



## A SUBMISSION TO THE SELECT COMMITTEE ON YOUTH SUICIDE IN THE NORTHERN TERRITORY

14<sup>th</sup> October 2011  
The Secretary  
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*“Suicide is a very hard word for most of us. And I’ve been avoiding the use of that word for a while. ...But now, we have to because its reality now and we’ve lost a lot of family members that have taken that path. And for us to grow strong and lead the way for our mob, for our children, for people in our community that are losing their way, to face suicide, to use that word to face and deal with that issue of trying to carry it out, or to break that cycle of thinking” (Shannon in Suicide Story, 2009)*

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# 1. Introduction

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The Mental Health Association of Central Australia welcomes the invitation to respond to the Select Committee on Youth Suicides in the Northern Territory. Our organisation has been a key player in addressing the impact of suicide on communities in Central Australia since the Life Promotion Program came under its management in 2001. This submission will focus on the strategic direction of the Central Australian Life Promotion Program. This strategic direction aligns with the funding agreement between the Northern Territory Government's Mental Health branch and the Life Promotion Program. This submission has not followed the terms of reference provided as a guide but has aligned its submission with the Northern Territory's Suicide Prevention Action Plan 2009 to 2011 and the Australian Government's LIFE Framework. These documents were the culmination of consultation into the key areas for action in regard to suicide prevention. In the Northern Territory these key areas include:

- Promoting wellbeing, resilience and community capacity across the NT;
- Enhancing protective factors and reducing risk factors for suicide and self-harm across the NT;
- Services and support within the community for groups at increased risk;
- Services for individuals at high risk;
- Partnerships with Indigenous people; and
- Progressing the evidence base for suicide prevention and good practice.

The actions identified in this document need to be evaluated in order to identify the future strategic direction of the NT. A new direction for the NT requires effective engagement across the whole of community, not just across Government. Funding sources need to be broadened beyond Government and the ownership and implementation of Northern Territory Strategic Plan needs to be a collective one. The Northern Territory Government currently funds a position in its Mental Health branch to coordinate suicide prevention activities across the Territory. This inquiry should allow for some discussion about the role of this position and whether it is best placed in the Mental Health branch of Government.

The recent alarming incidence of suicide among young people in the Northern Territory remind us that we must not lose sight of initiatives that specifically focus on this high risk group. This includes young people from 12 to 25 years. Focusing attention on one high risk group only can shift attention and resources away from the wide spread impact of suicide in the Territory. Evidence indicates that best practise approaches to suicide prevention follow a three pronged approach. *Universal* suicide prevention activities are those that are applied to the whole population (i.e. educational messages), *selective* measures are those applied to groups at an increased risk (i.e. Suicide Story training) and *indicated* interventions apply to individuals at imminent risk (i.e. Mental Health care and support for individuals who have previously attempted suicide). A Northern Territory Inquiry needs to ascertain the most effective means of allocating scarce funding to suicide prevention activities across all three types of interventions to have the greatest impact on suicide rates.

## 2. Recommendations

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### **NORTHERN TERRITORY POLICY**

1. The Northern Territory Government to commission an independent review of the NT Suicide Prevention Action Plan 2009 to 2011
2. The Northern Territory Government to re-establish an NT Suicide Prevention Committee to be kept informed, to act as an advisory group and to advocate for relevant funding and implementation of relevant suicide prevention activities
3. NT Government to continue to fund and support a Suicide Prevention Coordinator role, however in consultation with relevant stakeholders to consider the purpose of the role and the best location for this role
4. Re-establishment of the Top End Life Promotion Program based on the previous review in consultation with the NT Suicide Prevention Committee

### **EVALUATION AND RESEARCH**

5. Funding for suicide related research and evaluation.
6. Develop a means of collecting data on suicide attempts across Central Australia
7. Explore the prevalence and impact of marijuana among young Aboriginal people
8. Research the current referral and support procedures for people who attempt suicide in remote indigenous communities and town camps and their effectiveness
9. Funding for comprehensive evaluation of all aspects of the Life Promotion Program
10. Research into children and suicidal behaviour in the Northern Territory
11. Evaluation of general hospital services for patients who present with deliberate self-harm, including improved data collection on these presentations
12. Improved efforts needed and the provision of funds for independent evaluations on strength based programs in the Northern Territory and research into what they can tell us about improved mental health and protection from suicide.

### **CRISIS SUPPORT FOR PEOPLE AT RISK OF SUICIDE**

13. Provide an opportunity to open up a discussion with local stakeholders about the current system of support for people who are in a suicidal crisis including discharge procedures and follow up support
14. Provide an alternative care facility staffed by clinical specialists and support workers for people who attempt suicide based outside of the hospital similar to the “Life House”
15. Engage with young people about self-harming behaviour and suicide risk and help seeking behaviour
16. Support remote communities to develop community plans to prevent and contain suicide clusters
17. Lifeline Central Australia to identify the current use of their services for Indigenous people in remote communities and consider trialling a service that can support language speakers

### **BEREAVEMENT SUPPORT**

18. Ascertain the need for the re-establishment of a local Suicide Bereavement Support Group in consultation with local people who have been bereaved
19. Development of useful and appropriate post card information for police/night patrol to offer to family with information about support services and how to care for themselves after suicide
20. In consultation with relevant local Indigenous organisations, re-establish a support mechanism for Aboriginal people who have lost family members to suicide
21. Work with Indigenous people to support appropriate Healing Ceremonies in communities

22. Further funding to explore the stories of people bereaved through suicide with the intention of developing audio material for education purposes and radio broadcasting

## **YOUNG PEOPLE**

23. Headspace expansion to allow for indigenous outreach work and the development of a computer hub with information on mental health related sites
24. Greater focus on remote communities and suicide threats with a view to implement strategies to address this behaviour
25. Collaboration with youth workers, families and relevant service providers to develop training opportunities and workshops for young people in communities focused on resilience, coping skills, ways to address violence, parenting skills, risky behaviour, suicide threats, grief and substance misuse.
26. Greater sharing of funding for youth focused activities across communities, not just the growth towns and not just during school holidays
27. Initiatives to identify relevant local issues focusing on young people and sexuality

## **SUICIDE PREVENTION TRAINING**

28. Increased resourcing for the delivery and the training of trainers in ASIST, SafeTALK and Mental Health First Aid and the capacity to adapt these programs to suit remote communities and to suit the needs of young people
29. Provision of continued funding to build up the capacity to further develop and implement the Suicide Story Training Resource to meet the current demand for training in Indigenous communities throughout the Northern Territory
30. Improved support, training and recognition of the emergency services called to respond to suicide
31. In collaboration with Aboriginal Health Workers and Mental health Workers develop Paul Hill's Cranky Business Story into a simple visual poster as a means of working with young people who threaten suicide
32. Develop opportunities to work with communities to discuss cultural payback linked with suicide

## **PUBLIC AWARENESS**

33. To work with local men's health initiatives and encourage them to give greater attention to mental health and suicide prevention
34. Development of public awareness campaigns working in collaboration with media
35. 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 an appropriate messages regarding suicide

*This is a challenging issue. It makes us worried. Suicide is more impulsive here and often fuelled by grog. It might flare up anywhere. And we're worried because it seems to have become really common and accepted. It seems like just about every family is affected. It's hard to get services to respond. And we sometimes feel frustrated, because it's so tiring. We're worried about copy-cat behaviour and we're worried for the young ones who are growing up with this behaviour all around them. We're also worried about the effect on partners and carers of these people. They are under a lot of pressure, and they're getting stressed and tired out, and sometimes people might blame them, even when it's not their fault (Life Promotion - Little Red Threat Book 2007).*

### 3. Life Promotion Program

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**The Life Promotion Program** was established in both Darwin and Alice Springs in the late 1990's in an attempt to respond to the high incidence of suicide among young people at this time. The program in Darwin was reviewed both internally and through consultation with external stakeholders in 2005 and has not operated in its original structure since this time. The evaluation of the Top End Life Promotion Program and the subsequent defunding of this program would be useful information to inform this inquiry. A thorough external evaluation of the Central Australian Life Promotion Program would also be welcomed and would contribute to the evidence base for suicide prevention in the Northern Territory.

