DEPARTMENT OF
HEALTH

Northern Territory Suicide Prevention
Strategic Framework 2018-2023

Photo: Peter Eve, Tourism NT

www.health.nt.gov.au

NORTHERN TERRITORY GOVERNMENT

Needing Help

Thinking and reading about suicide can be distressing. If you need help please use the numbers below to access support.

SEEK HELP

Territory Crisis Services
MHAT 1800 682 288

National Crisis Services
Lifeline 13 11 14
Suicide Call Back Service 1300 659 467
MensLine Australia 1300 78 99 78

National General Support Services
Beyond Blue Support Service 1300 22 4636 or www.beyondblue.org.au
Lifeline www.lifeline.org.au/Get-Help/
Suicide Callback Service www.suicidecallbackservice.org.au
SANE Australia Helpline 1800 18 7263
Kids Helpline 1800 55 1800

Postvention Support Services
StandBy Response Service 0418 575 680
National Indigenous Critical Response Service (NICRS) 1800 805 801

If you, or someone you are with is in immediate danger please call 000 OR go to your nearest hospital emergency department or clinic

THANK YOU

Thank you to all those who contributed to the consultation process undertaken in 2017 to assist in preparing this strategy. Special thanks are extended to those traditional owners who delivered a Welcome to Country and to all who gave freely of their time. We are grateful to those who contributed and shared their own personal and family stories. Your courage and generosity is especially valued, and reminds us all of the urgency and importance of this work.

IN MEMORY

This plan is dedicated to the many people whose lives were lost to suicide. Their struggles are acknowledged, and their lives are honoured for the vital contributions they made to their communities.

CONDOLENCES

Sincere condolences are offered to the families, friends and communities of those bereaved by suicide, and for the sadness and suffering you have, and continue, to experience.

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Minister's Foreword

Suicide affects our whole community. Almost every week in the Northern Territory, a person takes their own life – and leaves behind family, friends, and a broader community, grieving for the life that tragically ended too soon.

The Northern Territory Government is committed to reducing this burden of loss and grief, and supporting all in our community to live lives filled with meaning and purpose. As a government we are committed to seeing suicide rates in the Northern Territory reduce by half over the next ten years.

This strategic framework is informed by the Fifth National Mental Health and Suicide Prevention Plan (2017-2022), contemporary research about suicide and suicide prevention. Importantly, it is also informed by a process of public consultation, so that what is known and understood at a national and international level is considered within a local, Northern Territory specific context.

The strategic framework aims to provide a vision for how everyone in our community can work together to reduce suicide. The framework identifies three priority areas for focus:

1. Building stronger communities that have increased capacity to respond to and prevent suicidal behavior through raising awareness and reducing stigma,
2. Informed, inclusive services that provide timely, integrated, compassionate and culturally safe responses that meet the diverse needs of people across the Territory, and
3. Focused and evidence-informed support for the most vulnerable groups of people.

The Northern Territory Framework will be reviewed as Fifth National Mental Health and Suicide Prevention Plan (2017-2022), is rolled out nationally, ensuring that it remains contemporary and relevant to the needs of all Territorians.

The Implementation Plan developed to support this strategic framework will be overseen by the Northern Territory Suicide Prevention Coordination Committee, which will be convened by the Department of Health. The committee includes government departments and non-government organisations providing representation for those whose lives have been impacted by suicide and suicidal behavior.

The committee will continue to monitor suicide rates, and to facilitate better collaboration and integration of services, so that those who feel vulnerable are able to access support in a timely manner with a sense of confidence that they will receive best evidence informed care.

We know that significantly reducing suicide rates in our community will take time. Many factors will contribute to that change. The task ahead is challenging. However, it is a task driven by the greatest of imperatives – that every life in the Territory matters.

Minister for Health, the Honourable Natasha Fyles MLA

A Territory where everyone is empowered to live a life filled with purpose, hope and meaning, and where fewer lives are lost through suicide.

Introduction

Suicide affects people of all ages and backgrounds. The NT's suicide statistics are sadly the highest in the country. In 2015, 50 Territorian lives were taken by suicide. Young people, males and Aboriginal people are particularly overrepresented in those figures. The NT Government is committed to halving the number of suicide related deaths over the next 10 years.

Suicide is a complex public health issue, involving biological, psychological, social, cultural, economic, spiritual and other factors, including the physical environment in which people live.[1] These factors can interact and lead a person to suicidal thoughts and behaviours. Whilst there is no single reason that explains why people die by suicide and no simple answers to these complexities, we do know from research evidence that there are some factors that increase a person's vulnerability and others that are protective, and can reduce risk.

The World Health Organization recently emphasized the need for a renewed focus on suicide prevention, and the recently endorsed Fifth National Mental Health and Suicide Prevention Plan has a clear commitment to reducing suicide in the community and especially among Aboriginal and Torres Strait Islander peoples. It calls for communities to develop and co-ordinate their own local suicide prevention plans. Integral to this co-ordination is the integration and collaboration between Primary Health Networks (PHNs), Local Health Networks (LHNs), Aboriginal Community Controlled Health Services (ACCHSs), as well as non-government services providers.

In 2016, the NT Government was also concerned about the impact of suicide on the lives of so many Territorians. The Government has prioritised suicide prevention, committing to reducing the rates of suicide by half over the next 10 years.

Preventing suicide is therefore a priority and while it can be challenging, we can take hope from the fact that there is much research and evidence that demonstrates that suicides can be prevented.

This strategy is informed by national and international research, as well as by consultations across the Territory. Important themes from those consultations include:

- Improved awareness of the supports available in the community if a person, a loved one, or a person known to someone is feeling vulnerable;
- Improved and easier access to those supports;
- Better co-ordination of services so people get seamless support and continuity of care without having to "retell' their story;
- Respectful and better coordinated involvement of families and carers in developing plans to support a vulnerable person;
- Ready access to centralized, reliable information to support people, recognizing the diverse needs across the Territory; and
- Community based campaigns that raise awareness and reduce stigma through safe, open dialogue.

