



Northern
Territory
Government

DEPARTMENT OF HEALTH

**SUBMISSION TO THE LEGISLATIVE
ASSEMBLY OF THE NORTHERN
TERRITORY SELECT COMMITTEE
ON YOUTH SUICIDES IN THE
NORTHERN TERRITORY**

SEPTEMBER 2011

Department of Health

NORTHERN TERRITORY GOVERNMENT

Introduction

This submission considers available data in relation to completed suicides in the NT, current and potential suicide prevention strategies and funding sources, and the information needed to effectively target scarce resources to reduce youth suicide.

The information presented in the body of this document is summarised, with greater detail provided in attachments in *Section A*. The Committee may wish to make all or part of this section public. To protect communities and families, some confidential information has been included in *Section B, Confidential Attachments*. This information is provided to assist the Committee's deliberations but is not suitable for publication or wider distribution.

The column on the right indicates the Terms of Reference (TOR) as outlined by the Select Committee

A: Commonwealth Funded Programs and proposals to access Commonwealth funding.

B: Youth Suicide Prevention Programs, including Schools.

C: Policies of government agencies in responding to suicide.

D: Current services/programs for high risk groups.

E: Adequacy, appropriateness of current programs for youth.

F: Suicide Reporting, Data and Risk Factors

Combining suicide data over a 5-year period provides a more reliable picture of differences across the States and Territories due to the relatively small number of suicides in some States and Territories in any one year.

The most recent figures published by the Australian Bureau of Statistics (ABS) indicate that over the five year period 2005-2009, the Northern Territory had the highest standardised death rates by suicide (20.1 per 100 000), followed by Tasmania (15 per 100 000) and South Australia (12.1 per 100 000). In contrast, New South Wales (7.9 per 100 000) and Victoria (9.3 per 100 000) had the lowest rates of suicide (3303.0 – ABS Causes of Death, Australia, 2009).

Suicide results from the interaction of a complex range of factors including issues such as mental health problems, drug and alcohol misuse, inadequate education, lack of meaningful or any employment, cultural or sexual identity issues, poverty, sexual and physical abuse and problems with family and the law. Factors such as the grief, loss and trauma experienced by many Aboriginal people and communities, can also have a significant impact on an individual's vulnerability. There is strong evidence which identifies a background of childhood neglect and abuse as a major contributor to the risk of suicide.

The decision to suicide can be influenced by one or more of these and other factors, occurring in a specific and individual context. Consequently, there is no guaranteed method of predicting suicides and no single approach to prevent them, nor are there simple solutions or explanations. Research

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suggests effective suicide prevention needs to combine a broad range of strategies and approaches that are sustained over many years.

These sustained approaches target the whole population, specific groups and individuals at risk and require a whole of government and community partnership approach. Early child development and health programs and targeted home visiting programs have strong evidence for preventing the child abuse and neglect which is associated with poor health and social outcomes which are manifested later in life including during adolescence. Such an approach needs to be appropriately resourced, supported and coordinated in order to ensure its effectiveness.

Population level approaches become less effective when targeting particular communities and individuals at elevated risk. At a local level, families, schools, workplaces and other organisations require knowledge to assist with identifying individuals in need of assistance and to guide them to support or treatment.

Local welfare workers and clinicians need the skills and support to provide assistance where needed and to refer to specialised services where local services are either ill-equipped or insufficient. Specialised services need the necessary resources to treat individuals with complex needs and the ability to assist primary care and other front line community based workers to enhance their skills and maintain people safely in local communities.

In relation to suicide prevention activities for youth, sport, cultural and artistic activity based programs are better accepted than discussion groups overtly addressing problems with living. Organised activities can be utilised as the basis for ongoing relationships with mentors and provide opportunities for modelling teamwork and other adaptive responses to difficulties. NT initiatives include targeting at-risk youth for inclusion in activity based programs, complimented by the addition of problem-solving, resilience enhancing and suicide prevention elements.

The method used for the majority of youth suicides, in common with all age groups in the NT, is hanging (around 80%). This is different from other jurisdictions and complicates prevention efforts. Removing the means of suicide is considered an effective prevention technique in many situations; although it is not known how often another means are substituted. Unfortunately, restricting means to hanging is virtually impossible.

In the event of a completed suicide, sensitive support is required to assist those affected by the loss and protect others who are at increased risk as a consequence. This is particularly important when a young person completes suicide.

This submission makes frequent use of data based on confirmed and more recent unconfirmed suicides in the NT. This data is collated from notifications received from the Coroner's Office. The NT data should be interpreted with caution as the relatively small numbers result in significant fluctuations from year to year, obscuring meaningful trends. For this reason averages over a number of years are used where possible.

Analysis of unconfirmed suicides in the NT between 2006 and 2011 (YTD) indicates the highest risk population for suicide is young Indigenous males

aged between 15 and 24 years. A worrying trend is the recent increase in the number in suicide of young Indigenous females. *Section B, Confidential Attachment 1* contains data around a recent spike in suicide among young people. The most common contextual factors appear to be alcohol (and/or substance use) and relationship problems. Although the largest numbers of suicides occur in the Darwin Urban Region, the most vulnerable communities (rate per 100 000 populations) appear to be in the Darwin Rural, East Arnhem and Barkley Health Regions.

Reports of suspected completed suicides from sources in the NT other than the Coroner's Office have been found to be misleading. It should be noted there may be minor differences between yearly statistics compiled by the Mental Health Program of unconfirmed suicide deaths (from notifications provided directly by the Coroner's Office) and the statistics published by the ABS.

Additional Suicide Prevention Funding

In the 2011/12 budget, a further \$2.4M was committed by the NT Government over three years to build on the work that has already been done. \$600 000 was allocated in 2011/12, \$880 000 in 2012/13 and \$1M in 2013/14 and recurrent. Initiatives to be funded include training for frontline workers, increased education in schools and targeted intervention for young people at risk. The strategies will also include improved data collection and research and targeting of 'hot spots' (communities and groups with high suicide and self harm rates).

Brief Overview of Suicide Data Issues

Caution should be exercised in reporting and interpreting suicide and self-harm data.

In the past, the reliability of suicide statistics was affected by a number of factors including differences in reporting methods across Australia, and delays in the processing of possible suicides by Coroners. The ABS has instituted a significant quality assurance process to improve the quality of coding of deaths data.

In order to further improve the accuracy of the data on suicide deaths, in 2010, the ABS commenced a new approach of revising the Causes of Death data each year. Consequently the previously released data for 2007 and 2008 have been revised to include additional information about deaths being examined by the Coroners in each State and Territory since the release of preliminary data.

However, the review by the ABS on the accuracy and consistency of suicide reporting across jurisdictions resulted in little change to the NT statistics.

Data on suicides can be reported in different ways, including as the number of people who died by suicide, as an age-standardised suicide rate per 100 000 people (which allows for the comparison of groups with different age structures and sizes) or as a percentage of deaths from all causes which were due to suicide.

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Overview of Suicide in the Northern Territory

In Australia those at the highest risk of suicide are those who are young, male, Indigenous and live in remote communities. The high suicide rate in the NT is significantly influenced by the fact that a large proportion of the population in the NT are in this population subgroup. Suicide rates in Non-Indigenous males are also higher in the NT than in other jurisdictions. Conversely, the overwhelming majority of Territorians in these high risk groups do not suicide.

Consequently, interventions must have widespread application and appeal in order to reach the people who may be contemplating suicide at any given time.

Data in relation to suicide in the NT is presented in the following Attachments:

Section A Attachment 1, provides comparative data of the NT Suicide rate within the Australian Context published by the ABS over time.

Section A Attachment 2, presents figures compiled by the Mental Health Program between 2005 – 2011. The data refers to unconfirmed suicides from information routinely provided to the Mental Health Program by the NT Coroner's Office.

Section B, Confidential Attachments 1 and 2, presents in confidence information regarding unconfirmed NT suicide deaths in the NT for the Committee's reference. This data is collected locally and may not necessarily align with ABS published figures.

Common contextual and risk factors associated with completed suicides in the NT

A file audit of completed suicides in the NT undertaken by the Department of Health Suicide Prevention Coordinator revealed a number of common contextual and risk factors in relation to suicide activity in the NT. Factors include alcohol and other substance abuse, cyber bullying, recent loss or bereavement, relationship difficulties, mental illness and learned behaviour.

Section A Attachment 3, outlines the range of static, dynamic and situational risk factors for suicide which might be considered in assessing an individuals level of risk.

A further element requiring more detailed examination are the social determinants of health and the range of protective factors which may influence a particular community, family or individual to not engage in suicide. *Section A Attachment 4* outlines some of the important early intervention options and protective factors mentioned in the literature.

Enhanced data collection and further targeted research on these factors (contextual, risk and protective) would assist with the development of future prevention plans. Recommendations for research are addressed later in this submission, see pages 22 and 23.

Overview of Suicide Prevention Frameworks and Action Plans

Living Is For Everyone (LIFE) Framework

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The Living Is For Everyone (LIFE) Framework is Australia's national framework for suicide prevention. The LIFE Framework is the latest in a series of national suicide prevention initiatives that began in the early 1990s. It provides national strategy for action based on the best available evidence to guide activities aimed at reducing the rate at which people take their own lives.

The materials aim to support population health approaches and activities that will assist in reducing the loss of life through suicide in Australia. The LIFE Framework is at *Section A Attachment 5*.

Northern Territory Strategic Framework for Suicide Prevention (NTSFSP)

The NTSFSP was released in October 2003. The framework was developed to provide a platform to guide planning and development of initiatives with a focus on life promotion and the prevention of suicide and self harm in the NT. The document is based on a whole of government and community approach. No funding specific was attached to the Framework. The NTSFSP is at *Section A Attachment 6*.

The NT Framework aligns closely with the revised National Life Framework but retains a specific focus on Indigenous Suicide Prevention.

Northern Territory Suicide Prevention Action Plan 2009 – 2011 (NTSPAP)

The NTSPAP is a 3 year Action Plan for Suicide Prevention, based on the NTSFSP, and was developed by a Cross Government Co-ordinating Committee for Suicide Prevention. *Section A Attachment 7*.

This committee included representatives from the Departments of Health and Families, Police, Justice, Education & Training, Chief Ministers, National Resources, Environment, The Arts and Sports and the Commonwealth Departments of Health and Ageing and Families, Housing, Community Services & Indigenous Affairs.

The Action Plan was developed as a whole-of-Government response representing the specific actions and initiatives aimed at reducing suicide and fostering individual and community resilience and capacity. It effectively translated the NT Strategic Framework for Suicide Prevention into measurable actions.

The Plan also recognised the Australian Government as a key partner and reflects the links between the key directions of both the NT and Australian Suicide Prevention Frameworks.

A progress report compiled in 2010, reporting on the first year of the plan (2009), provides information on initiatives undertaken across the Departments represented on the Committee. This document is at *Section A Attachment 8*.

The NT Suicide Prevention Action Plan 2009-2011 expires this year and is under review. A final report on progress over the three years of the plan is currently being compiled. Nevertheless, the fundamental principles

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underpinning this plan are well established: whole of government, whole of community responses including broad-scale and targeted programs.

The Department of Health (DoH) committed funding of \$330 000 for the first eighteen months of the Action Plan and a further \$200 000 for the second year to sustain existing initiatives and progress a small number of new initiatives. These included a range of suicide intervention training initiatives which targeted both Indigenous and non-Indigenous populations and also young people over the age of 15. Other initiatives implemented included the provision of training workshops to address non-fatal self-harming behaviour amongst young people and the facilitation of a range of forums focusing on mental health and suicide prevention.

As can be seen from the Action Plan, the existing stakeholders encompass a wide range of government departments, all of whom have direct input into factors that contribute to suicide prevention. However, there was no dedicated funding allocated to commit to new initiatives under the Action Plan in any other Department.

In the 2011/12 budget, a further \$2.4M was committed by the NT Government over the next three years (and recurrently) to build on the work that has already been done. Initiatives to be funded include training for frontline workers, increased education in schools and targeted intervention for young people at risk. The strategies will also include improved data collection and research and targeting of 'hot spots' (communities and groups with high suicide and self harm rates).

Consultation has commenced with stakeholders and it is anticipated a revised Action Plan for 2012-2014 will be developed. The findings and recommendations of the Northern Territory Select Committee on Youth Suicides will be used to inform the development of the revised Action Plan.

Evaluation of the Northern Territory Whole of Government Approach to Suicide Prevention 2007 - 2011

An evaluation of the effectiveness of whole of government approaches utilising suicide prevention as an example was supported by the Mental Health Program and undertaken under the auspice of the Menzies School of Health Research by Megan Lawrance (Phd Student). Ms Lawrance provided an interim summary of her findings to the Mental Health Program and has indicated she intends to make a submission directly to the Youth Suicide Select Committee in relation to her research findings.

Exploratory Study of Child and Youth Suicide in the Northern Territory

Menzies School of Health Research was commissioned by the Child Death Review Committee, established under section 209 of the NT Care and Protection of Children's Act, to undertake exploratory research focussing on child and youth suicide within the NT. This work was led by Professor Gary Robinson.

The Mental Health Program understands a submission containing the key findings of this study will also be submitted to the Northern Territory Select Committee on Youth Suicide.

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The Department of Children and Families (DCF)

DCF core services work across the broad spectrum of social elements which can be considered key risk and protective factors in the context of suicide prevention work including:

- Child Protection
- Homelessness / Supported Accommodation Assistance under the National Affordable Housing Agreement
- Family and Parenting Support
- Youth
- Domestic and Family Violence

DCF services are often called upon to intervene in times of crisis (i.e child protection and family violence) or at points where there is great potential for preventative measures to be taken (i.e. family and parenting support, youth, homelessness and supported accommodation assistance).

Family factors such as abuse and neglect, family violence and substance abuse amplify the risk of child and youth suicide, as underscored in the abovementioned Child Death Committee research. DCF services present opportunities to intervene at this stage of the suicide risk spectrum.

DCF services work to build the capacity of the social and other networks that support young people from a whole-life perspective.

DCF have implemented a number of programs to address children, youth and families at risk and continue to work to strengthen many of the relationship factors that may contribute to risk factors for suicide both individually and in communities, including Mobile Outreach Service Plus (MOSPlus), Men's and Women's Safehouses, the Mobile Child Protection Team and the Remote Aboriginal Family and Child Protection Workers.

DCF are making a submission to the Northern Territory Select Committee on Youth Suicide and will provide further details of these services. The DoH and DCF are committed to working closely together to share information and target those programs which have the most influence in reducing self harm and suicide and in strengthening mental health and wellbeing.

Northern Territory Department of Education and Training (NTDET)

A range of mental health and social emotional wellbeing programs well placed to contribute to suicide prevention amongst young Territorians are currently in place within NTDET. Programs include 'Mindmatters' (a program delivered in secondary schools) and 'Kidsmatter' (a program delivered in primary schools). NTDET also fund and support a comprehensive network of school counsellors throughout the NT.

A Summary of NTDET Programs and Activity in the context of these programs is at *Section A in Attachment 9*.

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Northern Territory Police

NT Police are a vital front line service in suicide prevention. Police are often the first on the scene and also respond to threats of suicide in both urban and remote communities. Police work closely with mental health services in response to crises in the community.

Police have indicated they intend to submit a response directly to the Select Committee on Youth Suicide.

Department of Housing, Local Government and Regional Services (DHLGRS)

DHLGRS delivers social housing programs and related infrastructure across the Territory, and seeks to build stronger regions and communities through sustainable economic development and effective local government.

DHLGRS provides a range of programs relevant to suicide prevention approaches including services to address housing and homelessness, local government, regional and community services and remote service delivery coordination.

A Summary of DHLGRS Programs is at *Section A* in *Attachment 10*.

Targeted Suicide Prevention Programs currently funded through the NT Department of Health Mental Health Program

The NT Mental Health Program first identified suicide as a major concern in the early 1990s and since this time has been working with limited resources to raise the profile of this area and establish services and programs to address this issue.

Life Promotion Program, Central Australia

In Central Australia, the Life Promotion Program (LPP) provides suicide prevention, education and training and a coordinated response to suicide in the region.

The program is based in both Alice Springs and Tennant Creek and is coordinated by the Mental Health Association of Central Australia (MHACA). This approach works well in this region as the population and agencies are small and know each other well. The group meets to coordinate support post-completed suicide.

MHACA Life Promotion Program also formulated the highly regarded "Suicide Story", in collaboration with indigenous communities. Suicide Story is an Indigenous-specific training tool to help create suicide safer communities and families. It includes a DVD comprised of short films that feature the voices of Indigenous people. Animation, art work and music combined with these voices focuses on nine issues relevant to suicide, and the DVD accompanies a full 3-day program.

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The aim of Suicide Story is to provide an Indigenous specific training resource to contribute to an increased level of understanding about suicide and the skills necessary to intervene when someone is a risk.

Accidental Counsellor, Central Australia

“Accidental Counsellor” was developed by Lifeline Central Australia for people who do not have training in counselling but might find themselves in situations where they are placed in the counselling role i.e. reception staff. The two day workshops are delivered to school teachers, support staff, youth workers, and staff in mental health services in Central Australia. The Sixth 2 day workshop since the program’s introduction is currently underway.

Applied Suicide Intervention Skills Training” (ASIST)

The LivingWorks “Applied Suicide Intervention Skills Training (ASIST) is delivered by Mental Health Services, Anglicare NT, and Lifeline Central Australia. The ASIST model provides practical help for caregivers seeking to prevent the immediate risk of suicide and is the most well regarded suicide-prevention training program across Australia.

Participants learn to recognise and review suicide risk and develop intervention skills. The emphasis is on suicide “first aid” – helping a person at risk, to stay safe, and seek further help. The program enables participants to make an initial response and become a link to ongoing community help for a person at risk of suicide.

There are continual requests from organisations such as Justice, Police, Health, Education, and NGOs within the NT to train front line workers in this program as well as general community members.

Safetalk, Central Australia and Top End

Safetalk is a half day training program, which can run either as a stand-alone or precursor to ASIST. The program focuses on teaching participants to recognise and engage people who might be having thoughts of suicide, and then to connect them with community or other professional resources trained in suicide intervention. It is an appropriate training program for front-line workers and community members interested in broadening their knowledge in this area. It can also be used with young people over the age of 15.

Safetalk has been delivered to 33 communities in the Top End by AngliCare NT, with further workshops delivered in 2011 in Wadeye, Maningrida, Darwin and Howard Springs. AngliCare are also funding an Indigenous trainer in the East Arnhem region to deliver this program in language within communities that have been experiencing high rates of self harming behaviour. In Central Australia, Safetalk has been delivered in three communities to 402 individuals by Lifeline Central Australia since 2010.

Response to Suicide in the Top End

In the Top End, suicide prevention and response services are provided through a range of Government and non-Government agencies including Top

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End Mental Health Services (TEMHS), Anglicare, and the NT Division of General Practice. However, unlike Central Australia, no one agency can provide a coordinated response across the Top End as the environment is much more complex. TEMHS provide support to the primary health centres as requested when a completed suicide occurs. Networks to address the issue of suicide in regional areas in the Top End are emerging. However, these require additional support to enable more effective coordination.

The true measure of all these programs is their effectiveness in preserving life however anecdotal feedback about acceptance, uptake and relevance of programs is currently the best guide to their strengths and weaknesses. Scientific factor analysis is almost impossible, due to multiple coexisting strategies and statistically small counts and the need to sustain the factor analysis over many years.

Both national and international evidence suggests that suicide prevention training programs have a significant impact on reducing rates of suicide within a community. The existing training programs in the NT, including ASIST, Suicide Story, Safe Talk and Accidental Counsellor have generated very positive feedback.

CounterPunch

CounterPunch is a new initiative funded by the NT Government through the Mental Health Program from 2011/12. Using the appeal of sport to youth, *CounterPunch* targets the physical and mental wellbeing of young people aged 10 to 25, combining the physical medium of amateur boxing with a psychological intervention and life skills program.

Referrals to the program come through schools, organisations servicing youth such as Mission Australia and *headspace* and through self referrals. *CounterPunch* shows particular promise for maintaining engagement of at-risk youth for sufficient duration to instil knowledge and provide avenues for personal development through sport and the relationships across age-groups and social divides built during training.

The program will initially be delivered in Darwin. A number of remote communities have expressed interest in the program and expansion of the program will be piloted. A train the trainer model is also being established and it is anticipated that participants will share knowledge with peers, ultimately benefiting many other young people.

CounterPunch will compliment more universal programs such as the Clontarf, as it will target young people who may be disengaged from school, and those who would benefit from more intensive individual or group participation. Strong interest has been expressed by local schools and other organisations and referrals of young people have been received. Services have commenced on a part-time basis, however these will be ramped up when the program moves to dedicated facilities in November 2011. Evaluation of the program will commence at this time.

For more detail on the policy context and historical funding for suicide prevention initiatives in the NT refer *Section A Attachment 11*.

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Current Commonwealth Funded Programs in the NT

Commonwealth funded programs active in the NT that are relevant to the Committee's Terms of Reference are as follows:

headspace NT

Headspace services have been established in both Palmerston and Alice Springs.

The aim of these services is to improve access to mental health and wellbeing services for young people aged 12 to 25 years by bringing together local youth mental health, drug and alcohol, primary care and education, training and support agencies. Each *headspace* service has been established by a consortium of local agencies working in partnership to facilitate provision of more coordinated, integrated and holistic care for young people.

Anglicare NT is the lead agency for *headspace* Top End. The consortium also includes the Department of Health (DoH) Mental Health Program, the General Practice Network of the NT (GPNNT) and Danila Dilba Aboriginal Medical Service.

Central Australian Aboriginal Congress is the lead agency for *headspace* Central Australia. The consortium includes the DoH Mental Health Program, the Mental Health Association of Central Australia, GPNNT and Alice Springs Youth Accommodation and Support Services.

Both *headspace* sites have now received confirmation of on going funding from the National Youth Mental Health Foundation for a further three years until 2014.

The new funding agreement is \$450 000 per site with some discretionary funding for sites that incur additional oncosts such as rent. *headspace* Top End will receive an addition \$174 000 in discretionary funding per annum to 2014. *headspace* Central Australia will receive discretionary funding of \$144 000 per annum until 2014.

Since opening in June 2008 *headspace* Top End has seen over 1150 young people and provided over 8000 occasions of service (an occasion of service is any contact in relation to the young persons care).

58% of the total number of young people seen is female with 42% male.

The most common presenting issue is recorded as depression, anxiety, behavioural problems and substance use.

OzHelp

OzHelp provides a range of activities and awareness sessions that promote mental health wellbeing in male dominated workplaces, specifically tradespeople and apprentices.

Activities include 'OzConnect' promotional barbeques. In 2010, OzHelp conducted 529 support visits on and off site, post OzConnect. They conduct 20 minute health screens on-site, suicide awareness and prevention training

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and alcohol and drug awareness training. A Graduate Development Programme re diet/budget/health for white collar workers, is also being developed and will be taken to the Top End in 2012.

OzHelp Programmes 2010-2011

OzHelp run a 20 minute "Tradies Tune Up" health screen with a nurse and Ozhelp Field Officer. 45 individuals participated in this initiative in 2010 with more expected in 2011. Other training provided in 2010 consisted of:

- General Awareness Training (GAT) – one hour suicide awareness training delivered to 524 tradespeople in 2010 and 528 (YTD) in 2011.
- Safetalk – 3 hour Livingworks Suicide Prevention Workshop – In 2011 there have been 87 participants in this program (including managers, workers and apprentices and 41 CDU trades lecturers).
- Other courses provided are Mental Health in the Workplace, Resilience and Assertiveness, Conflict Resolution, Communication in the Workplace and Workplace Bullying.
- Ozhelp trained 35 apprentices in Gove in Safetalk, Mental Health at Work and some Drug and Alcohol awareness training in 2011.
- ALERT training (1 hour awareness training) suicide awareness for Managers and Occupational Health has also been provided.

ATAPS Suicide Prevention Service in Darwin, GPNNT

The General Practice Network NT (GPNNT) administers the Access to Allied Psychological Services (ATAPS) Suicide Prevention Service as part of the Commonwealth Better Outcomes in Mental Health Care program. This suicide prevention service enables GPs to refer consumers at risk of suicide to private sector allied health professionals remunerated by the program. Phone referrals are triaged according to the urgency of the problem.

The psychologist contacts the client within 24 hours and makes a face to face appointment within 72 hours. Once clients are referred, they can also utilise after hours support. Currently the program is only offered in Darwin, by one psychology service.

It is envisaged this program will expand to Alice Springs in the transition phase to the NT Medicare Local and later be expanded to include a range of allied health providers over a broader area. Further detail about this program is available on the GPNNT website.

FAHCSIA Youth in Communities program

Funded under the Closing the Gap in the NT - Youth in Communities program maintains and strengthens youth services in the NT. See *Section A* in *Attachment 12* for program details.

Save a Mate (SAM)

An initiative of the Australian Red Cross, the *Save-a-mate* (SAM) program provides education, training, first aid services, and support to young people on

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health issues with a particular emphasis on mental health and alcohol and other drug use. The SAM program has three major components:

1. education and training - aimed at young people and those who work with youths. The following training courses are offered through SAM: the alcohol and other drugs emergencies course; alcohol and other drugs peer education; mental health peer education; and SAM 'our way';
2. festivals and events - volunteers attend festivals and events to provide health related services to young people; and
3. health promotion and advocacy - using public relations, the internet, and activities with young people, SAM seeks to promote health behaviours among youths. SAM is also involved in advocacy, participating in steering and advisory bodies.

The SAM program recruits young people, usually aged 18-30 years, to the deliver its services to other young people aged 12-25 years. The program has been designed to target a broad range of youth groups, including (but not limited to) at-risk youths, Indigenous groups, rural and remote youths, and injecting drug users.