The program in Alice Springs moved from the NT Government into the non-Government organisation of Mental Health Association of Central Australia in 2001. Since it began in 1998, this program has been funded from the NT Government Mental Health Program. It was successful in sourcing major project funding from the Australian Government Suicide Prevention Strategy in collaboration with Waltja Tjutanku Palyapayi Aboriginal Association from 2006 through to 2008. More recently the program is receiving additional funding from the Department of Health and Ageing and through a partnership with OZHELP for the development and delivery of Suicide Story Training.

The Life Promotion Program current focus addresses some key areas:

- a. Effective co-ordination and collaboration via the facilitation of the Life Promotion Steering Committee in Alice Springs and Barkly Reference Group in Tennant Creek
- b. "Suicide Story" Training for Aboriginal people in remote communities and town camps
- c. Resource development and provision on locally identified issues such as Suicide threats
- d. Coordination of an Interagency Response to a death by Suicide in Central Australia in recognition of the risk of "copycat" suicides and the needs of people bereaved by suicide
- e. Skilling up the local workforce to better respond to suicide risk via information sessions and training in ASIST, SAFE Talk and Mental Health First Aid

- f. Healing Ceremonies such as World Suicide Prevention Day in Alice Springs and Tennant Creek to raise public awareness and to acknowledge the need to grieve
- g. Advisory Role for national projects and inquiries to inform on the issues of relevance to this region
- h. Minimal advocacy role

*“The term Life Promotion emerged from a community-driven response to the first of a series of waves of suicides in Aboriginal communities of north Queensland and elsewhere since the late 1980s. As the death toll mounted, a group of residents of Yarrabah, a small community 40km south of Cairns, sought help from a range of sources, including mainstream service providers, experts in suicide prevention and indigenous communities in North America that had “been there”. Numerous solutions were suggested and hopes raised, only to be dashed by another funeral”, (Hunter 2011)*

Hunter maintains that the Yarrabah Life Promotion Program made sense from a public health perspective. The program was in keeping with proposals that supported community-driven initiatives. He did not believe that the model that operated in Yarrabah could be duplicated in other regions of Australia where there was a similar high incidence of suicide unless there was some thorough evaluation of the model and how it might apply in a different context (Hunter 2011). In seeking solutions to the high incidence of suicide in the 1990’s the Northern Territory sought advice from Hunter and others and established the Life Promotion Programs in the Northern Territory.

Unlike Yarrabah the Life Promotion Program in the Northern Territory was not driven from the needs of one indigenous community experiencing high incidence of youth suicide, but rather its establishment was driven by a collective group of Government and non-Government representatives in the urban settings of Darwin and Alice Springs seeking solutions.

The Central Australian Life Promotion Program has developed its current strategic direction via the advice and input from its steering committee members, issues raised through community engagement and networks, and current NT and Australian policy direction in regard to suicide prevention. This program has been able to listen to the voice of local indigenous people on this often misunderstood and silenced issue.

It has also gathered knowledge from workers on issues that had not been talked about before such as suicide threats. The program has encouraged more dialogue on this issue and created the safe space for people to talk about suicide such as at World Suicide Prevention Day.

Life promotion has collected credible data for ten years on suicide deaths and provided a coordinated level of support after a death. On limited resources and a staff team of two for many years, the Life Promotion program has played a crucial role in suicide prevention in this region. The Top End Life Promotion Program was reviewed in 2005. The results of this review need revisiting and consideration given to an equivalent service in the Top End.

## 4. Life Promotion Steering Committee

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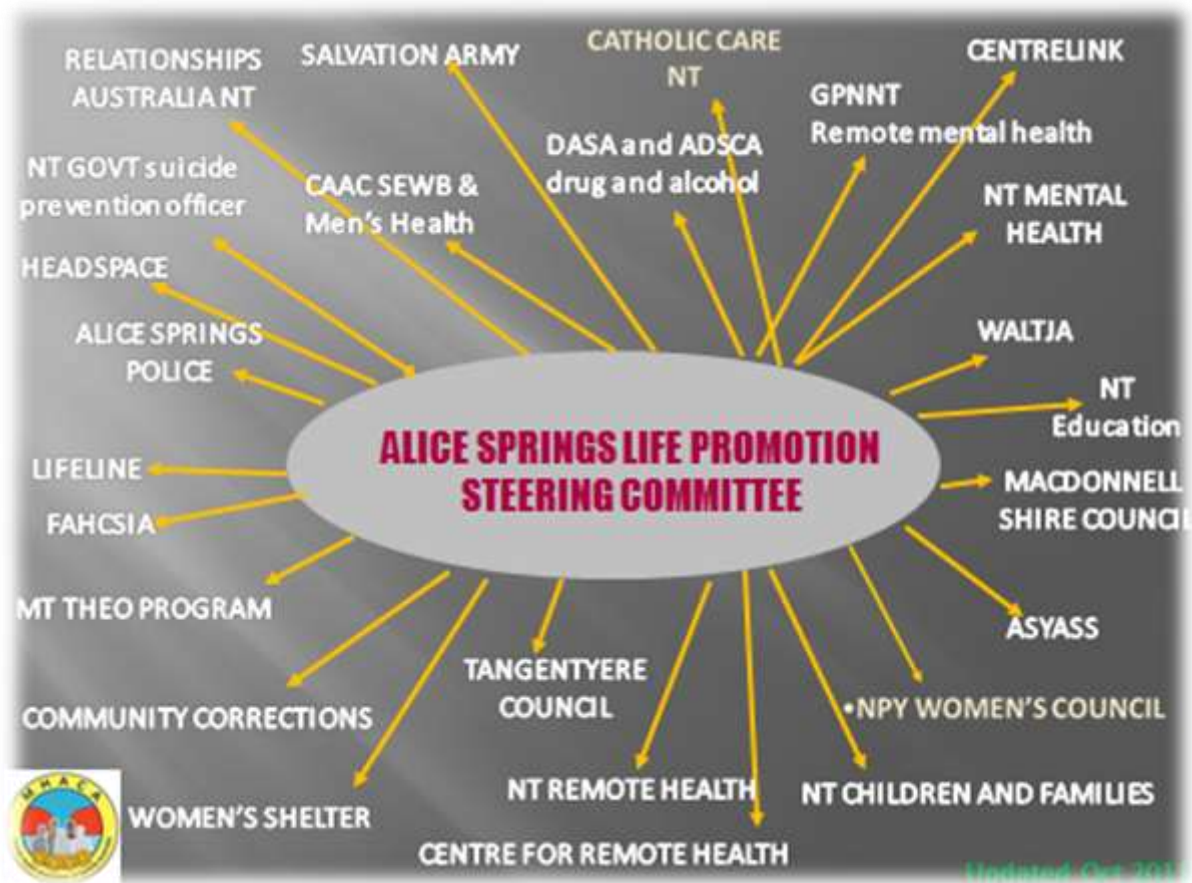
It is important to acknowledge the many players that contribute to our body of knowledge on suicide. Academics, mental health professionals, people with a lived experience of being suicidal or having lost someone to suicide, and various services who engage with suicidal people. This is not an exact science and there is still much we do not know about this issue especially how it is experienced by Indigenous people. Suicide does not fit neatly into the mental health system. Its causes are varied and the solutions are wide ranging. Saving lives has as much to do with being a compassionate and empathetic listener as it does with being a mental health practitioner. Suicide is a mystery to most people. It's seen as a concern for individuals rather than a major public health issue.

Working in Central Australia draws attention to the different nature of suicidal behaviour, and the frequency of this behaviour forces all those who live and work here to gain some knowledge on the issue. For this reason it's essential to collaborate with a wide range of players in order to develop solutions.

