suicide but are reported as accidents. Many suicide deaths of members of Central Australian communities happen outside the community, in the town centres such as Alice Springs, Tennant Creek or at an alcohol outlet on the highway. Witnesses are often intoxicated themselves, have a poor history with the police or have English as a second or subsequent language. Witnesses could also be bound for cultural reasons not to volunteer information. In some cases there can be serious consequences for the last person known to be in contact with a person who has committed suicide. These circumstances make it difficult for the police and coroner to collect good background information that could shed light on intent. Self-harming behaviour is also poorly recorded in communities and there can be a cross-over of data across the South Australia and Western Australia borders.<sup>355</sup>

It is widely accepted that official statistics on suicides are underestimated by between 10 and 30%.<sup>356</sup> The 2010 Senate Committee inquiry into suicide in Australia also found that the actual rate of suicide may be higher than current figures.<sup>357</sup> Attempted suicides are significantly under-reported, especially in Aboriginal communities.<sup>358</sup> The Department of Health informed the Committee that there may be minor differences between yearly statistics of unconfirmed suicides compiled by the Mental Health Program from notifications provided by the Coroner's Office and the ABS figures.<sup>359</sup>

The most current statistics from the ABS are for 2009. The ABS advises that care must be taken when interpreting data on suicide and comparing 2009 suicide data with previous years.<sup>360</sup> Delays in resolving cases before the Coroner mean that statistics can

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<sup>354</sup> Submission No. 18, Department of Health, 4 October 2011, p21

<sup>355</sup> Submission No. 3, Central Australian Aboriginal Congress, 21 September 2011

<sup>356</sup> Submission No. 20, Suicide Prevention Australia, 6 October 2011

<sup>357</sup> Senate, Community Affairs References Committee, 2010, 'The Hidden Toll: Suicide in Australia', Parliament of Australia

<sup>358</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>359</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>360</sup> Australian Bureau of Statistics, 3303.0 - Causes of Death, Australia, 2009, Media Release, 3 May 2011, 'Heart disease still the leading cause of death in Australia', <http://www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbytitle/63AFD409CBAA7592CA25757C00272CF2?OpenDocument>, at 26 February 2012

be two or three years behind.<sup>361</sup> The ABS advises that the number of suicide deaths for 2009 is likely to increase as data is revised. The ABS conducted a quality assurance review of its statistics on causes of death for 2007 and 2008.<sup>362</sup> This resulted in little change to the statistics for the Northern Territory.<sup>363</sup> The ABS does not include detailed information about child suicide rates for children under 15 years of age because the number registered each year is relatively low and is likely to be underestimated.<sup>364</sup>

## Public Reporting on Suicide

In recent years, the media has accepted greater responsibility for its role in suicide prevention, including preventing imitation and contagion arising from media reports, through more responsible reporting. Following its review of guidelines for reporting on suicides, in 2011 the Australian Press Council released its 'Standards Relating to Suicide'. The guidelines acknowledge the need to protect the individual and their family and contribute to the public good by generating broad public discussion about suicide and its impacts.<sup>365</sup> Public discussion generated at this level can help to reduce the stigma associated with suicide which in turn can improve help seeking behaviour. Mindframe argues that while more community discussion is desirable, more media coverage is not the best way for this to be achieved. Instead Mindframe would like more indirect media support through involvement in national suicide awareness campaigns like 'R U OK? Day'.<sup>366</sup>

In Queensland, guidelines for public reporting on suicides associated with children in State care were recently reviewed and the Queensland Government has made a decision to make changes to privacy legislation to allow for automatic release of reports into investigations into deaths of children in official care.<sup>367</sup>

## 2.5.2 Research

Further research into the links of alcohol and other drugs with suicide can help to improve prevention strategies and treatments through better understanding of the role these substances play as triggers.<sup>368</sup> The contribution of alcohol as a factor in domestic violence has been acknowledged. Strategies to reduce the availability of alcohol were

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<sup>361</sup> Australian Bureau of Statistics, 2011, '3303.0-Causes of Death, Australia, 2009, 'Explanatory Notes' 28-32, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Explanatory%20Notes12009?OpenDocument>, at 26 February 2012

<sup>362</sup> Australian Bureau of Statistics, 3303.0-Causes of Death, Australia, 2009, Explanatory Notes, <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3303.0Explanatory%20Notes12009?opendocumen&tabname=Notes&prodno=3303.0&issue=2009&num=&view=>, at 25 January 2012

<sup>363</sup> Submission No. 18, Department of Health, 4 October 2011

<sup>364</sup> Australian Bureau of Statistics, 2011, '3303.0-Causes of Death, Australia, 2009, 'Explanatory Notes' 82, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Explanatory%20Notes12009?OpenDocument>, at 26 February 2012

<sup>365</sup> Australian Press Council, 2011, 'Standards Relating to Suicide', Sydney

<sup>366</sup> The Australian, 21 March 2011, 'Suicide a Subject the Media Treats Cautiously', Sally Jackson

<sup>367</sup> The Australian, 7 September, 'Reports into Queensland Teen Deaths to be Shown', Rory Callinan

<sup>368</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Children's Commissioner and Convenor of Child Death Review Committee

recommended in many submissions. CAYLUS praised the current measures being implemented in the Northern Territory through the 'Enough is Enough Alcohol Reforms' but asked the Committee to promote the replication of these Northern Territory tools to South Australia, Western Australia and Queensland in order to prevent cross border transportation and further reduce availability.<sup>369</sup>

The Committee was informed that there is a significant lack of understanding of suicides and suicide attempts among Indigenous children and youth. The Centre for Remote Health for example called for future research concerning Aboriginal child and youth suicides aimed at the community level so that specific prevention initiatives can be better informed, applicable and effective. Further, that any research must translate into interventions, including training for professionals and community education programs targeted to Aboriginal people and communities, taking in culture, language and region specifics.<sup>370</sup>

Professors Pridmore and Kuipers recommend that outcomes-oriented research be conducted in partnership with Indigenous organisations, Government and non-government agencies that is culturally safe on the broader sociological context of completed and threatened suicides among young Aboriginal people in the Northern Territory, especially factors related to alcohol abuse, and provide for an alternative perspective to conventional 'medicalised' treatments.<sup>371</sup>

Other researchers recommended that investment needs to be made into research relating to pre-existing factors and social determinants of suicide, demographic trends, effective models of prevention, intervention and postvention for youth suicide.<sup>372</sup>

Some submissions called for further research on protective factors. Aboriginal Peak Organisations would like to see more research into the differences in suicide prevalence between Northern Territory communities and the determining factors for any differences.<sup>373</sup> The Department of Health called for more detailed examination of the social determinants of health and the range of factors that may influence and protect an individual, family or community not to engage in suicide.<sup>374</sup> Prof. Colin Tatz referred to evidence of sport as a protective factor against suicide such as articles that appeared recently in the Australasian Psychiatry Journal in reference to aspects of Aboriginal emotional and physical wellbeing. However, Prof. Tatz notes that there is little research in Australia to back up these ideas on sport as a protective factor.<sup>375</sup>

Menzies School of Health Research highlighted the need for access to more current data and information on suicide to support research initiatives and development of effective

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<sup>369</sup> Committee Hansard, Darwin Public Hearing, 30 January 2012, Witness: Blair McFarland, Manager, Central Australia Youth Link-up Service (CAYLUS)

<sup>370</sup> Submission No. 11, Centre for Remote Health, A joint centre of Flinders University and Charles Darwin University, 30 September 2011

<sup>371</sup> Submission No. 7, Professor Saxby Pridmore and Associate Professor Pim Kuipers, 29 September 2011

<sup>372</sup> Submission No. 15, Leonore Hanssens, 30 September 2011

<sup>373</sup> Submission No. 28, Aboriginal Peak Organisations, 14 October 2011

<sup>374</sup> Submission No. 18, Department of Health, 5 October 2011

<sup>375</sup> Submission No. 4, Professor Colin Tatz, AO, 23 September 2011, p9-10

prevention strategies. Menzies School of Health Research calls for improved capacity to monitor and investigate suicide causes and that this needs to be achieved at the following levels:

- The epidemiological level – data linkages between agencies and surveys to look at risk population concentrations, communities and regions to support policy development and communities about risk profiles and ways to reduce risks;
- The case level – research based on audits of suicide records; and
- The level of service capacity to improve wellbeing and reduce suicide risk, informed by evidence.<sup>376</sup>

Menzies School of Health Research have been developing a project proposal for a comprehensive study of suicide trends in the Northern Territory in collaboration with the Australian Institute of Suicide Research and Prevention (AISRP) and Adelaide University.<sup>377</sup> Menzies School of Health Research have a proposal before the National Health and Medical Research Council (NHMRC) for the initial stages of the proposed research. Stage one of the research project would be an epidemiological study of suicides in the Northern Territory 1990-11. Stage two would be a study of suicide risk factors and service use in the Northern Territory.<sup>378</sup>

Menzies School of Health Research have recommended the creation of a Suicide Register. The recommended register is to be based on the Queensland model which operates in partnership with Queensland Health, Queensland State Coroner's Office and the Queensland Police Service and in collaboration with AISRP through Griffith University. The Committee was advised by the Territory Coroner that a suicide register already exists through the NCIS and the creation of a suicide register in the Northern Territory would have to pay great attention to the need to protect private and confidential information of individuals and their families.<sup>379</sup>

In evidence before the Committee, calls were made for further research into the use of electronic social networking and cyber-bullying, the impacts of media reporting and increased discussion of suicide, and the evaluation of the effectiveness of programs delivered in the Territory.

The Committee supports the House of Representatives Committee into Health and Ageing recommendation that priority targeted research agenda for youth suicide be developed through the ASPAC and the NHMRC with the support and collaboration of relevant national, State and Territory Government agencies and research bodies.<sup>380</sup>

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<sup>376</sup> Submission No. 12, Menzies School of Health Research, Centre for Child Development and Education, 30 September 2011

<sup>377</sup> Tabled Paper, 31 January 2012, Menzies School of Health Research, 'An NT Suicide Register'

<sup>378</sup> Tabled Paper, 31 January 2012, Menzies School of Health Research, 'An NT Suicide Register'

<sup>379</sup> Committee Hansard, Darwin Public Hearing, 14 March 2012, Witness: Mr Greg Cavanagh, Territory Coroner, Mr Greg Cavanagh

<sup>380</sup> Parliament of Australia, House of Representatives, Standing Committee on Health and Ageing, 2011, 'Before it's too late: Report on Early Intervention Programs Aimed at Preventing Youth Suicide', Canberra

The Northern Territory can access opportunities through existing partnerships and projects being undertaken by research co-operatives such as the Cooperative Research Centre for Young People, Technology and Wellbeing (YAW-CRC) which is currently collecting the first consolidated Australian data on young people's use of technology, research to support digital education and training programs on cybersafety, mental health and wellbeing and research towards the establishing online wellbeing centres and clinics.

The Australian Institute for Suicide Research and Prevention (AISRP) in Queensland has been conducting a project mapping existing suicide prevention programs and services in Queensland. The project involves identifying, reviewing and disseminating information about all current programs and services towards suicide and self-harming prevention. The aim of the project is to improve access to information on suicide prevention programs and service to be used in the community. Links and gaps in service delivery will be identified through the mapping exercise which will benefit decisions on future programs and services as well as funding and investment decisions for better service delivery and future research. This project is relevant to the Northern Territory's own mapping project. Lessons learnt by the AISRP can help inform the mapping of programs and services in the Northern Territory.<sup>381</sup>

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<sup>381</sup> Australian Institute for Suicide Research and Prevention, <http://www.griffith.edu.au/health/australian-institute-suicide-research-prevention/research>, 20 March 2012

### 3. ACTION

In considering how to respond to the issues raised in evidence before the committee, four themes have arisen for further action.

It was clear first and foremost that suicide is a social problem. Many of the risk factors for suicide relate to social issues, such as unemployment, alcohol abuse and violence. While helping those in crisis is important, building communities where individuals are less likely to meet the range of factors that may lead to suicide, and who are more able to deal with life's stresses as they arise, will provide the greatest benefit in the long run. The first theme for action is therefore **building stronger communities**.

It was also apparent to the Committee that there needs to be more done to help those who are at risk of self-harm. Individuals in crisis need to be able to access the help they require to get them through, whether that be a place to be safe from their current problems for a while, mental health services, or a means of rebuilding their place in their community. Also, the family and friends of those who may be in crisis need the resources to be able to identify when that person requires assistance and enable that person at risk to access the help required. The second theme for action is therefore **identifying and helping those at risk**.

The Committee was both moved by and concerned with the impact of completed suicides. Completed suicides cause terrible grief and trauma for family and friends and the community at large. This also creates risk of further suicides, resulting in some communities having to deal with a number of suicides in a short period of time. It is apparent to the Committee that a suicide itself is a point of crisis that must be addressed to help the bereaved deal with their grief and stem the risk of contagion resulting in further suicides. **Helping the bereaved and stopping the contagion** is the third theme identified by the Committee.

Another issue that arose throughout the evidence received by the Committee is the need for better coordination and management of service delivery. It is apparent that without proper integration, access to services can be patchy. Service delivery in the Northern Territory in regional and remote areas faces significant challenges arising from the Territory's geography and climate. Strategies are required to ensure we can make the most of our limited resources, including ensuring that services work effectively together, sharing rather than duplicating resources where possible, and provide a holistic rather than fragmented service to those requiring help. It is essential that services meet the needs of the communities they serve, and empower those communities rather than create dependence. We also need funding mechanisms that look to the long term and enable services to grow and develop within a community, while at the same time ensuring accountability and not wasting money on services that cannot deliver the best and most sustainable outcomes. The fourth theme is therefore **smarter service delivery**.

As highlighted in the previous chapter, suicide is a complex, multi-dimensional issue. The Committee heard that whilst a wide range of risk factors have been identified as increasing the likelihood of suicide, finding causes has proven particularly difficult given

the extent to which they vary from one individual to another. Moreover, as noted in the *Breaking the Silence* report, the complexity of suicide has often been cited as “a barrier to investing in suicide prevention efforts.”<sup>382</sup>

Ms Bronwyn Hendry (Director of Mental Health, Department of Health) advised the Committee that, although there is a wealth of evidence which indicates a strong correlation between mental illness and suicide, it is important to note that this relationship is not necessarily causal.<sup>383</sup> In fact, “[t]he vast majority of people who experience a mental illness do not experience or show signs of suicidal thoughts or behaviours and a person does not have to have a mental illness to have a suicide risk.”<sup>384</sup>

The Committee was also advised that many of the mental health issues cited as risk factors in suicide are often a consequence of adverse sociological factors impacting on individuals, families and communities. For example, the *2007 National Survey of Mental Health and Wellbeing* found that sociological factors such as unemployment, homelessness, social isolation, marital status, and incarceration, were highly associated with a range of mental health conditions including anxiety disorders affective disorders, depressive episodes, bipolar affective disorder, alcohol and substance disorders.<sup>385</sup>

The submission from Professor Saxby Pridmore suggested that medicalisation (the classification of non-medical problems as medical problems), and research methods such as psychological autopsies have seriously undermined both understandings of suicide and the development of subsequent prevention strategies. As such, Professor Pridmore noted that further research regarding the sociological context of suicide is required in order to develop a “sustainable and holistic response to suicide in the NT.”<sup>386</sup> A number of other submissions also highlighted the shortcomings of viewing youth suicide primarily as a mental health issue, and the subsequent failure of suicide prevention strategies to acknowledge or address sociological precursors of mental illness.<sup>387</sup>

The Committee has responded to the current and emerging issues in youth suicide through the four themes outlined above in recognition of the multidimensional nature of suicide. The primary aim being to formulate recommendations to facilitate effective

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<sup>382</sup> J Mendoza and S Rosenberg, *Breaking the Silence*, ConNetica Consulting Pty Ltd, Moffat Beach, 2010, p. 21 – this report was prepared by ConNetica Consulting Pty Ltd on behalf of Lifeline Australia, The Inspire Foundation, OzHelp foundation, Centre for mental Health Research (ANU), Suicide Prevention Australia, The Salvation Army and the Brain and Mind Research Institute, in response to the 2010 Senate Inquiry into Suicide in Australia and the subsequent release of the Senate’s report *The Hidden Toll: Suicide in Australia*, 25 June 2010.

<sup>383</sup> Ms Bronwyn Hendry, Director of Mental Health, Department of Health, *Committee Hansard*, 4 November 2011, p. 3

<sup>384</sup> Mendoza and Rosenberg, *op.cit.*, p. 63

<sup>385</sup> Australian Bureau of Statistics, *2007 National Survey of Mental Health and Wellbeing: Summary of Results*, 4326.0, Canberra, 2008, pp. 6-18

<sup>386</sup> Professor Saxby Pridmore, *Submission 7*, pp. 1-3

<sup>387</sup> Northern Territory Council of Social Services, *Submission 25*, pp. 4-6; Aboriginal Peak Organisations Northern Territory, *Submission 28*, pp. 6-14; Katherine Youth Interagency Tasking and Coordination Group, *Submission 24*, pp. 7-11; NT Department of Children and Families, *Submission 35*, pp. 4-5

suicide prevention, intervention and postvention strategies across the Northern Territory and reduce the Territory's youth suicide rates over the longer term.

### 3.1 Building Strong, Healthy and Resilient Communities

From a national perspective, those most at risk of suicide are young (under 24), male, Indigenous, and living in rural, regional or remote locations.<sup>388</sup> As Ms Hendry pointed out, whilst suicide rates in the Northern Territory are higher than elsewhere in Australia, it is important to acknowledge that a significant proportion of the Northern Territory population falls within this high risk cohort.<sup>389</sup> Compared to many other parts of Australia, there is an over representation of those living in rural and regional communities and remote Indigenous communities; all of which “experience higher rates of suicide than metro dwellers and non-Indigenous communities.”<sup>390</sup> For example, in the five year period from 2006/07 to 2010/11, NT Police attended a total of 419 attempted suicides of people under the age of 25. Of these, 64% occurred in rural or remote areas, 66% were Indigenous and of the 54% of attempted suicides by males, 70% were Indigenous.<sup>391</sup>

Moreover, as the Suicide Prevention Australia submission noted:

Suicide in a rural [i.e. non metropolitan] 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.<sup>392</sup>

These include a range of modifiable, social and contextual risk factors such as employment status, living arrangements, familial dysfunction, social disintegration, social and economic disadvantage, social and geographic isolation, and addictive behaviours such as gambling or substance abuse.<sup>393</sup>

Given what is known about the causes of youth suicide in the Northern Territory, it is clear that it is symptomatic of much broader issues relating to social disadvantage and community dysfunction. The Committee heard that it is essential that suicide prevention activities focus on the promotion and maintenance of wellbeing at the individual, family and community level.<sup>394</sup> The Department of Health noted that current research suggests that, “effective suicide prevention needs to combine a broad range of strategies and approaches that are sustained over many years.”<sup>395</sup>

In many respects suicide rates are an indicator of the overall health and wellbeing of communities at differing points in time. As highlighted in the submission from the Menzies School of Health Research, the unprecedented rise in youth suicide rates amongst Indigenous communities in the Kimberley and the Northern Territory in the 1980’s, has been linked to rapid social change in the 1970’s including:

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<sup>388</sup> The Senate Community Affairs Reference Committee, *The Hidden Toll: Suicide in Australia*, Canberra, 2010, pp. 89-99

<sup>389</sup> Ms Bronwyn Hendry, *loc.cit.*; Suicide Prevention Australia, *Submission 20*, p.2; Australian Bureau of Statistics, *Regional Population Growth, Australia*, 3218.0, Canberra, 31 March 2011, Table 7

<sup>390</sup> Suicide Prevention Australia, *op.cit.*, p. 2; see also: Australian Bureau of Statistics 2011, *loc.cit*

<sup>391</sup> Commissioner John McRoberts, NT Police, *Committee Hansard*, 4 November 2011, p. 21

<sup>392</sup> Suicide Prevention Australia, *op.cit.*, p. 4

<sup>393</sup> Mendoza and Rosenberg, *op.cit.*, p. 56

<sup>394</sup> Ms Bronwyn Hendry, *loc.cit.*

<sup>395</sup> Department of Health, *Submission 18*, p. 3

rising cash incomes, mobility and above all a rapid increase in access to alcohol. This produced a serious deterioration in the quality of childrearing, parenting and early object relationships, leading to a higher incidence of psychopathology and elevated risk of suicide in these children as they reached adolescence.<sup>396</sup>

Similarly, as pointed out by Suicide Prevention Australia, spikes in suicide rates in rural communities have been linked to issues such as drought, de-population, declining profitability of core industries and subsequent increases in unemployment; all of which have been shown to negatively impact on social integration, familial relationships, the incidence of domestic violence, alcohol and substance abuse, and depression.<sup>397</sup>

Given the above, and on the basis of the submissions and evidence provided to the Committee, it is clear that reducing the rate of youth suicide in the Northern Territory is largely contingent upon the capacity of communities, in conjunction with all levels of government, to address issues relating to geographic isolation, community resilience, and strengthening families. Since it is not within the scope of this inquiry to address the myriad of sociological factors that impact on the risk and protective factors associated with suicidal behaviour, this report concentrates on specific aspects highlighted to the Committee as issues of particular concern. Actions to address these are considered below.

### 3.1.1 Challenges of Geographic Isolation

Overcoming the tyranny of distance is an on-going challenge when it comes to service delivery in the Northern Territory. Acknowledging the Northern Territory's unique service delivery context, the Suicide Prevention Australia submission notes that whilst geographic isolation necessitates a certain degree of self sufficiency in remote communities:

The Northern Territory 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.<sup>398</sup>

As is the case nationwide, youth suicide in the Northern Territory is more prevalent in the rural, regional and remote areas. However, unlike urban residents, access to services such as mental health and allied health services, drug and alcohol, unemployment, bereavement and carer support services, follow up care for those that may have attempted suicide, and recourse to services which promote social connectedness and community inclusion is often lacking.<sup>399</sup> Moreover as the Suicide Prevention Australia submission noted, "even where mental health and other services exist...they are often under-funded and under-resourced compared to those in urban areas."<sup>400</sup> During the course of the inquiry, witnesses identified access to youth specific counselling, allied health and mental health services as priority issues for residents in the outlying rural

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<sup>396</sup> Menzies School of Health Research, *Submission 12*, p.10

<sup>397</sup> Suicide Prevention Australia, *Submission 20*, Attachment 2: *Position Statement Responding to Suicide in Rural Australia*, p. 4

<sup>398</sup> Suicide Prevention Australia, *op.cit.*, p. 7

<sup>399</sup> *Ibid*, Attachment 2, p. 7

<sup>400</sup> *Ibid*

area of Darwin, Katherine, Tennant Creek, Nhulunbuy and remote Indigenous communities in particular. The lack of infrastructure to support community based services, including staff housing, short term residential options for youth at risk and recreational facilities were noted as an inter-related issue that also needs to be addressed.

As noted elsewhere in this report, whilst outreach and fly in, fly out services are a means of ensuring that all Territorians, irrespective of the size or remoteness of the community, have access to a range of services, the current model lacks the capacity to address the level of need of young people at risk. For example, in terms of counselling and mental health services, Charity McAleer (Counsellor, Wellbeing Team, Taminmin College) noted that it was very difficult to get services, which are often over-stretched, to travel out to the rural area.<sup>401</sup> The Committee heard that this becomes very difficult when dealing with 'high risk' young people. As Ms McAleer pointed out, in situations where someone is feeling suicidal but are not willing to go to the Tamarind Centre the options are extremely limited:

a huge issue for me as the counsellor is if I have a suicide with a young person who is involuntary, Tamarind will not touch it and headspace is non-clinical. They said I can get one appointment with the travelling psychiatrist who is there every six weeks.<sup>402</sup>

Ms McAleer noted that part of the problem is that the Tamarind Centre is not designed for young people and can often prove to be a traumatic experience in itself:

Going into the Tamarind Centre and sitting next to you is an old man who is floridly psychotic, for a 15 year old, is a terrifying experience and they will never go back. They never want to walk through those doors again.<sup>403</sup>

The Committee also heard that access issues were further compounded by the fact that Darwin and Palmerston based services are not funded to provide outreach services into the rural area. As Mr Stuart McMillan, (Pastor, Living Water Uniting Church, Humpty Doo) noted:

So, even the people who are coming and doing rural – a day a week at Taminmin for headspace, the Somerville counselling that happens out of our place, or the baby health clinic, or whatever – none of those organisations have operational funds to provide a rural counsellor, or provide a rural headspace worker. They are stretching what they already have. We are constantly doing that with community services at the operational level.<sup>404</sup>

As Mr McMillan further noted, in the absence of funding to provide outreach services, there is no capacity for organisations to back fill when they do go out to the rural area. In order to provide services in Humpty Doo, for example, services in Palmerston or Darwin suffer as a result. The Committee heard that given the level of need in the rural area one

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<sup>401</sup> Ms Charity McAleer, Counsellor, Wellbeing Team, Taminmin College, *Committee Hansard*, 2 December 2011, p. 20

<sup>402</sup> *Ibid*

<sup>403</sup> *Ibid*

<sup>404</sup> Mr Stuart McMillan, Pastor, Living Water Uniting Church, Humpty Doo, *Committee Hansard*, 2 December 2011, p. 31

option being considered is to offer small group counselling, however this necessarily has its limitations and can deter people from accessing assistance.<sup>405</sup>

The Palmerston Positive Learning Centre, which provides support for “children with extreme behaviours”<sup>406</sup> was acknowledged as an excellent initiative. However, as Ms Beverley Ratahi (Chair, Taminmin College Council) noted, it does not have the capacity or resources to cater to the needs of the rural area as well as Palmerston. The Committee was advised that to date, Taminmin has only been able to access support for two students, with a further six on the waiting list.<sup>407</sup> It was suggested that given the student population at Taminmin, let alone other rural schools, there was a need for a similar centre in the rural area.<sup>408</sup>

In terms of young people’s access to mental health services in the more remote areas of the Northern Territory, headspace advised the Committee that they had been informed by local service providers and workers that:

the current mechanisms funded by the Federal government to access mental health services (e.g. ATAPS and Better Outcomes) are not working in the Territory. For example, the requirement for young people to have a Mental Health Treatment Plan through a GP is problematic and many are being told they are not eligible and are turned away.<sup>409</sup>

The Committee was further advised that both the Top End and Alice Springs **headspace** centres are currently providing services to families that have been advised that “their child has not met the criteria for the Territory funded mental health services.”<sup>410</sup> **headspace** informed the Committee that it was evident that “referral pathways and access to services need to be improved and tailored to the specific needs and environment of the NT.”<sup>411</sup>

The Committee heard that young people in Katherine are reliant upon services provided by the Tamarind Centre, which sends a youth specific mental health team down from Darwin for “one day (6 hours) per month.”<sup>412</sup> In Tennant Creek it was noted that the Department of Health currently employs “three mental health staff and two staff in the drug and alcohol service, which provide limited counselling for young people under sixteen.”<sup>413</sup> The only other option open to young people is a paediatrician and psychologist who operate on a fly in fly out basis for three days every six weeks and can only be accessed “after a lengthy referral process from a General Practitioner.”<sup>414</sup> The Northern Territory Council of Social Service’s submission highlighted the need for services such as **headspace** in both Katherine and Tennant Creek.<sup>415</sup> On the basis of

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<sup>405</sup> *Ibid*

<sup>406</sup> Ms Beverley Ratahi, Chair, Taminmin College Council, *Committee Hansard*, 2 December 2011, p.21

<sup>407</sup> *Ibid*

<sup>408</sup> *Ibid*

<sup>409</sup> headspace, *Submission 23*, p. 11

<sup>410</sup> *Ibid*

<sup>411</sup> *Ibid*

<sup>412</sup> NTCOSS, *op.cit.*, p. 4

<sup>413</sup> *Ibid*

<sup>414</sup> *Ibid*

<sup>415</sup> NTCOSS, *loc.cit.*

the evidence received, the Committee notes that there is also a need for headspace services in Nhulunbuy. The Committee is of the view that **headspace** centres located in each of the regional centres would also have the capacity to provide a significant amount of outreach and support to the more remote communities.

The Committee heard that in the absence of dedicated adolescent mental health services in regional areas, young people that have been identified as 'high risk' are generally evacuated to the Cowdy Psychiatric ward in Darwin. Here again the Committee was advised that this was not a satisfactory solution given that Cowdy is not a youth specific facility. Dr Jill Pettigrew (Katherine Mental Health) noted that whilst the current situation is not ideal there have been some important advances in recent times, such as the video link service between regional centres and the Cowdy Ward.<sup>416</sup>

We have a video link with Cowdy every Tuesday morning. So anyone that comes in from our region, we discuss. There is always information sharing and there is always lots of discussion around discharge. If we are not happy with the arrangements, then we are very vocal about that. If we think it is premature for someone to be discharged, then we very much make that case strongly and try to have as much set up so that it is an optimal discharge rather than a rapid discharge.<sup>417</sup>

However, as Ms Jane Hair (Community Mental Health Nurse, Katherine Mental Health) advised the Committee, if the patient is from a remote community once they are discharged from Cowdy the community clinic has to manage them; irrespective of whether or not they have any specialist mental health staff.

At the end of the day, the community actually manages these people. We only visit. We go out every two weeks, but that is only every two months, to every community. So, it is more of a consultation liaison.<sup>418</sup>

The Committee noted that there was a significant need for short term youth respite facilities in regional areas to enable young people, whose condition does not necessarily warrant them being evacuated to the Cowdy Ward, to be monitored and assessed. The only option at present is for young people to be admitted to the local hospital:

Given that much youth suicide is impulsive and driven by immediate circumstances, often if you can just withdraw that person from the immediate environment – even though we do not have designated beds... If we feel they are manageable and the staff are feeling okay about safety, then we will have someone in for a few days just to allow for a reasonable assessment and to see if this was just a reaction to family rows or relationship issues, or whatever, or if there is something more serious that can be better addressed in an inpatient environment. We are aware that Cowdy is for the very severely ill people. There is not a less stressful environment, and we do not want to traumatise people who are naive to that sort of ill health; to put them in that environment, if we can avoid it.<sup>419</sup>

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<sup>416</sup> Dr Jill Pettigrew, Katherine Mental Health, *Committee Hansard*, 6 February 2012, p. 28

<sup>417</sup> *Ibid*

<sup>418</sup> Ms Jane Hair, Community Mental Health Nurse, Katherine Mental Health, *Committee Hansard*, 6 February 2012, p. 28

<sup>419</sup> Dr Jill Pettigrew, *op.cit.*, p.30

The Committee was advised that the Remote Family Violence Women's and Men's Safe Places initiative should be extended to include regional centres and non growth towns.<sup>420</sup>

As noted in the submission from the Department of Children and Families:

The Australian and Northern Territory Governments have funded 20 safe places in 15 remote communities and two transitional houses in Darwin and Alice Springs. Safe houses are staffed by local aboriginal people. There are 8 Men's Places and 12 remote Women's Safe Houses. Men's Places run programs for Men in communities i.e. Bush Mob, AOD and strong Men's Groups. Unaccompanied children may not stay overnight at Women's Safe Houses or Men's Places.<sup>421</sup>

Given the number of witnesses that highlighted the need for more short term residential options available for young people at risk, the Committee welcomed the news that the Department of Children and Families was currently in the process of establishing two, eight bed, residential facilities to be based in Darwin and Alice Springs.<sup>422</sup> The Committee heard that these facilities will provide:

therapeutic services through a Tier 2 secure care environment that could, potentially, be used by young people who suffer from suicide ideation or some other mental health issue. It is a short term model that will allow for them to be assessed over a period of time.<sup>423</sup>

The Committee acknowledged that similar facilities are urgently required in Katherine, Tennant Creek and Nhulunbuy.

The lack of staff housing was cited by numerous witnesses as a major impediment to the provision of more community based allied and mental health services. As Ms Kate Ganley (Secretary, Katherine Youth Interagency Tasking and Coordination Group) pointed out to the Committee:

One of the real challenges of recruiting to Katherine is a lack of available accommodation. I know Alice, Darwin and Nhulunbuy all have the same problems. For the record, the rental vacancies in Katherine are 0%. There is just nowhere to place professionals or anybody – it is across the board lack of housing – and it really does impact on the quality of service provision in Katherine.<sup>424</sup>

The Committee notes that lack of staff housing has also severely impacted on the capacity of the Shires in terms of remote service delivery. For example, the lack of housing in Nhulunbuy and Jabiru is such that both West Arnhem and East Arnhem Shires have had to establish satellite headquarters in Darwin. Needless to say this expenditure necessarily limits the revenue available for service delivery. Given that access to staff housing affects service delivery options of all three tiers of Government and the non-government sector, the Committee has recommended that a review of departmental staff housing requirements be undertaken as a matter of priority and that strategies be developed to address this issue.

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<sup>420</sup> Ms Valda Shannon, Aboriginal Mental Health Worker, Mental Health Association of Central Australia, *Committee Hansard*, 9 November 2011, p.16

<sup>421</sup> NT Department of Children and Families, *Submission 35*, Attachment C

<sup>422</sup> Ms Clare Gardner-Barnes, CEO, NT Department of Children and Families, *Committee Hansard*, 31 January 2012, pp. 29

<sup>423</sup> *Ibid*

<sup>424</sup> Ms Kate Ganley, Secretary, Katherine Youth Interagency Tasking and Coordination Group, *Committee Hansard*, 6 February 2012, p. 23

As highlighted in the section below, access to youth, sport and recreational facilities is particularly important in terms of social inclusion and social connectedness; both of which are acknowledged as significant protective factors for youth suicide. It is also noted that access to youth drop in centres reduces the likelihood of young people engaging in at risk behaviours such as juvenile delinquency and substance abuse. However, the Committee heard that youth drop in centres do not currently operate in either Katherine or Tennant Creek. Similarly, it was noted that young people living in the outlying rural area of Darwin have very limited options when it comes to recreational activities. The only locally based recreational options currently available in Humpty Doo are a skate park and the Gathering Inc: a small youth drop in centre which is totally reliant upon volunteers.

The Committee notes that in 2010 the Northern Territory Government announced that it was “[c]ommitted to building a facility in the Litchfield area where local residents...can access a variety of recreational opportunities.”<sup>425</sup> The Government subsequently funded the YMCA to undertake a scoping study at two proposed sites; Taminmin College at Humpty Doo and Freds Pass Reserve. Assessments of the two sites were based on the inclusion of a 25 metre swimming pool, wading pool, gymnasium, health club and cafe area suited for year-round use. This study found that the Freds Pass Reserve site was the more sustainable option in terms of overall community benefit.<sup>426</sup> In October 2010 the Government sought feedback from the community regarding the two options. At the time it was noted that once this was received:

A detailed business case could proceed including consideration of land tenure arrangements, location and dimensions, construction, fit-out, overall operating mechanisms, and indicative costs.<sup>427</sup>

Whilst there was general agreement on the part of the community for this project to go ahead on the Freds Pass Reserve Site, witnesses noted that very little seems to have occurred since. In light of the evidence regarding youth, sport and recreation options available to rural residents, the Committee recommends that funding be prioritised for the construction of the Litchfield Activity Hub.

### **Recommendation 1**

**The Committee recommends that the Northern Territory Government, in conjunction with the Australian Government, urgently:**

- a) provide extensive and effective community based professional development and training of existing local staff in relation to facilitating access to mental health assessments and counselling services (including grief counselling) in regional, rural and remote communities; and**

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<sup>425</sup> Northern Territory Government, *Have your say on the future of the Litchfield Activity Hub*, retrieved 16 February 2012, <http://www.ewsroom.nt.gov.au/index.cfm?fuseaction=printRelease&ID=7507>

<sup>426</sup> NT Department of Housing, Local Government and Regional Services, *Litchfield Activity Hub*, Retrieved 16 February 2012, <http://www.nt.gov.au>

<sup>427</sup> Northern Territory Government, *Ibid*

- b) **include mental health care specialists and counselling services (including grief counselling) as locally based or regularly and frequently visiting staff in all health clinics across the Northern Territory.**

### **Recommendation 2**

**The Committee recommends that the Northern Territory Government:**

- a) **review the status of visiting officers quarters in terms of:**
- **the extent to which current facilities meet the needs of visiting services;**
  - **maintenance and upgrade requirements; and**
  - **options for funding and development of required infrastructure to facilitate visiting service requirements.**
- b) **conduct a staff housing audit in Katherine, Tennant Creek, Jabiru, Nhulunbuy and Growth Towns to identify:**
- **staff housing requirements of the Shires, Northern Territory and Australian Government departments for the delivery of community based services including those provided by non-government organisations on behalf of the Northern Territory and Australian Governments; and**
  - **strategies and funding options for the additional staffing housing requirements;**
- c) **table a report on the progress of the audit and review of service infrastructure in the Legislative Assembly by 30 June 2013.**

### **Recommendation 3**

**The Committee recommends that the Northern Territory Government, and the Australian Government, prioritise Youth specific infrastructure funding for:**

- a) **graded accommodation options and mental health facilities for young people at risk of suicide, young people with severe substance abuse or mental health issues, and those requiring respite from adverse family circumstances, in Palmerston, Katherine, Tennant Creek, Alice Springs and Nhulunbuy;**
- b) **youth, sport and recreation facilities and youth drop in centres in regional towns such as Katherine, Tennant Creek and Nhulunbuy, and remote communities; and**
- c) **construction of a Litchfield Activity Hub as a 'one-stop' youth wellbeing facility in the outer Darwin region.**

### 3.1.2 Building Community Resilience

Research evidence indicates that “[r]esilience, self-esteem, connectedness, belongingness, supportive environments and positive life events”<sup>428</sup> are both important safeguards against risk factors associated with suicide, and the ability of friends, families and communities to deal with incidences of attempted or completed suicide.<sup>429</sup> As noted in the background section of this report, the Committee acknowledges that there are a number of Northern Territory and Australian Government initiatives already in place which aim to address issues relating to social disadvantage and build the resilience of communities; for example the Territory 2030 Strategic Plan, Safe Territory: Enough is Enough Alcohol Reforms and Domestic and Family Violence Reporting, Working Future – Territory Growth Towns initiative, and the Closing the Gap Indigenous Reform Agenda.