With regard to Indigenous youths, a pilot program, *Save-a-mate 'our way'*, is underway with Indigenous youth in the NT. This program is primarily aimed at young Indigenous people and focuses on issues of health and wellbeing. The emphasis is on delivering the program in a culturally appropriate and relevant way.

In the NT SAM-our way is a program jointly funded by Beyondblue and Red Cross, delivered by Red Cross in some NT Indigenous communities. The program engages young people and uses a yarn style to build trusting relationships which then leads to specific training on: building the resilience and skills of young people to support themselves and each other, mental health issues, alcohol and other drug issues, youth leadership and peer skills.

New Commonwealth Funding for Mental Health

The Commonwealth Government announced an additional \$1.5 billion over 5 years, to deliver on its commitment to make mental health a national priority.

Initiatives in the 2011/12 Budget included:

- \$571M over 5 years to expand services and improve coordination for people with severe mental illness;
- \$343.8M 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.

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The proportion of the new funding and services that will be available to Territorians is not clear at this stage. Most of the funding will be allocated to NGOs, most likely through a competitive tender process.

It is likely the Territory will receive some additional funding for *headspace* services, Personal Helpers and Mentors and other existing NGO programs already funded by the Commonwealth under the *COAG National Action Plan on Mental Health 2006-2011*.

Some new initiatives will require matched contributions from States and Territories, including Early Psychosis Prevention Intervention Centres (EPPIC) and services implemented under the new National Partnership on Mental Health. States and Territories will be required to tender for funding for these services on a competitive basis.

Additional ATAPS funding for psychological services has also been allocated to assist people who are currently unable to access private psychological services on a fee for service basis through Medicare.

Commonwealth Funding announced in 2011

- \$197.3M has been allocated for an additional 30 new *headspace* sites and to reduce current waiting times. *headspace* provides early intervention services to 12 – 25 year olds. In the NT it does not make sense to establish a new *headspace* site, rather expand the capacity of the existing sites in Darwin and Alice Springs;
- \$222.4M has been allocated for an additional 12 **Early Psychosis Prevention and Intervention Centres (EPPIC)**, bringing the total number of new centres funded to 16. Early psychosis services focus on providing service to young people between the ages of 16 and 25 years who are experiencing a first episode of psychosis. Services aim to intervene earlier and provide more intensive treatment and support to improve outcomes and minimise long term psychiatric disability associated with chronic psychosis and the accompanying distress/trauma experienced by the young person and their family. This cohort is also at high risk of suicide

Unlike other health conditions, the highest burden of mental illness is experienced in this age group, and health services are ill equipped to respond.

Implementation of this initiative will require matched contributions from States and Territories. When the initial four sites were announced a 60% Commonwealth and 40% States/Territory funding split was proposed. The cost of each site was estimated to be a total of \$2.5M, thereby requiring a \$1M State/Territory contribution. The costs of establishing a centre has been revised to between \$5M for a population of 350 000, up to \$10M for a population of 1 million. States and Territories will be required to contribute a minimum of 50% of the operational costs and 100% of capital costs. Strict adherence to the EPPIC model is required.

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The Commonwealth has indicated it may consider a more flexible, scaled down version in the NT.

- The Commonwealth has commenced negotiating a new **National Partnership on Mental Health**. \$201.3M over five years for incentives to states and territories to address major service gaps in mental health services including accommodation, emergency departments and community-based crisis support has been allocated. There will be no guaranteed allocation for each State and Territory. States and Territories will access this funding pool through a competitive process. The Commonwealth will seek co-investments from the States and Territories to leverage greater investment. There is no guaranteed allocation for each State and Territory.
- \$11M over 5 years in building strong and healthy kids, to help build resilience and identify emerging mental health problems early. This will include development of **Mental Health and Wellbeing Check** to be included in the Healthy Kids Check for children three and four years old.
- \$1.5M for a **Social Engagement and Emotional Development (SEED) survey** for 8 to 14 year olds.
- \$61M to double the number of **Family Mental Health Support Services** (from 40 to 80). These services provide a way for families to get help for their children who are showing early signs of problems, or at risk of mental illness, outside of the clinical mental health system.
- \$220M over 5 years to **improve access in the primary health care** system for people with mental illness; and
- \$205.9M to expand the **Access to Allied Psychological Services (ATAPS)** program to better ensure mental health services are targeted to those who need them most, including children, Indigenous communities and socio-economically disadvantaged communities. ATAPS is currently administered through Divisions of General Practice. This should increase access to psychological services in the NT, although access will still be limited by where these services can be provided.
- \$14.4M to establish a single **mental health on-line portal**. This will provide easy, "One Stop" access to evidence-based online psychological therapy. Online mental health therapy provides an alternative means off accessing services for people who can't, or don't want to, access a service provider face-to face.
- \$32M to establish a National Mental Health Commission to increase accountability and transparency, including \$12 million in new funding. The National Mental Health Commission will be established within the Prime Minister's portfolio, and will report back to the Parliament.

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- \$2.4M to increase employment participation for people with a mental illness to build the capacity of employment services providers to identify and better assist people with mental illness to secure employment, and is in addition to the new Building Australia's future Workforce Package, also announced in the Budget.

New Commonwealth Funded Suicide Prevention Initiatives

The Australian Government announced as part of the broader \$1.5 Billion dollar investment to make mental health a priority, including a targeted package of initiatives aimed at tackling suicide.

Boosting the capacity of crisis hotlines, including Lifeline (\$18.1m)

This funding will be provided to Lifeline Australia to increase the capacity of their support hotlines. Lifeline currently receives around 450 000 per year. Almost 6 per cent of these calls involve a high risk of suicide. This additional funding will enable Lifeline to increase their call capacity by around 60 per cent to around 700 000 over time.

The additional funding will also enable calls to Lifeline from mobiles to be toll-free. More than half of all callers to Lifeline are from mobile phones, which frequently attract higher call costs. High call costs can be a real barrier to people seeking crisis counselling services.

Lifeline will also be provided with funding to establish dedicated lines at suicide 'hotspots' so that people who are actively contemplating suicide and have taken the step of going to a destination where they could commit suicide, have help at hand.

Mental health first aid' training: for frontline community workers (\$6.1M)

Under this initiative, funding will be provided to train front line community workers, such as financial, legal and relationship counsellors, and healthcare workers, to better identify and respond to the needs of people at risk of suicide or who have attempted suicide in around 40 regions around Australia.

Improving safety at 'hotspots' (\$9.0M)

To reduce access to common means of suicide, capital funding will be provided to local governments to improve safety and infrastructure at notable suicide 'hotspots', for example by improving fencing barriers, night lighting, and closed circuit television monitors.

This is in addition to the funding which will be provided to Lifeline to establish dedicated phone counselling lines from 'hotspots'. This funding is not relevant to the NT context given the specific criteria to be met in order to access the funds.

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Outreach teams to schools (\$18.7M)

An estimated 2 to 3 high school aged young people die by suicide each week in Australia. This measure will fund a nationwide network of mental health promotion officers, to provide outreach services from local *headspace* sites or psychology services, to work with government and non-government school-based mental health workers and provide counselling and other support to school communities in the event of a school student suiciding.

Supporting communities to reduce risk of suicide (\$22.4M)

This initiative will provide funding to support community-led suicide prevention activities targeted at groups and communities which are at high risk of suicide, including Indigenous people, men, gay, lesbian and bisexual people, and families and colleagues recently bereaved by suicide.

Activities funded under this initiative could include training community leaders to better identify and respond to suicide, and activities to better build resilience and positive mental health. For example, in Indigenous communities, brokering visits by elders from communities that have successfully responded to suicide clusters in the past to communities currently experiencing a spate of suicides, to help these communities build their own responses to their community circumstances.

Expanding the National Workplace Program (\$11.0M)

Funding will be provided for the National Workplace Program currently delivered by Beyondblue, which helps workplaces identify and support workers with depression who are not receiving treatment.

An additional 350 workplaces each year will benefit from being assisted to identify and support workers with depression. The expanded program would target particular sectors (such as blue collar work and trades) and subsidise increased participation by small businesses.

Increasing the capacity of helplines for men (\$2.8M)

Beyondblue will be provided with funding to increase the capacity of their helpline to provide information and assistance to up to 30 000 more men each year. Helplines can be the first place that people in crisis will approach, with many men not having seen a doctor for their depression and not being in receipt of any medical treatment or support. Help lines provide an anonymous way to seek information and advice.

Targeted campaigns for men's mental health (\$9.0M)

Funding will also be provided with funding for targeted campaigns on mental illness for men to reduce stigma associated with mental illness and encourage more men to seek help for depression and mental illness. Stigma associated with mental illness is one of the major reasons men who have depression or other mental health problems don't seek help. These campaigns will target

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The Department of Health and Aging (DoHA) is close to finalising a process to engage the services of a consultant to develop the Strategy. There will be a requirement for the consultant to conduct an extensive consultation process with key stakeholders and communities to seek views on the appropriate mental health and well being approaches for Aboriginal and Torres Strait Islander communities. DoHA is also close to finalising the establishment of an Indigenous Suicide Prevention Working Group to guide the development of the Indigenous specific suicide prevention strategy.

National Suicide Prevention Program (NSPP)

The NSPP is the Australian Government funding program dedicated to suicide prevention activities. The funding allocation covers two streams of activities:

- *Community-based Projects*, impacting on issues at a local level; and
- *National investment*, largely taking a population health approach and supporting infrastructure and research.

The NSPP has made Aboriginal and Torres Strait Islander Australians a priority target group for funding. For the period 2009 -10 to 2010-11, \$11.6M (or 25% of NSPP funding) has been provided under the NSPP to 13 projects that provide services specifically targeted towards Aboriginal and Torres Strait Islander communities.

Case Study - Maningrida

There is currently some concern over an increased rate of completed suicides in Maningrida and an increase in self harm attempts. The DoH Mental Health Program has been liaising closely with the local reference group to identify concerns and plan a coordinated approach to these matters.

A report on the current situation in Maningrida is attached in the *Section B Confidential Attachment 3*.

The local reference group have also advised they intend to develop a local submission to refer to the Select Committee on Youth Suicide.

Summary of Tiwi Intervention

The Tiwi Islands had the highest suicide rate in Australia in 2002, with 10 completed suicides recorded. With a strong community response and support from government in a number of areas, this figure has been substantially reduced and the community is now thriving. *Refer Section A, Attachment 13* for a report outlining the actions taken.

Dr Robert Parker, Director of Psychiatry provided information for this report and has indicated that he intends to provide a separate submission to the Select Committee on Youth Suicide.

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Reporting and Research

There are substantial differences in suicide statistics between Australia as a whole and the NT and further differences in suicide profiles between various communities in the NT. Interventions need to be based on the best available evidence from Australia and overseas together with local responses based on research of local factors.

Reliable reporting of numbers of suspected and confirmed suicides is achieved by the Coroner's Office. However, the coronial process results in a time lag between reports of suspected suicide and determination of the cause of death, which may not be suicide. This time lag can be in excess of a year if the death is subject to a full Coronial inquest. Thus there is not only a potential discrepancy between suspected and confirmed cases of suicide, but also a discrepancy between the year of the event and the year of the Coronial finding.

This explains, in part, minor differences in the year to year statistics from the Australian Bureau of Statistics (ABS) and the NT Coroner. Coroners around Australia are working towards uniform reporting but differences remain between jurisdictions. As stated previously, a reworking of data from previous years by the ABS resulted in little revision of NT statistics but markedly increased suicide rates for some jurisdictions, notably Queensland.

As in other jurisdictions around the world, there is debate about including deaths caused by risk taking, such as many single vehicle motor accidents, in suicide data. There is also a general reluctance by Coroners to make findings of suicide when any doubt exists as to a person's intent, so some findings of accidental death may, in other analysis, be counted as suicide. Reports of suspected suicides from unofficial sources have been found to be misleading and are not utilised. These caveats apply to all jurisdictions.

Attempted suicide data

Reporting and recording of attempted suicide is complex and unreliable and not currently undertaken in the NT or any other jurisdiction in a coordinated manner (with the possible exception of WA). Reports from multiple sources can easily include multiple counts of one event unless the identity of the person is able to be recorded accurately within confidentiality boundaries.

A further complication is the difficulty of defining what to include in a spectrum ranging from suicide threats to near-death requiring hospitalisation. For example, information from police about call-outs for suicide covers a great range of severity, and would overlap with information provided by hospitals about patients seen in Emergency Departments classified with suicide risk.

There has been initial inter-agency discussion about the potential benefit of information sharing and collation to aid in identification of those at elevated risk to enable targeted intervention. If confidentiality, technical and resource limitations are overcome, data from this source could enhance both research and service planning.

A feasibility study will be commissioned by the Mental Health Program in 2012/13, funded through the recent NT Government allocation. The study will

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consider current recording of suicide attempts across the various systems collecting this information to develop and coordinate a framework for suicide related information management and analysis better equipped to inform suicide prevention activity.

Inter-Departmental Cooperation

The effectiveness of the interventions of individual agencies is hindered by a lack of collaboration between agencies and programs, despite any willingness of agencies to engage with each other. Barriers to collaboration include the proliferation of small programs consequential to short-term fragmented funding, confidentiality impediments, and incompatible information systems. Information sharing would help to compile individual risk profiles. However, the risk factors are often of a sensitive nature. Examples include history of sexual abuse, involvement of child welfare, legal problems, substance misuse, and mental health history.

Complete information from all sources is collated following a suicide, 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. Relaxing confidentiality requirements is a serious matter and a cost-benefit analysis is indicated before there is further consideration of this. It is recommended that this be undertaken as part of a project investigating suicide information management.

Recommendations

The Mental Health Branch makes the following recommendations:

- 1) That Suicide Prevention is included as a standing item on a high level interdepartmental committee (for example, the Community Safety Working Group).
- 2) That ongoing funding is committed to existing programs funded under the NT Emergency Response that are aligned with suicide prevention. Owing to the importance of sustained interventions, and the long-term nature of changes needed to reduce suicide rates, existing programs that are demonstrating evidence of effectiveness or even just promise should be sustained.

For example, if sporting and diversionary projects funded under the NTER Closing the Gap in the NT Youth in Communities (YiC) Program are discontinued, not only will youth be without the recently introduced supports, they will also feel devalued by their activities being discontinued. These programs require recurrent funding. See Section A Attachment 10 for information on YiC projects.

- 3) That a six month project is commissioned to develop and coordinate a framework for suicide information management, including information about at-risk individuals and information for improved statistics following completed suicides. This can be undertaken within the additional Mental Health funding for Suicide Prevention.

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- 4) That capacity to share/report information across systems to enable information exchange within and across departments is scoped.

The current inability of various computer systems to talk to each other inhibits the timely exchange of relevant clinical information. In contrast, the changes made to the Community Care Information System (CCIS) database recently enable DCF, Alcohol and Other Drugs, Aged and Disability and Mental Health programs to see when each has an active case and who to contact if exchange of limited information is justified. It is suggested that this be expanded to include the Primary Care Information System database, and that CCIS is included in the scope for the E Health initiative.

- 5) That the Mental Health Program liaise with agencies in Western Australia who are working on similar issues, particularly in the Kimberley region, to exchange information on strategies and interventions found helpful (including Commonwealth funded suicide prevention initiatives).
- 6) That further analysis of adult suicides on the coronial database similar to that undertaken on child suicides by Menzies School of Health Research for the Suicide of Children and Youth in the NT 2006-2010 report is commissioned utilising the additional NTG Suicide Prevention Funding.
- 7) That the Mental Health Program work with research organisations like the NT Child Development and Education at the Menzies School of Health Research to access funding such as that provided by the National Health and Medical Research Council and Australian Research Council through partnership or linkage grants which match the cash and in-kind contribution of applicants to undertake research.
- 8) That funding is increased for ASSIST training. There is an unmet need for training that cannot be fulfilled within the capacity of existing ASSIST trainers.
- 9) That a response to any emergence of clusters of suicide or suicidal behaviours in communities builds on established relationships within the community and supports existing community structures. The nature of additional resources offered should be negotiated with the community and in collaboration with agencies providing existing programs in the community.
- 10) Develop and Coordinate services in partnership with other organisations to respond to spikes in suicide and self harm in particular communities or populations.
- 11) That further place-based mapping of services be undertaken to assist in the coordination of appropriate suicide prevention activities and response.

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12) That support for emerging suicide networks in the Top End is increased to enable more effective suicide prevention and response in regional areas. In Darwin, the Darwin Regional Indigenous Suicide Prevention Network (DRISPN) has recently been established. \$5000 seed funding was provided by Wesley Mission. More financial assistance is currently being sought by DRISPN to establish a website and provide resources.

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13) That a Telepsychiatry Service to Growth Towns is established. Establishing a clinical Telepsychiatry Service, utilising Digital Regions Initiative infrastructure, would enable increased support to remote primary health services and individuals in remote communities. This would expand access to specialist mental health services, at a reduced cost, and increase capacity to treat more people when they are in crisis.

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Public mental health services in the NT see a higher proportion of the population than public mental health services in any other jurisdiction. However, the number of contacts each individual receives is the lowest of all jurisdictions, largely due to the dispersal of the population.

Videoconferencing is a cost effective way of delivering more immediate specialist mental health assessment, consultation and follow up services to individuals in remote communities, and would reduce the number of evacuations to acute units.

The service would complement the existing visiting specialist services, facilitate increased access to sub-speciality services, such as forensic services and services for young people in regional centres and remote communities, and provide increased support, education and training opportunities for remote staff.

To compliment the establishment of the remote Telepsychiatry service, it is also proposed to progressively increase the number of Aboriginal Mental Health Workers based in remote communities to provide day to day support to people with a mental illness and undertake suicide prevention activities.

Many of the Territory Growth Towns identified increased mental health services as a priority in their Local Implementation Plans (LIPS), and additional Aboriginal Mental Health Workers would be based in these communities.

14) Consideration be given to expanding the scope of existing safe houses established in a number of communities to provide a safe environment for individuals at immediate risk of suicide. This model would need to consider also including off-site support from mental health services (through the 1800NTCAT 24 hour telephone triage and crisis response service).

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15) Develop and submit a tender to partner with the Commonwealth Government to establish an EPPIC centre in the NT that is adapted to suit the local context and service environment.

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- 16) Develop and submit a tender to partner with the Commonwealth Government under the National Partnership on Mental Health Reform to address service gaps in the NT including services for young people who present in crisis to emergency departments or other relevant services.
- 17) That the Mental Health Program and other non-government organisations participate in implementation strategies which will flow from the NT Early Childhood Plan currently being developed under the leadership of the Department of Education.

Links and References

A number of helpful weblinks and references relevant to suicide prevention in Australia and the NT have been provided at *Section A Attachment 14* for the Committee's consideration.

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SECTION A

ATTACHMENTS

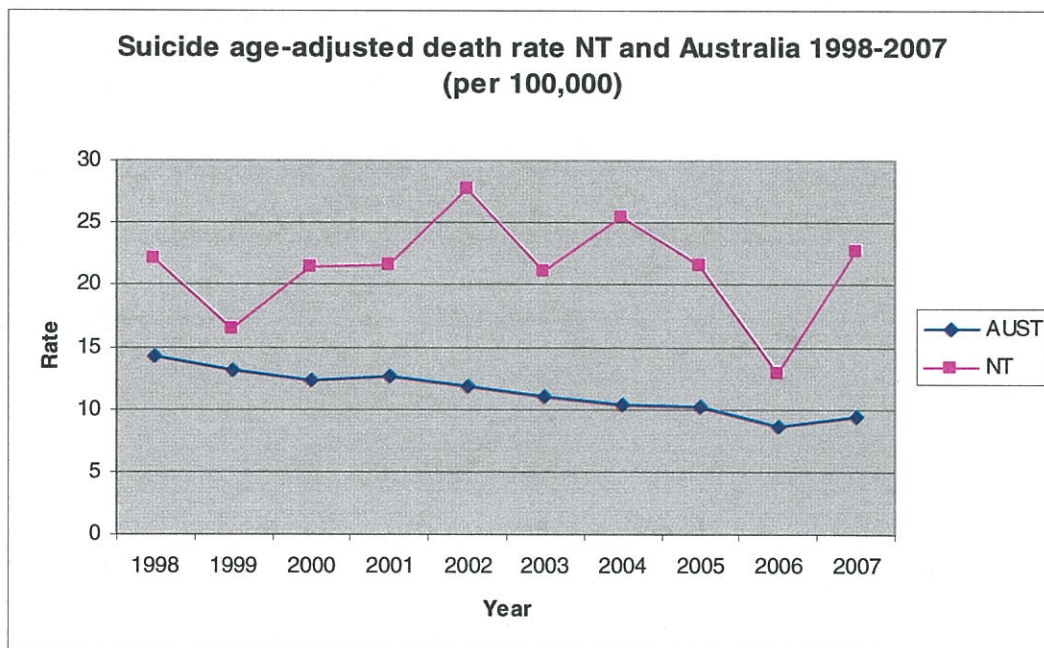
Section A - Attachment 1

REVIEW OF NT SUICIDES WITHIN AUSTRALIAN CONTEXT

Suicide is a significant issue for the NT. It occurs across all demographics and in a range of locations from urban Darwin to remote regions of Central Australia. The highest rates are noted in young Indigenous males and older non-Indigenous males.

The differing time-periods for the data highlighted in this submission is due to the differing information available for these periods.

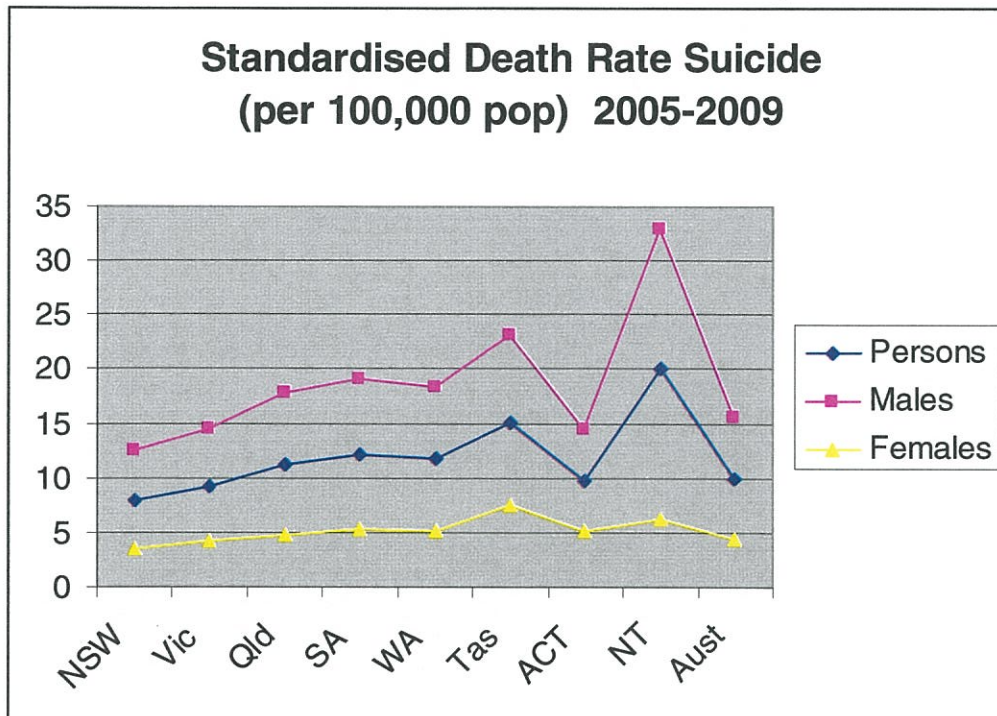
In the NT the annual number of deaths from suicide has increased substantially from the mid 1990s and reached a high in 2002. Since 2002 rates have continued to fluctuate with no sustained decrease.



Data source: ABS Death Registration Data

This trend has gone against currently reported national rates and although additional care in interpreting data does need to be taken in smaller jurisdictions where significant yearly fluctuations can be observed due to the relatively small number of suicide deaths, combined data for the period 2003-2007 suggested an NT suicide rate 22.8 per 100 000 compared to national rate of 9.8 per 100 000 for the same period (ABS 2009).

Although more recent ABS data indicates a slight decrease in the suicide rate, estimated to be 20.1 per 100 000 in the NT in the five year period 2005-2009, the NT rate is still double the National average



(Data Source: ABS 3303.0 Causes of Death, Australia, 2009)

The differing rates of suicide in the NT compared to the rest of Australia have to be viewed in the context of the number of different issues that affect the NT population.