Currently the LPP Steering Committee is made up of approximately thirty people representing non-Government organisations, Government Departments and Indigenous organisations with a vested interest in suicide prevention. The committee meets four times a year and keeps representatives informed about current research, funding and local suicide prevention strategies. Guest speakers are invited on occasion to discuss relevant local issues such as data collection, the Coroner's process in relation to suicide and local practitioner insights. Relevant reports, LIFE updates, or current news related to this issue are circulated via email. This group has been consulted on the recent Hotspots and Clusters Project, they are approached for advice on new initiatives and the representatives are encouraged to raise issues that they might be aware of within their own sphere of work. This group were informed of and consulted regarding the Senate Inquiry into Suicide in 2010, the Hotspots and Clusters Project and this NT Inquiry into Youth Suicide. They are informed about training opportunities for staff and community members, conferences and events related to raising public awareness and reducing stigma.

*"Suicide prevention is about reducing family violence and sexual assault; it's about restricting access and supply of alcohol and drugs, and rehabilitating addicts and criminal offenders; it's about effective school education and youth programs; it's about accessible employment and financial stability; it's about early childhood programs, effective child protection and parenting education; it's about opportunities to retain language and culture; it's about affordable housing and it's about an effective mental health system for adults and for young people" (Grant 2010).*





The effectiveness of the Life Promotion Steering Committee is subject to a number of factors;

1. The ability of the Life Promotion staff to keep the list of representatives up to date as staff move from organisations and as new and relevant programs and organisations enter Alice Springs
2. Including this role as part of the core business of Life Promotion in order to ensure consistency in the coordination of this committee and the availability of an historical record that sits with the program
3. Having the coordination function written into the service agreement with the NT Government to ensure its longevity
4. The commitment and willingness of organisations to allocate some resourcing (in the form of staff time and occasional extra duties) to the issue of suicide prevention.
5. The ability of representatives to keep their management and colleagues informed of the outcomes and the information circulated of these meetings
6. Attendance at meetings and/or the reading of minutes and information

This aspect of the Life Promotion Program has not been evaluated externally. This would provide us with useful information as to the value of this group and areas for improvement.

## 5. Collecting Data on Suicide

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The most recent ABS data indicates that there were 2,130 deaths in Australia due to suicide in 2009. Of these deaths, males accounted for over three-quarters or 76.6 per cent. Youth suicide rates have been declining since 1997 when the rate for 15 to 19 year olds peaked at 18.4 per 100, 000. In 2009, the rate for this age group was 9.3 per 100 000. In 1997, the suicide rate for young men between 15 years and 24 years was 42.8 per 100, 000. In 2009, the rate had declined to 19 per 100, 000, (Mindframe 2011). Despite the decline in numbers, suicide was the leading cause of death in the 15-24 age groups in 2009, (Australian Bureau of Statistics, 2011).

The Northern Territory has recorded the highest rate of suicide in Australia since the early 1990's (ABS 2011). In 1983 there were 6 deaths by suicide in total in the NT whilst in 2002 there were 55 deaths by suicide. The most recent data indicates that 38 people died by suicide in the NT in 2009. The first reported suicide of an Aboriginal person in the NT was in 1981. (Measey, M., Qin Li, S., Parker, R 2005). Aboriginal deaths by suicide increased throughout the 80's and 90's and currently make up approximately half of all deaths by suicide in the NT. (ABS 2011)

*“...suicide had been an alien concept in Aboriginal life. In my long involvement in Aboriginal Affairs, especially in the Northern Territory, Queensland and Victoria, suicide had not been an issue. It was never mentioned by Aborigines, anthropologists, linguists, government officials, missionaries, magistrates, pastoralists or police. In 1968, Kidson and Jones found an absence of 'classical neuroses, psychosomatic illness and suicide' among Western Desert people. John Cawte's (1974) medico-sociological expedition to Arnhem Land in 1968 found 'nothing alarming' about Aboriginal suicide rates... In the late 1980's Harry Eastwell confirmed the “low risk of suicide among Yolgnu of the Northern Territory”. (Tatz 2005)*

In the Northern Territory the death of Indigenous people by suicide increased from 7 suicides from 1981-1985; 6 suicides from 1986–1990; 15 suicides from 1991–1995; 73 from 1996–2000; 123 from 2001–2005 and 99 from 2006–2010, a total of 323 Indigenous suicides in three decades (Hanssens 2011). In Central Australia, the highest number of suicides occurred in 2002 with 18 people dying by suicide that year. This region (from Elliot in the north to the borders of QLD, SA and WA) has on average reported 10 deaths by suicide each year. The rates have remained steady. If this data were to capture all those deaths by suicide that occurs across the borders (i.e. NPY lands, Mt Isa and Halls Creek) and that impact on families and services located in the NT, this figure would be much higher. In 2011, there have been 8 suspected deaths by suicide in Central Australia (notified by the Police but not confirmed by the NT Coroner). Of these deaths, 5 have been of young Aboriginal people under 25 years of age. (Life Promotion Program 2011)

The number of deaths by suicide is under-reported due to the difficulty in determining intent and variations in coronial practices in relation to determining intent in Australia (Senate Committee Report 2010). Deaths by drowning, single driver vehicle collision, drug overdose, falls from high places and hanging by very young people are difficult to confirm as suicide. Coroners may not record their finding officially under the request of family due to the stigma associated with suicide (Senate Committee Report 2010). Under-reporting of suicide can mask the true picture and consequently influence where resources are directed and not directed. The current data doesn't accurately capture those people who make a "serious" attempt on their lives even though this is a key indicator of future suicide risk (Hawton and Fagg, 1988; Suominen, Isometsa et al., 2004 cited in Robinson 2011).

Accurate and timely numbers of all deaths by suicide can be useful for the purposes of raising public awareness at various speaking engagements about the extent of the problem in our region, in order to gain support and funds for suicide prevention efforts, to be able to compare the rates in the Northern Territory and to stop misinformation and exaggeration. It can also help to prevent and contain suicide clusters, a common phenomenon among the Northern Territory's indigenous population (Hanssens 2011).

*Suicide clusters occur with exposure to another person's suicide death, assuming close temporal, geographic, interpersonal proximity and the reach of news of a suicide death, all of which precipitate imitative suicidal behaviour and further suicides (Hanssens 2011)*

The more comprehensive the detail collected on the person who dies by suicide, the more complete a picture can be presented of the risk factors that can lead to suicide and the factors that protect us from suicide. Details about school attendance, employment, sexuality, history of sexual abuse, previous suicide attempts, and history of self-harming behaviour, criminal record and death by suicide in the family would be useful. Also whether there was a possible trigger or motive for the death such as drug or alcohol dependency, relationship problems, a death in the family, financial problems or possible criminal activity. This would assist in knowing where efforts should be directed in relation to suicide prevention.

## 6. Warning Signs for Suicide

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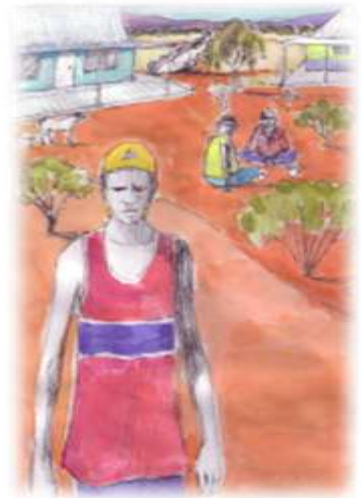


### Warning Signs for suicide

Warning signs are early indications that someone might be at risk of suicide. They provide a clue that a person is acting out of character, or that something is not right. These can be separated into risk factors, warning signs and tipping points.

#### Risk factors

- Mental health problems
- Aboriginal male
- Family discord/violence/abuse
- History of abuse/trauma
- Family history of suicide
- Bereavement
- Alcohol and substance misuse
- Financial stress
- Previous suicide attempt
- Physical health problems



#### Warning Signs

- Withdrawal from friends, family or activities
- Spending significant periods of time alone
- An increase in excessive at risk behaviour (reckless driving, excessive drinking)
- Change in appearance, behaviour, mood, conversations, thinking, eating)
- Giving possessions away or letting people know they are going away
- Expressing that they wish to be dead or be with dead relatives
- Talking of worthlessness, loneliness, powerlessness or being overwhelmed
- Hurting themselves
- Unable to make decisions or concentrate
- Feeling lethargic constantly – sleeping a lot



#### Tipping Points

- Relationship ending
- Death or suicide of relative or friend
- An argument
- Being abused or bullied  
NB: Tipping Points mixed with too much alcohol can increase the danger
- Loss of status or job and/or respect/shame
- Debilitating physical illness or accident



*All pictures by Sue McLeod and copyright of Suicide Story Training*

These pictures are an effective tool for engaging with Aboriginal people and their family about difficult issues.

