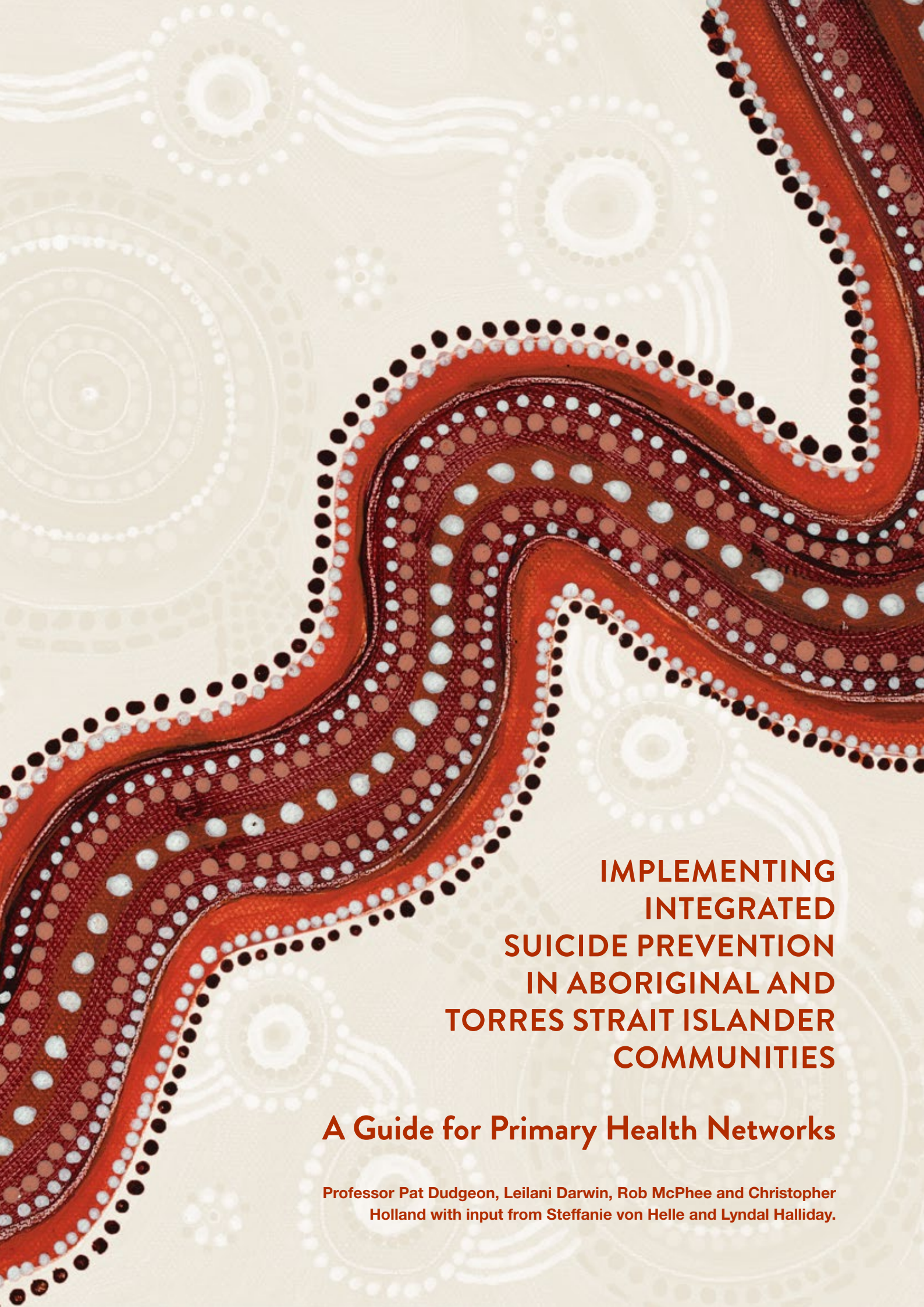


The background of the cover features a complex Indigenous-style pattern. It includes several concentric circles in white and light beige on the left side. A prominent, thick, wavy band in shades of red and orange runs diagonally across the right side, filled with a dense pattern of small white and black dots. The overall color palette is warm, dominated by earthy tones.

IMPLEMENTING INTEGRATED SUICIDE PREVENTION IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

A Guide for Primary Health Networks

**Professor Pat Dudgeon, Leilani Darwin, Rob McPhee and Christopher
Holland with input from Steffanie von Helle and Lyndal Halliday.**



**The Centre of Best Practice in
Aboriginal and Torres Strait
Islander Suicide Prevention**



**Black Dog
Institute**

Artwork: *'Shifting Sands'* by Roma Winmar

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The opinions, comments and analyses expressed in the document are those of the author/s and individual participants and do not necessarily represent the views of the Government and cannot be taken in any way as expressions of Government Policy.



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**WESTERN
AUSTRALIA**

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Indigenous Health

KEY DOCUMENTS

This Guide is a companion to: Centre for Evidence and Implementation & Black Dog Institute (2017). *LifeSpan Implementation Framework: Implementing Integrated Suicide Prevention*. Sydney: Black Dog Institute. As such, it follows its structure and uses its implementation science terms.

This Guide also refers extensively to: Dudgeon, P., Milroy J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G., & Holland, C. (2016). *Solutions That Work – What the Evidence and Our People Tell Us, The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*. Perth: University of Western Australia. Extracts are also included in this Guide, particularly descriptions of suicide prevention activity in Indigenous communities that were evaluated as successful.

This Guide also builds on the following publications, and some text is based on information within them:

- Dudgeon, P., Milroy J., Luxford, Y., & Holland, C (2017). *Report of the Critical Response Pilot Project, The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*. Perth: University of Western Australia.
- Dudgeon, P., Calma, T., & Holland, C. (2017). *Context and Causes of Indigenous Suicide in Australia*, Te Mauru – Pimatisiwin, Vol 2, Issue 2, in which much of the material in Section 2 was first published. Available online at: <https://journalindigenousewellbeing.com/media/2017/09/82.65.The-context-and-causes-of-the-suicide-of-Indigenous-people-in-Australia.pdf>
- Dudgeon, P., Calma, T., & Holland, C. (2016). 'Aboriginal and Torres Strait Islander communities'. Section 3 of the Black Dog Institute (2016). *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring*. Canberra: Commonwealth of Australia. In particular, the case study 'The establishment of the Western NSW PHN Aboriginal Health Council' is an extract from this source.
- Australian Government (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023*. Canberra: Department of the Prime Minister and Cabinet.

In this Guide, the term 'Indigenous people(s)' is generally used when referring to both First Peoples of Australia—Aboriginal peoples and Torres Strait Islander peoples.

PREFACE

This document is a companion guide to the Centre for Evidence and Implementation and Black Dog Institute's *LifeSpan Implementation Framework – Implementing Integrated Suicide Prevention*. It is intended to support Primary Health Networks (PHNs) as they work to implement integrated approaches to suicide prevention in Aboriginal and Torres Strait Islander (Indigenous) communities.

Action 4 of the 2017 *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) requires integrated approaches to be implemented across Australia, including in Indigenous communities, as the foundation of a new national approach to suicide prevention. Currently, these are being trialed in a number of PHN sites. This Guide is intended for PHNs working with Indigenous communities in this context, especially those that are funded by the Department of Health under the National Suicide Prevention Trials project. These include both high fidelity research trial sites implementing the LifeSpan approach, and non-research trial sites that have the option to implement other integrated approaches.

This companion guide recognises that Indigenous suicide deaths are associated with different historical, political and social factors than those of the non-Indigenous population; therefore, different approaches to prevention may be required. Secondly, Indigenous rights to self-determination, cultural differences and recognised good practice require a non-negotiable approach to engagement, process and governance that empowers and respects community self-determination and culture.

While the LifeSpan model for integrated suicide prevention is the focus of this Guide, this does not represent an endorsement by the authors or the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATISIP) of its suitability for use in Indigenous communities. This is because the evidence base that justifies the recommended interventions in LifeSpan – or other integrated suicide prevention models, such as that of the European Alliance Against Depression (EAAD) that some PHNs are currently implementing – is not specific to indigenous populations.

Indeed, much of the evidence informing this report remains untested in Indigenous settings, and is likely to require cultural adaptation and a strong commitment to ongoing evaluation and refinement during the initial implementation stage to ensure it responds effectively to community need. Further, additional elements and/or recommended interventions may be required to meet the different suicide prevention needs of particular Indigenous communities; in this context, the Guide is informed by Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project's (ATSISPEP) *Solutions That Work* report.

This Guide has been commissioned by the Black Dog Institute, funded by the Australian Government Department of Health, and developed in partnership between the LifeSpan Program in the Black Dog Institute and the CBPATISIP at the University of Western Australia. This ongoing partnership will produce numerous other resources, including a guide to implementing cultural governance to support integrated approaches to suicide prevention in Indigenous communities, which is currently in progress.

CONTENTS

Key Documents	1
Preface	2
Executive Summary – Action Checklist.....	4
1.0 Policy and Other Contexts	8
1.1 The Fifth National Mental Health and Suicide Prevention Plan	8
1.2 National Suicide Prevention Trial Sites	9
1.3 LifeSpan and Its Recommended Interventions	10
1.4 The LifeSpan Implementation Framework	11
2.0 The Need for an Indigenous-Specific Companion Implementation Framework	14
2.1 Indigenous Suicide Deaths in Historical, Political and Social Context	14
2.2 Working in an Indigenous Rights-Based Framework	15
2.3 Working in an Indigenous Cultural Framework	17
2.4 ATSIPEP and the Evidence Base for Indigenous Suicide Prevention	18
3.0 How to Engage.....	20
3.1 Organisational Readiness to Engage	20
3.2 Supporting an Indigenous Health Council	21
3.3 Approaching Communities	22
3.4 Engagement Agreements	23
4.0 Co-exploration: Identifying Challenges, Gaps and Resources.....	24
4.1 Involving Relevant Stakeholders	24
4.2 Suicide Audit	25
4.3 Health and Mental Health Services Review	25
4.4 Workforce Review	28
4.5 Working with the Community to Assess Its Readiness	29
4.6 Resources Review	29
5.0 Co-designing and Adopting An Integrated Approach.....	30
5.1 Considering the Strengths and Weaknesses of LifeSpan-Recommended Interventions	31
5.2 ATSIPEP Success Factors as a Guide to Potential Additional Elements of an Integrated Approach	34
6.0 Co-installation and Co-implementation	39
6.1 Collaborative Governance Arrangements and Implementation Teams	39
6.2 Employment of New Staff	40
6.3 Partnering with, and Supporting the Development of Aboriginal Community Controlled Health Services	41
Appendices	43
1.0 Indigenous Suicide Deaths in Historical, Political and Social Context	43
2.0 European Alliance Against Depression (EAAD) model	47
3.0 National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023	48
4.0 Gayaa Dhuwi (Proud Spirit) Declaration	49
5.0 The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026	51
6.0 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy	52
7.0 The Elders Report into Preventing Indigenous Self Harm and Youth Suicide	54
8.0 Further Reading	56
Endnotes	57

EXECUTIVE SUMMARY – ACTION CHECKLIST

Presented below is a summary table of ‘pointers for action’ recommended in this Guide with reference to *LifeSpan Implementation Framework* concepts that emphasise process over prescribing content.