The NT Suicide Prevention Strategy at a Glance

THE NT SUICIDE PREVENTION STRATEGIC FRAMEWORK 2018-2023

VISION

Where fewer lives are lost through suicide, and where individuals and communities are enabled to improve their mental health and wellbeing

GOALS

[1] Building stronger communities that have increased capacity to respond to and prevent suicidal behavior through raising awareness and reducing stigma

[2] Informed, inclusive services that provide timely, integrated, compassionate and culturally safe responses that meet the diverse needs of people across the NT

[3] Focused and evidence informed support for the most vulnerable groups of people

OUTCOMES

Reduced suicide rate in the whole population and among particularly vulnerable groups

Reduced stigmatised attitudes to mental health and suicidal behaviour at population level and across vulnerable groups

PRINCIPLES

- build hope and resilience
- apply a public health approach
- trauma-informed
- recovery focused
- underpinned by human rights
- equity
- complement current initiatives in suicide prevention

NT

- NT Suicide Prevention Strategic Action Plan 2015-2018
- NT Mental Health Strategic Plan 2015-2021
- NT Health Aboriginal Cultural Security Framework 2016-2026
- Gone Too Soon: A Report into Youth Suicide in the Northern Territory 2012

AUSTRALIA

- LIFE framework (2007) (Life in Mind)
- A National Framework for recovery-oriented mental health services (2013)
- Fifth National Mental Health and Suicide Prevention Plan 2017-2022
- ATSISPEP Final Report (2016)
- Cultural Respect Framework 2016-2026
- Consumer and Carer Participation Policy
- Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services 2014
- Trauma Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia (2013)
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013)
- National Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing Framework 2017-2023
- LifeSpan Integrated Suicide Prevention (Black Dog Institute)
- National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health & Suicide Prevention Strategy (2016)

INTERNATIONAL

- UN Principle for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care
- Convention on the Rights of Persons with Disabilities
- International Covenant on Civil and Political Rights
- Convention on the Rights of the Child
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- WHO Preventing suicide: A global imperative
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of All Forms of Discrimination Against Women
- International Convention on Elimination of All Forms of Racial Discrimination
- UN Declaration on the Rights of Indigenous Peoples
- WHO Comprehensive Mental Health Action Plan

What do we know about suicidal behaviours

Suicide affects families and communities across Australia and the world. In 2015, suicide rates in Australia were at their highest in the preceding 10 years, with 3027 people taking their lives – that is over 12 people for every 100,000 in the population. In 2014 suicide death accounted for 97,066 years of potential life lost, which is the highest of any cause of death and over three times that lost to breast cancer.[2]

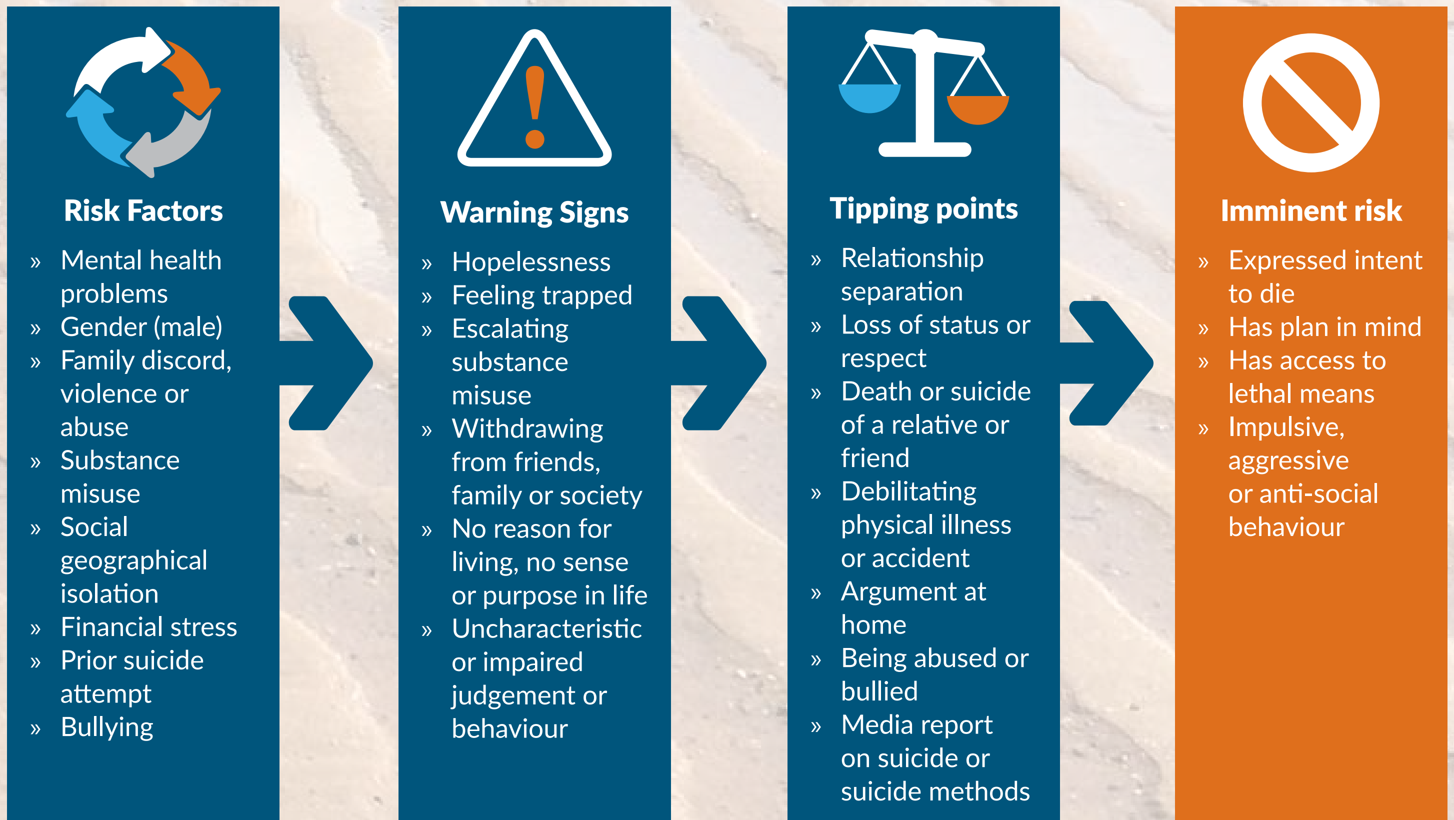
The NT had the highest rate of death due to suicide across Australia, where almost one person lost their life to suicide every week of the year (50 deaths due to suicide in 2015).

It is not always possible to identify what leads a person to suicide. A person may have risk factors which make them more vulnerable. Some people may show changes in their behaviours which can identify to those around them that they are experiencing difficulties, but others may show no change in how they present. Specific events may act as a tipping point for someone who is vulnerable. The table on Page 7 demonstrates how these factors may link together to help explain how suicidal behavior may present. These are important things to consider, because they offer potential points for intervention and support.

Suicides by State and Territory 2011-2015 (Age standardised rate per 100,000)

SOURCE: ABS (2016) 3303.0 Causes of Death, Australia, 2015

The interaction between different risks and protective factors, tipping points and precipitating events



Protective factors such as good mental health and wellbeing, the capacity to cope with difficult situations, community involvement, family support and positive educational experiences reduce the influence of existing risk factors across this continuum.

ADAPTED FROM: Queensland Suicide Prevention Action Plan 2015-2017

What groups of people are at increased risk for suicidal behaviours

While it is recognised that suicide can affect anyone within the community, research continues to highlight there are some community groups considered at higher risk of suicide than others. Knowing that particular groups are at increased risk is important because it allows for more targeted prevention strategies and interventions. This will help in reducing suicide rates.