## 7. Responding After a Suicide

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When a suicide occurs, those first on the scene are usually family or friends, but there are times when a person who is not known to the deceased is first on the scene. In remote communities, clinic staff members are usually called to the scene and the police are notified. Children and young people can be witness to these scenes. Hanssens (2010) discusses the need for timely, efficient and targeted responses to suicide. She lists various tasks that are shared responsibility of an Interagency group and a crisis team - such as confirming the facts, identifying people at risk, providing support for family and community and providing long-term monitoring and support. This was a major focus of the Life Promotion Programs established in both Darwin and Alice Springs in the late 1990's. It is still a focus of the Alice Springs program however there are many factors that inhibit a comprehensive response.

The Central Australian Life Promotion Program, as part of the service agreement with the NT Government and as part of an agreement with the Coroner's Office in Alice Springs, receives information on every suspected death by suicide usually within a 12 hour period. The purpose of this is to:

- a. Identify suicide risk in the family or community
- b. to coordinate support for families by local service providers with the capacity to respond and those with established relationships with family
- c. to identify long and short term strategies that could be put in place for this community (i.e. training, information, development of safety plans, healing ceremonies etc.)

This response to suicide is a means of ensuring collaboration between the non-Government sector and Government departments in efforts to contain further suicide risk and in acknowledging that this issue is a shared responsibility of a number of services. It also provides one point of contact in regard to a death by suicide in Central Australia and it can prevent too many agencies from entering a community and duplicating efforts of support. The response meetings also endeavour to stop rumours and misinformation from spreading. Annual reviews of the interagency response meetings have indicated that a wide range of support is provided to immediate family and others impacted by a suicide. This support can vary from the provision of food and blankets for family in sorry camps to the engagement of mental health practitioners in assessment of risk. A designated team devoted to this alone would allow for more effective post vention response such as that provided by the StandBy program. "One of the features of the StandBy model is the provision of assistance to people bereaved by suicide at any time after a loss, even if the death occurred many years ago. The service is available for people bereaved by a local suicide, as well as those who lost someone to suicide elsewhere". (United Synergies 2011)



The Interagency Group has no capacity to respond to suicide attempts or suicide threats. The Life Promotion staff members involved in facilitating these meetings have limited capacity to follow up with all the agencies that played a role in supporting the community and monitor the well-being of those affected by this suicide. This year (2011) the Life Promotion team responded to 7 deaths by suicide in a three month period. There is limited capacity at present to do this role well, especially when there is a spike in suicides over a short period of time.

## 8. Community Plans for Preventing and Responding To Suicide Clusters

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Recently the Australian Government funded the development of Guidelines for communities to manage and contain potential or actual suicide clusters. A cluster of suicides can occur when one person's suicide



seems to influence the occurrence of further suicidal behaviour in a particular setting (i.e. school, prison or remote community) and within a short space of time. They are sometimes referred to as “copycat suicides”. Clusters of Suicide in Australia have been most commonly documented in Indigenous communities and in young people (The University of Melbourne 2011).

The process of developing these guidelines involved consultation with a wide range of people including members of the Life Promotion Steering Committee in Alice Springs and the Indigenous Suicide Prevention Network in Darwin. The guidelines recommend that every community develop their own community plan to prevent and contain suicide clusters. The guidelines involve three phases; Preparedness,

Intervention/Postvention and Follow up (The University of Melbourne 2011).

Some of the issues raised in the Northern Territory during consultation are useful for consideration of where to allocate resourcing for the purposes of developing and implementing these guidelines in remote Indigenous Communities and in various town based settings.

- Who would be the lead agency and authority within Indigenous communities? The focus group discussed this and suggested that a steering committee or coalition rather than a single lead agency would be more appropriate. Possibly the Aboriginal Medical Services could act as the lead agency. It would depend on the community.
- The written document would require adaptation to make it more suitable for Indigenous communities.

- The plan could be accompanied by a pictorial diagram (i.e. Menzies School of Health Research Aim HI information)

*“It’s just a complicating factor. Even for health workers, they want to talk to families and help them through the suicide, but there’s this complicating factor in the background and they might not want to talk about it straight away, because they’re suspicious, or they’re thinking something else is going on, but the health worker wants to get in there and talk straight about it, but they have to wait until the family is ready and it mightn’t be until after the funeral because they can’t talk for weeks about it. That’s what they said from Galiwinku (Elcho Island) anyway” (Darwin Region Indigenous Suicide Prevention Network 2011).*

- In order to enact this community plan, the Coronial Office in the NT would need to release the information to the appropriate coordination agency immediately after a suspected suicide has occurred. For deaths that are suspected suicides that occur in Central Australia, the Life Promotion Program has an agreement with the local Coronial Office to receive this information. This is part of the service agreement with the NT Government who fund this program. In the Top End this is not the case as there is no agreement in place and no coordination point to enact a response to suicide deaths. (Life Promotion Steering Committee 2011)

## 9. Suicide Attempts

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As previously noted, the Life Promotion Program was established in 1998 in response to the high incidence of youth suicides at this time with one of the original project objectives “to develop an interagency response if there was a suicide or attempted suicide of a young person”. The National Youth Suicide Prevention Strategy became the National Suicide Prevention Strategy in 2000 and Life Promotion altered its focus to address suicide prevention across the life span in keeping with the most current research at that time that indicated a decline in youth suicides.

The Life Promotion Program in Alice Springs was originally positioned with the NT Government Mental Health Service. During this time, the LPP Officers had access to information regarding people who had been referred to the Mental Health team having attempted suicide. The LP Program moved into the non-Government sector of Mental Health in 2001 and it seems that from this time on there was less referral of people at risk from the clinical mental health team. The process of referral was not clear, nor the shared roles in the support of people who had attempted suicide. In reflecting on this time, I think that the plan for the two staff members of the Life Promotion Program to focus on responding to every individual who came to the attention of local service providers as having attempted suicide was well intentioned but unrealistic.

The Life Promotion Program Coordinator began querying the role of this program in responding to people at risk of suicide and those who had attempted suicide. In July 2004 the Life Promotion Steering Committee asked “**what was the role of agencies in response to suicide attempts.**” Many members present felt that all agencies have a role to play in responding to suicide attempts and the aftermath of a death by suicide.

In 2004, the protocol in place for the Life Promotion Program to co-ordinate responses to attempted suicide was problematic for a number of reasons.

- a) Information about people at risk of suicide who came to the attention of the NT Government mental health team was confidential
- b) While this information was once shared with the Life Promotion team (especially when they were NT Government employees) when there were alarming incidence of youth suicide, later clinicians were reluctant to pass on this information and it was unclear as to the role of Life Promotion officers who were not trained clinicians
- c) At the September 2005 LPP meeting it was acknowledged that there are variations in how an attempted suicide is defined, however it was agreed that an effort needs to be made to collect whatever information is available. It was agreed that a protocol for reporting suicide attempts that presented to the Emergency Department of the Alice Springs Hospital would be drafted for comment. This protocol was seen as the first step in the process. This protocol could then be adapted for remote clinics, police stations and non-government organisations.
- d) In the event that other outside agencies called LP regarding people who had made attempts on their life, LPP was to inform these agency workers to contact the NT Government Mental Health service who would then carry out a mental health assessment.
- e) LP received anecdotal information from service providers that the response from the NT Government service was not always adequate. People could wait for long periods of time in Accident and Emergency before being seen by a mental health clinician. Sometimes, clinicians would not take the referral as it was deemed as not serious or attention seeking behaviour. The referring agency worker had to argue their case strongly if the referral was to be acted on. ASIST (Applied Suicide Intervention Skills Training) trained workers had to qualify their expertise in suicide risk assessment. People referred were sometimes assessed as no longer at risk and sent home with no follow up. The response varied from worker to worker. Information was not relayed back to the referring agency as to the outcome of the assessment or the follow up action. People could be discharged from the ward after having attempted suicide without notifying the referring agency or appropriate family member. Mental Health Practitioners most often will instruct the referring person or agency to bring the suicidal person to Accident and Emergency or to contact the police to do this. This practise is based on the notion that the person who is suicidal may pose a



risk to the safety of the practitioner. It is also about resources and time. This response can prevent any action from being taken for the care of the suicidal person or it can aggravate the situation.