How to engage	
Organisational readiness to engage	• Appoint local Indigenous PHN board members who work with Indigenous communities within the region to provide overarching technical and adaptive leadership. In many cases, Aboriginal Community Controlled Health Services CEOs will be ideally placed for such a role. • Ensure that Community Advisory Councils (CACs) and Clinical Councils include Indigenous members with expertise in the issues impacting communities within the PHN region, and that have the capacity to reach into remote communities if relevant. • Ensure that PHN boards, CACs and Clinical Councils have protocols in place to ensure the cultural safety of their Indigenous members and to otherwise support them. Examples might include: adding Indigenous issues, including suicide prevention, to meeting agendas as standing items that are distinct from general population concerns; ensuring that a minimum of two Indigenous people are present in any fora; and providing financial or transport support to attend meetings, particularly for people from remote areas. • Ensure that CACs develop an overarching Indigenous community engagement strategy that is designed, delivered and evaluated under Indigenous leadership. • Ensure Indigenous people are employed at all levels of a PHN's organisational structure, including by direct recruitment and upskilling of existing Indigenous staff. This can provide technical and adaptive leadership from within the organisation and help acculturate the organisation and its non-Indigenous staff to work better with Indigenous communities. • Employ Indigenous community mentors for senior and relevant staff, and to guide organisational engagement with communities. • Require all non-Indigenous staff to undergo cultural capacity building to understand the history, culture and other contexts within which local Indigenous communities operate in the PHN region. Preferably, this training should be commissioned from local ACCHSs or Indigenous providers. • Aim to understand a community's history and what might be contributing to suicidal behaviours or challenges related to suicide prior to contact. Understanding a community's history at least in broad terms might include understanding any legacies of distrust following previous decades of experience of interacting with Australian governments and their agencies, not all of which may have been positive.
Supporting an Indigenous Health Council	• Appoint an Indigenous Health Council within the PHN/organisation structure. This could be as a Community Advisory Committee subcommittee or as a standalone body. Such Councils can provide a collective point of contact including for (but not limited to) the development of regional Indigenous mental health and suicide prevention plans that incorporate integrated approaches to suicide prevention. Cross membership between an Indigenous Health Council, a PHN Board and other organisation structures can help ensure the integration of the former into the work of the PHN, and into all levels of a PHN's structure. • Fund and otherwise support member attendance at Indigenous Health Councils. • Appoint members with lived experience of suicide to the Indigenous Health Council and otherwise as appropriate within the organisation.
Approaching communities	• Be proactive – reach out to Indigenous communities rather than waiting to be contacted. Early and frequent engagement and time should be allowed for the development of trusting and open relationships at both the interpersonal and organisational level. • As a starting point, build CEO to CEO relationships with local Aboriginal Community Controlled Health Services (ACCHSs) and community organisations as the basis for exploration work. Where they exist, an ACCHS is likely to occupy a leadership role within a community, or be able to connect an organisation to a community's governing body. They are also ideally placed to support the co-design and co-implementation of systems approaches to suicide prevention in partnership with PHNs. These partnerships can then underpin and support the later exploration, installation and implementation stages of integrated suicide prevention activities. • Ascertain whether language barriers may exist and employ translators if necessary.

Engagement agreements	• Agree on engagement protocols that include recognition of Indigenous community leadership (for example, ACCHSs or recognised governance bodies), and enable work with particular Indigenous communities reflecting the diversity among them. These could include: – Commitments from all parties to developing long-term sustainable relationships based on trust – Transparency about decision making – Contracts or agreements (to provide a sense of greater power in otherwise unequal engagements) – Strong mutual accountability relationships in agreements and a willingness to share responsibility for shared objectives – Collaboratively-developed criteria and indicators for annual self-assessments – Agreed conflict resolution processes – Practical steps, such as providing places and ways for Indigenous community members people to physically come together to support Indigenous community governance activity, may be an important part of an engagement agreement.
Co-exploration: identifying challenges, gaps and resources	
Involving relevant stakeholders	Stakeholders working in Indigenous suicide prevention must have the capacity to inform and support or contribute to the implementation of an integrated suicide prevention approach in a community setting. A stakeholder group may include representatives from the following community groups: • Community governance bodies and recognised local leaders • Elders and elders' groups • Men's and women's groups • Community members with lived experience of suicide, including family, friends and carers • Aboriginal Community Controlled Health Services • Existing suicide prevention programs • Postvention and crisis response services • Other Aboriginal and Torres Strait Islander community organisations • Relevant local and regional programs, such as the National Empowerment Project • Local media • Aboriginal and Torres Strait Islander health workers • It may also include representatives from the following local or even regional services: • Mental health services • Local hospitals • headspace • Psychology and psychiatry services • General practice and allied health services • Social work, mental health and counselling services • Link Up workers • Police and other emergency services • Child and maternal health services • Alcohol and other drug rehabilitation services • Disability, environmental health, education, employment, training, housing, justice, family and community services.
Suicide audit	• Be flexible about what constitutes 'data' that will drive data-driven decision making. In an Indigenous community context, a focus on deaths deemed as suicide by coronial inquest that excludes anecdotal reports and community identification of suicide deaths may be counterproductive. Some commentators believe that suicide is significantly unreported in Indigenous communities. This underscores the need for suicide audits to also occur under community leadership if an accurate foundation picture for suicide prevention activity is to be established.

Service gap analysis ACCHSs	Review whether ACCHS offer, or coordinate, integrated: - Physical health, social and emotional wellbeing (SEWB) support, primary mental health care, alcohol and drug treatment and suicide prevention services - General-practitioner-provided medical care, including pharmacotherapies of all types - Psychological care from a range of mental health professionals, including counsellors - Social and cultural support, including long-term, community-based case management when needed.
Service gap analysis Culturally respectful mainstream services	Reviews of mainstream services must be community led. In addition to capacity review (as for ACCHSs above), while cultural competence staff training and so on should be considered, cultural competence and cultural safety must be recognised as subjective experiences that are owned by the Indigenous consumers and communities these services work with.
Service gap analysis General	When reviewing services, ask: - Are services trauma informed, as indicated by the Closing the Gap Clearinghouse paper: <i>Trauma-Informed Services and Trauma-Specific Care for Indigenous Australian Children</i>? - Are services' time protocols adequate to meet the needs of people who have attempted suicide or who are at risk of suicide? - Do services offer postvention support?
Workforce review	- As with all elements of implementation, a workforce-population ratio appropriate to the community or region in question must be developed with full community participation. When reviewing workforce, ask: - Are there enough mental health professionals and related workers to meet the needs of Indigenous communities? If not, why? What is the shortfall? - What is the presence of Indigenous community members in services? If there a sufficient presence? If not, why? What is the shortfall? - Are Elders and peers employed? If not, why?
Community readiness	- Community governance bodies should utilise their own methods of decision making when assessing the readiness of the communities they serve. - Particular challenges may need to be addressed before the adoption or within the context of an integrated approach to suicide prevention. - If a community is not ready for a systems approach to be adopted, this may because it needs support to understand the relevance of the approach, or how it might be of benefit. Community education about SEWB, mental health and suicide prevention may play an important role in this context. - Cultural resources and strengths, such as Elders, men's and women's groups, cultural healers, cultural practices and so on, should be assessed as part of a broader review of suicide prevention resources.

Co-designing and adopting an integrated approach

Questions to ask	The <i>LifeSpan Implementation Framework</i> suggests asking communities the following questions to help guide the co-design and adoption process: - What is the problem your community aims to solve by implementing an integrated model of suicide prevention? - What are the outcomes you want to achieve by implementing an integrated model of suicide prevention? - Is it LifeSpan as a whole that is of interest to you, or only parts of it? - Which agencies in your community will be implementing an integrated model of suicide prevention? - How will an integrated model of suicide prevention be funded, both in the short term of two years and beyond? - What sort of organisational or agency support is required for your site to successfully implement an integrated model of suicide prevention (e.g. support from schools, social service agencies, GP clinics, etc.)? - What are the potential barriers within your community or participating organisations that may hamper the implementation of an integrated approach to suicide prevention? - For how long can you commit to implementing an integrated model of suicide prevention? (<i>Fifth Plan, page 18</i>).
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Co-installation and co-implementation	
Installation	Indigenous community leadership and 'ownership' of multi-agency governance groups and their activities is essential for the successful delivery of systems approaches across regions. Community leadership and direction in multi-agency governance group activity at the community level will, similarly be key to the success of installing and implementing in communities.
Implementation	- When commissioning elements of integrated approaches, a PHN should aim to employ local and community people as much as possible. - Where service gaps are identified and when commissioning suicide prevention activity, a PHN should aim to build community capacity (including ACCHS and other community-controlled organisational capacity) as much as possible, including as an important part of committing to the empowerment of communities in the context of suicide prevention. - An effective way of exploring potential untested elements in any integrated approach is by Participatory Action Research (PAR) methodologies. - PAR-based evaluations and processes should be disseminated to help build an increasing evidence base for Indigenous systems approaches to suicide prevention and suicide prevention in general, and should support the expansion of integrated approaches to suicide prevention in Indigenous communities across Australia.

1.0 POLICY AND OTHER CONTEXTS

1.1 THE FIFTH NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN

The *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) commits Australian governments to implement integrated approaches to suicide prevention and to develop a new national suicide prevention implementation strategy. Integrated approaches involve the simultaneous use of multiple evidence-based suicide prevention interventions, from the universal to indicated-levels, in any given setting. The key principle is that the synergistic effect of combining multiple interventions produces an outcome that is greater than the sum of its individual parts.¹

The Fifth Plan seeks to broadly align these integrated approaches to 11 specific elements in order to ensure some degree of national consistency (see Text Box 1 below). It is noteworthy that the LifeSpan, EEAD and ATSISEEP *Solutions That Work* report success factors broadly align with these 11 elements.

TEXT BOX 1: Extracts from the *Fifth National Mental Health and Suicide Prevention Plan* relevant to systems approaches to suicide prevention

Consistent with the WHO's *Preventing Suicide: A Global Imperative*, the Fifth Plan commits all governments to a systems-based approach which focuses on the following 11 elements:

1. **Surveillance:** increase the quality and timeliness of data on suicide and suicide attempts.
2. **Means restriction:** reduce the availability, accessibility and attractiveness of the means to suicide.
3. **Media:** promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
4. **Access to services:** promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.
5. **Training and education:** maintain comprehensive training programs for identified gatekeepers.
6. **Treatment:** improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
7. **Crisis intervention:** ensure that communities have the capacity to respond to crises with appropriate interventions.
8. **Postvention:** improve response to and caring for those affected by suicide and suicide attempts.
9. **Awareness:** establish public information campaigns to support the understanding that suicides are preventable.
10. **Stigma reduction:** promote the use of mental health services.
11. **Oversight and coordination:** utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

Action 5 of the Fifth Plan is that governments will support PHNs and Local Hospital Networks (LHNs) (known as Local Health Districts in NSW; Hospital and Health Services in Queensland, Local Health Networks in South Australia, and Tasmanian Health Organisations in Tasmania) to develop integrated, whole-of-community approaches to suicide prevention. This will include engaging with local communities to develop suicide prevention actions as part of a joint regional mental health and suicide prevention plan. These regional plans will be consistent with the 11 elements above and informed by the National Suicide Prevention Implementation Strategy as it is developed.

The Fifth Plan also affirms improving Indigenous mental health and social and emotional wellbeing (SEWB), and reducing suicide, as a national priority (Priority Area 4). It includes a commitment that Australian governments will work with PHNs and LHNs to implement integrated planning and service delivery for Indigenous populations and communities at the regional level (Action 10).

Furthermore, when working to improve Indigenous mental health and implement approaches to suicide prevention, the Fifth Plan also states that PHNs and LHNs are to be guided by six Indigenous-specific strategic documents, as set out in Table 1 on the following page. Indeed, the intent of this document is to give life to these principles when implementing a systems approach.

TABLE 1: PHN sources of guidance when working to improve Indigenous mental health and implement systems approaches to suicide prevention, as set out in the *Fifth National Mental Health and Suicide Prevention Plan*

Guidance	Page number in the Fifth Plan	In this document
ATSISPEP <i>Solutions That Work</i> report ²	pp.24 & 28	Table 2, next section
<i>National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023</i> ³	p.28	Appendix 3
<i>Gayaa Dhuwi (Proud Spirit) Declaration of the National Aboriginal and Torres Strait Islander Leadership in Mental Health</i> ⁴	Action 12.3	Appendix 4
<i>National Drug Strategy 2017–2026</i> which includes an Indigenous-specific component, the <i>National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014–2019</i> ⁵	p.8	
<i>The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026</i> ⁶	p.28, Action 11	Appendix 5
<i>National Aboriginal and Torres Strait Islander Suicide Prevention Strategy</i> ⁷	pp.6 & 28	Appendix 6

1.2 NATIONAL SUICIDE PREVENTION TRIAL SITES

Twelve Commonwealth-Government-funded PHN trials of integrated approaches to suicide prevention are currently underway across diverse community settings. While there is no requirement for these to trial any particular integrated approach model, these trials have been broadly guided by:

- the Black Dog Institute's LifeSpan model (LifeSpan), comprising nine evidence-based strategies (see below) and six principles for implementation.
- the European Alliance Against Depression (EAAD) model, a four-level system approach that focuses on reducing the prevalence and impact of depression strongly associated with suicidal behaviours (see Appendix 2).
- In New South Wales, the Black Dog Institute, the Mental Health Commission of New South Wales and the Paul Ramsay Foundation are also funding an additional four high fidelity research trials of the LifeSpan model.