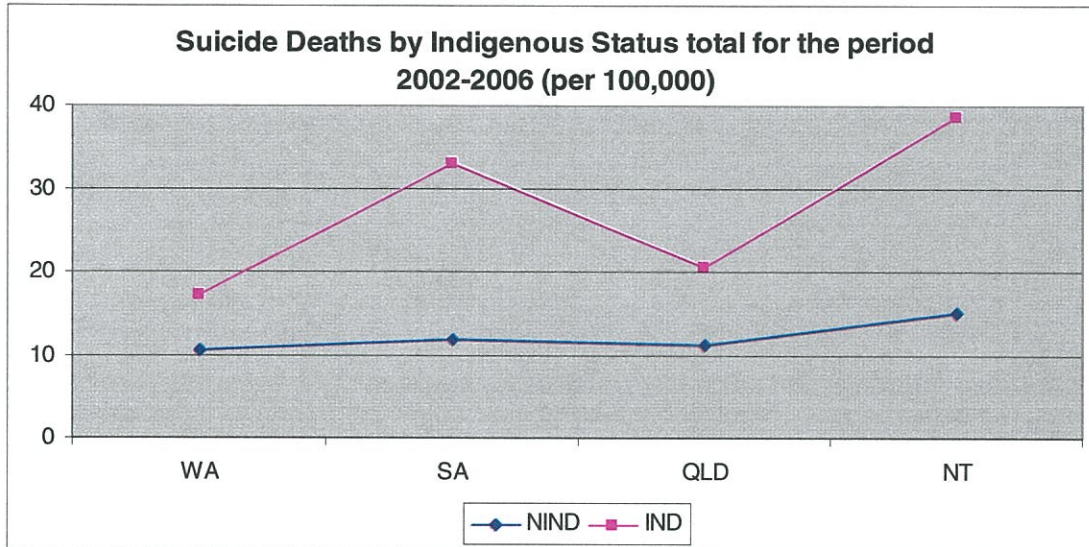
Indigenous Suicide

Suicides amongst Indigenous people in the NT occur in a range of contexts and can vary greatly between regions. In some areas there have been no reported deaths from suicide, or deaths are rare and occur in isolation. There are other regions which experience high rates of suicide and self-harming behaviours.

Significantly more research is required to determine why this occurs and whether there are differences in risk factors and protective factors between communities with high rates of self-harm and those where suicidal behaviour is rare or occurs in isolation.

The highest rates of suicide generally occur amongst younger Indigenous males, are often impulsive with strong links to alcohol and other drug abuse and occur in the context of relationship breakdown. (Measey, Li SQ & Parker, 2005).

Anecdotal reports also suggest that rates of attempted suicide and suicidal threats, particularly in some remote Indigenous communities, are exceptionally high, although there is currently limited data to support this.



Data source: ABS Death Registration Data

The four Jurisdictions in the table are the only Jurisdictions with reliable Indigenous status data.

Non-Indigenous Suicide

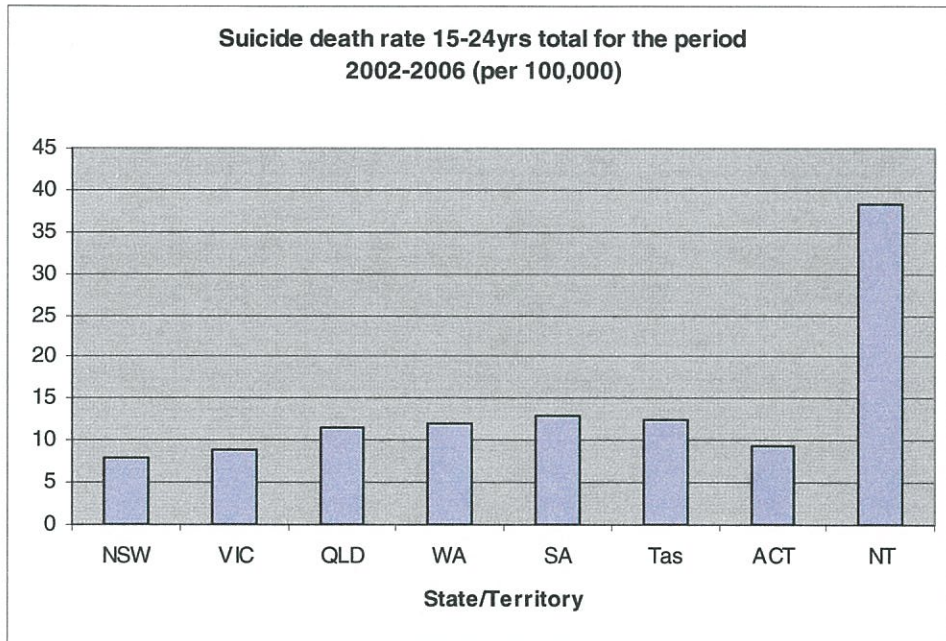
The difference between the proportion of deaths due to suicide amongst Indigenous and non-Indigenous people varies by State and Territory. In 2006, the biggest difference was observed for South Australia, where 7.3% of deaths of Indigenous people were due to suicide compared with 1.3% of non-Indigenous deaths. In contrast, in the NT 3.3% of deaths of Indigenous people were due to suicide, compared to 4.4% of deaths of non-Indigenous people (ABS 2008).

In 2006 the rates of suicide for the non-Indigenous population in the NT was higher than both the national average and rates in all other States and Territories (ABS 2008). Although significantly more research is required to understand why this is the case and to identify contributing factors, these rates should be viewed in the context of a higher male to female ratio, regional isolation and high rates of alcohol abuse.

Current information suggests that the majority of non-Indigenous deaths occur in males aged between 30-55 years old, residing in urban areas in the Top End region of the NT, often in the context of alcohol abuse and relationship breakdown.

Youth

The NT experiences higher rates of suicide in younger people than those experienced in many other parts of Australia. This is generally attributable to the high rate of suicide in the NT's Indigenous population in this age group. In contrast, among non-Indigenous males in the NT, the risk of suicide appears to increase with age (Measey, Li SQ, Parker 2005).



Data Source: ABS Death Registration Data

Anecdotal reports also suggest higher rates of self injury and other self harming behaviours in younger age groups. This issue also requires further investigation and research.

Section A - Attachment 2

Unconfirmed Suicide Data Sourced from notifications from the Coroner's Office 2005 – 2011 (August 2011 YTD actual estimated to full-year on a pro-rata basis)

Table One: Number of Unconfirmed Suicide Deaths by Region 2005 – 2011 (YTD - Estimated)

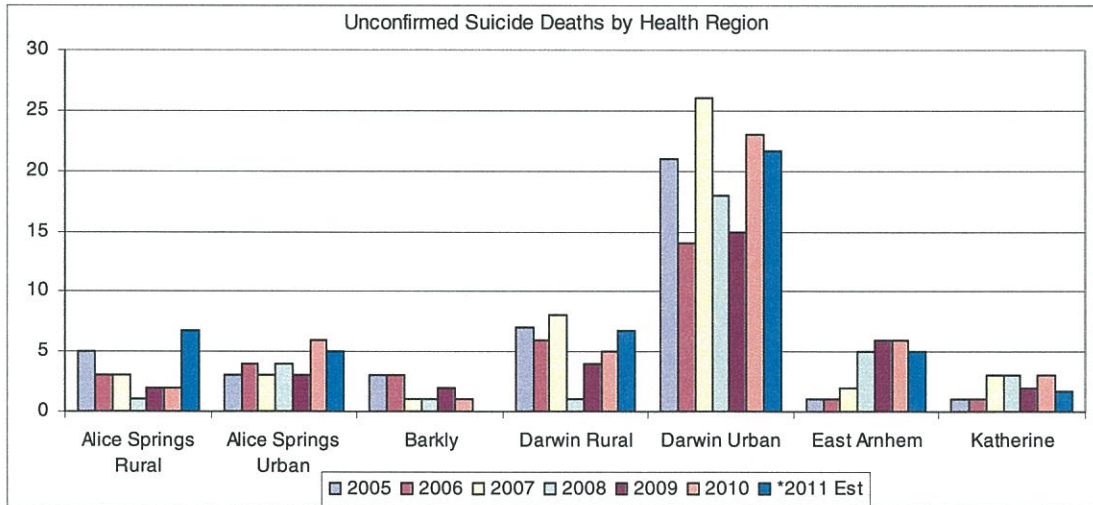


Table Two: Number of Unconfirmed Suicide Death Rates by Health Region per year 5 year average 2006-2010

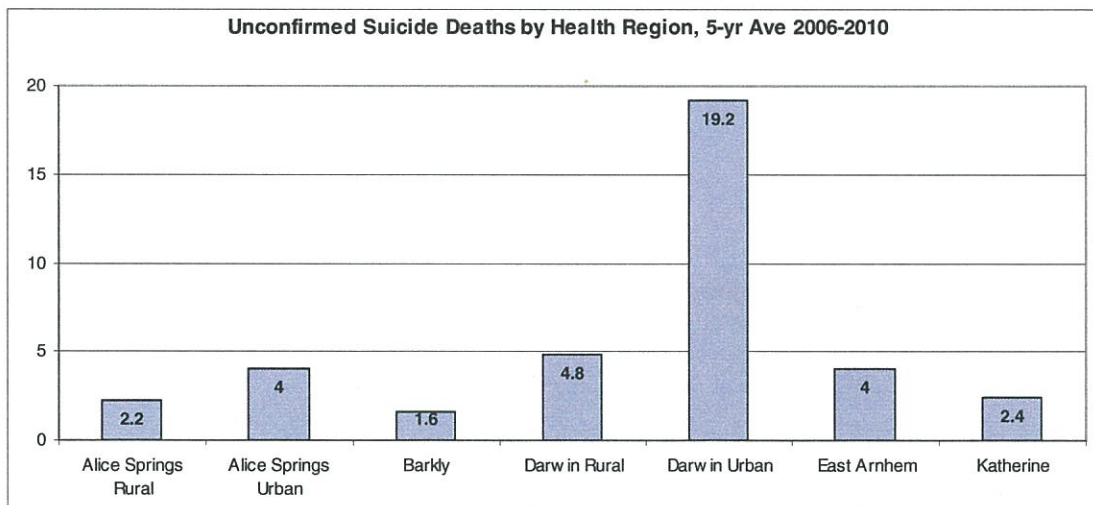


Table Three: Unconfirmed Suicide Death Rates by Health Region per year per 100 000 population 2005 – 2011 (estimated)

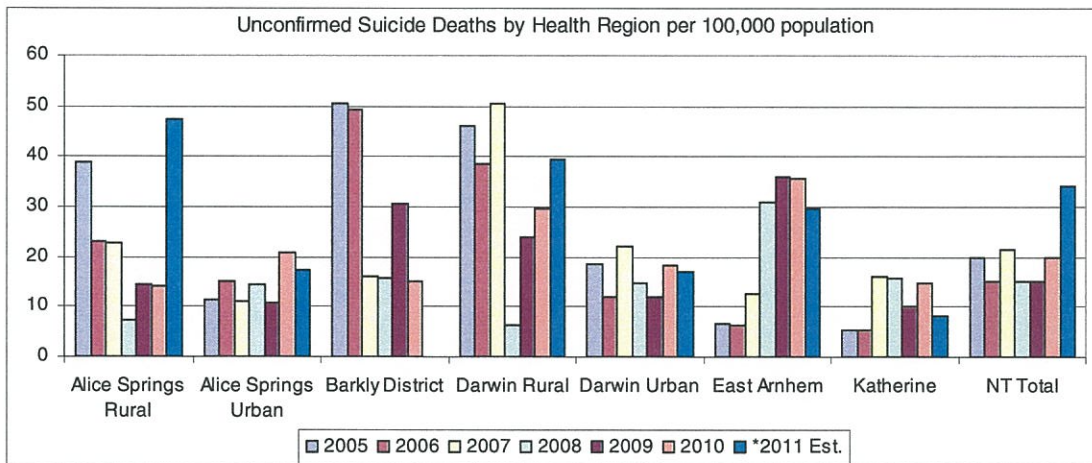


Table Four: Unconfirmed Suicide Death Rates by Health Region per 100 000 population 5 year average 2006-2010

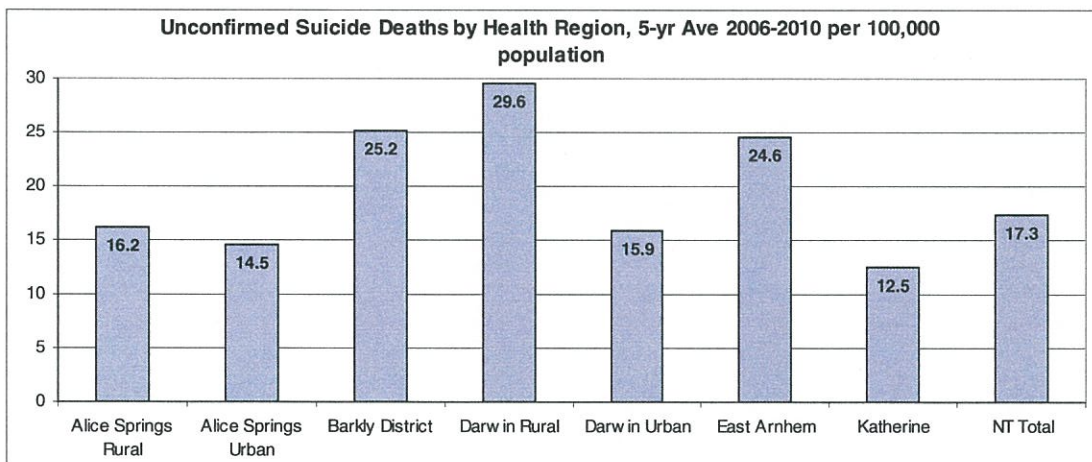
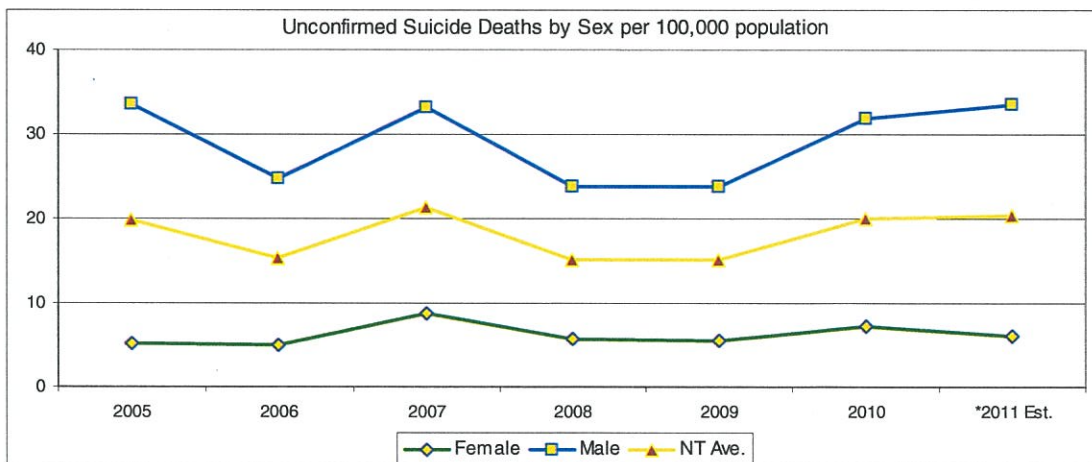
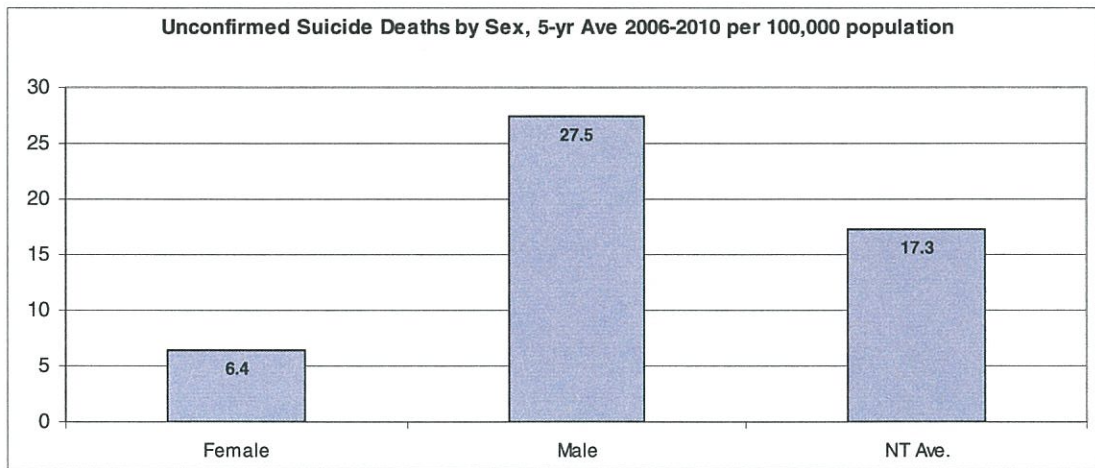


Table Five: Unconfirmed Suicide Deaths by Sex – 5 year average 2006-2010 per 100 000 population.



**Table Six: Unconfirmed Suicide Deaths by Sex - 5 year average
2006-2010 per 100 000 population**



**Table Seven: Unconfirmed Suicide Deaths by Indigenous Indicator
per year per 100 000 population**

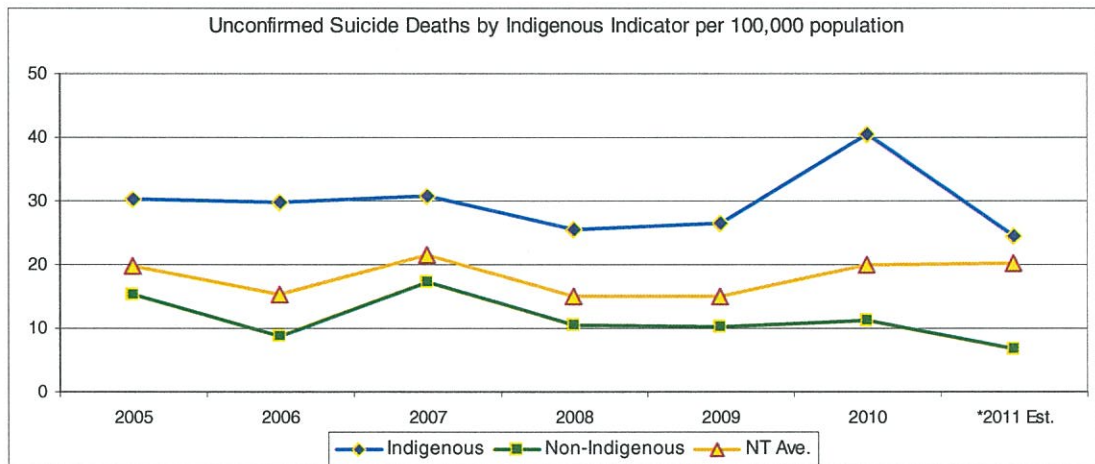


Table Eight: Unconfirmed Suicide Deaths by Indigenous Indicator, 5 year average 2006-2010 per 100 000 population

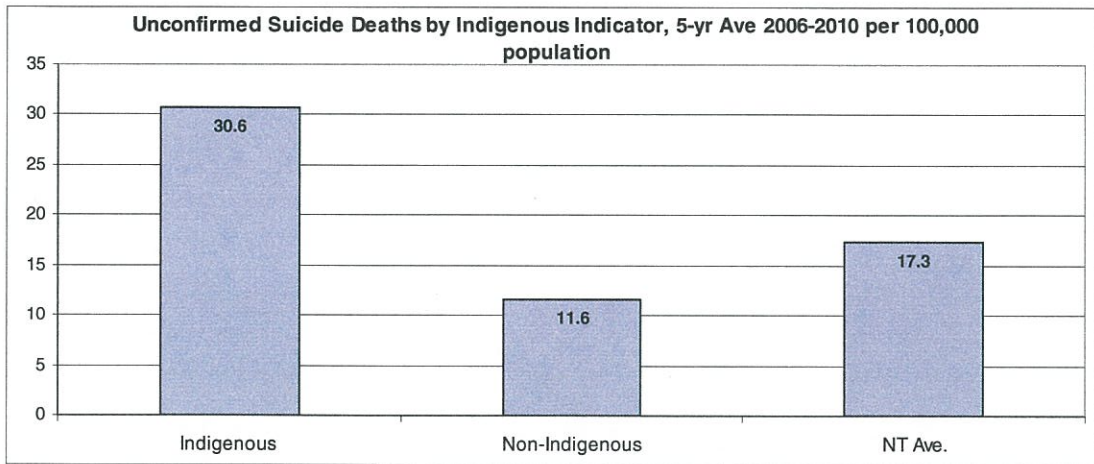
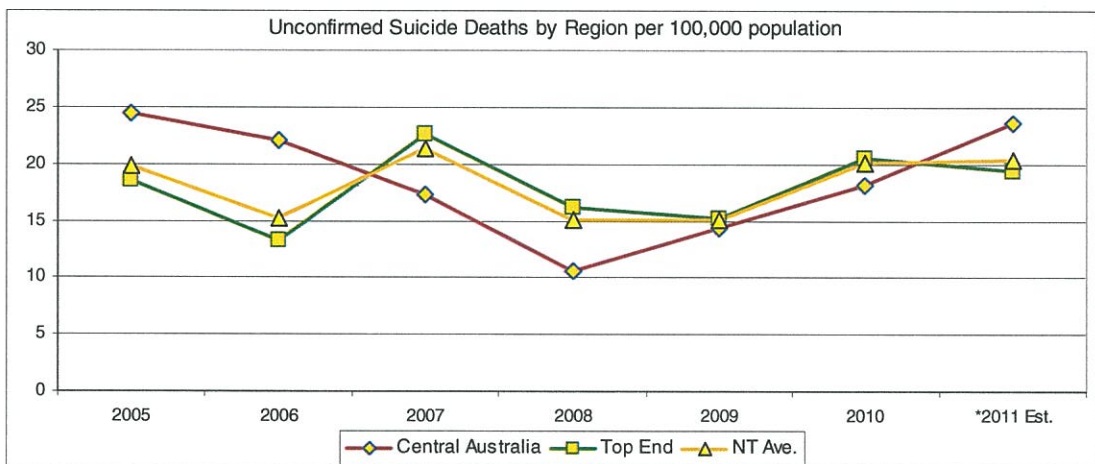
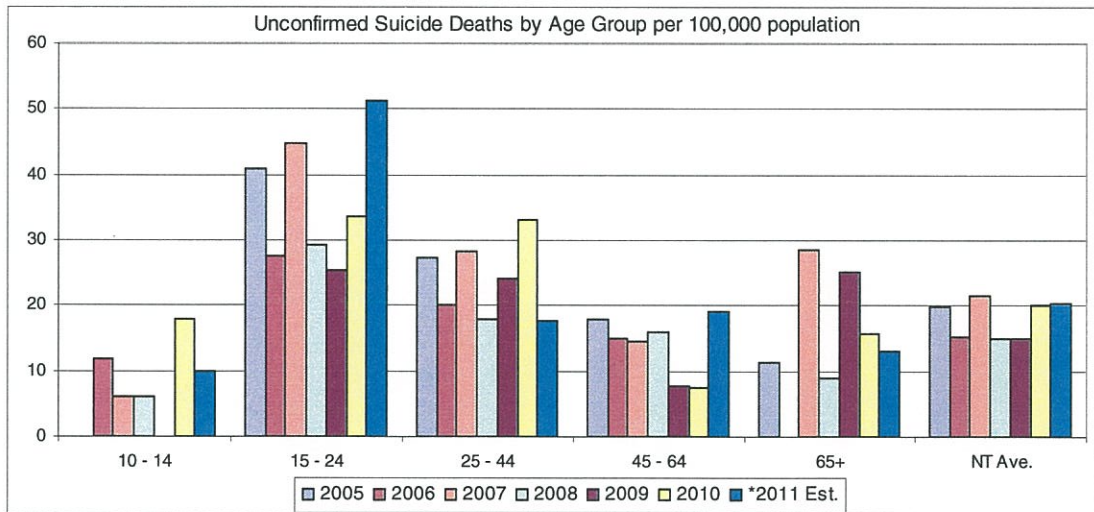


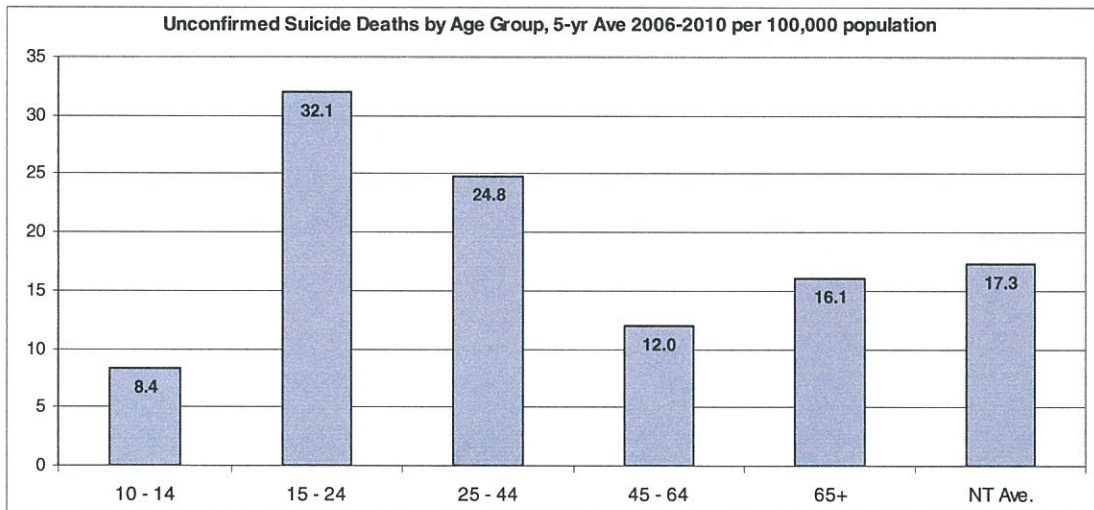
Table Nine: Unconfirmed Suicide Deaths by Top End and Central Regions per year per 100 000 population



**Table Ten: Unconfirmed Suicide Deaths by Age Group
per year per 100 000 population**



**Table Eleven: Unconfirmed Suicide Deaths by Age Group - 5 year average
2006-2010 per 100 000 population**



Risk Factors for Suicide

| Risk factors for suicide | |
|---------------------------------|--|
| Static | <p>Family violence</p> <p>Sexual abuse</p> <p>Physical health issues</p> <p>Low educational attainment</p> <p>Mental illness</p> <p>Substance abuse</p> <p>History of family suicide</p> <p>Previous self harming behaviour</p> <p>Inadequate housing</p> <p>Cultural issues</p> |
| Dynamic | <p>Current suicidal ideation</p> <p>Feelings of desperation, abandonment, hopelessness</p> <p>Current substance abuse</p> <p>Current diagnosis of depression or other mood disorder</p> <p>Other psychiatric illness</p> |
| Situational | <p>Isolation and loneliness</p> <p>Recent suicide of family or friend</p> <p>Recent loss, bereavement, relationship</p> <p>Recent stressful event</p> <p>In young people an identifiable stressful event precedes 75% of all suicides</p> |

Early Intervention

Clear-cut evidence for effective prevention in young people has proven difficult to establish. Nevertheless, there is increasing international evidence supporting an integrated approach covering many areas that includes the mental health of the individual to their family, their school and the wider community.