These priority groups include:[1]

- Men
- Young people
- Older people
- Aboriginal and Torres Strait Islander people
- Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) people
- People in rural and remote communities
- People experiencing mental illness
- People who have previously attempted suicide or who engage in self-harm
- People bereaved by suicide
- Migrant and refugee communities
- Current and former Australian Defence Force personnel
- People in custody

MEN

Across Australia, three times as many men die by suicide as women. In 2015, the standardised death rate[2] for males was 19.3 deaths per 100,000 people, while for females it was 6.1.[3] Across Australia, and including the NT, men are less inclined to communicate feelings of despair or hopelessness, are more likely to present a stoic outlook towards hardship,[4,5] are less likely than women to seek help[6] and often have fewer social connections. A lack of awareness regarding available supports and resources, and the perception that services are unable to effectively cater for their needs or provide any assistance in their situation may also make people less likely to seek help[7,8].

YOUNG PEOPLE

Internationally, suicide is the second leading cause of death among 15-20 year olds.[9] Similarly in Australia, suicide was the leading cause of death of children between 5-17 years of age and accounted for one third of deaths among young people aged 15-24 years in 2015.[10] Among respondents aged 12-17 years in the recent second Australian Child and Adolescent Health and Wellbeing Survey, 7.5% reported as having considered suicide in the past year and 2.4% had made an attempt.[11] This equates to approximately 41 000 Australian adolescents.

Statistics also reveal that youth suicide numbers in Australia have increased steadily over the last 10 years, with approximately eight children and young people dying by suicide every week in 2015.[12]

1 It is important to remember that while a person may be a member of one or more of these groups, thus statistically at increased risk of suicide, it does not mean they will lose their life to suicide.

2 Age-standardised death rate means that for every 100, 000 people in a population or sub-group, that number (i.e. 19.3) died by suicide in that given year.

Child and Youth suicide in Australia 2006-2015[13, 14]

Death by Intentional Self Harm (Suicide)	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
0-14	8	12	11	3	13	16	16	22	21	14
15-19	110	116	98	105	117	117	131	152	130	145
20-24	188	184	190	171	190	218	195	205	232	246
TOTAL PER YEAR	**306**	**312**	**299**	**279**	**320**	**351**	**342**	**379**	**383**	**405**

Children aged 0-14 years made up 21.6% of the NT population in 2016.[15] When all child (0-14 years) suicide deaths are combined for years 2011-2015, the NT reported the highest jurisdictional rate of child deaths due to suicide, with 13.6 deaths per 100,000 persons. The corresponding rate for Australia for this age group was 2.2 deaths per 100,000 persons.[3]

Factors contributing to suicidal behaviour in young people include socio-economic disadvantage, impulsivity, contact with youth justice, mental illness and mental health problems (including depression, anxiety, personality disorder, substance use disorders), sexual orientation, childhood adversity, family conflict and/or breakdown, disengagement from school, social and geographical isolation, personal vulnerabilities, exposure to stressful life circumstances, and social, cultural and contextual factors.[16] These factors are often compounded by low rates of help-seeking, and difficulties accessing services. It has been estimated that up to 70 per cent of young people who experience mental health and substance use problems do not actively seek services.[17]

There are important gender differences in suicide-related behaviour in young people. Males have higher rates of completed suicide, and females higher rates of other suicidal behaviours (thinking, planning, attempting). Similar to the rest of Australia, approximately three out of four (76%) calls to Kids Helpline from NT in 2015 were from females, with one in four (23%) from males. The top three reported concerns of young Territorians were mental health problems, family relationship issues and emotional wellbeing.[18]

A recent report concerned with psychological distress and help-seeking behaviours of young Australians (15-19 years) in the five years to 2016 found that in addition to disadvantage experienced by Aboriginal people, marked differences were evident between urban and rural survey respondents, highlighting inequities in health access and outcomes for these groups.[19]

Most research about suicide prevention and appropriate interventions has been in the context of adults. More research is needed to identify effective prevention and intervention strategies for children and young people, to guide both clinical practice and policy development.[20]

In addition to developmental differences, it is essential to consider contextual factors most pertinent to individuals, families, communities and the NT and to not assume there is a 'one size fits all' approach to suicide prevention with children and young people. One such important factor for the NT is children in out-of-home-care. Whilst across Australia 1 in 33 children received child protection services, Aboriginal children across Australia are significantly over-represented, being seven times more likely to have received these services.[21] The rate of children in out-of-home-care in the NT was almost double (16.2 per 1000 children) the national rate (8.6 per 1000 children), with almost nine out of every 10 children placed in out-of-home-care being Aboriginal.[22]

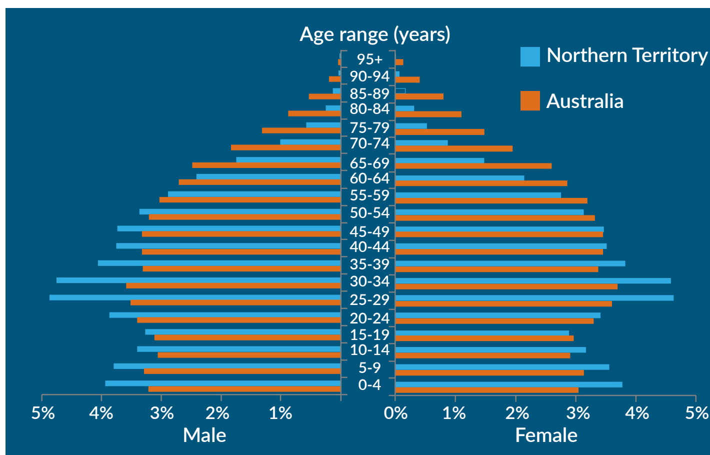
The recommendations of the Select Committee on Youth Suicides in the NT, including the need to build strong, healthy and resilient communities, to identify and support those at risk, provide more support for the bereaved, and smarter service delivery remain relevant to suicide prevention efforts.[23]

3 Due to the relatively small numbers of suicides in some states and territories, even one or two deaths can have a significant impact on standardised suicide rates. Thus comparisons across Australia must be done carefully (ABS 2016, Hunter Institute Mental Health 2016)

OLDER PEOPLE

The highest age-specific suicide death rate in Australia for eight of the 10 years prior to 2013 was in males aged 85 or over.[24] Whilst Australia as a whole has an ageing population it is important to note that the median age in the NT remains the lowest of all jurisdictions (32 years compared with 38 across Australia in 2016). Territorians aged 65 years and over made up 7.2% of our population, compared with 15.8% across Australia.[25] Notably, the proportion of the NT's population aged 65 years and over has increased over the last 20 years from 3.0% to 6.9% due, in part, to an increasing life expectancy in the NT's population.[26]

Age in the Northern Territory compared with Australia: 2016



SOURCE: Australian Bureau of Statistics 2016 Census Data Seminar NT presentation, page 15

Over the same period, the largest percentage increase of people aged 85 years and over in Australia occurred in the NT (9.6%).[27]

Factors that may contribute to suicide of older people can include physical or financial dependency, mental and/or physical health problems, chronic pain, grief and loss, and loneliness.[28] The reduced likelihood of disclosing suicidal thoughts may also be a contributing factor among older people.[29]