There needs to be an improved response to suicidal behaviour. One that is less obstructive and more culturally appropriate.

It was considered necessary to have an open discussion on how the system of support for people at risk of suicide might be improved. However, in order for this to occur, agencies needed to agree that the current system needed to be improved and that there was the scope and the energy for all agencies to work together to improve on current practice.

It was noted that a report released in January 2005 and prepared by the Officer in Charge of the Nhulunbuy Police Station, Senior Sergeant Tony Fuller collated information about the number of deaths by suicide and attempted suicides that occurred in North East Arnhem Land over a two year period from January 2003 and January 2005. His intention was to highlight that a disturbing trend in suicide rates was occurring and that interagency collaboration and community discussion needed to occur to try to help reduce the rates of suicidal behaviour (Fuller 2005). In July 2005, East Arnhem received \$100,000 funding to deliver workshops for local health workers in suicide prevention. I believe that this report contributed to discussion, interagency collaboration, community taking some control over this issue and Government resourcing for the region. Central Australia also needed to collect information, not only on the number of deaths by suicide, but also on suicide attempts to give a more truthful picture of the suicide in this region.

Efforts to collaborate with the NT Government to gather data via the emergency department of the Alice Springs hospital did not lead to any action. The Life Promotion Program shifted its focus to address the development of Suicide Story Training. But this issue is still an important one and there needs to be some honest and open discussion about how the collection of data on suicide attempts could be done via health clinics in communities, linked to the NT Government systems and allowing for information to be fed in from a range of service providers and family.

Many more people attempt suicide than those who present to the Alice Springs or Tennant Creek hospitals. An Australian study claims that only one third of all suicide attempts end up in Accident and Emergency Units of Hospitals (De Leo et al 2005 cited in Suicide Prevention Australia 2010). A previous suicide attempt is the highest single risk factor for suicide and following up with a person after an initial crisis contact or hospitalisation has been identified as a critical element in effective suicide prevention (SPA 2010). In Norway, chain-of-care networks made up of a multidisciplinary team provide and co-ordinate follow-up support for those who have attempted suicide. This has led to a decline in further suicide

attempts and improved monitoring of individuals in areas where it has been implemented (Mann, R. et al 2005)

“I recently heard a story told by an Aboriginal women about her nephew being placed in a ward with “mad people” after he attempted suicide. She could not make any sense of the association between the actions of her nephew and his admission to the mental health ward and repeated her concerns a number of times. It was as if he had been locked up and yet had committed no crime and in her opinion was not mentally ill. I tried to explain that he had tried to kill himself and now needed a safe place to reside and a place where he could be cared for by mental health practitioners. She would not accept this”, (Grant 2011)

The current system of accommodating suicidal people in acute adult psychiatric units was frequently highlighted as inadequate in the submissions to the Senate Inquiry on Suicide (Australian Government 2010). One issue was the frequent lack of available beds, but the other issue was the need to consider more suitable options of care and alternative accommodation for people at risk of suicide, (Commonwealth Government 2010). Clinical specialists and support workers could accompany and support suicidal patients outside the hospital setting (Suicide Prevention Australia 2010).

*It is equally important to remember that pathways to care for mentally ill and suicidal individuals are not (and should not be) restricted to those of a clinical context alone. For instance, mental health professionals may bear a greater chance of intervening in the progression of suicidal ideation into suicidal attempt if they identify other recent instances of social, situational, emotional or interpersonal precipitating risk factors, such as “upsetting social interactions, diagnosis of a disabling physical illness or recent job losses” (Fairweather et al., 2006, p. 1243 cited in Lifeline Joint Submission 2009). Similarly, the identification of social support networks and peers as a protective factor towards suicide risk is also essential, (Lifeline 2009).*

The system of care for people in Central Australia following a serious suicide attempt requires a comprehensive review. How adequate is the support for people after a suicide attempt? Why is it that mental health practitioners site safety issues as preventing them from supporting a person who is suicidal at the site? How well coordinated is the care between services? Do family members notify clinics and if so, what response is provided. Does it vary from remote community to remote community? How is a decision made to take the person in to the hospital? If the person is not admitted overnight, how are they supported in the community? Is there a cultural safety component for those Aboriginal people admitted to the hospital after a suicide attempt? How satisfied are people who have attempted suicide with the care provided from hospital? Is the procedure different if the person has been drinking? If the system could be improved, what would it look like?

## 10. Suicide Threats

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*"I'm gonna hang myself". I seem to hear this statement every day out bush (Hills 2011)*

The use of 'suicide as a weapon for threat or manipulation' has been an emerging problem that has troubled many of those who live and work in Central Australia. Despite the prevalence of this issue, there were no resources or information that Life Promotion were aware of to help us better understand this problem. The Little Red Threat Book emerged out of the 'Suicide as a Threat' community workshop held at Campfire in the Heart in Alice Springs in November 2007 (Life Promotion 2007).

*"It causes us a lot of distress when suicide is used as a threat. For seemingly small demands, lives are put in the balance, and the strain of living in this unstable world wears people out, tears at relationships and damages the safety of those who are trying to care. In a community workshop in November 2007, we asked, 'When does this happen? What do we worry for? And what can we do?' The answers revealed deep and thoughtful community knowledge and refreshed our energy to deal with the problem of when suicide is used as a threat" (Schubert 2007).*

This workshop recognised that workers and family members who are living and working in remote communities in Central Australia have expertise and a collective knowledge on this issue (suicide threats). Some of the insights captured in this book include:

- Suicide threats have different degrees of 'seriousness'. It seems the person hasn't invested much in the threat, and they didn't necessarily say it because they meant it, but more because it's an accepted phrase, sort of like swearing: something to shock people into responding.
- Other times a person seems to have lost all sense of perspective and, charged up with anger or jealousy or grog, they react to some situation with intense threats to take their own life.
- Maybe people don't know how else they can negotiate for the things they want. Maybe they haven't learnt this skill
- We worry that he'll follow through on the threat.
- We worry that he might not understand that hanging will almost definitely damage his body and end his life.
- We worry that he doesn't understand how quick it is, and that hanging doesn't leave time for people to respond or rescue, nor does it leave time for him to change his mind.
- We also worry for the person on the receiving end of these threats. (Life Promotion 2007)

This workshop was an important start in grappling with a problem that needs to be considered as a separate suicide related issue but one that needs a different set of strategies. It was always the intention of Life Promotion to hold a follow up workshop where we could spend more time considering the solutions to this worrying trend in Central Australia. Ways of working with young people using a narrative therapy approach and a simple tool that helps to change the story from one of helplessness to one of control has been documented by a local mental health practitioner, Paul Hills (2011). This “Cranky Business” story needs to be further explored and developed for practical use in communities.

Paul gives some thought to different meanings attached to suicide threats for Aboriginal people. “There is: the weapon; the decoy; jealousy; shame job; wrong skin; problem solver; sorry or grief; get-me-out of here; get-me back there; remember your obligation; avoidance; and cultural infringement”. (Hills 2011) His ideas need to be further explored and developed pictorially for wider application in communities.

## 11. Mental Health Related Programs – how do they assist in suicide prevention?

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Suicide Prevention activities are generally divided into Universal interventions that work with whole of population (i.e. public awareness campaigns), Selective interventions that work with specific groups at risk (i.e. Aboriginal young people in remote communities or people bereaved by suicide) and Indicated interventions that work with individuals presenting with signs of suicide risk (i.e. suicide risk assessments, support, follow up and monitoring). There is a complicated mix of service delivery in Central Australia and many of these services relate to suicide prevention, but there is actually a limited range of specific suicide prevention projects being implemented and funded in Central Australia. Life Promotion including Suicide Story, Lifeline and possibly part of the Mt Theo program would be the only funded suicide prevention programs.