It is worthwhile studying the recommendations of the recently published *Improving the Transition: Reducing social and psychological morbidity during adolescence - A report from the (NZ) Prime Minister's Chief Science Advisor (May 2011)*, which devotes a chapter to reviewing the best available evidence in regard to youth suicide (pages 207-16). This report identifies that:

"It is a waste of resources to engage in programmes whose effectiveness cannot be evaluated, unless strong international evidence of benefit already exists ... evaluation is often difficult, but this is not a reason not to attempt it."

The Report further cautions against relying on untested claims concerning suicide prevention, noting: "some proposals can be potentially harmful, no matter how intuitive they may sound. The recent suggestion that increased coverage of suicide in the media will reduce suicide is a good example. There is no evidence at all to support this theory, and much evidence that it would actually do harm."

Significantly, it is acknowledged that "young people who die by suicide are more likely than others to come from a troubled family background. This includes having parents who are no longer together or have a poor relationship or a history of psychiatric disorder. In a study of suicides under the age of 15, the picture was of "a disadvantaged, vulnerable and distressed group of adolescents growing up in extremely difficult circumstances". A family history of completed or attempted suicide is also a risk factor ... Childhood physical, emotional and sexual abuse are linked with self-harm, perhaps indirectly ... Social connectedness is protective for young people."

In addition to the strategies addressing the known proximal risk factors for youth suicide described in the rest of this submission, greater attention needs to be paid to addressing more effectively these earlier, significant determinants of youth suicide and mental illness (described above). This imperative becomes more urgent when it is recognised how difficult it continues to be to demonstrate that these adolescent-focussed interventions are actually effective in preventing youth suicide.

To reduce the likelihood that children grow into adolescents with increased predisposition to youth suicide, it is necessary to ensure the provision of a comprehensive suite of more effective early child development programs in NT. These would need to include:

- A universal and standard early child development platform, such as “Healthy Under 5 Kids” Program to identify vulnerable children growing up in families with additional needs.
- More effective targeted early childhood development interventions to improve caregiving in vulnerable families with identified additional stressors and other needs.
- Maintained effort in the provision of more specialised treatment services for children who have a specific health or developmental problem identified.

While clinical treatment remains (and will continue to remain) a key element of early childhood services, it is clear that the more established that the problem in the child becomes and that the older the child is there will be diminished benefit from most interventions. This is especially marked in problems that disrupt normal child growth and development. In a community with such disturbingly elevated rates of child maltreatment these considerations take on added significance.

The provision of these kinds of services would need to engage with both primary healthcare services, as with the more specialised paediatric and child/youth mental health services. However, rather than relying on screening and child health checks, program emphasis would need to be on completeness of coverage, and the coherence of the programs themselves, with the main focus being on program support for caregivers to provide more effective parenting and care to their children.

Primary health care teams in remote communities provide assessment and treatment for acute illness ranging from minor illness to serious life threatening conditions. They also provide comprehensive programs across the life span in collaboration with outreach services. These include maternal health programs for pregnant women and their families, child health programs and chronic disease prevention and management. There is increased recognition of the impact of mental health conditions at all ages. The DoH is currently introducing the Edinburgh screening tool for depression into routine antenatal and postnatal practice. Menzies School of Health research and DoH are leading a research project examining the issues around routine screening in primary care for anxiety and depression in remote PHC centres. Aboriginal community workers are being trained to screen young people, those with chronic disease as well as pregnant women. The project has identified appropriate referral pathways drawing on both community resources as well as professional support.

DoH has designated Rural Medical Practitioners with a focus on youth health. They are working closely with *headspace* to raise awareness, train primary health care staff and develop more effective guidelines. They are currently collaborating with Aboriginal health services in NT and other jurisdictions to develop a youth health check, and an audit tool to monitor implementation. The main focus on this check would be social and emotional well being as well as substance abuse. The recent Chronic Disease Network conference

held in September 2011, focused on the common co- existence of mental health problems and chronic physical conditions such as diabetes and heart disease. The conference was attended by 250 people, with a high proportion of participants being Aboriginal and Torres Strait Islander health professionals. NT Aboriginal PHC services are actively engaged in continuous quality improvement, and all the clinical audits including a component focusing on mental health screening and referral which is contributing to further awareness and skills development amongst the PHC teams.

Protective factors

A number of factors which appear to reduce the probability of suicidal behavior have been identified in the literature. In general, health and security and a sense of connection to others seem to be important in the prevention of suicide.

The following protective factors have been suggested:

- Connectedness - a sense of connection with family, school or the community;
- Significant other - the presence of a caring adult to provide support for a young person, or the presence of a caring partner or family member for an adult;
- Responsibility for children - for adults, having the responsibility for children or for family communication is protective;
- Personal resilience - some personal attributes enhance resilience, such as problem solving skills and positive coping styles;
- Spirituality and beliefs - protective factors may include a strong spiritual or religious faith, a sense of higher meaning or purpose in life, or a belief that suicide is wrong;
- Economic security - economic security is protective, particularly in older people;
- Good health - good physical and mental health is a protective factor;
- Effective treatment - the early identification and effective treatment of mental health problems such as depression is important in protection from suicide; and
- Restricted access - lack of access to a means of suicide can help to reduce suicide risk, such as restricting the presence or accessibility of guns or certain medications.



A framework for prevention of suicide in Australia



Living Is For Everyone (LIFE) Framework (2007)

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Using the Living Is For Everyone (LIFE) resources

Which LIFE (2007) resource is most useful to you?

What do you want to know?

You want to know about the latest understanding of suicide and suicide prevention.

You want to know that your suicide prevention activities are well founded and well informed.

You want to know about the overall purpose, structure, principles and priorities for suicide prevention in Australia.

You want something that explains more about suicide, why people suicide, and tells you what you can do or say to help prevent suicide, or to help people bereaved by suicide.

Who are you?

You may be an academic, researcher, policy maker, member of parliament, health or community services professional, service provider or community organisation.

You may be a community member, professional carer, service provider, employer, friend, family, work colleague or associate of someone you think is suicidal, or of people affected by a suicide – or you yourself may be at risk of suicide.

Which document matches your needs?



*Living Is For Everyone: **Research and Evidence in Suicide Prevention*** sets the context for suicide prevention activity, summarising current theories, research, evidence and statistics relating to suicide and suicide prevention in Australia.



*Living Is For Everyone: **A Framework for Prevention of Suicide in Australia*** provides a summary of current understandings of suicide and outlines the vision, purpose, principles, Action Areas, planned outcomes and strategies for suicide prevention in Australia.



*Living Is For Everyone: **Practical Resources for Suicide Prevention*** is a set of plain language **fact sheets** arranged around topic areas that summarise the key issues in suicide prevention and suggest further sources of information and help.

The Living Is For Everyone website: livingisforeveryone.com.au has up-to-date information on suicide prevention activities in Australia and links to a wide range of resources, guidelines and fact sheets.

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Living is for every

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Living Is For Everyone (LIFE) materials



Living Is For Everyone (LIFE) Framework (2007) is the latest in a series of national suicide prevention initiatives in Australia that began in the early 1990s. It provides national policy for action based on the best available evidence to guide activities aimed at reducing the rate at which people take their own lives. The materials aim to support population health approaches and prevention activities that will assist in reducing the loss of life through suicide in Australia.

The LIFE (2007) package of materials includes:

This document, *Living Is For Everyone: A Framework for Prevention of Suicide in Australia (2007)*, outlines the vision, purpose, principles, action areas, and proposed outcomes for suicide prevention in Australia. It replaces the *Living Is For Everyone (LIFE) Framework (2000)*.

The LIFE Framework is based on the understanding that:

- suicide prevention activities will do no harm
- there will be community ownership and responsibility for action to prevent suicide; and
- service delivery will be client-centred.

Living Is For Everyone: Research and Evidence in Suicide Prevention sets the context for suicide prevention activity, summarising current theories, research, evidence and statistics relating to suicide and suicide prevention in Australia.

Living Is For Everyone: Practical Resources for Suicide Prevention is a set of fact sheets, arranged by topic areas, providing practical information about suicide prevention.

The LIFE (2007) package of materials is located at livingisforeveryone.com.au

Australia was one of the first countries to develop a national strategic approach to suicide prevention.

Audience for the LIFE (2007) materials

The LIFE (2007) materials have been produced for use by people across the Australian community who are involved in suicide prevention activities. The materials aim to improve understanding about suicide, of appropriate ways of responding to people considering taking their own life or who have been affected by suicide, and of the role that people can play in reducing the tragic loss of life to suicide in Australia.

The two documents, *Living Is For Everyone: Research and Evidence in Suicide Prevention* and *Living Is For Everyone: A Framework for Prevention of Suicide in Australia* are particularly aimed at academics, researchers, policy makers, health or community services professionals, service providers and community organisations.

Living Is For Everyone: Practical Resources for Suicide Prevention is primarily aimed at community members, carers, service providers, employers, friends, family, work colleagues or associates of someone who may be suicidal, or who has been affected by a suicide.

How the LIFE (2007) materials were developed

In 2000, the *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* (the LIFE Framework) was released. That framework provided a strategic plan for national action to address the tragedy of suicide, to prevent suicide, and promote mental health and resilience across the Australian population. It has played an important role in providing research, evidence and information about suicide and suicide prevention internationally and within Australia, and it remains an important source document.

In early 2006, an independent review and consultation with key stakeholders on the LIFE Framework was commissioned. It became apparent that a set of more practical documents and resources was needed to assist the wider community in suicide prevention. As a result of that review a redevelopment of the LIFE Framework was commissioned in 2007.

The new framework was developed after extensive consultations from November 2006 to June 2007. These consultations involved the wider Australian community and included representatives from national and state government departments, academics and researchers; health and community service professionals; peak bodies and service providers in the public and non government sectors; local communities, services and recreation clubs; special interest groups; people bereaved by suicide; and families, friends and individuals. The consultations were supplemented by a wider canvassing of the most recent international and national research.

The new LIFE Framework suite of resources was developed in 2007 from these consultations and is a revision and replacement of the earlier LIFE Framework.

Suicide Prevention in Australia

Background

Australian governments, communities and organisations have supported suicide prevention efforts for more than ten years, and these efforts have contributed to a decrease in the age standardised rate of suicide from a peak of 14.7 suicides per 100,000 people in 1997 to 10.3 per 100,000 people in 2005. The LIFE Framework (2007) is the latest in a series of national suicide prevention initiatives in Australia that began in the mid 1990s.

Australia was one of the first countries to develop a national strategic approach to suicide prevention. The initial focus was primarily on youth suicide. In the 1995-1996 Federal Budget, \$13 million was allocated over four years to develop and implement a national plan for youth in distress. In the following year, a further \$18 million was allocated to expand the National Youth Suicide Prevention Strategy, with a total of \$31 million allocated between 1995 and 1999.

In 2000, *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* provided a strategic framework for national action to prevent suicide and promote mental health and resilience across the Australian population.

In 2006-07, a redevelopment of the LIFE Framework was commissioned, and these resources are designed to replace the original LIFE Framework.

The Council of Australian Governments (COAG)ⁱ Agreement July 2006

In July 2006, COAG agreed to a National Action Plan on Mental Health 2006-2011 involving a joint package of measures and significant new investment by all governments over five years to promote better mental health and provide additional support to people with mental illness, their families and their carers.

The National Action Plan on Mental Health 2006-2011 focuses on promotion, prevention and early intervention; improving mental health services; providing opportunities for increased recovery and participation in the community through employment and stable accommodation; better-coordinated care; and building workforce capacity.

This National Action Plan sets out agreed funding commitments, outcomes, and most importantly, specific policy directions for action that emphasise coordination and collaboration between government, private and non-government providers. The COAG statement emphasised the need for a more seamless and connected care system.

A key element of the National Action Plan is the commitment from the Australian Government to double funding for the National Suicide Prevention Strategy (from \$61 million to \$123 million) to enable the expansion of suicide prevention programs, particularly those targeting groups at high risk in the community.

A COAG Mental Health Group in each State and Territory has been established. These groups involve the Commonwealth and the States and Territories working together to coordinate implementation. In some cases, such as Queensland, it includes community sector and other non-government representatives.

The Plan will also be monitored against nationally agreed progress measures over a five-year period and will be subject to an independent review at the end of this period.

Government and non-government suicide prevention and related activities

Contact details for further information on these initiatives can be found at Appendix A.

ⁱCOAG is the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA).

More than two thousand
Australians take their
own lives every year.



What is known about suicide and suicide prevention?

Around two thousand Australians take their own lives every year with impacts on families, friends, workplaces and communities.

People of all ages and from all walks of life in Australia take their own life and the causes often appear to be a complex mix of adverse life events, social and geographical isolation, cultural and family background, socio-economic disadvantage, genetic makeup, mental and physical health, the extent of support of family and friends, and the ability of a person to manage life events and bounce back from adversity.

In 2005, 2,101 deaths by suicide were registered in Australia (Australian Bureau of Statistics, 2007):

- This is an age-standardised rate of 10.3 per 100,000 people¹¹. This rate has been dropping steadily since a peak of 14.7 suicides per 100,000 people in 1997.
- Males accounted for nearly 80% of these deaths.
- This compares with 1,638 deaths by motor vehicle accidents in the same period.
- Suicide accounted for almost a quarter of all deaths amongst young men aged 20 to 34.
- Suicide rates are fairly similar for females of all ages with the highest age-specific rate in the 35-39 years age group (6.9 per 100,000) and the lowest in the 15-19 years age group (3.6 per 100,000).
- The age-specific suicide death rates for males shows significant variations between age groups, with the highest being in the 30-34 years age group (27.5 per 100,000) and the lowest in the 15-19 years age group (9.5 per 100,000), and in men aged over 75 the rate was 21.6 per 100,000.

Reducing the rate at which people take their own lives is the responsibility of all Australians and this is best achieved by a coordinated response across the community.

Risk and protective factors for suicide

The many factors that influence whether someone is likely to be suicidal are known as:

- *risk factors*, sometimes called vulnerability factors because they increase the likelihood of suicidal behaviour; and
- *protective factors*, which reduce the likelihood of suicidal behaviour and work to improve a person's ability to cope with difficult circumstances.

Risk and protective factors are often at opposite ends of the same continuum. For example, social isolation (risk factor) and social connectedness (protective factor) are both extremes of social support.

Risk and protective factors can exist at three levels:

- the *individual or personal level* which includes mental and physical health, self-esteem, and ability to deal with difficult circumstances, manage emotions, or cope with stress;
- the *social level*, which includes relationships and involvement with others such as family, friends, workmates, the wider community and the person's sense of belonging; and
- the *contextual level or the broader life environment* which includes the social, political, environmental, cultural and economic factors that contribute to available options and quality of life.

Risk and protective factors may be:

- *modifiable* - things we can change; and
- *non-modifiable* - things we cannot change.

For example, in some areas of Australia isolated older men may be more likely, according to statistics, to take their own life. Nothing can be done about their age or gender (non-modifiable factors that increase risk), but it is possible to change their social isolation (modifiable factors).

¹¹ The age-standardised rate accounts for the changing age structure of the Australian population over time.

Influencing risk and protective factors

Suicidal behaviours, both fatal and non-fatal, result from interactions between risk factors across a person's life span. Risk factors for people taking their own life – that is, the characteristics that increase the likelihood that a person will become suicidal can be divided into two broad groups (Moscicki, 1999). These are:

- *distal risk factors* (further away in time from becoming suicidal) are those that expose a person to the risk of taking their own life or are likely to increase the person's vulnerability. They include, for example, genetic factors and psychopathology; and
- *proximal risk factors* (closer to the time of becoming suicidal) can be viewed as triggers for a person to take their own life. However, they are not sufficient in themselves, nor are they a necessary precursor for a person to take their own life. Proximal risk factors include negative recent life events, or a crisis.

In each person, it is the action of distal and proximal risk factors together that might result in suicidal behaviours.

In assessing the risk of someone taking their own life, it is important not to assume that an individual in a particular group or population necessarily shares the characteristics and risks of that group or population (Platt & Hawton, 2000). For example, based on research, it might be assumed - incorrectly - that every male or every elderly person is automatically at increased risk. Similarly, because suicide and mental illness are linked, it may be assumed - again, wrongly - that everyone who engages in suicidal behaviour is mentally ill. This is one of the common myths about suicide (De Leo & Krysinska, 2008).

Equally, it cannot be assumed that low risk means no risk. Risk factors are indicators only and it is incorrect to assume that suicide in a person with one risk factor is less likely than suicide in another person with several risk factors.

People who attempt to take their own life usually have many risk factors and few protective factors. But risk and protective factors don't explain everything about suicide. Most people with multiple risk factors do not attempt to take their own life, and some who do take their lives have few risk factors and many protective factors.

Particular risk factors are more important for some groups than others. For example, the factors that may put a young man at risk are generally quite different to those that increase the risk for a retired, older man. Applying an understanding of risk factors to prevent suicide involves identifying:

- the risk factors (individual, social, contextual) that are present for a particular person or group of people;
- individuals who are most likely to be badly affected by these risk factors, and those who are most likely to be resilient; and
- which of the risk factors can be changed (modifiable) to reduce the level of risk.

There is not a straight one-to-one relationship between reduced risk and the presence of protective and/or risk factors, which may be for a number of reasons:

- The same life event can have very different impacts on individuals, depending on what else is happening in a person's life at the time, and their ability to grow and learn from life's challenges. To assist someone who is feeling suicidal it is critical to understand their sense of self, their ability to cope and their personal competence.
- People vary widely in their beliefs about what makes life worth living, and these views may also change over time. Despite many years of research, researchers have not yet been able to explain how and why these differences occur.

What assists in protecting people against suicide?

A further challenge lies in the strong relationship between socio-economic factors and health. At present in Australia, there is a strong link between geographic location (regional, rural and remote), socio-economic disadvantage (low socio-economic status) and ill health. This relationship also exists for suicide - suicide rates tend to be much higher in regional, rural and remote locations and in areas of higher socio-economic disadvantage.

Applying our knowledge of risk and protective factors in suicide prevention

The most recent research suggests that an understanding of risk factors in suicide is best used to identify populations or specific socio-economic groups that might be at risk, rather than attempting to identify individuals at risk. The main reason is that the majority of people who can be categorised as at risk do not and will not ever take their own life. It is extremely difficult to determine from risk factors alone which individuals within an at risk group are more or less likely to become suicidal.

Most researchers recommend that suicide prevention initiatives should focus on constellations of risk and protective factors. Activities may include:

- reducing exposure to social and contextual risk through structural changes that target specific at risk groups such as remote Indigenous communities, socially or geographically isolated older men or people with a mental illness. For example, developing social support networks, improved employment prospects or access to affordable housing.
- increasing individual protective factors through activities that help to build self-esteem, psychological strength and personal competence. For example, teaching young people social and emotional skills, fostering positive peer relationships and relationships with teachers and other adults, and encouraging help-seeking behaviours.
- providing easier access to appropriate care and support that is in the right place, at the right time, using the right approach. For example, non-judgemental assistance for people bereaved by suicide, provided by their peers, in the places they frequent and where they feel most comfortable.
- reducing risk and increasing protection for people who are in current crisis. Such groups might include those who have attempted to take their own life, or who have been recently discharged from mental health care.

Everyone experiences stress and difficult circumstances during their life. Most people can handle these tough times and may even be able to make something good from a difficult situation. There are others however who may respond negatively when faced with difficult or traumatic events and may become discouraged or defeated and become more vulnerable. One of the main aims of suicide prevention activities is to build resilience in individuals, their families and in whole communities, to increase their capacity to respond to life's events, whatever they may be.

Many factors shape how each person develops self-image, life skills and the ability to manage and survive under pressure or when faced with life changing events. Some of these factors are genetic, some are linked to current and past physical or mental health, some are the result of previous life or family experiences, some are cultural or gender-related, and some relate to the person's social support systems.

What is resilience?

Resilience is the ability to bounce back after experiencing trauma or stress, to adapt to changing circumstances and respond positively to difficult situations. It is the ability to learn and grow through the positive and the negative experiences of life, turning potentially traumatic experiences into constructive ones. Being resilient involves engaging with friends and family for support, and using coping strategies and problem-solving skills effectively to work through difficulties.

The same circumstance may contribute either to vulnerability or to resilience. For instance a family environment that is supportive and caring will enhance resilience, while lack of family support or exposure to abuse or trauma in a family may make a person more vulnerable and less able to cope in the future with potentially traumatic incidents.

There have been many theories about how individuals develop and how they build their resilience, wellbeing and attitude to life. **Figure 1** summarises the main internal building blocks of individual health and wellbeing that are regarded as contributing to resilience and building strengths and capacities to prepare individuals for their life's events and stresses, and support them through those experiences.

However, individual health and wellbeing described in **Figure 1** is just one of the four main factors that work together to build individual resilience and increase the capacity to manage when placed in difficult or anxiety-provoking situations. Other external factors that impact on the individual's ability to manage the range of events that can occur throughout their life include family life, social interactions and accumulated experiences from the past (cultural, social, family), and anticipation of the future (expectations, hopes, dreams and fears).

Figure 2 summarises these factors that together work to influence a person's reaction to life events (Commonwealth of Australia, 2007).

FIGURE 1: Factors that contribute to individual health and wellbeing.

| Individual health and wellbeing | |
|---------------------------------|--|
| Self-image | Sense of self includes: Self-esteem; secure identity; ability to cope; and mental health and wellbeing. |
| Behaviour | Social skills include: Life skills; communication; flexibility; and caring. |
| Spirit | Sense of purpose includes: Motivation; purpose in life; spirituality; beliefs; and meaning. |
| Heart | Emotional stability includes: Emotional skills; humour; and empathy. |
| Mind | Problem solving skills includes: Planning; problem solving; help-seeking; and critical and creative thinking. |
| Body | Physical health includes: Health; physical energy; and physical capacity. |

(Adapted from Beautrais, 1998; Kumpfer, 1999; Maslow, 1943; Rudd, 2000)

FIGURE 2: The four main groups of factors that influence a person's ability to respond positively to adverse life events.

| | |
|---|--|
| Individual health and wellbeing | Sense of self; social skills; sense of purpose; emotional stability; problem solving skills; and physical health. |
| Predisposing or individual factors | Genes; gender and gender identity; personality; ethnicity/culture; socio-economic background; and social/geographic inclusion or isolation. |
| Life history and experience | Family history and context; previous physical and mental health; exposure to trauma; past social and cultural experiences; and history of coping. |
| Social and community support | Support and understanding from family, friends, local doctor, local community, school; level of connectedness; safe and secure support environments; and availability of sensitive professionals/carers and mental health practitioners. |

Vulnerability and suicide risk

Despite many years of research into suicide and suicide prevention in Australia and overseas, it is still not possible to predict reliably whether a person is likely to take their own life; or to be sure which interventions are the most effective to prevent people from taking their own life. For some, suicide may be an impulsive and irrational act. For others it may be a carefully considered choice - particularly where the person believes that his or her death will benefit others. Some people take their own life or harm themselves apparently without warning. Some give an indication of suicidal intent, especially to friends and loved ones and to professionals. The most recent theories about the different motivations for people to take their own life suggest that it may be any one or combination of:

- a direct result of a mental illness, such as clinical depression or schizophrenia. However, many people with a mental illness are not affected by suicidal thoughts or behaviour, and not everyone who takes their own life is mentally disturbed or mentally ill.
- an outcome of reckless behaviour. Suicide is, for example, often associated with alcohol or other drugs, or it may result from dangerous or life threatening activities. Such behaviour is sometimes referred to as a death wish.
- an attempt to end unmanageable pain. This may be psychological pain and despair, stemming from humiliation, guilt, shame, or loss; or it may be chronic physical pain or debilitating illness.
- an attempt to send a message or gain a particular outcome such as notoriety, vengeance, defiance, or to leave a particular legacy or impact.
- an altruistic or heroic act, relieving others of a burden, dying to save another, or dying for a cause; or
- an expression of the person's right to choose the manner of their death. In some circumstances, the specific means or place of taking their own life has particular symbolic significance to the person.

