Let’s Talk Suicide Scope of the problem

Acknowledging lived experience

A lived experience of suicide is having experienced suicidal thoughts, survived a suicide attempt, supported a loved one through suicidal crisis, or been bereaved by suicide.

(Adopted by the International Association for Suicide Prevention and World Health Organisation)

Aboriginal and Torres Strait Islander Lived Experience definition

(The Aboriginal & Torres Strait Islander Lived Experience Centre also co-designed a definition for Aboriginal and Torres Strait Islander people)

A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples ways of understanding social and emotional wellbeing.

Impact:

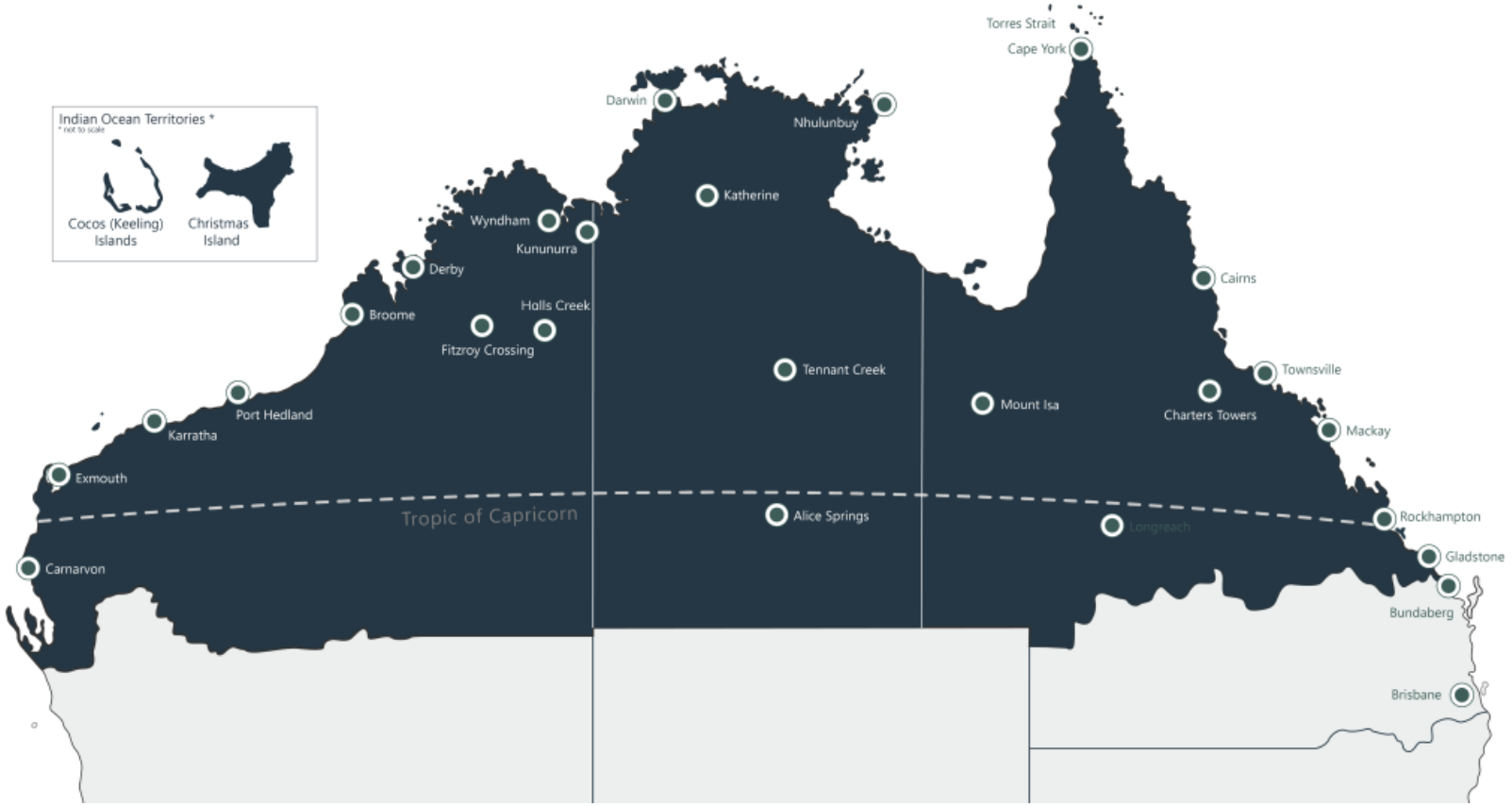
135 people for a death by suicide

Reach :