Better access to services for the aging population needs to be a priority. Ensuring that all who come into contact with elderly, especially those elderly who are in ill health and who are isolated are aware of the increased risks of this group, and able to assist if they feel people are especially vulnerable.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Across Australia the rate of suicide death for Aboriginal and Torres Strait Islander peoples is twice that of the broader population.[30] For Aboriginal people in the NT the suicide rate from 2012-2016 is considerably higher (26.4 per 100,000 people) compared to that for the broader NT population (14.4 per 100,000).[31] In 2016 Aboriginal people represented 2.8% of Australia's population, and 25.5% of the population in the NT. The 58, 248 Aboriginal NT residents represent 8.7% of Darwin's population and 51% across the rest of the NT.[32]

Mental health conditions, substance abuse disorders and suicide are associated with the hardship and social determinants experienced by Aboriginal and Torres Strait Islander peoples.[33] Some of the factors that negatively impact the mental health of Aboriginal people are also experienced across the broader population, including poverty, reduced access to health services and poor health status, lack of educational success, lack of transport, unemployment, and inadequate and overcrowded housing. These factors, however, are experienced by larger numbers of Aboriginal people, and more intensely.[34,35] Additional factors are cultural dislocation, racism and discrimination, removal from family, unresolved loss and grief, and chronic disadvantage.[36]

In considering suicide risks for Aboriginal people it is important to note that community level factors may provide more pertinent explanation of suicidal behaviours than those at an individual psychological level.[37] The recent 'Solutions That Work: What the evidence and our people tell us' report highlights that *"understanding the traumatic disruption of colonization on communities, cultures and families which are sources of social and emotional wellbeing"* is critical to suicide prevention efforts.[38] Any effective efforts to reduce suicide and self-harm, and increase wellbeing for Aboriginal Territorians requires genuine understanding of mental health and social and emotional wellbeing as it relates to local communities, families and individuals.[39] Importantly, these elements of Aboriginal social and emotional wellbeing also provide a framework to identify and strengthen protective factors and resilience against psychological distress, mental illness and suicide.

LGBTQI PEOPLE

In Australia the term 'LGBTQI' refers collectively to people who are lesbian, gay, bisexual, transgender, queer, and/or intersex. Although Australian and international research has highlighted concerns regarding the mental health status and suicidal behaviours of LGBTQI people, it is important to acknowledge that significant knowledge gaps remain.[40] This is predominantly due to the lack of routinely collected data on suicide prevention and mental health outcomes for LGBTQI communities.[41,42] Recent evidence indicates that mental illness, self-harm, suicide attempts and suicidal ideation rates are disproportionately higher for LGBTQI Australians when compared with the broader population.[43]

An additional compounding factor for LGBTI people and communities is experiences of stigma, prejudice, discrimination, abuse, violence, isolation and exclusion. There is evidence that such experiences, in conjunction with existing predisposing risk factors, result in an increased susceptibility to a range of mental health issues as well as an increased risk for suicidal behaviours.[44]

A recent Australian study of suicide cases found key risk factors that may be specific to LGBTQI people were a lack of acceptance by family and self, a high incidence of romantic relationship conflict and aggressive behaviours, and a greater prevalence of depression and anxiety and alcohol and substance use disorders.[45] Similarly, LGBTQI adolescents may struggle with disclosure of their sexual identity, be subjected to unsupportive responses from family and friends, and experience victimization.[46] These factors may partially explain the disproportionate rates of suicidal behaviors in this population.

Preliminary results of a recent survey of 54 LGBTQI respondents across the NT suggest that barriers to people accessing appropriate services include cost, lack of available services, and services not being informed about or inclusive of the LGBTQI community.[47]

Efforts to reduce the incidence of suicidal behaviours, and increase mental health and wellbeing for LGBTQI people and communities require ongoing and inclusive collaborations to further understand specific risk and protective factors.

LGBTQI cohorts	Suicide Attempts	Suicide Ideation	Self-harm
LGBT young people	Aged 16-27 are five times more likely to attempt suicide	Lesbian, Gay and Bisexual people aged 16+ are over six times more likely to have suicidal thoughts	Nearly twice as likely to engage in self-injury
Transgender	18+ are nearly eleven times more likely	18+ are nearly eighteen times more likely	Are six and a half times more likely
Intersex	16+ are nearly six times more likely	16+ are nearly five times more likely	Are three times more likely
Young who also experience abuse and harassment	Even more likely to attempt suicide	Even more likely to have suicidal thoughts	Even more likely to have self-harmed

SOURCE: Morris, S. (2016) Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People and Communities

PEOPLE LIVING IN RURAL AND REMOTE AREAS

People in rural and remote areas are more likely to take their own lives than those in urban areas,[48] with young males, farmers, older people and Aboriginal people being most at risk.[49, 50] In addition to those faced by the broader Australian population, suicide in rural and remote Australia may be exacerbated by a number of contextual risk factors.[51] These are summarised below:-

- Financial hardship
- Easier access to lethal means
- Reduced access to support services
- Concerns about stigma
- Cultural barriers
- Lack of public infrastructure
- Reduced access to communications
- Social isolation
- Reluctance to help-seek
- Poor availability of primary health care/hospital services
- Limited supply of specialist professionals
- Distance and cost associated with accessing services
- Higher rates of risky alcohol/drug consumption
- Natural disasters (droughts, floods, bushfires, cyclones)

ADAPTED FROM: National Rural Health Alliance Inc. (2017) FACT SHEET March 2017; Bishop, L., Ransom, A., Laverty, M., & Gale, L. (2017). *Mental health in remote and rural communities.*

What is known is that self-harm and suicide risk in Australia increases with remoteness suggesting that there are significant issues impacting mental health in rural and remote Australia that need to be addressed.[52, 53]

It is clear that purposeful efforts are required to improve the mental health and wellbeing of remote and rural Australians and to reduce the incidence and impacts of suicide on these communities. A recent Australian research report highlights that multi-sectorial collaborations are required to improve access to evidence-based, culturally appropriate mental health and wellbeing services and suicide prevention and intervention activities for remote and rural Australians.[54] Efforts to reduce suicide in rural and remote NT need to consider the strengths and opportunities of each region and community in building wellbeing and resilience through local initiatives and leadership.[55]

PEOPLE EXPERIENCING MENTAL ILLNESS

Approximately 20% of Australians are affected by some form of mental illness every year.[56, 57] Mental illness can be described as a wide spectrum of mental health and behavioural disorders which can vary in both severity and duration, and can affect the cognitive, social and emotional abilities of an individual.[58] The term 'mental health problem' includes problems experienced at a sub-clinical level (such as stress, anxiety, depression or alcohol and/or other drug dependence), where a person experiencing one, or more, of these problems does not meet the diagnostic criteria for mental illness.[59] At least 45% of Australians will experience a mental illness during their lives.[60] This suggests that around 7.3 million Australians experience an anxiety, affective or substance use disorder each year.[61]

Furthermore, 45% of the global burden of disease among young people aged 10-24 years is attributable to mental illness.[62] Given the NT has the youngest mean population age in Australia this warrants considerable attention.