Two of the 12 Commonwealth-Government-funded PHN sites are focused on implementing integrated approaches specifically and exclusively in Aboriginal and Torres Strait Islander (Indigenous) communities. At least five other sites involve suicide prevention in Indigenous communities.

As noted, while PHNs are being guided by different models in trialing integrated approaches to suicide prevention, they are not required to implement complete models, and may select elements from LifeSpan or EAAD or other elements (broadly within the 11 elements set out in the Fifth Plan) relevant to their region or to particular communities.

Recognising such flexibility is an important aspect of this Guide – the evidence base that justifies the elements or 'recommended interventions' in both the LifeSpan and EAAD models is of universal application, rather than specific to Indigenous populations.

Indeed, as set out in this Guide, many elements in both models remain untested in Indigenous community settings. Therefore, they are likely to require cultural adaptation and a coincident strong commitment to ongoing evaluation and refinement in order meet the needs of different Indigenous communities. Further, and as strongly suggested by the ATSISPEP *Solutions That Work* report, additional non-universal and cultural-specific elements may be required.

12 COMMONWEALTH PHN SUICIDE PREVENTION TRIAL SITES

- Western New South Wales
- Central Queensland, Wide Bay, Sunshine Coast
- Darwin (Indigenous-specific)
- Mid-West, Western Australia
- Brisbane North
- North Coast NSW
- North Western Melbourne
- Perth South
- Townsville
- The Kimberley (Indigenous-specific)
- Tasmania
- Country South Australia

In response, this Guide emphasises implementation in the broader context of the six ‘process’ elements of the outer circle of the LifeSpan wheel (See Diagram 1 below), rather than on the nine ‘mainstream’ elements they enclose. Those process elements are:

- Local ownership and adaptation;
- Community engagement;
- Cultural governance and inclusion;
- Data-driven decision making;
- Workforce information and development; and
- Lived experience inclusion at every level.

While all six process elements are relevant to this Guide, it is the first three (local ownership and adaptation, community engagement, and cultural governance and inclusion) that are of particular importance in Indigenous community settings.

1.3 LIFESPAN AND ITS RECOMMENDED INTERVENTIONS

A brief overview of the strategies is provided with the wheel diagram (Diagram 1) below. The nine strategies that comprise LifeSpan can be found inside the wheel, and the six process elements are found in the outer ring.

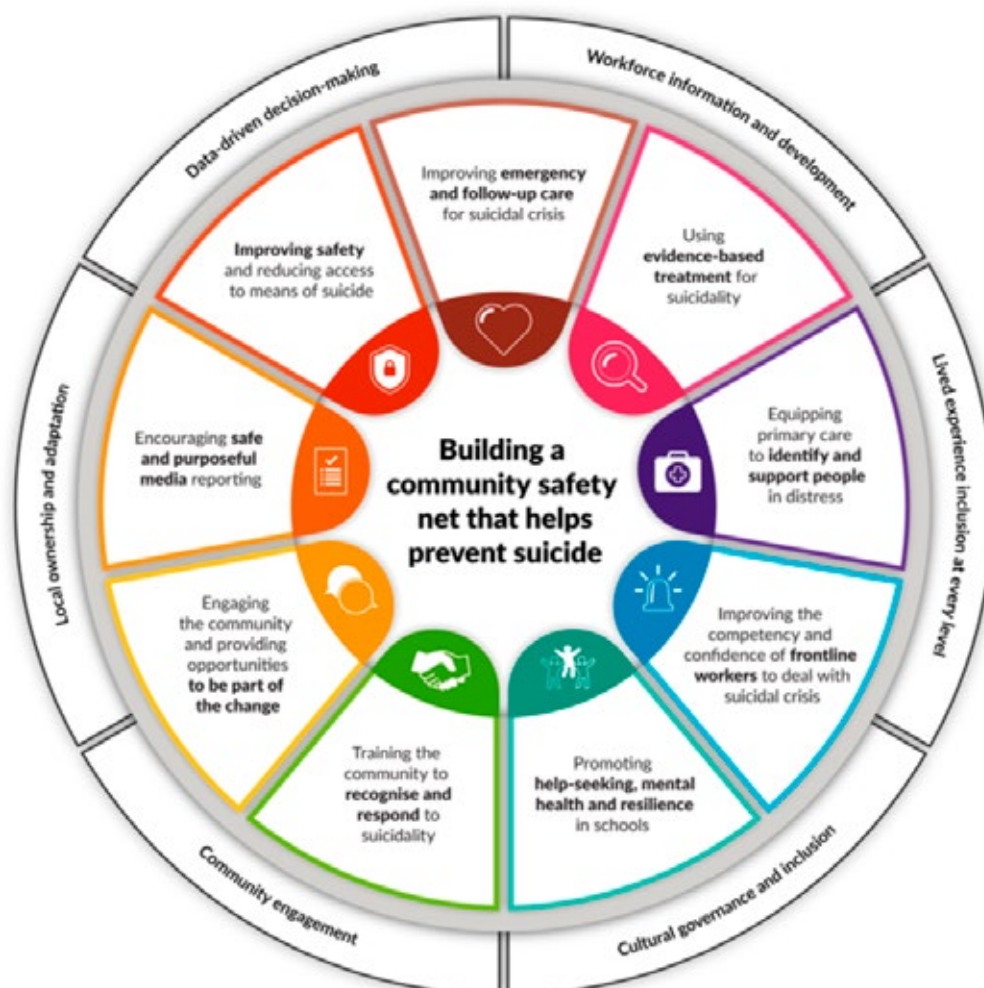


DIAGRAM 1: A wheel diagram showing the LifeSpan integrated approach to suicide prevention model, with six process elements (outer circle) and nine elements (inner circle)

The *LifeSpan Implementation Framework* identifies 14 recommended (or ‘usable’) interventions against the nine elements for mainstream systems approaches, as set out on the following page in Table 2.

TABLE 2: LifeSpan nine elements with identified recommended interventions

Nine elements		Recommended interventions
1	Improving emergency and follow-up care for suicidal crisis	(1) Aftercare service (2) Guidelines for integrated, suicide-related crisis and follow-up care
2	Using evidence-based treatment for suicidality	(3) Advanced Training in Suicide Prevention (ATSP) (4) Collaborative Assessment and Management of Suicidality (CAMS)
3	Equipping primary care to identify and support people in distress	(5) Advanced Training in Suicide Prevention (6) StepCare
4	Improving the competency and confidence of frontline workers to deal with suicidal crisis	(7) Target training for paramedics, police, mental health workers
5	Promoting help-seeking, mental health and resilience in schools	(8) Youth Aware of Mental Health (YAM)
6	Training the community to recognise and respond to suicidality	(9) Applied Suicide Intervention Skills Training (ASIST) (10) Question, Persuade, Refer (QPR)
7	Engaging the community and providing opportunities to be part of the change	(11) Community campaign (RUOK?)
8	Encouraging safe and purposeful media reporting	(12) Mindframe Plus
9	Improving safety and reducing access to means of suicide	(13) Means restriction (14) Suicide audit

1.4 THE LIFESPAN IMPLEMENTATION FRAMEWORK

To assist with implementing the LifeSpan model in community settings, the Australian Government Department of Health has commissioned the abovementioned *LifeSpan Implementation Framework* to which this Guide is a companion document. This is based on the National Implementation Research Network's 2005 Active Implementation Framework,⁸ which is among the most prominent implementation frameworks used in education and social welfare.

The *LifeSpan Implementation Framework* acknowledges that implementation happens in stages and unfolds over time. It cannot be considered as a single event taking place when the decision to adopt a particular integrated approach to suicide prevention has been made. Local implementation begins *before* this adoption decision and it lasts for a long time *after*.

The *LifeSpan Implementation Framework* distinguishes between three implementation stages: exploration, installation and implementation (initial and full). These are discussed below and on the following page.

Exploration	An implementation begins with 'exploration'. This exploration should be focused on the problems a local community wants to solve and the solutions that potentially respond to the problem. A community with an interest in enhancing its suicide prevention practices and services should: - Describe and analyse its core challenges in this area – preferably based on data that can indicate the magnitude and intensity of the problem, and involving all relevant key stakeholders who can contribute to creating solutions - Assess whether any particular integrated approach (such as LifeSpan or EAAD) to suicide prevention is a potential solution to this problem, including: - How the approach would be operationalised across different stakeholder agencies - The strengths and weaknesses of different elements of the recommended interventions - Their fit and feasibility within the community context. These questions may need to be tailored to particular recommended interventions (see below). The exploration phase ends with an adoption decision – the decision to adopt a particular integrated approach to suicide prevention. This decision should preferably be made collectively among as many key stakeholders as possible to ensure that broad community support is present from the beginning and can be capitalised upon in later stages of the implementation process.
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Installation	The focus within the installation phase is on preparing to apply the different elements and recommended interventions of a particular integrated approach to suicide prevention. The first steps in this process focus on creating collaborative governance structures that can help a site to progress implementation over time. The <i>LifeSpan Implementation Framework's</i> multi-agency governance framework mandates that local suicide prevention collaboratives must include representation from PHNs and/or LHDs, as well as from people with lived experience of suicide. A local collaborative should also include as many local stakeholders and representatives from priority populations as possible. Furthermore, when preparing to implement a particular integrated approach to suicide prevention, new staff may need to be hired, different types of training delivered, new organisational and community structures developed, and data systems built. In this sense, installation can be a rather <i>technical</i> phase that requires strong communication and good organisational skills from participants given the many interventions that may be required. However, this phase also needs to have a strong awareness of the <i>adaptive</i> aspects of an implementation process. Implementing a particular integrated approach to suicide prevention drives organisational and system changes that require individuals to change their behaviour. Such behaviour change depends on the individual readiness of staff in the different organisations involved in the LifeSpan implementation – general practitioners, school teachers, social workers, volunteers, gatekeepers.
Initial implementation	Initial implementation is a fragile phase. The new integrated approach to suicide prevention will be implemented in different areas and organisations of the community and applied for the first time. To begin with, even highly experienced clinicians, educators or administrators may feel slightly awkward because new behaviours and routines need to be learned, and old habits unlearned. This may lead to a feeling of incompetence or loss of control that has to be temporarily accepted. The focus of this phase is on quality assurance and improvement. As soon as new practices and interventions are in use, data collection should begin. The data should be assessed regularly to identify and understand the most immediate and crucial local or central implementation barriers and facilitators.
Full implementation	After becoming familiar with the application of a new approach to integrated suicide prevention, the next step is full implementation. The focus in this phase is on consolidating the different interventions and enabling their skillful implementation among relevant clinicians and agencies. Full implementation may also imply that the community confidence gained by implementing the intervention within a single team, clinic, school or agency is now enabling its expansion into to other teams, units or organisations.

Key LifeSpan Implementation Framework implementation concepts include:

Usable or recommended interventions	According to the <i>LifeSpan Implementation Framework</i> a 'usable intervention' is one which can be used and replicated in any given context. When the essential elements of the 'usable interventions' are documented, staff can be trained and the intervention can be implemented and properly evaluated. In this companion Guide, the term used is 'recommended intervention'.
Implementation drivers	Key capacities and resources needed to support change are named 'implementation drivers'. These include: • Competency drivers. Implementation requires the selection and recruitment of staff with appropriate skills and qualifications and/or providing the appropriate training and ongoing coaching and support to existing staff. • Organisation drivers. An implementing organisation may require technical equipment for carrying out the intervention, sufficient administrative and data collection processes, effective work teams and other structures. • Leadership drivers. There are two types: – Technical leadership makes new resources available for putting the LifeSpan interventions into practice. – Adaptive leadership is required for more complex challenges, such as engaging service providers or ensuring that stakeholders and leaders have endorsed an integrated approach to suicide prevention collectively.
Implementation teams	Implementation teams actively support and guide the implementation process, which spans several stages. A Central Implementation Team is already in place at the Black Dog Institute for the four NSW high fidelity research trials, and Black Dog also offers centralised support to the other national suicide prevention trial sites. Local sites should form a Local Implementation Team with representatives from key agencies and systems, who are charged with guiding the overall implementation of an integrated approach to suicide prevention in the community. A local site may also consider forming practice implementation teams. These are in direct contact with organisations delivering services at the frontline and are best suited to identifying and monitoring local implementation practice. The implementation teams are interlinked through continuous feedback loops, ensuring that crucial implementation information generated at the front-level of service delivery reaches local and central implementation levels and vice versa.
Improvement cycles	Improvement cycles rely on a 'plan-do-study-act' logic and enable an intervention provider to establish purposeful continuous quality improvement processes. Through these processes, an intervention can be continuously improved in response to feedback.