Tipping points

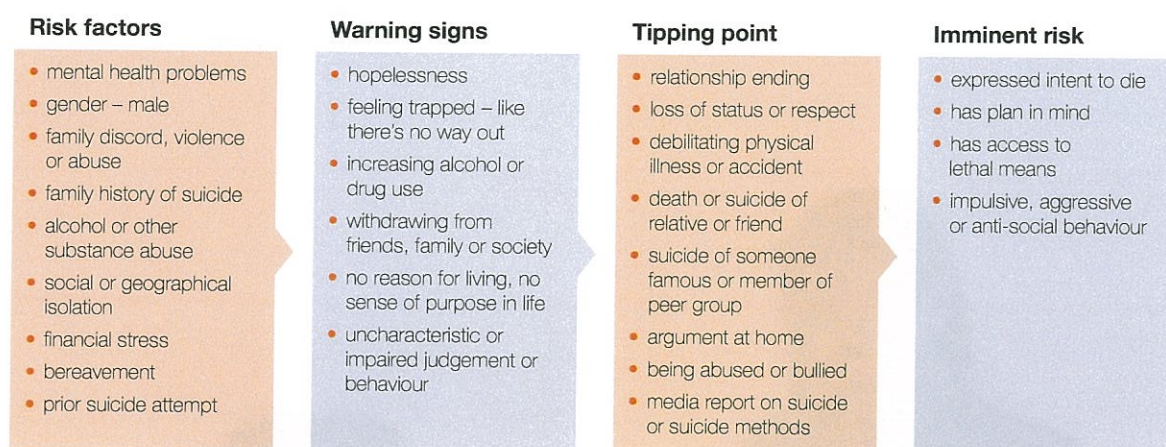
Many people who are thinking of taking their own life do not want to die, but can't see any other way out of their situation. They are likely to be deeply ambivalent or confused about their suicidal thoughts or intentions. Their state of mind may change rapidly in a short period of time. People take their own life usually as the result of a complex range of factors, but it is often just one or two things that can trigger actions such as making a plan or finding a means to take their own life.

The point at which a person's risk of taking their own life increases due to the occurrence of some precipitating event may be called a tipping point. Tipping points vary for every individual, but there are some indicators of times at which people may be under particular stress. The warning signs and tipping points can be likened to signposts that give early warning of the potential for someone to take their own life. Sometimes referred to as triggers or precipitating events, they include mental disorders or physical illnesses, alcohol and/or other substance abuse, feelings of interpersonal loss or rejection, or the experience of potentially traumatic life events (unexpected changes in life circumstances).





FIGURE 3: Examples of typical triggers and precipitating events to suicide.



Warning signs

For families, friends and work colleagues, knowing the main warning signs and responding to them quickly and effectively may save a person's life. This is the main component of indicated interventions that are outlined in the following section. However, it should be noted that in many cases of someone taking their own life, there appear to be no warning signals that are obvious and even the most skilled professionals may miss them.

A warning sign indicates that a person might be at a heightened risk, is having serious thoughts about taking their own life, and may be planning or taking actions towards this. Warning signs may be a cry for help, and they can provide a chance for family, friends, associates and professionals to intervene and potentially prevent the person from dying or injuring themselves. The following behaviours are more common among people who are feeling like taking their own life, although many people show some of these signs at some point in their lives, especially when they are tired, stressed or upset:

- threatening to hurt themselves or take their own life;
- looking for ways to take their own life, or talking about their plan to do so;
- talking or writing about death, dying or taking their life (especially when this is out of character or unusual for the person);

- expressing feelings of hopelessness;
- using expressions of rage, anger or seeking revenge;
- engaging in reckless or risky behaviours, seemingly without thinking;
- expressing feelings of being trapped, like there's no way out;
- increased use of alcohol or other drugs;
- withdrawing from friends, family or the community;
- anxiety or agitation;
- abnormal sleep patterns - not sleeping or sleeping all the time;
- dramatic changes in mood, such as sudden feelings of happiness after a long period of sadness or depression;
- giving away possessions or saying goodbye to family and/or friends; and/or
- saying they have no reason for living or no sense of purpose in life.

For families, friends
and work colleagues,
knowing the main
warning signs
may save a
person's life



The Living Is For Everyone (LIFE) Framework for Suicide Prevention

Context

Traditionally, approaches to care in the health sector were based on the concepts of primary, secondary and tertiary prevention. Primary prevention aims to prevent the onset of a particular disorder. Secondary prevention aims to identify and treat persons who have no symptoms, but have developed risk factors or preclinical disease. Tertiary prevention aims to minimise the effects of an established disorder, and prevent complications (U.S. Preventative Services Task Force, 1996).

In the 1980s, with increasing awareness of the complexity of the factors (risk, protective, contextual, personal) that influence any illness, the traditional model was replaced by the universal, selective and indicated prevention model, introduced by Gordon (1983).

This model focussed on different groups of clients rather than on the treatment mechanisms. Universal measures can be applied to everybody, a whole population or a whole community; selective preventative measures can be applied to a sub-group at known increased risk; and indicated measures target individuals who are at high risk. This approach is now the basis of suicide prevention in the United States.

Mrazek and Haggerty (1994) adapted Gordon's model to include the whole spectrum of interventionsⁱⁱⁱ (prevention, treatment, maintenance, recovery).

This model has been widely used, and has been adapted for use in the Australian National Mental Health Strategy (Raphael, 2000) and the 2000 version of the Australian National Suicide Prevention Strategy (Commonwealth of Australia, 2005).

The LIFE (2007) model

In light of recent research and consultations, the Mrazek and Haggerty (1994) model was adapted further in 2007 for the LIFE Framework to focus on the following key features:

- The individual's health, wellbeing and responses to life events are at the centre of the model, recognising that people respond and cope differently, and vary in their vulnerability and resilience;
- The new model uses more everyday language, to make it accessible to a wider audience;
- Community-based safety nets to support people as they move from one treatment setting to another, or are discharged back into the community. There is strong evidence - both from health systems generally, and in relation to suicide in particular - that people are most exposed to risk at these handover points between interventions. This is when things are most likely to go wrong and when support is most critical; and
- The model recognises that individuals respond differently when faced with adverse events. They do not always follow a logical or linear decline in health – from risk, to warning sign, to tipping points, to the need for specialised care. A person may move, with no apparent warning, from apparent good health directly into distress and despair and a need for immediate specialised care.

ⁱⁱⁱ Intervention - To take action or provide a service so as to produce an outcome or modify a situation. Any action taken to improve health or change the course of, or treat a disease or dysfunctional behaviour.

LIFE Framework continuum of suicide prevention activities

The LIFE (2007) model is based on the premise that:

- the responsibility for suicide prevention rests with individuals, professional groups and services across the community and that interventions should be provided in a coordinated and integrated way according to the needs of the individual and community;
- in order to reduce the loss of life through suicide, activities will occur across eight overlapping domains of care and support (see Figure 4); and
- safety nets should be provided to support people moving between treatment options, and back into the community through:
 - community-based services to support and foster recovery after discharge from clinical care;
 - effective client hand-over practices between services and back into the community; and
 - cooperation and communication between health professionals, community support services, families, workplaces, and community groups.

The eight domains are:

1. *Universal interventions* aim to engage the whole of a population or populations to reduce access to means of suicide, reduce inappropriate media coverage of suicide, and to create stronger and more supportive families, schools and communities.
2. *Selective interventions* entail working with groups and communities who are identified as at risk to build resilience, strength and capacity and an environment that promotes self-help and support. This might include, for instance, working with families of those who have taken their own life to respond to their grief and loss and their elevated risk of suicide; or working with children who are survivors of child abuse to build strength and resilience.
3. *Indicated interventions* target people who are showing signs of suicide risk or present symptoms of an illness known to heighten the risk of suicide (eg severe depression). These people can be helped to manage their current situation by solving some of the problems that have caused the illness. Alternatively, referral can be given to doctors or psychologists, or family and community members can be educated to recognise warning signs and take appropriate action to support people at-risk.
4. *Symptom identification* - knowing and being alert to signs of high or imminent risk, adverse circumstances and potential tipping points by providing support and care when vulnerability and exposure to risk are high.
5. *Finding and accessing early care and support* when treatment and specialised care is needed. This is the first point of professional contact that provides targeted and integrated support and care, and monitors interventions to ensure client's access to further information and care as needed.
6. *Standard treatment* when specialised care is needed. Integrated, professional care to manage suicidal behaviours and comprehensively treat and manage any underlying conditions, improve wellbeing and assist recovery.
7. *Longer-term treatment and support* to assist in preparing for a positive future. This entails continuing integrated care to consolidate recovery and reduce the risk of adverse health effects. In particular, this may be a time to directly focus on distal or background risks for suicide to remove them or to reduce their impact in the future. Alongside this, efforts can be made to improve protective factors for the individual, their immediate family and their local community.

8. *Ongoing care and support* involving professionals, workplaces, community organisations, friends and family to support people to adapt, cope, and build strength and resilience within an environment of self-help. This may be the opportunity to increase broader community education about the issues and build awareness of the strategies that may be needed to prevent recurrences.

Suicide prevention interventions that are represented across these domains include:

- assisting people to help themselves and creating an environment that supports self-help (promoting self-help);
- recognising early warning signs and providing early intervention to assist people to resolve issues and/or access appropriate help (responding to help-seeking behaviours);
- increasing understanding of suicide and suicide prevention and the capacity for individuals and local communities to recognise and respond to early warning signs and to take appropriate steps to make people safe (promoting local understanding and support);

- building the capacity for meeting the needs of individuals who might be feeling suicidal (targeted support and care);
- providing access to specialist care and integrated local support for those who are feeling chronically suicidal or are exposed to greater risk of suicide (specialised care); and
- maintaining an environment where individuals, families and communities can build resilience and improve their general health and wellbeing during times of adversity (individual, family and community growth and development).

Figure 4 provides a summary of the range of types of suicide prevention activities and interventions that are essential for a whole of community response to reducing the rate of suicide in Australia, and the risk of suicide, of suicide attempts and of suicidal behaviours in individuals. For each activity/intervention the following is defined: the target group; the proposed outcomes; and who might be involved in the activity/intervention.



FIGURE 4: LIFE Framework continuum of suicide prevention activities.

| | Target groups | Outcomes | Who is involved? |
|--|---|--|---|
| Universal intervention | Activities that apply to everyone (whole populations) | Reducing access to means of suicide, altering media coverage of suicide, providing community education about suicide prevention and creating stronger and more supportive families, schools and communities. | Involving: individuals, families, consumer and carer organisations, multicultural organisations, local councils, sporting and recreational clubs, workplaces, media, educational organisations, providers of education and information on mental health and suicide prevention, service clubs and pubs. |
| Selective intervention | For communities and groups potentially at risk | Building resilience, strength and capacity and an environment that promotes self-help and help-seeking and provides support. | Involving: individuals, families, consumer and carer organisations, multicultural organisations, local councils, sporting and recreational clubs, workplaces, media, educational organisations, Divisions of GP, service clubs and pubs. |
| Indicated intervention | For individuals at high risk | Building strength, resilience, local understanding, capacity and support; being alert to early signs of risk; and taking action to reduce problems and symptoms. | Involving: individuals, families, consumer and carer organisations, multicultural organisations, GPs, police, gerontologists, rehabilitation providers, emergency workers, specialist physicians, sporting and recreational clubs, workplaces, educational organisations, service clubs and pubs. |
| Symptom identification | When vulnerability and exposure to risk are high | Being alert to signs of high risk, adverse health effects and potential tipping points; and providing support and care. | Involving: GPs, help lines, police, gerontologists, rehabilitation providers, emergency workers, specialist physicians, teachers, pharmacists, workplaces family and friends and other gatekeepers. |
| Early treatment | Finding and accessing early care and support | Providing first point of professional contact; targeted and integrated support and care; and monitoring and ensuring access to further information and care. | Involving: GPs, psychologists, allied mental health professionals, Aboriginal Health Workers, emergency departments, police, gerontologists, emergency workers, specialist physicians, community health services, help lines, crisis teams, school counsellors. |
| Standard treatment | When specialised care is needed | Providing integrated professional care to manage suicidal behaviours and improve wellbeing as a step in recovery. | Involving: psychiatrists, psychologists, GPs, allied mental health professionals, Aboriginal Health Workers. |
| Longer-term treatment and support | Preparing for a positive future | Providing ongoing integrated care to consolidate recovery and reduce the risk of adverse health effects. | Involving: psychiatrists, psychologists, GPs, allied mental health professionals, families, workplaces, local community organisations and clubs, rehabilitation services, Aboriginal Health Workers, help lines. |
| Ongoing care and support | Getting back into life | Building strength, resilience, and adaptation and coping skills, and an environment that supports self-help and help-seeking. | Involving: GPs, allied mental health professionals, Aboriginal Health Workers, community service providers, families, local community organisations, workplaces and clubs. |

Safety Nets for people moving between treatment options, and back into the community. These include:

- community-based services to support and foster recovery after discharge from clinical care
- effective client hand-over practices between services and back into the community; and
- effective cooperation and communication between health professionals, community support services, schools, families, workplaces and community groups.

The LIFE Framework for Action

Strategic directions

The LIFE Framework reflects a vision that suicide prevention activities will reduce suicide attempts and the loss of life through suicide by providing individuals, families and communities with access to support so that no-one in crisis or experiencing personal adversity sees suicide as their only option.

The purpose of the LIFE (2007) materials is to provide information, resource materials and strategies that will support population health approaches and suicide prevention activities undertaken across the Australian community and thereby contribute to a reduction in suicide and suicide attempts.

The central goal of the LIFE Framework is to reduce suicide attempts, the loss of life through suicide and the impact of suicidal behaviour in Australia. This requires a number of interlinked and coordinated strategies that reflect universal, selective and indicated approaches.

Suicide prevention activities, programs and interventions will aim to build:

- stronger individuals, families and communities
- individual and group resilience to traumatic events
- community capacity to identify need and respond
- the capability for communities and individuals to respond quickly and appropriately; and
- a coordinated response, and provide smooth transitions to and between care.

Principles underpinning the LIFE Framework for Action

There are a set of binding principles underpinning the LIFE Framework. They are:

1. Suicide prevention activities should first do no harm. Some activities that aim to protect against suicide have the potential to increase suicide risk amongst vulnerable groups. Activities need to respect the context, health, receptivity and needs of the person who is feeling suicidal.
2. Suicide prevention is a shared responsibility across the community, families and friends, professional groups, and non-government and government agencies.
3. Activities should be designed and implemented to target and involve:
 - the whole population
 - specific communities and groups who are known to be at risk of suicide; and
 - individuals at risk.
4. Activities need to include access to clinical or professional treatment for those in crisis and support for people who are recovering and getting back into life.
5. Activities must be appropriate to the social and cultural needs of the groups or populations being served.
6. Information, service and support need to be provided at the right time, when it can best be received, understood and applied.
7. Activities need to be located at places and in environments where the target groups are comfortable, and where the activities will reach and be accessible to those who most need them.
8. Local suicide prevention activities must be sustainable to ensure continuity and consistency of service.
9. Suicide prevention activities should either be, or aim to become, evidence-based, outcome focused and independently evaluated.

10. Activities need to be sensitive to the broader factors that may influence suicide risk – the many social, environmental, cultural and economic factors that contribute to quality of life and the opportunities life offers – and how these vary across different cultures, interest groups, individuals, families and communities.
11. Services for people who are recognised as suicidal should reflect a multi-disciplinary approach and aim to provide a safe, secure and caring environment.

Considerations in implementing the LIFE Framework for Action

In designing activities, actions and programs, the following must be taken into account:

- Care and support must match people's different needs. In particular, whether the path towards suicide is gradual and visible, or rapid with no outward sign of distress, specialised care needs to be readily and rapidly available when it is needed.
- There should be a focus on:
 - reducing exposure to risk of suicide;
 - reducing access to the means of suicide;
 - improving protective factors;
 - providing individuals who are feeling suicidal with access to a range of support - from the family and community, in the workplace, from professional carers and health services;
 - identifying the individual's particular needs and providing the right support, in the right place, at the right time;
 - improving community understanding of the needs of those who are mentally ill, grieving, profoundly distressed or traumatised; and
 - education for the immediate family, friends, social networks, the local doctor and work colleagues of people at risk.



Summary of Action Areas

Action Area 1

Improving the evidence base and understanding of suicide prevention.

Improving the quality of the evidence for suicide and suicide prevention is fundamental to the development, implementation and review of effective suicide prevention policies and practices. A sound evidence base will assist in:

- improving understanding about the prevalence and causes of suicide;
- increasing understanding about interventions that are likely to be the most effective;
- determining what services and interventions are needed, for which specific groups;
- evaluating interventions and services provided; and
- providing reliable information to the community about suicide and suicide prevention.

Action Area 2

Building individual resilience and the capacity for self-help.

Protecting against suicidal behaviour includes implementing preventative measures such as providing environments where appropriate support is accessible as well as implementing programs that promote and support wellbeing, optimism and social connectedness.

Action Area 3

Improving community strength, resilience and capacity in suicide prevention.

Improving individual, family and community awareness and understanding of suicide and suicide prevention will increase the capacity of communities to prevent and respond to suicide.

Action Area 4

Taking a coordinated approach to suicide prevention.

Effective suicide prevention relies on communities, organisations and all levels of government working together using sound evidence, with a careful assessment of outcomes.

Action Area 5

Providing targeted suicide prevention activities.

To address the needs of individuals and prevent suicide, there are a number of key elements:

- early identification and intervention;
- building individual resilience and the capacity for self-help;
- creating environments that encourage and support help-seeking;
- creating environments where it is acceptable to express emotions and suicidal thoughts without a fear of acrimony, personal weakness or stigmatisation; and
- ensuring access to the range of required support and care for people feeling suicidal.

Action Area 6

Implementing standards and quality in suicide prevention.

Suicide prevention programs need to reflect evidence of what works and does not work, and to communicate it effectively to the point of need.

The importance of evaluating suicide prevention activities

Systematic evaluation of all suicide prevention projects, activities and programs is essential for the continued development of best practice. It will ensure that interventions are based on a solid foundation of evidence, that resources and effort are allocated appropriately and that the required outcomes and impacts can be achieved.

For an evaluation to be effective it must be planned, built into all activities and measure the significant outputs and outcomes that will show how well a program is working. Measures relevant to suicide prevention may include:

- reductions in suicide attempts and/or suicidal thinking;
- reductions in risk factors and vulnerabilities to suicidal behaviours (eg mental illness, feelings of hopelessness);
- increase in individual and/or community awareness of appropriate suicide prevention;
- changes in behaviours and response to suicide prevention strategies;
- improvements in individual protective or resiliency factors (eg improved coping skills, more help-seeking behaviours, better social connectedness, better understanding of mental illness); and

- improvements in service models or practices to reduce the adverse impact of the system on individuals.

The type(s) of evaluation used will depend on the size, scope and intent of each project. For instance, evaluation of a prototype or an innovative idea will focus largely on what can be learnt from its development and implementation (process evaluation). In projects of this type, evaluation is often fed back into the project as it unfolds, to improve and refine the development of the project (practice or process improvement).

On the other hand, where a project that is known to work, has been funded or sponsored by an outside agency, the evaluation will usually focus on whether the project has made a difference or achieved its stated objectives (impact) or delivered on its contractual obligations (accountability).

It is assumed that all suicide prevention activities arising from the action areas defined on the following pages will be systematically evaluated.

Evaluations of suicide prevention activities may focus on indicators of:

- effectiveness
- program quality
- efficiency; and
- quantity.

Figure 5 sets out eleven categories of measures that may be useful in evaluating and reporting suicide prevention activities against these indicators.

FIGURE 5: Indicators for evaluation of suicide prevention activities.

| Effectiveness indicators | Program quality indicators | Efficiency indicators | Quantity indicators |
|--|---|--|---|
| 1. Policy and program objectives outcomes met <ul style="list-style-type: none"> • policy objectives • program objectives • project/service objectives | 4. Quality of process <ul style="list-style-type: none"> • conforms to requirements • quality of activities and methodologies • engagement of key stakeholders | 7. Allocative efficiency <ul style="list-style-type: none"> • best use of available resources in addressing the issue of suicide prevention • best return on investment for this outcome | 11. Quantity delivered in terms of: <ul style="list-style-type: none"> • policy • need • agreed targets • inputs to project |
| 2. Stakeholder satisfaction <ul style="list-style-type: none"> • sponsoring agency • key stakeholders • project partners • customers/consumers | 5. Quality of products <ul style="list-style-type: none"> • adequacy • right type, mix, range • appropriate to need • target market covered | 8. Resource efficiency <ul style="list-style-type: none"> • staffing • infrastructure • consumables | |
| 3. Sustainability <ul style="list-style-type: none"> • outcome is relevant and applicable • outcome is easily understood and adopted • outcome is sustainable | 6. Quality of service <ul style="list-style-type: none"> • accessible • equitable • professional • competence/knowledge and understanding | 9. Cost efficiency <ul style="list-style-type: none"> • absolute cost • recurrent cost • value for money | |
| | | 10. Time efficiency <ul style="list-style-type: none"> • responsiveness • meets agreed timelines | |

The Living Is For Everyone (LIFE) Action Areas

Action Area 1

Improving the evidence base and understanding of suicide prevention

Improving the quality of the evidence for suicide and suicide prevention is fundamental to the development, implementation and review of effective suicide prevention policies and practices. A sound evidence base will assist in:

- improving understanding about the prevalence and causes of suicide;
- increasing understanding about interventions that are likely to be the most effective;
- determining what services and interventions are needed, for which specific groups;
- evaluating interventions and services provided; and
- providing reliable information to the community about suicide and suicide prevention.



Action Area 1

| Outcomes | Strategies |
|---|---|
| <p>Outcome 1.1. Understanding of imminent risk and how best to intervene</p> | <ul style="list-style-type: none"> i. Identify and clarify the link between suicide prevention activities and interventions and their impact on, and relevance to, the incidence of suicidal behaviours. ii. Improve the evidence base for the identification and differentiation of warning signs, tipping points and imminent risk factors. |
| <p>Outcome 1.2. Understanding of whole of community risk and protective factors, and how best to build resilience of communities and individuals</p> | <ul style="list-style-type: none"> i. Develop a better understanding of the positive and negative impacts of economic, social and environmental influences on suicide and suicidal behaviours. ii. Improve the evidence base for the impact of community capacity and resilience building in the long-term prevention of suicide, including in rural and remote communities and/or those adversely affected by climate change or natural disasters. iii. Research the influence and impact on suicidal behaviours of new technologies/multi-media communication (eg media, internet, MySpace, YouTube, chat rooms, instant messaging). iv. Improve understanding of the cultural significance of suicide and how suicide can be prevented across different cultural and at-risk groups v. Synthesise and strengthen understanding of suicide through incorporation in relevant systematic, longitudinal, multi-disciplinary, multi-site studies. |
| <p>Outcome 1.3. Application and continued development of the evidence base for suicide prevention among high risk populations</p> | <ul style="list-style-type: none"> i. Apply and develop the research and evidence of interventions that work for Aboriginal and Torres Strait Islander communities. ii. Apply and develop the evidence base to identify and address the needs of people bereaved by suicide. iii. Apply and develop the evidence base of interventions to encourage men's help-seeking behaviour and emotional openness. iv. Measure the effectiveness of management and care options for people who have previously attempted suicide or engage in self-harming behaviours. |
| <p>Outcome 1.4. Improved access to suicide prevention resources and information</p> | <ul style="list-style-type: none"> i. Contribute to a centre for the collection and dissemination of quality information and resources in suicide prevention. ii. Progress a national standardised recording system relating to deaths through suicide. |

Action Area 2

Building individual resilience and the capacity for self-help

Protecting against suicidal behaviour includes implementing preventative measures such as providing environments where appropriate support is accessible as well as implementing programs that promote and support wellbeing, optimism and social connectedness.

Action Area 2

| Outcomes | Strategies |
|---|--|
| <p>Outcome 2.1. Improved individual resilience and wellbeing</p> | <ul style="list-style-type: none"> i. Develop and promote universal programs to support the acquisition of life skills that enhance individual and community resilience (eg social competence, communication, problem-solving, community development skills). ii. Develop and promote mental health and wellbeing programs for the whole community, including those designed to support particular high risk groups or populations (eg culturally appropriate programs for diverse communities, initiatives for children whose parents have a mental illness, etc). iii. Provide support to professions that have a key role in suicide prevention or trauma response, to safeguard mental health and wellbeing, enhance service delivery, improve staff retention and minimise the likelihood of suicide (eg health professionals, law enforcement officers, emergency services personnel, education and social service professionals). iv. Foster environments (eg families, schools, workplaces) where it is acceptable to express emotions (anxiety, stress, sadness, grief) without a fear of stigmatisation. |
| <p>Outcome 2.2. An environment that encourages and supports help-seeking</p> | <ul style="list-style-type: none"> i. Develop and promote programs that raise awareness of the importance of social and emotional wellbeing, mental disorders and suicide prevention (eg via the media, schools and workplaces). ii. Develop and promote programs to enhance help-seeking behaviour among high-risk groups and in people that are known to be least likely to seek help including young people, men, Aboriginal and Torres Strait Islander communities and people from some culturally and linguistically diverse communities. iii. Work to destigmatise conditions that contribute to suicide risk (eg mental illness, homelessness, financial hardship) with a view to encouraging help-seeking behaviour. |

Protecting against
suicidal behaviour includes
implementing programs
that promote wellbeing,
optimism and support
social connectedness.



Action Area 3

Improving community strength, resilience and capacity in suicide prevention

Improving individual, family and community awareness and understanding of suicide and suicide prevention will increase the capacity of communities to prevent and respond to suicide.