Mental disorders such as major depression, psychotic illnesses and eating disorders are associated with an increased risk of suicide, particularly after discharge from hospital or when treatment has been reduced.[63, 64] Knowing this allows us to put more effective supports in place during this recognized period of increased vulnerability.

PEOPLE WHO HAVE PREVIOUSLY ATTEMPTED SUICIDE OR WHO ENGAGE IN SELF-HARM

A prior suicide attempt is the single most important risk factor for suicide in the general population.[65] Findings of a recent retrospective analysis of all NT residents with a hospital admission involving a diagnosis of suicidal ideation or intentional self-harm between 2001 and 2013 showed that:-

- the rate of hospitalisations involving suicidal behaviour for NT residents has significantly increased every year since 2000, especially for Aboriginal people
- the risk of subsequent suicidal behaviour is increased for the first 6-12 months following initial hospitalisation, and remains elevated for approximately 24 months following a hospitalisation involving suicidal behaviour
- the Aboriginal cohort was found to be consistently at higher risk of subsequent suicidal ideation, intentional self-harm and suicide following a hospitalisation involving suicidal behaviour
- the risk of subsequent suicide increases with the number of hospitalisations involving intentional self-harm, irrespective of the type of initial suicidal behaviour
- age was an important distinguishing factor. Aboriginal youth and older non-Indigenous residents were found to be at higher risk of suicidal ideation and suicide. Older residents of the Darwin region and younger residents in the rest of the NT were at higher risk of subsequent intentional self-harm
- a higher proportion of the Aboriginal cohort hospitalised for suicidal ideation were identified with primary and mental health service contacts. Further analysis of associations between patterns of service usage and these outcomes may help to better identify opportunities for prevention.[66]

This research highlighted that among the 4483 cases analysed:-

- the risk of suicide increased for the first 12 months following a hospitalisation involving suicidal behaviour and remained elevated for approximately 24 months.
- Males were at a much greater risk of suicide compared to females following hospitalised suicidal behaviour.
- The younger Indigenous and older non-Indigenous population were at higher risk of suicide.
- The risk of suicide increased with each subsequent hospitalisation involving intentional self-harm.[67]

Self-harm is a predominant issue for young people across Australia. Factors commonly associated with self-harm include experiences of trauma, social problems (like bullying, isolation and exclusion, sexual and gender diversity issues), experiencing psychological distress, or experiencing low self-esteem.[68] A recent Australian report highlighted a 48% increase in the hospitalization of Aboriginal people for intentional self-harm since 2004/05, that in 2012/13 the rate of hospitalisation for intentional self-harm for Aboriginal people was two and half times that for the broader population, and the rate for Aboriginal people was higher in remote areas than other geographical areas.[69]

PEOPLE BEREAVED BY SUICIDE

Bereavement by suicide is a specific risk factor for suicide attempt among young bereaved adults, whether they are related to the deceased or not.[70] Exposure to suicide of a close contact is associated with:

- increased risk of suicide in partners bereaved by suicide;
- increased risk of required admission to psychiatric care for parents bereaved by the suicide of an offspring;
- increased risk of suicide in mothers bereaved by an adult child's suicide; and
- increased risk of depression in offspring bereaved by the suicide of a parent.[71]

People who have lost a relative or friend to suicide tend to perceive more social stigma around the death, such as the embarrassment or discomfort of others and loss of community supports; some researchers argue that reducing this stigma may help reduce the impact on survivors' lives.[72]

> "Stigma can also discourage the friends and families of vulnerable people from providing them with the support they might need or even from acknowledging their situation. Stigma plays a key role in the resistance to change and implementation of suicide prevention responses"
> *(World Health Organization, 2014, p. 32)*[73]

MIGRANT AND REFUGEE COMMUNITIES

Persons born outside of Australia accounted for 25.1% of all suicide deaths between 2001 and 2010, a rate closely aligned with the estimated 27% of all persons born overseas.[74] In 2016, 20% of the NT population was born overseas. Just over two thirds of this population resided in Darwin, with the remainder living across the rest of the NT.

There is a significant population of refugees in the NT with specific mental, and physical, health needs. These needs have been identified as:-

» being more likely to experience poorer health status with increased rates of long-term medical and psychological conditions,

» high levels of depression and anxiety,

» health problems associated with physical and psychological trauma and lack of access to health care prior to arrival in Australia.[75]

CURRENT AND FORMER AUSTRALIAN DEFENCE FORCE PERSONNEL

A recent Australian study on the incidence of suicide among serving and ex-serving ADF personnel indicates that men who were in full-time service, or in the reserve, were significantly less likely to die by suicide than Australian men generally.[76] A recent review identified a number of protective factors likely to reduce suicide risk for current serving ADF members, including:-

» access to a wide array of supporting services and benefits, including medical services;

» strong sense of camaraderie, purpose and belonging.[77]

Conversely, the rate of suicide of former service men was more than twice that of current serving and reserve members, and slightly higher than that for men in the broader Australian population.[78] Suicide rates for ex-serving men aged 18-49 years were three to four times higher than for ex-serving men aged 50-84. Higher suicide rates were found to be associated with the following factors[79]:-

» Involuntary discharge, in particular for those discharged for medical reasons;

» Leaving the ADF after less than one year service; and

» All ranks other than commissioned officers

PEOPLE IN CUSTODY

Prisoners represent a particularly vulnerable and high risk group for suicide, with rates typically three to five times greater than those for the broader community.[80] Despite a decline in Australian custodial suicide rates, suicide still accounts for 30%-50% of Australian prisoner deaths.[81] Recent Australian data indicates that almost one quarter (23%) of those entering prison report having previously engaged in intentional self-harm, with 13% of male and 14% of female prison entrants reported having thoughts of self-harm during the previous 12 months.[82] It is important to also highlight that Australian studies have identified higher rates of suicide among unsentenced prisoners when compared with sentenced prisoners.[83]

Aboriginal youth are unacceptably over-represented, comprising approximately 97% of the youth detainee population in the NT, and are more likely to have been charged multiple times, and commit their first office at a younger age than those across the broader population.[84] A recent review of youth detention in the NT calls for the underlying causes for young people's offences to be recognised and addressed, and highlights "*many young people in the youth justice system come from homes where poverty, alcohol abuse, violence and dysfunctional relationships are the norm. These are young people in greatest need and the ones who are likely to require a higher level of intervention and case management*".[85]

In the NT Aboriginal people comprise 84% of the adult prisoner population, compared with a national average of 27%. Men comprise 92% of the adult prisoner population. Unsentenced prisoners represent 28% of the adult prisoner population, with the median time spent on remand by unsentenced prisoners being 2.1 months.