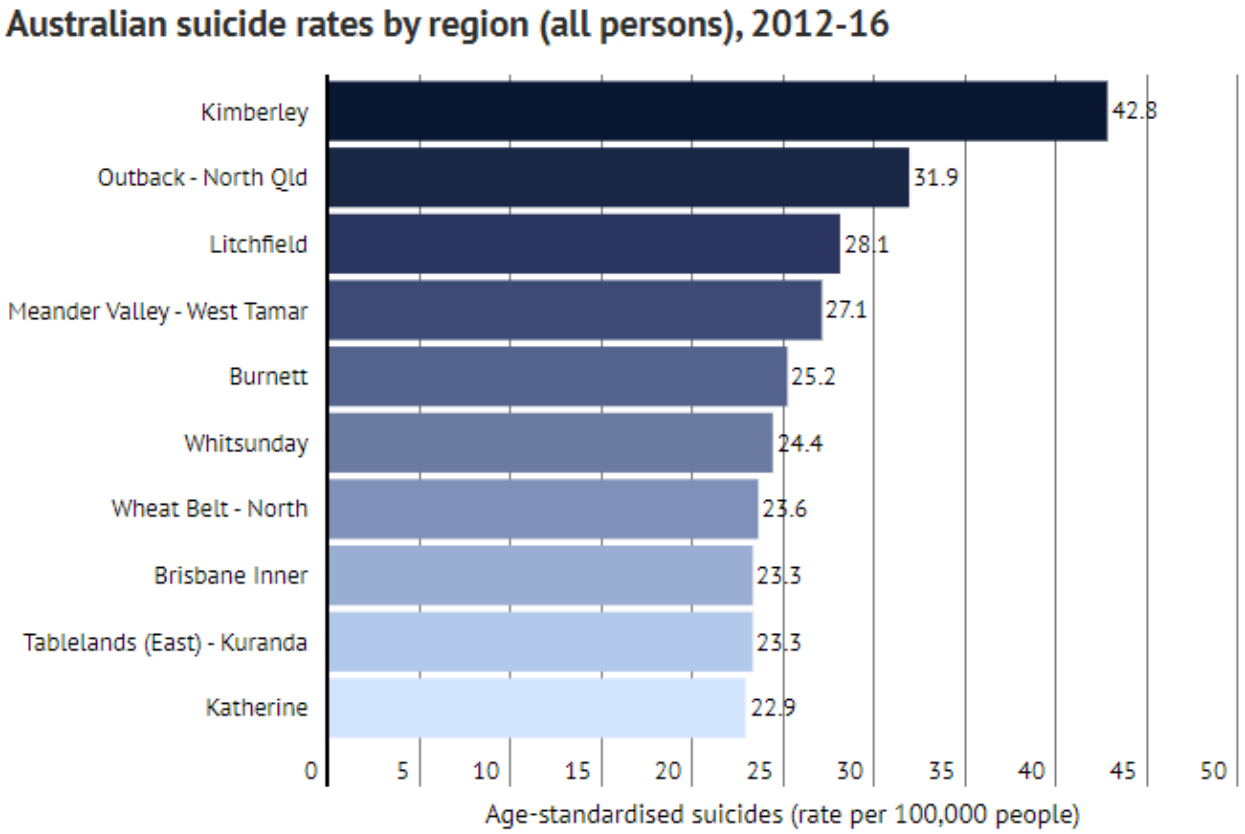
a leading cause of death
15-44 yrs. olds nationally

What is Northern Australia ?