Action Area 3

| Outcomes | Strategies |
|---|---|
| <p>Outcome 3.1. Improved community strength and resilience</p> | <ul style="list-style-type: none"> i. Raise awareness of the characteristics of healthy and resilient communities, and support their development. ii. Use mentoring and leadership development programs to promote the development and sharing of good practice in local communities. iii. Develop and promote strategies that enable and support groups within local communities to work together on suicide prevention. |
| <p>Outcome 3.2. Increased community awareness of what is needed to prevent suicide</p> | <ul style="list-style-type: none"> i. Educate communities to identify and respond to warning signs, tipping points and imminent risk factors associated with suicide. ii. Work with the mainstream and multilingual media to improve community knowledge and understanding of suicide and suicide prevention and encourage responsible coverage of these issues. iii. Reduce the stigma and myths surrounding suicide by actively communicating the range and complexity of factors that contribute to suicidal behaviours. iv. Develop and promote strategies that enable organisations to work together to reduce risk factors and strengthen protective factors in individuals and communities. |
| <p>Outcome 3.3. Improved capability to respond at potential tipping points and points of imminent risk</p> | <ul style="list-style-type: none"> i. Enable locally based networks and cooperative partnerships to respond effectively to traumatic incidents or significant changes in local circumstances (eg drought, industry closures). ii. Develop materials and provide locally based support to assist staff and volunteers in organisations such as pubs, clubs, cultural and religious centres and recreational and sporting groups, to identify potential suicidal behaviour and to respond effectively. iii. Expand and resource the capacity of schools, workplaces and other relevant settings, to identify and provide support to those at risk. iv. Use the media and other strategies to raise awareness of the risk factors, warning signs and tipping points for suicide. v. Develop and disseminate resources that recognise and support the important role of and impact on family, friends, colleagues and peers in suicide prevention. |

Action Area 4

Taking a coordinated approach to suicide prevention

Effective suicide prevention relies on communities, organisations and all levels of government working together using sound evidence, with a careful assessment of outcomes.

Action Area 4

| Outcomes | Strategies |
|---|--|
| <p>Outcome 4.1. Local services linking effectively so that people experience a seamless service</p> | <ul style="list-style-type: none"> i. Encourage and resource integrated, cross-functional, cross-agency solutions to locally based suicide prevention activities. ii. Develop an understanding of people's journeys to find services in order to inform and improve service responses. iii. Develop and promote client-centred, shared case-management approaches to suicide prevention in local communities. iv. Strengthen the capacity for families, schools, workplaces, pubs, clubs and sports, recreational and social groups to identify quickly and respond effectively to indicators of potential suicidal behaviour. v. Develop practical tools for information sharing, including shared service agreements, dealing with privacy and confidentiality requirements and barriers, developing local data and outcome measures, and joint service/client protocols. vi. Promote and support linkages between community based and clinical initiatives in suicide prevention. |
| <p>Outcome 4.2. Program and policy coordination and cooperation, through partnerships between governments, peak and professional bodies and non-government organisations</p> | <ul style="list-style-type: none"> i. Develop cross-government mechanisms to improve the integration of health, housing, community, justice, employment and other policy and programs, for better suicide prevention. ii. Support and improve linkages and cooperation between governments, academic institutions, non-government organisations (NGOs), peak and professional bodies, to support information sharing and reduce duplication of effort. iii. Design and implement resources and tools (eg shared care guidelines, protocols and evaluation tools for professionals, multidisciplinary teams and service providers) to support coordinated community service provision. iv. Address the information needs of different professional and community groups concerned with suicide prevention. |
| <p>Outcome 4.3. Regionally integrated approaches</p> | <ul style="list-style-type: none"> i. Promote natural catchment approaches, including reducing jurisdictional barriers, to support better regional cooperation in suicide prevention activities. ii. Increase cooperation within regions to improve suicide prevention activities. iii. Actively engage local government in suicide prevention. iv. Strengthen local capacity by supporting sharing of practice and experience across agencies involved in community and emergency services. v. Develop shared service agreements, local data and service metrics, joint service protocols and joint client assessments. |

Action Area 5

Providing targeted suicide prevention activities

To address the needs of individuals and prevent suicide, there are a number of key elements:

- early identification and intervention;
- building individual resilience and the capacity for self-help;
- creating environments that encourage and support help-seeking;
- creating environments where it is acceptable to express emotions and suicidal thoughts without a fear of acrimony, personal weakness or stigmatisation; and
- ensuring access to the range of required support and care for people feeling suicidal.

Action Area 5

| Outcomes | Strategies |
|---|---|
| <p>Outcome 5.1. Improved access to a range of support and care for people feeling suicidal</p> | <ol style="list-style-type: none"> i. Develop and promote innovative programs to reach those in high-risk populations who traditionally do not access health services. ii. Make services highly visible and approachable. iii. Develop support systems for individuals who have attempted suicide and their families. iv. Support people with mental illness and related problems who are at risk of suicide. |
| <p>Outcome 5.2. Systemic, long-term, structural interventions in areas of greatest need</p> | <ol style="list-style-type: none"> i. Identify communities in which suicide and suicidal behaviour is prevalent, and proactively develop strategies and services that address the underlying causes and contributing factors. ii. Provide and resource mentoring and support for high risk groups and communities, to enable them to undertake effective suicide prevention activities. |
| <p>Outcome 5.3. Reduced incidence of suicide and suicidal behaviour in the groups at highest risk</p> | <ol style="list-style-type: none"> i. Support interventions for groups identified as high risk. This includes men aged 20-54 and over 75, men in Aboriginal and Torres Strait Islander communities, people with a mental illness, people with substance use problems, people in contact with the justice system, people who attempt suicide, people in rural and remote communities, gay and lesbian communities, and people bereaved by suicide. ii. Develop effective and sustainable interventions for groups and communities where suicidal behaviours are prevalent, by encouraging ownership and active involvement. iii. Develop and promote mental health and wellbeing programs in occupational groups whose members are subject to frequent traumatic events (eg Police, Emergency Services). iv. Provide support to the caring professions to minimise the likelihood of suicide amongst carers and clinical professionals. |
| <p>Outcome 5.4. Improved understanding, skills and capacity of front-line workers, families and carers</p> | <ol style="list-style-type: none"> i. Implement guidelines and support tools to improve the understanding and skills of front-line workers who routinely interact with high risk groups, to identify and respond rapidly to suicide warning signs, tipping points and imminent risk factors. ii. Provide education and information for consumers and carers involved with at-risk individuals and groups to enable them to identify and respond rapidly to suicidal behaviour. iii. Develop and resource discharge planning, clinical handover and transition to community care and support that recognises the increased risk to individuals at and after discharge. iv. Educate and inform professionals, service providers, families and community organisations in the provision of safe and secure care environments for people at risk. v. Provide access to training programs at undergraduate, post-graduate and vocational levels. Wherever possible, these should be multidisciplinary and cross-agency. |

Action Area 6

Implementing standards and quality in suicide prevention

Suicide prevention programs need to reflect evidence of what works and does not work, and to communicate it effectively to the point of need.

Action Area 6

| Outcomes | Strategies |
|--|---|
| <p>Outcome 6.1. Improved practice, national standards and shared learning</p> | <ul style="list-style-type: none"> i. Develop and promote national standards specific to suicide prevention. ii. Disseminate evidence to underpin practice. iii. Identify the skills and training required to work effectively in suicide prevention. |
| <p>Outcome 6.2. Improved capabilities and promotion of sound practice in evaluation</p> | <ul style="list-style-type: none"> i. Promote systematic evaluation of suicide prevention initiatives. ii. Promote the role of evaluation and research in expanding the evidence base of suicide prevention and assist in continuously improving practices. iii. Develop and promote robust and accountable evaluation models and processes. iv. Improve the capacity to undertake sound evaluations. |
| <p>Outcome 6.3. Systemic improvements in the quality, quantity, access and response to information about suicide prevention programs and services</p> | <ul style="list-style-type: none"> i. Develop and maintain timely, robust and transparent reporting systems to ensure that information on suicide programs is available. ii. Enable access to information about suicide prevention programs, so that new programs can build on past experience. iii. Encourage and support shared learnings to reduce duplication and promote good practice. iv. Promote and provide funding arrangements to enable and facilitate flexible community responses to emerging practice and identified and demonstrable needs. |

Appendix A: Relevant government and non-government policies, programs and activities

Australian Government

National Suicide Prevention Strategy
livingisforeveryone.com.au

Department of Health and Ageing
www.health.gov.au and www.mentalhealth.gov.au

National Drug Strategy 2004-2009
www.nationaldrugstrategy.gov.au

National Alcohol Strategy 2006-2009
www.alcohol.gov.au

National Policy Framework for Indigenous people
www.indigenous.gov.au

Department of Families, Housing, Community
Services and Indigenous Affairs' Community Mental
Health Programs
www.facsia.gov.au

Family Court of Australia Mental Health Support Program
www.familycourt.gov.au

Department of Veterans' Affairs
www.dva.gov.au

State and Territory Government

Western Australia

WA Ministerial Council on Suicide Prevention
www.mcsp.org.au

WA Suicide Prevention Plan
www.mcsp.org.au/prevention/prevention_plan

South Australia

Government of South Australia Department of Health
www.health.sa.gov.au

Mental Health
www.health.sa.gov.au/mentalhealth

New South Wales

NSW Health
www.health.nsw.gov.au

Centre for Mental Health
www.health.nsw.gov.au/policy/cmh

Victoria

Victoria Health
www.health.vic.gov.au

Mental Health
www.health.vic.gov.au/mentalhealth

Tasmania

Department of Health and Human Services
Tasmanian Suicide Prevention Steering
Committee (TSPSC)
www.dhhs.tas.gov.au

Mental Health
[www.dhhs.tas.gov.au/health_and_wellbeing/
mental_health](http://www.dhhs.tas.gov.au/health_and_wellbeing/mental_health)

Queensland

Department of Communities
www.communities.qld.gov.au

Suicide Prevention
[www.communities.qld.gov.au/community/
suicide_prevention](http://www.communities.qld.gov.au/community/suicide_prevention)

Northern Territory

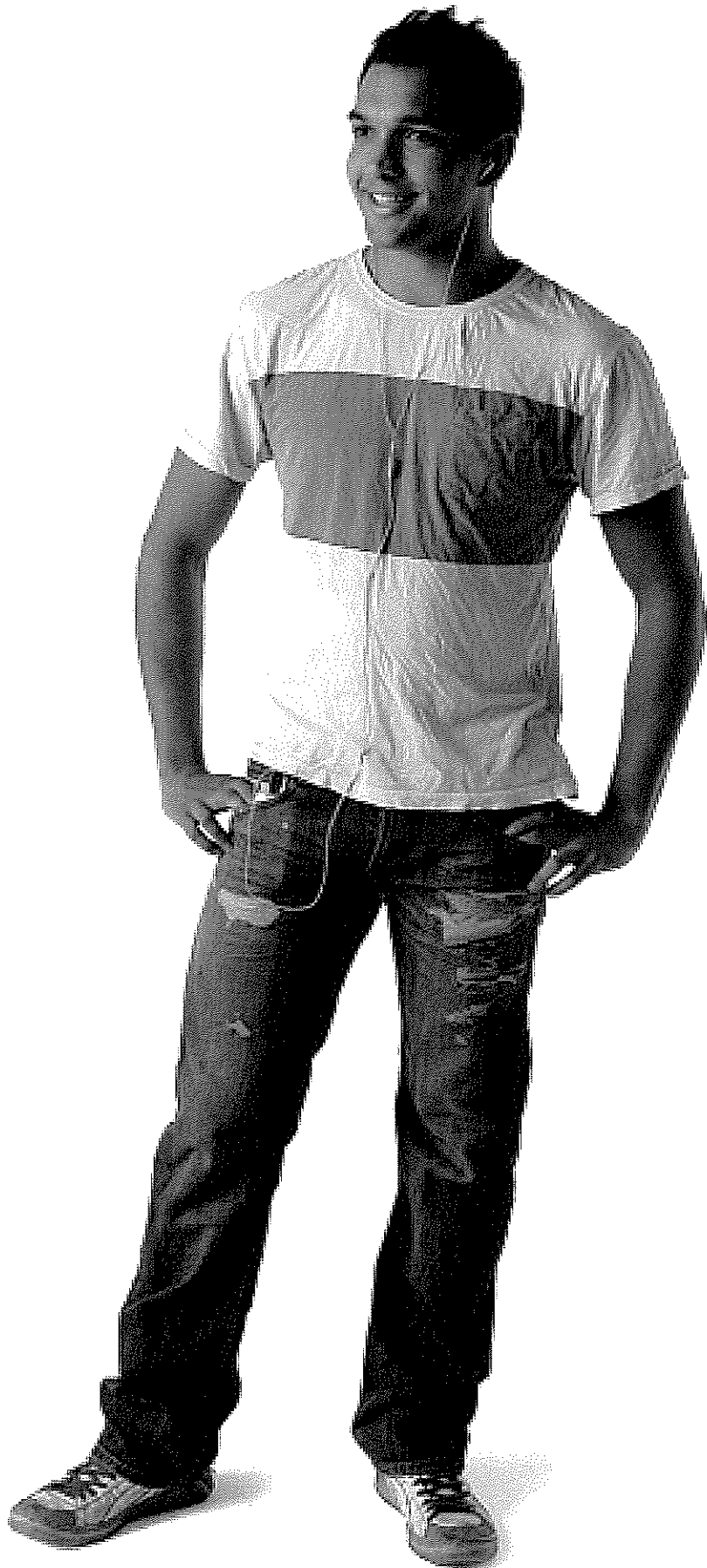
Department of Health and Families
www.health.nt.gov.au

Mental Health
www.health.nt.gov.au/Mental_Health

Australian Capital Territory

ACT Health
www.health.act.gov.au

Mental Health
www.health.act.gov.au/mentalhealth



Glossary of terms

Aboriginal and/or Torres Strait Islander: A person who is of Aboriginal or Torres Strait Islander descent; and identifies as an Australian Aboriginal or Torres Strait Islander person; and is accepted as such by the community in which s/he lives or has lived.

Adverse life event: An incident within one's life that has the potential to cause emotional upset, disruption, or negative health outcomes.

Bereavement: The period after a loss (usually through death) during which grief is experienced and mourning occurs (Raphael, 1984).

Best practice: The use of methods (often evidence-based) that achieve improvements and/or optimal outcomes.

Capacity building:

Individual - Enhancing and/or developing personal aptitude, strength, coping and/or independence.

Community - The ability of a community's organisations, groups and individuals (collectively) to build their structures, systems, people and skills, so they are better able to define, implement, manage and achieve their shared objectives.

Client-centred: Client-centred therapy or the person-centred approach is a movement associated with humanistic psychology that emphasises 'the capacity of each individual to arrive at a personal understanding of his or her destiny, using feelings and intuition rather than being guided by doctrine and reason. Rather than focusing on the origins of client problems in childhood events (psychodynamic) or the achievement of new patterns of behaviour in the future (behavioural)... concentrate on the here and now experiencing of the client' (McLeod, 2003, p. 157).

Clinical paradigm: This paradigm focuses on repairing damage within a disease or medical model of human functioning.

Cognitive: Mental processes and conscious intellectual activities such as planning, reasoning, problem solving, thinking, remembering, reasoning, learning new words or imagining.

Common factors (therapy): Features of therapy that are common to success, despite the differing theoretical position of each therapist and the specific techniques used.

Community ownership: A community takes responsibility for an issue, such as suicide, and agrees to work together to develop effective and sustainable solutions.

Connectedness: Enquiry into protective factors for suicide has focused on the capacities within people (resilience factors) and on external protective factors (Seifer *et al.* 1992), including a person's sense of belonging and connectedness with others. There is evidence that connections with family, school or a significant adult can reduce risk of suicide for young people. Feelings of connectedness to a partner or parent or responsibility for care of children appear to be protective factors, and connectedness within a community has been linked to health and wellbeing.

Content: The quality and the proportion or quantity of information adequately matched to the need.

Continuing care: Engagement with longer-term treatment, support and care where needed.

Data: Statistics that inform on specific aspects of suicide, such as rates and trends of suicide and suicide attempts. Data collection can also be a means of monitoring service arrangements, such as post-discharge follow-up or outcomes.

Glossary of terms (continued)

Deliberate self-harm: Any behaviours causing destruction or alteration of body tissues, with or without the intent to die, including self-injury.

Distal factors: see risk factors.

Effectiveness: Whether there is the capacity to bring about an effect or outcome.

Efficacy: The capacity of a service to deliver a desired result or outcome.

Efficiency: The production of an agreed output with a minimum of waste and the minimum consumption of resources (time, cost, labour).

Evaluation: 'The continuous process of asking questions, reflecting on the answers to these questions and reviewing ongoing strategy and action' (Commonwealth of Australia, 2001, p.4).

Evidence-based: Approaches that use and are based on clear evidence from existing literature.

Gatekeeper: A person who holds an influential position in either an organisation or a community who coordinates or oversees the actions of others. This could be an informal local opinion leader or a specifically designated person, such as a primary-care provider, who coordinates patient care and provides referrals to specialists, hospitals, laboratories, and other medical services.

Help-seeking: The process of an individual asking for help or support in order to cope with adverse life events or other difficult circumstances.

Holding environment: Refers to a therapeutic setting that permits the client to experience safety, and thus enhances therapeutic work.

Imminent risk: The point at which suicide is extremely likely in the near future; intervention may be necessary.

Indicated Intervention: Work with individuals who are showing early signs of risk for health problems, with the aim of preventing a condition from arising.

Indigenous Australians: A person who is of Aboriginal or Torres Strait Islander descent; and identifies as an Australian Aboriginal or Torres Strait Islander person; and is accepted as such by the community in which s/he lives or has lived.

Integrated response: Interventions that respond to a range of issues using a multi-faceted approach.

Intervention: To take action or provide a service so as to produce an outcome or modify a situation. Any action taken to improve health or change the course of or treat a disease or dysfunctional behaviour (Moore, 2004).

Jurisdiction: The area for which a particular government (Commonwealth, State or Territory) is responsible.

Loss: Loss is produced by an incident which is perceived to be negative by those involved and results in long-term change.

Medium: The mode, means or carrier (person or resource) through which information or support is provided.

Mental disorder: A recognised, medically diagnosable illness or disorder that results in significant impairment of an individual's thinking and emotional abilities and may require intervention. There are many different mental disorders.

Mental health problem: A situation in which a person experiences some disturbance or impairment of normal emotions and/or thinking.

Glossary of terms (continued)

Mental health promotion: Action to maximise mental health and wellbeing among populations and individuals.

Multi-faceted: Having many aspects or facets.

Multi-sector, multi-disciplinary approach: Approaches that involve a combination of expertise from a range of disciplines and professions, involving agencies, organisations, and persons from a range of distinct parts or branches of enterprise and/or society.

Peer education: The use of identified and trained peers to provide information aimed at increasing awareness or influencing behaviour change.

Population-based interventions: Interventions targeting populations rather than individuals. They include activities targeting the whole population as well as activities targeting population subgroups such as rural or Aboriginal and Torres Strait Islander peoples.

Post Traumatic Stress Disorder (PTSD):
A psychological disorder affecting individuals who have experienced or witnessed profoundly traumatic events, such as torture, murder, rape, or wartime combat, characterised by recurrent flashbacks of the traumatic event, nightmares, irritability, anxiety, fatigue, forgetfulness, and social withdrawal (Edgerton, 1994).

Postvention: Interventions to support and assist the bereaved after a suicide has occurred.

Predisposing factors: Non-modifiable factors that may increase a person's susceptibility to suicidal behaviours, such as genetic and neurobiological factors, gender, personality, culture, socio-economic background and level of isolation.

Prevention: Preventing conditions of ill health from arising.

Primary care: The care system that forms the first point of contact for those in the community seeking assistance. It includes community-based care from generalist services such as general practitioners, Aboriginal medical services, school counsellors and community-based health and welfare services.

Protective factors: Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.

Proximal factors: see risk factors.

Receptivity of client: The capacity and willingness of the person to receive and absorb information and support.

Recovery: Recovery is the process of a gradual restoration of a satisfying, hopeful and meaningful way of life.

Resilience: Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of suicide. Resilience is often described as the ability to bounce back from adversity. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, cognitive and emotional skills, communication skills and help-seeking behaviours.

Risk factors: Factors such as biological, psychological, social and cultural agents that are associated with suicide/suicide ideation and increase their probability. Risk factors can be defined as either distal factors, such as genetic or neurochemical factors, or proximal factors, such as life events or the availability of lethal means - factors which can 'trigger' a suicide or suicidal behaviour.

Selective intervention: Activities that target population or community groups at higher risk for a particular problem, rather than the whole population or particular individuals. This might include working with the families of those bereaved through suicide or, for instance children who have been traumatised or abused over time.

Self-injury: Deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Sometimes called non-suicidal self-injury, self-inflicted injuries or self-harm.

Suicide: The act of purposely ending one's life.

Suicidal behaviour: Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

Suicidal ideation: Thoughts about attempting or completing suicide.

Suicide prevention: Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

Support: To assist with the burden or the weight of an issue, problem or adversity. Support can take many forms, including information provision, services and face-to-face counselling.

Glossary of terms (continued)

Sustainability: The ability of a program to function over the long-term.

Timeliness of service: Provision of information, service or support at the most appropriate or opportune moment for it to be received, understood and meaningfully applied.

Tipping point: The point at which a person's risk of suicide increases due to the occurrence of some precipitating event, such as a negative life event or an increase in symptoms of a mental disorder.

Universal intervention: Interventions that target the whole of a population or populations. In suicide prevention, these include activities to reduce access to means of suicide, or to create stronger and more supportive families, schools and communities.

Warning signs: Behaviours that indicate a possible increased risk of suicide, such as giving away possessions, talking about suicide or the withdrawal from family, friends and normal activities.

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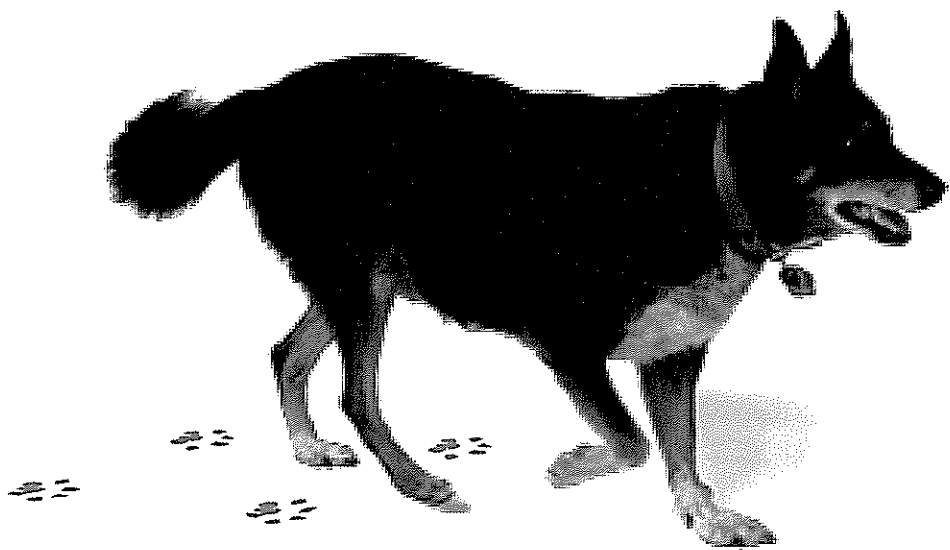
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**NORTHERN TERRITORY STRATEGIC FRAMEWORK
FOR SUICIDE PREVENTION**

**A framework for the prevention of suicide and
self-harm in the Northern Territory 2003**

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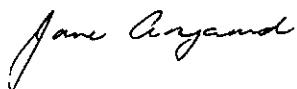
FOREWORD

This Northern Territory Strategic Framework for Suicide Prevention acknowledges and builds on existing initiatives responding to suicide and self-harm, as well as confirming key directions and pathways for future activities supported by government and non-government sectors, communities and individuals across the Territory. It responds to widespread concern about the high rates of suicide and self-harming behaviour among some age groups and populations, and presents the evidence on actions that can help address this tragedy.

The Framework reflects Government's priorities, including a commitment to improving mental health care and is linked to a number of related national initiatives, including the National Suicide Prevention Strategy and the National Mental Health Strategy.

I would like to take this opportunity to thank all those people who contributed to the development of the Framework. It has been informed by consultation with community groups and individuals through intersectoral and public forums across the Northern Territory (NT). It has been developed with considerable assistance from the Suicide Prevention Interdepartmental Committee (SPIDC) and members are thanked for their valuable contribution in ensuring the document reflects key concerns and directions. The Committee comprised senior representatives from the Departments of Health and Community Services (Chair); Employment, Education and Training; Chief Minister (Office of Youth Affairs); Community Development, Sport and Cultural Affairs; Justice; Police, Fire and Emergency Services; and the Commonwealth Department of Health and Ageing.

I also want to specifically acknowledge the valuable contribution and support provided by the NT Coroner's Office in compiling this Framework.



The Hon. Jane Aagaard MLA
Minister for Health and Community Services

October 2003

EXECUTIVE SUMMARY

Background

Suicide is a tragedy that affects many Australian families and communities each year. There is nation-wide concern, with action being undertaken across all levels of government and the community. Suicide is complex and related to an accumulation of risk and protective factors. It intersects with a range of problems across society including mental health, drugs and alcohol, family issues, employment, cultural identity, law enforcement, criminal justice, education and poverty.

This Strategic Framework for Suicide Prevention 2003 provides a platform to guide planning and development of initiatives with a focus on life promotion and the prevention of suicide and self-harm in the Northern Territory (NT). It is based on a whole-of-government and community approach that supports action across all levels of government, covers the entire lifespan, includes a spectrum of interventions and builds on existing services and supports. It provides key directions and pathways for future activities undertaken by sectors and communities with an interest in suicide prevention. It is a significant effort that is consistent with Government's priorities and good practice across a spectrum of approaches.

Key related initiatives include: Living is for Everyone (LIFE): A framework for prevention of suicide and self-harm in Australia (Commonwealth Department of Health and Aged Care CDHAC 2000a), the cornerstone of the National Suicide Prevention Strategy (NSPS); the National Mental Health Strategy; National Drug Strategic Framework 1998–99 to 2002–03; and National Anti-Crime Strategic Framework; the NT Government's Supporting Families and Building A Safer Community: Tough on Drugs policies and Domestic and Aboriginal Family Violence Strategies; and the NT Aboriginal Emotional and Social Wellbeing Strategic Plan (under development).