There are more players in mental health in Central Australia than there were ten years ago and this should mean that there is scope for greater support for families in regard to suicide risk and mental health issues. The following list includes many of the services providing support in Alice Springs and remote communities and town camps related to mental health. This list doesn't factor in those services and programs within many other related sectors such as alcohol and other drugs, emergency services, youth services, criminal justice, family violence or child safety.

1. ***GPNNT (General Practise Network of Northern Territory)*** in Central Australia provides culturally appropriate Primary Mental Health services to remote communities and outstations
2. ***The Social & Emotional Wellbeing (SEWB)*** social health team provides an extensive range of counselling and support services to clients confronting an increasingly complex range of social issues. The SEWB branch also provides an extensive service to youth, through the Youth Outreach

team, Safe and Sober Support Service, Targeted Family Support Service and Community Wellbeing Team

3. ***The Personal Helpers and Mentoring Program (PHaMs)*** recognises and promotes the spiritual, cultural, mental and physical healing for Indigenous Australians living with mental illness in remote communities. Mission Australia has funds to deliver this program in Papunya and Alice Springs while CatholicCare NT provides PHaMs services in Tennant Creek, Elliot and Amata.
4. ***The Royal Flying Doctors Service (RFDS)*** in Alice Springs provide an outreach mental health service covering the region South East of Alice Spring and is run in close collaboration with General Practice Network NT (Alice Springs) and the Northern Territory Mental Health service
5. ***Headspace*** in Alice Springs is a one-stop health shop for young people, aged 12-25
6. ***Lifeline Central Australia*** supports the network of ASIST (Applied Suicide Intervention Skills Training) trainers in Central Australia in addition to providing regular ASIST, Safe Talk and the Accidental Counsellor Training.
7. ***The Jaru Pirrjirdi Project***, facilitated as part of The Mt Theo Program in Yuendumu, aims “to resolve the many issues that may place Warlpiri youth ‘at risk’ such as substance abuse, self-harm, family violence and/or criminal behaviour and to create positive and meaningful futures for young Warlpiri people” (Mt Theo Program 2010).
8. ***The Mobile Outreach Service Plus (MOS Plus)*** as part of the “Closing the Gap” supports children, young people, families and remote communities by providing counselling and education where children and young people up to 7 years are at risk of, or have been traumatised by, abuse or neglect. This includes sexual, physical and emotional abuse.
9. ***NT Government Central Australian Mental Health Service*** provides services to facilitate optimal care for people with serious mental illness and associated disability and/or risk which necessitate specialist mental health services.
10. ***Relationships Australia NT (RANT)*** received funding from Communities for Children auspiced by Anglicare to deliver a counselling service to vulnerable children aged five to twelve years and their families. The project is based on a unique model to build the capacity of the network of services in Alice Springs to understand and better meet the needs of children who have experienced interpersonal trauma and their families. In addition, the project aims to strengthen the existing referral and case management pathways for traumatised and vulnerable children and families between services in Alice Springs”.
11. ***NPY Women’s Council Ngangkari Team***. “The task of the *Ngangkari*... is to restore, revitalise, reconnect a person to *Kurunpa* (a term often translated as ‘spirit’ but which I prefer to link to the embodied sense of a person’s vitality, coherence, continuity) when depleted, lost or blocked from being in the right place in the body. *Ngangkari* have held this line for us in an unbroken thread right down from the beginning of human time... perhaps for 2,000 generations - Time enough to establish an experiential evidence base, time enough to make mistakes and recover; time enough to

learn how to help and heal body mind - maintain cohesion of self/soul family/ country through all the ups and downs of civilisation (San Roche 2011)

12. *MindMatters* is a resource and professional development program supporting Australian secondary schools in promoting and protecting the mental health, and social and emotional wellbeing of all the members of school communities. *Whole School Matters* is the cornerstone booklet of the MindMatters resource suite. It sets out a whole school approach to mental health and wellbeing for educational sites with suggestions for implementation. The whole school approach involves using MindMatters in a comprehensive and culturally inclusive way involving leadership, school core teams, parents, students and the community.
13. *Mental Health Association of Central Australia* provides support for people with mental health issues, assisting with housing, employment, social activities and advocacy. MHACA provides training in mental health first aid and suicide prevention and raises public awareness through events and publications.
14. *Mental Health Carers NT and Team Health* provide support, information and respite for people who are caring for someone with a mental illness
15. *Mental Health Counselling and Family Well Being Support Services in Santa Teresa and Amoonguna* helps to strengthen the capacity of community members to respond to difficult situations, encourages leadership and employment opportunities, assists in liaison with service providers and the community, and gives a voice to local people in regard to their social and emotional well-being.
16. *Family Well Being Program of Tangentyere Council* has a broad aim to contribute to the wellbeing of Aboriginal people in Central Australia. It creates opportunities for healing and positive change for those affected by family and community violence, loss and grief, substance abuse and unhealthy relationships. It is also aimed at people who are interested in learning to support others in need. Many Program participants speak of a positive 'ripple effect' within their families and communities. Once the individual has become stronger, often they support others to do the same (Hoult 2011)
17. *Yarrenyty Arltere Learning Centre, Larapinta Valley Town Camp* is a family resource and learning centre that aims to improve the social, health, environmental and economic well-being of the community in a way that strengthens and respects culture
18. *Private psychologists*, general practitioners, school counsellors and related support roles.
19. *Akeyulterre, an Aboriginal healing centre in Alice Springs* offers traditional healing and cultural support for local Arrernte families in and around Alice Springs. The healing centre was established in the late 1990s.

**IN ADDITION TO THESE PROGRAMS AND SERVICES ARE COLLABORATIVE NETWORKS INCLUDING:**

- a. NTCOSS (NT Council of Social Services) – this organisation plays a coordination, advocacy, policy and sector development, and leadership and information role for the Social and Community Sector in the NT
- b. The Life Promotion Program Steering Committee facilitated by Mental Health Association of Central Australia – suicide prevention network
- c. Alcohol and Other Drug Interagency Meeting – facilitated by ADSCA (Alcohol and Drug Service of Central Australia – NT Government) to share information across the sector and to collaborate on public awareness initiatives and workforce development.
- d. Youth Services Alice Springs Network Interagency facilitated by NTCOSS to share information across the sector and collaborate on advocacy campaigns and events
- e. Central Australian Family Violence and Sexual Assault Network facilitated by the Women’s Shelter
- f. The Mental Health Collaborative Group facilitated by the GPNNT
- g. Mental Health co-case management meetings facilitated by MHACA

**THERE ARE ALSO TOOLS AND RESOURCES TO ASSIST IN MENTAL HEALTH RELATED SERVICES SUCH AS:**

- h. *Dulwich Centre Narrative Therapy’s* approach “to counselling and community work centre people as the experts in their own lives and views problems as separate from people. Narrative approaches assume that people have many skills, competencies, beliefs, values, commitments, and abilities that will assist them to reduce the influence of problems in their lives” (Dulwich Centre 2011)
- i. *Tracy Westerman’s Assessment Tool the WASC\_Y* (for ages 13 to 17 years) and the WASC\_A (the adult version is currently being developed and tested) “is the first culturally and scientifically validated psychological test that has been developed specifically for use with Aboriginal Australians. The WASC-Y ...is a self-report measure useful for identifying young Aboriginal people who are at risk of anxiety, depression and suicidal behaviours. The instrument can only be purchased after the person has completed training with IPS” (Westerman 2011)
- j. *AIMhi NT - Australian Integrated Mental Health Initiative* “was a 5 year action research project that engaged with managers, service providers, Aboriginal Mental Health Workers and communities to explore mental health in remote communities and to find new ways to deliver services. This was the largest mental health research project to date in the NT. It established base

line measures, explored understandings of mental health from the community perspective, developed service based strategies for improved cross cultural assessment, conducted the first Indigenous mental health clinical trial of a new brief psychotherapy, and developed a range of resources for service providers and the community linked with a training program” (Nagel, T 2011)

The question could be asked, without these programs, resources and opportunities to collaborate, would the suicide rates and suicidal behaviour in Central Australia be greater? How can we ensure that local communities get the best out of all of these initiatives? Their strength lies in the strength of the workers, the sharing of information and knowledge, the employment and support of Indigenous staff, the strength of the relationships with local indigenous people, the ability to retain and support staff and adequate resources to do the job well. This includes additional administration support, effective evaluation expertise and funds for mentoring, training and supervision of staff. It also requires support from Senior Management to work “effectively” with local Indigenous people and this necessitates time to learn and opportunities to be creative and flexible in regard to practice.