- Home to 1.3 million people or 5.3% of the national population
- A young and diverse population with a median age of 35-39 years
- An Indigenous population of over 200,000 or 16% of Northerr Australia's population, compared to a rate of 3.8% nationally



Northern Australia's experience of Suicide

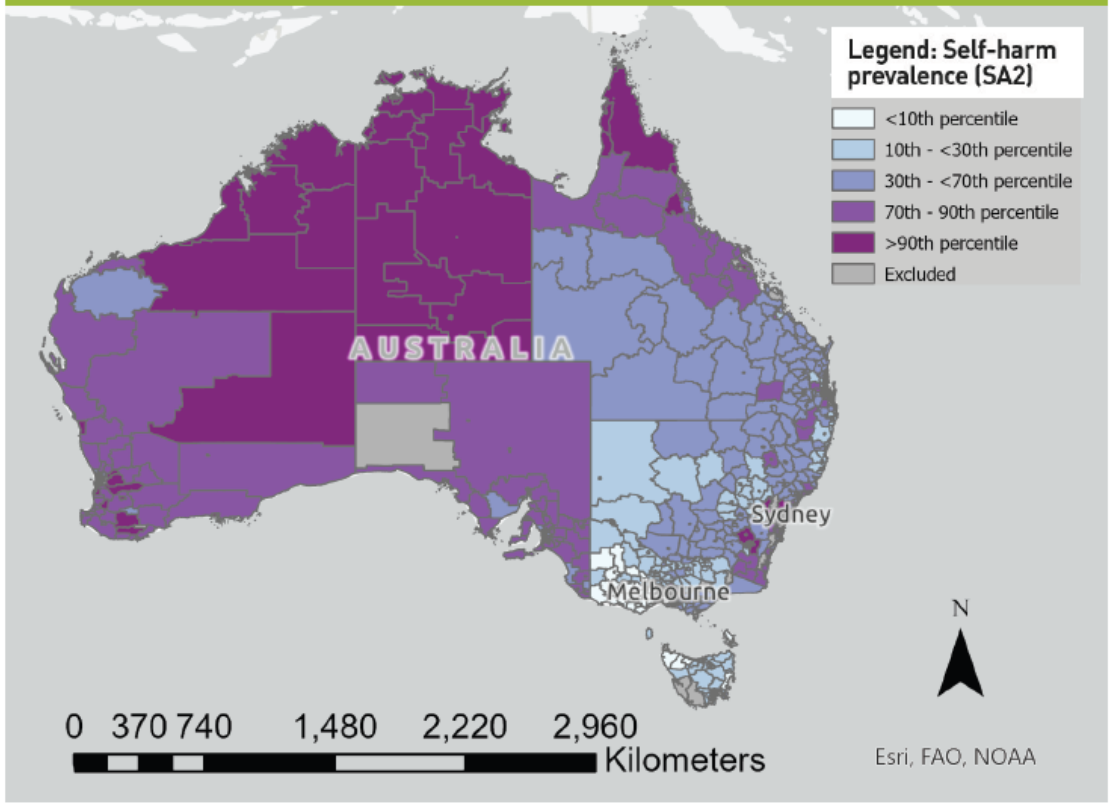


Source: Australian Institute of Health and Welfare

Self-Harm Prevalence

Map 1 shows synthetic self-harm prevalence estimates (in 2019) among young Australians aged 12-17 years. Primary outcome of self-harm (irrespective of intent) in the previous 12 months. The below map shows the distribution of self-harm prevalence in each Statistical Area Level 2 (SA2) across Australia i.e., the size of suburbs within cities. Synthetic self-harm estimates were derived from multilevel modelling (see Chapter 2).

Map 1: 12-month self-harm prevalence, 12-17 years, Australia (2019)



Interpretation of Map 1

"Dark Purple" indicates higher prevalence (i.e., above the 90th percentile), and "Light Blue" indicates lower prevalence of self-harm (i.e., below the 10th percentile). As seen in Map 1, Northern Territory (NT), Western Australia (WA), and South Australia (SA) had the highest state prevalence of youth self-harm (irrespective of intent).

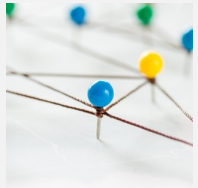
Dot density maps (self-harm cases per sq km,*not shown*) found high density areas were mainly located in the capital cities and some larger regional towns in each state and territory.

Maps created using ESRI ArcGIS Pro software

Immediate reflections

Where do we start, it’s overwhelming isn’t it?

The issues and social determinates are very similar for this population



Are there common threads for action or hope?