2.0 THE NEED FOR AN INDIGENOUS-SPECIFIC COMPANION IMPLEMENTATION FRAMEWORK

This implementation framework (the Guide) is a companion to the 2017 Centre for Evidence and Implementation and Black Dog Institute publication *The LifeSpan Implementation Framework – Implementing Integrated Suicide Prevention* (LIF), which guides PHNs to implement LifeSpan in mainstream/non-Indigenous community settings.

A companion Guide is needed because:

- Indigenous suicide deaths are associated with different historical, political and social factors compared to those in the non-Indigenous population. As such, they can require different approaches to prevention.
- Indigenous rights to self-determination, cultural differences and recognised good practice require non-negotiable and different approaches to engagement, process and governance that empower and respect community self-determination and culture.

2.1 INDIGENOUS SUICIDE DEATHS IN HISTORICAL, POLITICAL AND SOCIAL CONTEXT

At a population level, there are patterns in Indigenous suicide deaths that require specialised approaches to suicide prevention, including during the implementation of integrated approaches. These are summarised here; more detailed information and references are provided in Appendix 1.

Indigenous history since colonisation has been a story of resilience and survival. Indigenous peoples were subjected to a process of colonisation that included forced child removals. The impact of this colonisation has been characterised as genocidal, and was collectively and inter-generationally traumatic and challenging to community governance and family life.

Today, many remote Indigenous communities remain socially excluded from the benefits of Australian social and economic life. Intergenerational poverty remains a challenge. Furthermore, these factors are associated with greater exposure to stressful and traumatising incidents that can cause psychological distress and trauma, and – in some cases – can overwhelm a person's resilience and ability to cope, even leading to suicide.

Studies suggest that psychological distress, trauma and depression are associated with Indigenous suicide deaths. Sources of trauma and psychological distress that are associated with Indigenous suicide deaths include:

- adverse childhood experiences
- racism
- lateral violence
- intergenerational impacts of colonisation, including dispossession, loss of cultural practices, introduction of alcohol, and loss of kinship connections
- contact with the criminal justice system
- relationship challenges, including breakdown such as family or interpersonal conflict
- bereavement, ongoing grieving and sorry business
- unemployment rates and lack of access to education and employment opportunities.

Excessive alcohol consumption has also been associated with Indigenous deaths by suicide. Indigenous suicide deaths, however, should not be described as 'impulsive' because of the association with alcohol use. Research suggests that there are precipitating factors involved, including relationship breakdowns, interpersonal conflicts and others.

An important part of Indigenous suicide prevention is access to mental health services. But the evidence suggests that an Indigenous person challenged by mental health difficulties and suicidal ideation is less likely to have access to the mental health services they need than that of a non-Indigenous person in the same position. In remote communities in particular, access is restricted by distance and the limited reach of services. Ensuring access to mental health service care is particularly important for people who have already attempted suicide.

The prevalence and reasons for suicide 'clustering' require further research for the phenomena to be properly understood in an Indigenous context. However, there has been substantial research about imitation and suicide in the non-Indigenous context. At present, the risk of suicide clusters in Indigenous communities is addressed through postvention and responses to suicide or traumatic crisis. These, too, are likely to be important elements in systems approaches in Indigenous communities.

2.2 WORKING IN AN INDIGENOUS RIGHTS-BASED FRAMEWORK

Empowerment is a necessary and non-negotiable characteristic of any response to Indigenous community challenges, including suicide. There are both rights-based and good practice reasons for this.

In terms of good practice, empowerment is likely to contribute to suicide prevention itself within the context of 'upstream' preventative measures, as suggested by the work of Chandler and Lalonde (see Appendix 1). Further, a focus on empowerment should be considered as contributing to risk management in the trial sites by helping PHNs avoid common pitfalls that have the potential to result in harm, such as assuming that what works in one Indigenous community will work in another, or imposing integrated approaches designed for non-Indigenous community settings.

In the context of this Guide, in practice, empowerment means respecting community governance and following community direction across the exploration, installation and implementation phases. It means working in partnership with Indigenous communities and respecting a community's right to give, withhold or revoke free, prior and informed consent, as discussed below, at any stage of the process.

There are also human rights considerations when working with Indigenous communities. In particular, and as discussed in Text Box 2, the 2007 *United Nations Declaration on the Rights of Indigenous Peoples* (Declaration) is of direct relevance.

The Declaration recognises Indigenous peoples' cultural difference and needs, and histories of colonisation. It begins by affirming that Indigenous peoples are entitled to the same set of individual and collective human rights as all other peoples (Article 1),⁹ but its foundation is Article 3, which states that Indigenous peoples have the right to self-determination.¹⁰ Through various articles, the Declaration then sets out the standards that nation states and their 'representative institutions' (including LHNs and PHNs) should conform to in order to ensure Indigenous peoples' self-determination is respected at every level of decision-making that affects them.

TEXT BOX 2: United Nations' Declaration on the Rights of Indigenous Peoples on self-determination¹¹

After the Second World War, self-determination was recognised in international law as a right of 'peoples'. It was enshrined as Article 1 of both the 1966 *International Covenant on Civil and Political Rights* (ICCPR) and the 1966 *International Covenant on Economic, Social and Cultural Rights*, the two most important international human rights treaties that Australia is party to.

All peoples, Indigenous and non-Indigenous, have the same right to self-determination. Collectively, Australian citizens are deemed a 'people' for these purposes and exercise self-determination every time a Commonwealth, State and Territory, and council election occurs and they 'freely determine' their destiny by voting.

For Indigenous peoples within the United States, Canada, New Zealand and Australia (and other countries), how their right to self-determination is to be exercised was set out in the 2007 United Nations (UN) *Declaration on the Rights of Indigenous Peoples* (Declaration).¹² The Declaration was overwhelmingly adopted by the General Assembly of the UN in September 2007, with the Australian Government announcing its support in 2009. It is now referenced in a range of Australian Government documents, including the Fifth Plan (page 11) itself.

Selected key articles include:

- Article 23 – ... Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions.
- Article 18 – Indigenous peoples have the right to participate in decision making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own Indigenous decision-making institutions.
- Article 19 – States shall consult and cooperate in good faith with the Indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Free, prior and informed consent

The UN *Declaration on the Rights of Indigenous Peoples* requires not only that Indigenous communities be 'actively involved' and 'participate' in decision making that affects them, but that before measures (including integrated approaches to suicide prevention) are adopted, a community must provide free, prior and informed consent to them.

The UN Permanent Forum on Indigenous Issues has provided guidance as to what free, prior and informed consent means in practice. It is summarised in Table 3 on the next page.

TABLE 3: Free, prior and informed consent – summary characteristics¹³

Who	Indigenous peoples should specify which representative institutions are entitled to express consent on behalf of the affected peoples or communities.
Free	No coercion, intimidation or manipulation.
Prior	Consent has been sought sufficiently in advance of any authorisation or commencement of activities and respects the time requirements of Indigenous consultation/consensus processes.
Informed	Information should be accurate and in a form that is accessible and understandable, including in a language that the Indigenous peoples will fully understand. The format in which information is distributed should take into account the oral traditions of Indigenous peoples and their languages. Information is provided that covers (at least) the following aspects: • The nature, size, pace, reversibility and scope of any proposed project or activity. • The reason/s or purpose of the project and/or activity. • The duration of the above. • The locality of areas that will be affected. • A preliminary assessment of the... impact, including potential risks. • Personnel likely to be involved in the execution of the proposed project (including Indigenous peoples, private sector staff, research institutions, government employees and others). • Procedures that the project may entail.
Consent	• As a core principle of free, prior and informed consent, all sides of the consent process must have equal opportunity to debate any proposed agreement/development/project. 'Equal opportunity' should be understood to mean equal access to financial, human and material resources in order for communities to fully and meaningfully debate in Indigenous language/s as appropriate... • Consultation and participation are crucial components of a consent process. Consultation should be undertaken in good faith. The parties should establish a dialogue that allows them to find appropriate solutions in an atmosphere of mutual respect in good faith, and full and equitable participation. Consultation requires time and an effective system for communicating among interest holders. Indigenous peoples should be able to participate through their own freely chosen representatives and customary or other institutions. The inclusion of a gender perspective and the participation of Indigenous women is essential, as well as the participation of children and youth as appropriate. This process may include the option of withholding consent...

In Text Box 3, the Harvard Project is briefly described. It underscores the importance of governance shaped by culture effective Indigenous community development activities. While the Harvard Project examined governance in a Native American Indigenous context, the principles are understood here to be suitable for application in Indigenous communities in Australia, and for developing and implementing systems approaches to suicide in partnership with communities and their governing bodies.

TEXT BOX 3: The Harvard Project on American Indian Economic Development¹⁴

The Harvard Project has been researching and developing Indigenous governance in the context of successful social and economic development since 1987. It has concluded that characteristics of successful development activity are that:

- Indigenous communities/nations have real decision-making power
- there is an 'institutional environment' that encourages community/nation members and others to invest time, ideas, energy and money in the nation's future
- there has to be a fit between governing institutions and an Indigenous community/ nation's political culture
- institutions have to match Indigenous peoples' ideas about how authority should be organised and exercised to be considered legitimate and be supported by a community/nation.

Ensuring a community initiates and/or drives the processes associated with a systems approach to suicide prevention is critically important. In particular, empowerment cannot be 'forced' onto a community; instead, it will only occur as communities create their own momentum, gain their own skills, advocate for their own changes and set their own timeframes, compatible with their own cultural protocols. As such, empowerment-based approaches informed by a commitment to community self-determination and culture are also likely to be more effective.

2.3 WORKING IN AN INDIGENOUS CULTURAL FRAMEWORK

Social and emotional wellbeing (SEWB) is widely understood to be the foundation for Indigenous peoples' good physical, spiritual and mental health. While the SEWB concept varies between different cultural groups, shared features include that it is inseparable from culture, comprises a set of *cultural determinants* of Indigenous wellbeing, and that it affirms a stronger association between collective and individual wellbeing than that generally acknowledged in Western societies.¹⁵

The cultural determinants that make up SEWB include the health of families (including culturally determined concepts of 'extended' family), kin and communities, and the individual's connections (and the strength of their connections) to family, community, land, culture, spirituality and ancestry. Different SEWB elements can be more or less important at different parts of the life cycle of an Indigenous person.¹⁶

Strong SEWB includes an empowered sense of self and cultural identity that can provide meaning and resilience in times of adversity.¹⁷ Identifying, participating in and engaging with culture are essential to the development of strong and resilient SEWB in Indigenous children and young people.¹⁸ In particular, a positive cultural identity has been found to assist Indigenous children and young people to navigate being a minority group in their own country.¹⁹ In part, this is because Indigenous cultures contain protective factors such as supportive kinship networks.²⁰

As a source of resilience, SEWB also works to reduce the potentially negative impacts of life stressors by providing a buffer against them.²¹ This is important because, as discussed below, Indigenous peoples experience stressful life events at higher rates than other Australians.²² Exposure to such events can otherwise leave individuals, families and communities vulnerable to psychological distress and trauma.

SEWB and cultural determinants also provide a strengths-based perspective for mental health promotion and mental health difficulty, as well as for suicide prevention activity, that builds on existing personal and collective sources of wellbeing, self-esteem and resilience. Activities in this context can include cultural revitalisation; strengthening personal and family connections to culture, country and community; and supporting a strong Indigenous cultural identity in young people.²³

Diagram 2 below, reproduced from the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023*, illustrates the cultural, social and emotional wellbeing (SEWB) concept and the influence of historical, political and social determinants on SEWB.



DIAGRAM 2: The SEWB concept expressed as a diagram²⁴

Cultural rights and the 'right to take part in cultural life'²⁵ apply equally to all Indigenous and non-Indigenous individuals and communities and are directly relevant to integrated approaches to suicide prevention. Here, the UN *Declaration on the Rights of Indigenous Peoples* also provides a guide to ensure Indigenous peoples' cultural rights are respected in government processes, such as implementing systems approaches to suicide prevention. This includes healing and medical systems of knowledge.

Article 24 is particularly relevant. This states that:

*Indigenous peoples have the right to their traditional medicines and to maintain their health practices...*²⁶

This includes the right to cultural healing practices in both traditional and contemporary, revitalised forms, and access to cultural healers. These healers could be chosen by Indigenous communities to play a significant role within an integrated approach to suicide prevention.

