What are some opportunities available in NT in Suicide prevention?

- A single point of reference for organisations that is geographically based, aligned with the stepped care model and articulates referral criteria and pathways. Include services that address social determinants and support for families. It is an investment and money will be required to maintain it. The value add to families, MH workforce, schools will be enormous. Look at ShelterME created by homelessness sector as it us the closest example in the NT.
- It is all up to community action and lived experience knowledge
- Services don’t get into the epicentre of suicide behaviour
- . suicide is predominately a social phenomenon EG ...Employment saves live...
- There’s a tension with “leadership” . Either we have grass roots focused services in each community (which struggle to connect) or we have a coordinated approach with a framework that is set up in the big smoke. How do we get the best of both worlds.
- Those in control of funding need to show leadership in coordination of services.
- There is energy and optimism within the NT to take action and there is recognition that services need to be integrated and coordinated.
- Support community action groups with focus on Suicide prevention and awareness raising. development of community based safe places
- Regular combined meetings of service
- With an election looming let’s make suicide prevention a main election issue
- Strategy and action in post - vention. Grief takes our strength.Establish a clear roadmap for families who have children with suicidal ideology to see immediate help.
- There are plenty of challenges in preventing life loss to suicides. If we all decide to get together and work together, surely we can make a significant difference!
- engage those with lived experience to help inform and shape policy and services, they have a lot to offer
- Schools as health hubs
- The work done by Lidia and family and other like organisations have built momentum NOW let’s act.
- Start now
- Build resilience and help seeking behaviour in our youth
- Services are not restricted by KPIs ... only the interpretation of them Joined up service responses is the funding future

What are some challenges faced in NT in Suicide prevention?

- We are lacking a whole of a community approach to prevent suicide. Better coordination among all agencies, improving access to care, building community resilience and the capacity of our health workforce!
- It’s about the power of the “ And” not the “or”. 1) clinical and community mental health need to work hand in hand. They are both needed at different points , but the argue like siblings over whose the favourite child rather than working as a family. 2) best practice vs innovation. We need both working together. Best practice benchmarks from research and while it’s safe it takes time. innovation is trying new things that may make sense but haven’t been tested.
- Describing prevention as facet of being humane, it’s not necessarily a program it’s out daily lives.... our apparently routine lives have prevention in-built. It’s natural to “ prevent” suicide behaviours. ‘This is implicit in and transcends programs’ Small NT population and scattered population pockets fundamentally means Community coordinated responses ...
- It doesn’t decide elections
- Ignirance
- How to effectively engage with impacted families and communities who have lost loved ones to suicide
- Not enough safe safe places for people who need help to go to when they need it
- Knowledge and resources and leadership at community level
- Famillies being able to gain knowledge and confidence in dealing with suicide
- Police need better skills to deal with troubled young people
- Many of the children and young people who get themselves into trouble have suicide ideation, the intervention needs to be wholistic, currently we hand these people around from service to service without any real intervention.
- Programs targeted at children aged 10 and over as ‘early intervention’ are not enough. It is important to start build resilience in early childhood.
- Developing grass roots responses- silo approaches Need to be overcome
- No community cultural inductions for new community members on employment contracts.
- Access to clinical psychologists and psychiatrists that specialise in youth / adolescents.
- 1.Funding, 2.coordination between agencies,3. Capacity building.
- Lack of resourcing both financial and staffing. Lack of government awareness of remote challenges.

- Distance, cost, lack of community resource / acces, change from to collective community to individualism, inter generational trauma leading to genetic changes that predispose people more towards anxiety and depression and the lack of understanding that this can be changed
- How to effectively engage with impacted families and communities who have lost loved ones to suicide
- Community stigma
- Local voices, community members voices not heard enough.
- Turning lived experience into lived expertise
- Does the Police and other frontline services have the skills to deal with children and you people exhibiting high risk and suicide behaviours
- Describing prevention as facet of being humane, it’s not necessarily a program it’s out daily lives.... our apparently routine lives have prevention in-built. It’s natural to “ prevent” suicide behaviours. ‘This is implicit in and transcends programs’ Tim K
- Coordinating agencies, groups and resources to work together
- Not enough safe safe places for people who need help to go to when they need it