However, the evidence provided to the Committee also highlighted a number of areas which are not necessarily specifically addressed under the aforementioned initiatives. Similarly, the Committee heard that whilst there are many programs in place which aim to build the resilience of communities, there are issues around resourcing and equity of access that need to be addressed. The following discussion considers actions required to optimise the potential and effectiveness of services and service delivery models in terms of their capacity to develop the resilience of individuals, strengthen families and, as such, assist in the building of strong, healthy and resilient communities.

#### Developing the Mental Health and Wellbeing of Young People

As noted by Suicide Prevention Australia, in 2008 the Ministerial Council on Education, Employment, Training and Youth Affairs acknowledged that schools “play a vital role in promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development of young Australians.”<sup>430</sup> **headspace** advised the Committee that a key recommendation from the evaluation of the National Suicide Prevention Strategy, focused on “building capacity in the educational sector and increasing awareness of mental health issues among secondary students.”<sup>431</sup> Consequently, schools have been recognised as a primary location for the promotion of youth mental health and wellbeing programs.<sup>432</sup>

A number of submissions and witnesses noted the value of universal mental health and wellbeing programs such as *MindMatters*, aimed at high school students, and *KidsMatter*, which targets primary school students. Both programs are designed to promote the development of protective factors such as personal resilience, problem solving, coping skills, optimism, family, social and community connectedness, and the ability or willingness to seek help when required.<sup>433</sup> *MindMatters* was developed in

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<sup>428</sup> Suicide Prevention Australia, *op.cit.*, p. 5

<sup>429</sup> *Ibid*

<sup>430</sup> *Ibid*

<sup>431</sup> headspace, *Submission 23*, p. 13

<sup>432</sup> *Ibid*

<sup>433</sup> See for example: Suicide Prevention Australia, *Submission 20*, p.5; Menzies School of Health Research, *op.cit.*, p.3; Department of Health, *op.cit.*, p. 3; Mental Health Association of Central Australia Inc, *Submission*

recognition of the key role that secondary schools play in promoting youth mental health and wellbeing and is funded by the National Youth Suicide Prevention Strategy.<sup>434</sup> However, uptake of the *MindMatters* program in its entirety, both in the Northern Territory and elsewhere in Australia, has been limited.<sup>435</sup> As Dr Bath noted, only two Territory high schools (Taminmin and Kormilda) have fully embraced the *MindMatters* framework.<sup>436</sup>

As noted in the appendix to the Suicide Prevention Australia submission, a national survey of *MindMatters* found that two-thirds of schools have accessed training and utilised the program in some way from time to time, resulting in “small, but statistically significant, improvements in student attitudes following teacher training.”<sup>437</sup> Evaluation of the *MindMatters* curriculum resources *Understanding Mental Illness* was more encouraging; with teachers noting that it had “positive impacts on students’ knowledge, attitudes and behavioural intentions.”<sup>438</sup> Teachers’ knowledge of mental illness was identified as a key barrier to the effective implementation of this component of the program; “indicating the importance of comprehensive teacher professional development, prior to utilisation.”<sup>439</sup>

The Committee heard that key barriers regarding uptake of the *MindMatters* framework as a whole-of-school strategy included: shortage of teacher time, resources, staff turnover, and the on-going training and professional development requirements of the program.<sup>440</sup> In terms of the latter, the Committee heard that whilst it is generally acknowledged that teachers have a significant role to play in ensuring the social and mental health and wellbeing of their students, it is not something that is necessarily covered in teacher training courses.<sup>441</sup> Ms Beverley Ratahi (Chair, Taminmin College Council) also advised the Committee that, given the expectation that teachers will undertake professional development courses in a range of areas over and above core curricula requirements, the current funding allocation of 1.5 days of professional development per teacher per year is inadequate.<sup>442</sup>

The Committee also heard about *Love Bites*, a relationship violence prevention program aimed at young people aged 14-16, which is being utilised by Taminmin High School,

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29, p. 25; Aboriginal Peak Organisations Northern Territory, *Submission 28*, p. 6; Inspire Foundation, *Submission 17*, p. 3; Mr Gary Barnes, CEO, NT Department of Education and Training, *Committee Hansard*, 24 November 2011, pp. 8-9; Ms Erin Evans, Health Promoting Nurse, Taminmin High School Wellbeing Team, *Committee Hansard*, 2 December 2011, p.18; Mr Gerard Waterford, *Social Worker/Counsellor, Central Australian Aboriginal Congress, Committee Hansard, 10 November 2011*, p. 11; Ms Lauren Moss, Representative Youth Minister’s Round Table of Young Territorians, *Committee Hansard*, 30 January 2012, p. 31,

<sup>434</sup> Suicide Prevention Australia, *Attachment 3, op.cit.*, p 20

<sup>435</sup> *Ibid*

<sup>436</sup> Dr Howard Bath, *op.cit.*, p. 6, see also: *MindMatters, School Stories*, retrieved 3 February 2012 [http://www.mindmatters.edu.au/whole\\_school\\_approach/school\\_stories/school\\_stories.html](http://www.mindmatters.edu.au/whole_school_approach/school_stories/school_stories.html)

<sup>437</sup> Suicide Prevention Australia, *ibid*

<sup>438</sup> *Ibid*

<sup>439</sup> *Ibid*

<sup>440</sup> *Ibid*; see also: Mr Gary Barnes, *op.cit.*, p.11; Ms Bronwyn Hendry, *op.cit.*, p.6

<sup>441</sup> Ms Erin Evans, Health Promoting Nurse, Taminmin College, *Committee Hansard*, 23 December 2011, p.

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<sup>442</sup> Ms Beverley Ratahi, Chair, Taminmin College Council, *Committee Hansard*, 2 December 2011, p.22

Kormilda College, Batchelor Area School and a number of other schools in Darwin.<sup>443</sup> Offered through the National Association for Prevention of Child Abuse and Neglect, this initiative aims to break intergenerational cycles of family violence and sexual assault. *Love Bites* focuses on the development of young people's skills in terms of recognising safe, equal and healthy relationships, problem and conflict resolution, and accessing support services.<sup>444</sup>

Whilst acknowledging the benefits of mental health and wellbeing programs targeting high school students, the Committee heard that there is a growing body of research evidence which suggests that:

prevention and intervention strategies applied early in life are more effective in altering outcomes and reap more economic returns over the life course than do prevention and intervention (or punitive) strategies applied later.<sup>445</sup>

Findings from the child and adolescent component of the national survey of mental health and wellbeing indicate that, "14% of Australian primary school children experience mental health difficulties."<sup>446</sup> Moreover, it is estimated that up to 50% of all mental health problems are evident before the age of 14, and are inclined to "become stable and...resistant to change in the long term."<sup>447</sup>

The Committee heard that research indicates that prevention and intervention programs, such as *KidsMatter*, which target 'at risk' children and their families have been shown to be particularly effective in terms of achieving a sustained impact on risk factors associated with adolescent suicide.<sup>448</sup> This research suggests that this is, in part, due to the fact that they are able to influence a range of risks and outcomes, and, as such, may represent the most substantial value for money if implemented widely enough and sustained over time.<sup>449</sup>

*KidsMatter*, which complements *MindMatters*, is the first national, evidence based, early intervention and mental health promotion program specifically developed for primary schools. Based on a risk and protective factors model, this initiative focuses on the development of a positive school community, social and emotional learning, parenting support and education, and early intervention for students experiencing mental health difficulties. As such, it incorporates universal, selective and indicated approaches.<sup>450</sup>

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<sup>443</sup> Ms Marilyn Morris, Community Recreation Officer, Coomalie Council, *Committee Hansard*, 2 December 2011, p.13; Ms Charity McAleer, Community Wellbeing Team, Taminmin High School, *Committee Hansard*, 2 December 2011, p.20

<sup>444</sup> National Association for Prevention of Child Abuse and Neglect, *Love Bites*, retrieved 10 February 2012, <http://www.napcan.org.au/programs/love-bites/uj>

<sup>445</sup> Office of the Prime Minister's Science Advisory Committee, *op.cit.*, pp. 15-16; see also: NT Department of Children and Families, *op.cit.*, p.2

<sup>446</sup> Department of Health and Ageing, *KidsMatter Australian Primary Schools Mental Health Initiative*, Commonwealth of Australia, Canberra, ACT, 2009, p.2

<sup>447</sup> NT Department of Children and Families, *loc.cit.*

<sup>448</sup> J. M. Burns and G. C. Patton, 'Preventive interventions for youth suicide: a risk factor-based approach', in *The Australian and New Zealand Journal of Psychiatry*, 34 (3), pp. 388-407

<sup>449</sup> *Ibid*

<sup>450</sup> Department of Health and Ageing, *loc.cit.* Commonwealth of Australia, *Commonwealth Response to The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs Reference Committee*, Commonwealth of Australia D0146, Canberra, 2010, p.52

First implemented in 101 primary schools across Australia in 2007-08, evaluations of the pilot phase indicate:

multiple benefits, including school cultural changes in relation to mental health difficulties and the promotion of protective factors... and measured improvements in the mental health of children with with recognised mental health difficulties.<sup>451</sup>

A total of 23 primary schools across the Northern Territory have implemented the *KidsMatter* framework – 16 in the Greater Darwin area (including Howard Springs and Humpty Doo), one in Nhulunbuy, and five in Central Australia including the remote community of Yuendumu.<sup>452</sup> The Department of Health submission noted that, on the basis of the evaluation of the pilot phase, and in response to the 2010 Senate Inquiry into Suicide in Australia, the Australian Government has provided a further \$18.4m to expand the *KidsMatter* initiative to an additional 1700 primary schools.<sup>453</sup>

Following on from the success of *KidsMatter*, in 2010 a pilot phase of *KidsMatter Early Childhood* was launched in over 100 preschools and long day care centres across Australia; including ten services in the Northern Territory – six in the Darwin metropolitan area, one in Katherine, one in Jabiru, and two in Alice Springs.<sup>454</sup> Providing a continuous improvement framework, this initiative facilitates service providers' capacity to plan and implement evidence based mental health promotion, prevention and early intervention strategies. The *KidsMatter Early Childhood* initiative aims to improve the mental health and wellbeing of children from birth to school age, reduce mental health problems among children, and achieve greater support for children experiencing mental health difficulties and their families.<sup>455</sup>

Mr Gary Barnes (Chief Executive Officer, NT Department of Education and Training), advised the Committee that whilst the explicit teaching of resilience was recognised as an effective suicide prevention measure, the current curriculum did not deal with this as well as it should.<sup>456</sup> It was further noted that the Australian Government is due to launch a new health and physical education curriculum in 2012 and that this would incorporate the teaching of resilience.<sup>457</sup> However, in spite of the overwhelming evidence regarding the need for, and benefits of, a more comprehensive approach to youth mental health and wellbeing, the department advised the Committee that uptake of programs such as *MindMatters* or *KidsMatter* was voluntary and a decision for individual schools.<sup>458</sup>

Whilst the Committee acknowledges the value of school autonomy to determine what types of extra curricula programs are most suited to the needs of their community, it is suggested that the Northern Territory Department of Education take a more proactive

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<sup>451</sup> KidsMatter, *Participating Schools*, retrieved 9 February 2012, <http://www.kidsmatter.edu.au/primary/schools-map/nt/schools/>

<sup>452</sup> *Ibid*

<sup>453</sup> Department of Health, *op.cit.*, p. 19

<sup>454</sup> KidsMatter, *Ibid*

<sup>455</sup> Department of Health and Ageing, *KidsMatter Australian Early Childhood Mental Health Initiative*, Commonwealth of Australia, Canberra, ACT, 2010, p.2

<sup>456</sup> Mr Gary Barnes, *op.cit.*, p.8

<sup>457</sup> *Ibid*, pp. 8-9

<sup>458</sup> *Ibid*, p.11

stance and actively encourage the uptake of social and emotional wellbeing programs, such as those discussed above, at the primary, middle and secondary level in both government and non-government schools

#### Recommendation 4

**The Committee recommends that the Department of Education and Training increase the professional development opportunities for all teachers in relation to mental health and wellbeing, and recognising and assisting young people at risk of suicide.**

#### Anti-Bullying Programs

In light of a number of high profile suicide deaths, Suicide Prevention Australia highlighted the importance of anti-bullying measures in schools as a means of increasing the safety of young people, reducing psychological distress and the risk of suicide. The Committee heard that, with the advent of social networking via internet sites such as Facebook and mobile phones, the incidence of bullying has become increasingly common.<sup>459</sup> As the submission from the Mental Health Association of Central Australia Inc pointed out, whilst mobile phones and social networking might be viewed as a means of staying socially connected they have the capacity to “alienate young people as much as unite them.”<sup>460</sup> Moreover, the:

psychological and emotional outcomes of cyber bullying are similar to real-life bullying outcomes, except for the reality that with cyber bullying there is often no escape. School ends at 3 p.m., while the internet is available all the time.<sup>461</sup>

As Ms Miriam McDonald (Principal, Taminmin College) advised the Committee, social media is an emerging management issue for both schools and parents. Although it was noted that there are a number of government websites that provide advice on the use and abuse of social networking sites, a more direct approach was required to raise awareness and educate parents and carers about this issue.<sup>462</sup> Ms McDonald informed the Committee that whilst the school’s e-News incorporates handy hints for parents in this regard:

Parents need to be empowered... It is a very difficult one to manage, but our recommendation is to the kids and to the parents, if it is happening, to look at the account, block the person...but it involves much education and empowerment of kids and parents.<sup>463</sup>

Ms McDonald also noted that the school had recently upgraded its policy regarding the use of mobile phones. Since the majority of students have mobile phones and the technology is acknowledged as a valuable teaching tool, the new policy states that they

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<sup>459</sup> Suicide Prevention Australia, *op.cit.*, p.10; Ms Amelia Callaghan, State Manager QLD, NT, WA, headspace, *Committee Hansard*, 3 November 2011, p. 14

<sup>460</sup> Mental Health Association of Central Australia, *op.cit.*, p. 26; see also SAFT, *Submission 41*, pp.1-4

<sup>461</sup> Do Something.Org, *Facts About Cyber Bullying*, retrieved 29 February 2012, <http://www.dosomething.org/tipsandtools/11-facts-about-cyber-bullying>

<sup>462</sup> Ms Miriam McDonald, Principal, Taminmin College, *Committee Hansard*, 2 December 2011, p.28;

<sup>463</sup> *Ibid*

can only be used for “appropriate educational purposes during school time... If it is inappropriate, offensive or anything that is illegal we will remove the phone and contact the parents.”<sup>464</sup> The Committee heard that Youth Engagement Police Officers also “liaise with schools to raise awareness of issues surrounding the increase in cyber bullying and cyber offences.”<sup>465</sup>

The submission from Stronger Aboriginal Families Together highlighted the fact that cyber bullying was particularly pervasive and extremely problematic in many Indigenous communities.<sup>466</sup> The Committee heard that recent research indicates that Indigenous people are amongst “the highest users of mobile phones and associated technologies, including Facebook.”<sup>467</sup> As Stronger Aboriginal Families Together noted, this reflects the fact that “[d]eveloping and maintaining social networks and contacts within Aboriginal communities are important for maintaining cultural connections and a strong cultural identity.”<sup>468</sup>

The Committee was further advised that in November 2011, the organisation consulted a broad range of service providers and individuals regarding the improper use of social networking and mobile phones. Participants noted that the following concerns had been raised in a number of communities, including Galiwin’ku, Yuendumu, Santa Teresa, Maningrida, Alice Springs and the urban Town Camps:

- The link to increased levels of aggression and harassment. Evidence that *Diva Chat* is commonly used to incite, exacerbate and inflame community violence, and that ‘cyber payback’ is becoming an increasing problem.
- Evidence that at least one recent suicide of a young Aboriginal girl was due to cyber bullying via Facebook.
- A recent incident involving two primary school aged children, where one was ‘de-friended’ by the other via Facebook, resulting in the offended child resorting to violence, the family becoming involved and the violence having a ripple effect.
- The prolific use of sexting and the sending and receiving of explicit ‘in house’ pornographic images and video footage of children and young people to their peers and, even more disturbingly, to adult sex predators.<sup>469</sup>

The Committee notes that the Australian Communication Media Authority has developed a wide range of training programs, awareness raising and educational resources targeting children, adolescents, parents, schools, libraries, and teachers that are freely available from the Australian Government’s *cybersmart* website.<sup>470</sup> However, as

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<sup>464</sup> *Ibid*

<sup>465</sup> Northern Territory Government, *Review of the Northern Territory Youth Justice System: Report*, Northern Territory Government, 2011, p. 87

<sup>466</sup> Stronger Aboriginal Families Together, *loc.cit*

<sup>467</sup> *Ibid*

<sup>468</sup> *Ibid*

<sup>469</sup> *Ibid*, pp. 2-3

<sup>470</sup> Australian Government ACMA, *Cybersmart – Internet and mobile safety advice and activities*, retrieved 29 February 2012, <http://www.cybersmart.gov.au>.

Stronger Aboriginal Families Together pointed out, these resources are neither particularly accessible nor necessarily suitable for Indigenous people living in remote communities.<sup>471</sup> It was noted that “there is clearly a need to extend this awareness and to develop a culturally appropriate education program aimed at NT Aboriginal children, young people and their families.”<sup>472</sup> The Committee was further advised that research is required to better understand patterns of use of social networking sites and smart phone applications among NT remote Aboriginal children and youth, “in order to develop evidence based approaches to addressing this growing problem in the longer term.”<sup>473</sup>

Whilst all government schools are required to have an anti-bullying policy in place which complies with the *Safe Schools NT Code of Behaviour*, the Committee heard that these were site specific, developed in consultation with their school community and, as such, do not necessarily incorporate policies regarding the use of mobile phones. As Mr Nyhuis advised the Committee, the issue of cyber bullying is currently a topic that is attracting considerable debate at the national level in terms of, “how do you engage with technology as a learning medium but not have it be an antisocial or negative one.”<sup>474</sup>

Mr Barnes acknowledged that there was a need to review the department’s current policy and noted that Queensland has recently brought out a new policy regarding social networking, cyber bullying and use of mobile phones in schools. However, as Mr Barnes also noted:

It is a vexed question because these are the communication tools with which students are familiar, comfortable, and they are almost an extension of their own individuality. What we need to look at is, maybe, how those things are used, when they are used, and for what purpose – and being stringent around that – because I tell you if it is a blunt approach to banning things, then sometimes that just makes a smarter mouse.<sup>475</sup>

The Suicide Prevention Australia submission also acknowledged that whilst the research suggests that school based anti-bullying programs can be extremely effective in reducing unacceptable behaviours, particularly amongst younger pre-secondary students, problem solving approaches were found to have far more consistent and positive results than punitive measures. Whilst the direct impact of anti-bullying programs on suicide rates is yet to be fully determined, the evidence currently available is quite promising. Prevention of bullying, in particular cyber bullying, outside of the school environment is a far more challenging issue; one that “may require cultural and social changes, including legislation and anti-discrimination law compliance.”<sup>476</sup>

## Recommendation 5

**The Committee recommends that the Department of Education and Training:**

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<sup>471</sup> Stronger Aboriginal Families Together, *op.cit.*, p. 3

<sup>472</sup> *Ibid*, p. 2

<sup>473</sup> *Ibid*, pp.3-4

<sup>474</sup> Mr Paul Nyhuis, *op.cit.*, p. 37

<sup>475</sup> Mr Gary Barnes, *op.cit.*, p. 10

<sup>476</sup> Suicide Prevention Australia, *loc.cit.*

- a) **review its anti-bullying policy guidelines and incorporate a policy regarding cyber bullying and the use of mobile phones during school hours and direct all schools to implement this policy as a matter of priority; and**
- b) **actively encourage the uptake of educational resources and training available through the Australian Communication Media Authority's *cybersmart* website.**

## **Positive Youth Development**

The importance of ensuring young people have access to a range of youth, sport and recreational activities was highlighted in a number of submissions and the evidence of witnesses appearing before the Committee.<sup>477</sup> Positive Youth Development programs, in contrast to Youth Diversion services as discussed in 3.2.4 below, are available to all young people in a community rather than targeting only those “with defined problems or in high-risk situations.”<sup>478</sup> It is an assets-based approach which focuses on assisting young people to develop the inner resources and skills required to meet the challenges of adolescence and adulthood. As such, Positive Youth Development programs are proactive and seek to provide:

activities and experiences which help them [young people] to become socially, morally, emotionally, physically and cognitively competent. It addresses the broader developmental needs of young people.<sup>479</sup>

As the submission from Suicide Prevention Australia noted, social inclusion and community connectedness have been identified as key protective factors in terms of suicide risk amongst young people. Conversely, young people that are socially isolated, disconnected from their family, homeless or unemployed, are at a far greater risk of engaging in self-harm or experiencing suicidal thoughts.<sup>480</sup> The Committee heard from Dr Bath that research into youth suicide in the Northern Territory indicates that:

in a significant number of cases there was weak engagement of that young person with the broader community. For instance, school, sport activities, cultural programs etc, all of which help to provide some support and structure for young people at times of emotional distress.<sup>481</sup>

The submission from the Katherine Youth Interagency Coordination and Tasking group noted that boredom was cited by young people as the main reason for:

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<sup>477</sup> See for example: Professor Colin Tatz, *Submission 4 and Committee Hansard*, 3 November 2011, pp. 47-52; Mental Health Association of Central Australia, *op.cit.*, pp. 27-28; Katherine Youth Interagency Tasking and Coordination Group, *op.cit.*, p.6; NTCOSS, *op.cit.*, p. 3; CAYLUS, *op.cit.*, pp. 5-7; add others from Bees Creek, Yirrkala Forum and Tennant

<sup>478</sup> Supervisory Training to Enhance Permanency Solutions, *Definitions and Key Characteristics of a Positive Youth Development Approach*, retrieved 28 February 2012, <http://www.steps-umms.org/uploadedFiles/DefinitionsandKeyCharacteristicsofPositiveYouthDevelopmentApproach.pdf>

<sup>479</sup> *Ibid*

<sup>480</sup> Suicide Prevention Australia – Attachment 3, *op.cit.*, p.8

<sup>481</sup> Dr Howard Bath, *op.cit.*, p.3

engaging in a range of risky behaviour, including drinking, drug taking, drink driving and criminal behaviours including break and entering, criminal damage, stealing vehicles.<sup>482</sup>

In addition to relieving boredom, the Committee heard that the provision of facilities such as youth drop in centres fulfil a significant role in terms of providing spaces where young people can legitimately “gather and socialise, learn new skills, build self-confidence and create pathways to employment.”<sup>483</sup> The Committee was also advised that arts, cultural, recreational and other organised activities can also be used as an effective basis for “on-going relationships with mentors and provide opportunities for modelling teamwork and other adaptive responses to difficulties.”<sup>484</sup> Moreover, the consequences of developing effective, non-threatening and trusting relationships between youth workers and young people based around activities are that:

young people may be more likely to disclose areas of concern with a youth worker and/or youth workers may be more likely to notice if a young person has concerns in their life.<sup>485</sup>

The importance of the mentoring component of positive youth development programs was also highlighted to the Committee by Mr George Kasperek, Scout Leader, Humpty Doo.<sup>486</sup> Mr Kasperek noted that the scouts program in Humpty Doo attracts on average 50, six to 15 year olds every Wednesday night and a further 15 slightly older ones on Thursday nights.<sup>487</sup> The Committee hear that it was not unusual for young people to disclose things to Scout Leaders that they would not necessarily feel comfortable talking about to their parents. As Mr Kasperek noted, this was particularly important for those young people who lacked supportive home environments.<sup>488</sup>

The lack of youth designated spaces such as drop in centres in Darwin’s rural area, Katherine and Tennant Creek was highlighted to the Committee as an area of particular concern.<sup>489</sup> The Katherine Youth Interagency Tasking and Coordination Group also pointed out that the provision of safe and secure after hours locations for young people to interact is particularly important.<sup>490</sup> The fact that the majority of youth services do not operate after 5pm was highlighted as an area that needs to be reviewed by the Central Australian Aboriginal Congress and participants at the inquiry’s Tennant Creek Forum.<sup>491</sup>

The Committee notes that the only youth focussed service currently based in Darwin’s rural area is *The Gathering Inc* located in Humpty Doo. This service provides

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<sup>482</sup> Katherine Youth Interagency Tasking and Coordination Group, *op.cit.*, p.6

<sup>483</sup> Mental Health Association of Central Australia, *op.cit.*, p. 27

<sup>484</sup> Department of Health, *op.cit.*, p. 3

<sup>485</sup> Mental Health Association of Central Australia, *ibid*

<sup>486</sup> Mr George Kasperek, Scout Leader, Humpty Doo, *Committee Hansard*, 2 December 2011, p. 13

<sup>487</sup> *Ibid*

<sup>488</sup> *Ibid*

<sup>489</sup> *Katherine Youth Interagency Tasking and Coordination Group, op.cit.*, p.10; see also: S, Crook and K, Johnson, *Youth Station: Investigating the feasibility of establishing a Youth Station in Darwin’s Rural Area*, Youth Minister’s Round Table of Young Territorians, Northern Territory, 2010, pp. 9-11; Ms Valda Shanon *Committee Hansard*, 9 November 2011, p. 10

<sup>490</sup> Katherine Youth Interagency Tasking and Coordination Group, *op.cit.*, p.10

<sup>491</sup> Central Australian Aboriginal Congress, *op.cit.*, p. 29; Ms Sharon Lake, Community Services Manager, Berkley Shire, and Ms Valda Shanon *Committee Hansard*, 9 November 2011, pp. 6 & 10

emergency relief, counselling, mediation, and a personalised mentoring program. *The Gathering Inc*, which has been in operation for ten years and is staffed primarily by volunteers, also operates a small drop in centre and organises a range of activities such as a boxing club, craft group, dance parties, live music events and pool competitions.<sup>492</sup> As an indication of the need for these types of services in Darwin's rural area, the Committee notes that:

in the 2008/09 financial year they [*The Gathering Inc*] serviced 1112 clients, this financial year [2009/10] they have serviced 3818 clients. On average a client is equivalent to a family of two adults and two children.<sup>493</sup>

CEO of *The Gathering Inc*, Ms Sharon Crook advised the Committee that, in addition to Humpty Doo, the organisation provides youth mentoring and counselling services in Berry Springs, and Marrakai and is also starting to provide services in Batchelor.<sup>494</sup>

The Committee heard that access to positive youth development programs was also important in terms of young people who are either disengaged from school or are post school age. As the submission from NTCOSS highlighted:

In the case of many remote communities there is no high school and young people are no longer in school from age 12. Programs and services targeting this age group (12 -17) must be implemented at a community level through approaches such as youth development and community wellness programs.<sup>495</sup>

Ms Crook noted that the Gathering Inc's Humpty Doo Youth Drop in Centre attracts a lot of young people who do not normally go to school.<sup>496</sup> Ms Crook advised the Committee that the centre also caters for a number of young adults who are post school age and unemployed.<sup>497</sup>

As highlighted to the Committee, there is a significant need for funding programs that facilitate the provision of recreational activities for young people; especially given that "young people increasingly become the largest population in many communities"<sup>498</sup> As Mr Blair McFarland, (Manager, CAYLUS) advised the Committee, youth services should be available to all young people since:

there are very clear indications that participation in youth programs decreases the risk of suicide, decreases the risk of substance abuse, increases school attendance, improves health, reduces chronic illness, reduces obesity and generally improves wellbeing and social engagement with the wider community.<sup>499</sup>

However, as the Committee was advised that funding programs for positive youth development programs are extremely limited. The Committee notes that the NT Office of Youth Affairs currently offers three grants under its *Youth Engagement Grants Program*:

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<sup>492</sup> S, Crook and K, Johnson, pp.11-13

<sup>493</sup> *Ibid*, p.13

<sup>494</sup> Ms Sharon Crook, Pastor Bush Baptist Church and CEO of The Gathering Inc, *Committee Hansard*, 2 December 2011, p. 2

<sup>495</sup> *Ibid*

<sup>496</sup> Ms Sharon Crook, Pastor Bush Baptist Church and CEO of The Gathering Inc, *Committee Hansard*, 2 December 2011, p. 3

<sup>497</sup> *Ibid*

<sup>498</sup> CAYLUS, *op.cit.*, p.5

<sup>499</sup> Mr Blair McFarland, Manager, CAYLUS, *Committee Hansard*, 30 January 2012, p.14

National Youth Week Grants, Youth Vibe Holiday Grants and Quick Response Grants. Whilst stating that the Government is “committed to providing positive opportunities for all young Territorians to access suitable programs and activities.”<sup>500</sup> the Committee notes that these grants are very limited in what they actually offer.

In terms of 2012, *National Youth Week Grants* of between \$500 and \$2,000 are available for events to be run from 13-22 April and incorporate two categories of grants. Category 1: Drug and Alcohol Free Entertainment: provision of funding for young people, community groups and organisations to enable young people to plan, organise and participate in a variety of drug and alcohol free activities. Category 2: Youth Development and Leadership: provision of funding to young people, community groups and organisations to increase the access of young people to personal and community development programs.<sup>501</sup>

*Youth Holiday Vibe Grants* of between \$500 and \$2,000 are available for the same categories of activities as listed above during the June/July and December/January school holiday periods. Quick Response Grants up to \$500 only, are also available for the same two categories of activities throughout the year. In the absence of specific funding rounds, Quick Response grants are available until such time as the funding pool is fully expended. The Committee notes that the 2011-2012 funding allocation was fully expended mid way through the financial year.

The Australian Government’s *Youth Development Support Program*, with a national funding pool of \$500,000, is the only other source of positive youth development funding. Here again, the Committee learned that this program is both quite prescriptive and somewhat limited. The overall aim of the program is to provide funds for “initiatives that inspire and encourage young people to engage with government and their community, and help them develop skills and connections within their communities.”<sup>502</sup> Specific objectives include:

- Inspiring young people in Australia to recognise and achieve their full potential and to be active citizens;
- Supporting the development of young people and their transition to independence and adulthood;
- Supporting opportunities for young people and local youth organisations to engage with the Australian Government’s youth initiatives such as the National Strategy for Young Australians and the Australian Youth Forum; and
- Promoting positive perceptions of young people as respected young citizens in their communities.<sup>503</sup>

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<sup>500</sup> Department of Children and Families, *Youth Engagement Grants Program*, retrieved 28 February 2012, [www.youth.nt.gov.au](http://www.youth.nt.gov.au)

<sup>501</sup> *Ibid*

<sup>502</sup> [www.youth.gov.au](http://www.youth.gov.au), *Youth Development Support Program*, retrieved 28 February 2012, [http://www.youth.gov.au/News/Pages/ydsprogram\\_010410.aspx](http://www.youth.gov.au/News/Pages/ydsprogram_010410.aspx)

<sup>503</sup> *Ibid*

Unfortunately funding is only provided to community organisations or National Youth Organisations; as such Local Government Authorities are not eligible. The Committee also notes that access to this funding stream is also limited by the fact that it is theme based. The theme for 2011-12 was *Youth Arts and Creative Enterprises*. The Committee understands that two Northern Territory initiatives were successful in the 2011-12 funding round: The Waltja Tjutangku Palyapayi Aboriginal Corporation (\$18,200 for arts enterprise projects based in Mount Liebig and Papunya), and the Catholic Church of the Diocese of Darwin Property Trust (\$40,000 for a Harmony in Our Community project in Wadeye.)<sup>504</sup>

In reviewing the youth programs currently available to young Territorians, the Committee notes the current focus is on youth diversion focus. Whilst it is acknowledged that many such programs incorporate elements of positive youth development, for example the Mt Theo Program and the youth service provided by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council's, the vast majority of programs are deficit based, problem oriented programs. Given the overwhelming benefits of positive youth development initiatives in terms of their capacity to mitigate risk factors and promote protective factors associated with youth suicide, the lack of funding available for such is somewhat difficult to comprehend. The Committee notes that the Youth in Communities program alone provided \$26 million over a 3 year period for youth diversion initiatives in the Northern Territory. Whilst the Committee acknowledges the need for youth diversion programs which specifically target many of the problems young people are facing, it is suggested that a greater investment in positive youth development may well minimise the need for such a disproportionate investment in youth diversion in the longer term.