Similarly, Article 31 states:

*Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures.*²⁷

In practice, the involvement of Elders cannot be separated from community leadership; this is particularly so for elements in systems responses to suicide prevention that require cultural governance. Elders are also best placed to ensure any proposed systems approach is delivered within a cultural framework. As noted in the Preface, a further complementary cultural governance framework will be developed to guide PHNs in this area.

2.4 ATSISPEP AND THE EVIDENCE BASE FOR INDIGENOUS SUICIDE PREVENTION

A primary reference in this companion Guide is the work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). This was established by the Australian Government under Indigenous leadership to build an evidence base for what works in Indigenous-specific suicide prevention.

ATSISPEP's *Solutions That Work* report summarises this evidence base. It is the distillation of:

- twelve Indigenous community, risk group and subject-matter-specific suicide prevention roundtable consultations that took place across Australia over March 2015 – April 2016
- a literature review on what works in community-led Indigenous suicide prevention
- an analysis of 69 previous consultations on Indigenous suicide prevention that took place across Australia between the years 2009 and 2015, and that involved 1,823 participants
- an analysis of other credible and relevant sources, including the *Access to Allied Psychological Services (ATAPS) Operational Guidelines for Indigenous Suicide Prevention Services*, and state and territory general population suicide prevention strategies
- key themes and recommendations from the inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference held in Alice Springs on 5–6 May 2016.²⁸
- From the above exercise, the authors identified, described and evaluated programs that were successful with Indigenous people. They marked out the 'success factors' that made the interventions effective across universal, selective and indicated settings. These are summarised in the Table 4, organised by level of intervention.

A common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and 'lived experience' elements, but also because of, as discussed, the right of Indigenous people to be involved in service design and delivery as that affects them.

ATSISPEP also generated the following tools and resources for use by Indigenous communities along with stakeholders, government, organisations and funding agencies such as PHN, to support Indigenous suicide prevention activity:

- An evaluation tool for evaluating proposals for Indigenous suicide prevention activity
- A community tool to support the development of Indigenous suicide prevention activity
- An evaluation framework for Indigenous suicide prevention activity for use by communities, government and PHNs
- Interactive maps showing Indigenous suicide numbers and rates by postcode
- Fact sheets
- Discussion papers.

All of the ATSISPEP reports can be accessed at www.atsispep.sis.uwa.edu.au.

These tools and resources respond to the importance of community leadership and recognise that responses cannot be standardised across differing communities. Instead, they must reflect local needs.

To assist with cross referencing Table 5 (page 37) sets out the ATSISPEP *Solutions That Work* success factors with approximate co-relations to the Fifth Plan's 11 elements; the four levels of EAAD model; and LifeSpan's nine elements of its systems approach model.

TABLE 4: Summary of success factors identified by ATSIPEP²⁹

SUMMARY TABLE OF SUCCESS FACTORS IDENTIFIED BY ATSIPEP

The following outlines success factors for Indigenous suicide prevention, with those identified in the meta-evaluation of evaluated community-led Indigenous suicide prevention programs in **blue font**.

UNIVERSAL/ INDIGENOUS COMMUNITY- WIDE In this report 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates	Primordial prevention	- Addressing community challenges, poverty, social determinants of health - Cultural elements – building identity, SEWB, healing - Alcohol /drug use reduction
	Primary prevention	- Gatekeeper training – Indigenous-specific - Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy - Reducing access to lethal means of suicide - Training of frontline staff/GPs in detecting depression and suicide risk - E-health services/internet/crisis call lines and chat services - Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	School age	- School-based peer support and mental health literacy programs - Culture being taught in schools
	Young people	- Peer-to-peer mentoring, and education and leadership on suicide prevention - Programs to engage/divert, including sport - Connecting to culture/country/Elders - Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	Clinical elements	- Access to counsellors/mental health support 24/7 availability - Awareness of critical risk periods and responsiveness at those times - Crisis response teams after a suicide/postvention - Continuing care/assertive outreach post ED after a suicide attempt - Clear referral pathways - Time protocols - High quality and culturally appropriate treatments - Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	Community leadership/ cultural framework	- Community empowerment, development, ownership – community-specific responses - Involvement of Elders - Cultural framework
	Provider	- Partnerships with community organisations and ACCHS - Employment of community members/peer workforce - Indicators for evaluation - Cross-agency collaboration - Data collections - Dissemination of learnings

3.0 HOW TO ENGAGE

3.1 ORGANISATIONAL READINESS TO ENGAGE

Domain 1 of the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026* discusses the need for whole-of-organisation approaches and commitments to working effectively with Indigenous communities.

The 2016 Black Dog Institute publication *An Evidence-based Systems Approach to Suicide Prevention: Guidance on Planning, Commissioning and Monitoring* also provides some guidance in this area. Some of this is included in the pointers to action below.

Using *LifeSpan Implementation Framework* terminology, the following can be described as ‘competency drivers’ for organisational readiness to begin empowering engagement with Indigenous communities. In this document the term ‘pointers to action’ is used to describe practical applications that a PHN can use to achieve organisational readiness.

POINTERS TO ACTION

- Appoint local Indigenous PHN board members who work with Indigenous communities within the region to provide overarching technical and adaptive leadership. In many cases, Aboriginal Community Controlled Health Services’ CEOs will be ideally placed for such a role.
- Ensure that CACs and Clinical Councils include Indigenous members with expertise in the issues impacting communities within the PHN’s region and that reach into remote communities if relevant.
- Ensure that PHN boards, CACs and Clinical Councils have protocols in place to ensure the cultural safety of their Indigenous members and to otherwise support them in their roles. Examples might include: adding Indigenous issues, including suicide prevention, as standing items on meeting agendas that are distinct from general population concerns; ensuring that a minimum of two Indigenous people are present in any fora; and providing financial or transport support to attend meetings, particularly for people from remote areas.
- Ensure that Community Advisory Committees (CACs) develop an overarching Indigenous community engagement strategy that is designed, delivered and evaluated under Indigenous leadership.

The National Mental Health Commission’s *Paid Participation Policy* is a useful guide to how a PHN can support Indigenous people, including those with lived experience of suicide, to participate in its CACs and Clinical Councils, Indigenous Health Councils (as discussed below) by offering:

- a daily or pro rata payment for an individual’s time when they are personally nominated or invited to give expert advice and share their experiences to inform the Commission’s work
- to pay for travel and accommodation costs
- to reimburse any reasonable associated out of pocket expenses.³⁰

POINTERS TO ACTION

- Ensure Indigenous peoples are employed at all levels of a PHN’s organisational structure including by direct recruitment and upskilling of existing Indigenous staff. This can provide technical and adaptive leadership from within the organisation and help ‘acculturate’ the organisation and its non-Indigenous staff to work better with Indigenous communities.
- Employ Indigenous community mentors for senior and relevant staff and to guide organisational engagement with communities.
- Require all non-Indigenous staff to undergo cultural capacity-building training to understand the history, culture and other contexts within which local Indigenous communities operate in the PHN region. Preferably, this training should be commissioned from local ACCHSs or Indigenous providers.
- Aim to understand a community’s history and what might be contributing to suicidal behaviours or challenges related to suicide prior to contact. Understanding a community’s history at least in broad terms might include understanding any legacies of distrust following previous decades of experience of interacting with Australian governments and their agencies – not all of which may have been positive.

3.2 SUPPORTING AN INDIGENOUS HEALTH COUNCIL

As illustrated by Case Study 1 below (extracted from the Black Dog Institute publication *An Evidence-based Systems Approach to Suicide Prevention: Guidance on Planning, Commissioning and Monitoring*), support for an Indigenous Health Council within a PHN's structure is one way of demonstrating a whole-of-organisation commitment to working effectively with Indigenous communities.

If a PHN has multiple Indigenous communities within its region, as most will, an Indigenous Health Council can also provide a collective point of contact for the development of the regional mental health and suicide prevention plans that incorporate systems approaches. As discussed, these are required under Actions 5 and 12 of the *Fifth National Mental Health and Suicide Prevention Plan*. Further, the Council can identify regional economies of scale and provide a platform for, and oversight of, the co-design and co-implementation of suicide prevention activity, including systems approaches that are tailored to individual community needs.

CASE STUDY 1: The Western NSW PHN Aboriginal Health Council

Of the 31 PHNs in Australia, Western NSW PHN (WNSW PHN) is the only PHN with an Aboriginal Health Council. On 10 March 2016, the Aboriginal Health Council held its inaugural meeting.

The development of the WNSW PHN Aboriginal Health Council was identified as an important strategic initiative by the Consortium in their application to establish the WNSW PHN. The Consortium partners included Western NSW Medicare Local, Far West Medicare Local, Maari Ma Health Aboriginal Corporation, and Bila Muuji Health Services.

The WNSW PHN, in partnership with the region's Aboriginal communities, decided to establish an Aboriginal Health Council to build on the Consortium's significant engagement of Aboriginal Community Controlled Health Services and further support their strategic alliance across the region. Aboriginal people make up 11.8% of the region's population compared with 3.0% across NSW.

The Council is a skills-based organisation that assists with the engagement and development of the Aboriginal Community Controlled Health Services provider networks. It also provides advice to the Board to ensure a culturally aware and competent critique of the design and development of services for Aboriginal people. Additionally, the Council provides strategic guidance on matters relating to Aboriginal health at the state and national levels, including policy, legislation, and funding.

The Aboriginal Health Council also provides a critical point of contact for the Health Intelligence Unit, the Clinical Councils, and Community Councils to advise the Board on the PHN national key priority areas of Aboriginal health, mental health, population health, health workforce, digital health, and aged care.

POINTERS TO ACTION

- Appoint an Indigenous Health Council within the PHN/organisation structure. This could be as a CAC subcommittee or as a standalone body. Such Councils can provide a collective point of contact including for (but not limited to) the development of regional Indigenous mental health and suicide prevention plans that incorporate integrated approaches to suicide prevention. Cross membership between an Indigenous Health Council, a PHN Board and other organisational structures can help ensure the integration of the former into the work of the PHN, and into all levels of a PHN's structure.
- Fund and otherwise support member attendance at Indigenous Health Councils.
- Appoint members with lived experience of suicide to the Indigenous Health Council and otherwise as appropriate within the organisation.

3.3 APPROACHING COMMUNITIES

When requesting to work with Indigenous communities, the governance and leadership bodies of each community should be approached on their own cultural terms. There may be, for example, a formal governance body in place, or it may be appropriate to approach through traditional owner bodies. It is important not to 'cherry pick' (or selectively nominate) community leaders, but to identify and work with those with genuine governance capacity and community support, as illustrated in Text Box 4.

TEXT BOX 4: Indigenous Community Governance Project (ICGP)³¹

From 2004 to 2008, Reconciliation Australia and the Centre for Aboriginal Economic Policy Research (CAEPR) undertook the ICGP to explore 'what works, what doesn't work and why' regarding Indigenous community governance in diverse locations and contexts across Australia. The ICGP observed that 'it is useful to think about governance as being about people – how they organise themselves as a group to manage their own affairs and achieve the things that matter to them'. THE ICGP argued that in order to do that, community governance processes, structures, traditions and rules must be set so that participants can:

- determine the membership of their group
- decide who has authority, and over what
- ensure that authority is exercised properly
- enforce and implement their decisions
- hold their decision makers accountable
- steer their future direction
- negotiate their rights and interests with others
- establish the most effective and legitimate arrangements for getting those things done.

The ICGP also identified key factors that enable effective governance in Indigenous communities:

- Indigenous relationships and systems of representation provide the basis for working out organisational structures and processes.
- Culturally legitimate representation and leadership requires governance structures to reflect contemporary values and conceptions about the organisation of authority and exercise of leadership.
- The criteria for evaluating effective governance is different for Indigenous peoples and governments: Indigenous peoples value internal accountability and communication; governments emphasise 'upwards' accountability, financial micro-management and compliance reporting.

Approaches, particularly to Elders, should be made in a culturally respectful manner. For example, it is most likely to be inappropriate to send a male staff member to engage with senior community women.

POINTERS TO ACTION

- Be proactive – reach out to Indigenous communities rather than waiting to be contacted. Early and frequent engagement and time should be allowed for the development of trusting and open relationships at both the interpersonal and organisational level.
- As a starting point, build CEO to CEO relationships with local Aboriginal Community Controlled Health Services (ACCHSs) and community organisations as the basis for exploration work. Where they exist, an ACCHS is likely to occupy a leadership role within a community, or be able to connect an organisation to a community's governing body. They are also ideally placed for PHNs to partner with to support the co-design and co-implementation of systems approaches to suicide prevention in partnership with PHNs. These partnerships can then underpin and support the later exploration, installation and implementation stages of integrated suicide prevention activities.
- Ascertain whether language barriers may exist and employ translators if necessary.