*Services that work with Aboriginal culture—that, for example, tap into the proper, healthy functioning of cultural and kinship obligations—tap into the people’s natural ways of staying strong. Services that disrupt Aboriginal culture can make people less strong even when they are trying their best to help people feel stronger. When services negate cultural ways, they actually cause stress, possible trauma and disruption to wellbeing (Albrecht 2002; Nangala, Nangala, & McCoy 2008 cited in Schubert 2009).*



*We disempower people when we act like they don’t have their own ideas, their own resources and their own capacities: when we don’t give them a chance to express them, let alone a real opportunity to try them out. So to work well, programs and services need to acknowledge the strength of existing support system, the validity of these systems and the legitimacy of the underlying world-views that the natural caring systems come from (Schubert 2009). The Life Promotion Program, in partnership with Waltja Tjutanku Palyapayi Aboriginal Corporation developed The Working Well Guide: reflections on providing suicide prevention projects in remote Aboriginal Communities in Central Australia. This project was part of a Commonwealth funded suicide prevention initiative in 2007.*



## 12. Youth Specific Issues

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The Australian Institute of Family Studies was commissioned by the Commonwealth Department of Health and Aged Care to evaluate the National Youth Suicide Prevention Strategy 1995–1999 (Mitchell 2000).

“The National Youth Suicide Prevention Strategy was not just about suicide prevention, it was also about young people and their place in Australian society” (Mitchell 2000). Australia’s youth suicide prevention strategy implemented a number of strategies that have influenced the direction of youth mental health and suicide prevention today. These strategies included various programs and services to:

- enhance communication skills between young people and their parents
- reducing the availability of means to self-harm
- improving the public awareness of warning signs for suicide and ways of dealing with this
- development of resilience and coping skills among young people both in and outside the education system
- development of support networks for those bereaved by suicide
- the development of age-appropriate counselling services for people who have attempted suicide
- development of protocols for the management of suicide attempt and self-harm by all health facilities
- education for teachers and those who work with young people to improve identification of those at risk
- improvement of data collection systems
- legislation to restrict access to firearms for all but essential purposes and to ensure safe storage and
- the establishment of a national clearing house and research centre for suicide research and prevention.
- Initiatives focusing on young people and crime prevention including projects that focus on the use of public space, availability of youth focused public activities and events, domestic violence, early intervention and homelessness

There is a need to adapt school-based interventions to Aboriginal communities and to other settings to ensure that the information reaches youth who are not in school. Because emotional distress, suicidal ideation, as well as drug and alcohol use may begin earlier than this in many Aboriginal communities, it may be that programs should be developed that are aimed at younger children. Prevention programs at an earlier age can focus on family communication, problem solving, and coping skills (Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2008).

New factors can emerge that influence suicide rates among young people. Mobile phones and social networking were initially viewed as a convenient means of staying connected, communicating with friends

and parents and arranging social activities. They have also become tools for cyber-bullying and can alienate young people as much as unite them. The Inspire Foundation through its online service, Reachout provides young people with access to an online community and trusted information on a range of mental health related issues. They also have Reachout Pro for professionals to learn how to use the technologies and online resources. (Inspire 2010)

In 2007 34% of the Australian population aged 14 years and over had used cannabis (Lifeline 2010). Life Promotion have anecdotal evidence from various remote communities that Aboriginal people are concerned about marijuana use and believe it is linked to mental illness and suicide. In December 2006 the Mental Health Council of Australia released a comprehensive report, “*Where there’s Smoke*”, on the relationship between cannabis and mental illness. The report claimed strong links between cannabis use among young people and the risk of mental illness, (Lifeline 2010). Research into marijuana use in Central Australia could provide evidence to show the extent of use, the link between mental ill-health and suicide and the reasons for its use. Effective campaigns to address this issue could follow on from the evidence.

Currently there are no specific programs in Central Australia addressing suicide risk and mental health among young people who identify as gay, lesbian, bisexual or transgender. “The risk of suicide and self-harm among sexuality, sex and gender diverse communities is complex and is compounded by experiences of stigma, discrimination, and ‘minority stress’. Sexual orientation, sex and gender identity alone do not necessarily elevate risk; rather, experiences of homophobia are known to contribute to social isolation,



poorer mental health outcomes, substance misuse, and other socio-cultural and economic problems and conditions, which in turn place these young people at greater risk of suicide and self-harm” (Inspire 2010). Initiatives such as the Victorian guide to challenging homophobia in Schools could be adapted to suit the context of Central Australia. (Safe Schools Coalition Victoria 2011)

In Central Australia Youth Workers fulfil an important role providing arts, recreational and sports activities during holiday periods, weekends and after school. They fulfil a significant role in allowing space for young people to gather and socialise, learn new skills, build self-confidence and create pathways to employment. Effective relationships between youth workers and the young people they work with are non-threatening, trusting and based around activity. The consequences of these relationships 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. Youth work in Central Australia is challenging and many people who enter into it grapple with the complex issues that confront them (Scholtes 2011). Employers need to ensure that youth workers are provided with accessible and appropriate training, staff to back fill positions whilst they are absent from communities, professional development

opportunities, structured networking with their peers on a regular basis within the geographical region that they work, budgeted self-care opportunities such as massage and ongoing regular appropriate mentoring and/or professional supervision (Scholtes 2011).

Collaboration between youth workers, mental health and drug and alcohol workers could occur to develop training opportunities and workshops for young people in communities focused on resilience, coping skills, ways to address violence, parenting skills, risky behaviour, suicide threats, grief and substance misuse. These workshops should be available with funding sourced for all year round activities, not just during school holiday periods. The distribution of funds needs to be more equally distributed between communities. Collaboration with the Mt Theo Program's Jaru Pirrjirdi Program to share their expertise with other regions in creating opportunities for young people in communities to be mentored and trained as leaders and youth workers so that other communities can seek resources to establish similar models.

## 13. Suicide Story Training

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Suicide Story is a training tool for Indigenous people to share knowledge, understanding and skills to deal with suicide and to know how to seek further support. It has been developed over five years as a concept that grew into a major project. The Life Promotion Program questioned the suitability of the training programs on offer for Central Australia as did workers in other organisations. We were aware that the current training tools and resources needed to be adapted to suit Aboriginal people in this region, especially if we were to train in remote communities. We needed to consider the sourcing of more appropriate



material and we needed to consider developing a resource with Aboriginal people. This training was driven by Aboriginal people who wished to share their knowledge about suicide, how to notice warning signs and what to do to prevent suicide occurring.

*Suicide story is about getting the conversations happening, giving people permission to talk, and giving people better tools to know how to handle suicidal behaviour in their families and communities.*

There are few training resources worldwide for Indigenous people that focus on suicide prevention. So this is new and it's experimental. It's one tool and one strategy to address the high rates of suicide and it needs to be part of the bigger picture. We developed information into a DVD to make it easier to deliver. It allowed us to share the knowledge of Indigenous contributors every time we delivered the training. But because suicide is about life or death, programs must be safe and not contribute to unintended

consequences that increase the risk of suicide. Initiatives must be informed by research and best practise and they must be evaluated. MHACA developed a partnership with the Centre for Remote Health to independently evaluate the training resource. This training is effective because of the skills and engagement of Indigenous trainers, the involvement of cultural consultants and interpreters and the use of interactive activities. The cost can vary depending on the location of the training, whether people travel away from their communities to participate and the cost of catering. Currently it can cost up to \$6,000 to provide catering, the cost of interpreter work, and payment for consultant trainers and local advisors. On top of this are additional costs of MHACA's contribution in staff, administration, transport and basic accommodation. This training is presently delivered at no cost to participants and is being funded through NT Government and Department of Health and Ageing.