### **Recommendation 6**

**The Committee recommends that the Department of Children and Families' Office of Youth Affairs establish a substantial funding program to facilitate the introduction of positive youth development programs and that this funding stream be open to both Local Government Authorities and Non-government Organisations.**

### **Sport and Active Recreation**

Sport and Active Recreation programs fulfil a very similar function to positive youth development programs in terms of their role in the development and promotion of protective factors such as social inclusion and social connectedness. As the submission from Professor Colin Tatz notes, a number of studies have found that the odds of considering or planning suicide are significantly reduced in young people that are actively involved in sports.<sup>505</sup> The Committee heard that a study that looked at participation in sports and the incidence of depression and suicidal thoughts found that:

Sport typically boosts esteem, improves body image, increases social support and has an impact on substance abuse. As sports participation increases, the odds of

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<sup>504</sup> *Ibid*

<sup>505</sup> Professor Colin Tatz, *Submission 4*, p. 8

suffering from depression decreases (by 25 percent), while the odds of having suicidal thoughts decreases (by 12 percent).<sup>506</sup>

Professor Tatz advised the Committee that the protective function of sports did not only extend to the players but was also seen to have a positive impact on those that were involved in the administrative side, such as organising the next game or fundraising.<sup>507</sup> The Committee heard that a number of studies also highlight the protective nature of sports for those that are actively engaged as spectators. For example, in terms of the relationship between sport and juvenile delinquency, research evidence indicates that:

When the football – or whatever season, basketball season – was on the delinquency rates were almost invisible and, as soon as the sporting season came to an end, it all escalated enormously.<sup>508</sup>

The Committee was further informed that one of the problems associated with suicide amongst Indigenous youth is that they lack a sense of the future “they only dwell in the past and the present.” The Committee notes that this point was also made by a number of other witnesses including, for example, Drs John and Ruth Rudge who provide clinical psychology services on the Tiwi Islands and the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council.<sup>509</sup> As Professor Tatz noted, a central point about the relationship between sport and suicide is that apart from giving people a sense of purpose:

that sense of purpose is basically a present tense and a future tense oriented activity. When you think about sport you are thinking about next weekend’s match, you are thinking about next month’s match, you are thinking about next season’s match...We have to find mechanisms to get people to have some kind of future orientation that life has some kind of future.<sup>510</sup>

Although provision of sport and recreation programs is not a core service function under the NT Local Government Act, the Committee was advised that the Shires, with the notable exception of the Litchfield Shire, are the primary providers of such in remote Indigenous communities. However, a number of concerns were raised with the Committee regarding the capacity of the Shires to provide comprehensive sport and recreation programs in each of their constituent communities.<sup>511</sup> For example, as highlighted by Professor Tatz, the emphasis of current funding programs is on organised sports and active recreation to the exclusion of other leisure activities that do not necessarily fit within current funding guidelines. In citing the recent Crawford report in to sport, Professor Tatz pointed out that there is a clear need for funding bodies to recognise the value of community sports:

and community sport means all leisure and recreation activities such as “splashing in the pool, going on a camping hike, organising a food hunt, organising a whole host of

<sup>506</sup> *Ibid*

<sup>507</sup> Professor Colin Tatz, *Committee Hansard*, 3 November 2011, p. 50

<sup>508</sup> *Ibid*

<sup>509</sup> Drs John and Ruth Rudge, Clinical Psychologist, Southern Cross Clinical Psychology Services, *Committee Hansard*, 31 January 2012, p. 42 and Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *Submission 37*, p.2

<sup>510</sup> Professor Colin Tatz, *loc.cit.*

<sup>511</sup> Ms Sharon Lake, *op.cit.*, p.29

leisure and other rituals that are common in Aboriginal communities that is as much sport as the Nguiu Football Final.<sup>512</sup>

Similarly, whilst acknowledging the value of employing Indigenous staff in sport and recreation positions it was noted that attracting and retaining staff was difficult. As Ms Lake informed the Committee, Indigenous Sport and Recreation programs are currently based on part time positions;<sup>513</sup> which are “minimal paying positions.” The Committee heard that the Barkly Shire is currently allocated ten 0.5 positions under one program and a further six 0.5 positions under another.<sup>514</sup> In recognition of what is required of these positions, and in terms of attracting applicants, Shires are allowed to utilise two positions to bring them up to full time jobs. However, as Ms Lake advised the Committee, in the case of the Berkley Shire this only allows for a total of eight positions to service “seven communities, 16 homelands and everywhere else in between.”<sup>515</sup> It was further noted that there is currently no provision for sport and recreation positions in Tenant Creek.<sup>516</sup> Moreover, whilst the weekends and evenings have been identified as high risk periods where more sport and recreation activities would be particularly beneficial, under current funding programs employees “are not entitled to attract any penalties for the Saturday or Sunday nights.”<sup>517</sup>

As Alan Hudson (Chief Executive Officer, Tiwi Islands Shire Council) advised the Committee, there seems to be little recognition of the high proportion of young people in Indigenous communities that these programs are expected to cater for. Mr Hudson noted that the Tiwi Shire Council’s last submission for sport and recreation funding was initially refused. The Committee heard that it was not seen to be competitive enough as the Council had requested funding for additional staff as:

the current level of funding meant that the ratio of kids to supervisors was in the order of 50:1 which was totally unrealistic.<sup>518</sup>

The requirement for youth, sport and recreation staff to hold a *Working with Children* or *Ochre Card* was also cited as problematic when it came to employing Indigenous staff since many of those interested in the positions were ineligible due to criminal convictions.<sup>519</sup>

Professor Tatz also highlighted to the Committee the fact that, whilst the value of sport and recreation as a protective factor in relation to suicide was well recognised, by and large, sporting programs particularly in Indigenous communities have tended to be directed primarily at young men.<sup>520</sup> As Professor Tatz noted:

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<sup>512</sup> Professor Colin Tatz, *op.cit.*, p. 52

<sup>513</sup> Ms Sharon Lake, *loc.cit.*,

<sup>514</sup> *Ibid*

<sup>515</sup> *Ibid*

<sup>516</sup> *Ibid*

<sup>517</sup> *Ibid*

<sup>518</sup> Alan Hudson, Chief Executive Officer, Tiwi Islands Shire Council, *Committee Hansard*, 3 February 2012, p. 3

<sup>519</sup> Ms Larissa Knight, (Mental Health Worker, Mental Health Association of Central Australia Inc, Barkley Region), *Committee Hansard*, 9 November 2011, p. 13

<sup>520</sup> Professor Colin Tatz, *Committee Hansard*, 3 November 2011, p. 50

if there is \$100 available to get any one young Aboriginal male onto a sports field, there is only about \$1 to get a female onto the sports field. There is a huge disparity in fundraising, in sponsorships, in support systems for males as opposed to females.<sup>521</sup>

The *Clontarf* program was cited as a case in point, which up until quite recently was only directed at males.<sup>522</sup>

The Committee heard that *Clontarf* is not a sporting program per se, but a behavioural change program that uses sport as a means of engaging with Indigenous youth.<sup>523</sup> The *Clontarf Foundation* partners with schools to create sporting academies to attract and keep participants at school. There are currently 15 *Clontarf* academies operating across the Northern Territory in urban, regional and remote communities. Academies are staff with trained mentors who are often former teachers or professional sports men and women. The program aims to capture the participant's attention and gain their respect and trust. Through exposure to a wide range of life experiences designed to challenge participants the program develops self esteem and positive attitudes towards health, education and employment. The program assist graduates to find employment and supports them in the transition from school to work.<sup>524</sup>

The Committee heard that there are number of broad social benefits resulting from the program with statistical and anecdotal evidence of improved educational attendance and outcomes including:

- School attendance rates of 80% and above
- Re entry into education after prolonged absences
- Year on year retention at school – not less than 90% which is well above state averages
- Enhanced self esteem and self awareness
- Reduced cases of criminal re-offending
- Improved academic results from basic literacy and numeracy through to high school graduation
- A greater understanding of, and access to, the employment opportunities available to them
- More than 75% of *Clontarf* graduates engaged in employment or training within six months of completing school.<sup>525</sup>

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<sup>521</sup> *Ibid*

<sup>522</sup> Mr Gary Barnes, *op.cit.*, p.10

<sup>523</sup> *Clontarf Foundation, About Us: How we work*, retrieved 19 February 2012, <http://www.clontarf.org.au/content.php?req=2>

<sup>524</sup> *Ibid*

<sup>525</sup> *Ibid*

As one of the participants at the inquiry's Youth Forum informed the Committee, if it hadn't been for his involvement in the *Clontarf* program he would have dropped out in year 11 but it helped him to stick it out and finish year 12 and find employment:

If you ever needed to talk to someone or need help with something, they will always be there to help the students. They need more programs like that to go into more communities and to push Aboriginals as well as other people through school, as well as help them get a job after school.<sup>526</sup>

## Health – An Integrated Service Delivery Model for Indigenous Communities

The Committee heard that many of the health and wellbeing issues afflicting Indigenous remote communities could be addressed more effectively under an integrated service delivery approach. As the submission from Aboriginal Peak Organisations Northern Territory pointed out, the 2006 Senate Inquiry into Mental Health found that people with dual diagnosis (both mental health and substance abuse problems) are “so common that it should be regarded as the norm rather than the exception [and] it may be even more prevalent amongst Aboriginal people than in the Australian population generally.”<sup>527</sup> In spite of this being the case, the Committee heard that in the Northern Territory, alcohol and substance abuse and mental health problems are addressed as separate issues, and, more often than not, by separate specialist service providers.<sup>528</sup>

Given the correlation between substance abuse, mental health problems and interpersonal violence, self-harm and suicide risk, it would clearly be advantageous for mechanisms to be in place to ensure these types of issues are identified as early as possible and treated appropriately. However, as the Committee was informed, the current health care service delivery model represents a significant stumbling block in this regard.<sup>529</sup> Whilst the primary health care sector is seen to be best placed to detect, and act on, early signs of substance abuse or mental health problems, the Committee was advised that research indicates that:

clinicians in primary health care are much more likely to screen for mental health and alcohol and drug problems if they are confident that they can refer to high quality accessible alcohol and other drugs and mental health services.<sup>530</sup>

Unfortunately, the Committee heard that in most remote communities, specialist mental health, alcohol and other drug services are not necessarily available on-site and people are therefore reliant upon “fragmented and uncoordinated visiting services from external providers.”<sup>531</sup> The Committee also heard that even where mental health services are available, the focus is on treating those with clinically diagnosed conditions as services generally lack the capacity to provide early interventions in the form of counselling for example.<sup>532</sup> As the submission from Aboriginal Peak Organisations Northern Territory

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<sup>526</sup> Witness (name not for publication), *Committee Hansard*, 2 December 2011, p. 52

<sup>527</sup> Aboriginal Peak Organisations Northern Territory, *Submission 28*, p. 21

<sup>528</sup> *Ibid*

<sup>529</sup> *Ibid*, pp. 20-21

<sup>530</sup> *Ibid*, p.20

<sup>531</sup> *Ibid*, p.20

<sup>532</sup> East Arnhem Shire Council, *Committee Hansard*, 17 November 2012, p13

pointed out, apart from the fact that accessing multiple services tends to inhibit help seeking behaviour on the part of individuals:

Uncoordinated service delivery leads to suboptimal outcomes and is expensive, inefficient and burdensome for the primary health care service and community who deal with all the external visiting teams.<sup>533</sup>

In response to these issues, the Committee was advised that AMSANT has developed an evidence based model for the integration of alcohol and other drugs and mental health services into Aboriginal primary health care in the Northern Territory.<sup>534</sup> Incorporating a clinical and community development component, this model is supported by the Aboriginal Peak Organisations Northern Territory, the Central Australian Aboriginal Congress and the Jesuit Social Services.<sup>535</sup> Following is a brief overview of the model which was provided in full as an attachment to the submission from Aboriginal Peak Organisations Northern Territory.

The Committee was advised that the model involves the incorporation of Social and Emotional Wellbeing Teams into existing primary health care services. As noted in the submission from Aboriginal Peak Organisations Northern Territory, key features of the clinical component of this integrated service model include:

- Aboriginal Family Support Workers who are respected members of their community working in partnership with psychologists, social workers, Aboriginal alcohol and other drugs (AOD) workers and mental health nurses.
- No artificial divide between the management of people with alcohol and other drug and mental health problems. Dual diagnosis is very common and focused psychological therapies such as cognitive behavioural therapy are efficacious for both AOD and mental health problems. This is especially important for preventing suicide as those at the highest risk are likely to engage in high risk substance misuse and also demonstrate evidence of mental illness. In conventional service models, these people are poorly managed with neither the mental health nor AOD specialist services wanting to take responsibility.
- Screening within primary health care will occur during health checks and also opportunistically. People with significant problems will be referred to the Social and Emotional Wellbeing Team and will be managed through a care plan that incorporates the primary health care team (including the GP for medication management) and the Social and Emotional Wellbeing team.
- Provision of treatment to all age groups including children and young people.

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<sup>533</sup> Aboriginal Peak Organisations Northern Territory, *op.cit.*, p. 21

<sup>534</sup> *Ibid*, pp. 20-21 see also Attachment 1

<sup>535</sup> *Ibid*, p.7; Central Australian Aboriginal Congress, *Submission 32*, p.27; Jesuit Social Services, *Submission 26*, p. 4

- Focussed psychological therapies, including Cognitive Behavioural Therapy are the core of the clinical treatment and all professionals will be trained to deliver these therapies.<sup>536</sup>

The Committee heard that a community of 1,500 people would require four Aboriginal Family Support Workers, two skilled counsellors, and two of either an Aboriginal Mental Health Worker, Aboriginal AOD Worker, or a nurse with mental health or AOD qualifications and experience and one psychologist.<sup>537</sup> The Committee was further advised that Aboriginal Family Support Workers do not require formal qualifications but will be encouraged to obtain further training including becoming an Aboriginal AOD worker or a Aboriginal Health Worker. They could also undertake studies in community development and health promotion to support their work in community strengthening.<sup>538</sup>

The Central Australian Aboriginal Congress advised the Committee that, in terms of implementing this model, the minimum requirement would be a therapist (psychologist or accredited social worker) and an AOD worker in every primary health care service to work alongside the existing GP service, remote area nurses and Aboriginal Health Workers.<sup>539</sup> The Committee was further advised that the *Safe and Sober Support Service* currently run by Congress is based on this staffing regime which allows for “the essential three streams of care approach as outlined in the AMSANT service model: psychological therapy, social support and pharmacotherapies.”<sup>540</sup>

The Committee was advised that whilst there was little in the way of hard evidence regarding what is effective for suicide prevention in remote Aboriginal communities both within Australia and overseas, “[g]rass roots and bottom up approaches to suicide prevention have been successful in places where suicide clusters have occurred (such as Yarrabin and Tiwi Islands).”<sup>541</sup> As such, it was suggested to the Committee that community development work could well include:

- Development and support of alcohol management plans;
- Activities and support for high risk groups including young people;
- Working with other agencies in the community to develop community strengthening activities;
- Community education about mental health problems, in partnership with the clinical arm of the Social and Wellbeing team, which could be through the use of existing programs adapted for a local context; and

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<sup>536</sup> Aboriginal Peak Organisations Northern Territory ,*op.cit.*, p. 21

<sup>537</sup> *Ibid*

<sup>538</sup> *Ibid*, pp. 21-2

<sup>539</sup> Central Australian Aboriginal Congress, *loc.cit.*

<sup>540</sup> *Ibid*

<sup>541</sup> Aboriginal Peak Organisations Northern Territory ,*op.cit.*, p. 22

- Responding to clusters of suicide attempts or suicides in conjunction with the clinical team, Aboriginal leadership and mental health experts.<sup>542</sup>

The Committee heard that the community development component of the AMSANT model would be led by the Aboriginal Family Support Workers and guided by the board of the Aboriginal Community Controlled Health Services to “undertake community development activities in accordance with each community’s identified needs.”<sup>543</sup> The core function of the Aboriginal Family Support Workers would be around “working with families and building resilience in their communities using an approach that builds on cultural and community strengths.”<sup>544</sup> It was pointed out to the Committee that Aboriginal Family and Community Support Workers have played a central role in the Social and Wellbeing Team at Anyinginyi Congress in Tennant Creek for several years.<sup>545</sup>

The submission from the Jesuit Social Services also highlighted the value of “increasing workforce capacity in relation to dual diagnosis given the association between alcohol and drug use and high rates of suicide amongst young Indigenous males.”<sup>546</sup> The Committee was advised that the Jesuit Social Services is currently funded under the Australian Government’s *Improved Services Initiative* to develop the skills and abilities of their mental health and primary health care staff to “effectively identify and treat co morbid substance use and mental illness.”<sup>547</sup>

On the basis of their experience in delivering this initiative over the past three and a half years, the Jesuit Social Services advised the Committee that for dual diagnosis training to be most effective it should:

- be offered to both clinical and non clinical staff, in particular front line staff such as outreach workers, community workers, school support staff and youth workers, since these workers interact with young people experiencing alcohol, drug and mental health problems on a day to day basis and are best placed to engage them in the most appropriate services;
- incorporate units in Youth Mental First Aid, Suicide Risk Management, Motivational Interviewing, Hep C and other blood borne viruses, Managing Challenging Behaviours, the Impact of Trauma, Working with Borderline Personality Disorders, Supervision Skills (in particular culturally sensitive practices), and Self-Care for Workers including training on the impact of vicarious trauma; and
- include a focus on family, community and structural factors impacting on the individual and the influence of intergenerational factors, not just the individual’s psychological and physical presentation.<sup>548</sup>

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<sup>542</sup> *Ibid*

<sup>543</sup> Central Australian Aboriginal Congress, *op.cit.*, p. 24

<sup>544</sup> Aboriginal Peak Organisations Northern Territory – attachment 1, *op.cit.*, p. 61

<sup>545</sup> *Ibid*, p. 62

<sup>546</sup> Jesuit Social Services, *op.cit.*, p. 4

<sup>547</sup> *Ibid*

<sup>548</sup> *Ibid*, pp. 4-5

Whilst there is clear evidence as to the benefits of dual diagnosis training for both Aboriginal and non Aboriginal Health Workers, the Committee was advised this is not yet reflected in the mainstream training courses currently available. As Ms Joanne Townsend (Acting Executive Director, Social Inclusion Policy and Program Division, NT Department of Children and Families) informed the Committee, there is a Certificate IV in Alcohol and Other Drugs and a Certificate IV in Mental Health but nothing that combines the two.<sup>549</sup> Ms Townsend further noted that “[t]he Department of Health does deliver a dual diagnosis course – across alcohol and other drugs and mental health – but it is a limited course in the numbers.”<sup>550</sup>

On the basis of the evidence received, the Committee encourages the Department of Health to actively pursue funding, such as that available under the Australian Government’s *Improved Services Initiative*, to facilitate the implementation of dual diagnosis training in regional and remote areas of the Northern Territory.

### **Recommendation 7**

**The Committee recommends that the Department of Health, in conjunction with Aboriginal Medical Services Alliance Northern Territory (AMSANT), introduce the Integrated Service Delivery Model into Aboriginal Primary Health Care Services over the course of the next five years; with a particular emphasis on the regional centres of Katherine, Tennant Creek and Nhulunbuy and all remote area communities with a population of more than 200.**

### **Strengthening Families**

A supportive family environment where young people feel safe is recognised as an important protective factor against suicidal thoughts and behaviour. Conversely, as Dr Howard Bath (NT Children’s Commissioner and Convener of the Child Death Review and Prevention Committee) advised the Committee, research indicates that there is a strong correlation between adverse childhood events and youth suicide. The Committee heard that many suicide deaths in the Northern Territory are associated with:

a breakdown in family and community supportive structures. Many, but not all, of these young people have grown up in chaotic family circumstances...where there has been poor attachment, parenting difficulties, intrafamilial conflict, and substance abuse. An accumulation of adverse childhood events seems to be a feature of the majority of these young people.<sup>551</sup>

Dr Bath further noted that patterns of suicides elsewhere in Australia also indicate that adverse events are associated with suicide, “but not to the degree that that is a predicative situation in the Northern Territory.”<sup>552</sup>

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<sup>549</sup> Ms Joanne Townsend, Acting Executive Director, Social Inclusion Policy and Program Division, NT Department of Children and Families, *Committee Hansard*, 31 January 2012, p. 27

<sup>550</sup> *Ibid*

<sup>551</sup> Dr Howard Bath, NT Children’s Commissioner and Convener of the Child Death Review and Prevention Committee, *Committee Hansard*, 30 January 2012, pp. 2-3

<sup>552</sup> *Ibid*

The Committee heard that prolonged exposure to familial neglect, abuse, domestic and community violence has devastating consequences in terms of children's cognitive and emotional development. Dr Bath noted that the most significant impact of early relational trauma is the "loss of the ability to regulate the emotions."<sup>553</sup> Left unchecked this lack of capacity to regulate internal emotional states leads to situations where "irritation becomes rage, sadness morphs into despair"<sup>554</sup> where people become involved in "reactive impulsive violence...and self harm."<sup>555</sup>

Drs John and Ruth Rudge (Clinical Psychologists, Southern Cross Clinical Psychology Services) highlighted the inter-generational nature of reactive impulsive behaviour noting that, from their experience working in remote Indigenous communities, suicidal behaviour very often indicates a:

severe lack of skills to deal with day to day difficulties in a way that is in line with the actual difficulty. We find such skill deficits also present in the adult population thus youth have few role models who are able to teach them how to deal with life stressors. What we commonly see is that responses to life stressors include such things as substance abuse, self harm and violence, which are all dysfunctional coping strategies. Youth see adults behaving in these ways and these are their role models and so we see youth behaving in these ways.<sup>556</sup>

The Committee heard that suicidal behaviour was further exacerbated "by the use of internet social networking sites and texting, and by 'humbug'"<sup>557</sup>

The normalisation of suicide and the increasing incidence of impulsive suicidal threats and suicidal behaviour in remote Indigenous communities, in particular, were raised as issues of significant concern. As noted in the submission from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council:

Threats of suicide have become normalised. Children play at suicide Young people frequently threaten to kill themselves for what appear to be trivial or manipulative reasons...Some of these threats, albeit triggered by minimal issues, result in life-threatening or permanently damaging suicide attempts.<sup>558</sup>

The Committee heard that in many communities suicidal threats and behaviour are becoming "instilled as a common lingo and strategy; they are such powerful ways to influence or affect others."<sup>559</sup> As noted in the *little red threat book*, suicide threats can be triggered by a wide range of situations. At times it can be a reaction to not getting an immediate response to a request for something, at other times it can be triggered by "something really unexpected, like being asked to turn down the volume of the stereo."<sup>560</sup> The Committee heard that suicide threats also seem to have varying degrees of

<sup>553</sup> *Ibid*

<sup>554</sup> *Ibid*, p. 5

<sup>555</sup> *Ibid*

<sup>556</sup> Drs John and Ruth Rudge, *Submission 43*, p. 4

<sup>557</sup> *Ibid*

<sup>558</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, Attachment D, *op.cit.*

<sup>559</sup> K. Schubert, *Working Well Guide: reflections on providing suicide prevention programs in remote Aboriginal Communities in Central Australia, 2009*, Alice Springs, NT (in-house publication of the 'We Know Our Strengths' project funded by the Commonwealth of Australia: National Suicide Prevention Strategy), p.24

<sup>560</sup> Life Promotion Program, *the little red threat book*, Mental Health Association of Central Australia, 2008, Alice Springs, NT, p. 5

intensity. In some instances it is used more as “an accepted phrase, sort of like swearing: something to shock people into responding.”<sup>561</sup> At other times, threats seem to be far more intense especially when the person is “charged up with anger or jealousy or grog, they react to some situation with intense threats to take their own life.”<sup>562</sup> The Committee was further informed that:

As well as differences in the type of trigger and intensity of threat, there are differences in the number of people involved. Sometimes these situations are limited to one person threatening and one being threatened. At other times, whole interconnected groups get involved in issuing threats and feeling the stress of possible consequences.<sup>563</sup>

Moreover, the ‘tipping’ point in terms of whether or not a person will follow through on a suicide threat is often very difficult to determine. Threats are not consistent and “[s]ometimes there is not much warning: When people threaten it, they try it.”<sup>564</sup> This necessarily places parents and carers under a considerable amount of stress. As the Committee heard, parents and carers find it very difficult to know how to respond:

On the one hand desperate carers...are told to set boundaries to reduce the behaviour...On the other hand, suicide prevention workers state that families must take every threat seriously and do whatever it takes to...get them through periods of articulated risk...If they fail to appease an at risk person and it results in that person carrying out the threat to self harm even suicide, then they not only lose a loved one and see the terrible impact of this death across their family group, but they can often face the horror of being blamed and physically punished by the community through the payback process.<sup>565</sup>

In the absence of effective strategies to deal with these situations, parents and carers can become overwhelmed, their health and wellbeing can suffer and they can end up feeling suicidal themselves “becoming part of this cycle.”<sup>566</sup> Moreover, as the Committee heard, a significant proportion of parents in remote Indigenous communities, in particular, are teenagers and fall within the high risk cohort for suicide themselves.<sup>567</sup> As Ms Abigail White (Families as First Teachers Program) pointed out, in terms of youth suicide it is important to note that:

Many of these youth now are also parents, they are statistically high risk. In some cases there are issues of domestic violence. Sometimes their relationships are not sanctioned by families so there is a lot of pressure on those young couples.<sup>568</sup>

The Committee notes that the Families as First Teachers – Indigenous Parenting Support Services Program, an initiative of the Department of Education and Training, is a strengths based program which works from the belief that all families want the best start in life for their children. Delivered in remote communities across the Northern Territory incorporates four key elements: Early Learning, Child Development Knowledge, Health,

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<sup>561</sup> *Ibid*

<sup>562</sup> *Ibid*

<sup>563</sup> *Ibid*, p. 6

<sup>564</sup> K, Schubert, *op.cit.*, p. 26

<sup>565</sup> *Ibid*, p. 27

<sup>566</sup> Life Promotion Program, *op.cit.*, p. 15

<sup>567</sup> Ms Abigail White, Families as First Teachers Program, *Committee Hansard*, 17 November 2011, p. 11

<sup>568</sup> *Ibid*

Hygiene and Nutrition and Parenting and Family Support.<sup>569</sup> In terms of the latter, the Committee heard that the program aims to:

- Strengthen positive relationships in families;
- Promote positive behaviour in children; and
- Build confidence in parenting.<sup>570</sup>

The submission from the Central Australian Aboriginal Congress provided an overview of the Parenting Under Pressure Program (PuP). In light of the preceding discussion, the Committee was particularly interested to learn that this program combines:

Psychological principles relating to parenting, child behaviour and parental emotion regulation within a case management framework.<sup>571</sup>

The Committee heard that the overarching aim of the program is to assist families, that are experiencing a range of difficult life circumstances that impact on the functionality of the family, to “develop positive and secure relationships with their children.”<sup>572</sup> The program is home-based, delivered on a one-to-one basis and tailored to the specific needs of each family.<sup>573</sup> Teaching parents distress tolerance skills and how to manage their emotions when they are under pressure is a key feature of the program.<sup>574</sup> Dr Bath also noted that the maternal home visitation program provided by the Central Australian Aboriginal Congress is another promising initiative in terms of its capacity to minimise the incidence of child abuse and neglect and improve child health and development.<sup>575</sup>

Whilst acknowledging the value of these programs, the Committee notes that there is clearly a need for the development of more specific strategies to assist parents to deal with suicide threats. The Committee notes that the *little red threat book*, is currently the only resource that assists people to understand this problem. This resource was developed out of a *Suicide as a Threat* community workshop facilitated by the Mental Health Association of Central Australia Inc’s Life Promotion Program in November 2007.<sup>576</sup> The Committee heard that whilst this resource represents an important first step in coming to terms with the problem, there is an urgent need for the development of strategies and ways of working with families and young people to address this issue.<sup>577</sup>

## Recommendation 8

**The Committee recommends that the Department of Children and Families’ Domestic and Family Violence Policy Unit review community attitudes, public**

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<sup>569</sup> Department of Education and Training, *Families as First Teachers-Indigenous Parenting Support Services Program*, Retrieved 19 March 2012, <http://www.det.nt.gov.au/parents-community/early-childhood-services/families-as-first-teachersprogram>

<sup>570</sup> *Ibid*

<sup>571</sup> Central Australian Aboriginal Congress, *Submission 32*, p. 24

<sup>572</sup> *Ibid*

<sup>573</sup> *Ibid*

<sup>574</sup> *Ibid*, p. 25

<sup>575</sup> *Ibid*, p. 17; see also Dr Howard Bath, *op.cit.*, p. 9

<sup>576</sup> Mental Health Association of Central Australia Inc, *op.cit.*, p. 19

<sup>577</sup> *Ibid*

**awareness and cultural applicability in remote communities of the current *Stop the Hurting Campaign*.**

### 3.2 Identifying and Helping those at Risk

Adolescence is a period of significant social, emotional and physical change and development. As noted by **headspace**, suicidal thoughts during adolescence are not uncommon:

It is estimated that approximately 30% of adolescents aged 12-20 Have thought about suicide at some point in their lives, with around 20% reporting having had such thoughts in the previous year.<sup>578</sup>

From this perspective, all young people can be considered to be ‘at risk’ during adolescence. As a recent report into adolescent morbidity in New Zealand points out, “[y]outh suicide represents the ultimate failure of the transition from childhood to adulthood.”<sup>579</sup>

The Committee heard that those who are disengaged from society and lack familial or social support structures are known to be more likely to engage in ‘at risk’ behaviours such as substance abuse, self-harming or delinquency; all of which are known to contribute to an increased risk of mental illness or suicide.<sup>580</sup> As indicated previously, the correlation between mental illness and suicide is well documented; particularly in terms of youth suicide. The **headspace** submission pointed out that mental illness has been identified as the primary health issue facing young Australians, with three quarters of all mental health problems occurring before the age of 25.<sup>581</sup>

However, in many respects, the antecedents of youth suicide in the Northern Territory are somewhat atypical. As Ms Hendry highlighted to the Committee:

The majority of people who take their own lives in the Territory do not have a diagnosed mental illness and are not known to mental health services. This is particularly so for young people aged 15 to 24.<sup>582</sup>

Whilst it is acknowledged that this does not necessarily mean that they do not have any underlying mental health issues, the Committee heard that, “there is no indication from the primary health care service either that they have a mental illness.”<sup>583</sup> Rather, Dr Bath noted that current data indicates that social and contextual risk factors are far more significant indicators when it comes to identifying those young people most likely to attempt or complete suicide.<sup>584</sup> For example, Indigenous status, gender identity, childhood adversities, unemployment, geographic isolation, detention or contact with the

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<sup>578</sup> Centre of Excellence in Youth Mental Health, *Suicidal ideation: Myth Buster*, Orygen Youth Health Research Centre, Parkville, 2009, p.1 – **headspace** National Youth Mental Health Foundation Fact Sheet.

<sup>579</sup> Office of the Prime Minister’s Science Advisory Committee, *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*, Office of the Prime Minister’s Science Advisory Committee, Auckland, New Zealand, 2011, p. 208

<sup>580</sup> *Ibid.*, pp. 1-2

<sup>581</sup> *headspace*, *op.cit.*, p.4

<sup>582</sup> Ms Bronwyn Hendry, *loc.cit.*; see also: Dr Howard Bath, *op.cit.*, p. 3

<sup>583</sup> Ms Bronwyn Hendry, *op.cit.*, p.4

<sup>584</sup> Dr Howard Bath, *loc.cit.*; Menzies School of Health Research, *Submission 12*, pp. 1-3; Suicide Prevention Australia, *op.cit.*, p. 4

juvenile justice system, and friends or family displaying suicidality are cited in the literature as known risk factors for suicide.<sup>585</sup>

As highlighted in the submission from the Menzies School of Health Research, data from the National Coroners Information System, Australian Bureau of Statistics and the Department of Health show that suicide rates of both Indigenous and non Indigenous people aged 18-24 years in the Northern Territory has decreased over the past ten years; from 99.9 to 69.9 per 100,000 for Indigenous people and from 21.5 to 13.0 per 100,000 for non Indigenous people.<sup>586</sup> However, this data also indicates that the incidence of Indigenous suicide for those under 18 has been increasing at an alarming rate; from 18 per 100,000 in the period 2001-05 rising to 30 per 100,000 for the period 2006-10.<sup>587</sup> Moreover, the Committee heard that “[o]f 20 cases of self-inflicted death of persons under the age of 18 years from 2006 to 2010...all but one were by Indigenous persons”.<sup>588</sup> It was also noted that whilst national suicide rates in this age bracket indicate a male/female ratio of 4 or 5:1, for the Northern Territory it is 6:4.<sup>589</sup>

Moreover, the data for the period 2006-10 suggests that the incidence of suicide amongst young women has been on the increase.<sup>590</sup> Professor Tatz also noted that, in terms of the national statistics on suicide, “female suicide rates, especially amongst the young, are increasing and increasing at a fairly alarming rate.”<sup>591</sup> Professor Tatz further noted that the incidence of self-harm amongst young Aboriginal girls was particularly worrying; “that the phenomenon of girls engaging in self-harmful activity has increased noticeably.”<sup>592</sup> As noted previously, the impulsive nature of suicide attempts and completed suicides of those under 18, particularly in Indigenous communities, was also highlighted as an area of concern.<sup>593</sup>

Whilst all young people are potentially at risk of suicide, the Suicide Prevention Australia submission notes that for the majority this risk is limited, and even if individuals have experienced suicidal thoughts most will not go on to take their lives.<sup>594</sup> However, for the 15-20% that experience suicidal thoughts and are also exposed to multiple risk factors, such as those noted above, the likelihood of attempting or completing suicide is high to very high.<sup>595</sup> Given the geographic and demographic composition of the Northern Territory, a significant proportion of young people reside in areas subject to social or contextual factors known to compound and impact on suicide risk.

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<sup>585</sup> Suicide Prevention Australia, *Attachment 3: Position Statement Youth Suicide Prevention*, p. 8; see also: *Attachment 2: Position Statement Responding to Suicide in Rural Australia*, pp. 4-7

<sup>586</sup> Menzies School of Health Research, *op.cit.*, p.4; Lenore Hanssens, *Submission 15*, p.12

<sup>587</sup> *Ibid*

<sup>588</sup> Menzies School of Health Research, *op.cit.*, p. 2

<sup>589</sup> Dr Howard Bath, *op.cit.*, p.2

<sup>590</sup> *Ibid*

<sup>591</sup> Professor Tatz, *op.cit.*, p. 50

<sup>592</sup> *Ibid*

<sup>593</sup> Dr Howard Bath, *op.cit.*, p. 3; Menzies School of Health Research, *op.cit.*, p. 7; Mr Robert Parker, Director of Psychiatry Top End Mental Health Services, *Committee Hansard*, 4 November 2011, p. 4

<sup>594</sup> Suicide Prevention Australia, *Submission 20, Attachment 3: Position Statement Youth Suicide Prevention*, *loc.cit.*; Centre of Excellence in Youth Mental Health, *loc.cit.*

<sup>595</sup> *Ibid*

Dr Bath also highlighted to the Committee that numerous studies have shown that the accumulation of adverse childhood events (such as neglect, sexual and physical abuse, familial substance abuse and suicidal behaviour, and domestic and community violence), is a significant risk factor in terms of cognitive development, emotional reactivity, and the early onset of suicidality.<sup>596</sup> Moreover, research indicates that the incidence of impulsive suicide is more likely in those young people who have very fragile support systems and are most affected by adverse childhood experiences; where the final trigger for suicide may well be quite a minor argument.<sup>597</sup>

In addition to the broader strategies referred to in the previous section regarding the building of healthy, suicide proof communities, the Committee heard about a wide range of suicide prevention programs which focus more on the development of protective factors and mental health literacy at the individual level. The following overview considers a number of initiatives highlighted to the Committee during the course of the inquiry. Whilst many of these are already in place across the Northern Territory, the Committee was alerted to a number of issues and inequities which need to be addressed if the youth suicide rate is to be reduced in the longer term.

### 3.2.1 Gatekeeper Training

Gatekeeper training is designed to provide people the skills required to recognise a person at risk of suicide and to connect them to help. The primary objectives of gatekeeper training courses include: improving communities' ability to identify people at risk by educating them about risk factors and warning signs; provide gatekeepers with initial intervention skills so they know what to do if they suspect someone might be suicidal; and increase people's confidence and ability to make appropriate referrals to link suicidal people to resources and professional assistance.<sup>598</sup> The Committee heard that Gatekeeper Training is widely recognised as an invaluable tool in terms of both recognising and responding to suicide risk.<sup>599</sup> In the context of youth suicide prevention, parents and teachers are recognised as the primary gatekeepers.<sup>600</sup> However, as pointed out in the NT Police submission, it is generally acknowledged that all those who are in regular contact with young people have a gatekeeper role and would benefit from appropriate training; in particular those working in remote communities.<sup>601</sup>

As noted by the Department of Health, research evidence indicates that "suicide prevention training programs have a significant impact on reducing rates of suicide within

<sup>596</sup> Dr Howard Bath, *op.cit.*, p.2; see also: Menzies School of Health Research, *op.cit.*, pp.6-10; Department of Health, *op.cit.*, p.2

<sup>597</sup> Office of the Prime Minister's Science Advisory Committee, *op.cit.*, pp. 209-210

<sup>598</sup> People Prevent Suicide, *Suicide Prevention Gatekeeper Training*, Retrieved 18 March 2012, <http://www.peoplepreventsuicide.org/gatekeeper-training/>

<sup>599</sup> See for example: NT Police, *op.cit.*, p. 3; headspace, *op.cit.*, pp. 13-14; NTCOSS, *Submission 25*, p. 12; Suicide Prevention Australia, *op.cit.*, p. 13; Mt Theo Program, *Submission 30*, p. 14, Mr Stuart McMillan, Pastor, Living Water Uniting Church, *Committee Hansard*, 2 December 2011, p. 9; Department of Health, *op.cit.*, pp. 9 – 10; Mental Health Association of Central Australia, *Submission 29*, p. 5; Ms Michelle Tillman, Community Services Consultant and Trainer, *Committee Hansard*, 17 November, 2011, p. 9

<sup>600</sup> Suicide Prevention Australia, *op.cit.*, p.13

<sup>601</sup> NT Police, *loc.cit.*

a community.”<sup>602</sup> The Suicide Prevention Australia submission also highlighted gatekeeper training as a “measure that deserves increased policy and funding attention.”<sup>603</sup> As indicated in the previous chapter, the Department of Health’s Mental Health Program currently funds a number of gatekeeper training courses that are offered across the Territory.