As well as risks associated with imprisonment, the first few weeks immediately following release from prison is a time of high risk of suicide, with this group at greater risk than the general population.[86] Greater understanding of the patterns that may exist for custodial suicides can play a key role in informing suicide prevention activities and identifying particular cohorts at greater risk within the broader prison population.[87] Some of the pertinent risk factors specific to people in custody are summarised below:-

Prison-specific risk factors	
Individual	**Forensic**
» Male (especially young males) » Elderly (especially males) » Indigenous » Mental illness » Pharmacological treatment » Substance related/ addictive disorder » Previous suicide attempts » Relationship/social support changes.	» Single cell incarceration » > 18 month sentence » Incarceration prior to conviction » Violent offence.

SOURCE: Grigg, K., & Ogloff, J. (2016) Considerations for suicide prevention in Australia's prisons, Inpsych 38 (1) accessed https://www.psychology.org.au/inpsych/2016/feb/grigg/

"Many factors contribute to the higher rate of suicide in the NT including the remote and extremely remote nature of much of the population, a low availability of psychosocial support in many areas and the high percentage of people who fall into high risk categories. Ongoing efforts are required to reduce the impact and counter these contributing factors"

NT PHN https://www.ntphn.org.au/suicide-prevention

How suicidal behaviour can be prevented

Suicide prevention is a responsibility that is shared by everyone in our community. It is an issue that affects all our community. It requires concerted and sustained support by all of Government. It requires coordination and collaboration across multiple sectors of society, including health and other sectors such as education, industry, agriculture, business, justice, law, defence, politics, and the media.[88]

Contemporary approaches to suicide prevention need to be public health initiatives. Suicide can impact on any person in our population – so a population based approach to intervention is required, with services becoming more targeted as risk and vulnerability increases. Integral to this approach is the need for services to be accessible, integrated and well-coordinated. They have to be client centred and recovery focused, building on hope and resilience, and helping a person to feel more connected to their family and community.

"Efforts must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide."

WHO (2017) Suicide Fact Sheet

NORTHERN TERRITORY GOVERNMENT

SUICIDE PREVENTION INTERVENTION POST VENTION

PREVENTION

This includes the very broad range of interventions that target the whole population.

- **Public education**
  Community awareness
  Service promotion
  services that provide help and support
- **Community programs**
  address the social aspects of our sense of wellbeing - housing, employment, and education
- **Self management**
  using all aspects of our community to support ourselves as well as each other

INTERVENTION

These are the activities that respond to the immediate stress and distress that someone may be facing that increases their immediate vulnerable and risk of suicide.

- **Detection of thoughts**
  of self-harm or suicide in general health care settings and in the community
- **Community support**
  when someone has made a suicide attempt
- **Connection and belonging**
  when someone has made a suicide attempt

POST VENTION

These are the responses that communities can make in the event of a suicide.

- **Family support**
  offering support to families and significant others who have been bereaved
- **Respect and sensitivity**
  initiatives that help a community to respond to suicide in a way that is sensitive and respectful
- **Reduce further instances**
  reduces the likelihood of others in that community feeling despair and thinking about taking their own life

can occur at the following levels

POPULATION BASED LEVEL (UNIVERSAL)	TARGETED LEVEL	INDIVIDUAL LEVEL
- raising public awareness about suicide - encouraging all people to be sensitive to the needs of those around them - reducing access to lethal means of suicide - tackling the issues that lead to harmful use of alcohol and drugs - sensitive media responses where there is a suicide	- these are those interventions that apply in certain settings where people are known to be vulnerable (e.g in primary health care, in schools, prisons and in emergency services) - these interventions ensure that staff working in those settings are aware of the risks associated with people using those services, assess for vulnerability, and help a person who is vulnerable to access more specialist support	- these are the interventions directed to those who have attempted suicide, or those identified as being at an immediate risk - they include comprehensive assessment, and integrated support for people that addresses their psychological as well as social needs - the support can come from primary care level (e.g training GPs in cognitive behavioural therapy) and ensuring that people with mental illness receive high quality integrated care and ongoing support. - this especially applies to people who have been discharged from hospital in-patient wards as well as from emergency departments (e.g Wayback)

www.suicideprevention.nt.gov.au

How this framework will guide suicide prevention activity

This NT Suicide Prevention Strategy and actions that arise from it will be embedded in contemporary evidence informed approaches to help to address this important public health issue.

The Fifth National Mental Health and Suicide Prevention Plan was endorsed in August 2017. It demonstrates a commitment from all governments to work together to achieve outcomes in eight priority areas, two of which are specific to suicide prevention:-

1. achieving integrated regional planning and service delivery
2. effective suicide prevention
3. coordinating treatment and supports for people with severe and complex mental illness
4. improving Aboriginal and Torres Strait Islander mental health and suicide prevention
5. improving the physical health of people living with mental illness and reducing early mortality
6. reducing stigma and discrimination
7. making safety and quality central to mental health service delivery
8. ensuring that the enablers of effective system performance and system improvement are in place

The Fifth Plan identifies 11 elements for a systems-based approach to suicide prevention which are based on World Health Organization recommendations. These are shown in the table opposite.

Many existing strategies, plans and actions of governments, peak bodies, commissioning agencies and service providers already align with the elements above. The critical step that needs to be taken is to coordinate all of these individual actions into a consolidated comprehensive suicide prevention implementation strategy with national, cross-jurisdictional governance and oversight.[89]

FOCUS ELEMENTS OF SYSTEMS-BASED APPROACH TO SUICIDE PREVENTION	
Surveillance	increase the quality and timeliness of data on suicide and suicide attempts
Means restriction	reduce the availability, accessibility and attractiveness of the means to suicide
Media	promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media
Access to services	promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care
Training and education	maintain comprehensive training programs for identified 'go to' people
Treatment	improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt
Crisis intervention	ensure that communities have the capacity to respond to crises with appropriate interventions
Postvention	improve response to and caring for those affected by suicide and suicide attempts
Awareness	establish public information campaigns to support the understanding that suicides are preventable
Stigma reduction	promote the use of mental health services
Oversight and coordination	utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours

SOURCE: Advanced Reading Copy of Fifth National Mental Health and Suicide Prevention Plan 2017-2022

How will this Framework help

This framework will provide the overarching strategic direction for suicide prevention activities in the NT over the next five years. The goals, which have been informed by the community consultation process, give the priority areas that the NT Government will commit to, in its efforts to work in close collaboration with all services, to reduce suicide in the Territory.

GOALS

[1]

Building stronger communities that have increased capacity to respond to and prevent suicidal behavior through raising awareness and reducing stigma

Strategic Direction

The NT Government is committed to building a healthy, safe and inclusive Territory where people are engaged with their community and live meaningful lives. Participation by all members of the community is encouraged and sought – and is especially inclusive of those who are more disadvantaged to ensure that their voice is heard.

Key Focus

Raised awareness; families, community based organisations and broader communities, the workplace, Government services, schools, the media.