3.4 ENGAGEMENT AGREEMENTS

In the context of a power imbalance, empowerment is the transfer of power from one party to another. In most cases, it will be the PHN that holds legal/administrative and financial power when working with Indigenous communities; therefore, an engagement agreement will require the PHN to transfer power, particularly decision-making power and control of implementation processes, to the local community.

The Close the Gap Clearinghouse Issues Paper *Engaging with Indigenous Australia—Exploring the Conditions for Effective Relationships with Aboriginal and Torres Strait Islander Communities* provides useful guidance on such agreements and good practice.

POINTERS TO ACTION

- Agree on engagement protocols that include recognition of Indigenous community leadership (for example, ACCHSs or recognised governance bodies), and for working with particular Indigenous communities reflecting the diversity among them.

These could include:

- commitments from all parties to developing long-term sustainable relationships based on trust.
- transparency about decision making.
- contracts or agreements (to provide a sense of greater power in otherwise unequal engagements).
- strong mutual accountability relationships in agreements and for shared objectives.
- collaborative developed criteria and indicators for annual self-assessments.
- agreed conflict resolution processes.³²
- practical steps, such as providing places and ways for Indigenous community members people to physically come together to support Indigenous community governance activity, may be an important part of an engagement agreement.

4.0 CO-EXPLORATION: IDENTIFYING CHALLENGES, GAPS AND RESOURCES

From the LifeSpan Implementation Framework

An implementation begins with 'exploration'. This exploration should be focused on the problems a local community wants to solve and the solutions that potentially fit with the problem. A community with an interest in enhancing its suicide prevention practices and services should ... describe and analyse its core challenges in this area – preferably based on data that can indicate the magnitude and intensity of the problem, and involving all relevant key stakeholders who can contribute to creating solutions.³³

The implementation of an integrated approach to suicide prevention starts with the concept of 'exploration'. This section is focused on identifying the particular suicide-related challenges faced by a region or community, the community's readiness for an integrated approach, and the resources and services available to support a response. In particular, it aims to identify gaps in which elements or recommended interventions of an integrated approach to suicide prevention can be adopted.

4.1 INVOLVING RELEVANT STAKEHOLDERS

The exploration phase should involve a PHN working under community direction to bring together a stakeholder group that could, in the installation and implementation phases, also function as a multi-agency governance group.

POINTERS TO ACTION

Stakeholders working in Indigenous suicide prevention must have the capacity to inform and support or contribute to the implementation of an integrated suicide prevention approach in a community setting.

A stakeholder group may include representatives from the following community groups:

- Community governance bodies and recognised local leaders
- Elders and elders' groups
- Men's and women's groups
- Community members with lived experience of suicide including family, friends and carers
- Aboriginal Community Controlled Health Services
- Existing suicide prevention programs
- Postvention and crisis response services
- Other Aboriginal and Torres Strait Islander community organisations
- Relevant programs as they exist such as the National Empowerment Project
- Local media
- Aboriginal and Torres Strait Islander Health Workers

It may also include representatives from the following local or even regional services:

- Mental health services
- Local hospitals
- headspace
- Psychology and psychiatry services
- General practice and allied health services
- Social work, mental health and counselling services
- Link Up
- Police and other emergency services
- Alcohol and other drug rehabilitation services
- Child and maternal health services
- Disability, environmental health, education, employment, training, housing, justice, family and community services.

With the stakeholder group established, according to the *LifeSpan Implementation Framework*:

... baseline gap analysis and readiness surveys will be delivered in each site to support PHNs to review existing services against the evidence base, measure levels of community readiness, awareness and stigma, and support commissioning of the LifeSpan interventions, based on a clear gap analysis for each trial site.

Service gap analyses and community readiness assessments are discussed further in this section.

An Indigenous community and those with lived experience should lead and direct assessments and activities where considerations of cultural safety and cultural competence are required.

Another important activity to be undertaken with the guidance of the stakeholder group is a 'suicide audit', also discussed below.

4.2 SUICIDE AUDIT

In the context of this document, a suicide audit refers to the systematic collection of trial site data on Indigenous suicidal behaviours and other relevant community information as the basis of the exploration stage. ATSISSIP's *Solutions That Work* reports also recommends a similar audit as the foundation of suicide prevention activity.

According to the LIF, an audit should aim to:

- identify whether and where local geographical suicide 'hot spots' exist within a site
- determine if there are patterns of suicide methods that could be a target of a means restriction initiative
- identify groups strongly associated with suicidal behaviours and challenges that might be associated with suicide clusters (*LifeSpan Implementation Framework*, p.12). In addition to suicide drivers shared with non-Indigenous people (mental health issues, alcohol and drug use, depression and mental illness), community-specific challenges should also be assessed.

POINTERS TO ACTION

- Be flexible about what constitutes 'data' that will drive data driven decision-making (on the outer circle of the LifeSpan wheel – Diagram 1). In an Indigenous community context, a focus deaths deemed as suicide by coronial inquest that excludes anecdotal reports and community identification of suicide deaths may be counterproductive. Some commentators believe that suicide is significantly unreported in Indigenous communities.³⁴ This underscores the need for suicide audits to also occur under community leadership if an accurate foundation picture for suicide prevention activity is to be established.

4.3 HEALTH AND MENTAL HEALTH SERVICES REVIEW

Ensuring a community's access to mental health services and treatments is one of the Fifth Plan's 11 elements of integrated approaches to suicide prevention. It is also an element of the LifeSpan model and EEAD model (level 3).

The following should be a part of a review of Indigenous community health and mental health services.

• **Review of Aboriginal Community Controlled Health Services**

As noted by the Fifth Plan:

... strong Aboriginal Community Controlled Health Services are an important component of a culturally responsive mental health service system. These organisations can play a vital role in:

- *prevention and early intervention to address risk of developing mental health problems*
- *enabling access to primary and specialist mental health services and allied health*
- *facilitating the transition of consumers across the primary and specialist/acute interface*
- *connecting consumers with the range of community-based social support services*
- *working with mainstream community mental health and hospital services to enhance cultural capability through provision of cultural mentorship, advice and training placements for non-Indigenous staff*
- *working as part of multi-agency and multidisciplinary teams aimed at delivering shared care arrangements'*

However, the *Online Service Reports* completed by Australian-Government-funded Indigenous Primary Health Care Organisations, including Aboriginal Community Controlled Health Services (ACCHSs), report long-standing and significant mental health, SEWB and alcohol, tobacco and drug service gaps.³⁵

Assessing whether such gaps exist in a particular location is an important part of the review process, and will necessarily be informed by the outcomes of the suicide audit. For example, if alcohol and other drug use is a major community challenge associated with suicide deaths, the absence of alcohol and drug services is a clear gap that should be addressed both by the relevant PHN and in the broader development of integrated suicide prevention.

Priority Area 1 of the Fifth Plan states:

Integration is the pivotal theme underpinning the Fifth Plan. It is a priority area in its own right and is interlinked with all other priority areas of the plan. It represents the flagship of actions agreed by governments for ensuring that consumers and carers are at the centre of the way in which services are planned and delivered. (page 18 Fifth Plan).

As discussed in Appendix 1, challenges to an Indigenous person's mental health, including depression and substance abuse, are associated with suicide.³⁶ As such, the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023* requires that in Indigenous communities, SEWB, mental health, alcohol and other drug and suicide prevention services should offer access to three streams of integrated care:

- General practitioner provided medical care including pharmacotherapies of all types and mental health care plans to access psychological care, as well as supporting continuity of care across the mental health system.
- Psychological care by a range of mental health professionals, paraprofessionals and workers providing structured therapies including cognitive behavioural therapy, dialectical behavioral therapy, mindfulness, and other evidence based therapeutic approaches as appropriate.
- Social and cultural support, including case management when needed. This is the key to long term rehabilitation including vocational rehabilitation.³⁷

In addition, the presence of counselling and/or mental health support in the broad context of suicide prevention activity was identified as a success factor in the *ATSISPEP Solutions That Work*, as discussed in Text Box 5.

TEXT BOX 5: Counsellors and mental health support as an ATSISPEP Indigenous suicide prevention success factor

The Warra-Warra Kanyi: Mt Theo Program engaged a permanent, locally-based, qualified counsellor with tertiary qualifications to develop client care plans, identify and implement coping strategies, identify and access sources of support, monitor and manage risk, and explore the deeper causes and triggers for the issues in young people's lives.

Additionally, the UHELP (Inala, QLD) Action Learning Model provides culturally appropriate counselling and culturally safe places to deliver services at headspace Inala. The ATSISPEP report notes that there has been a significant increase in referral rates to headspace Inala since the UHELP program began.

In an Indigenous context, PHNs should adopt the above as criteria for the assessment of service gaps and integration.

POINTERS TO ACTION

Review whether ACCHS offer, or coordinate, integrated:

- physical health, SEWB support, primary mental health care, alcohol and drug treatment and suicide prevention services
- general practitioner provided medical care including pharmacotherapies of all types
- psychological care from a range of mental health professionals, including counsellors
- social and cultural support, including long term, community-based case management when needed.

• Review of mainstream services

Are services culturally respectful?

In communities where ACCHSs are not available to deliver integrated mental health services, the evidence base demonstrates the importance of integrating Indigenous cultural safety and competence protocols into mainstream service environments. These protocols should be integrated into the delivery of coordinated physical and SEWB services listed above, and are discussed further in Text Box 6.

TEXT BOX 6: Cultural safety and cultural competence in health services

- Institutional racism refers to the administration of institutional policies, rules and procedures that 'purport to treat everybody equally, but are unfairly or inequitably administered... in dealings with people belonging to a particular racial, ethnic, religious or cultural group'.³⁸ Because it is not overt, such racism often goes unrecognised by institutions.³⁹ In particular, mainstream Australian health services that do not have cultural safety practices may indirectly discriminate against Indigenous people.
- Culturally-safe service environments are welcoming, respectful and supportive of Indigenous people. Markers of culturally safe environments include Indigenous staff working at all positions of an organisation, and artwork and posters celebrating Indigenous life and culture. Further, for many Indigenous people, little or no English may not be spoken at home; therefore, translators will be required as a part a culturally tailored, consumer-centred program or service. Cultural safety also enables Indigenous health workers to work effectively in mainstream health services, ensuring they are free from discrimination; that their Indigeneity is valued; and that they feel secure, safe and respected as individuals.⁴⁰
- Cultural competence is the ability to understand, communicate with and effectively interact with people across cultures. It includes being aware of one's own world view, developing positive attitudes towards cultural differences, and gaining knowledge of different cultural practices and perspectives. Cultural competency also requires that organisations have a defined set of values and principles, and that employees demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally.⁴¹
- Contemporary quality service indicators aim to ensure that clinical and cultural competence are fully integrated into all forms of health service delivery, and the forms of competencies are indistinguishable in practice.

Further information is provided in the *Cultural Respect Framework* in Appendix 5.

In cases where a service, program or professional is not considered acceptable by the local Indigenous community, the community may agree that training or education could resolve the issue/s over time. Where a community's relationship to a provider has irretrievably broken down, new providers should be commissioned.

POINTERS TO ACTION

- Reviews of mainstream services must be community led. In addition to capacity review (as for ACCHSs above), while cultural competence staff trainings and so on should be considered, cultural competence and cultural safety must be recognised as subjective experiences that are owned by the Indigenous consumers and communities these services work with.

• **Are services trauma informed?**

The associations between trauma and suicide are well documented, particularly in the aftermath of military engagement.⁴² Indigenous veterans who have served in virtually every conflict and peacekeeping mission in which Australia has participated since the start of the last century (see Appendix 8) have been exposed to this kind of trauma. Further, and as discussed in Appendix 1, rates of trauma among Indigenous people in Australia are significantly higher than those of non-Indigenous populations.

Responsive trauma-informed care is an important characteristic of integrated approaches to suicide prevention in Indigenous communities; as such, it should be the subject of a services review in this context. Trauma-informed care is grounded in an understanding of, and responsiveness to, the impact of trauma on Indigenous wellbeing at the personal and collective levels. The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023* refers the qualities of trauma-informed care, as described in the Closing the Gap Clearinghouse paper: *Trauma-Informed Services and Trauma-Specific Care for Indigenous Australian Children*. These are set out in Text Box 7.