Mr Stuart McMillan (Pastor, Living Water Uniting Church) also informed the Committee about the *Mental Health First Aid program* which he completed as part of an initiative funded by Taminmin College.<sup>604</sup> Offered through the Orygen Youth Health Research Centre, University of Melbourne, this program is designed for members of the general public and provides training “in how to support someone in a mental health crisis situation or who is developing a mental illness.”<sup>605</sup> The Committee heard that, following the completion of facilitator’s training, the college ran the course in a Year 11 class. Mr McMillan noted that, as a result, a young girl’s life was saved:

A year 11 boy recognised what was going on with a year 10 girl that he was friendly with, did all the appropriate stuff, got hold of the girl’s father, told the girl’s father what was going on with his friend, got some relevant referrals, and kept supporting that girl through that period of time.<sup>606</sup>

The importance of providing gatekeeper training for young people was highlighted to the Committee by representatives from the Youth Ministers Round Table of Young Territorians and participants in the inquiry’s Youth Forum.<sup>607</sup> The Committee heard that, in the first instance, young people will either use social networking sites to express themselves or will turn to their friends for help.<sup>608</sup> A witness from the inquiry’s Youth Forum provided the Committee with a poignant example, noting that her first experience with a young person expressing suicidal thoughts was via Facebook. The witness noted that she didn’t know how to deal with it, how to respond or what to suggest since the young person lived interstate. In spite of her efforts to reach out to her and let her know she was around if she needed to chat, the young person took her own life. Since that time, the witness noted that she has utilised *ASIST* resources to guide her through similar conversations.<sup>609</sup> Having recently attended a youth health conference, the witness advised the Committee that what young people were saying was:

We want to reach out and help our friends. We don’t know how. Equip us with skills and knowledge so we can say the right thing or link our friends up with a service.<sup>610</sup>

Whilst acknowledging the value of gatekeeper training, in terms of changing the attitudes, understandings and skills of gatekeepers, the research literature cautions

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<sup>602</sup> Department of Health, *op.cit.*, p. 11

<sup>603</sup> Suicide Prevention Australia, *op.cit.*, p.7

<sup>604</sup> Mr Stuart McMillan, *loc.cit.*

<sup>605</sup> Mental Health First Aid, *Mental Health First Aid Training and Research Program*, retrieved 12 February 2012, <http://www.mhfa.com.au/cms/wp-content/uploads/2011/07/SummaryMHFA14July.pdf>

<sup>606</sup> Mr Stuart McMillan, *loc.cit.*

<sup>607</sup> Ms Alpha Capaque, Ms Lauren Moss, Ms Tylee Wirth, Representatives Youth Minister’s Round Table of Young Territorians, *Committee Hansard*, 30 January 2012, p. 31, Youth Forum, *Committee Hansard*, 2 December 2012, pp. 43-47

<sup>608</sup> *Ibid*

<sup>609</sup> Witness, *Committee Hansard*, 2 December 2012, p. 44

<sup>610</sup> *Ibid*

against the current trend towards viewing gatekeeper programs as a mainstay of suicide prevention, especially with respect to Indigenous peoples.<sup>611</sup> As noted previously, there is a strong degree of impulsivity associated with suicidal behaviour in Indigenous communities which makes it particularly difficult to recognise the warning signs:

Suicidal behaviour seems to occur spontaneously and randomly, often when people have been drinking, smoking ganja or sniffing. People suddenly go 'rama rama' [crazy] or 'lose it'. They might be okay they might not. A lot of people threaten to commit suicide. A lot don't actually go through with it. It's hard to spot the warning signs.<sup>612</sup>

**headspace** further noted that it was important to acknowledge that gatekeeper training for non Indigenous workers who are working in remote communities should also include cultural competence training.<sup>613</sup> The Committee is also mindful of the fact that, by and large, gatekeeper training programs are designed for non Indigenous workers. Given the heterogeneous nature of Indigenous cultures and communities there is a need to adapt resources, such as the Indigenous specific *Suicide Story*, to suit the needs of individual communities. The submission from the Wesley LifeForce Program also highlighted the lack of available community training resources suited to the Indigenous context.<sup>614</sup> The Committee welcomed the fact that *Safetalk* has been delivered in 33 remote communities and that Anglicare was funding an Indigenous trainer in the East Arnhem region to deliver the program in language in communities that have experienced high rates of self-harming behaviour.<sup>615</sup>

The Northern Territory Council of Social Service pointed out to the Committee that ensuring all frontline workers were equipped with gatekeeper training was extremely difficult given the high turnover of staff in the more remote areas of the Territory, and the capacity of training organisations to respond to requests for training.<sup>616</sup> The Committee also learnt that the research evidence indicates that gatekeeper training cannot be treated as a one-off qualification since the effects of training diminish over time if not sustained.<sup>617</sup>

The Committee was further advised that, although clearly effective in terms of identifying those at risk and ensuring they are referred on for appropriate assistance, gatekeeper training does little in terms of addressing underlying causal factors associated with suicide and, "there is almost no reported evidence of its effectiveness in reducing risk factors in young people."<sup>618</sup> Concerns were also raised regarding the potential for increased referral activity, in the absence of an increased capacity on behalf of mental

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<sup>611</sup> M. Isaac, B. Elias, L. Y. Katz, S. L. Belik, F. P. Deane, M. W. Ens and J. Sareen, 'Gatekeeper training as a preventative intervention for suicide: a systematic review', in *Canadian Journal of Psychiatry*, 54 (4), 2009, pp. 260-8

<sup>612</sup> K, Schubert, *op.cit.*, p.26

<sup>613</sup> *headspace, op.cit.*, p.13

<sup>614</sup> Wesley LifeForce Program, *Submission 40*, p. 10

<sup>615</sup> Department of Health, *op.cit.*, pp. 9-10

<sup>616</sup> NTCOSS, *loc.cit.*

<sup>617</sup> M. Isaac et.al., *loc.cit.*

<sup>618</sup> *Ibid*

health services to respond, to lead to a “checklist approach to assessment and treatment.”<sup>619</sup>

Rather, the Committee heard that, at a very minimum, for gatekeeper training to be effective it needs to be linked with a strategy of active engagement of young people in their peer social networks and in situations of risk, such as school drop-out or homelessness. This is more likely to lead to contact with families who may well be experiencing difficulties as a result of marriage break-up, parental mental illness or other problems, and suggests the need for more effective targeting of services rather than the provision of training across existing service arrangements.<sup>620</sup>

On the basis of the many comments received from young people, the Committee encourages schools and youth services to provide opportunities for young people to access training such as *SafeTalk*; to provide them with the skills to identify and assist their peers to access the support and services they may require to ensure their safety and address any mental health and wellbeing issues or concerns.

### 3.2.2 School Counselling and Guidance Services

The NT Coroner, Mr Greg Cavanagh, highlighted the importance of young people being able to access youth counsellors. The Committee heard that many young people who attempt or complete suicide are extremely unhappy and do not necessarily have the parental support required to navigate their way through adolescence.<sup>621</sup> For those that are growing up in families where drunkenness and domestic violence are the norm, they need a mentor who can help them through the hard times:

If you...really want to stop people, young people, from suiciding, then youth workers and youth counsellors attached to the schools – where they have to go – or within a small community...the more you can define the problem. Mentoring, youth counsellors and advisors need to be there on the ground – and I am not being facetious – to hold the hands of unhappy people.<sup>622</sup>

In recognition of the difficulties many young people face during adolescence, in 2006 the Northern Territory Department of Education and Training established the *School Counsellor Project* within the department’s student services section, “to ensure that secondary students had improved access to qualified school counsellors (social workers, psychologists, or counsellors).”<sup>623</sup> The objective of this initiative was to improve the capacity of schools to “intervene in social and emotional difficulties of students through a range of interventions including engaging families and implementing preventative measures.”<sup>624</sup>

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<sup>619</sup> *Ibid*

<sup>620</sup> J. M. Burns and G. C. Patton, ‘Preventive interventions for youth suicide: a risk factor-based approach’, in *The Australian and New Zealand Journal of Psychiatry*, 34 (3), pp. 388-407

<sup>621</sup> Mr Greg Cavanagh, NT Coroner, *Committee Hansard*, 14 March 2012, p. 7

<sup>622</sup> *Ibid*

<sup>623</sup> Northern Territory Department of Education and Training, *School Counsellors*, retrieved 3 March 2012, [www.det.nt.gov.au/students/support-assisstance/safety-wellbeing/school-counsellors](http://www.det.nt.gov.au/students/support-assisstance/safety-wellbeing/school-counsellors)

<sup>624</sup> *Ibid*

As Mr Paul Nyhuis (General Manager Student Services, NT Department of Education and Training) informed the Committee, the student services section is the key service provider regarding issues around mental health and child protection.<sup>625</sup> The Committee heard that the primary role of school counsellors was to:

- Identify and understand issues facing students;
- Initiate and manage preventative mental health programs and interventions;
- Assist teachers and students to resolve issues and problems; and
- Adopt a rigorous follow up and evaluation approach.<sup>626</sup>

The Committee was advised that the department's current commitment is to ensure that school counsellors are allocated to every middle school and every high school.<sup>627</sup> However, it was noted that where a middle school and senior school are co-located on the same campus they are only allocated one counsellor to service both schools, irrespective of the number of students.<sup>628</sup> As Ms Ratahi highlighted to the Committee, for schools such as Taminmin with a combined middle and senior school population of 1200, the current system is inequitable and constitutes a significant and unrealistic workload for one counsellor.<sup>629</sup> The Committee also heard from Ms Erin Evans (Health Promoting Nurse, Taminmin College) who stated that when she first started at Taminmin in 2001 "there were 465 students at the school and now there are 1200. There is still one of me."<sup>630</sup> The submission from NT Police also noted that "feedback from YEPOs [Youth Engagement Police Officers] and school students indicates that increased access for young people to counsellors may reduce potential harmful outcomes."<sup>631</sup>

In the more remote areas of the Territory, Mr Nyhuis advised the Committee that counsellors "operate in a group school capacity so they service a number of schools within a region."<sup>632</sup> The Committee heard that whilst the focus of the department's counselling and guidance service is at the middle and high school level, where counsellors have the capacity they are also available to provide services to feeder schools and primary schools.<sup>633</sup> Mr Nyhuis further advised the Committee that the department had recently allocated a counsellor to begin working with the Palmerston and rural area in a primary school capacity.<sup>634</sup> Mr Barnes noted that, given that puberty begins in upper primary, the department acknowledges that there is a need for counsellors to be available to primary schools.<sup>635</sup>

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<sup>625</sup> Mr Paul Nyhuis, General Manager Student Services, NT Department of Education and Training, *Committee Hansard*, 4 November 2011, p. 30

<sup>626</sup> Northern Territory Department of Education and Training, *School Counsellors*, *loc.cit*

<sup>627</sup> *Ibid*, p.34

<sup>628</sup> *Ibid*

<sup>629</sup> Ms Beverley Ratahi, *op.cit.*, p.16

<sup>630</sup> Ms Erin Evans, *op.cit.*, p. 18

<sup>631</sup> NT Police, *loc.cit*

<sup>632</sup> Mr Paul Nyhuis, *op.cit.*, p.31

<sup>633</sup> *Ibid*

<sup>634</sup> *Ibid*

<sup>635</sup> Mr Gary Barnes, *op.cit.*, p. 9

In terms of remote communities, Mr Barnes advised the Committee that:

We probably need, in some of those places, less teachers, more social workers, more counsellors, people with that dedicated experience to ensure the kids have the wellbeing and strategies so that they can take advantage of their schooling.<sup>636</sup>

The Committee was advised that, in order for the department to adopt a more holistic approach to the education of young people, a further 20 to 30 full time counsellor positions would be required.<sup>637</sup>

Participants in the inquiry's Youth Forum also advised the Committee that there is often a considerable amount of reluctance on the part of young people to access school counsellors. The primary reason cited was that, generally, school counsellors are located within the main administration block, the door has counsellor written on it, and everyone can see where you are going and it can often result in public humiliation. As such, it was suggested that the Northern Territory Department of Education should consider locating Counsellor's offices in less public areas of the school.<sup>638</sup>

### **Recommendation 9**

**The Committee recommends that the Department of Education and Training determine an optimum ratio of students per school counsellor for primary schools, middle schools and high schools and allocate counsellors on that basis.**

### **3.2.3 Youth Engagement Police Officers**

Commissioner McRoberts advised the Committee that police "can play a very important part in schools in influencing young people and the decisions and choices they make, particularly through adolescence, but into adult life."<sup>639</sup> The Committee heard that in 2010 the Northern Territory Police Service changed the name and role of school based constables; the new "YEPOs [Youth Engagement Police Officers] now have a broader function, and are no longer solely based at schools".<sup>640</sup> As noted in the NT Police submission, the service currently includes 22 Youth Engagement Police Officers co-located between schools and local police stations in key urban and regional centres.<sup>641</sup> Their primary function is the provision of "a range of supports to the school system, particularly focussed on young people offending, those seriously at risk of suicide or with issues of self-harm."<sup>642</sup> Where possible, Youth Engagement Police Officers support teachers with the delivery of the Drug and Personal Safety Awareness program in remote communities.<sup>643</sup>

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<sup>636</sup> *Ibid*

<sup>637</sup> *Ibid*

<sup>638</sup> Ms Alpha Capaque, Ms Lauren Moss, Ms Tylee Wirth, Representatives Youth Minister's Round Table of Young Territorians, *Committee Hansard*, 30 January 2012, p.29, Youth Forum, *Committee Hansard*, 2 December 2012, p. 47

<sup>639</sup> Commissioner John McRoberts, *op.cit.*, p. 22

<sup>640</sup> Northern Territory Government, *loc.cit*

<sup>641</sup> NT Police, *op.cit.*, p. 3

<sup>642</sup> NT Police, *loc.cit.*.

<sup>643</sup> *Ibid*

Youth Engagement Police Officers also provide assistance with the implementation of the Family Responsibility Agreement and order process, including identification of 'at risk' young people and families, establishing initial contact with families, and maintaining contact with them during the term of the agreement.<sup>644</sup> In addition to supporting the school system, the Committee heard that police officers take a proactive role in engaging with school-aged children outside of school, through initiatives such as sporting activities and blue light discos.<sup>645</sup> Commissioner McRoberts acknowledged that:

Police play a very important part in their [young people's] development and that is something we will pursue because anything we can do in a proactive sense, particularly if we are able to reduce the potential for a young person to even think about suicide, has to be a very good return on our investment.<sup>646</sup>

The Committee noted that some police officers, consulted as part of the *Review of the Youth Justice System*, raised concerns that the move from school based constables to Youth Engagement Police Officers effectively reduces the time officers spend in schools as they were also required to undertake other general duties.<sup>647</sup> The recent review of the Northern Territory Youth Justice System found that:

In particular, there was concern that spending less time in schools would not provide YEPOs with the 'on the ground' contact required to assist young people at risk of offending. Indeed, there was concern from some stakeholders that, as a result of the changes, NTP is becoming less proactive and more reactive.<sup>648</sup>

Although changes in the role of the former school based constables is still relatively new, the Committee notes that the aforementioned review encourages the Northern Territory Government to:

monitor this change and consider establishing an independent evaluation of its success or otherwise...to ascertain whether they [YEPOs] consider their expanded role is beneficial to young people, and particularly those at risk of offending. Young people, teachers and parents should also be consulted.<sup>649</sup>

## Recommendation 10

**The Committee recommends that the NT Police Service assign Youth Engagement Police Officers to all Growth Towns, and other remote communities that NT Police have identified as having particularly high levels of youth offending, substance abuse, and family or community violence in the past 12 months.**

### 3.2.4 Youth Diversion Programs

Youth diversion programs provide a vital role in assisting individuals who have been identified as being at risk of suicide. In contrast to positive youth development, as discussed previously, youth diversion programs focus on young people deemed to be 'at

<sup>644</sup> Police, Fire and Emergency Services, *Northern Territory Police – Youth Engagement Officers*, retrieved 10 February 2012, <http://www.pfes.nt.gov.au/Police/Young-People/Youth-engagement-officers.aspx>

<sup>645</sup> Commissioner John McRoberts, *loc.cit.*

<sup>646</sup> *Ibid*

<sup>647</sup> Northern Territory Government, *loc.cit.*

<sup>648</sup> *Ibid*

<sup>649</sup> *Ibid*

risk'. Whilst many youth diversion programs incorporate positive youth development principles, they are more inclined to be based on the deficit model of youth development: problem oriented, reactive and targeted; focusing on the treatment and remediation of issues such as substance abuse, mental health problems or delinquency for example, where the young person is generally the recipient of services.<sup>650</sup>

The Committee heard that there is a considerable amount of anecdotal evidence as to the positive benefits of culturally appropriate, community driven youth diversion programs. As the Department of Health pointed out to the *Review of the Youth Justice System*, "youth diversion activities have assisted communities to effectively manage their volatile substance abuse."<sup>651</sup> The NT Police also highlighted the success of the Tiwi Islands program which, since its establishment in 2003, has "managed many hundreds of family interventions, involving young people and their families."<sup>652</sup> The Committee received evidence about a number of programs that indicated that they were helping individuals in crisis and their communities. The Committee was concerned, however, that the provision of such programs was inconsistent across the Territory.

### **NT Department of Children and Families' Youth Diversion Funding**

The Committee heard that the NT Department of Children and Families currently funds thirteen organisations to deliver youth diversion programs in the following urban areas and communities: Darwin, Palmerston, Katherine, Tennant Creek, Alice Springs, Papunya, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Lands, Galiwin'ku, Gunbalanya, Ngukurr, Numbulwar, Borroloola, Groote Eylandt, and Nguiu.<sup>653</sup> The Committee was advised that service providers, which include local government authorities and non-government organisations, "provide local responses to problems [and] are contracted to work with youth at risk within a community development framework."<sup>654</sup> The Committee was further advised that the NT Police has a significant level of involvement in a number of youth diversion programs since many of these services also provide "case management support to young offenders for NT Police clients on formal Youth Diversion."<sup>655</sup> Examples of some of these programs are outlined below.

The youth diversion program provided by the **Central Australian Youth Link-Up Service** (CAYLUS) is specifically aimed at preventing petrol sniffing and other forms of substance abuse.<sup>656</sup> The submission from CAYLUS notes that, from their experience, the incidence of suicide is closely linked to substance abuse. The Committee heard that "in one community there were a series of very public completed suicides by sniffers in the years leading up to Opal rollout."<sup>657</sup>

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<sup>650</sup> Steps, *Ibid*

<sup>651</sup> Northern Territory Government, *op.cit.*, p.94

<sup>652</sup> *Ibid*, p. 98

<sup>653</sup> NT Department of Children and Families, *Ibid – Attachment D*

<sup>654</sup> NT Police, *Ibid*, p. 5

<sup>655</sup> *Ibid*

<sup>656</sup> CAYLUS, *op.cit.*, p. 1

<sup>657</sup> *Ibid*

Whilst noting that the incidence of suicidal behaviour has decreased since the roll out of Opal fuel, the Committee heard that “youth suicide and threats of suicide remain a major issue in our communities and are often closely connected to the use of cannabis and alcohol.”<sup>658</sup> CAYLUS further highlighted that addressing substance abuse issues amongst young people in Indigenous communities are often hampered by the fact that, in many cases, it is an intergenerational issue amongst families and the community as a whole.<sup>659</sup>

In addition to providing traditional diversion alternatives for young offenders, the **Tiwi Island’s Youth Development and Youth Diversion Program**, based in Nguiu, works in close association with the *Tiwi for Life Mental Health* team (established in 2002 in response to the high rate of suicides in the community) to tackle substance abuse and mental health issues. The Committee heard that a dispute resolution and conflict management program has also been developed that seeks to address and manage family and community disputes through interventions based on skin groups. The value of this initiative was acknowledged in a recent federally funded project aimed at “supporting the development of more effective approaches to managing conflict involving Indigenous Australians.”<sup>660</sup> The Tiwi Islands Youth Development and Diversion Unit has also developed programs “aimed at encouraging attendance and good behaviour at school.”<sup>661</sup>

The youth program delivered by the **Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council** focuses on an “holistic approach to youth work, using a variety of integrated and complementary activities.”<sup>662</sup> As noted in the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council’s submission to the inquiry, the youth team is particularly concerned with the “death and disability in young people caused by petrol sniffing and other substance abuse.”<sup>663</sup> As such, this service incorporates casework and support to address substance abuse, mental health problems, violence, and homelessness. After school and holiday recreation programs are also seen as a valuable diversionary activity.

In noting that the NT Department of Children and Families has yet to evaluate any of the aforementioned youth diversion programs it currently funds, the Committee supports the view of the *Review of the Youth Justice System* that, in order to determine what works and what doesn’t and gain a better understanding of the outcomes of these services, evaluation of community based diversion programs is essential and should be completed as a matter of priority.<sup>664</sup> The Committee further notes the Northern Territory Government’s support of recommendation 9 from the *Review of the Youth Justice System* which, in part, states that:

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<sup>658</sup> *Ibid*

<sup>659</sup> *Ibid*

<sup>660</sup> Northern Territory, *op.cit.*, p. 98; see also: NT Police, *op.cit.*, p. 5

<sup>661</sup> *Ibid*, pp. 98-99

<sup>662</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *Submission 37*, p. 3

<sup>663</sup> *Ibid*

<sup>664</sup> *Ibid*, p. 94

all programs delivered for young people in, or at risk of entering, the youth justice system have built in evaluation processes.<sup>665</sup>

The Committee understands that the newly formed Youth Justice Unit will be responsible for establishing the on-going evaluation and monitoring processes for such.<sup>666</sup>

### ***Mt Theo Program***

The Committee was particularly impressed by the Mt Theo Program which is widely acknowledged as an exemplary and sustainable model of community based youth diversion in remote Indigenous communities. The Mt Theo Program was established in 1993 by elders from Yuendumu in response to chronic petrol sniffing issues within the community.<sup>667</sup> An initiative of the Walpiri Youth Development Aboriginal Corporation (WYDAC), the program began by removing petrol sniffers from the community to the Mt Theo outstation for a period of “cultural respite and rehabilitation under the care of Walpiri elders.”<sup>668</sup> A seven day and night diversionary service in Yuendumu was also developed consisting of a range of sport, cultural, and recreational activities designed to engage Walpiri youth, and in 2002 the outstation program was expanded to include other forms of substance abuse or any youth at risk issues.<sup>669</sup>

In 2008 the MT Theo Program established the Warra-Warra Kanyi Counselling and Mentoring service in Yuendumu to target critical youth issues such as “alcohol or other substance abuse, suicidal behaviour, sexual health, relationship breakdown, domestic violence, depression and grief...as well as providing services in crisis response, education, group project work and bush trips.”<sup>670</sup> Over the past seven years WYDAC has also assisted other Walpiri communities (Willowra in 2005, Nyirripi in 2008 and Lajamanu in 2009) to establish youth diversionary programs. As noted by community leader and local teacher Barbara Martin:

When Mt Theo started, it was the community coming together to deal with the problem of petrol sniffing. We didn't have funding from the Government; families and some organisations donate a little bit of food or money. It was something that came from the community, and I think that any new program that wants to deal with a problem has to start like this, small and from the community. Ngurlu-jangka, watiya-kirra; its like a big tree that grew from a small seed. This is a metaphor for the Mt Theo Program, and for how kids grow up and become strong. This is why Yuendumu people feel strong and know how to take action when things are going wrong with their kids.<sup>671</sup>

### ***Galupa Marngarr Suicide Prevention Group***

The Committee was also extremely impressed by the commitment and work of the Galupa Marngarr Suicide Prevention Group. The volunteer group was initially

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<sup>665</sup> Northern Territory Government, *op.cit.*, p.ix, see also: Northern Territory Government, *Government's Response to the Review of the Youth Justice System*, retrieved 28 February 2012, <http://www.newsroom.nt.gov.au/index.cfm?fuseaction=printReleaseandID=871>, p.3

<sup>666</sup> *Ibid*

<sup>667</sup> Mt Theo Program - Walpiri Youth Development Aboriginal Corporation, *Submission 30*, p. 4

<sup>668</sup> *Ibid*

<sup>669</sup> *Ibid*

<sup>670</sup> *Ibid*

<sup>671</sup> *Ibid*, pp. 4-5

established in 1996 in response to the rising incidence of youth suicides in the Yolngu community of Ski Beach (Marngarr) located on the Gove Peninsula.<sup>672</sup> At this time the group's primary focus was on the provision of support for those bereaved by suicide. However, in 2007 it was determined that a more proactive approach was required given that the incidence of suicidal behaviour in the community had reached an alarming rate. Community Elder Ms Gayili Marika Yunupingu (Chair, Galupa Marngarr Suicide Prevention Group) noted at the time, "[w]e decided enough was enough. We had to act to save Yolngu people."<sup>673</sup>

As noted in the submission from NT Police, whilst the community of Ski Beach has a population of only 400, in the period between January 2007 and December 2008, "six Yolngu took their lives [and] NT Police responded to more than 30 attempted or threatened suicides."<sup>674</sup> NT Police further noted that during this period, Ski Beach had "one of the world's highest suicide rates."<sup>675</sup> The Committee heard that the community was particularly concerned that suicide was becoming a normalised response to stress and relationship problems, especially when alcohol was involved.<sup>676</sup>

In terms of diversionary activities, the Committee heard that the Galupa Marngarr Suicide Prevention Group implemented a number of measures including the provision of:

- Crisis intervention - immediate, localised responses to community issues such as domestic violence and alcohol related incidents before they escalate;
- Suicide Watch – remaining on alert 24 hours to watch over young people who have threatened suicide;
- Mentoring and Family Mediation – working with young people at risk and their families to reconnect them with their family and culture.<sup>677</sup>

NT Police noted that these measures, in conjunction with the group's concerted efforts to raise community awareness of issues relating to suicide, had a significant impact on the incidence of completed suicides in the community. As Senior Sergeant Wurst noted in November 2009, "[t]here are promising signs. Police have not been called to investigate a suicide in the Ski Beach area for almost 12 months."<sup>678</sup>

Ms Sharon Yunupingu informed the Committee that young people identified as being at a high risk of self-harming will often be taken to the Galupa outstation; where "the people in that community help to look after that person and just keep them going and keep their mind strong."<sup>679</sup> The Committee welcomed the news that the Galupa Marngarr Suicide

<sup>672</sup> LifeForce Suicide Prevention Program Update, *Galupa Marngarr Suicide Prevention Group*, retrieved 2 March 2012, <http://www.livingisforeveryone.com.au/News.aspx?PageID=309>

<sup>673</sup> The Age, *Saving the Yolngu People*, retrieved 8 March 2012, <http://www.theage.com.au/national/saving-te-Yolngu-people-20091106-i28q.html>

<sup>674</sup> NT Police, *op.cit.*, pp. 3-4

<sup>675</sup> *Ibid*

<sup>676</sup> Ms Sharon Yunupingu, Secretary, Galupa Marngarr Suicide Prevention Group, *Committee Hansard*, 17 November 2011, p.2

<sup>677</sup> LifeForce Suicide Prevention Program Update, *loc.cit*

<sup>678</sup> Senior Sergeant Wurst, cited in The Age, *op.cit.*

<sup>679</sup> Ms Sharon Yunupingu, *Ibid*

Prevention Group is currently considering the potential of establishing a more formal cultural mediation and rehabilitation centre on an outstation in the East Arnhem region similar to that of the Mt Theo Program.<sup>680</sup>

The Committee notes that in recent years the Galupa Marngarr Suicide Prevention Group has also been actively involved in the development of the local Community Night Patrol service and the Sobering Up Shelter initiative in Gove. On World Suicide Prevention Day, 10 September 2011, Gayili Marika Yunupingu's work in the area of suicide prevention was formally acknowledged when she was named of the national Suicide Prevention Australia LIFE Award's Indigenous category. These awards "recognise the outstanding contributions made to suicide prevention in Australia."<sup>681</sup>

### ***Youth in Communities Program***

The Committee also heard about the *Youth in Communities* program, which was introduced in 2009 for a three year period as part of the Northern Territory Emergency Response, targets young people from 10 – 20 years of age at risk of substance abuse (illicit drugs, alcohol, petrol or volatile substances), suicide or intentional self-harm, and entering or re-entering the criminal justice system.<sup>682</sup> Funded by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs, the primary objective of the program is to deliver a comprehensive youth strategy in the Northern Territory that:

- Provides an effective diversion for young Indigenous people from at risk behaviours;
- Improves life choices and outcomes for young Indigenous people, through
- engaging them in positive activities that promote pathways to better health
- and wellbeing, community capacity building and participation in school, work and social networks; and
- Strengthens and improves the youth services infrastructure, both in number of youth workers employed and the facilities available for providing youth services and activities.<sup>683</sup>

The Committee heard from a number of witnesses that the funding guidelines were quite prescriptive in terms of which communities were eligible for the infrastructure stream and which were eligible for the youth services component. Funding was distributed to the 15 Commonwealth Government priority communities (all of which are also classified as Northern Territory Growth Towns), three of the remaining five Growth Towns (the exceptions being Ali Curung and Daguragu/Kalkarindji), an additional four communities

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<sup>680</sup> Dhayirra, *Committee Hansard*, 17 November 2011, p. 5

<sup>681</sup> Suicide Prevention Australia, *Life Awards 2011*, retrieved 8 March 2012,

<http://www.live4life.org.au/blog/2011/9/20/live4life-has-won-an-honourable-mention-in-the-200-suicide.html>

<sup>682</sup> FAHCSIA, *loc.cit*

<sup>683</sup> *Ibid*

within McDonnell Shire, six in Central Australia, ten in the Katherine area, and 25 Laynhapuy Homelands communities.<sup>684</sup>

The Committee also noted that in some instances multiple organisations were funded to provide services under the *Youth in Communities* program within the same community, and in other cases there appeared to be a lack of coordination in terms of service delivery within the same Shire. For example, AFL NT, the Australian Sports Commission, and Australian Red Cross were all funded to provide services in Wadeye.<sup>685</sup> In West Arnhem, the Shire was funded to extend the existing youth diversion facility in Gunbalanya, but the Australian Red Cross and the Australian Sports Commission were funded to provide diversionary services in Gunbalanya.<sup>686</sup> Similarly, in East Arnhem the Shire Council was funded to provide youth diversion services in all but one of its major communities; with the Australian Red Cross responsible for service delivery in the remaining community.<sup>687</sup> In the case of Roper Gulf Shire, the Committee noted that it currently receives funding for youth diversion services in Ngkurr, Borooloola and Numbulwar under both the *Youth in Communities* program and from the NT Department of Children and Families.<sup>688</sup>

The Committee heard that the *Youth in Communities* initiative has made a considerable difference to the funded communities, but the program needed to be extended to provide greater equity of access across the Territory. The Committee was particularly concerned to hear that funding under the *Youth in Communities* program was set to finish in June 2012, and, as yet, FAHCSIA has not made any commitment to either continue the program or provide any alternate source of funding to maintain the services that have been established.<sup>689</sup> The Department of Health submission noted that the Commonwealth should commit to providing on-going funding for any initiatives funded under the NT Emergency Response that are aligned to suicide prevention, given the “importance of sustained interventions, and the long term nature of changes needed to reduce suicide rates.”<sup>690</sup> It was further noted that discontinuing funding for the *Youth in Communities* program would be quite counterproductive given that “not only will youth be without the recently introduced supports, they will also feel devalued by their activities being discontinued.”<sup>691</sup>

At the time of writing it was still unclear as to whether or not the Youth in Communities program funding would be extended. As Mr McFarland advised the Committee at the Public Hearing of 30 January 2012:

we think possibly they will continue some youth and community type funding which would be great. However services on the ground that are tied into that funding cycle are losing people because [they] are looking for more long-term work. They can only assure people contracts until June and people are already starting to move away

<sup>684</sup> FAHCSIA, *Ibid*

<sup>685</sup> Department of Health, *op.cit.*, Section A-Attachment 12, pp. 26-30

<sup>686</sup> *Ibid*

<sup>687</sup> *Ibid*

<sup>688</sup> *Ibid*, and NT Department of Children and Families, *Attachment D*

<sup>689</sup> *Ibid*, p.4

<sup>690</sup> Department of Health, *op.cit.*, p. 22

<sup>691</sup> *Ibid*

from remote positions...The agencies on the ground are now trying to recruit for five months in a remote community, which can be quite tricky.<sup>692</sup>

### ***Northern Territory Early Intervention Pilot Program (NTEIPP)***

The Committee heard from Jeanette Callaghan (NTEIP Program Coordinator, NT Police) who spoke about the Early Intervention Pilot Program currently operating in Alice Springs and Katherine. An initiative of the Youth Services section of the NT Police, the program was launched in December 2010 for a two year period and is funded by the Australian Government under the *National Binge Drinking Strategy*.<sup>693</sup> As stated in the submission provided by NT Police, this initiative aims to reduce the incidence and harm of youth binge drinking, and acknowledges the impact of substance abuse in cases of suicide and suicidal thoughts; noting that a recent study in the Northern Territory found that alcohol and drug use was recorded in 71% of suicides.<sup>694</sup>

The Committee was advised that the strategic aim of the NT Early Intervention Pilot Program is “to improve the referral of underage binge drinkers to health services [and is] informed by a ‘what works’ evidenced based practice framework.”<sup>695</sup> The program incorporates both community development practices and a harm minimisation model which focuses on “the development of partnerships to facilitate community ownership and solutions to youth binge drinking.”<sup>696</sup> The whole of community approach aims to “ensure that NTEIPP focus on areas of critical need and does not duplicate existing service delivery.”<sup>697</sup>

On the basis of broad consultations with the community the NT Early Intervention Pilot Program developed a range of resources, known as the NTEIPP Kit, for use by the police and community partners.<sup>698</sup> As noted in the *NT Early Intervention Pilot Program February to August 2011 Progress Report*, on-going consultation with stakeholders, including young people, is critical in terms of ensuring that the program is specific to the needs of individual communities. It was further noted that:

NTEIPP supports community driven initiatives which increase healthy activities, reduce the risk of boredom and target improvements in resilience and well being for young people. NTEIPP will enhance diversionary options that are focussed on increasing the referral of young people to health, counselling and support services.<sup>699</sup>

The Committee notes that the NTEIPP program incorporates the following key elements:

- Delivery of NTEIPP workshops with police and youth and community services groups designed to build capacity within the community around the appropriate engagement of young people, encouraging self responsibility and behaviour

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<sup>692</sup> Mr Blair McFarland, *op.cit.*, p. 14

<sup>693</sup> J, Callaghan, *NT Early Intervention Pilot Program February to August 2011 Progress Report*, unpublished, p. 3

<sup>694</sup> NT Police, *op.cit.*, p. 7

<sup>695</sup> J, Callaghan, *loc.cit*

<sup>696</sup> *Ibid*

<sup>697</sup> *Ibid*

<sup>698</sup> *Ibid*

<sup>699</sup> *Ibid*

change through the frameworks of Brief Intervention, Restorative Justice and Community Development;

- Distribution of NTEIPP Wrist Bands to workshop participants to use as a way of engaging young people early to **Take Control and Limit the Alcohol**. The glow in the dark wrist bands provide a referral pathway for young people to access a health service – NT Alcohol and Drug Information Service (NT ADIS) on their 24/7 hotline **1800 131 350**. Workshops also highlight other on the ground services that are registered with NT ADIS;
- Provision of youth workshops and education sessions within the pilot sites of Katherine and Alice Springs delivered by the NTEIPP team in conjunction with local services, NT Police Youth and Community Engagement Officers; and
- Diversion of young offenders, where alcohol has been assessed as a factor, to counselling or programs where a fee for service is met by NTEIPP.<sup>700</sup>

The Committee understands that the Menzies School of Health Research has been commissioned to evaluate the pilot program.<sup>701</sup> The data provided to the Committee suggested this program has potential to be extended to other communities and the Committee hopes the Government will give the final results and recommendations of the evaluation close consideration.

### **Youth Camps Program**

The Committee heard that the NT Department of Children and Families is also responsible for program development, service level negotiations and monitoring of the organisations that operate the Territory’s three youth camps: Brahminy, Tangentyere and Balunu.<sup>702</sup> Ms Clare Gardner-Barnes (CEO, NT Department of Children and Families) advised the Committee that the youth camps program was established in 2008, as part of the Youth Justice Strategy, to provide more intensive diversion programs through short term residential options for young people deemed to be particularly vulnerable.<sup>703</sup> Ms Gardiner-Barnes noted that the camps are “actually dealing with quite complex cases – children in some cases.”<sup>704</sup>

The Committee was informed that young people can be referred to the youth camp program through the Youth Justice Court, diversion programs, from police, the NT Department of Children and Families, alcohol and other drugs programs or from parents. However, as Ms Gardner-Barnes pointed out, these camps are generally fully subscribed and very difficult to get into.<sup>705</sup> The Committee notes that the Northern Territory

<sup>700</sup> *Ibid*

<sup>701</sup> *Ibid*

<sup>702</sup> Northern Territory Government, *Ibid*, pp. 69 and 77

<sup>703</sup> Ms Clare Gardner-Barnes, CEO, NT Department of Children and Families, *Committee Hansard*, 31 January 2012, pp. 28-9

<sup>704</sup> *Ibid*, p. 29

<sup>705</sup> *Ibid*

Government has supported the recommendation from the *Review of the Youth Justice System* regarding expansion of the youth camps program.<sup>706</sup>

### **Other Initiatives**

The Committee also heard that the Victoria Daly Shire Council was currently rolling out a Shire wide Youth Engagement Program.<sup>707</sup> Ms Catherine Harris (Regional Youth Engagement Coordinator, Victoria Daly Shire Council) informed the Committee that the program focuses on a range of youth related issues such as “health and hygiene, alcohol and other drugs, sexual health, gambling, mental health, employment, nutrition and healthy lifestyles.”<sup>708</sup> Ms Harris informed the Committee that, in the absence of an alternate funding source, this program is currently funded as part of a CDEP initiative but there was no guarantee that funding will continue beyond June 2012.<sup>709</sup>

The Committee also heard that the West Arnhem Shire Council is currently funded by the Northern Territory Department of Health for a Volatile Substance Abuse Worker in Gunbalanya. However, as Mr Nathan Mclvor (Regional Coordinator Community Safety/Shire Services Waruwi, West Arnhem Shire Council) pointed out to the Committee, the Shire is limited as to what it can achieve under this program since the funding only covers the position and “there is no money in that position to run any programs or anything like that.”<sup>710</sup>

The Committee found many examples of programs that were making a significant difference for young people at risk of self-harm in communities across the Territory. The Committee was particularly impressed by programs that communities had developed themselves to assist their young people such as the Mt Theo Program and the Galupa Marngarr Suicide Prevention Group; as noted by Gayili Marika Yunupingu, only “Yolngu can solve a Yolngu problem.”<sup>711</sup> Whilst government funding programs such as Youth in Communities and the NT Department of Children and Families’ Youth Diversion are clearly helping communities, the Committee remained concerned about the uneven distribution and threats to continuation of some of these programs. These issues are further explored below in the section on Smarter Service Delivery. In particular, the Committee is concerned to see the maintenance and expansion of the Youth in Communities Program.