Trends in suicide rates

Extra care needs to be taken when interpreting suicide rates in the NT because of the relatively small number of suicide deaths and yearly fluctuations. However, it is clear that there are some significant differences between NT and national suicide rates and trends. The suicide rate for the NT has been higher than the national rate for the past decade and continues to rise. Whilst the national suicide rate has remained relatively constant, suicide deaths in the Northern Territory have increased over the past decade. In 2000, the NT rate was approximately 45–50% higher than the national rate (20 per 100,000 compared to 13 per 100,000) (ABS Information Paper: Suicides 2001).

Indigenous suicide rates have increased significantly. Until the early 1990s, reported suicide rates amongst Indigenous people in the Territory were significantly lower than for non-Indigenous Territorians. In 1990, no suicide deaths were recorded amongst Indigenous people. Whilst the relatively small numbers overall make it difficult to identify significant trend changes, 18 Indigenous people were recorded as having completed suicide in 1999 (ABS 2000), reflecting a substantial increase over a relatively short period of time. The suicide rate for NT Indigenous males has significantly increased in the 15–24 year age group since 1995, whilst there was a slight increase in suicide rates in the same non-Indigenous cohort over this period (ABS Death Registration Data).

The high and increasing national suicide rate for men aged 25–44 years is consistent with NT trends. There has been an increase in suicide rates for both Indigenous and non-Indigenous NT males in this age group over the past decade (ABS 2000). The rate amongst non-Indigenous NT males is comparable to the national average. Indigenous males in the NT within this age cohort experience significantly higher rates of suicide than the national average (ABS 2000).

What influences suicide?

While there is debate about the relative importance of different risk and protective factors related to suicide, some studies indicate that the most significant risk factors are: a history of mental illness; mental illness combined with harmful drug use; prior suicide attempt or deliberate self harm; and a family history of suicide or suicidal behaviour (CDHAC 2000b; Hilman et al 2000).

While comparatively little research has been conducted on the relationship between individual protective factors and suicide, the available evidence suggests that connectedness to family and community, relationships, personal resilience and economic security all play a part (CDHAC 2000b).

Effective responses to suicide

There is no single route to a reduction in suicide rates. It is nationally and internationally recognised that effective suicide prevention should combine population strategies with those aimed at high-risk groups. Prevention efforts need to minimise risk and enhance protective factors using a range of approaches targeting the whole population, specific groups and individuals 'at risk'. This means responsibility and ownership of suicide prevention initiatives is broad and must involve all levels of government, the non-government sector, local communities and individuals.

Areas for Action

The six areas for action in this Strategic Framework are based on the LIFE framework and include supporting rationales, evidence base and strategies for each action area:

| | |
|-----------------------------|--|
| Rationale | Sets out the reasons which support the choice of action. |
| Evidence | Presents the available evidence for the most effective approaches in each action area. Examples of existing approaches and projects, which have demonstrated effectiveness, are also provided. |
| Suggested Strategies | Identifies a broad range of tasks that will make a difference when implemented. |
| Assessing Progress | Provides a check list to track progress toward the anticipated outcomes and benefits arising from the implementation of each strategy. |

Action Area 1 — Promoting wellbeing, resilience and community capacity across the NT. Enhance protection against suicide by strengthening wellbeing, optimism, connectedness, resilience, health and capacity across the entire community, with a particular focus on young people and their families.

Action Area 2 — Enhancing protective factors and reducing risk factors for suicide and self-harm across the NT. Support initiatives that reduce risk factors and promote protective factors for suicide and self-harm, giving increasing attention to 'critical periods' or transition points through the life course where interventions have the potential to be most effective.

Action Area 3 — Services and support within the community for groups at increased risk. Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of suicide and self-harm, through prevention, recognition and response.

Action Area 4 — Services for individuals at high risk. Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal behaviour.

Action Area 5 — Partnerships with Indigenous people. Provide culturally appropriate programs that support community responses to high rates of suicide in Indigenous communities.

Action Area 6 — Progressing the evidence base for suicide prevention and good practice. Ensure that programs have the greatest chance of benefit and minimum risk of harm by building the evidence base, sharing good practice and providing education and training.

INTRODUCTION

Suicide is complex. It results from an accumulation of risk factors and intersects with problems across society that include mental health, drugs and alcohol, family issues, employment, cultural identity, law enforcement, criminal justice, education and poverty. Cross-government and community partnerships are critical to strengthen the ability of individuals, communities and agencies to tackle the high rates of suicide and self-harm in the Territory.

There is increasing evidence about interventions which help to prevent suicide and self-harm, and provide alternative life-affirming choices for individuals and communities impacted by the loss and grief that accompanies a suicide. This Strategic Framework aims to provide a conceptual and policy platform for effective suicide prevention in the NT. It explores the size and scope of the problem; including who is affected, which groups are at higher risk and what factors influence suicide risk. It also recognises that whilst mental health problems and disorders are a risk factor for suicide, and the health sector is a crucial player, effective suicide prevention approaches are dependent on a collaborative effort across all levels of government and the community. Responsibility and ownership of initiatives rests with all sectors where risk and protective factors are present.

POLICY CONTEXT

Suicide prevention activities in Australia are taking place in the context of worldwide concern about increasing rates of suicide, particularly among young males. Australia is recognised as one of the first countries to have developed a comprehensive approach to suicide prevention: Living is for Everyone (LIFE): A framework for prevention of suicide and self-harm in Australia is the cornerstone of the National Suicide Prevention Strategy (NSPS).

In line with the LIFE framework, the NT Strategic Framework identifies six areas for action with correlating strategies and indicators for assessing progress. It builds on existing services and supports that promote life and respond to suicide and self-harm, as well as confirming key directions and pathways for future activities supported by government and non-government sectors and communities across the Territory. Strategies are underpinned by a whole-of-government and community approach that supports action across all levels of government, covers the entire lifespan, and includes a spectrum of interventions. It is a significant effort that is consistent with Government's priorities and evidence based practice.

Key related initiatives include: the National Mental Health Strategy; National Drug Strategic Framework 1998–99 to 2002–03; and National Anti-Crime Strategic Framework which forms the empirical and policy basis for crime prevention in all jurisdictions; the NT Government's Supporting Families and Building A Safer Community: Tough on Drugs policies and Domestic and Aboriginal Family Violence Strategies; and the NT Aboriginal Emotional and Social Wellbeing Strategic Plan (under development).

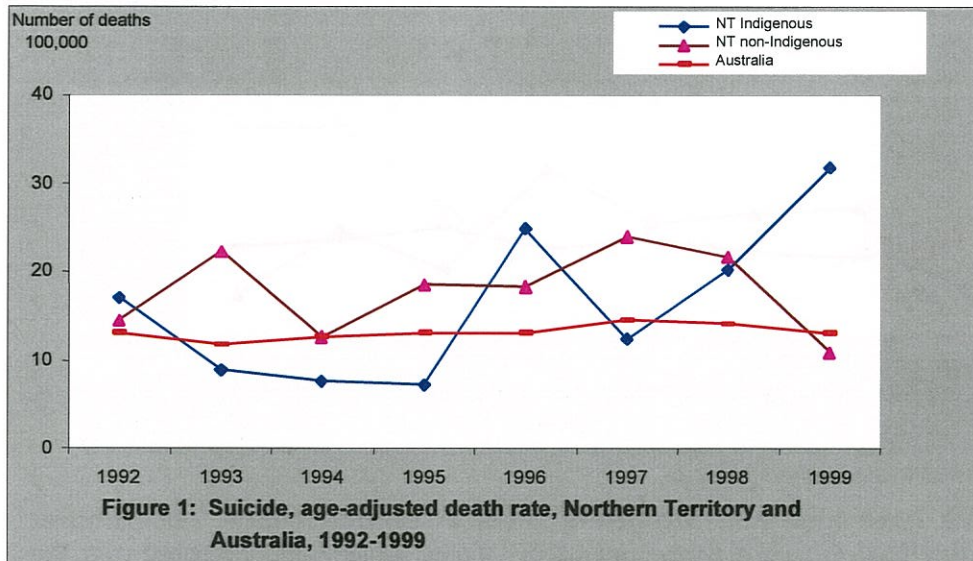
PREVALENCE OF SUICIDE IN THE NT

Several sources of data informed the development of this Strategic Framework including the Australian Bureau of Statistics (ABS), Northern Territory hospital and Coroner's records and the National Coroner's Information System (NCIS). Other sources included national and international studies, evidence-based reviews and reports. An analysis of the most recent published ABS data up to 1999, and evidence from unpublished sources indicates a number of significant trends.

The Northern Territory has high rates of suicide. Whilst the national suicide rates have remained relatively constant, suicide deaths in the Northern Territory have

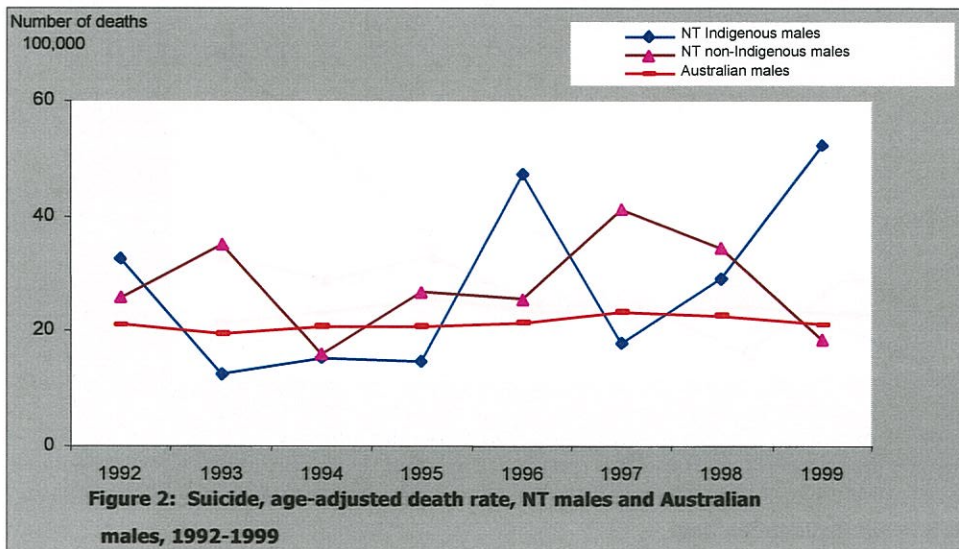
increased over the past decade. In 1999, the NT rate was 28% higher than the national rate (16.6 per 100,000 compared to 13.0 per 100,000).

Indigenous suicide has significantly increased. Until the early 1990s, reported suicide rates amongst Indigenous people in the Territory were significantly lower than for non-Indigenous Territorians. In 1990, no suicide deaths were recorded amongst Indigenous people. Whilst the relatively small numbers overall make it difficult to identify significant trend changes, 18 Indigenous people were recorded as having completed suicide in 1999, reflecting a substantial increase over a relatively short period of time. The adjusted suicide death rate of Indigenous people in the NT of 32 per 100,000 population in 1999 (Figure 1).



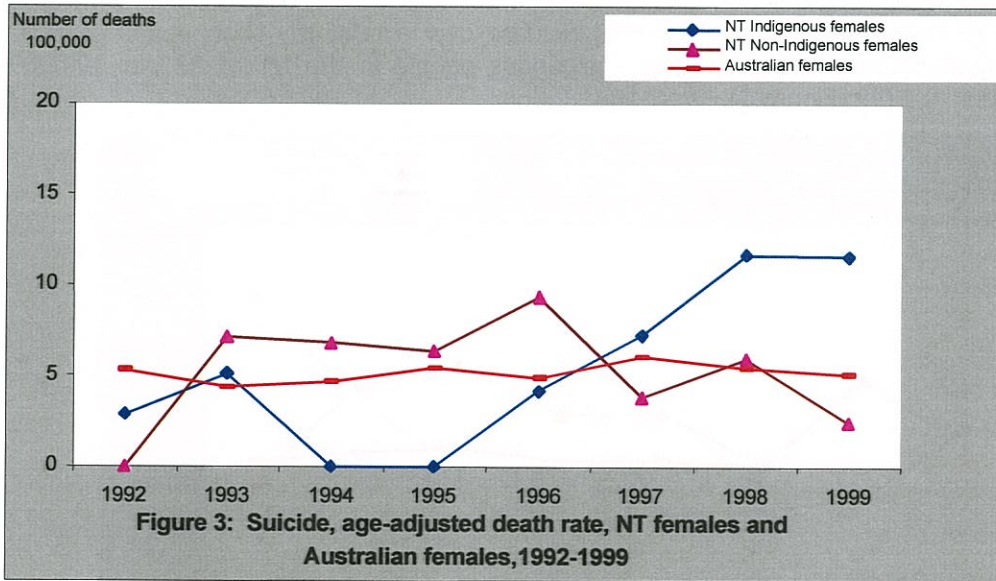
Data source: ABS Death Registration Data.

Indigenous men have increasing rates of suicide. NT Indigenous males had much lower suicide death rates in the early 1990s but have experienced a significant increase over the last ten years. The suicide death rate amongst Indigenous men in the NT has increased rapidly since 1997 to a point where in 1999, it was substantially higher than both the NT non-Indigenous male rate and the overall national rate (Figure 2).



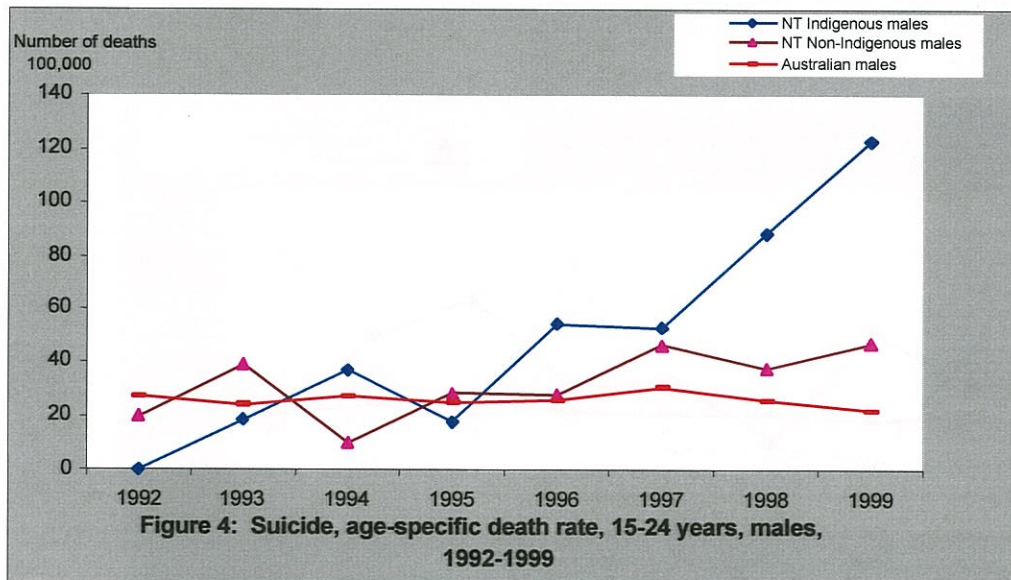
Data Source: ABS Death Registration Data

Indigenous females have increasing rates of suicide. NT Indigenous females had much lower suicide death rates in the early 1990s. There has been a consistent increase in the suicide rate over the last decade. There has been a rapid increase in suicide rates among Indigenous females in the NT since 1995 to a point where in 1999 the rate was substantially higher than both the NT non-Indigenous female rate and the national rate (Figure 3).



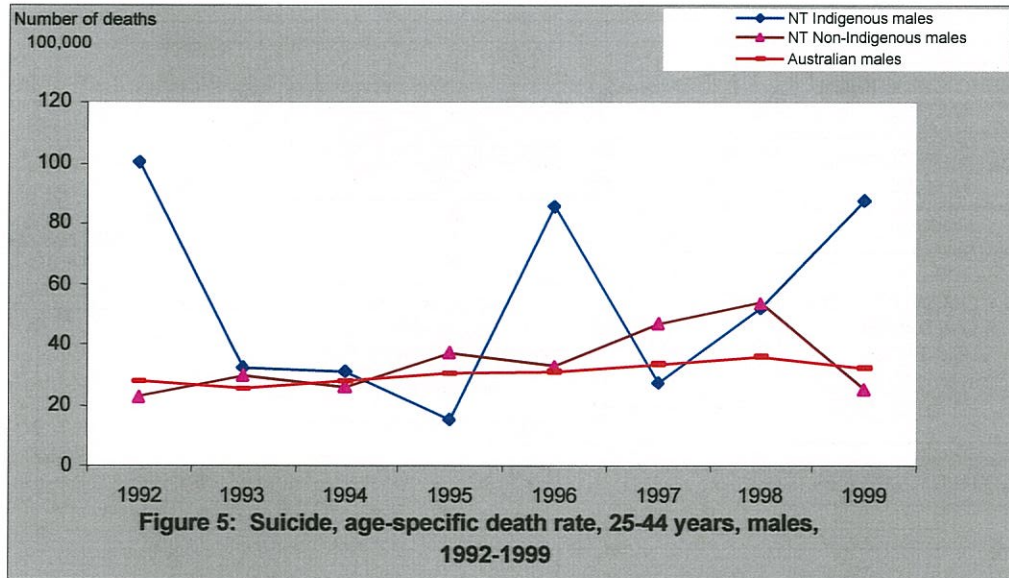
Data Source: ABS Death Registration Data

Young men have high and increasing rates of suicide death. Of particular concern is the trend in suicide rates amongst NT males, which have increased over the past decade. Young Indigenous males have recorded a rapid increase since 1997. The suicide rate for NT Indigenous males significantly increased in the 15–24 year age group from zero per 100,000 in 1992 to approximately 120 per 100,000 in 1999. There has also been an increase in the suicide rate for non-Indigenous males in the 15–24 year age group from 20 per 100,000 in 1992 to approximately 40 per 100,000 in 1999 (Figure 4).



Data Source: ABS Death Registration Data

High rates of suicide by men aged 25–44 years. The high and increasing national suicide rate for men aged 25–44 years is consistent with NT trends. There has been an increase in suicide rates for both Indigenous and non-Indigenous NT males in this age group over the past decade (ABS 2000). The rate amongst non-Indigenous NT males is comparable to the national average, however, Indigenous males in the NT within this age cohort experience significantly higher rates of suicide than the national average (ABS 2000) (Figure 5).



Data Source: ABS Death Registration Data

Attempted suicide and deliberate self-harm is a serious problem. Evidence from international studies suggest that the ratio of attempted suicide to suicide ranges from 4:1 to around 200:1. Women are also thought to be more likely to attempt suicide than men (CDHAC 2000b).

Data regarding intentional self-harm and attempted suicide is collected in NT public hospital records but needs to be treated with caution as:

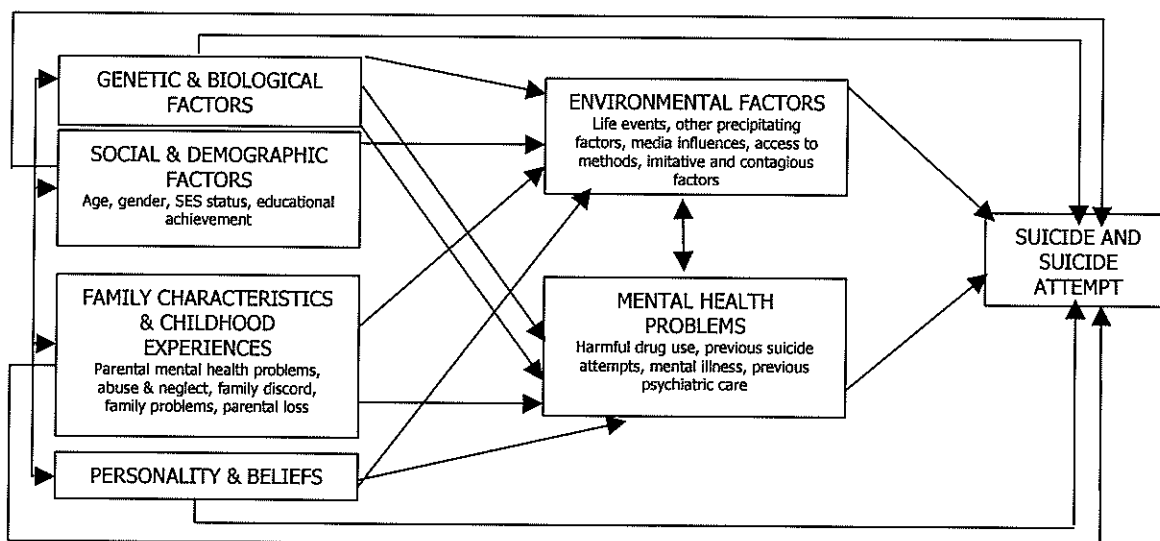
- not all people who attempt suicide present at hospital or places where this data could be registered;
- not all attempts are recognisable and may lead to misclassification eg single motor vehicle accidents; and
- self reporting measures for suicide attempts may not be reliable.

In addition, many incidents of intentional self-harm may not feature deliberate intent to commit suicide. Self-inflicted injury may occur in the context of cultural practices or risk-taking behaviours where there is no suicidal intent. Nevertheless, available data indicates the incidence of these behaviours presents a serious problem in the NT.

WHAT INFLUENCES SUICIDE?

A number of researchers have developed models on pathways to suicide and the complex interplay of factors involved. A model of risk factors for suicide and suicide attempts developed by Beautrais (1998) has been adapted for inclusion in the LIFE framework and is presented in Figure 1.

Figure 6: Risk pathway for suicide and suicide attempts



Source: Commonwealth Department of Health and Aged Care 2000 - Learnings About Suicide, p39.

Risk factors

The LIFE framework provides a detailed analysis of the available evidence on factors that influence suicidal behaviour. Most notable risk factors are: a history of mental illness; mental illness combined with harmful drug use; prior suicide attempt or deliberate self-harm; and a family history of suicide or suicidal behaviour (CDHAC 2000b; Hilman et al 2000). Other important factors include:

- socio-economic disadvantage, including low educational achievement and unemployment;
- legal problems, imprisonment or behaviour that brings the person into conflict with the law or society;
- sexual orientation, with studies showing gay, lesbian and bisexual people, particularly adolescents and young adults are at increased risk of suicidal behaviours and thinking;
- family adversity and child abuse and neglect;
- availability of means of suicide;
- stress, crises and losses, including loss of employment or physical health, relationship breakdown, death and other interpersonal loss; and
- cultural and social factors, including in particular those related to grief, loss and trauma experienced by Aboriginal people and community (CDHAC 2000b).

Limited research on suicide has been undertaken in the NT, however, a recent study of factors related to suicide by Parker and Ben-Tovim (2002) in the Top End found:

- mental illness prior to suicide;
- the most common stresses experienced by individuals prior to their death were relationship breakdown, trouble with family and friends and medical illness

(ranging from upper respiratory infections and mild diarrhoea to terminal cancer and HIV); significant alcohol abuse prior to suicide, particularly amongst males;

- in 60% of cases, families and friends described the victim as showing signs of a and
- 65% of people who died by suicide did not seek help prior to their death.

Protective factors

Comparatively little research has been conducted on the relationship between protective factors for individuals and suicide, however, the available evidence suggests they may include:

- connectedness to family and school;
- responsibility for children, family communication patterns;
- the presence of a significant other, an adult for a young person, a spouse or partner;
- personal resilience and problem-solving skills;
- good physical and mental health;
- economic security in older age;
- strong spiritual or religious faith;
- community and social integration; and
- early identification and treatment of mental disorders (CDHAC 2000b).