TEXT BOX 7: Trauma-informed care

- Understand trauma and its impact on individuals (such as children), families and communal groups.
- Create environments in which children feel physically and emotionally safe.
- Employ culturally competent staff and adopt practices that acknowledge and demonstrate respect for specific cultural backgrounds.
- Support victims/survivors of trauma to regain a sense of control over their daily lives and actively involve them in the healing journey.
- Integrate and coordinate care to meet children's needs holistically.
- Support safe relationship building as a means of promoting healing and recovery.⁴³

- Are service time protocols and availability during critical periods adequate?

The 2012 *Operational Guidelines for the Access to Allied Psychological Services, Aboriginal and Torres Strait Islander Peoples Suicide Prevention Services* were developed by the Aboriginal and Torres Strait Islander Mental Health Advisory Group. This group is comprised mainly of Indigenous mental health and suicide prevention experts in partnership with the (then) Commonwealth Department of Health and Ageing. The guidelines include time protocols or minimum time periods between a person presenting at or being admitted to a service and being seen by a mental health professional following a suicide attempt or at self-identifying as at risk of suicide.⁴⁴

Further, the ATSIPEP *Solutions That Work* report identified the need for the 24/7 availability of suicide prevention services during elevated suicide risk periods (such as Christmas time) or during times of elevated risk resulting from particular situations. Being able to predict or otherwise identify periods of elevated risk is critical to planning for the allocation of staff, resources and preventive activities to meet elevated need.

- Do services offer postvention responses?

Suicide clusters within communities are an important aspect of any response to Indigenous suicide prevention. This topic is discussed in more detail in Appendix 1 of this Guide, and at length in the ATSIPEP *Critical Response Pilot Project Report*.

POINTERS TO ACTION

When reviewing services, ask:

- Are services trauma informed, as indicated by the Closing the Gap Clearinghouse paper: *Trauma-Informed Services and Trauma-Specific Care for Indigenous Australian Children*?
- Are services' time protocols adequate to meet the needs of people who have attempted suicide or who are at risk of suicide?
- Do services offer postvention support?

4.4 WORKFORCE REVIEW

- Are there enough mental health professionals and workers to meet the needs of this Indigenous community?

A workforce population ratio that could be used as the basis for a review is included in the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023* (p.39). The ratio was developed as part of a 2009 study undertaken by the Aboriginal Medical Services Alliance Northern Territory (AMSANT). It included the development of appropriate needs-based population workforce ratios for psychologists, psychiatrists and ACCHS-based SEWB teams for a community of 1500 people. Eight indigenous workers should be comprised of:

- four Aboriginal Family Support Workers (including at least one of each gender), with one position identified as a manager
- two skilled counsellors able to deliver cognitive behavioural therapy
- two of either a mental health nurse or registered mental health worker (or one of each).
- That is, there should be eight Aboriginal and Torres Strait Islander Health Workers in addition to the eight core primary health care clinical staff (two general practitioners and six nurses).

Based on the workforce ratio described above, psychologists would be based in specific zones, with one for every 1500 people. They would supervise counsellors and manage complex client situations, including addiction, interpersonal violence and complex problems in young people. There would be one psychiatrist for every 8,000 people, based in regional centres.

A further example can be found in the *NSW Aboriginal Mental Health and Wellbeing Policy 2006-2010*, which set a workforce target of one local health district-based Aboriginal mental health worker per 1000 Aboriginal people in NSW.⁴⁵

- Does the workforce include community members, such as Elders and peers?

As noted in ATSIPEP's *Solutions That Work* report, successful health promotion and prevention strategies (including for suicide prevention) incorporate culture and cultural determinants in programs that employ and otherwise utilise Elders. Peer-to-peer mentoring and work is another common feature of successful Indigenous suicide prevention programs, particularly those aimed at young people.⁴⁶

Employing community members in health and mental health services and suicide prevention activity is an important component of an integrated suicide prevention approach.

POINTERS TO ACTION

- As with all elements of implementation, a workforce-population ratio appropriate to the community or region in question must be developed with the full community participation.

When reviewing workforce, ask:

- Are there enough mental health professionals and related workers to meet the needs of Indigenous communities? If not, why? What is the shortfall?
- What is the presence of Indigenous community members in services? If there is a sufficient presence? If not, why? What is the shortfall?
- Are Elders and peers employed? If not, why?

4.5 WORKING WITH THE COMMUNITY TO ASSESS ITS READINESS

In an empowerment-based approach to suicide prevention, community governance bodies should utilise their own methods of decision making when assessing the readiness of the communities they serve. It is critically important that an Indigenous community feels a sense of ownership over any community-based responses to suicide, including systems approaches, for them to be effective.

- Challenges that may need to be addressed prior to, or within, an integrated approach

In some communities, particular challenges may need to be addressed before a systems or integrated approach can be implemented. In particular, feuding within a community will undermine the whole-of-community commitment required to successfully implement suicide prevention activities, and can also make governance structures difficult to identify. However, resolution cannot be forced upon a community; a PHN may need to wait for, or support, communities to restore harmony before starting significant work on a systems approach. Some jurisdictions offer mediation services to assist with conflict resolution.⁴⁷

Similarly, challenges related to significant alcohol and drug use may require dedicated responses *before* an integrated approach is implemented. If drug and alcohol issues are otherwise manageable, they should be addressed within the context of an integrated approach where community support exists. It is critically important for the community to assess the point at which these challenges should be met.

If a community is not ready for a systems approach to suicide prevention, this may indicate a need for support in understanding relevance and/or value of the initiative. Examples such as the National Empowerment Project have been grounded in community education prior to other activity commencing;⁴⁸ this has resulted in communities being supported to consider and respond to their specific situations in an informed manner, and to otherwise maintain their right to give free, prior and *informed* consent. Some communities may need 'in language' education programs that focus on mental health literacy in order to make informed decisions about a systems approach. Again, whether such education takes place as part of, or prior to, a systems approach, is an issue for community governance bodies to decide upon.

4.6 RESOURCES REVIEW

A strategic review of resources ultimately identifies what is realistic and practical in the co-design and adoption stage of exploration (discussed in the next section). It can also help empower a community where the suicide prevention potential of cultural practice, such as utilising Elders, has not been fully recognised by the community, and is an important part of assessing community readiness.

A resources review should account for existing community and cultural strengths and resources. These include community-controlled services and programs; outreach activities from other services; Elders, men's and women's groups; night patrols; existing suicide prevention activity; cultural healers; and cultural practices and activities that might be useful or scalable within an integrated approach to suicide prevention.

ATSISEPP's *Report of the Critical Response Project Trial Report* describes a broader mapping process that begins with key stakeholders (mental health services, for example) and expands to include the multi-agency governance group or equivalent that would assist in postvention and crisis responses.

POINTERS TO ACTION

- Community governance bodies should utilise their own methods of decision making when assessing the readiness of the communities they serve.
- Particular challenges may need to be addressed either before the adoption of or within the context of an integrated approach to suicide prevention.
- If a community is not ready for a systems approach to be adopted, this may be because it needs support to understand the relevance of the approach, or how it might be of value. Community education about SEWB, mental health and suicide prevention may play an important role in this context.
- Cultural resources and strengths, such as Elders, men's and women's groups, cultural healers; and cultural practices and so on, should be assessed as part of a broader review of suicide prevention resources.

5.0 CO-DESIGNING AND ADOPTING AN INTEGRATED APPROACH

From the LifeSpan Implementation Framework

A community with an interest in enhancing its suicide prevention practices and services should... assess whether any particular integrated approach to suicide prevention is a potential solution to this problem, including:

- how it would be operationalised across different stakeholder agencies,
- the strengths and weaknesses of different elements or recommended interventions
- their fit and feasibility within the concrete community context.
- These questions may need to be tailored to particular 'usable interventions'.

The exploration phase ends with an adoption decision – the decision to adopt a particular integrated approach to suicide prevention. This decision should preferably be made collectively among as many key stakeholders as possible to ensure that broad community support is present from the beginning and can be capitalised upon in later stages of the implementation process.⁴⁹

Actions 5 and 10 of the *Fifth National Mental Health and Suicide Prevention Plan* require PHNs and LHNs to work with local Indigenous communities in developing an overarching regional mental health and suicide prevention plan. This plan should include actions aimed at specific communities (that is, adopted elements of integrated approaches) as required. With reference to the terminology used in the *LifeSpan Implementation Framework*, this relates to the exploration stage that ends in the co-design and adoption of an integrated approach.

At all stages of the process, communities must take on leadership roles and drive the activity. As noted, the evidence base that justifies the elements or 'usable interventions' in both the LifeSpan and EAAD models is of universal application, rather than specific to Indigenous populations. Indeed, many elements in both models remain untested in Indigenous community settings and are likely to require cultural adaptation to succeed. The risk that an element may cause harm should be at the forefront of considerations, as discussed in Text Box 8.

TEXT BOX 8: How might an integrated approach element cause harm?

- Re-traumatising people who have lived experience of suicide or traumatic events.
- Increasing a sense of alienation or hopelessness in people at risk of suicide due to language, educational, cultural or other barriers.
- Creating mistrust of mental health and other support services.
- Stigmatising those who have attempted suicide, or who are at risk of suicide, as mentally ill, thereby increasing their social isolation.
- Inadvertently depriving people at risk of suicide of family, community or cultural support.
- Taking away a person's, family's or community's sense of agency.
- Adding to a person's, family's or community's stress levels.
- Undermining a person's individual and collectively-drawn self-esteem.
- Other perverse consequences, such as contributing to intra-community conflicts.

Because of these risks, and as discussed in the next section, a strong commitment to what the *LifeSpan Implementation Framework* refers to as 'improvement cycles' should be embedded in the initial implementation stage of any suicide prevention activity. These cycles ensure immediate and ongoing evaluation and refinement of activity in order to ensure 'fit' with the needs of different Indigenous communities.

It is worth repeating that a community is not required to implement either LifeSpan, EAAD, or any other model in its entirety, but can pick and choose from a variety of sources in co-designing an integrated approach. Further, prior to resource allocation and implementation a community may wish to prioritise those elements predicted to have the greatest impact and/or those that may require a substantive approach (i.e. address feuding).

POINTERS TO ACTION

The *LifeSpan Implementation Framework* suggests asking communities the following questions to help guide the co-design and adoption process:

- What is the problem your community aims to solve by implementing an integrated approach to suicide prevention?
- What are the outcomes you want to achieve by implementing an integrated approach to suicide prevention?
- Is it LifeSpan as a whole that is of interest to you, or only parts of it?
- Which agencies in your community will be implementing an integrated approach to suicide prevention?
- How will an integrated approach to suicide prevention be funded, both in the short term of two years and beyond?
- What sort of organisational or agency support is required for your site to successfully implement integrated approach to suicide prevention (e.g. support from schools, social service agencies, GP clinics, etc.)?
- What are the potential barriers within your community or participating organisations that may hamper the implementation of an integrated approach to suicide prevention?
- For how long can you commit to implementing an integrated approach to suicide prevention?

Additional guidance can be found in the *ATSISEEP Solutions That Work* report.⁵⁰

5.1 CONSIDERING THE STRENGTHS AND WEAKNESSES OF LIFESPAN-RECOMMENDED INTERVENTIONS

(a) *Engaging the community and providing opportunities to be part of the change* **Intervention: R U OK?**

R U OK? is based on a theoretical model of suicide prevention developed in the US and is aimed at people in the general community who are facing isolation from community, family and friends. R U OK? encourages people to make meaningful connections with 'anyone struggling with life' by calling on people's sense of responsibility to support others including through an annual 'R U OK Day' held annually in mid-September.⁵¹ R U OK Day has been actively promoted by National Indigenous Television (NITV) to its Indigenous audience.⁵²

ATSISEEP's work includes consideration of several campaigns to raise community awareness about suicide prevention that could also be used in some form by other communities. These stress the importance of conveying messages without assumptions of literacy (i.e. by DVDs) and of working in language. They include:

- the Queensland Aboriginal and Islander Health Council (QAIHC) Suicide Prevention Project: Lighting the Dark, which works with local communities to build individual, family and community capacity to identify and respond to suicidal behaviours. QAIHC identified the importance of health literacy around suicide, the challenges associated, and appropriate strategies and interventions to assist people.
- the Alive and Kicking Goals program, which includes a DVD as a tool for communicating with participants. In evaluation, many of the participants reported that the narrators of the DVD were people they could identify with and that the content was relevant to their communities. While challenged by literacy, all participants indicated the DVD's positive impact – in their increased awareness of suicide as a risk among their peers, and their ability to respond effectively.