### **Recommendation 11**

**The Committee recommends that the Northern Territory Government urge the Australian Government to continue the Youth in Communities program, and:**

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<sup>706</sup> Northern Territory Government, *Government’s Response to the Review of the Youth Justice System*, pp. 2-3

<sup>707</sup> Ms Catherine Harris, Regional Youth Engagement Coordinator, Victoria Daly Shire Council, *Committee Hansard*, 6 February 2012, p. 34

<sup>708</sup> *Ibid*

<sup>709</sup> *Ibid*

<sup>710</sup> Mr Nathan Mclvor, Regional Coordinator Community Safety/Shire Services Manager Waruwi, West Arnhem Shire Council, *Committee Hansard*, 31 January 2012, p.20

<sup>711</sup> The Age, *Ibid*

- a) **Expand the program to provide greater equity of access;**
- b) **Ensure service providers have the capacity to provide outreach services as required; and**
- c) **Ensure that service providers effectively liaise with providers of complimentary youth, sport and recreation services funded by the Northern Territory and Australian Governments.**

### 3.2.5 Young Offenders and the Criminal Justice System

Whilst the Committee acknowledges that the recent *Review of the Youth Justice System*, and the Government's subsequent support of the recommendations, addressed a number of concerns highlighted in submissions and evidence provided to this inquiry, given that the literature on suicide indicates that contact with the juvenile justice system is the "second most frequent event preceding death...second only to interpersonal conflict."<sup>712</sup>, the following issues were identified as requiring action.

In calling for more youth specific mental health workers and psychologists, the Aboriginal Peak Organisations NT submission noted that the research literature indicates that "intellectual disability was particularly high amongst Aboriginal young offenders and that over 88% of young people in custody reported symptoms consistent with mental illness."<sup>713</sup> Given the high incidence of Aboriginal incarceration in the Northern Territory, it was suggested to the Committee that this is an area which warrants further research.<sup>714</sup> Whilst the Committee notes that the *Review of the Youth Justice System* was unable to source primary diagnostic data to confirm the number of young offenders with mental health problems in the Northern Territory, there is substantial anecdotal evidence which indicates that:

Virtually all youths who come before the Youth Justice Court have some risks to their wellbeing for often complex reasons including homelessness, substance misuse, having been the victim of abuse or having mental or physical health problems.<sup>715</sup>

However, as Ms Ruth Barson (Advocacy Lawyer, North Australian Aboriginal Justice Agency) pointed out to the Committee, many young people seem to cycle through the criminal justice system without necessarily ever receiving the specialist mental health interventions which could identify and begin to address underlying causes of offending.<sup>716</sup> Ms Barson advised the Committee that, in the absence of comprehensive medical records, it is often left up to the lawyer, prosecutor or magistrate to determine whether or not a young person presenting at court has a mental health problem and is able to understand the court process and comply with the requirements of an order.<sup>717</sup> Ms

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<sup>712</sup> Suicide Prevention Australia – Attachment 3, *op.cit.*, p.7; see also: Aboriginal Peak Organisations Northern Territory, *op.cit.*, p. 23

<sup>713</sup> Aboriginal Peak Organisations NT, *op.cit.*, p. 30

<sup>714</sup> *Ibid*

<sup>715</sup> The Northern Territory Government, *op.cit.*, p.136

<sup>716</sup> Ms Ruth Barson, Advocacy Lawyer, North Australian Aboriginal Justice Agency, *Committee Hansard*, 3 November 2011, pp. 55 and 63-64

<sup>717</sup> *Ibid*, p.55

Barson informed the Committee that in NSW and Victoria, for example, they have dedicated children's courts which incorporate on site children's clinics which can both undertake mental health assessments prior to court appearances, and take referrals from the magistrate in terms of follow up treatment options.<sup>718</sup>

The Committee notes that multi-disciplinary child and youth mental health teams, located in Darwin and Alice Springs, are responsible for "providing assessment, liaison with other service providers, support for staff at the youth detention centres and community follow up."<sup>719</sup> However as the Northern Territory Legal Aid Commission advised the *Review of the Youth Justice System*, since the Department of Health lacks the resources required:

reports can take between 4 to 6 weeks to be prepared. This has led to a situation where reports are only requested where the charges are serious, a term of detention is imminent and/or the behaviour is highly suggestive of a health issue.<sup>720</sup>

As Ms Barson highlighted to the Committee, not having access to information regarding the mental health of young people appearing before court can have far-reaching implications in terms of the young person's involvement with the criminal justice system:

For example, if you have a 14 year old or a 15 year old who is suffering from foetal alcohol syndrome, but no-one knows about that; they don't have the developmental capacity to meet the requirements of an order...and they don't report the next day to corrections, they come back to court...they are yelled at by the magistrate for not meeting that [the order] but no-one has actually gone back a step and said actually developmentally are they even capable of meeting this?"<sup>721</sup>

As such, Ms Barson noted that it would be particularly beneficial if mental health professionals were available at the Darwin Magistrate's court on youth justice sitting days.<sup>722</sup>

The aforementioned concerns were also raised with the Committee by the NT Department of Justice and the NT Department of Corrections. As noted in the submission from the NT Department of Justice, incarceration significantly escalates "the risk factors associated with ideation and enactment of self-harm/suicide behaviours amongst youth."<sup>723</sup> However, under the current system, the NT Department of Corrections is reliant upon information from the police or the courts regarding whether or not a young person entering detention is considered to be at risk of self-harming.<sup>724</sup>

Where this is the case the Committee was advised that the young person is monitored and kept under close supervision "until they are assessed by a professional, who will then decide whether they stay at risk or are taken off."<sup>725</sup> The Committee was also advised that whilst individual counselling is provided to all young offenders identified as being at risk, the NT Correctional Service:

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<sup>718</sup> *Ibid*, p. 55

<sup>719</sup> The Northern Territory Government, *op.cit.*, p.137

<sup>720</sup> *Ibid*

<sup>721</sup> *Ibid* p. 63

<sup>722</sup> *Ibid*

<sup>723</sup> NT Department of Justice, *Submission 19*, p.1

<sup>724</sup> Mr David Ferguson, Manager Professional Standards Unit and Intelligence, NT Department of Corrections, *Committee Hansard*, 31 January 2012, p.2

<sup>725</sup> *Ibid*

harbours on-going concerns about the capacity to appropriately house a young offender who is deemed at risk and is concurrently suffering from a mental illness. Those offenders who have long-term mental illness are currently not provided with on-going multi-disciplinary interventions such as those that exist at the Tamarind Centre.<sup>726</sup>

Similarly, whilst the transition from detention back into the community is widely recognised as a potential risk point for young offenders, the Committee heard that there were “significant gaps in the on-going treatment and through care of offenders...identified as at risk of self-harm or suicide.”<sup>727</sup> The Committee was advised that unless young offenders are considered to be at risk during the pre-court process, and there is a subsequent court order that relates to a parole period or treatment post release, for example, there is little the NT Department of Corrections can do about ensuring they receive the appropriate follow up.<sup>728</sup>

Although Mr Greg Shanahan (CEO, NT Department of Justice) informed the Committee that the Government supported the recommendation from the *Review of the Youth Justice System* that a through care model be established, the Committee acknowledges that this will take some time to be fully implemented.<sup>729</sup> The Committee further notes that the Department of Health’s submission to the *Review of the Youth Justice System* suggests:

as an interim measure, that dedicated specialist staff be placed on call in court and detention settings for assessment and acute interventions as required and as a link to ongoing community based care following release.<sup>730</sup>

In light of the above concerns, both the Central Australian Aboriginal Congress and the Aboriginal Peak Organisations NT requested that the Committee give serious consideration to “supporting and resourcing multi systemic therapy services to work with those young people most at risk and assist them with the myriad of disadvantages in their lives that may contribute to suicidal ideation or behaviours.”<sup>731</sup> The Committee heard that multi systemic therapy is an evidenced based, intensive family and community based treatment program which has been used for over 30 years to great effect with adolescent male and female offenders, between the ages of 12 and 17. Focusing on the young person’s entire social and contextual backdrop (including home, family, friends, school, and community), multi systemic therapy utilises cognitive behavioural therapy, behaviour management training, family therapies and community psychology to reach and engage with young people at risk.<sup>732</sup>

The Committee was advised that key features of multi systemic therapy are as follows:

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<sup>726</sup> NT Department of Justice, *op.cit.*, p.2

<sup>727</sup> *Ibid*

<sup>728</sup> *Ibid*, pp. 3-4

<sup>729</sup> Mr Greg Shanahan, CEO NT Department of Justice, *Committee Hansard*, 31 January 2012, p.5

<sup>730</sup> Northern Territory Government, *loc.cit*

<sup>731</sup> Aboriginal Peak Organisations Northern Territory, *op.cit.*, p. 18; see also: Central Australian Aboriginal Congress, *loc.cit*

<sup>732</sup> Aboriginal Peak Organisations Northern Territory, *op.cit.*, p. 17, Central Australian Aboriginal Congress, *loc.cit*

- MST clinicians go to where the young person is and are on call 24 hours a day; seven days a week;
- MST clinicians work intensively with parents and caregivers to put them in control;
- MST clinicians work with caregivers to keep the young person focused on school and gaining job skills;
- MST clinicians and caregivers introduce the young person to sports and recreational activities as an alternative to 'hanging out'<sup>733</sup>

Given the disproportionate suicide and incarceration rates of Indigenous young people in the Northern Territory, the Aboriginal Peak Organisations NT submission noted that:

In an environment in which young people are experiencing behavioural problems, substance misuse, excessive impulsivity and poor brain function, it is important to embrace models of therapy that have demonstrated success in connecting with at-risk young people.<sup>734</sup>

The Committee was advised that following 18 separate evaluations multi systemic therapy has repeatedly been shown to assist in:

- Keeping young people in their home, reducing out of home placements up to 50%;
- Keeping young people in school;
- Keeping young people out of trouble, reducing re-arrest rates up to 70%;
- Improving family relations and functioning;
- Decreasing adolescent psychiatric symptoms; and
- Decreasing adolescent drug and alcohol use.<sup>735</sup>

The Committee notes that the *Review of the Youth Justice System* acknowledged that there is a considerable amount of national and international research that highlights the fact that:

Intensive supervision programs, such as multi systemic therapy (MST) and family functional therapy have been shown to reduce youth offending.<sup>736</sup>

The *Review* further noted that multi systemic therapy is currently used in NSW with positive results. In addition, the results of a 2007 pilot program to provide evidence based mental health services to children (including those with significant behavioural and mental health challenges who were involved in multiple systems such as child welfare, mental health and juvenile justice), supported existing research regarding the capacity of

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<sup>733</sup> *Ibid*

<sup>734</sup> *Aboriginal Peak Organisations Northern Territory, op.cit., p. 17*

<sup>735</sup> *Ibid*, pp. 17-18

<sup>736</sup> Northern Territory Government, *op.cit.*, p. 80

multi systemic therapy; “showing that reductions in offending of between 25% and 65% were achievable.”<sup>737</sup>

### Recommendation 12

**The Committee recommends that the Department of Justice, in conjunction with the Department of Health, Aboriginal Medical Services Alliance Northern Territory (AMSANT) and the North Australian Aboriginal Justice Agency (NAAJA):**

- a) **ensure that dedicated specialist mental health staff are placed on call in court and detention settings for assessment and acute interventions as required and as a link to ongoing community based care following release; and**
- b) **trial the use of Multi Systemic Therapy treatment for young offenders with repeat arrest histories.**

### 3.2.6 Telephone Counselling and Online Strategies

Telephone counselling and crisis support services (such as Lifeline, Kids Helpline and Domestic Violence Help lines) have been in existence for a number of years, and more recently an increasing number of internet based services have emerged. Given that the internet is a dominant feature of youth culture, online services (such as **e-headspace**, *Reach Out and Lifeline*) are acknowledged as a particularly relevant, accessible and appropriate means for young people to increase their mental health literacy, access information about suicide prevention and obtain counselling and support.<sup>738</sup> In terms of acknowledging cultural barriers, Ms Callaghan, informed the Committee that, where needed, the **e-headspace** service incorporates “use of cultural interpreters or support around appropriate language for young people”<sup>739</sup>

The fact that telephone and internet based services are available 24/7 and are anonymous was cited as a significant advantage in terms of young people overcoming any reticence to seek help. Similarly, both service types were acknowledged as providing additional options for young people living in regional, rural and remote areas who do not necessarily have ready access to counsellors or mental health professionals.<sup>740</sup> However, as Ms Wirth pointed out to the Committee, the majority of young people living in the more remote communities (such as Lajamanu, Kalkarindji or Yarralin for example) do not have access to any internet facilities, mobile phone and internet reception is often patchy, most don’t have landlines at home, and public phones are often not working.<sup>741</sup> The Committee also heard that, whilst Lifeline receives a high percentage of calls from the Northern Territory, the service may have limited relevance to some Indigenous

<sup>737</sup> *Ibid*

<sup>738</sup> Suicide Prevention Australia, *op.cit.*, p. 11; see also: headspace, *op.cit.*, p. 10

<sup>739</sup> Ms Amelia Callaghan, *op.cit.*, p. 9

<sup>740</sup> headspace, *loc.cit.*

<sup>741</sup> Ms Tylee Wirth, *op.cit.*, *Committee Hansard*, 30 January 2012, p. 30

communities given Lifeline's current lack of capacity to provide a comprehensive Aboriginal interpreter service.<sup>742</sup>

Ms Moss raised the issue of mobile phone call costs associated with telephone counselling as a significant barrier in terms of young people seeking help.<sup>743</sup> Whilst all calls are now free to the Lifeline telephone counselling service, the Committee was concerned to learn that this does not yet apply to the Kids Helpline; especially given that it is the only telephone counselling service that targets young people from 5 to 25 years of age.<sup>744</sup> The Committee notes that approximately 70% of calls to the Kids Helpline are made from mobile phones. However only those made via Optus, Vodaphone, or Virgin are currently free of charge.<sup>745</sup> What is most concerning is the fact that:

Two in five calls to Kids Helpline come from regional and remote areas, where Telstra is the largest provider. This means that young people living outside of metropolitan areas are significantly disadvantaged. Not only do they have limited choices in accessing youth appropriate services in their area, they also are expected to pay to contact the nation's only youth specific telephone counselling service.<sup>746</sup>

### **Recommendation 13**

**The Committee recommends that, in accordance with the Australian Government's support of Recommendation 23 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), and in light of evidence regarding the incidence of suicide in young people under the age of 25 in the Northern Territory, the Northern Territory Government:**

- a) **calls upon Telstra, in the interests of corporate citizenship, to drop call charges for mobile phone calls made to the *Kids Helpline* as a matter of priority; and**
- b) **promote and encourage the use of telephone counselling and on-line crisis support services in media campaigns and relevant departmental information brochures.**

### **3.2.7 Youth Friendly/Youth Specific Mental Health and Counselling Services**

As noted in section 3.1.1, the lack of youth friendly and youth specific mental health and counselling services in the Northern Territory was highlighted to the Committee as an

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<sup>742</sup> Ms Jane Johnson, CEO, Lifeline Top End, and Mr Rob Loane, Director, Lifeline Central Australia, *Committee Hansard*, 10 November 2011, pp.45-46

<sup>743</sup> Ms Lauren Moss, Youth Minister's Round Table of Young Territorians, *Committee Hansard*, 30 January 2012, p. 30

<sup>744</sup> Kids Helpline, *Mobile Phones*, retrieved 13 February 2012, <http://www.kidshelp.com.au/kids/get-help/more-info/mobile-phones.php>

<sup>745</sup> Kids Helpline, *Kids in crisis dubbed able to pay* – media release June 20 2011, retrieved 23 February 2012 <http://www.kidshelp.com.au/upload/22892.pdf>

<sup>746</sup> *Ibid*

area of particular concern.<sup>747</sup> Moreover, as Mr Gary Robinson (Associate Professor, Menzies Centre for Child Development and Education) pointed out to the Committee, this has been a long held concern amongst a range of professionals that work with children and young people across the Territory.<sup>748</sup> The Committee heard that following the inquest into a suicide death of a young person in the Northern Territory in 1999 “the Coroner recommended the establishment of an adolescent health service.”<sup>749</sup>

As indicated previously, depression, anxiety and suicidal thoughts is not uncommon during adolescence. The Committee was informed that for most young people their preferred sources of help during this period of life are their friends and family, and are the “least likely demographic to seek professional help for a mental health problem.”<sup>750</sup> However, as the submission from Suicide Prevention Australia highlighted, for those experiencing suicidal thoughts, irrespective of any clinical disorder, mental health or counselling services are generally acknowledged as the most appropriate services to respond to their needs.<sup>751</sup>

The Committee heard that a number of barriers have been identified relating to young people’s help-seeking behaviour. These include, lack of knowledge about what services are available, reliance on parents for transport, stigma associated with accessing mental health services, cost – especially where access to services requires a referral from a GP, attitudes of staff towards young people, concerns around confidentiality and anonymity – especially for young people whose primary access to professional assistance is the family GP, and anxiety or embarrassment regarding disclosure of personal issues.<sup>752</sup> At the inquiry’s Youth Forum the Committee heard that, for males in particular, seeking assistance from a counsellor was often seen as a sign of weakness.<sup>753</sup> It was also noted that for Indigenous young people there was the additional cultural barrier relating to ‘shame’, “being too shamed to go and see someone...it took me like six months before I actually talked to someone, that I had some concerns.”<sup>754</sup>

As noted in the **headspace** submission, “[t]o address the health needs of young people, health services need to change the way that they offer and deliver health care.”<sup>755</sup> Heralded as a model for youth mental health service provision, **headspace**, the national youth mental health foundation, was established in 2006. Funded by the Australian Government, **headspace** “has provided services to more than 45,000 young people at

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<sup>747</sup> See for example: Aboriginal Peak Organisations Northern Territory, *op.cit.*, p. 17; NT Police, *op.cit.*, p. 4; Katherine Youth Interagency Tasking and Coordination Group, *Submission 24*, p. 10; headspace, *op.cit.*, p.11

<sup>748</sup> Mr Gary Robinson, Associate Professor, Menzies Centre for Child Development and Education, *Committee Hansard*, 31 January 2012, p. 51

<sup>749</sup> *Ibid*

<sup>750</sup> Suicide Prevention Australia – Attachment 3, *op.cit.*, p. 5; see also: headspace, *op.cit.*, p. 4

<sup>751</sup> Suicide Prevention Australia – Attachment 3, *op.cit.*, p. 16

<sup>752</sup> headspace, *loc.cit.*; *Suicide Prevention Australia, loc.cit.*

<sup>753</sup> Youth Forum, *Committee Hansard*, 2 December 2012, p. 47

<sup>754</sup> *Ibid*

<sup>755</sup> headspace, *op.cit.*, p.12

30 centres in metropolitan, regional and remote areas across Australia.<sup>756</sup> Ms Callaghan advised the Committee that two **headspace** centres

currently operate within the Northern Territory – **headspace** Central Australia located in Alice Springs and **headspace** Top End located in Palmerston.<sup>757</sup>

Ms Callaghan noted that all **headspace** centres provide:

mental health, drug and alcohol, primary health or GP services, and Social and vocational services, with the goal of being an entry point for young people, so that all young people regardless of what they are presenting with, or what they are having concerns with, can present to a **headspace** centre and we will assist them either to provide support on site at **headspace** or to link in with an appropriate service in the area.<sup>758</sup>

In addition to the services mentioned above, Ms Sally Weir (Service Integration Manager, **headspace** Top End) informed the Committee that the Top End centre provides outreach services to schools in the Palmerston, Howard Springs and Humpty Doo area. The centre also provides a fortnightly service to Kormilda College and will travel into Darwin and meet young people at Anglicare if they are unable to get out to Palmerston.<sup>759</sup>

The Committee visited the **headspace** centre in Palmerston and was particularly impressed with the strategies the organisation employs to ensure services are accessible, appropriate and free of charge. In terms of the types of services young people accessed through the Northern Territory **headspace** centres, Ms Callaghan advised the Committee that at the Top End centre they tended to be focussed on client supportive counselling, care planning, cognitive behaviour therapy, and assertive monitoring of young people's mental health. At the Alice Springs centre there was more call for care planning (coordinating young people's access to services), medical check-ups, supportive and relationship counselling, and cognitive behaviour therapy.<sup>760</sup>

During the course of the inquiry the Committee received a significant amount of positive feedback regarding the **headspace** model in terms of its collaboration with schools and other services in Alice Springs and Darwin, its non-judgemental youth friendly approach, and provision of a one-stop shop for young people's physical, social, emotional and mental health care needs.

The need for a more integrated approach to the health care needs of young people was also highlighted to the Committee by Aboriginal Peak Organisations NT and the Central Australian Aboriginal Congress.<sup>761</sup> As discussed more fully in section 3.1.2, the Committee was advised that, in terms of remote Indigenous communities in particular, given the incidence of and correlation between substance abuse, mental health issues

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<sup>756</sup> *headspace, op.cit.*, p.3

<sup>757</sup> *Ibid*

<sup>758</sup> Ms Amelia Callaghan, *op.cit.*, 3 November 2011, p.8

<sup>759</sup> Ms Sally Weir, Service Integration Manager, **headspace**, *Committee Hansard*, 2 December 2011, p. 41

<sup>760</sup> Ms Amelia Callaghan, *op.cit.*, p. 11

<sup>761</sup> Aboriginal Peak Organisations Northern Territory, *op.cit.*, pp. 20-22; Central Australian Aboriginal Congress, *op.cit.*, pp. 24-29

and suicide risk, treatment of such should be incorporated into existing primary health care services.<sup>762</sup> The importance of early detection and intervention in substance abuse and mental health issues in relation to suicidal thoughts has been clearly demonstrated in the literature, and, as noted by Aboriginal Peak Organisations NT, is best achieved through the primary health care sector; especially in the absence of on-site specialist mental health, alcohol or other drugs services.<sup>763</sup>

As the Committee heard, the current service mix neither acknowledges nor caters for the high number of young people with dual diagnosis – both mental health and substance abuse problems:

Unfortunately most of remote NT receives fragmented and uncoordinated visiting services from external providers...Some services are only funded to provide mental health services rather than a comprehensive service that also addresses alcohol and other drug issues. Similarly, while some remote services now have funding for small alcohol and other drugs teams through COAG funding, these teams often can only cover a small area and exclude mental health and therefore are not able to provide integrated service delivery.<sup>764</sup>

Dr Ruth Rudge (Clinical Psychologist, Southern Cross Clinical Psychology Services) noted that whilst the wider community has access to psychology services, for Indigenous people living in remote communities access to such was extremely limited.<sup>765</sup> This view was reiterated by Aboriginal Peak Organisations NT, who noted that, for young people living in remote communities, there is a chronic shortage of, and access to, clinical services such as focused psychological services which are critical when it comes to treating serious alcohol and other drug problems, reducing the likelihood of subsequent mental health problems and the risk of suicide.<sup>766</sup>

The Committee was advised that Drs Ruth and John Rudge have been providing outreach psychology services to the communities of Nguiu (two days per fortnight) and Milikapiti (one day per fortnight) on the Tiwi Islands since 2008, and are currently trialling a service in the community of Pirlangimpi. As Dr Ruth Rudge and others also highlighted to the Committee, whilst the outreach model is a cost effective way of ensuring some degree of equity of access for rural and remote communities, when it comes to mental health services it can take a considerable amount of time to develop the relationships with people that are required for them to feel comfortable about disclosing personal information.<sup>767</sup>

#### **Recommendation 14**

**The Committee recommends that the Northern Territory Government actively lobby the Australian Government to:**

<sup>762</sup> *Ibid*, p. 27; Aboriginal Peak Organisations Northern Territory, *op.cit.*, p.21;

<sup>763</sup> Aboriginal Peak Organisations Northern Territory, *loc.cit.*

<sup>764</sup> *Ibid*, pp. 20-21

<sup>765</sup> Dr Ruth Rudge, Clinical Psychologist, Southern Cross Clinical Psychology Services, *Committee Hansard*, 31 January 2012, p.39

<sup>766</sup> *Aboriginal Peak Organisations Northern Territory, op.cit.*, p. 20

<sup>767</sup> *Ibid*, p.4, see also: Katherine Youth Interagency Tasking and Coordination Group, *op.cit.*, p. 10; NT Police, *op.cit.*, p. 4; Aboriginal Peak Organisations Northern Territory, *op.cit.*, p. 20

- a) **establish and fund *headspace* centres in Katherine, Tenant Creek and Nhulunbuy; and**
- b) **provide *headspace* outreach services to remote Northern Territory communities.**

### 3.3 Helping the Bereaved and Stopping the Contagion

The submission from the Jesuit Social Services noted that, conservative estimates indicate that for every death by suicide, “on average, another 14 people will be severely affected by intense grief.”<sup>768</sup> Whilst other studies suggest that this figure could be as high as 100, Ms Alyson Evans (Project Officer, Darwin Community Arts) and Commissioner McRoberts pointed out to the Committee that the capacity for suicide to affect entire communities is also well documented.<sup>769</sup> For example, in small rural or remote Indigenous communities where the deceased is often related or known to a significant proportion of the population, or the mass grief teachers have encountered in school communities following the suicide of a student.<sup>770</sup>

The Salvation Army noted that, given the stigma associated with suicide, research indicates that the grief experienced by those bereaved by suicide is exacerbated by feelings of guilt, anger, shame or embarrassment.<sup>771</sup> Subsequent police and coronial investigations can further compound the stress and anxiety experienced by those left behind and prolong the grieving process.<sup>772</sup> As Mr Alain Staines (Director, Salvation Army Suicide Prevention – Bereavement Support Services) highlighted to the Committee, the inability of those around a person mourning suicide to accept or understand death by suicide can result in a lack of social support and a profound sense of isolation for that person.<sup>773</sup> This can have an extremely detrimental impact on the social, physical, emotional and mental health and well-being of those bereaved by suicide. It can also inhibit help-seeking behaviours and heighten the risk of suicide ideation.<sup>774</sup>

The contagion effect of suicide is well documented in the literature. Empirical and clinical evidence suggests that those bereaved through the suicide of a significant other have a fivefold increased suicide risk compared to the rest of the population.<sup>775</sup> Of particular concern is the prevalence of imitative suicide amongst adolescents and young adults, “wherein the suicide or attempted suicide of one person may trigger suicidal behaviours...in vulnerable individuals who become aware of the suicide.”<sup>776</sup> Ms Lenore Hanssens (Researcher) noted that suicide contagion and imitation can also spark suicide clusters of “two or more completed suicides occurring in close temporal and geographic

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<sup>768</sup> Jesuit Social Services, *op.cit.*, p. 5

<sup>769</sup> Jesuit Social Services, *Ibid*; Mendoza and Rosenberg, *op.cit.*, p.85; Commissioner John McRoberts, *loc.cit.*; Ms Alyson Evans, Project Officer, Darwin Community Arts, *Committee Hansard*, 3 November 2011, pp. 45-46

<sup>770</sup> Mr Alan Staines, Director, Salvation Army Suicide Prevention – Bereavement Support Services, *Committee Hansard*, 3 November 2011, p. 28; Mendoza and Rosenberg, *loc.cit.*

<sup>771</sup> Salvation Army, *Submission 21*, p.3; The Senate Community Affairs Reference Committee, *op.cit.*, p. 104; Commissioner John McRoberts, *op.cit.*, p. 22

<sup>772</sup> Mental health Association of Central Australia Inc, *op.cit.*, p. 29; Mendoza and Rosenberg, *op.cit.*, p.86

<sup>773</sup> Mr Alan Staines, *op.cit.*, pp. 27

<sup>774</sup> Jesuit Social Services, *op.cit.*, pp. 5-7; Mental health Association of Central Australia Inc, *op.cit.*, p. 30

<sup>775</sup> Jesuit Social Services, *op.cit.*, p. 5; The Senate Community Affairs Reference Committee, *loc.cit.*

<sup>776</sup> Mendoza and Rosenberg, *loc.cit.*; see also: Suicide Prevention Australia, *op.cit.*; p. 6; Darwin Community Arts, *Submission 6*, p. 1; Ms Bronwyn Hendry, *op.cit.*, p. 11

proximity.”<sup>777</sup> Ms Hanssens advised the Committee that her research indicates that Indigenous communities have the highest incidence of imitative suicide and suicide clusters; with the latter accounting for 77% of Indigenous suicides in the Northern Territory in the ten year period from 1996 to 2005.<sup>778</sup>

Given the above, postvention strategies at the individual, family and community level are critical; both in terms of helping the bereaved and stopping the contagion.<sup>779</sup> As noted in the 2011 *Economic Evaluation of the StandBy Response Service*, the provision of bereavement support services:

measurably improves the health and wellbeing of people bereaved by suicide which, in turn can reduce the economic burden on the health system, employers, communities and society generally [and] has several other important benefits including...increased community capacity and awareness and, perhaps most importantly, a potential reduction in the number of future suicides.<sup>780</sup>

During the course of the inquiry a number of issues were highlighted which impact on the provision of bereavement support services in the Northern Territory, or impede the implementation of postvention strategies. Actions to address these are outlined below.

### 3.3.1 Social and Cultural Perceptions of Suicide

Reducing the stigma associated with suicide, and thereby alleviating the burden of guilt, shame, embarrassment and isolation experienced by those bereaved by suicide and the potential for contagion, requires a fundamental shift in social and cultural perceptions of suicide. During the course of the inquiry, a number of witnesses highlighted the need for greater community awareness of, and willingness to openly discuss, suicide.<sup>781</sup>

The Committee notes that a recent survey commissioned by the Salvation Army found that:

there is still a sense of ignorance about the full extent of suicide in Australia. We know that more people die by suicide in a single year than through road trauma and yet the awareness levels of the issues surrounding these two social issues in Australia is vastly different. We are constantly reminded through public awareness campaigns about the extent of the road toll and how we can remain safe on our roads and yet the issue of suicide remains shrouded in mystery and seems to be seen as an individual issue and not fully recognised as the public health issue that it is.<sup>782</sup>

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<sup>777</sup> Ms Lenore Hanssens, *Submission 15*, p. 4; see also: Ms Louise Flynn, Jesuit Social Services, *Committee Hansard*, 3 November 2011, pp. 3-4

<sup>778</sup> Lenore Hanssens, *loc.cit*

<sup>779</sup> Salvation Army, *op.cit.*, pp. 3-5; Lenore Hanssens, *op.cit.*, p. 11; Mendoza and Rosenberg, *op.cit.*, p. 103

<sup>780</sup> United Synergies, *Economic Evaluation of the StandBy Response Service*, retrieved 22 February 2012, [http://www.unitedsynergies.com.au/index.php?option=com\\_content&view=article&id=39&Itemid=23](http://www.unitedsynergies.com.au/index.php?option=com_content&view=article&id=39&Itemid=23)

<sup>781</sup> See for example, Suicide Prevention Australia, Attachment 3, *op.cit.*, p. 12; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *op.cit.*, p. 5; Mental Health Association of Central Australia, *op.cit.*, p.5; Ms Ngaire Ah Kit, Darwin Region Indigenous Suicide Prevention Network, *Committee Hansard*, 3 November 2011, pp. 16-17; Wesley LifeForce Program, *op.cit.*, pp. 5-11; Ms Alpha Capaque, *op.cit.*, p. 29; Ms Lauren Moss, *op.cit.*, p. 31;

<sup>782</sup> The Senate Community Affairs Reference Committee, *op.cit.*, p. 57

This lack of awareness in the community is also seen to have resulted in misconceptions about suicide; in particular the perception that suicide is primarily a medical problem or a response to mental illness.<sup>783</sup> As Mr Cavanagh, advised the Committee, “there is this feeling that people who commit suicide are mentally ill; they are mad. Why would you do it? That is what well-adjusted happy people think.”<sup>784</sup> However, as Mr Cavanagh pointed out, from his 15 years experience as a Coroner, this is certainly not the case. Rather, the majority of people who suicide are “not psychotic, are not particularly mentally ill, may be unhappy, and make what they consider to be a rational decision – it is just not worth living.”<sup>785</sup> The submission from the NT Department of Children and Families notes that, this general lack of community awareness fails to acknowledge both the complexities of suicide and the many social determinants of suicide; “[d]efining youth suicide as a mental health issue does not acknowledge the many causes of self-harm.”<sup>786</sup> Moreover, given the stigma associated with mental illness this misconception serves to further exacerbate the alienation experienced by those bereaved by suicide.

The Committee heard that whilst raising community awareness about suicide has the potential to reduce the stigma associated with suicide, there was considerable debate as to how this can be best achieved whilst, at the same time, ensuring that it does not result in “negative consequences for vulnerable populations.”<sup>787</sup> As noted in the Suicide Prevention Australia submission, the Australian Government funded Mindframe National Media Initiative and Sane Media centre have had considerable success in reducing irresponsible reporting and ensuring public representations of suicide do not cause harm; “a result supported by the World Health Organisation as an effective method of preventing suicide.”<sup>788</sup> However, Suicide Prevention Australia further notes that research is lacking on the:

potential benefits of positive media reporting upon increased awareness of suicide warning signs and the promotion of help- seeking...although the lack of suicide awareness in the public domain suggests that media could be further utilised to promote suicide awareness and prevention.<sup>789</sup>

The Committee notes that whilst the 2010 Senate Inquiry into Suicide Australia considered that a national suicide awareness campaign would be beneficial in terms of both raising the profile of the issue and encouraging help-seeking behaviour; this was not supported by the Australian Government.<sup>790</sup> In responding to the Senate’s report, *The Hidden Toll: Suicide in Australia*, the Australian Government highlighted:

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<sup>783</sup> *Ibid*, p. 58

<sup>784</sup> Mr Greg Cavanagh, *op.cit.*, p. 5

<sup>785</sup> *Ibid*

<sup>786</sup> NT Department of Children and Families, *op.cit.*, p. 5

<sup>787</sup> Suicide Prevention Australia, *loc.cit*

<sup>788</sup> *Ibid*

<sup>789</sup> *Ibid*

<sup>790</sup> The Senate Community Affairs Reference Committee, *op.cit.*, p. 77

the tension between a need for increased awareness and knowledge about suicidal behaviour, and a need to maintain duty of care in the way suicide is reported, discussed and communicated to minimise risk to vulnerable individuals.<sup>791</sup>

The Australian Government further noted its continuing support for World Suicide Prevention Day, celebrated on 10 September each year.<sup>792</sup> On World Suicide Prevention Day 2011 the newly formed Darwin Region Indigenous Suicide Prevention Network coordinated a Walk for Suicide Prevention and Awareness and invited local service providers to set up information stalls.<sup>793</sup> The Committee was advised that the Galupa Marn Garr Suicide Prevention Group has been organising World Suicide Prevention Day events for a number of years. In 2011 the event incorporated a memorial service and cultural ceremony to commemorate the young lives lost to suicide; a play 'Helping Hands', (written and performed by network members and students from Yirrikala school), denouncing suicide in their communities; and an alcohol free dance and music event.<sup>794</sup>

The Committee also heard that healing ceremonies are held in Alice Springs and Tennant Creek each year.<sup>795</sup> As noted in the submission from the Mental Health Association of Central Australia Inc:

these ceremonies over the years have allowed young people to share their experiences of loss...they are an important means of collective grieving, a chance to raise public awareness about the issue and an opportunity to reduce the shame and stigma associated with it.<sup>796</sup>

The Committee notes that the Australian Government also supports the R U OK? Day which is funded under the National Suicide Prevention Strategy.<sup>797</sup> R U OK? is a non profit organisation whose purpose is to "provide a national focus and leadership on suicide prevention in Australia by empowering people to make a difference by having open and honest communication."<sup>798</sup> R U OK? has four key priorities:

- Connecting people to stop little problems turning into big ones.
- Supporting sector partners at the coalface of suicide prevention.
- De-stigmatising conversations about suicide.
- Developing tailored national programs to promote R U OK? and encourage participation.<sup>799</sup>

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<sup>791</sup> Commonwealth of Australia, *Commonwealth response to The Hidden Toll: Suicide in Australia Report of the Senate Community Affairs Reference Committee*, Commonwealth of Australia, Canberra ACT, 2010, p. 40

<sup>792</sup> *Ibid*, p. 41

<sup>793</sup> Ms Ngaire Ah Kit, Darwin Region Indigenous Suicide Prevention Network, *Committee Hansard*, 3 November 2011, p. 16

<sup>794</sup> LIFE: suicide prevention, *Live & Learn – World Suicide Prevention Day September 2011: A day of remembrance and celebration of life and culture*. Retrieved 2 March 2012, <http://www.livingisforeveryone.com.au/News.aspx?PageID=309>

<sup>795</sup> Mental Health Association of Central Australia Inc, *op.cit.*, p. 30

<sup>796</sup> *Ibid*

<sup>797</sup> Commonwealth of Australia, *loc.cit.*

<sup>798</sup> RUOK?, *Official R U OK? Policy*, retrieved 27 February 2012, <http://www.ruokday.com.au/content/official-r-u-o-k-policy.aspx>

<sup>799</sup> *Ibid*

R U OK?Day 2012 will be celebrated on Thursday 13 September.