Indigenous people who come to this training do not have to be in paid employment, however many are employed and require their employers to release them from work to attend the training over two days. The Centre for Remote Health evaluated the Suicide Story training DVD and found that "trainees' level of understanding about suicide increased and their confidence to respond to suicide was enhanced" (Lopes, et al., 2010). This resource and its development is an achievement that all those involved should be proud of. It incorporates principles of cultural safety that acknowledges that Aboriginal people are experts about their personal experiences of suicide and their involvement in the development of solutions will be the most effective way forward on this issue.

## 14. Support for People Bereaved By Suicide

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### **AWARENESS FOR AGENCY WORKERS RE SORRY BUSINESS AFTER A DEATH BY SUICIDE** by Valda Napurrula Shannon

This information is from the Tennant Creek and Barkly communities although some aspects of sorry business are similar to other communities of Central Australia. At Sorry Camps family members can feel very frustrated, angry and confused about the loss of a loved one. In many cases, families tend to lean towards physical punishment (payback) to feel satisfied that some level of justice was achieved, according to Aboriginal Law. People who are likely to receive payback are:

- Mothers, fathers, aunts and uncles who did not show care, concern or interest for the deceased child.
- Friends who were around the deceased and did not do anything to stop him/her.

- Other community members who were around that person in the time of the death.

People who have the duty to influence decisions to carry out these punishments are kinship workers. No other person has the right to do this unless asked by kinship workers to discuss or carry out payback.

**Kinship workers** are people who are related to the deceased assister, brother and cousin. These people are allowed to make decisions and carry out directions given by grieving families. Grieving families sometimes feel frightened because they know it is possible to be punished by extended family members.

**Death by suicide is difficult for everyone.** Death by suicide is a very sensitive issue to Aboriginal people. Not many people feel comfortable talking about it. Mixed emotions of anger, sadness, shame and possible guilt make this kind of death difficult. In Aboriginal Law individuals are only allowed to talk to a certain few people to express their anger or shock. And the certain few are people from the kinship group. Sometimes the mourners talk to each other to stay strong. Most people would rather keep their emotions locked in rather than show them. Many Aboriginal people feel that there is little or no support for close families, the widow and the children at this time. Delays such as by police investigation can cause much more stress, confusion, grief and anger.

***What would be helpful?***

**POLICE** – The police officers need to talk to the “right” person regarding the death that has occurred. If they don’t know who this is they should ask someone. It would be respectful for the police officer to explain clearly to the mourners the process of an investigation. Keeping these families informed about this process will help them to understand the reason for the delays.

**FAMILY SUPPORT** - Throughout sorry business it is important to have good ongoing communication and support. This support and communication requires involvement of kinship workers (interpreters), cultural counsellors and professional support workers. Sometimes family might need practical assistance like transport or food and blankets.

**MENTAL HEALTH SUPPORT** - Contact Council of Elders and Respected Persons Office (CERP) in Tennant Creek to identify kinship workers. The kinship workers will seek permission and/or explain the importance of other support. Go into sorry camp with a kinship worker, cultural counsellor to speak with families. Enter into the sorry camp with an open mind. Do not ask too many questions, offer help one step at a time, sit quietly for a while, don’t rush conversation and speak slowly in a low voice.

Do give time for the kinship worker to interpret and the cultural counsellor to speak. When people feel respected and listened to, they will open up and let you know how they would like to be helped.

Opening up to one another is a great step forward towards healing. Try to find out who the family are worried for now that this death has occurred. Others can be at risk of suicide after a death by suicide has occurred and it is important to assess and monitor these people. Check in on the family and others after sorry business and the funeral have taken place.

## ***BEREAVEMENT SUPPORT GROUPS***

Losing a close family member or friend to suicide is a risk factor for mental health problems and for complications to pre-existing health problems. This is a major public health issue, especially since such reactions can substantially heighten the risk of suicidal ideation, behaviours and attempts among those bereaved by suicide.

While those bereaved by suicide may not be clinically unwell, they are at a high risk of becoming so. Indeed, the adverse physical and mental health reactions typically associated with suicide bereavement can increase the likelihood of development of other health risks during bereavement (Clarke, 2009).

Bereavement Support Groups are helpful for those who have had a similar loss through suicide (i.e. parent losing a child). Throughout 2005 and 2006 the Life Promotion program assisted with a Bereavement Support Group – this is no longer in operation. The members of this group responded positively to a structured meeting with others with a similar experience but also to sharing ways of working through this experience.

Aboriginal women who had lost a child to suicide were supported in an informal and less structured way through the Social and Emotional Wellbeing Program of Congress around this time. One of the women in this group spoke publicly at the World Suicide Prevention Day event in Alice Springs and said she was grateful for the support that was offered to her at that time. Life Promotion has been collecting stories of people bereaved through suicide with the purpose of sharing the knowledge of those who have had a lived experience of suicide loss. This information will shape an educational resource to assist others.

Healing ceremonies such as those held each year in Alice Springs and Tennant Creek for World Suicide Prevention Day are also an opportunity for people to come together to remember all those who have died by suicide in Central Australia. It's a chance to remember and a chance to grieve together quietly. These ceremonies over the years have allowed for young people to share their experiences of loss, for Aboriginal men to talk about their own struggles with suicide and the strengths and support that helped them through this time and for Aboriginal mothers to speak publicly about the loss of young men in their families. They are an important means of collective grieving, a chance to raise public awareness about this issue and an opportunity to reduce the shame and stigma associated with it.

## **15. Strength Based Programs**

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Strengths based programs can build resilience and protect people from suicide. It is as important to consider risk factors for suicide as it is to consider protective factors. Protective factors can include supportive and loving relationships, meaningful employment, safe and secure housing, feeling valued, and having skills and interests. The following are a few examples of strengths based programs:



**KANYIRNINPA (HOLDING)** *“Fred Myers described kanyirninpa (holding) as a deeply embedded value*



*for desert Aboriginal people. He explained it as authority with nurturance where older people ‘grew up’ and protected younger people. Can a cultural understanding of kanyirninpa provide any insight or response to the high rates of suicide among young Aboriginal men today” (McCoy 2009).* McCoy claims that it is the fracturing of kanyirninpa in recent times in Indigenous communities that has wounded young men and has broken the long line of

continuity of knowledge and nurturing. This in turn has had major implications for men's health and the associated self-harming behaviour, high risk behaviour, violence and suicide. Efforts of Aboriginal families to sustain this “social expression of kanyirninpa” can give strength and protection for young men and offer hope to reduce the incidence of suicide (McCoy 2009)

### **ALIVE AND KICKING GOALS PROGRAM**

Two years ago players from The Broome Saints Football Club teamed up with the Men’s Outreach Service to create the **Alive and Kicking Goals Program**, a project aimed at reaching out to young people who need help, especially if they were feeling depressed or suicidal. Football was seen as the ideal vehicle for making that change. The team gathers around a campfire after training and discusses mental health issues, people they know who may be at risk of suicide and ways to help them. Through the program, participants have learned how to recognise the signs that friends or family may be suicidal and have developed the skills and courage to help. (Dewhurst 2010)

### **DRUM ATWEME**

In 2003, Peter Lowson began working with young people at the Irrekerlantye School and formed what became known as Drum Atweme. Drum Atweme is a drumming group made up of young people from town camps in Alice Springs. The group was established in 2004 and has about 30 core performers, with another 100 students participating in drumming lessons each week. Almost all public events in Alice Springs and many conferences held in Alice Springs include a performance by this popular group. (Tangentyere 2011)

**BUSHMOB** emerged out of the interests of some young people in Alice Springs town camps in 1991 to travel out bush and be safe. The vision of Bush Mob is that “Journeys are made in Central Australia by, and for, young people to get the self-respect, trust and courage and skill to have a good life because grog, sniffing, drugs and crime are no good.(Bush Mob 2011).

There are many more of these programs involving sport, recreation, music and the arts operating in Central Australia and other regions of Australia. A concerted effort needs to occur so that we can consolidate what we know about these programs and what they can tell us about the link between strength based activities and improved mental health and protection from suicide.

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