Outcomes

- Improved community and individual awareness
- Increased resilience and wellbeing in the community
- Increased access to free suicide prevention oriented training and education across the whole community
- Annual local community based suicide prevention forum that bring communities together and support and enhance locally based developments

[2]

Informed, inclusive services that provide timely, integrated, compassionate and culturally safe responses that meet the diverse needs of people across the NT

Strategic Direction

Recognising and celebrating the increasing diversity of our community and ensuring that services are adapted to meet all their needs. Creating a comprehensive network of services that is client-centred, recovery focused, integrated and coordinated.

Key Focus

Health services, mental health services, primary care, the Primary Health Network, schools, justice system, non-government service providers and industry.

Outcomes

- A clear public policy, across government that supports suicide prevention
- Transparent funding arrangements between all agencies to ensure best use of resources regarding suicide prevention
- A readily accessible, contemporary and easy to navigate guide to local services
- Effective linking of services so that people experiencing distress access a safe system that is easy to navigate, and provides a seamless service regardless of the point of entry

[3]

Focused and evidence informed support for the most vulnerable groups of people

Strategic Direction

Suicide and suicidal behaviours are driven by a complex interplay of factors, and in order to respond services need a wide range of evidence based initiatives delivered in a safe and timely manner

Key Focus

Children, young people, men, Aboriginal people, people with mental health issues, people who have recently harmed themselves, those who are bereaved by suicide, ex-service personnel, members of the LGBTQI community

Outcomes

- Targeted training for health and social care staff in supporting vulnerable people, especially those in primary health care services;
- Provision of selected and indicated programs for all groups of people

Achieving these goals will require intensive and sustained effort from all sectors. The NT Suicide Prevention Coordination Committee will take a lead role in developing the Implementation Plan. An integral part of that work will involve ensuring that resources are targeted, avoiding both gaps in services and duplication. Activities and outputs will be monitored, and outcomes measured.

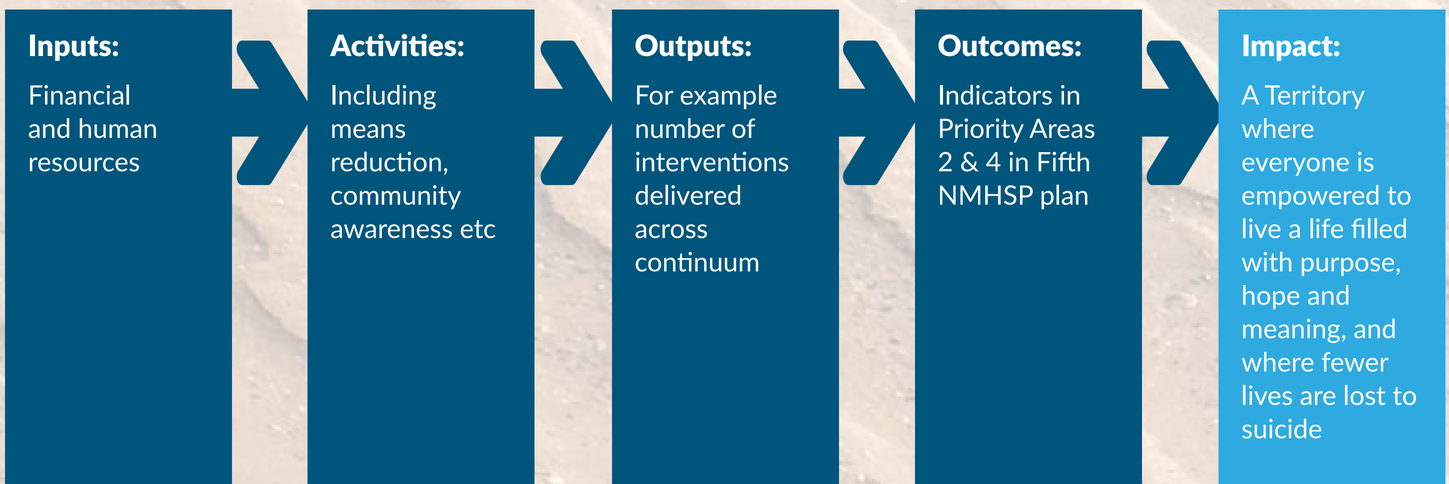
The following table is summarises how the goals of the Strategic Framework link to Government's strategic directions, the intended outcomes of the Framework and the focus elements supporting these outcomes.

Goal	Strategic Direction	Outcomes	Focus Elements
[1] Building stronger communities that have increased capacity to respond to and prevent suicidal behaviour through raising awareness and reducing stigma	The NT Government is committed to building a healthy, safe and inclusive Territory where people are engaged with their community, and live meaningful lives. Participation by all members of the community is encouraged and sought – and is especially inclusive of those who are more disadvantaged to ensure that their voice is heard.	» Improved community and individual awareness	Surveillance Means restriction Media Access to services Training and education Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» Increased resilience and wellbeing in the community	Means restriction Access to services Training and education Treatment Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» Increased access to free suicide prevention oriented training and education across the whole community	Access to services Training and education Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» Annual local community based suicide prevention forum that bring communities together and support and enhance locally based developments	Surveillance m Media Access to services Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination

Goal	Strategic Direction	Outcomes	Focus Elements
[2] Informed, inclusive services that provide timely, integrated, compassionate and culturally safe responses that meet the diverse needs of people across the NT	Recognising and celebrating the increasing diversity of our community and ensuring that services are adapted to meet all their needs. Creating a comprehensive network of services that is client-centred, recovery focused, integrated and coordinated.	» A clear public policy, across government that supports suicide prevention	Surveillance Media Access to services Training and education Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» Transparent funding arrangements between all agencies to ensure best use of resources regarding suicide prevention	Surveillance Access to services Training and education Treatment Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» A readily accessible, contemporary and easy to navigate guide to local services	Access to services Training and education Treatment Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» Effective linking of services so that people experiencing distress access a safe system that is easy to navigate, and provides a seamless service regardless of the point of entry	Access to services Training and education Treatment Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination

Goal	Strategic Direction	Outcomes	Focus Elements
[3] Focused and evidence informed support for the most vulnerable groups of people	Suicide and suicidal behaviours are driven by a complex interplay of factors, and in order to respond services need a wide range of evidence based initiatives delivered in a safe and timely manner.	» Targeted training for health and social care staff in supporting vulnerable people, especially those in primary health care services	Surveillance Means restriction Access to services Training and education Treatment Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination
		» Provision of selected and indicated programs for all groups of people	Surveillance Access to services Training and education Treatment Crisis intervention Postvention Awareness Stigma reduction Oversight and coordination

COLLABORATIVE MULTI-SECTORAL FRAMEWORK LOGIC



Adapted from WHO (2014)

The challenges ahead are significant. They are however challenges we must all commit to addressing. The death of every single person to suicide is a loss to all of us – to family, friends and the broader community.

Every person in the Territory is a vital member of our vibrant and diverse community. Every person has a contribution to make.