In terms of de-stigmatising conversations about suicide, the Committee was particularly disturbed to hear that there is still considerable reticence on the part of schools in the Northern Territory when it comes to responding to suicide deaths of students.<sup>800</sup> The Committee notes that all government schools are required to have an *Emergency Management Plan* in place which:

describes preventative measures, actions to be undertaken during and following an event to ensure the safety and minimise trauma or distress to students, staff and visitors and minimise damage, and recovery planning to assist in restoration of school routines.<sup>801</sup>

Given the impact the suicide death of a student can have on the school community and the potential for contagion, the Committee was concerned to learn that the current policy does not provide any specific guidance on the development of critical incident plans in the case of student suicide. Mr Nyhuis noted that all emergency management plans were site specific and not all schools would necessarily have a critical incident plan relating to suicide.<sup>802</sup> The Committee heard that in the event that the department is called in to provide support a school where a suicide has occurred:

then I encourage the staff to actually sit with the principal if there has not been a plan, to actually then engage in the development of a plan.<sup>803</sup>

Ms Eva Nicholls Manager of Mental Health and Child Protection, Student Services, NT Department of Education and Training advised the Committee that the departmental guidelines (Emergency Management Kit for Schools) do include “a page at the end that actually talks about engaging with people like school counsellors, school staff, to actually develop an intervention – your own plan...”<sup>804</sup> The Committee noted their concern regarding the fact that schools were not required to have critical incident plans for student suicide prior to an incident occurring.

Mr Barnes advised the Committee that schools certainly do need to have a structured approach to the way in which they respond to student suicides, in terms of both the way in which the principal reacts and what the counsellors or guidance officers need to do. The Committee heard that counsellors and guidance officers are responsible for the:

broader strategy for dealing with the young people who are directly impacted, for ensuring the significant networked others are dealt with in a different way. The one thing we know about suicide is it runs in patterns and the biggest link to future episodes of suicide is the relationship and the nature of the relationship with the young person that as committed suicide, and then how to engage families and community.<sup>805</sup>

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<sup>800</sup> Ms Alpha Capaque, *op.cit.*, p. 29

<sup>801</sup> NT Department of Education and Training, *Policy Emergency Preparedness and Continuity Management for Schools*, PDF, Retrieved 8 March 2012, <http://www.det.nt.gov.au> p. 1

<sup>802</sup> Mr Paul Nyhuis, *op.cit.*, p. 31

<sup>803</sup> *Ibid*

<sup>804</sup> Ms Eva Nicholls, Manager of Mental Health and Child Protection, Student Services, NT Department of Education and Training, *Committee Hansard*, 4 November 2011, p. 31

<sup>805</sup> Mr Gary Barnes, *op.cit.*, p.12

Whilst acknowledging Mr Barnes' comments, the Committee notes that the department's current policy, which is not due to be reviewed until 2013, does not adequately address the issue of student suicide. At present there is only one paragraph at the end of the guidelines which refers to the death of students. The Committee further notes that it neither suggests that a specific critical incident plan should be developed, nor fully acknowledges the impact that student suicide can have on the school community:

In the event of a student death, a letter to parents/carers of the student's class or year level should be sent home by the principal as soon as possible, preferably on the first day, advising them of the incident. Parents need to be aware of behavioural changes that they may notice, be encouraged to provide support and to seek help. Adolescents often look to their peers for support and families need to be informed this is normal. Student Services support will usually be provided depending upon the incident.<sup>806</sup>

The Committee notes that the Federal Department of Health and Aging recently provided funding for the **headspace** school support program. This new initiative will provide support to secondary schools affected by the suicide of a student. Whilst it is not a crisis service it can be used in conjunction with the relevant Education Department, Independent Schools Association or Catholic Education Office or mental health services that assist schools immediately following a suicide. The support is individually tailored to the schools needs and can be accessed for:

- Short and long term responses following a suicide or suspected suicide;
- Support and advice regarding managing a suicide in a school setting; and
- Resources including a Suicide Postvention Toolkit and fact sheets.<sup>807</sup>

The Committee heard that young people found it extremely frustrating that schools do not recognise the importance for young people to have an opportunity to discuss issues associated with suicide; especially immediately following the suicide of a student or ex-student. Ms Capaque advised the Committee that even where students do not personally know the person that suicides it is still important to talk about it:

There was that sense of loss but no one can grasp what has really happened. It is important that we talk about it. It is a real issue...that is one of the things we usually talk about – that no one is talking about it.<sup>808</sup>

The potential for contagion when students are not given the opportunity to openly discuss issues around a completed suicide was graphically highlighted to the Committee by Ms Evans.<sup>809</sup> A Community Arts worker, Ms Evans informed the Committee that in 2007/08 she was working in a small community in Wales where, over a two year period, there had been 25 suicides of young people; "it had got to the point where everyone

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<sup>806</sup> NT Department of Education and Training, *Guidelines: Emergency Management Kit for Schools*, PDF, Retrieved 8 March 2012, <http://www.det.nt.gov.au> p. 4

<sup>807</sup> Headspace – Australia's National Youth Mental Health Foundation, *headspace School Support*, Retrieved 19 March 2012, <http://www.headspace.org.au/what-works/school-support>

<sup>808</sup> Ms Alpha Capaque, *op.cit.*, p. 29

<sup>809</sup> Ms Alyson Evans, *op.cit.*, pp. 45-9

knew someone who had committed suicide.”<sup>810</sup> Ms Evans noted that what kept coming up was:

Young people were saying: ‘We want to speak about it, but no one will let us speak.’ Because there was a lot of panic in the schools, many teachers were saying: ‘No, let us not talk about it, let us just carry on’ and there was nothing for the young people.<sup>811</sup>

Ms Evans advised the Committee that, in response to the concerns of the young people she was working with, she adapted a novel based on suicide into a theatre play. The play was then performed in youth centres and community centres in the affected area. Each performance was followed by a facilitated discussion with the audience around issues raised in the play.<sup>812</sup> Ms Evans noted that school teachers and other stakeholders were invited to participate in the discussions:

so creating a forum between the young people and the service providers creating a direct link between the two. Local youth help organisations such as ‘Just Ask’ came on board...bringing information to each performance...on where to find help...so the young people were given the resources if they wanted to seek help.<sup>813</sup>

The submission from the Jesuit Social Services highlights the valuable contribution arts based initiatives such as these can play in addressing complex social issues.<sup>814</sup> The Committee heard that a review of the role of the arts in social inclusion noted that there is significant evidence that arts initiatives foster social connections and are a particularly effective means of:

engaging marginalised young people [and] provide opportunities for expression and healing and also result in enhanced community connectedness and wellbeing.<sup>815</sup>

The Committee heard that one of the major benefits of utilising arts initiatives to explore complex, and often confronting, social issues is that they are “overwhelmingly viewed positively by participants and they provide important interactive contexts in which difficult social issues can be addressed.”<sup>816</sup> The submission from the Mental Health Association of Central Australia also called for:

Greater collaboration between the ARTS and the community sector to create visual materials for use in workshops with Indigenous communities and with young people, and performance pieces that assist in communicating appropriate messages regarding suicide.<sup>817</sup>

### ***Cultural Perceptions of Suicide***

A number of witnesses advised the Committee that the need for de-stigmatising and open conversations around suicide was particularly pertinent in relation to cultural

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<sup>810</sup> *Ibid*, p. 45

<sup>811</sup> *Ibid*, p. 46

<sup>812</sup> *Ibid*

<sup>813</sup> Darwin Community Arts Inc, *Submission 6*, p. 2

<sup>814</sup> Jesuit Social Services, *op.cit.*, p. 9

<sup>815</sup> *Ibid*

<sup>816</sup> *Ibid*

<sup>817</sup> Mental Health Association of Central Australia Inc, *op.cit.*, p. 5

perceptions of suicide.<sup>818</sup> The Committee heard that there are a range of cultural factors which impinge on understandings of and discussions about suicide and, as a consequence, the implementation of effective bereavement support in Indigenous communities. As noted in the submission from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, "there is enormous stigma around suicide in communities and this complicates grief resolution."<sup>819</sup>

The Committee heard that since suicide is a relatively recent phenomenon in Indigenous communities, there is no word to describe suicide in Aboriginal language.<sup>820</sup> As Ms Kay Thurlow (Deputy President, East Arnhem Shire Council) pointed out to the Committee:

so how do you explain suicide if you do not explain it as suicide: a person deciding themselves to take their own life, with no intervention from anyone else...it often becomes: well, who caused that person to be killed? It is a murder or it is a *gulka*, as we would call it; a spirit.<sup>821</sup>

As Mr Waterford noted in his submission to the inquiry, attributing responsibility or blame for any sudden death is a feature of traditional Aboriginal culture:

People wanted a world that was understandable. So explanations used often gave spiritual powers to people, other family groups, mystical figures and even objects, that were blamed for causing a tragedy.<sup>822</sup>

The Committee heard that, following a death, senior law men and women would then meet to "give weight to one interpretation of events. This then flowed into controlled and measured 'pay back' responses."<sup>823</sup> However, as the Committee was informed, not only is the concept of suicide quite foreign but:

existing culture and laws about justice, death and healing couldn't give people immediate guidance about how they could respond to it or to those who had lost someone to it.<sup>824</sup>

Although many Indigenous communities have been dealing with the incidence of suicide since the late 1970's, attributing blame and responsibility for suicides on others is still commonplace. The Committee was advised that it is not unusual for family members; the last person to have been seen speaking to the dead person; those who find the body such as Night Patrol Officers; or Aboriginal Mental Health workers who may have been involved in the treatment of someone who completes suicide, to be held responsible for triggering or failing to prevent the death.<sup>825</sup> The Committee heard that in Indigenous

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<sup>818</sup> See for example, Mr Gerard Waterford, *Submission 3*, p. 12 and *Committee Hansard*, 10 November 2011, pp.9-10; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *op.cit.*, p. 5; Mental Health Association of Central Australia, *op.cit.*, pp. 27-30; The Age, *op.cit.*, Cr Barayuwa Mununggurr, *Committee Hansard*, 17 November 2011, p. 11; Dr Michael Dudley, Chair, Suicide Prevention Australia, *Committee Hansard*, 24 November 2011, p. 6; Ms Valda Shannon, *op.cit.*, p.16

<sup>819</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *op.cit.*, Attachment D

<sup>820</sup> Cr Keith Hansen, East Arnhem Shire Council, *Committee Hansard*, 17 November 2011, p. 1; Cr Kay Thurlow, Deputy President, East Arnhem Shire Council, *Committee Hansard*, 17 November 2011, p. 5

<sup>821</sup> Cr Kay Thurlow, *loc.cit.* see also, K, Schubert, *op.cit.*, p. 23

<sup>822</sup> Mr Gerard Waterford, *op.cit.*, p. 10

<sup>823</sup> *Ibid*

<sup>824</sup> K, Schubert, *op.cit.*, p. 22

<sup>825</sup> Mr Gerard Waterford, *op.cit.*, p. 11; K, Schubert, *op.cit.*, p. 25; Witnesses, East Arnhem Shire Council, *Committee Hansard*, 17 November 2011, p. 5

communities the guilt that many people experience in relation to the suicide of a significant other is:

complicated by the blame and payback which are the norm in communities. Fear engendered by payback combined with a feeling of guilt can be toxic for vulnerable family members, siblings and friends increasing the potential for copy-cat suicide...and have led clinicians to negotiate with elders to limit or defer cultural payback processes in order to prevent further suicides.<sup>826</sup>

The Committee was also advised that, in some communities, issues relating to blame and payback are often exacerbated by young people who:

take little account of the authority of older, senior people, even those within their immediate family...[and]...often make decisions to carry out acts of substance-affected revenge under the guise of it being traditional payback punishment.<sup>827</sup>

In small communities where there is a high level of inter connectedness of Aboriginal people through marriage, suicide clusters resulting from fear of payback or other issues result in a large proportion of the population participating in “funerals and ‘sorry business’ arrangements...over most months of the year.”<sup>828</sup> As the submission from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, noted “[I]oss piles on loss before any resolution can be achieved.”<sup>829</sup> The incidence of illness and substance abuse was also noted as a consequence of unresolved grief in Indigenous communities.<sup>830</sup>

The NT Coroner also questioned the extent to which Indigenous funerals, that often last for a number of days, increased the potential for contagion; for copy cat suicides amongst the more vulnerable young people that may be feeling unloved or unhappy. In reference to a coronial investigation that involved a number of suicides in a short space of time the Coroner noted that:

One of the sad things coming out of that...was the kids would see the funerals that went on for three, four or five days, saw that the most attention that the deceased ever got was in the funeral period ...it was almost an incentive for them to do it.<sup>831</sup>

The Committee also heard that the provision of effective bereavement support is hampered by cultural practices which place constraints on referring to deceased people by name, given that:

Most grief and loss counselling and group work rely on being able to engage the grieving person in discussions that explore their relationship with the deceased.<sup>832</sup>

The submission from Mr Waterford further notes that, as such, mainstream bereavement support services are often seen as “not respecting or offending against culture.”<sup>833</sup> Moreover, concerns that contemporary bereavement practices are tantamount to an

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<sup>826</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *loc.cit.*

<sup>827</sup> Mr Gerard Waterford, *op.cit.*, p. 10

<sup>828</sup> *Ibid*

<sup>829</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *loc.cit.*

<sup>830</sup> *Ibid*, p. 6

<sup>831</sup> Mr Greg Cavanagh, *op.cit.*, p. 6

<sup>832</sup> Mr Gerard Waterford, *op.cit.*, p. 12

<sup>833</sup> *Ibid*

erosion of culture can “effectively stop participants from attending; silencing them...[and]...can work to have counselling programs withdrawn from communities.”<sup>834</sup>

In terms of stopping the contagion, the Committee heard that cultural beliefs and practices, relating to “complex relational confidentialities and obligations within family networks”<sup>835</sup>, inhibits help seeking behaviour on the part of those that may be feeling suicidal, the capacity of others to support them, and efforts to talk about or address the issue of suicide:

Also, the person who's feeling suicidal may not want to put pressure on anyone else in their family. Maybe the strong person in the family doesn't want to hear, because it's a huge burden for them...So perhaps, It's just easier for everyone to say nothing.<sup>836</sup>

The Committee was informed that there are an increasing number of Indigenous communities that are acknowledging the need to address the issue of suicide, and that unresolved grief is “an important component of suicidal idealisation and high risk behaviour.”<sup>837</sup> In quoting Ms Valda Shannon (Aboriginal Mental Health Worker and national winner of a 2011 Suicide Prevention Australia LIFE Award), Mr Michael Dudley noted that there is a growing awareness of the need for communities to:

actually name the problem, to actually accept that it is their responsibility and it is no one else's responsibility, and to apply all potential community remedies – both remedies that could be imported but also obtain a local approach or local authority to actually address your problem effectively.<sup>838</sup>

That addressing suicide in Indigenous communities is particularly challenging is undeniable. As Ms Valda Shannon advised the Committee, although she has been working in the area of suicide prevention for the past two years delivering *Suicide Story* training:

When I first heard about suicide prevention work it did not sit right with me. For 25 years, I kept my distance: it's all whitefella business, nothing to do with our people. For that long, people like me even sitting back and holding back, when we should have been stepping in.<sup>839</sup>

The work of the Tiwi for Life program and the Galupa Marngarr Suicide Prevention Group, highlights what can be achieved with a concerted, sustained and strengths based approach. Both Nguui and Ski Beach were known to have the highest suicide rates in the world, but turned this around and succeeded in restoring a sense of equilibrium in their communities. As both Valda Shannon and Gayili Marika Yunupingu pointed out, at times this has necessitated acting in a manner that would not, under normal circumstances, be accepted as culturally appropriate. Moreover, when it comes to "a matter of life and

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<sup>834</sup> *Ibid*

<sup>835</sup> K, Schubert, *op.cit.*, p. 23

<sup>836</sup> *Ibid*,

<sup>837</sup> Mr Gerard Waterford, *loc.cit.*

<sup>838</sup> Mr Michael Dudley, *loc.cot.*

<sup>839</sup> Ms Valda Shannon, *op.cit.*, p. 17

death, we just got to go in there and forget about that rule, our cultural law...you just got to put that aside.”<sup>840</sup>

### Recommendation 15

**The Committee recommends that the Department of Education and Training review its *Emergency Preparedness Policy and Emergency Management Kit* and incorporate requirements for the development of specific procedures to respond to suicide, and direct schools to implement this policy as a matter of priority.**

### 3.3.3 Organisational Capacity to Respond to Suicide

Ensuring those affected by suicide are afforded an appropriate level of support is not without its difficulties. Since grieving is an intensely personal and individual process, the level and type of support required varies enormously from one person to the next. As the Jesuit Social Services submission points out, on the basis of current research and their experience, there is a:

need for flexibility in timing for bereavement support interventions, and flexibility in service types to ensure optimum responsiveness to differences in grieving styles (including cultural differences) and the delivery of developmentally appropriate services for the suicide bereaved.<sup>841</sup>

Irrespective of where suicides occur the Police are generally one of the first organisations that are called to the scene. Where the death occurs in the home this can be a particularly traumatic experience for those left behind, since the area is generally classified as a crime scene until the police have completed their assessment of the situation.<sup>842</sup> As Commissioner McRoberts advised the Committee, it is important to note that it is the coroner, and not the police, that determines whether a death is suicide or not, and this determination is based on the evidence that the police gather on the coroner’s behalf.<sup>843</sup> As such, Commissioner McRoberts noted that “all deaths that police respond to are dealt with as a crime scene in the first instance.”<sup>844</sup> The Committee was advised that this is critical in terms of ensuring that police “can make a thorough and objective assessment of the circumstances that led to that person’s death.”<sup>845</sup>

The Committee heard that this approach is both what the wider community expects of police, and is “the most appropriate way to deal with it on behalf of the family.”<sup>846</sup> As Commissioner McRoberts pointed out to the Committee:

It would be a terrible circumstance to treat a matter informally as suicide, not gather appropriate evidence, and later find there was some involvement by another party,

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<sup>840</sup> Ms Valda Shannon, *op.cit.*, p. 26; see also The Age, loc.cit.;

<sup>841</sup> Jesuit Social Services, *op.cit.*, p. 6

<sup>842</sup> Salvation Army, *op.cit.*, p. 16

<sup>843</sup> Commissioner John McRoberts, *op.cit.*, p. 22

<sup>844</sup> *Ibid*

<sup>845</sup> *Ibid*

<sup>846</sup> *Ibid*

and because it was not handled in an appropriate manner on first arrival, we have lost some evidence or an opportunity to pursue a prosecution.<sup>847</sup>

Commissioner McRoberts further advised the Committee that from his experience, irrespective of the cause of death, the thing those left behind want most is information.<sup>848</sup> Moreover, providing people with as much information as possible about the incident is particularly important in small communities in terms of preventing rumours and avoiding an escalation of the situation.<sup>849</sup> Commissioner McRoberts advised the Committee that the police are also “very well equipped with referral material”<sup>850</sup> for those bereaved by suicide.

In noting the importance of ensuring that first responders provide sensitive support, the submission from the Salvation Army also pointed out that, in addition to the provision of referral material it is crucial that police “follow up contacts with people who have lost a loved one by suicide.”<sup>851</sup> As noted previously, ensuring that those affected by suicide are provided with immediate crisis and ongoing support is critical; both in terms of assisting people through the grieving process and limiting the likelihood of contagion.

However, the Committee heard that feedback from those bereaved through suicide indicated that the follow up provided by police varied quite considerably and “seemed to depend on the action of the particular policeman who attended.”<sup>852</sup> For example the following comment made by Ms Stephanie Bell (CEO, Central Australian Aboriginal Congress), regarding a recent case of suicide on one of the Town Camps in Alice Springs, shows that police can play a positive role in helping the bereaved, but that this is not necessarily the norm:

The CIB came to the sorry camp people set up, sat down with the people and had a conversation with people about it. The family was quite taken by the fact that the CIB took that role of sitting down in sorry camp with Aboriginal people talking about it.<sup>853</sup>

In terms of police officers’ capacity to respond to those bereaved by suicide in remote Indigenous communities, the Committee heard that police receive suicide prevention training and ongoing training around cultural issues. Aboriginal Community Police Officers also have a role in assisting officers to “understand the complexities of cultural issues in the communities in which they are posted.”<sup>854</sup> Whilst many police officers undoubtedly respond to suicide in a compassionate and culturally appropriate manner, it was noted that all frontline staff required to respond to suicide could benefit from bereavement support training.<sup>855</sup> In terms of stopping the contagion, the Committee was

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<sup>847</sup> *Ibid*

<sup>848</sup> Commissioner John McRoberts, *loc.cit*

<sup>849</sup> *Ibid*

<sup>850</sup> *Ibid* p.24

<sup>851</sup> Salvation Army, *op.cit.*, p.15

<sup>852</sup> *Ibid*

<sup>853</sup> Ms Stephanie Bell, CEO, Central Australian Aboriginal Congress, *Committee Hansard*, 3 November 2011, p. 57

<sup>854</sup> *Ibid*

<sup>855</sup> Salvation Army, *op.cit.*, p.5

advised that it is important to recognise that “suicide postvention can also be suicide prevention.”<sup>856</sup>

The NT Coroner, Mr Greg Cavanagh, explained the role of the Coroner’s Office in relation to investigating reportable deaths; which includes any “unexpected, violent or suspicious death”:<sup>857</sup>

My job is to find out what happened, when it happened, who it happened to, where it happened and the circumstances of how it happened so that I can report to the family, the senior next of kin.<sup>858</sup>

The Committee was advised that whilst a coronial investigation is a legal requirement in all instances of reportable deaths this will not necessarily involve a coronial inquest.<sup>859</sup>

Mr Cavanagh informed the Committee that although the NT Police are generally the first to respond in cases of reportable deaths, it is the responsibility of the Coroner’s constables (police assigned to the Coroner’s office) to collect the body, start the investigation and be the first point of reference for the family.<sup>860</sup> Once the coronial investigation is completed, which generally involves an autopsy to determine the cause of death, the Coroner is responsible for releasing the body back to the family so that the burial can take place.<sup>861</sup>

Given that the Coroner’s office necessarily has a significant role in terms of dealing with the family and keeping them informed during the coronial investigation process, the Committee heard that “almost all...coronial offices around Australia have dedicated grief counsellors.”<sup>862</sup> These counsellors generally accompany coronial constables to the scene, provide any immediate support or assistance that may be required and, most importantly, ensure the bereaved have access to the on-going counselling support that is so often required. However, the Committee heard that in the Northern Territory this is not the case; “we do not have any.”<sup>863</sup>

As Mr Cavanagh noted, grief counselling is a very specialised area and whilst “coroner’s constables...do what they can...it is not a speciality of theirs.”<sup>864</sup> In the absence of grief counsellors all the coroner’s constables can do is provide the bereaved with referral material. However, as noted in the submission from the Salvation Army, “[t]here is an urgent need for human contact and practical assistance to be provided immediately after a suicide death, particularly in the hours afterwards when the police are dealing with the ‘crime scene’.”<sup>865</sup>

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<sup>856</sup> *Ibid*

<sup>857</sup> Mr Greg Cavanagh, *op.cit.*, p. 3

<sup>858</sup> *Ibid*

<sup>859</sup> *Ibid*, p. 4

<sup>860</sup> *Ibid*

<sup>861</sup> *Ibid*,

<sup>862</sup> *Ibid*, p. 5

<sup>863</sup> *Ibid*

<sup>864</sup> *Ibid*

<sup>865</sup> Salvation Army, *op.cit.*, p. 16

The Committee heard that although there are a number of services throughout the Territory that provide postvention support, the distribution of these services is quite patchy. For example, whilst the *Information and Support Pack: for those bereaved by suicide or other sudden death (NT)* indicates that there are a range of bereavement support services available to people living in the urban and metropolitan areas of the Territory, this is not necessarily the case for people living in regional, rural and remote communities.<sup>866</sup> The Committee heard that the provision of effective postvention support in the more remote communities of the Territory is challenging to say the least; both in terms of cultural factors such as those mentioned in the preceding section, and issues relating to geographic isolation.

Moreover, Dr Robert Parker, (Director of Psychiatry, Top End Mental Health Services) advised the Committee that there is also an increased potential for contagion in remote communities. As Dr Parker pointed out, suicides in metropolitan areas are generally fairly anonymous events; people tend to kill themselves in the confines of a house and, apart from the family of the deceased, the psychological meaning or impact of what happened in that house is largely unknown.<sup>867</sup> Conversely, in remote communities suicides are far more inclined to be public events:

In a community you have a body that is often in a public place, is often seen by lots of people, and there is a significant psychological impact of that sort of public suicide...and when you get a vulnerable population...it has a lot more meaning and it can have a lot more effect.”<sup>868</sup>

The Committee was particularly impressed by the suicide response model employed by the Mental Health Association of Central Australia Inc. The Committee heard that the Northern Territory Department of Health’s Mental Health Program currently provides funding to the Mental Health Association of Central Australia Inc to deliver the *Life Promotion Program* which incorporates suicide prevention, education and training, and the provision of a coordinated response to suicide in Alice Springs and Tennant Creek. The *Life Promotion Program* was first established in the late 1990’s in response to the high number of youth suicides at that time.<sup>869</sup>

In terms of responding to suicide, Ms Laurencia Grant (Manager *Life Promotion Program*, Mental Health Association of Central Australia Inc) advised the Committee about the importance of ensuring families are given immediate offers of support; i.e. within 24-48 hours of the death.<sup>870</sup> The Mental Health Association of Central Australia Inc’s submission also noted that since the issue of suicide is a shared responsibility of a number of services, it is critical to ensure a collaborative response on the part of

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<sup>866</sup> Commonwealth of Australia, *Information and Support Pack: for those bereaved by suicide or other sudden death (NT)*, Commonwealth of Australia, Canberra ACT, 2010

<sup>867</sup> Dr Robert Parker, Director of Psychiatry, Top End Mental Health Services, *Committee Hansard*, 4 November 2011, p.12

<sup>868</sup> *Ibid*

<sup>869</sup> Department of Health, *op.cit.*, p.9

<sup>870</sup> Ms Laurencia Grant, Manager Life Promotion Program, Mental Health Association of Central Australia, *Committee Hansard*, 10 November 2011, p.13

Government departments and the non-government sector in an effort to prevent contagion.<sup>871</sup>

The Committee was advised that, as part of the Mental Health Association of Central Australia Inc's service agreement with the Department of Health and as part of an agreement with the Alice Springs Coroner's Office, the organisation receives information on every suspected death by suicide within 12 hours. This then triggers a response by the *Life Promotion Program* team to convene a meeting with relevant stakeholders to:

- Identify suicide risk in the family or community;
- Coordinate support for families by local service providers with the capacity to respond and those with established relationships with the family;
- Identify long and short term strategies that could be put in place for the community such as: training, information, development of safety plans, healing ceremonies etc; and
- Limit the spread of rumours and misinformation.<sup>872</sup>

As the one point of contact in terms of a death by suicide in Central Australia, the organisation can also "prevent too many agencies from entering a community and duplicating efforts of support."<sup>873</sup>

However, as Ms Claudia Manu-Preston (General Manager, Mental Health Association of Central Australia Inc) advised the Committee, whilst the organisation has the ability to coordinate an immediate response to suicide, "many of our response units work from 8.30 am until 4.21 and that is not when suicides are completed."<sup>874</sup> It was further noted that the Mental Health Association of Central Australia also lacks the capacity to follow up with agencies or monitor whether or not they have done what they said they would do.<sup>875</sup> As Ms Grant noted, "[I]t is very difficult for us, especially this year, with one suicide after another. We often get caught up in the next one."<sup>876</sup> As highlighted in their submission to the inquiry, in 2011 "the *Life Promotion* team responded to 7 deaths by suicide in a three month period."<sup>877</sup>

The Committee also heard that, given the nature of the work, retaining staff was an issue. As Ms Grant pointed out "it is not an area of work that people see as an attractive career opportunity."<sup>878</sup> Mr Mclvor also advised the Committee that there was a need for more in the way of debriefing and counselling for workers regularly exposed to suicide.<sup>879</sup>

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<sup>871</sup> Mental Health Association of Central Australia, *op.cit.*, p.13

<sup>872</sup> *Ibid*, p.13

<sup>873</sup> *Ibid*

<sup>874</sup> Ms Larissa Knight, *op.cit.*, p. 2

<sup>875</sup> Ms Claudia Manu-Preston, General Manager, Mental Health Association of Central Australia Inc, *Committee Hansard*, 10 November 2011, p.16

<sup>876</sup> Ms Laurencia Grant, Manager Life Promotion Program, Mental Health Association of Central Australia Inc, *Committee Hansard*, 10 November 2011, p.16

<sup>877</sup> Mental Health Association of Central Australia, *op.cit.*, p. 14

<sup>878</sup> Ms Laurencia Grant, *op.cit.*, p. 14

<sup>879</sup> Mr Nathan Mclvor, *op.cit.*, p.22

For example, the Committee learnt that although Night Patrol Officers are often the ones that find completed suicides, there are no formal mechanisms in place to ensure that they are debriefed. It was noted that in one incident involving multiple deaths a child protection worker provided the debriefing.<sup>880</sup>

It was further noted that, in the absence of specialist services, families were generally reliant upon the clinic for debriefing and counselling support.<sup>881</sup> As noted in the submission from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, clinic staff generally work long hours and are called upon to attend both attempted and completed suicides at all hours of the day and night by community members.<sup>882</sup> Moreover, the Committee was advised that, even where they have the necessary skills:

They have limited time available for in-depth casework and follow-up with the high numbers of at risk community members...in the face of the overpowering demands of primary health care.<sup>883</sup>

Drs John and Ruth Rudge noted that it was important to acknowledge the enormous pressure this places on clinic staff; in particular Aboriginal workers given the limited support or supervision available in remote communities.<sup>884</sup> As highlighted in their submission to the inquiry, unlike service providers in mainstream communities:

Aboriginal workers are usually related to families involved which results in complex, stressful and often traumatic situations. Workers are often burnt out from previous experiences. We are aware of workers in the NT who have taken their lives due to such pressure.<sup>885</sup>

In terms of reducing the potential for contagion, the Committee was advised that the Mental Health Association of Central Australia Inc lacked the capacity to ensure those most at risk were afforded the on-going long term follow up that is required.<sup>886</sup> It was further noted that "a designated team devoted to this alone would allow for a more effective postvention response such as that provided by the *StandBy* program."<sup>887</sup> The Committee heard that, in the absence of initiatives such as the *Life Promotion Program*, the organisational capacity to respond to suicide and provide effective postvention support services in the more remote communities of the Northern Territory is particularly difficult. As highlighted previously, whilst the *Life Promotion Program* aims to provide a systematic and streamlined response to suicide, "there are many factors that inhibit a comprehensive response."<sup>888</sup>

As Ms Hendry pointed out to the Committee, it is important to acknowledge that whilst the police always ask the family if they would like support, "[I]t really needs to be tailored to that community, that individual and whether the family actually at that time are

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<sup>880</sup> *Ibid*

<sup>881</sup> *Ibid*, p.23

<sup>882</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *op.cit.*, p. 4

<sup>883</sup> *Ibid*

<sup>884</sup> Drs John and Ruth Rudge, *op.cit.*, p. 4

<sup>885</sup> *Ibid*

<sup>886</sup> Ms Claudia Manu-Preston, *loc.cit.*

<sup>887</sup> Mental Health Association of Central Australia, *op.cit.*, p.13 – see section 3.3.3 for an overview of the *StandBy Response Program*

<sup>888</sup> Mental Health Association of Central Australia, *loc.cit.*

accepting of support.”<sup>889</sup> The Committee was informed that the initial response to acute situations in remote communities, including suicide, is generally provided by the on-ground clinic staff who “will be involved in supporting that family in various ways coping with that event.”<sup>890</sup> However, as Ms Alira Capararo (Clinical Psychologist) and Ms Lyn Byers (Remote Nurse Practitioner) noted, clinic staff “usually have limited professional education or training around mental health and/or suicide.”<sup>891</sup>

Ms Hendry advised the Committee that the Department of Health has specialists available that can either “provide support directly to a community if that is required, or to the local service providers to support those families.”<sup>892</sup> Nevertheless, reliance on outreach models of service delivery was highlighted to the Committee as a major issue of concern; especially in terms of continuity of care and the on-going postvention support required at the individual, family and community level to limit the potential of contagion. As Ms Hanssens pointed out in her submission:

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...people at risk.”<sup>893</sup>

Mr Gerard Waterford (Social Worker/Counsellor, Central Australian Aboriginal Congress) and others also pointed out to the Committee, that the expectation that outreach services have the capacity to provide the on-going counselling, therapeutic, case management or crisis intervention that may be required is quite unrealistic in two important respects. Firstly, most visiting services “have quite a large travelling agenda...[and]...often have 5, 6, 7, or 8 communities they visit about every three months.”<sup>894</sup> Secondly, workers in outreach services “often have very little relationship to the people who are living in some of these communities.”<sup>895</sup> Given the highly personal nature of the grieving process this latter point was noted as critical in terms of the provision of effective postvention support.

The Committee was concerned to learn that where it was not possible for outreach services to provide the on-ground support required following a suicide, subsequent serious incidences of attempted suicide entailed evacuating the individual to hospital accident and emergency wards as a means of obtaining a mental health assessment.<sup>896</sup> However, given the impulsive nature of many suicide attempts, by the time the person is seen by a mental health clinician they do not necessarily present with symptoms of suicidal thoughts.<sup>897</sup> Or, as noted in the submission from the Mental Health Association of Central Australia Inc, “[s]ometimes, clinicians would not take the referral as it was

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<sup>889</sup> Ms Bronwyn Hendry, *op.cit.*, p.11

<sup>890</sup> *Ibid*

<sup>891</sup> Alira Capararo and Lyn Byers, *Submission 14*, p. 2; see also: Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *loc.cit.*

<sup>892</sup> Ms Bronwyn Hendry, *loc.cit.*

<sup>893</sup> Lenore Hanssens, *op.cit.*, p.9

<sup>894</sup> Mr Gerard Waterford, *op.cit.*, p. 3; see also: Ms Alira Capararo and Ms Lyn Byers, *loc.cit.*, Ms Cate Ryan, Coordinator Hidden Valley Community Centre, Tangentyere Council, *Committee Hansard*, 10 November 2011, p. 31; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *loc.cit.*

<sup>895</sup> Mr Gerard Waterford, *loc.cit.*, see also Ms Leonie Sheedy, Coordinator Yarrenyty Arltere Learning Centre, Tangentyere Council, *Committee Hansard*, 10 November 2011, p. 31

<sup>896</sup> Alira Capararo and Lyn Byers, *op.cit.*, pp. 2-3

<sup>897</sup> *Ibid*

deemed as not serious or attention seeking behaviour.”<sup>898</sup> The Committee was informed, that on these occasions there was generally minimal, if any, intervention follow-up whilst they were in town prior to being transferred back to the community.<sup>899</sup>

The Committee heard that, in many instances, the referring agency was not contacted regarding either the outcome of the assessment or what follow up action had been determined necessary. Furthermore, it was noted that it was not unusual for people to be “discharged from the ward after having attempted suicide without notifying the referring agency or appropriate family member.”<sup>900</sup> Even where a mental health review maybe arranged:

There is often a significant time lag between return to the community and mental health review visits, due to an approximate 6-8 week turn around between visits to any one community, and the person may not even be present in the community when mental health arrive.<sup>901</sup>

The Committee also heard from the Central Australian Aboriginal Congress and the Hidden Valley Community Centre that, even where there were services on the ground and accessible to communities, there was a lack of staff with qualifications and experience in case management.<sup>902</sup> As Ms Ryan pointed out to the Committee, whilst there were a number of organisations funded to provide case work they were employing support workers or family workers who did not have either the qualifications in social work or an understanding of the importance of case work:

When something difficult comes up like a young person threatening suicide they might do the token thing they know they need to, but then do not do the follow through. There is no follow-up because they do not understand the process and it is too daunting.<sup>903</sup>

In terms of mitigating some of the issues outlined above, Mr Robinson noted that whilst the outreach service delivery model was probably an inevitability when it came to providing a range of services to many of the more isolated areas of the Territory, it was important to achieve the right mix of:

fly-in expertise and community capacity based on training and developing people who are in the communities a much greater proportion of the time, including Aboriginal Health Workers and others.<sup>904</sup>

As previously mentioned in this report, the Committee was advised through a number of submissions that the provision of on-ground mental health services in regional and remote communities and better coordination of services are key factors when it comes to addressing and alleviating many of the issues associated with responding to suicide and ensuring continuity of care for those at risk.<sup>905</sup> The Committee was also advised that

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<sup>898</sup> Mental Health Association of Central Australia, *op.cit.*, p. 16

<sup>899</sup> Alira Capararo and Lyn Byers, *op.cit.*, p. 3

<sup>900</sup> Mental Health Association of Central Australia, *op.cit.*, p. 17

<sup>901</sup> Alira Capararo and Lyn Byers, *op.cit.*, p.-3

<sup>902</sup> Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 10 November 2011, p. 9; Ms Cate Ryan, *op.cit.*, p.35

<sup>903</sup> *Ibid*

<sup>904</sup> Mr Gary Robinson, *op.cit.*, p. 51

<sup>905</sup> See for example: Aboriginal Peak Organisations NT, *Submission 28*; Central Australian Aboriginal Congress, *Submission 32*; NT Police, *Submission 34*; Mr Gerard Waterford, *op.cit.*; NTCOSS, *Submission*

there needed to be a far greater emphasis on the development of bottom up responses to suicide within communities; that are “locally based and recognise the local issues and challenges.”<sup>906</sup>

#### **Recommendation 16**

**The Committee recommends that the Northern Territory Government:**

- a) provide *Suicide Bereavement Training* for all frontline staff required to respond to those bereaved by suicide; and
- b) resource the Office of the Coroner to provide fully qualified grief counselling.