A FRAMEWORK FOR ACTION

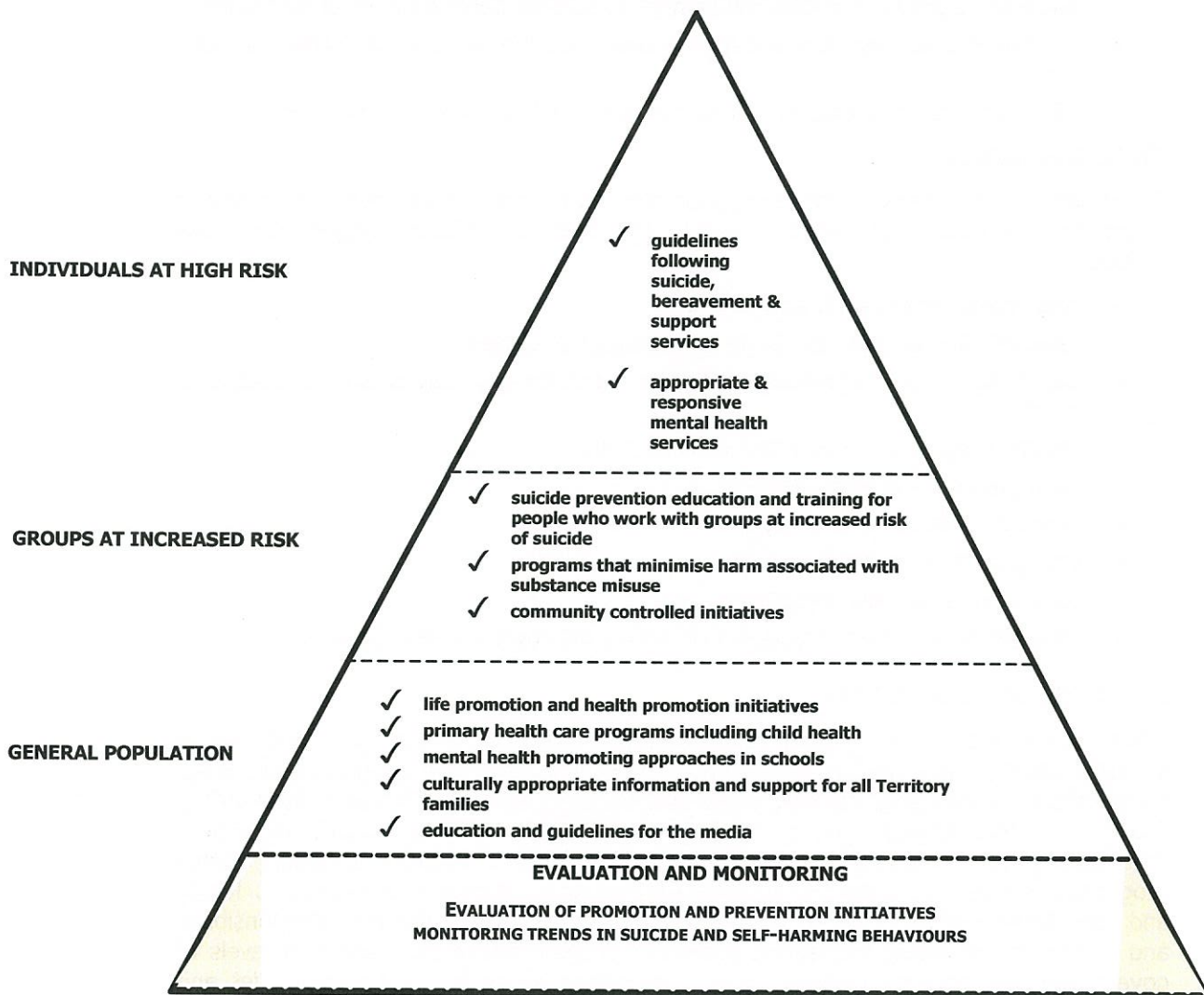
Whilst mental disorders and substance abuse are key factors that make the health sector a crucial player, many risk and protective factors for suicide also operate across other social outcomes, including violence, crime and school achievement (Resnick et al 1997). Broad preventive strategies need to be built upon what is known about the shared determinants and interventions across these domains, to harness synergies across programs, sectors and government portfolios including education, employment, family and community welfare, health, crime prevention and substance misuse. Responsibility and ownership of suicide prevention initiatives is broad and must involve all levels of government, the non-government sector, and include action by local communities and individuals.

It is nationally and internationally recognised that effective suicide prevention should combine population strategies with those aimed at high risk groups. Prevention efforts need to minimise risk and enhance protective factors with a diversity of approaches targeting the whole population, specific groups and individuals 'at risk' (See Figure 7).

The six areas for action described in this Strategic Framework address these different levels of suicide prevention, including:

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

Figure 7: Three levels of suicide prevention interventions



The six action areas cover the following aspects:

| | |
|-----------------------------|--|
| Rationale | Sets out the reasons, which support the choice of action. |
| Evidence | Sets out the available evidence for the most effective actions in the area. Examples of existing approaches and projects, which have demonstrated effectiveness, are provided. |
| Suggested Strategies | Identifies a broad range of tasks that will make a difference when implemented. |
| Assessing Progress | Intended to provide a check list of the anticipated outcomes and benefits resulting from the implementation of strategies. |

Responsibility for Action and Evaluation

Evaluation is critical to increasing the evidence base for future planning, monitoring trends and measuring the impact of action. As a lead agency, the Department of Health and Community Services will assume responsibility for coordinating a final review of the Framework that will include major achievements and progress by all relevant Departments.

ACTION AREA ONE

Promoting wellbeing, resilience and community capacity across the NT.

Enhance protection against suicide by strengthening wellbeing, optimism, connectedness, resilience, health and capacity across the entire community, with a particular focus on young people and their families.

Rationale

Increased personal resources such as resilience, self esteem and life skills as well as a sense of connectedness to others and belonging within family and the community may mediate life stresses or events and protect at risk groups from suicide. These strengths are best applied universally across the population and are most achievable through shifts in public policy which prioritises them as fundamental to the delivery of services to the community.

Evidence

'Happy, healthy, successful individuals with good social supports don't suicide, do they?' (Martin 2002, p.250). Traditionally, suicide prevention programs have largely focused on the prevention or reduction of risk factors and are yet to fully encompass the concept of enhancing health, particularly mental health. There is widespread belief that suicide does not occur in those who have good mental health, good interpersonal relationships, and family and community support. Martin (2002) suggests that to prevent suicide 'our best opportunity may be to increase the level of mental health in Australia, so that suicide never crosses anyone's mind'.

The concept of 'connectedness' as a protective factor against a range of ill health outcomes, including suicide and mental health problems, has received much literary attention in recent years. Research into the social determinants of health has convincingly demonstrated that social support and good social relations make an important contribution to health (Wilkinson and Marmot 1998).

Childhood and adolescence are particularly important periods for strengthening wellbeing and resilience. Evidence suggests that young people who are emotionally connected to their families, schools and community are less likely than their peers to suffer emotional distress, have suicidal thoughts and behaviours, be violent, drunk, smoke cigarettes or use cannabis (Roche 1999).

Examples of existing broad based strategies in the NT include expanded recreation and sporting programs sponsored by the Department of Community Development, Sport and Cultural Affairs, a range of programs promoting self-esteem by recognising and celebrating achievements of young people, recreational and developmental activities including National Youth Week funded by the Office of Youth Affairs, community based crime prevention initiatives, the Juvenile Diversion Program, universal parenting programs and family support services funded through the Department of Health and Community Services, and an

A Mental Health Promotion Resource for Secondary Schools

MindMatters is an innovative national mental health promotion program, which is being implemented in NT secondary schools following a successful professional development program for principals and teachers. MindMatters endeavours to strengthen young people's life skills and resilience whilst fostering a supportive school environment and a culture which encourages partnerships between school, family and the community.

increased focus on prevention and early intervention in the Mental Health and Alcohol and Other Drugs Programs.

| Strategies | Assessing Progress |
|---|--|
| <ul style="list-style-type: none"> • Implement and evaluate evidence based population approaches to improve mental health in settings and across the lifespan eg programs in childhood, schools, families, workplaces and community organisations. • Cross program resourcing for the implementation and evaluation of mental health promotion programs in primary and secondary schools. • Identify, review and adapt safe, accurate and appropriate community education materials that address stigma and discrimination. • Establish partnerships in mental health promotion and suicide prevention across government and community organisations including Health, Education, Justice, Sport and Recreation and Local Government. | <ul style="list-style-type: none"> • Increased number of programs based on primary prevention approaches to mental health (see National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000). • Increased number of schools adopting a health-promoting schools approach. • Increased number of community education materials disseminated and extent of dissemination. • Increased number of formal and informal partnerships that support population approaches across sectors eg MoUs and Agreements. |

ACTION AREA TWO

Enhancing protective factors and reducing risk factors for suicide and self-harm across the NT.

Support initiatives that reduce risk factors and promote protective factors for suicide and self-harm, giving increasing attention to 'critical periods' or transition points through the life course where interventions have the potential to be most effective.

Rationale

International and national data highlight key social and individual factors that are known to be associated, in a cumulative way, with higher rates of suicide. These include mental disorders, drug and alcohol problems, family adversity, child abuse and neglect and involvement in the justice system. These factors do not cause suicide, however, it has been suggested that they culminate in a constellation of stresses which undermine a person's capacity to cope. A coordinated whole-of-government and community approach is required to address these factors and develop personal skills and social structures to mediate their impact.

There is accumulating evidence and support for introducing strategies at particular developmental transitional points or 'critical periods' throughout the lifecourse when individuals tend to be more receptive to advice, support and learning opportunities that will help them successfully move into the next phase of life. Transitional periods include changing from primary to secondary school, leaving the family home, job insecurity, the transition to parenthood and events involving major change or loss.

Evidence

Given the strong association between mental health disorders and suicidal behaviour, suicide risk could potentially be reduced by increasing the general population's understanding of early signs of mental health problems and disorders and the availability of advice and effective treatment.

The use of peer support and peer based models can provide interventions at timely points and in settings where many services and professionals have limited opportunities to intervene. Research shows that peers are often the first points of contact when young people are seeking support, help and advice. Research also shows that peer models can stem the flow of inaccurate and inappropriate information being shared amongst peers and peer groups.

There is evidence to suggest that media and public presentations of suicide can increase rates of suicide. Similarly, the negative portrayal of mental illness further marginalises population subgroups and potentially affects help-seeking behaviour, particularly amongst young people. The Commonwealth Department of Health and Ageing has funded the development of a media resource kit, 'MindFrame', to encourage the responsible reporting and portrayal of suicide and mental disorders.

There is also growing consensus that school-based suicide awareness programs may encourage, rather than prevent, suicidal behaviour amongst young people. It is therefore recommended that general mental health issues are incorporated into school curricula and not suicide specific programs. 'MindMatters', a mental health promotion resource for secondary schools, and the 'Peer Skills Program' are examples of initiatives operating in some NT secondary schools.

Strong parental attachment, effective parenting skills and positive role modelling have consistently been identified as protective factors against a range of social problems. Roche (1999) argues that a strong relationship with a caring, capable adult (usually a parent) is the single most important protective influence on normal psychosocial development. This supports a focus on parents but also suggests that mentoring and extended family involvement should be fostered where parental participation is not possible.

| Strategies | Assessing Progress |
|---|---|
| <ul style="list-style-type: none"> • Work in partnership with other government departments and non-government agencies to address issues, which can increase risk of child abuse and neglect, drug and alcohol problems and involvement with the criminal justice system. • Develop and introduce a range of initiatives to support Territory families eg Triple P parenting program. • Disseminate information throughout the community about early signs and symptoms of mental health problems and help-seeking behaviour. • Implement early intervention initiatives targeting groups at risk of suicide identified in the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 eg education and training activities for young people, families and service providers on recognising depression. • Disseminate and support the 'MindFrame' project and media guidelines for reporting suicide and mental illness. • Identify and promote good practice in reporting suicide and mental illness. | <ul style="list-style-type: none"> • Increased number of joint initiatives and intersectoral action plans that address drug and alcohol problems, child abuse, criminal and juvenile justice issues. • Increased number of programs that address protective factors, eg increased number of programs that foster positive parenting skills. • Increased availability of information on the early signs and symptoms of mental health problems and disorders with particular reference to young people, eg range of appropriate materials, education and training that provide information on mental health problems and where to get help. • Increased opportunities for mental health practitioners and other frontline workers to improve their skills in assessment of young people who have or are at risk of developing mental health problems. • Decreased number of inappropriate portrayals of suicide and mental disorders in the media. • Increased availability of information to support media when reporting suicide and mental illness. |

ACTION AREA THREE

Services and support within the community for groups at increased risk.

Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of suicide and self-harm, through prevention, recognition and response.

Rationale

Stand alone services for suicide prevention are neither practical nor effective in the Northern Territory context. Prevention is best achieved by reorienting and focusing existing services and by enhancing the effectiveness of services that support individuals who are most at risk.

Mainstream services and agencies need to have an awareness of suicide issues, self-harm and associated risk factors and be equipped to act and refer appropriately. Primary health care and community based service providers are important contact points for people in crisis. It is therefore important to provide accessible and effective support, care and referral through these services.

Remote and rural communities face particular challenges. Suicide rates are often higher in these regions and access to services is limited.

Evidence

The majority of young people enjoy good health and the very young rarely present with suicidal behaviour. However, adolescence and young adulthood is a time when the individual is engaged in developmental tasks involved in establishing an adult identity separate from their parents. During this period, individuals are particularly vulnerable to substance related harm, development of mental health problems, and involvement in the justice system. The individual may also find it difficult to ask for and accept protective support from family or other care-givers. Prevention efforts need to be considered in the context of the young person's developmental processes, their peer relations and respond to the broad range of causal and contributory factors, including the promotion of protective factors such as resiliency, life skills and feelings of belonging.

It is understood that the process leading to suicide is often not an impulsive act but rather a continuum, beginning with suicidal thinking, suicide attempts and ending with completed suicide. A recent national survey found that, while more than one in five adults meet the criteria for a mental health disorder, 62% do not seek professional help (Andrews et al 1999). A recent study conducted in the Top End of the Northern Territory, indicated that nearly two-thirds of individuals who died by suicide had not sought help prior to their death (Parker and Ben-Tovim 2002).

However, most people contemplating suicide do give some signs of their intention. The people most likely to observe indications of suicidal tendencies are those close to the individual, such as their family, friends, teachers and colleagues. These people are also likely to know about any precipitating events and adverse factors in the individual's local environment and be useful resources for responding to the situation.

Applied Suicide Intervention Skills Training (ASIST)

The Living Works – **Applied Suicide Intervention Skills Training (ASIST)** program is a two day intensive participatory course designed to help participants recognise and assess persons at risk of suicide and master a model for effective suicide intervention. A support network for trainers who complete a five day program has also been established in the NT.

The evidence indicates that building the capacity of workers and organisations is crucial. Training programs for workers to identify, refer and work effectively with individuals at risk of suicide, may improve care and reduce suicide rates. The Living Works – Applied Suicide Intervention Skills Training (ASIST) program has been implemented across the Territory, including a significant number of remote communities. ASIST is a two day intensive participatory course designed to help participants recognise and assess persons at risk of suicide and master a model for effective suicide intervention. Participants are employed in a wide range of government, non-government and private organisations. A support network for trainers who complete a five day program has also been established in the NT. The Department of Health and Community Services has funded training on co-occurring mental health and substance abuse problems for clinicians and remote community workers.

| Strategies | Assessing Progress |
|---|--|
| <ul style="list-style-type: none"> • Implement and evaluate education and training, support materials and policies in issues relating to suicide that are culturally appropriate for people who work in a broad range of sectors including health, police, teachers, council workers and youth workers. • Develop systems for help seeking, advice and referral with a range of access points including local services (eg school counsellors, clergy, community health). • Ensure the availability of suicide prevention and mental health materials, support, resources and training that are culturally appropriate to workers in rural and remote communities. | <ul style="list-style-type: none"> • Increased training opportunities for workers to improve their capacity to recognise, respond to and refer individuals from a range of groups who are at increased risk of suicide, with particular reference to young people, Indigenous people and men. • Increased number of service providers who have received appropriate and quality suicide prevention training. • Increased number of rural and remote communities that have implemented suicide prevention initiatives. |

ACTION AREA FOUR
Services for individuals at high risk.

Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal behaviour.

Rationale

Efforts to prevent suicide must focus on those identified as high risk through targeted strategies and coordinated responses to suicidal behaviour. Health care providers are one of the main contact points for people with suicidal or self-harming behaviour, with many individuals considered 'high risk' presenting at emergency services and others seeking assistance from the primary care sector including community controlled organizations and General Practitioners. People who have mental health problems or mental disorders, misuse alcohol and other drugs, or have been exposed to forms of abuse and neglect are at particular risk.

Action Area Four selectively targets improvements in suicide prevention and intervention toward those individuals demonstrating disproportionate increases in risk of death by suicide, specifically Indigenous people, young people and men.

Evidence

One of the strongest indicators of suicide risk is a previous suicide attempt or deliberate self-harm and a history of mental illness. There is accumulating evidence from clinical and population studies indicating that harmful levels of alcohol and other drug use is also over-represented among those who die by suicide (Hillman et al 2000). Harm minimisation strategies that target substance misuse may also help reduce the incidence of suicide and self harm. Examples of strategies in place in the NT include liquor restrictions, complementary measures that support individuals affected by substance abuse, and the development of alcohol plans in remote communities.

Government's Supporting Families and Building A Safer Community: Tough on Drugs policies and Domestic and Aboriginal Family Violence Strategies identify risk and protective factors that are also linked to suicide and self-harm. Implementation of these policies will, in addition to preventing violence, criminal and antisocial behaviour, also contribute to the prevention of suicide and self-harm in the NT.

The potentially contagious impact of suicide death, particularly on young people and Aboriginal communities, can be more effectively managed if workers have access to good practice guidelines, and bereavement and support services

are available for family members and friends following a death by suicide. Postvention strategies for families, schools, workplaces and communities are also part of a suite of interventions required to respond to 'at risk' populations.

Life Promotion Officers have facilitated the establishment of suicide response task groups in some Top End and Central Australian communities. These groups work collaboratively with NT Coroner's Constables to provide follow-up support to people who attempt suicide, and postvention support and referral for bereavement counselling for those who have lost a loved one through suicide.

The **Bereavement Support Contact Card** and **Care and Support Pack** offers a referral point for family, friends, peers, communities and other relevant people affected by suicide. It is a collaborative venture between the Life Promotion Program and the Coroner's Department of the Northern Territory. NT Coroner's Constables and Accident and Emergency Department staff distribute the card.

| Strategies | Assessing Progress |
|--|---|
| <ul style="list-style-type: none"> • Build effective links between services responding to incidents of attempted suicide and self-harm including emergency departments, ambulance services, police, community mental health, GPs, community health, general hospital, drug and alcohol treatment and prevention services. • Provide appropriate training and support to staff responding to suicide, self-harm, drug harm or mental health crises. • Incorporate policies and practices that support suicide prevention initiatives and respond to attempted or completed suicides within emergency services, mental health services, schools, workplaces and juvenile and adult correctional facilities. • Establish partnerships between police, ambulance, hospitals, schools and community organisations to improve support in the community for people bereaved or affected by suicide. | <ul style="list-style-type: none"> • Evidence of agreed protocols and guidelines in departments/agencies providing emergency response to suicide and self-harm. • Evidence of compliance with agreed protocols/guidelines on responding to suicide and self-harm. • Evidence of links and collaborative practice approaches between key programs and agencies including mental health and alcohol and drugs services. • Increased numbers of government and non-government service providers who have received training on effective interventions for people who are at high risk of suicide. • Increased suicide prevention initiatives focusing on Indigenous people and men aged 25–44 years. • Evidence of protocols for responding to attempted and completed suicides within emergency services, mental health services, schools, workplaces and juvenile and adult correctional facilities. • Evidence of protocols in hospitals and community health settings for staff on the use of risk assessments and notification of persons who are considered at risk. • Increased initiatives to respond to, and support people bereaved or directly affected by suicide. |

ACTION AREA FIVE
Partnerships with Indigenous people.

Provide culturally appropriate programs that support community responses to high rates of suicide in Indigenous communities.

Rationale

Although traditional culture protects against suicide in some communities, it is recognised that Aboriginal people may be at increased risk because they experience a greater burden of social problems and stresses which may be exacerbated by a lack of access to health and social support services. Despite such adversity, Aboriginal people have shown tremendous strength and resiliency. Connectedness to country, culture and community, and relationships with extended families are important sources of strength and offer some protection from the effects of racism.

Community involvement and control is essential in any efforts that aim to break the cycle of suicide, self-harm, grief, loss and trauma. The National Aboriginal Community Controlled Health Organisation (NACCHO) defines Aboriginal community control as 'a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the community' (NACCHO 1997).

Specific prevention strategies for Indigenous people need to be integrated with culturally effective health services and community capacity building to facilitate action on a range of social issues including self-harm. This approach acknowledges the relationship between suicide risk and other health and social issues and is consistent with a community development approach.

Evidence

Renowned for his contribution to an increased understanding of Aboriginal suicide, Colin Tatz (2001) identified a number of risk factors specifically relevant for Aboriginal populations, including:

- no sense of purpose in life;
- few role models and mentors;
- ineffective parenting;
- sexual assault;
- alcohol and other drugs;
- animosity and jealousy;
- grief cycles; and
- illiteracy.

The Ways Forward report highlighted the critical importance of Aboriginal community control and community participation in the development, implementation and evaluation of programs (Swan and Raphael 1995). Examples of successful community initiated action includes 'Strong Men's' and 'Strong Women's' groups established in many remote communities.

Based on community development principles, **Crisis Intervention Committees** promote physical, emotional, spiritual and cultural well being of people, families and communities by facilitating community responsibility through community owned and developed initiatives. It aims to heal and empower Indigenous communities to reduce self-harm and suicide by providing options to move to a healthier lifestyle through culturally relevant initiatives. Committees have been established in some Top End and Central Australian communities. In communities with existing structures and processes, for example, preventable chronic disease networks and the night patrol networks, the Life Promotion Team build the capacity of these committees to address suicide prevention and related issues. Committees are coordinated by local government community councils and include representatives from different language and skin groups, and service providers.

The groups facilitate community discussion on issues of concern and identify local solutions to problems. Some communities have also established a Crisis Intervention Committee based on community development principles, to provide a coordinated, community response to crisis events. These Committees are often coordinated by local government community councils and include representatives from different language and skin groups and service providers. Many people in remote communities have also participated in the Applied Suicide Intervention Skills Training (ASIST), which has increased their ability to respond to crisis situations.

International and national evidence indicates that Indigenous health and welfare services are most effective when delivered by Indigenous professionals. Greater emphasis needs to be placed on the unique expertise and understanding of Aboriginal emotional and social wellbeing that Aboriginal health and mental health workers, traditional healers and other community members possess (RANZCP 2002).

The Top End Division of General Practice (TEDGP) manages a program that enables remote communities to engage, train and support Aboriginal Mental Health Workers (AMHWs) to work in partnership with General Practitioners (GPs). A Partnership Agreement has been developed to formalise cooperative arrangements between the TEDGP, Top End Mental Health Service, Batchelor Institute of Tertiary Indigenous Education and Charles Darwin University to support AMHWs, GPs and visiting teams in addressing mental health needs in remote communities in a culturally appropriate service delivery model.

| Strategies | Assessing Progress |
|--|---|
| <ul style="list-style-type: none"> • Ensure information and training support is available to mainstream and Indigenous health and community agencies on suicide prevention throughout the NT. • Increase the input of Indigenous people into policy, program and service development. • Support the implementation of linked initiatives including the NT Emotional and Social Wellbeing Strategic Plan and the NT Domestic and Aboriginal Family Violence Strategies. • Increase access to effective life promotion and suicide prevention initiatives and activities that are culturally appropriate and relevant for Indigenous people's wishes, stage in life, education background and state of health. | <ul style="list-style-type: none"> • Increased number of initiatives that effectively address issues such as substance abuse, violence and relationship breakdown as social issues contributing to self-harm and suicide in Aboriginal communities. • Increased opportunities for remote community members to participate in training on suicide prevention eg ASIST. • Evidence of Indigenous organisations and communities' involvement in the design, implementation and evaluation of policies, planning and service development. • Evidence of the implementation and monitoring of the NT Emotional and Social Wellbeing Strategic Plan and the NT Domestic and Aboriginal Family Violence Strategies. • Continued resourcing for life promotion and suicide prevention programs grounded in the culture of Indigenous people. |

ACTION AREA SIX

Progressing the evidence base for suicide prevention and good practice.

Ensure that programs have the greatest chance of benefit and minimum risk of harm by building the evidence base, sharing good practice and providing education and training.

Rationale

A strong evidence base is needed to guide planning and funding for effective interventions in resource challenged environments. The complexity of suicide as a social problem and the considerable investment in prevention efforts across Australia, require a commitment to continued development, implementation and evaluation of best practice models as well as a skilled workforce. This process is integral to ensuring the effectiveness of programs and developing a knowledge base about what works.

Evidence

Data on suicide and suicidal behaviour is available from several sources and is important to determine the size and scope of suicide and associated problems. Ensuring this information is presented in an accurate, timely and useful manner presents a significant challenge. There are lengthy delays in the release of official data from the Australian Bureau of Statistics (ABS) due to a range of factors including complex validation processes. However, enhancements to the National Coronial Information System (NCIS) will enable more accurate, timely and comprehensive data on suicides. Effective links between key agencies such as the Department of Health and Community Services and the Coroner's Office will also improve the quality of data collection and analysis.

The Department of Health and Community Services has commissioned the Cooperative Research Centre for Aboriginal Health to undertake **a review of health promotion strategies that are effective in improving Indigenous mental health** to guide future planning.

This authoritative evidence based document will be a key resource to inform action across a range of sectors, including workers and planners with an interest in violence, suicide prevention, crime prevention and social development.

Suicide prevention programs need to be based on good practice and the best available evidence. This requires systematic and appropriate evaluation of intervention and prevention programs, research into a range of issues related to suicidal behaviour and suicide prevention and regular reviews of literature to determine effective suicide prevention programs. Research and evaluation results need to be widely disseminated to inform future action.

| Strategies | Assessing Progress |
|--|--|
| <ul style="list-style-type: none"> • Establish and support partnerships between coronial and health information systems, and population and mental health surveillance systems, including mental health services, GPs, private psychiatrists and Aboriginal medical services. • Investigate the development of data systems to underpin suicide prevention activities across health, welfare, justice and education sectors. | <ul style="list-style-type: none"> • Evidence of up-to-date information being maintained on suicide and self-harm data, trends and emerging issues to inform research, policy and service delivery. • Evidence of formal partnerships and agreements between key agencies with an interest in research, information and evidence-based practice in suicide prevention. |

| | |
|---|---|
| <ul style="list-style-type: none"> • Support research that builds the evidence on what helps reduce risk factors for suicide and self-harm, and enhances protective factors for good mental health. • Support development and dissemination of good practice guidelines for responding to suicide, self-harm and mental health problems and disorders. • Support evaluation of suicide prevention initiatives through publication, dissemination of evaluation resources and, where appropriate, education and training. | <ul style="list-style-type: none"> • Evidence of research that builds the evidence base for good practice in preventive approaches in the NT. • Evidence and implementation of guidelines and protocols consistent with good practice identified through research, evaluation, consumer consultation and expert consensus. • Increased numbers of workers participating in suicide prevention training in urban, rural and remote areas. • Dissemination of evaluation resources to service providers and community agencies. • Evidence of suicide prevention related programs being evaluated. |
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