Some key groups

Quantitative analyses also identified key factors that should inform general (national) targets for future youth self-harm/ suicide prevention initiatives, including targets for further research inquiries. This includes continued concerted efforts for improving the **mental health** of young Australians (via mental illness prevention initiatives), improving **employment and socio-economic outcomes** of single parents, as well as further investigations into the potential protective elements of **being a child of parents born overseas**. Proportion of **young people identifying as Aboriginal and/or Torres Strait Islander** was another key factor in area-level spatial modelling, including self-harm clustering in regions with Aboriginal communities across Western Australia, Northern Territory, and North Queensland. The high rates of self-harm and suicide

Australian Youth Self-Harm Atlas

Suicide Prevention Australia

QIMR Berghofer Medical Research Institute

Roses in the Ocean
stemming the tide of suicide

Australian National University

THE UNIVERSITY OF WESTERN AUSTRALIA

Some key groups

Using the CSC (MilSuper) data set of 112,114 ex-servicemen under 55 years of age, the following table illustrates examples of the trends identified for this age cohort.

Remote/Regional Locations	U55s	Proximity to ADF Base	U55s
Port Headland	329	Townsville	4761
Geraldton	119	Ipswich	2482
Darwin/Top End	2621	Wagga	534
Katherine	134	Albury/Wodonga	950
Kalgoorlie	135	Williamtown	2395
Emerald/Gladstone	949	ACT/Queanbeyan	5046
Mt Isa	131	Elisabeth SA	1473
Broken Hill	78	Townsville	4761
Alice Springs	116		

What are the common threads ?

What's the national plan – how can you localise ?

Proposed Structure

The principles, focus areas and enablers outlined below are intended to form the basis for the Strategy, providing an organised structure through which the actions required to achieve significant improvements can be identified.

Figure 1: Principles, focus areas and enablers for the National Suicide Prevention Strategy

LIFEWAYS Suicide Prevention Model (current thinking)

Define what are you targeting?

- System Development to enhance wellbeing.
- Reducing Divers of distress
- Early Engagement
- Primary Care
- Community Based Intensive Interventions
- Bed Based Services
- Supports for long term wellbeing.

Define who are you targeting?

General Population

Workplace Populations

Secondary School Populations

University Populations

Selective Prevention

- Indicated Prevention (general distress)
- Indicated Prevention (Suicidal Thoughts)
- Indicated Prevention (suicidal thoughts and plans and means)
- Indicated Prevention (self-harm)
- Indicated Prevention (suicide attempt)
- Indicated Prevention (persistent suicidality)
- Postvention (persons bereaved by suicide)
- Postvention (persons impacted by suicide)

Define A Version of Success

Best Practice Program Requirement

1

Indigenous Ownership

Aboriginal and Torres Strait Islander people were involved in the development, implementation and governance of the program or service, and lead the operations and delivery of the program

- Evidenced by Indigenous-led steering committee or advisory group.

2

Community Leadership

The program or service is working within or with the local Aboriginal Community Controlled Health Service, and/or has relationships or integrates with other Indigenous community organisations, programs or services.

- Evidenced by formal partnerships or collaborations.

3

Community Consultation and Co-design

- An Aboriginal and Torres Strait Islander community reference group was established for the program or service, and included key stakeholders or members of the target group (e.g., youth, Elders, consumers, carers, LGBTQI+, lived experience) and meetings were held regularly.
- Evidenced by minutes of meetings.

4

Evaluation

Ongoing program or service evaluation is in place to ensure continuous quality improvement, including feedback from participants or community, during delivery or after completion of the program or service.

- Evidenced by internal review documenting any resulting action plan, including timeline and status update when actioned.

5

Cultural Responsiveness

Non-Indigenous staff have undertaken cultural responsiveness and safety training.

- Evidenced by documentation of completion of training.

6

Capacity Building

The program builds Indigenous community capacity through the training, mentoring and support of Aboriginal and Torres Strait Islander people to lead and deliver future similar programs or services.

- Evidenced by plans for training and other capacity building activities.

Understand your locality or target group

Trust your lived experience & local instincts

A moment in time :

a large portion of people who have died by suicide have had contact with a health service

1 month prior to death…

Are people showing signs or help seeking more than we think ?

Focus on Pre-emptive Planning & Action

Predictable Events for an individual, family, community & population

What are the opportunities ?

- Transient groups (who could be activated)
- Existing Resilience (what's dormant)
- Leverage (uncommon allies)