#### **Recommendation 17**

**The Committee recommends that, in accordance with the Australian Government’s support of Recommendation 11 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), the Northern Territory Government review debriefing procedures and counselling support available to frontline workers regularly exposed to suicide and attempted suicide related incidents; including Northern Territory Government, Local Government and Non-government service providers.**

#### **Recommendation 18**

**The Committee recommends that, in accordance with the Australian Government’s support of Recommendations 9 and 11 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), the Northern Territory Government:**

- a) mandate that hospital accident and emergency departments maintain at least one person with mental health training and capacity to conduct suicide risk assessments at all times; and
- b) establish mandatory procedures to provide follow up support to young people that have been in psychiatric care, have been treated following an attempted suicide or who are assessed as being at risk of suicide.

### **3.3.4 Community Based Responses to Suicide**

During the course of the inquiry a number of highly successful community based, suicide prevention and bereavement support initiatives were identified to the Committee. The following examples highlight the strength, resilience and commitment of the communities concerned to confront the issue of suicide, engage with service providers and form partnerships, to develop community specific strategies to reduce the incidence of suicide and relieve the burden of individual, familial and community grief. Covering urban,

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25; Mental Health Association of Central Australia Inc, *Submission 29*; Alira Caparao and Lyn Byers, *Submission 14*; Wesley Mission – LifeForce Suicide Prevention Program, *Submission 40*

<sup>906</sup> Mr Gerard Waterford, *op.cit.*, p. 5

metropolitan and remote initiatives, each of these examples has the capacity to form the basis for similar strategies that can be replicated across the Northern Territory.

### ***Wesley LifeForce Community Suicide Prevention Networks***

Mr Tony Cassidy (Manager, Wesley LifeForce Program) advised the Committee that the Wesley LifeForce Program was funded by the Department of Health and Ageing under the National Suicide Prevention Program to develop and support community based suicide prevention networks.<sup>907</sup> The Committee heard that currently there are 21 networks operating nationally, including 3 in the Northern Territory.<sup>908</sup> Mr Cassidy advised the Committee that the Community Suicide Prevention Networks program is a whole of community approach to suicide which encourages personal and community awareness and the capacity to reduce the impact and incidence of suicide:

It is a model that adapts to the requirements of the community committees, and supports a group's capacity for self-determination and development of committee skills. Wesley LifeForce provides an effective framework for the networks to operate within and connects the networks nationally to encourage a collaborative and cohesive response to local needs.<sup>909</sup>

Mr Cassidy informed the Committee that community suicide prevention networks are established by first considering available data on where the high risk areas are, "where are the communities that may be in need of something like this?"<sup>910</sup> Once a community has been identified, Wesley will host a suicide prevention training workshop in the target community to identify key stakeholders such as services that may be involved in suicide prevention, for example Lifeline or Anglicare, and determine whether or not there is an interest or need for a network:

We try to get their feedback and, quite often that will help us identify who the drivers may be for a network. It will help identify whether the network concept, that model would work in that community.<sup>911</sup>

The Committee heard that the networks Wesley develops are not service providers, "they are about the community taking ownership of what is already there and ensuring it is put out as available for use."<sup>912</sup> As noted in the submission provided by Wesley, the specific aims of the LifeForce Community Suicide Prevention Networks program are to:

- Identify and bring together community participants with an interest or service provision in suicide prevention, mental health issues and mental well-being promotion;
- Facilitate the exchange of information;
- Coordinate suicide awareness and prevention activities to minimise silo delivery and duplication of services;

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<sup>907</sup> Mr Tony Cassidy, Manager, Wesley LifeForce Program, *Committee Hansard*, 30 January 2012, p. 22

<sup>908</sup> *Ibid*, p.21

<sup>909</sup> Wesley LifeForce Suicide Prevention Program, *op.cit.*, p. 5

<sup>910</sup> Mr Tony Cassidy, *op.cit.*, p. 21

<sup>911</sup> *Ibid*, p. 20

<sup>912</sup> *Ibid*, p. 20

- Encourage sharing of skills and learning; and
- Advocate to raise the community's awareness of the risk of suicide and the contributing factors in the community.<sup>913</sup>

The Committee heard that in some instances Wesley will also identify existing community suicide prevention groups that may require additional support. In these cases Wesley will arrange to meet with the group to talk about the advantages of the network, how it may work in their community, what Wesley can bring to their group, and how Wesley might be able to support and grow what they are currently doing.<sup>914</sup> The Committee was advised that Wesley currently supports three networks in the Northern Territory, all of which "have evolved differently according to local needs and priorities."<sup>915</sup> The Galupa Marngarr Suicide Prevention Group and the Darwin Region Indigenous Suicide Prevention Network are considered below.

As noted previously, the **Galupa Marngarr Suicide Prevention Group** has played a significant role in suicide prevention, intervention and postvention on the Gove Peninsula for a number of years. A recent LifeForce Suicide Prevention Program update notes that:

Originally founded in 1996, this volunteer group has organised unfunded community initiatives in a ground swell response to fight together against the tragedy of suicide occurring in their small community.<sup>916</sup>

The Committee heard that, in addition to the diversionary activities mentioned previously, the Galupa Mangarr Suicide Prevention Group provides:

- Postvention support services including counselling and assisting those bereaved by suicide through the organisation of culturally significant community gatherings and ceremonies to support extended family members;
- Culturally appropriate follow-up care for young people that have attempted suicide which includes taking referrals from GP's based in Gove.<sup>917</sup>

Mr Cassidy advised the Committee that Wesley LifeForce had only been associated with the Galupa Marngarr Suicide Prevention Group since March 2011; following a chance remark by someone, who in highlighting the achievements of the group, suggested that they might benefit from Wesley's support.<sup>918</sup> In preliminary discussions with Wesley, the group noted that maintaining community ownership and having their agreed strategies taken seriously by mainstream service providers was hindering their capacity to effectively address underlying issues associated with suicide amongst Yolngu people.<sup>919</sup>

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<sup>913</sup> Wesley LifeForce Suicide Prevention Program, *loc.cit*

<sup>914</sup> Mr Tony Cassidy, *op.cit.*, p. 22

<sup>915</sup> Wesley LifeForce Suicide Prevention Program, *op.cit.*, p. 7

<sup>916</sup> LifeForce Suicide Prevention Program Update, *loc.cit*

<sup>917</sup> *Ibid*

<sup>918</sup> Wesley LifeForce Program, *op.cit.*, p. 8; and Mr Tony Cassidy, *Committee Hansard*, 30 January 2012, p.

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<sup>919</sup> Wesley LifeForce Program, *loc.cit*.

As noted in the submission from Wesley LifeForce, the Galupa Marngarr Suicide Prevention Group, “embraced the concept model of Wesley LifeForce Networks as an opportunity to better address community needs.”<sup>920</sup> The Committee heard that the primary aim of this partnership was to:

bring greater recognition and influence to their community-led activities and to assist relationship building with relevant Nhulunbuy and Darwin based agencies.<sup>921</sup>

Whilst acknowledging that only Yolngu people can address the cultural factors that impact on understandings of, and responses to, suicide through open communication and dialogue about suicide at the community level, the group notes that there is also a need for mainstream services to acknowledge the impact their processes and procedures can have on Indigenous people at risk.<sup>922</sup> As highlighted in the submission from Wesley LifeForce, being without family is a profoundly isolating experience for Yolngu.<sup>923</sup> As a result, in the absence of locally based services, Yolngu are not inclined to voluntarily accept referrals to Darwin for mental health treatment:

Consequently, Indigenous patients are not referred as frequently as would normally be required, and support following an attempted suicide can become the responsibility of community members.<sup>924</sup>

Similarly, the Committee was informed that mainstream service providers “are not accepting of the relationship between court action and suicide attempts”<sup>925</sup> and the subsequent stress this puts the community under in terms of providing a 24 hour suicide watch service.

The work of the Galupa Marngarr Suicide Prevention Group was highlighted by a number of witnesses during the course of the inquiry, and, as Mr Cassidy noted, in terms of the LifeForce networks it is “probably the most successful of the Indigenous groups.”<sup>926</sup> At the Committee’s meeting with Galupa Marngarr Suicide Prevention Group members, Ms Sharon Yunupingu noted that:

This group has been out to even Galiwin’ku and Millingimbi because they have heard of this group. So, people are seeing that something is happening here that’s working and it is a strong group of people that can deal with people.<sup>927</sup>

The Committee heard that the Anindilyakwa Land Council had also invited the group over to Groote Eylandt to “collaborate on suicide prevention strategies.”<sup>928</sup> Mr Cassidy advised the Committee that, in conjunction with Wesley, the group had secured funding through the Mental Health Association of Australia to host an Indigenous Conference on

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<sup>920</sup> Wesley LifeForce Program, *loc.cit.*

<sup>921</sup> LifeForce Suicide Prevention Program Update, *loc.cit.*

<sup>922</sup> Wesley LifeForce Program, *loc.cit.*, see also The Age, *loc.cit.*

<sup>923</sup> Wesley LifeForce Program, *loc.cit.*,

<sup>924</sup> *Ibid*

<sup>925</sup> *Ibid*

<sup>926</sup> Mr Tony Cassidy, *op.cit.*, p. 22

<sup>927</sup> Ms Sharon Yunupingu, *loc.cit.*

<sup>928</sup> Wesley LifeForce Program, *op.cit.*, p. 9

Suicide Prevention for East Arnhem communities to be held in Nhulunbuy on 12 May 2012.<sup>929</sup>

The Committee heard that the **Darwin Region Indigenous Suicide Prevention Network** was formed in response to the *Save our Children from Suicide* rally held on the steps of Parliament House in October 2010.<sup>930</sup> Organised by the Balunu Foundation the rally sought to raise awareness of the number of Indigenous youth suicides that were occurring in Darwin and surrounding communities.<sup>931</sup> As Ms Ah Kit noted:

They organised the rally and that is when it was brought to my attention that there were some people out there, our local people, who wanted to get out there and make a difference.<sup>932</sup>

Given that a number of the network members have lost people to suicide, Ms Ah Kit advised the Committee that a large part of their work involved the provision of bereavement support. As Ms Ah Kit pointed out to the Committee, when people lose someone to suicide:

They want to be able to talk to somebody they know understands exactly what they've been through because that person's been through it as well.<sup>933</sup>

The Committee notes that surveys of those bereaved by suicide indicate that this kind of support is one of "the most important forms of assistance at the time of the suicide."<sup>934</sup>

The Committee heard that through their work in this area, the Darwin Region Indigenous Suicide Prevention Network had identified a significant need for more services that had the capacity to provide follow up bereavement support to Indigenous people. Ms Ah Kit noted that whilst there are a number of postvention support services available in Darwin, Indigenous people are not accessing them. From what the group could ascertain this was due to both language barriers and the fact that many services are "not delivered culturally appropriately."<sup>935</sup> Ms Ah Kit further noted that the group was discussing this issue with service providers and that Lifeline was keen to talk to them about "making sure that their delivery of services is culturally specific."<sup>936</sup>

Ms Desley Tamiano (Secretary, Darwin Region Indigenous Suicide Prevention Network) also advised the Committee that since the group had started to raise the profile of suicide prevention, they were receiving an increasing number of calls from people who are concerned that someone they know is at risk of suicide, but don't know what to do about it.<sup>937</sup> Ms Turner noted that, where possible, members will make home visits and

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<sup>929</sup> Mr Tony Cassidy, *op.cit.*, p. 25; and Wesley LifeForce Program, *op.cit.*, p. 9

<sup>930</sup> Ms Ngaire Ah Kit, *op.cit.*, p. 15

<sup>931</sup> D. Dodd, *Hand in Hand: A report on youth suicide prevention and awareness*, December 2011, Youth Minister's Round Table of Young Territorians, NT Office of Youth Affairs, p.15

<sup>932</sup> Ms Ngaire Ah Kit, *op.cit.*, p. 16

<sup>933</sup> *Ibid*, p.18

<sup>934</sup> United Synergies, *Postvention Suicide Prevention for the Future*, November 2009, unpublished submission to the Senate Community Affairs Reference Committee Inquiry into Suicide in Australia, p. 5

<sup>935</sup> Ms Ngaire Ah Kit, *op.cit.*, pp. 21-2

<sup>936</sup> *Ibid*

<sup>937</sup> Ms Desley Tamiano, Secretary, Darwin Region Indigenous Suicide Prevention Network, *Committee Hansard*, 3 November 2011, p. 19

walk people through what support services are available and the development of a safe plan for the person at risk.<sup>938</sup>

In an effort to make information on crisis support more accessible, Ms Tamiano informed the Committee that, with the support of Wesley LifeForce and local businesses, the network developed a wallet sized, fold out, crisis information card which lists the contact details of all the relevant local organisations and crisis telephone counselling services.<sup>939</sup> The card was launched at the Walk for Suicide Prevention and Awareness event the network coordinated to recognise World Suicide Prevention Day on 10 September 2011. Ms Ah Kit advised the Committee that feedback from community members indicated that the crisis card was a particularly useful resource and that it was not unusual for members to receive comments such as, "I ended up giving your information card to a cousin of mine in Tennant Creek."<sup>940</sup> At the inquiry's Tennant Creek Forum, Ms Shannon noted that there was a need for cards such as these to be distributed in the community, and further suggested that they could include "information on how to detect symptoms of suicide."<sup>941</sup> The Committee notes that this crisis card is included as one of the resources in the Northern Territory Early Intervention Pilot Program's resource kit and the bereavement support packs carried by NT Police.

Ms Ah Kit noted that, apart from the financial support the network has received, one of main the benefits of being aligned with the Wesley Life Force program is the fact that the network is "linked in with other Indigenous specific suicide prevention networks around Australia" and can benefit from their experience.<sup>942</sup> It was further noted that Wesley LifeForce "will assist the Darwin Network in the facilitation of their first planning meeting."<sup>943</sup>

In acknowledging the significant achievements of the Galupa Marngarr Suicide Prevention Group and the Darwin Region Indigenous Suicide Prevention Network, the Committee voiced their concerns regarding the potential for network members to suffer from the effects of vicarious trauma and sustaining the wellbeing of the driving forces behind volunteer networks.<sup>944</sup> Mr Cassidy noted that the workshops provided by Wesley LifeForce emphasise the fact that:

self-care is paramount, because you cannot do anything if you are not looking after yourself as well...you need to ensure you are getting the debriefing or support you need.<sup>945</sup>

Mr Cassidy further advised the Committee that whilst Wesley was currently looking at the issue of succession planning, "the majority of people involved in...networks are service

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<sup>938</sup> Ms Julie Turner, *op.cit.*, p. 24

<sup>939</sup> *Ibid*

<sup>940</sup> Ms Ngaire Ah Kit, *op.cit.*, p. 17

<sup>941</sup> Ms Valda Shannon, *op.cit.*, p. 10

<sup>942</sup> *Ibid*, p. 22

<sup>943</sup> Wesley LifeForce, *Ico.cit*

<sup>944</sup> Ms Marion Scrymgour, Committee Chair, *Committee Hansard*, 3 November 2011, p.20 and Ms Marion Scrymgour, Committee Chair, *Committee Hansard*, 30 January 2012, p. 22

<sup>945</sup> Mr Tony Cassidy, *op.cit.*, pp. 22-3

providers, so they are already getting their support, they have their own processes for getting that support in place.”<sup>946</sup>

However, given that the evidence provided to the Committee indicates that many network members in the Territory are not necessarily service providers, the Committee strongly encourages Wesley LifeForce to consider how it might provide additional support to volunteers where readily accessible debriefing or counselling services are not available. Similarly, given that dependence on one or two dynamic individuals is not uncommon in volunteer organisations, especially in small communities, the Committee further encourages Wesley LifeForce to provide networks with the support required to develop and implement succession plans for key personnel.

### ***Tiwi for Life Program***

As highlighted in the submission from the Department of Health, the Tiwi for Life suicide response was initiated following the occurrence of 10 suicides in 2002. Given the population of 2,500 at the time, this represented a suicide rate of 1:250, 400 times the national average.<sup>947</sup> The Tiwi Health Board determined the need for an holistic approach that would incorporate treatment of mental illness, drug and alcohol abuse, suicide and psychological problems by “community based Mental Health Workers, using local resources, supported by the (psychiatric) nurse.”<sup>948</sup> The Committee heard that three female and three male traditional elders were selected by the community to be trained as the community based mental health workers. As the Department of Health submission noted:

their knowledge of the culture, family and community structure was an integral component of the successful community based mental health program.<sup>949</sup>

The mental health program incorporated both traditional and western mental health skills and sought to demystify mental health services and make them more accessible for Aboriginal people and increase the likelihood of help seeking behaviours. Importantly the mental health workers were acknowledged as the “community elected advocates for holistic community health and representatives for mental health and mental health services.”<sup>950</sup>

A key feature of the program was that in addition to the training provided to the mental health workers, regular training programs were conducted on both Melville and Bathurst Islands that were open to all members of the community; including:

- Suicide Prevention
- Counselling
- Alcohol and Drugs Abuse

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<sup>946</sup> *Ibid*

<sup>947</sup> Department of Health, op.cit., Section A – Attachment 13, p. 31

<sup>948</sup> *Ibid*

<sup>949</sup> *Ibid*

<sup>950</sup> *Ibid*, p. 32

- Sexually Transmitted Disease
- Understanding Mental Illness and Bad Behaviour
- Anger Management and Communication
- Relationships<sup>951</sup>

The Committee was advised that the Mental Health Program included:

- Mental illness treatment and support
- Suicide intervention and prevention
- Strong Women's' and Strong Men's' Groups, forums where people can discuss issues and plan local responses
- Provision of court reports for Tiwi Offenders for the North Australian Legal Aid Service (NALAS), Magistrates and Corrections
- Rehabilitation of prisoners and offenders with a mental illness to reintroduce them in to the community and reduce offending
- Critical incident intervention with staff and families following trauma or attempted suicide<sup>952</sup>

In addition to the implementation of the Mental Health Program, the Committee heard that a number of other initiatives were also put in place at the time. For example, a working group was formed to develop a Community Safety Plan and the community worked with the Power and Water Authority to fence around the bottom of power poles and install caps on the tops of poles to inhibit the incidence of attempted and completed suicides "by people jumping from telephone poles and electrocuting themselves, or hanging from poles."<sup>953</sup> The links and working relationships between the Mental Health Team and other service providers in the community were strengthened, and a facility has been developed for "people with intellectual impairment who are employed in arts and crafts."<sup>954</sup> The Committee also heard that people with chronic mental illness are now able to be treated and supported in the community rather than being evacuated to Darwin.<sup>955</sup>

The Committee was advised that following the implementation of the Tiwi Island response to suicide, the rate dropped from ten completed suicides in 2002, to two in 2003, and whilst there were four in 2005 there have only been three suicides on the Tiwi Islands since 2006.<sup>956</sup>

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<sup>951</sup> *Ibid*, p. 31

<sup>952</sup> *Ibid*, p. 31

<sup>953</sup> *Ibid*, p.33

<sup>954</sup> *Ibid*, p.32

<sup>955</sup> *Ibid*

<sup>956</sup> *Ibid*

Dr Robert Parker (Director of Psychiatry, Top End Mental Health Service) noted that one of the main reasons that the Tiwi for Life initiative was so successful was that it built up the resources of members of the community:

who became like the experts and leaders within the community for suicides. So it was actually Tiwi people doing it rather than a bunch of visiting whitefellas...The whitefellas will come and go. It is trying to build up a skill base and a resource within the Aboriginal communities themselves, which I think in the end should be the point, so you have a range of skilled workers who are well resourced, well paid... and given opportunities, giving them a sense of governance so they can have an opportunity for regular education and feel supported in often very tough environments.<sup>957</sup>

However, as the Committee Chair Ms Marion Scrymgour (MLA for Arafura which incorporates the Tiwi Islands) pointed out, whilst funding was provided to establish the Tiwi for Life program it was not recurrent. This then led to a situation where “[w]hat we have is trained Tiwi people working in this area who were able to reduce suicides and they are not employed.”<sup>958</sup> During the course of the inquiry, it became clear to the Committee that:

Funding programs often agree to provide funds to establish a program, but then expect that ongoing funding will be sourced elsewhere. The Tiwi are not alone in this regard and other services have noted that money allocated on a short-term basis for pilot programs has made it difficult to sustain any gains made.<sup>959</sup>

This issue is further explored below in the section on Smarter Service Delivery.

### ***StandBy Response Service***

The Committee was advised that the *StandBy Response Service*, referred to in the submissions from the Mental Health Association of Central Australia Inc and Lenore Hanssens, is a community based, 24 hour postvention program developed by United Synergies and funded by the Commonwealth Department of Health and Ageing under the National Suicide Prevention Program. *StandBy* service delivery is achieved through partnership arrangements between United Synergies and established local agencies that are well regarded in their communities (for example, existing partners include Anglicare, Lifeline Community Care and Pilbara Health Network), and which have the capacity to provide the services on the ground.<sup>960</sup>

Similar to the Life Promotion Program, the Committee heard that the *StandBy Response Service* aims to:

- Reduce potential adverse health outcomes for those bereaved by suicide and in particular, assist in preventing further suicidal behaviour;
- Improve support for family members, friends and associates bereaved by suicide;

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<sup>957</sup> Dr Robert Parker, Director of Psychiatry, Top End Mental Health Service, *Committee Hansard*, 4 November 2011, p. 8

<sup>958</sup> Ms Marion Scrymgour, Committee Chair and Member for Arafura, *Committee Hansard*, 4 November 2011, p.8

<sup>959</sup> Dr Robert Parker, Top End Mental Health Service, *Submission 8*, Attachment 2, p.2

<sup>960</sup> United Synergies, *StandBy Response Service A Summary July 2011*, retrieved 22 February 2012, [http://www.unitedsynergies.com.au/index.php?option=com\\_content&view=article&id=39&itemid=23](http://www.unitedsynergies.com.au/index.php?option=com_content&view=article&id=39&itemid=23) p. 3

- Provide an integrated support system built on existing emergency and community response mechanisms; and
- Build sustainable capacity within communities to respond to and support those bereaved through suicide.<sup>961</sup>

The Committee was informed that an immediate response to those bereaved through suicide is provided by a locally based 24 hour crisis response telephone number. Face to face support is provided by skilled crisis response team members and referral to a centrally coordinated system of local support services to match individual client needs. The *StandBy* service is very flexible in its approach to the provision of support and the “range of services is also very broadly interpreted by each of the *StandBy* sites.”<sup>962</sup> A key feature of this model is the capacity for *StandBy Response* services to provide assistance to those bereaved by suicide:

at any time after a loss, even if the death occurred many years ago (and) the service is available for people bereaved by a local suicide, as well as those who lost someone to suicide elsewhere.<sup>963</sup>

As is the case with the *Life Promotion Program*, establishment and on-going operation of each *StandBy* service is guided by a steering committee or reference group made up of “people from across the local area whose work involves them with suicide events.”<sup>964</sup> Of the nine *StandBy* sites currently established across Australia, the Committee notes that the Pilbara, East and West Kimberley services were established service communities where a significant proportion of the population are Indigenous Australians. Acknowledging the importance of local cultural knowledge, at these three sites:

*StandBy* has been assisted by local Aboriginal services and community members with guidance support and approaches of shared care. This assistance has not only provided *StandBy* with increased options for bereaved people, but has also contributed to building local Aboriginal communities’ confidence in the *StandBy* service. This is reflected in a gradual increase in the willingness of bereaved people from these communities to access *StandBy*.<sup>965</sup>

The Committee notes that the Kimberley *StandBy Response* teams were named the 2011 winner of the national LIFE Award in the category of Healthy Communities and were also the 2011 recipient of the Blank Page Summit award. In both cases it was noted that:

Through their support, initiatives and the provision of their culturally appropriate education programs *StandBy* have made immeasurable contributions to suicide prevention and postvention in one of the most suicide affected regions of the country.<sup>966</sup>

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<sup>961</sup> *Ibid*, pp.3-4

<sup>962</sup> *Ibid*, p. 5

<sup>963</sup> *Ibid*, p. 4

<sup>964</sup> *Ibid*, p.8

<sup>965</sup> *Ibid*, p. 9

<sup>966</sup> Suicide Prevention Australia, *Life Awards 2011*, *loc.cit.*, Anglicare WA, *StandBy Suicide Response Team Receives Award at Summit*, retrieved 8 March 2012, <http://www.anglicarewa.org.au/news/article/01082011-07/standby-suicide-response-team-receives-award-at-summit.aspx>

Given the above, the Committee encourages the Northern Territory Suicide Coordination Committee, in consultation with existing bereavement support services and organisations, to investigate the potential of establishing *StandBy Response Services* and additional *Wesley LifeForce Community Suicide Prevention Networks* within the Territory.

### 3.4 Smarter Service Delivery

Whilst there are a number of areas where additional resources are required, the evidence received indicated that a far more pressing concern is to develop a more strategic approach to service delivery. As noted previously, the service delivery context of the Northern Territory presents a number of unique challenges. For example, ensuring equity of access given the size of the Territory and the distribution of the population; availability of, and ability to house and retain, an appropriately skilled labour force in many areas; access to culturally appropriate resources and programs; and the capacity to establish sustainable services that can grow and develop within a community. During the course of the inquiry the following three distinct, yet inter-related, elements were identified as key to the development of a smarter approach to service delivery.

Almost without exception, the submissions and evidence provided to the Committee highlighted the need for greater coordination of, and collaboration between, services.<sup>967</sup> As evidenced in the preceding sections of this report, risk and protective factors associated with suicide are extremely diverse. To a greater or lesser extent, all levels of government and all government departments are responsible for strategies, programs or services which impact on both risk and protective factors. The current lack of inter departmental and inter government communication, in combination with a number of non-government service providers funded through philanthropic bodies, has led to a situation where the Committee found it exceedingly difficult to gain a clear picture as to what services are delivered where and by whom. The first element identified by the Committee therefore was **coordination and collaboration**.

The Committee heard that, by and large, the top down approach to service delivery is limited in its capacity to address the specific needs of individual communities. Moreover, in many cases, this approach creates a culture of dependence which, over the long term, serves to diminish rather than grow individual and community capacity. That Government has an important role in terms of facilitating and supporting the development and provision of services is undeniable. However, it is imperative that service delivery models build on inherent strengths and empower communities to develop sustainable community and place based solutions. Moreover, in terms of Indigenous communities in particular, the demographic composition of the Northern Territory does not lend itself to the roll out of standardised, uniform programs. Rather, meeting the needs of these communities requires that programs and service delivery methods acknowledge the:

heterogeneous nature of Indigenous cultures and communities, and [in terms of the current inquiry] the significant differences in their understanding of, and their attitudes towards suicide and suicidal behaviour.<sup>968</sup>

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<sup>967</sup> See for example: NT Police, *op.cit.*, pp. 2-3; NT Department of Children & Families, *op.cit.*, pp. 5-6; NTCOSS, *op.cit.*, pp. 7-8; Mental Health Association of Central Australia, *op.cit.*, p.5; Department of Health, *op.cit.*, pp. 22-3; NT Department of Justice, *op.cit.*, p. 2; **headspace**, *op.cit.*, p. 16

<sup>968</sup> Centre for Remote Health, *Submission 11*, p. 2

**Community and place based services** was therefore the second element identified by the Committee.

The Committee heard that service delivery in the Northern Territory is, in many respects, subject to the vagaries of funding. For both local government authorities and non-government organisations, the provision of services is generally reliant upon a continual process of applying for, reporting on, and acquitting a wide range of Northern Territory Government, Australian Government and philanthropic grants. The Committee was informed that the capacity to establish services over the longer term is very often inhibited by the changing priorities of Governments and the absence of grant programs that offer recurrent funding.<sup>969</sup> Similarly, the ability of organisations to attract funding for new services is often hampered by the lack of research and evidence specific to the Northern Territory as to what works and what doesn't.<sup>970</sup> The third element therefore was **funding issues**.

### 3.4.1 Coordination and Collaboration

On the basis of the evidence received, it is clear that addressing the complex and multi-dimensional nature of youth suicide requires a strategic and coordinated approach to service delivery which actively encourages a high degree of collaboration between service providers. Determining resource requirements and priority areas for service delivery is, necessarily, dependent upon a thorough knowledge of the range and distribution of existing programs and an understanding of the specific needs of individual communities. Whilst there would appear to be a high degree of consensus amongst service providers regarding the latter, it was evident to the Committee that there was a general lack of awareness on the part of Northern Territory and Australian government departments, local government authorities and non-government service providers as to the range and distribution of services which impact on the risk and protective factors associated with youth suicide.

#### Distribution of Services

The Committee heard that the current service delivery model is fragmented and has resulted in an inequitable distribution of services across the Northern Territory. The Committee was advised that whilst there were significant service deficits in some areas, in others there was a high degree of service duplication. Moreover, even where it appears that a community is well catered for in terms of number of services, this does not necessarily mean that the specific needs of the community are actually being met.

For example, the submission from the Central Australian Aboriginal Congress notes that access to intensive case management services for young people and their families has been identified as critical if a real difference is to be made in the "lives of young people

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<sup>969</sup> Dr Robert Parker, Top End Mental Health Service, *loc.cit*

<sup>970</sup> See for example: CAYLUS, *op.cit.*, pp. 4-5; NTCOSS, *op.cit.*, p. 3; Department of Health, *op.cit.*, p. 22; Ms Catherine Harris, *op.cit.*, p. 34; Mr Nathan Mclvor, *op.cit.*, p. 20

who are getting into trouble with the police, disengage from school and get into alcohol and other drugs.”<sup>971</sup> However, the Committee was advised that whilst there are 35 youth services currently operating in Alice Springs, very few provide case management services. Even where case management services are available, the Committee heard that there is tendency to focus on the individual. As Dr John Boffa (Central Australian Aboriginal Congress) pointed out:

When you find a young person in crisis or with problems, who case manages the family and what interventions are provided to the family?<sup>972</sup>

The Committee also heard that in a remote community of 600 people, there were 14 separate organisations delivering mental health services with a social and emotional wellbeing component. However, none of them had the capacity to provide an integrated service delivery model that incorporated mental health, alcohol and other drug treatments that was so urgently required.<sup>973</sup> The Committee further notes that similar examples have been identified in relation to children and family services. As Report No 4 (December 2010 to May 2011) from the NT Coordinator General for Remote Services highlights, “there are currently 240 different direct services delivered in the 15 Remote Service Delivery priority towns, with a further 45 indirect services impacting on children or families.”<sup>974</sup>

Dr Boffa advised the Committee that research evidence indicates that when it comes to service delivery, more is not necessarily better:

If you have multiple service providers all with different philosophies, all with different views of what they are trying to do, all working with the same family, it does not work.<sup>975</sup>

As pointed out by Mr Chips Mackinolty (Manager, Research Advocacy and Policy, Aboriginal Medical Services Alliance Northern Territory), too many service providers is not only counterproductive but “can, in fact do more damage than not having anyone there at all.”<sup>976</sup>

The report from the NT Coordinator General for Remote Services sums up many of the issues afflicting the current service delivery situation in the Northern Territory noting that, in terms of services for children and families:

traditional service delivery models...are often still being delivered alongside some newer, innovative and more effective programs e.g. Families as First Teachers...Indigenous Parenting Support Service... This can lead to unnecessary competition for local resources and facilities and confusion for families and local governing bodies. There are inherent risks to the successful implementation of evidence-based programs, while the service environment is peppered with poorly resourced models. If all that money and expertise was pooled and managed more

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<sup>971</sup> Central Australian Aboriginal Congress, *op.cit.*, p. 29

<sup>972</sup> Dr John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, 10 November 2011, p.9

<sup>973</sup> Aboriginal Peak Organisations, *op.cit.*, p. 21; see also: Mr Chips Mackinolty, Manager, Research Advocacy and Policy, AMSANT, *Committee Hansard*, 3 November 2011, p. 54

<sup>974</sup> B, Beadman, *Northern Territory Coordinator General for Remote Services Report #4: December 2010 to May 2011*, NT Department of Housing, Local Government and Regional Services, Darwin, NT, 2011, p. 102

<sup>975</sup> Dr John Boffa, *loc.cit.*

<sup>976</sup> Mr Chips Mackinolty, *loc.cit.*

strategically towards implementing a coherent and effective plan, then some decent outcomes may emerge.<sup>977</sup>

The Committee notes that the current service delivery model is extremely complex with all tiers of government, the non-government sector and, in some instances, the commercial sector, represented as funders or providers and in many cases both.<sup>978</sup> However, the Committee also acknowledges that, given the unique service delivery context of the Northern Territory, ensuring that all Territorians have access to a range of services which address the specific needs of individual communities can only be achieved through a cooperative approach between the three levels of government, the non-government sector, and, most importantly, the communities concerned.

In terms of improving access to, and a more equitable distribution of, services; the fit between services and community needs; and ensuring the most efficient use of limited resources, the Committee has identified the need for a comprehensive mapping exercise of youth and community services as matter of the utmost priority. It is anticipated that this exercise will have the capacity to better inform all levels of government and the non-government sector as to service delivery priorities, the development of more effective and sustainable funding programs and a more strategic allocation of grant funding.