Appendix

PREFERRED WORDS

Some of the language used to talk about suicide and suicidal behaviour can stigmatise people who have attempted suicide and those bereaved by suicide. This strategy and associated plans aligns with the preferred terminology detailed below:-

✔ Do Say	✘ Don't Say	Issue
Died by suicide	Committed suicide	Associates suicide with crime or sin
Took their own life	Successful suicide	Presents suicide as a desired outcome
Concerning increase in rates	Suicide epidemic	Sensationalises suicide
'Non-fatal' 'Made an attempt on their own life'	Unsuccessful suicide	Presents suicide as a desired event, glamourises a suicide attempt

SOURCE: Hunter Institute of Mental Health (2014) Reporting suicide: a quick guide for the media.[90]

KEY TERMS

Aboriginal and Torres Strait Islander Peoples describes Aboriginal and Torres Strait Islander people of Australia as 'belonging naturally to a place', acknowledging Aboriginal and Torres Strait Islander peoples as the first peoples and original custodians of Australia, and recognising the great diversity of nations within Australia. NT Health recognises that Aboriginal peoples and Torres Strait Islander peoples have diversity of culture, histories and values. In recognition that the term Indigenous is a sensitive one for many Aboriginal and /or Torres Strait Islander people, NT Health use the term Aboriginal, inclusive of Torres Strait Islander people.[91]

PLEASE NOTE: 'Indigenous' is retained when it is part of a report or program.

Aboriginal Community Controlled Health Services are primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.[92]

Crisis intervention refers to direct efforts to prevent a person from attempting suicide. Interventions may be immediate at the time of an acute crisis, when there is high risk for suicide, after a suicide attempt or over a period of time. These supports (e.g., crisis line help, individual and group counselling and employee assistance programs) are aimed at helping a person reduce their pain and suffering, building their capacity to cope, and recover their wellbeing.

Cultural competence is the culture-specific knowledge, skills and attitudes required to care for diverse populations. This includes consideration of different cultural attitudes, worldviews, cultural realities and environments and being reflective of personal attitudes towards cultural differences. Therefore, culturally competent services require an understanding of the communities they serve and cultural influences on individual behaviour.[93, 94]

Cultural safety identifies that health consumers are safest where health professionals have considered power relations, cultural differences and patient rights. Culturally-safe services are respectful, inclusive and enable specific populations/communities to participate in decision-making. Most importantly cultural safety is defined by the experience of the health consumer, not the health professional.[95]

'Go To people' is a term referring to people who can play a role in suicide prevention because of their contact or relationship with those who may be at risk of suicide. 'Go To' people are often community members who may not be formally trained in suicide prevention but are accessed as natural support people (e.g., coaches, teachers, religious/spiritual leaders, elders, volunteers). Family and friends can also play a 'go to' role, particularly for children and young people.

Lived Experience refers to first-person knowledge about suicidal thinking and/or behaviour from having lived through one or more suicidal experiences.[96]

A **multi-sectoral approach** recognises the complex nature of suicide and draws expertise from, coordinates between and collaborates with a variety of disciplines, professions and perspectives, in order to address suicide in a holistic and collective way.[97]

A **population health perspective** focuses on improving the health status of the population. Action is directed at the health of an entire population, or sub-population, including the reduction in health status inequalities between population groups due to factors including the social determinants of health.[98, 99] The population health perspective has been described as consisting of three components; *"health outcomes, patterns of health determinants, and policies and interventions"*.[100]

Postvention refers to suicide prevention activities that provide support for people affected by suicide (such as those bereaved in the aftermath of suicide loss).[101] These activities are essential in coping with suicide loss and reducing further suicides, and may include peer support, employee assistance programs, and counselling.[102]

Protective factors characteristics, situations, or other elements in a person's life that make it less likely that they will develop a disorder or experience a suicidal crisis.

A **public health approach** focuses on preventing health problems in a way that extends better care and safety to entire populations rather than individuals. Public health approaches aim to prevent problems from occurring in the first place by targeting risk factors or social determinants.[103]

Recovery refers to a process in which people are empowered to actively participate in their own well-being. Recovery builds on individual, family and community strengths and can be supported by a range of services and treatments. Principles of recovery include hope, self-determination and responsibility despite behavioral health challenges.[104]

Resilience is a dynamic process through which psychological, social, cultural and physical resources are used to adapt to change and to sustain well-being in the face of illness, injury or hardship. Resilience can exist at multiple levels, including the individual, the family and the community.[105]

Risk factors characteristics, situations, or other elements in a person's life that make it more likely that he or she will develop a disorder or experience a suicidal crisis.[106]
Self-harm and self-inflicted injuries refer to behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm/self-inflicted injuries can include behaviours with and without the intention of suicide. While people who self- harm may not intend to end their lives, the consequences of this risky behaviour can be fatal, and it needs careful assessment and care by a health professional.[107, 108]

Social and Emotional Wellbeing refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.[109]

Social Determinants of Health include all the factors (social, environmental, cultural and physical) different populations are born into, grow up and function with across the lifespan which potentially have a measurable impact on the health of human populations.

Stigma refers to negative, unfavourable attitudes and the behaviour these produce. It is a form of prejudice that spreads fear and misinformation, labels individuals and perpetuates stereotypes.[110] For example, stigma against those who have experienced suicide-related behaviour, survivors of suicide attempt and survivors of suicide loss may prevent people from seeking help for themselves or for loved ones, denying them access to the support networks and treatment they need to recover.[111]

Suicidal behaviour refers to a range of behaviours related to suicide and include thinking about or considering suicide (thoughts), planning for suicide, intending, attempting suicide and suicide itself.[112]

Suicide: is death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour.[113] Many factors and circumstances can contribute to someone considering, attempting or dying by suicide (including loss, addictions, childhood or other forms of trauma, depression, serious physical illness, mental illness and major life changes.

Suicide Attempt refers to nonfatal suicidal behaviour.[114]

Suicide prevention is an umbrella term for the collective efforts of governments, community organizations, mental health practitioners and related professionals, and families and individuals across our community to enhance safety from suicide-related behaviour and reduce the incidence of suicide.[115]

Standardised death rate is the number of deaths by suicide during a given year (estimated mid-year population) per 100,000 population.[116]

Support is the action of providing assistance, encouragement and/or comfort to individuals, families or communities facing difficulties. Support can include increasing awareness, reducing stigma, providing information and delivering services.

The premise of the **systems approach** is that only by addressing the entire community's interactions can a complex behavioral problem such as suicide be reduced. This includes interventions at the individual, family, and community levels, as well as changes in interactions among levels.[117] Using a systems approach means that interventions need to target all these different factors across the suicide prevention continuum. This involves working with the individual, their family and peers, as well as the community and society that they live in.[118]

Thoughts of suicide (suicidal ideation) refers to thinking about, considering, or planning for suicide.[119, 120] These can range from fleeting thoughts to detailed planning. Although the majority of people who experience thoughts of suicide do not go on to attempt suicide, it is a risk factor.[121]

Trauma informed care and practice refers to an organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for consumers, their families and carers, and service providers.[122]

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