#### **Recommendation 19**

**The Committee recommends that, as a matter of the utmost priority, the Northern Territory Treasury, in conjunction with the Australian Government establish and maintain:**

- a) The comprehensive mapping of all youth and community related services (including, but not limited to, primary health, mental and allied health services, alcohol and other drug services, youth diversion, youth, sport and recreation, school counsellors, NT Police Officers and Youth Engagement Police Officers, child care) provided by all three tiers of government (Local, Northern Territory, Commonwealth) and the non-government sector in the outlying rural districts of Darwin (ie Humpty Doo, Noonamah, Batchelor), Jabiru, Katherine, Tennant Creek, Alice Springs, Nhulunbuy and remote Indigenous communities.**
- b) The development of a data base which clearly identifies the aims and objectives of programs, funding sources, funding amount, funding term and status (ie recurrent vs non recurrent), physical location of service, service delivery area, service provider and, where applicable, outreach service arrangements.**
- c) The use of this data to inform:**
  - development of funding programs and allocation of grant funding at the Australian Government (in terms of funding programs related to the**

<sup>977</sup> B, Beadman, *op.cit.*, pp. 102-03

<sup>978</sup> *Ibid*

**Stronger Futures policy), Northern Territory Government and Local Government level; and**

- **priorities for remote service delivery;**

**d) Access to the data base by Local Government Authorities, all Australian Government and Northern Territory Government Departments, service providers, and grant applicants on request.**

### **Inter-Department Coordination and Collaboration**

The Committee was particularly concerned to learn that the fragmented nature of the current system can result in young people falling between the gaps. Given the wide ranging nature of the risk and protective factors associated with youth suicide, effective coordination of services necessarily requires a high level of inter governmental and inter departmental cooperation. Furthermore, since the delivery of youth and community services is highly reliant on non-government service providers, it is critical that coordination mechanisms are inclusive of those service providers. However, the Committee heard that a number of barriers currently exist which hinder effective coordination of and collaboration between services. For example, the Department of Health noted that, in spite of a willingness on the part of individual agencies to engage with each other:

The effectiveness of the interventions of individual agencies is hindered by the proliferation of small programs consequential to short-term fragmented funding, confidentiality impediments, and incompatible information systems.<sup>979</sup>

Whilst it was noted that information sharing across service providers relating to identified risk factors would certainly assist in compiling comprehensive individual risk profiles, it was also acknowledged that information is very often of a sensitive and confidential nature; such as “history of sexual abuse, involvement of child welfare, legal problems, substance misuse, and mental health history.”<sup>980</sup> However, the Committee heard that, at times, client confidentiality requirements are clearly impacting on the capacity of agencies to implement effective suicide prevention strategies. As the Department of Health pointed out, in the event of a completed suicide information from all relevant sources is collated and:

when viewed in entirety, the convergence of risk factors becomes clear. If the lead agency working with a young person had access to such collated data, they would be better able to develop a comprehensive support plan.<sup>981</sup>

The submission from the NT Police also noted that in order to avoid the silo effect and improve cooperation and information sharing between agencies “barriers based on client confidentiality and privacy issues ... need to be resolved.”<sup>982</sup> The Department of Children and Families noted the need for “[o]pportunities to be explored for systemised and

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<sup>979</sup> Department of Health, *op.cit.*, p. 22

<sup>980</sup> *Ibid*

<sup>981</sup> *Ibid*

<sup>982</sup> NT Police, *op.cit.*, p. 4

consistent inter-agency governance and communications with a focus on youth suicide.”<sup>983</sup> The Committee heard that:

Youth Suicide could leverage from service models like the Family Responsibility Program and the Alice Springs Youth Hub for the operationalisation of inter-agency responses which have demonstrated success in data sharing protocols.<sup>984</sup>

In noting that any moves towards a relaxation of confidentiality requirements is a serious matter, the Department of Health suggested that this should be undertaken as part of a project “investigating suicide information management.”<sup>985</sup>

### **Suicide Information Management**

The submission from the Menzies School of Health also noted the fact that there are “significant gaps in coordination between agencies with responsibilities for child wellbeing and safety.”<sup>986</sup> In addition, the Committee was informed that there was a “need for improvement of information and data sources available to support suicide prevention policies and programs [and] the capacity to monitor and investigate the causes of suicide.”<sup>987</sup> The Committee heard that this could be achieved through the establishment of a *NT Suicide Register*. Based on the Queensland model, the Committee was advised that this register would enable data held by the Coroner’s office to be linked with data from a range of other agencies such as child protection, police and education:

The idea of a register is it would expand what is currently available by manually going through the Coroner’s records and you can code this information on a routine basis. It allows you to compare year to year, and it allows you to look at specific risk factors and get a much more complete picture of the whole issue.<sup>988</sup>

Whilst acknowledging that such a register would be useful, the Committee was very sympathetic to concerns raised by the Coroner that it was vital that appropriate confidentiality of sensitive personal information obtained from investigations be maintained so as to not compromise that investigation’s function. As Mr Cavanagh advised the Committee, “I am very concerned – as are all the other state Coroners – to see there is privacy and confidentiality on these files.”<sup>989</sup> The Committee further notes that, subject to an appropriate research proposal and ethics clearances, the Coroner’s Office does allow researcher to access files under strict supervision. In addition, researchers can access information held by the National Coroners Information System which holds data on all suicides in Australia. Nevertheless, the Committee acknowledges that a number of witnesses indicated that a suicide register would greatly assist further research into the risk factors associated with completed suicides and related prevention strategies. The Committee therefore recommends that the Coroner

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<sup>983</sup> NT Department of Children and Families, *op.cit.*, p. 6

<sup>984</sup> *Ibid*

<sup>985</sup> Department of Health, *op.cit.*, p. 22

<sup>986</sup> Menzies School of Health Research, *op.cit.*, p. 3

<sup>987</sup> *Ibid*

<sup>988</sup> Professor Sven Silburn, Head of the Centre for Child Development and Education, Menzies School of Health Research, *Committee Hansard*, 31 January 2012, p. 49

<sup>989</sup> Mr Greg Cavanagh, *op.cit.*, p. 2

maintain a suicide register and be funded for staff to develop and provide appropriate access to the register.

The Committee also noted that while the Coroner already rigorously investigates deaths and records that information on the NCIS database, there is no coordinated collation of information regarding self harming behaviour. The Committee considers that further work in identifying and understanding self harming behaviour to be a priority because it is a significant issue within itself. It is the major precursor to suicidal behaviour,<sup>990</sup> and is likely to provide more detailed and timely information about suicide risk and prevention than suicide statistics due to the time required to confirm suicides and the difficulties of interpreting the smaller statistical sample size of suicides within communities and the Territory as a whole. As Senior Constable Daniela Mattiuzzo (Chair, Katherine Youth Interagency Tasking and Coordination Group) pointed out to the Committee:

When we talk about data collection...it is also really important to have data collection about attempts...self-harm behaviour and self-harming<sup>991</sup>

Given the above, and in terms of addressing the concerns of the Departments of Health, Police and Children and Families, the Committee is of the view that it is imperative that the necessary protocols be developed to enable information sharing across agencies. This includes the procedures and the authority for doctors and other front line staff to report incidents of self harm to a centralised record. The Committee is of the view that it is critical and long overdue that those working with children and young people be able to report serious incidences of self-harm so that appropriate assistance can be provided.

The Committee further suggests that information provided by agencies of such incidences should form the basis of a *Youth Self-Harm Register*. This register would sit within the Department of Health who, as the lead agency, would be responsible for determining the extent to which this information should be shared with other agencies and non-government service providers that may be working with the young person concerned. It is anticipated that this information would also be readily accessible to the NT Police and Coroner in the event of a completed suicide. It is suggested that such a system would enable those working with young people at risk to be appropriately informed about safety and wellbeing concerns relating to their clients and enable the implementation of timely and appropriate interventions.

## Recommendation 20

**The Committee recommends that, in accordance with the Australian Government's support of Recommendation 12 of the 2010 Senate Inquiry into Suicide (*The Hidden Toll: Suicide in Australia* Report), the Northern Territory Government provide funding for a project to identify and link agencies and services involved in the care of young people at risk of suicide. This project should aim to implement agreements and protocols between police, correctional facilities, hospitals, mental**

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<sup>990</sup> Centre of Excellence in Youth Mental Health, *op.cit.*, p. 2

<sup>991</sup> Ms Daniela Mattiuzzo, Chair, Katherine Youth Interagency Tasking and Coordination Group, *Committee Hansard*, 6 February 2012, p. 23

health services, telephone crisis support services and community organisations to improve:

- a) awareness by different personnel of suicide prevention roles;
- b) expectations; and
- c) handover procedures and continuity of care for young people at risk of suicide.

#### Recommendation 21

The Committee recommends that the Northern Territory Government:

- a) fund the Coroner's Office to maintain and provide access to a suicide register.
- b) fund the Department of Health to investigate establishing a regulatory and administrative framework to enable serious incidences of child self-harm to be reported to the Department of Health and the Department to initiate appropriate responses;
- c) table a report on the findings of this investigation in the Legislative Assembly by 30 June 2013.

#### Inter-sectoral Coordination and Collaboration

In addition to the comments above regarding collaboration and coordination between government agencies, the Committee heard that in terms of youth and community services there was a need for a greater level of coordination between the three levels of government and the non-government sector. During the course of the inquiry the Committee noted that this varied quite significantly across the Northern Territory. For example, whilst there was a high degree of service level coordination and collaboration in Nhulunbuy and Katherine, there appeared to be far less in Tennant Creek.

Here again, the Committee was advised that there were a number of barriers to effective coordination and collaboration at the inter-sectoral level. For example, the Committee heard that many organisations lacked the capacity to take on a coordination role and provide the necessary administrative and secretarial support. In Tennant Creek for example, the Committee heard that:

You need a lot of energy and time to be able to network and put the effort into engaging with all those different organisations; organising, motivating and propelling it and most of us are exhausted and busy with our core service delivery. There can be gaps, you can lapse or you go on holidays, and there is no-one to pick it up. There needs to be one specific coordinator.<sup>992</sup>

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<sup>992</sup> Ms Bronwyn De Aldi, Manger, Barkly Mental Health Service, *Committee Hansard*, 9 November 2011, p. 11

The Committee notes that in the case of Nhulunby and Katherine the coordination of youth and community services is undertaken by a designated organisation. In Nhulunbuy the Youth Interagency Network is coordinated by Anglicare, and in Katherine it is the designated function of the Katherine Youth Interagency Tasking and Coordination Group which incorporates a paid Coordinator's position for this purpose.

The Committee also heard that whilst there were many examples of effective coordination and collaboration between non-government organisations, non-government networks often found it difficult to attract and retain the participation of Government agencies. For example the Darwin Region Indigenous Suicide Prevention Network noted that regular attendees at meetings were mainly from the non-government sector. Ms Ah Kit noted that a representative from the Department of Health attended at times but not regularly, and the NT Police attended for a while but "she was changing positions and in that transition we lost them."<sup>993</sup>

The Committee noted that the high turnover of staff in the Northern Territory clearly impacts on coordination efforts. As noted at the inquiry's Katherine Forum, when new staff come on board it takes time for them to come to terms with their responsibilities and during this period they do not necessarily have the capacity to attend networking meetings.<sup>994</sup> As Ms Lake pointed out to the Committee, "staff turnover interferes with connections that are made, and again it is a lack of a cohesive organising centre."<sup>995</sup> The Committee was particularly concerned to hear that competition for funding also inhibits collaboration between services.<sup>996</sup>

In acknowledging the benefits of a paid, designated coordinator, Senior Constable Daniela Mattiuzzo (Chair, Katherine Youth Interagency Tasking and Coordination Group) informed the Committee:

I am told constantly by people who come to Katherine as new Professionals that they are amazed and astounded at how well We work within our agencies, both NGO's and government agencies. We talk about organisational silos...but in Katherine the goodwill of professional organisations to share and work together is outstanding...<sup>997</sup>

However, it was noted that given that the Coordinator's position had recently been moved from one department to another it was unclear as to how much longer this crucial position might exist for.<sup>998</sup> Ms Kate Ganley (Secretary and Coordinator for the Katherine Youth Interagency Tasking and Coordination Group) noted that, at present:

Every region does youth coordination differently and that is an issue. when we are looking at coordination and responding the same in each region consistently we need to have consistent structures in place which we do not.<sup>999</sup>

The Committee notes that in other jurisdictions around Australia, it is the norm for youth and community development officers to be employed by local government authorities; as

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<sup>993</sup> Ms Ah Kit, *op.cit.*, p. 22

<sup>994</sup> Ms Catherine Harris, *op.cit.*, p. 35

<sup>995</sup> Ms Sharon Lake, *op.cit.*, p. 20

<sup>996</sup> *Ibid*

<sup>997</sup> Ms Daniela Mattiuzzo, *loc.cit.*

<sup>998</sup> Ms Kate Ganley, *op.cit.*, p. 21

<sup>999</sup> *Ibid*

is the case in Darwin and Palmerston City Councils. In recognition of the benefits of having a consistent approach to the coordination of services, as highlighted by Ms Ganley, core duties associated with these positions generally include:

- Liaising with communities, non-government service providers and government agencies;
- Facilitating regional coordination of youth and community services; Facilitating the engagement of communities in the development of community and place based youth and community strategies;
- In doing so, these positions have the capacity to engender a more collaborative and coordinated approach to service delivery, thereby optimising resources and achieving better outcomes for the community. It is the Committee's view that the establishment of youth and community development officer positions throughout the Northern Territory would be particularly advantageous in terms of achieving a more holistic and streamlined approach to service delivery.

### **Recommendation 22**

**The Committee recommends that the Government establish youth development and community development officer positions within each Shire throughout the Northern Territory to:**

- a) **Liaise with communities, non-government service providers, and Local, Territory, and Australian Government agencies;**
- b) **Liaise with and assist the Coordinator of the NT Suicide Prevention Coordination Committee in the monitoring of regional issues relating to self-harm and suicide;**
- c) **Facilitate regional coordination of youth and community services; and**
- d) **Facilitate the engagement of communities in the development of community based strategies to build community resilience, address issues relating to youth disengagement, familial and community dysfunction.**

### **NT Suicide Prevention Coordination Committee**

Acknowledging the fact that suicide prevention is not, in itself, a core function of any particular department or agency, but in fact cuts across a range of functions of all levels of government and the non-government sector, in 2007 the Northern Territory Government established a Suicide Prevention Coordinating Committee to implement a whole of government response to suicide prevention. However, "although not formally disbanded, the Committee has not been convened for almost 18 months."<sup>1000</sup>

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<sup>1000</sup> Ms Megan Lawrence, *Submission 13*, p. 11

Ms Megan Lawrence (PhD Student, Menzies School of Health Research) observed the operation of this committee as part of her Phd research which “examines the whole of government process for suicide prevention addressing the questions of how it operates and what purposes it was adopted for.”<sup>1001</sup> Ms Lawrence’s submission to the inquiry provides a number of invaluable insights into the operation of this Committee and the reasons it failed to achieve its stated objectives. In recommending that a new Suicide Prevention Coordination Committee be established, the Committee acknowledges many of the points Ms Lawrence raised in her submission.

In recognition of the fact that suicide is not primarily a health issue, the importance of ensuring a more appropriate and diverse level of representation on the committee, and the need to ensure that the lead agent has jurisdiction over member agencies, the Committee recommends that a new Northern Territory Suicide Prevention Coordination Committee be established as a matter of priority and sit within the Department of the Chief Minister.<sup>1002</sup> The Committee notes that it must incorporate high level representation from Mental Health, Children and Families, Education and Training, the Office of the Children’s Commissioner, NT Police, the Coroners Officer, the Australian Government and Non-government Sector.

To ensure that the Suicide Prevention Coordination Committee has the necessary professional and administrative support it is recommended that the Government provide funding to employ a full time Suicide Prevention Coordinator, a full time Suicide Prevention Research Officer and a full time Suicide Prevention Administration Officer, and an operational budget to facilitate the work of the Committee.<sup>1003</sup> To ensure that services on the ground are kept informed about initiatives, funding opportunities, training, research and statistical data, the Suicide Prevention Coordination Committee is to incorporate a clearinghouse function and be responsible for the dissemination of relevant information to member agencies, shires and relevant community organisations.

The first task of the NT Suicide Prevention Coordination Committee will be to formulate a 2013-2016 Action Plan. It is envisaged that this process will incorporate a review of Suicide Prevention Action Plans from elsewhere and will not necessarily follow the same format as the 2009-2011 Action Plan. Moreover, given that it is acknowledged that many of the activities currently undertaken by member agencies address underlying causes of suicide, it is not anticipated that such activities will be incorporated into the plan.<sup>1004</sup> Rather, development of the Action Plan is to take into consideration the themes, suggestions and recommendations of this report and utilise a *Working Backwards* approach whereby desired outcomes are clearly identified and defined at the outset and specific strategies are then developed to achieve these outcomes. The Action Plan is to clearly identify responsible agencies, resources required, milestones and evaluation methods.<sup>1005</sup>

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<sup>1001</sup> *Ibid*, p. 2

<sup>1002</sup> *Ibid*, p. 9

<sup>1003</sup> *Ibid*, p.10

<sup>1004</sup> *Ibid*, p. 8

<sup>1005</sup> *Ibid*, p. 12

It is expected that the development of strategies will involve collaboration with service providers and take account of the experience and expertise of relevant practitioners. It is further anticipated that strategies will be developed in conjunction with the communities they are being designed for, thereby taking into account local knowledge and tailoring solutions to meet specific needs and circumstances. In recognition of the disproportionately high rates of suicide in Indigenous communities and the subsequent potential for contagion, the Action Plan is to incorporate strategies designed to rapidly implement postvention services to Indigenous communities. Similarly, the Action Plan is to incorporate strategies for the development of culturally appropriate suicide prevention, intervention and postvention resources.

Finally, the Action Plan is to incorporate prioritised and fully costed funding proposals for a mix of suicide prevention, intervention and postvention strategies to be implemented in the first twelve month period of the Plan. The 2013 – 2016 Action Plan is to then be tabled by the Chief Minister in the Legislative Assembly prior to the 2013 budget sittings for the Government's consideration and subsequent allocation of resources.

### **Recommendation 23**

**The Committee recommends that a new Northern Territory Suicide Prevention Coordination Committee be established as a matter of priority and sit within the Department of the Chief Minister, and that:**

- a) The Suicide Prevention Coordination Committee must include high level representation from Mental Health, Children and Families, Education and Training, the Office of the Children's Commissioner, NT Police, the Coroners Officer, Australian Government and Non-government Sector.**
- b) The Government provide funding for:**
  - employment of a full time Suicide Prevention Coordinator, a full time Suicide Prevention Research Officer, and a full time Suicide Prevention Administration Officer; and**
  - an operational budget to facilitate the work of the Committee.**
- c) The Northern Territory Suicide Prevention Coordination Committee incorporate a suicide information clearinghouse function and be responsible for disseminating information to Shires, member agencies and relevant community organisations regarding:**
  - Suicide prevention, intervention and postvention strategies and training programs;**
  - Funding available for suicide prevention, intervention and postvention strategies and training programs;**
  - Statistical data relating to the incidence of suicide across the Northern Territory; and**
  - Research into suicide in the Northern Territory.**

- d) **The Northern Territory Suicide Prevention Coordination Committee formulate a 2013-2016 Action Plan as a matter of priority and that:**
- **Development of the Action Plan utilise a *Working Backwards* approach whereby the desired outcomes are defined at the outset and strategies then developed to achieve these outcomes which clearly identify responsible agencies, resources required, milestones and evaluation methods;**
  - **The Plan takes into consideration the themes, suggestions and recommendations of this report;**
  - **The Plan incorporate specific strategies for Indigenous communities, including initiatives to rapidly implement postvention services to Indigenous communities following a suicide to reduce the risk of contagion, and the development of culturally appropriate resources;**
  - **The Plan incorporate prioritised and costed funding proposals for a mix of suicide prevention, intervention and postvention strategies to be implemented in the first twelve month period of the Action Plan; and**
  - **The Chief Minister table the Plan in the Legislative Assembly before the 2013 budget sittings.**

### **3.4.2 Community and Place Based Solutions**

The Committee heard that services with a high degree of community ownership and control have also been seen to be more effective. As noted in the submission from the Centre for Remote Health, and highlighted by a number of examples throughout this report, research indicates that:

Programs that foster empowerment and have been developed and implemented specifically for the communities they are intended for appear to have more long term success.<sup>1006</sup>

In terms of developing effective community and placed solutions to youth suicide, the Committee was advised that it was particularly important that Governments support, enhance and strengthen existing structures.<sup>1007</sup> Similarly, with reference to remote Indigenous communities, Mr Waterford, noted that:

There is a great deal of strength and resilience in the Aboriginal community and it is looking at the strength and leadership that is there and existing at the moment and using it as a framework for building initiatives that work.<sup>1008</sup>

As noted previously, in many respects youth suicide is an indicator of the overall health and wellbeing of societies at differing times. The evidence presented in this report

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<sup>1006</sup> Centre for Remote Health, *loc.cit.*

<sup>1007</sup> Mr John Paterson, CEO, Aboriginal Medical Services Alliance Northern Territory, *Committee Hansard*, 3 November 2011, p. 59

<sup>1008</sup> Mr Gerard Waterford, *op.cit.* p. 3

indicates that social disadvantage and a range of other adverse childhood experiences are significant risk factors for suicide. The objectives of many of the Northern Territory and Australian Government initiatives noted in the background to this report are specifically aimed at redressing such; particularly in respect of Indigenous communities. In referring to the social crisis facing Alice Springs and Central Australia, the submission from the Central Australian Aboriginal Congress makes the following comment; one which is also very pertinent to the issue of youth suicide:

The crisis we face is not a new one, but a continuing one. It has been gathering for many years, and Aboriginal people and their organisations have been at the forefront of warning of the consequences of years of neglect and failure to act. These warnings have not been without self-criticism: we have also been aware of some failings within the Aboriginal community to show necessary leadership. Some in the Aboriginal community have failed in significant ways to respond to this continuing crisis.<sup>1009</sup>

During the course of this inquiry the Committee identified a number of issues which currently impede the development and implementation of community and place based strategies. Whilst the recommendations in this report seek to address these concerns, the Committee notes that it was not within the scope of this inquiry to address the multitude of sociological factors that underpin youth suicide; many of which also impact on the provision of community and place based services. The Committee also recognises that the unique service delivery context of the Northern Territory poses significant challenges.

For example, many of the submissions noted that the fly in, fly out service model was both ineffective and costly. Whilst additional infrastructure and staff housing in regional and remote communities has the capacity to diminish the reliance on outreach services, it also has to be acknowledged that the Northern Territory incorporates a number of very remote communities with extremely small populations. In infrastructure terms alone, community based services in the more remote communities are simply not an economically sustainable option. For these communities outreach services are a means of ensuring that all Territorians have access to a range of services that would otherwise be unavailable. Nevertheless, the Committee notes that current outreach models of service delivery need to be reviewed and consideration given to how they might be improved to better align them with the needs of communities.

Whilst Governments certainly have a role to play in supporting, enhancing and strengthening community capacity, the success of 'grass roots' strategies such as the Tiwi for Life Program, Galupa Marngarr Suicide Prevention Network and Mt Theo Program indicate that the willingness of communities to take responsibility for, and ownership of, the problem is absolutely critical. In each case the responses to the incidence of youth suicide were quite different and reflected the specific needs, understandings and attitudes of the individual communities concerned, yet all were just as effective in terms of addressing the problem. The Committee is also mindful of the fact that language barriers restrict the ability to roll out Territory wide suicide prevention

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<sup>1009</sup> Central Australian Aboriginal Congress, *op.cit.*, p. 2

initiatives and further highlights the need for programs that are tailored to each community.<sup>1010</sup>

The Committee also appreciates that there are a number of cultural factors, such as restrictions on who can help whom, fear of blame and payback, and cultural laws about funerals and 'sorry business', which impinge on the capacity of individuals and communities to implement effective intervention and postvention strategies in particular. For example, whilst the Committee heard that more Indigenous people should be employed in counselling roles to assist in addressing youth suicide, it was also noted that due to cultural factors no-one would be prepared to take on such a role.<sup>1011</sup> Governments cannot resolve these sorts of dilemmas. No matter how confronting the issue of youth suicide may be, it is crucial that community leaders begin the all important conversation as to how to deal with it and determine what type of assistance is required to effect change. Suicide Prevention Australia further notes that:

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.<sup>1012</sup>

In discussing the *remote employment policy challenge for government*, the submission from the Aboriginal Peak Organisations NT notes that, in addition to cultural factors, many of the positions available in remote communities require skill levels above that of the available labour pool.<sup>1013</sup> This situation inevitably results in a greater level of dependence on external service providers and increases the potential for programs and services that do not necessarily meet the specific needs of the communities they are intended for. Mr Paterson suggested to the Committee that where funding is allocated to non-Aboriginal organisations to provide services relating to youth suicide, consideration should be given to the suitability of the service model and that such organisations should have "Aboriginal representation on their government arrangements as well."<sup>1014</sup> The Committee notes that this might prove to be a limiting factor in terms of attracting appropriately qualified service providers. However, the Committee does acknowledge the merits of requiring all external service providers, whether they are looking at service provision in remote Indigenous communities or regional centres that lack the necessary skills base, to show how they intend to liaise with the local community and ensure proposed services meet their needs.

As highlighted in the previous section, the Committee has recommended that Youth and Community Development Officer positions be established in each Shire. A significant focus of these positions will be facilitating the engagement of individual communities in the development and implementation of community and placed based initiatives. They

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<sup>1010</sup> Suicide Prevention Australia, *op.cit.*, p. 7

<sup>1011</sup> East Arnhem Shire Council, *Committee Hansard*, 17 November 2011, pp. 9-11, see also: Ms Michelle Tillman, Community Services Consultant and Trainer, *Committee Hansard*, 17 November 2011, p. 25

<sup>1012</sup> Suicide Prevention Australia, *loc.cit.*

<sup>1013</sup> Aboriginal Peak Organisations NT, *op.cit.*, p. 16

<sup>1014</sup> Mr John Paterson, *op.cit.*, p. 59

will also be responsible for liaising between communities and the three tiers of government and facilitating the coordination of youth and community services at the regional level. It is envisaged that these officers will also be able to facilitate information sharing between communities, thereby assisting in the development of community capacity to initiate and implement 'grass roots' strategies.

### 3.4.2 Funding Issues

During the course of the inquiry witnesses raised a number of issues relating to program funding. As noted by the Department of Health, research evidence indicates that "effective suicide prevention needs to combine a broad range of strategies and approaches that are sustained over many years."<sup>1015</sup> However, the Committee heard that the sustainability of initiatives given current funding models was an issue of particular concern. For example, the majority of youth and community programs that address risk and protective factors associated with youth suicide are dependent upon non recurrent grant funding. Moreover, where recurrent funding is available, such as the Youth in Communities program, it rarely exceeds a period of three years.

Funding from these sources is mostly for short-term projects lasting from 1 to 3 years. Funding agencies often agree to provide funds to establish a program, but then expect that on-going funding will be sourced elsewhere.<sup>1016</sup>

The Committee also heard that even where agencies have an on-going commitment to fund preferred service providers for specific initiatives, such as the Attorney General's Night Patrol Program, grant recipients are still required to submit annual funding applications. Similarly, the administrative requirements associated with the reporting on and acquittal of multiple short term grants, in conjunction with the continual search for and development of grant applications to maintain programs is considerable. As noted a number of times throughout this report, the uncertainty as to whether or not grant programs will continue, or whether or not an alternate source of funding will be obtained when the current grant runs out, has a significant impact on the ability of organisations to attract and retain staff and maintain the momentum of initiatives:

the team is under continuous stress with regards to job security and considerable time and effort is allocated to obtaining funding.<sup>1017</sup>

These issues are particularly pertinent in the case of the Shires given that 90% of their non-core service delivery is reliant upon grant income. The Committee notes that in many cases Shires are responsible for administering in excess of 60 separate grants, each with its own reporting and acquittal requirements. This issue was highlighted by the NT Coordinator General for Remote Services in his first report in 2009 and reiterated in Report #4 two years later where he again called for:

3 year funding terms for shires and non government organisations (NGO's) in order for coherent planning and decent terms for contracted employees... Surely it is quite

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<sup>1015</sup> Department of Health, *op.cit.*, p. 3

<sup>1016</sup> Dr Robert Parker, *loc.cit*

<sup>1017</sup> *Ibid*

straightforward for the Northern Territory Government to direct its own agencies to simplify and standardise the acquittal and financial reporting requirements.<sup>1018</sup>

As noted previously in terms of the Youth Development Support Program, many of the grants available for youth and community services are not open to Local Government Authorities. Given the lack of non-government organisations currently located in the West and East Arnhem Shires for example, this seriously limits those regions' access to funding and further inhibits the capacity to ensure an equitable distribution of services.

The Committee also heard that the narrow focus and prescriptive nature of many grant programs was often problematic in terms of sourcing grants that meet the needs of the community. The Committee was further advised that the lack of major grants programs often means that a number of grants from different sources are required to enable the implementation of Shire wide initiatives. For example, the Committee heard that operational funding for the sport and recreation programs currently provided by the Shires involves balancing a complex mix of up to six separate grant programs spread across four departments at two levels of government.<sup>1019</sup> As noted by Dr Parker in relation to the *Tiwi for Life Program*:

Whilst there is core government funding for the psychiatric nurse position, from December 2005 all other positions have been funded from eight different external funding sources, including government and non-government agencies, each with their own set of objectives. As the team has had to source its own funding, service objectives identified by the team often have to be adapted to meet the objectives of funding bodies.<sup>1020</sup>

Concern was also raised as to the credentials of some organisations in terms of their capacity to implement programs. The Committee heard that in many cases allocation of funding seem to be based purely on how well written the application was.<sup>1021</sup> As Mr Patterson pointed out, whilst there was generally a requirement for service providers in most industry areas to be accredited, this was not the case when it came to a wide range of youth and community services. Rather, it was noted that essentially any organisation can, and do, apply for and obtain funding in this sector without necessarily having the experience or expertise required:

Maybe it's time for government to set standards and criteria around service providers. What do you have to do? What do you have to get to become accredited before you can become a service provider, particularly the services that are pertaining to youth suicide.<sup>1022</sup>

It was further suggested that service provider accreditation may also serve to limit the potential for so much duplication of services.<sup>1023</sup>

Conversely, a number of witnesses questioned the applicability of many of the key performance indicators included in funding agreements in terms of their capacity to

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<sup>1018</sup> B.Beadman, *op.cit.*, p. 8

<sup>1019</sup> Ms Larissa Knight, *loc.cit.*

<sup>1020</sup> Dr Robert Parker, *loc.cit.*

<sup>1021</sup> Mr Chips Mackinolty, *op.cit.*, p.57

<sup>1022</sup> Mr John Paterson, *op.cit.*, p. 57

<sup>1023</sup> *Ibid*

actually measure the effectiveness of initiatives. As Mr Mackinolty noted, in a recent discussion with a senior official from the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs it was acknowledged that:

Not a single one of their programs could be properly evaluated except in process terms: we fed 300 kids breakfast and we employed eight women to do it. That does not tell us anything. It does not tell us whether the kids, in fact were healthier or whether they went to school, or anything.<sup>1024</sup>

The Committee was further advised that, in the absence of funding to undertake independent evaluations of programs, the program evaluations provided to funding bodies are subjective and written by the organisation for the purposes of staking their claim in terms of future funding allocations. Consequently, a significant proportion of funding tends to be allocated on an “historic basis, because they ticked all the boxes last quarter of last year.”<sup>1025</sup>

In terms of developing effective evidence based prevention, intervention and postvention programs, it was noted that new funding streams need to be developed to support research and resource development, such as the relationship between cyber bullying and the incidence of self-harm, particularly self-harm amongst Aboriginal girls; the protective factors of Indigenous communities that exhibit low rates of youth suicide; research into and development of resources to assist in addressing suicide threats; and the development of culturally appropriate gatekeeper training and grief counselling resources.

The Committee acknowledges that many of the issues raised in this section have been long standing concerns for organisations and have a considerable impact on the sustainability of a wide range of youth and community services programs. In the interests of improving the quality, effectiveness and sustainability of initiatives that address the underlying causal factors of suicide, it is the Committees expectation that these issues will be considered and addressed as part of recommendation 19 c) which relates to the comprehensive mapping of youth and community services.

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<sup>1024</sup> Mr Chips Mackinolty, *op.cit.*, p. 59  
<sup>1025</sup> Mr Chips Mackinolty, *op.cit.*, p. 57

## 4. CONCLUSION

As this report highlights, suicide prevention is not the preserve of any one government department or agency, rather it is everybody's business. Similarly, whilst suicide prevention may not be considered to be a core activity for many agencies, much of what they do is, in fact, critical to ensuring that the underlying causal factors associated with suicide are addressed. At the same time, this inquiry has identified a number of areas of concern that require a range of departments and agencies to reassess their 'business as usual' priorities and collaborate on the development of coordinated responses to facilitate the implementation of suicide specific prevention, intervention and postvention strategies.

There is a clear need for all levels of government and the non-government sector to be more aware of what each other does; jointly reassess the distribution of services; acknowledge the gaps in services and develop strategies to address these; question the effectiveness of current services in terms of their capacity to address the needs of individual communities; and work together to rationalise and optimise services to ensure the most effective use of limited resources. Similarly there is a need for all levels of government, the non-government sector and communities to work together on the development and implementation of strategies which facilitate the implementation of community based services and address specific issues such as the normalisation of suicide, cyber bullying, positive youth development, the availability of culturally appropriate resources, and access to a more appropriate level of youth friendly mental health, counselling and respite services.

The evidence of witnesses and submissions provided to the Committee serve to highlight the considerable impact that incidences of self-harm and completed suicides have on families, friends and communities. As noted previously, in the five year period from 2007 to 2011, the NT Police responded to 419 cases of serious self-harm of young people under the age of 25.<sup>1026</sup> In the same period there were a total of 225 completed suicides in the Northern Territory. Of particular concern to the Committee is the fact that of these 225 completed suicides 28 of them, or 12.4%, were of young people under the age of 18.<sup>1027</sup>

Quite apart from the considerable grief and trauma that this level of self-harm and suicide causes, suicidal behaviour also exacts significant economic costs on individuals, families and communities. For example, there are the direct costs associated with hospital treatment, post-mortems, police attendance, coronial investigations and funerals. In addition there are in-direct costs including loss of life years, lost productivity

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<sup>1026</sup> NT Police, *op.cit.*, p. 21

<sup>1027</sup> Mr Greg Cavanagh, *op.cit.*, p. 6

and earnings.<sup>1028</sup> Then there are the intangible costs, the “substantial emotional and social costs that are difficult to quantify in economic terms.”<sup>1029</sup>

The submission from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council suggests that the economic costs associated with suicide are quite likely to be significantly higher in Indigenous communities. As the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council point out, in addition to the social and emotional costs which impact on the entire population of small communities, the economic costs associated with suicide are far more wide reaching than is the case in mainstream communities:

The ripple effect of suicide trauma in communities includes ‘Sorry Camp’ effects where children miss school and the community shuts down with jobs and wages lost. All activities, jobs, education and training are postponed or cancelled.<sup>1030</sup>

In light of the above, investing in suicide prevention and addressing the associated underlying causal factors of youth suicide clearly has the capacity to result in significant social, emotional and economic benefits for the Northern Territory over the longer term. As Mr Cavanagh pointed out to the Committee, when it comes to suicide it is not so much a case of prevention is better than a cure, it is more a matter of “[p]revention is better than death. Prevention is the cure.”<sup>1031</sup>

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<sup>1028</sup> United Synergies, *Senate Community Affairs Reference Committee Inquiry into Suicide in Australia: Postvention Suicide Prevention for the Future*, Tewantin, Qld (unpublished submission), 29 November 2009, pp. 2-3

<sup>1029</sup> *Ibid*, p. 3

<sup>1030</sup> Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, *op.cit.*, p. 2

<sup>1031</sup> Mr Greg Cavanagh, *op.cit.*, p. 10

## Appendix A: Submissions received

1. Geoff Wilson, Aquaponics, 6 September 2011
2. Frank Gorman, 7 September 2011
3. Central Australian Aboriginal Congress, 21 September 2011
4. Professor Colin Tatz, 23 September 2011
5. Brian Charlton, 28 September 2011
6. Darwin Community Arts, 28 September 2011
7. Professor Saxby & Pim Kuipers, 29 September 2011
8. Robert Parker, Top End Mental Health, 29 September 2011
9. Dr Howard Bath, 30 September 2011
10. Dulwich Centre Foundation, 30 September 2011
11. Centre of Remote Health – Flinders NT, 30 September 2011
12. Menzies School of Health and Research CCDE, 30 September 2011
13. Megan Lawrance, 30 September 2011
14. Alira Capararo & Lyn Byers, 30 September 2011
15. Leonore Hanssens, 30 September 2011
16. Dr Yolande Lucire, 30 September 2011
17. Inspire Foundation, 30 September 2011
18. Department of Health, 4 October 2011
19. Department of Justice, 5 October 2011
20. Suicide Prevention Australia, 6 October 2011
21. Salvation Army Hope for Life, 6 October 2011
22. Maningrida Suicide Prevention Service Providers, 7 October 2011
23. headspace, 7 October 2011
24. Katherine Youth Interagency Tasking & Coordination Group, 7 October 2011
25. NTCOSS, 7 October 2011
26. Jesuit Social Services, 7 October 2011
27. Department of Education, 13 October 2011
28. Aboriginal Peak Organisations NT, 14 October 2011
29. Mental Health Association Central Australia, 14 October 2011
30. Mt Theo Program, Walpiri Youth Development, 14 October 2011
31. Principals Australia, MindMatters, 14 October 2011
32. 32, Central Australian Aboriginal Congress, 14 October 2011
33. Dr Craig San Roque, 16 October 2011
34. NT Police, 19 October 2011
35. Department of Children and Families, 4 November 2011
36. Ting Walker, 9 November 2011
37. NPY Women's Council, 14 November 2011
38. Neil Lanceley, 3 November 2011
39. Caylus, 21 November 2011
40. Wesley LifeForce Suicide Prevention Program, 7 December 2011
41. SAFT, 19 January 2012
42. Brian Butler, 27 January 2012
43. Department of Local Government, Housing and Regional Services, 31 January 2012
44. Jim Sullivan, 1 February 2012
45. Southern Cross Psychology Services, 1 March 2012
46. Dr Rob Roseby, 1 March 2012

## **Appendix B: Hearings and Forums**

Public Hearing – Darwin – 3 November 2011

Public Hearing – Darwin – 4 November 2011

Public Forum – Tennant Creek – 9 November 2011

Public Hearing – Alice Springs – 10 November 2011

Closed Hearing – East Arnhem Shire Council, Nhulunbuy – 17 November 2011

Closed Forum – Causeway, (Gove) – 17 November 2011

Public Forum – Yirrkala – 17 November 2011

Public Hearing – Darwin – 24 November 2011

Public Forum – Bee Creek – 2 December 2011

Closed Youth Forum – Palmerston – 2 December 2011

Public Hearing – Darwin – 30 January 2012

Public Hearing – Darwin – 31 January 2012

Public Hearing – Katherine – 6 February 2012

Public Forum – Katherine – 6 February 2012

Closed Forum – Darwin (with Tiwi Shire Council) – 3 February 2012

Public Hearing – Darwin – 14 March 2012