Many programs use DVDs to convey information to a specifically Indigenous audience (e.g. Suicide Story, UHELP, Aboriginal Mental Health First Aid). Indigenous language speakers and effective communication strategies for those with hearing loss should also be considered in these activities.

(b) Encouraging safe and purposeful media reporting
Intervention: Mindframe National Media Initiative (Mindframe)

Mindframe aims to promote reporting and portrayals of suicide and mental illness that reduce potential harm and enhance community understanding. With the risk of suicide clusters among young people, including Indigenous young people, potentially being elevated by 'sensational' or otherwise inappropriate reporting, such guidelines are particularly important. The guidelines include specific guidance for reporting on Indigenous suicide deaths and have been adopted by many Indigenous media outlets.⁵³

(c) Gatekeeper training
Interventions: ASIST (Applied Suicide Intervention Skills Training) and QPR (Question, Persuade, Refer), with training targeted at frontline workers

A gatekeeper is someone in a position to recognise the signs that someone may be contemplating suicide. Gatekeepers can be anyone, but include parents, friends, neighbours, teachers, ministers, doctors, nurses, office supervisors, squad leaders, foremen, police officers, advisors, caseworkers, firefighters and many others who are strategically positioned to recognise people challenged by suicide and provide help, including by connecting them to mental health services.⁵⁴

Applied Suicide Intervention Skills Training (ASIST) is a two-day workshop that trains community and family members to intervene and help prevent the immediate risk of suicide. ATSIPEP's consideration of Indigenous adaptations of ASIST is discussed in Text Box 9.

TEXT BOX 9: Suicide Story

ATSIPEP's work included consideration of an Indigenous-specific adaptation of ASIST by the Mental Health Association of Central Australia's Life Promotion Program (LPP). In consultation with Indigenous people and other related services, the LPP team initially developed Indigenous-specific resources and a training known as 'Suicide Story' based on ASIST.

Over seven years, the content and delivery of the program has been reworked and adjusted through a continuous cycle of Participatory Action Research and quality improvement processes based on feedback from facilitators and participants. The program incorporates the use of a DVD consisting of short films that feature the voices of Indigenous people, combined with animation, artwork, music, pictures/posters to generate scenarios, and a focus on conversations/discussion.

A further example of an Indigenous gatekeeper training is Aboriginal Mental Health First Aid (AMHFA), which has been shown to be effective in training Indigenous participants to identify people with mental health difficulties and respond effectively, but is not one of the recommended LifeSpan interventions as it doesn't yet have the requisite level of evidence for being effective as a suicide prevention activity. Otherwise, this has been used in many contexts; for example, AMHFA was a critical part of the National Empowerment Project facilitator training.⁵⁵

'QPR' stands for Question, Persuade and Refer, a training course that teaches lay and professional gatekeepers to recognise and respond positively to someone at risk of, or contemplating suicide. It is a relatively inexpensive, short training course that's available face-to-face and online and aims to provide people with:

- the knowledge and skills to identify signs that someone may be experiencing suicidal ideation
- the confidence to talk to them about it and connect them with professional care.⁵⁶

The Australian QPR Institute recommends that at least one person in each family is trained in QPR, as families are potentially the most important gatekeepers particularly in youth suicide prevention. While QPR recognises Indigenous peoples as a priority group for suicide prevention activity, to date there does not appear to be a culturally adapted QPR for Indigenous people or families.

(d) Promoting help seeking, mental health and resilience in schools
Intervention: Youth Awareness of Mental Health (YAM)

YAM is a universal evidence-based mental health promotion program for 14–16 year olds that was developed in the US and is currently being adapted for Australian young people. YAM is based on behavioural therapy, using role-play to help young people think about the challenges in their past, present and future and to explore different ways they could respond to them. The program does not suggest a specific set of skills or rule-based discipline to promote mental health, instead young people are invited to reflect by comparing, explaining and evaluating their possible responses. YAM also provides young people with a list of local mental health resources, as well as contact information for different youth organisations in the community.⁵⁷

YAM is being implemented in multiple schools in NSW, with a focus on Year 9 students, as part of the wider Black Dog Institute's LifeSpan initiative. The NSW Department of Education deliver YAM in public schools; in independent and Catholic schools, it will be rolled out by headspace and Relationships Australia. The YAM organisation and Black Dog Institute are currently collaborating with local Indigenous community members, including Indigenous health and youth professionals and Indigenous young people, to assure that YAM appropriately adapted to an Indigenous context.⁵⁸

An initial cultural review of YAM has been conducted to assess its suitability for both the general Australian population and Aboriginal and Torres Strait Islander youth, with a specific focus on its language and content. This noted that the program was not originally developed by, or for, Indigenous people, and that there had been no community consultation and input into the overall program's content and cultural relevance. Changes that resulted from the initial review included to some of the language used in the YAM program; the adoption of culturally inclusive practices such as an Acknowledgement of Country in all delivery settings; and that YAM facilitators should first seek guidance from local Elders when delivering the program in Indigenous settings.⁵⁹

Teaching Indigenous culture in schools was identified through ATSISEPP as a way of building SEWB and a strong cultural identity in Indigenous school children.

(e) Using evidence-based treatment for suicidality

Interventions: StepCare and Collaborative Assessment and Management of Suicidality (CAMS)

StepCare is a point of entry into the 'stepped' primary mental health care system that was announced by the Australian Government in 2015. StepCare begins with a digital mental health assessment delivered in GP waiting rooms. Patients who are over the age of 18 years and who have an email address will be asked to complete a general mental health assessment on a tablet immediately prior to meeting their GP. The results are intended to facilitate further discussion between the patient and GP about any mental health and wellbeing challenges the patient may be experiencing. The GP will also receive a combined symptom range, a stepped care treatment recommendation and prompts to assist further assessment. For mild symptoms, internet-based therapies may be recommended in the first instance.⁶⁰

The patients involved in this phase of StepCare are monitored fortnightly for 12 weeks. Regular online feedback is sent to patients and GPs to inform treatment reviews. Notifications are also sent to GPs if a patient does not follow through with the treatment recommendations. If a patient's mental health weakens during this time, or they develop suicidal ideation, they might be 'stepped up' to pharmacotherapy or consultations with psychiatrists, as appropriate. A StepCare trial commenced in some of the National Suicide Prevention Trial Sites in July 2017, in partnership with the Black Dog Institute and selected GPs.⁶¹

At time of writing, an adaptation of StepCare for Indigenous people was not available.

CAMS is a flexible therapeutic framework in which patient and provider work together to assess the patient's suicide risk and plan and manage specific suicide prevention treatments. A multi-purpose clinical tool called the Suicide Status Form is developed collaboratively between the patient and practitioner and guides the patient's assessment and treatment throughout the course of therapy. The duration of the CAMS treatment varies depending on the patient's condition.

A randomised controlled trial of CAMS showed a reduction in suicidal ideation one year after treatment. In patient self-reports, CAMS has also been identified as a key factor in reducing suicidal behavior, though these studies did not use a comparison group.⁶² The Black Dog Institute is currently promoting CAMS as a useful tool in the treatment of suicidal adults. However, the appropriateness of CAMS for Indigenous peoples is yet to be assessed, and there are no current plans to adapt CAMS for use in Indigenous settings.

5.2 ATSISPEP SUCCESS FACTORS AS A GUIDE TO POTENTIAL ADDITIONAL ELEMENTS OF AN INTEGRATED APPROACH

The spread on page 37 compares and contrasts the success factors in the ATSISPEP *Solutions That Work* report with the elements of *Fifth National Mental Health and Suicide Prevention Plan* and the LifeSpan and EAAD systems approach models. In broad terms, the following differences can be observed, and should be considered in the development of Indigenous systems approaches. The examples provided below are all extracted from the ATSISPEP *Solutions That Work* report.

(a) Surveillance mechanisms

In addition to national surveillance systems, the 2017 ATSISPEP *Critical Response Project Report* stressed the importance of good community relationships as the foundation of effective critical responses to suicide or traumatic incidents. In particular, the report identified a need to notify suicides, suicide clusters or suicide behaviours more quickly, and much closer to 'real time' than would occur through official channels only.⁶³ The further development of protocols to identify challenges associated with suicide should be explored with those Indigenous communities and with stakeholders in the *LifeSpan Implementation Framework*-defined multi-agency groups, including ACCHSs, local hospitals and police forces.

(b) Complementary focus on SEWB/mental health promotion and primordial prevention

Upstream approaches that aim to promote SEWB and/or respond to community challenges from a strengths-based perspective should be an important part of a systems approach to suicide prevention in some communities. As discussed, it should be up to communities to decide whether these challenges should be addressed prior to the development of a systems approach or as an element of a systems approach.

ATSISPEP evaluated the following as success factors in Indigenous suicide prevention that are not present in either the LifeSpan or EAAD model:

- Elements building on cultural strengths/healing

SEWB promotion proactively supports and expands the health and wellbeing of individuals and the health and cohesion of families and communities. It means supporting, reclaiming and promoting culture as a source of family and community cohesion outside of health service contexts and promoting strong Indigenous identities in contemporary Australia. It also means supporting and building upon Indigenous peoples' contemporary cultural identities and practices.

The below list includes examples of strengths-based suicide prevention activity that build on cultural strengths to promote healing, SEWB, mental health and resilience promotion:

- As part of the Mowanjum Connection to Culture program, the Mowanjum Keeping Place and Media Project in Western Australia records stories of people, places, language and perspectives for families and language groups in the region. This activity promotes culture and law through intergenerational teaching and learning for current and future generations. Multimedia and digital archives capture storylines, songs and dance. These learning tools attract young people to the program and help them engage with culture on their own terms. Young people are also encouraged to contribute to the archives.
- The Junba Project in Western Australia uses 'Junba', a form of storytelling through traditional song and dance. The project increases the number and scope of opportunities for young people to engage with Junba by arranging workshops that pair youth with community Elders and multimedia specialists. Junba gatherings on country are arranged in the lead-up to the annual Mowanjum Festival. During this time, Elders, parents and young people practice Junba together. Sessions are recorded for the Mowanjum archive discussed above.
- Red Dust Healing is a national cultural healing program working with Indigenous male offenders, those at risk of offending, as well as Indigenous individuals and families. The program was originally designed in response to the founder's work in, and frustration with, the contemporary juvenile justice system. The program identifies a model of oppression and its impact on removing the four core values (identity, responsibilities, relationships and spirituality) from the individual, and seeks to reverse the colonisation process in terms of men's views of themselves, their roles, responsibilities and actions. The program offers an innovative approach to assisting men and women to heal and make better choices for themselves and in their relationships. Like other contemporary Aboriginal healing programs, Red Dust Healing explores the role of history and historical trauma and invokes Aboriginal culture and spirituality as core elements of the therapeutic process in an individual's transformative journey.
- The Healing Foundation is a national program with a critical role in supporting the healing and reconnection to culture for Indigenous individuals, families and communities. By funding locally-driven, culturally strong healing initiatives across the country, the Healing Foundation enables Indigenous people to more effectively participate in employment, education, parenting, cultural and community life and in self-determining their health and wellbeing outcomes. Several projects work in partnership with government and community organisations to ensure communities are safe by supporting families to address the role that violence, gambling or substance misuse plays in their lives. All projects contribute to improving the health and wellbeing of Indigenous people by creating healing from pain, suffering and trauma.

- The Family Wellbeing program in Queensland supports Indigenous people's capacity to regain SEWB and begin to rebuild the social norms of their families and community. It successfully operationalises the links between empowerment at the personal/family, group/organisational and community/ structural levels and provides mechanisms to address Indigenous SEWB issues, such as family violence and abuse, suicide prevention and incarceration.
- For Indigenous people with weakened SEWB and who require mental health support (including for those at risk of suicide), treatment is effective when approached holistically with the aim of treating the whole person. This includes, potentially, supporting individuals to build on, or even restore, their relationships to family, kin, community and culture alongside counselling and social supports.

Individual and community healing can happen in many different ways. Spirituality and specific Indigenous healing approaches can play an important role in this regard. Many healing practices and programs occur outside of the responsibility of the health sector. Communities may decide to develop and promote pathways to healing practices and cultural healers as an important element of a systems approach.

The South Australian Traditional Healers Brokerage Program is an example of an existing program that provides access funding to traditional healing services in accordance with Indigenous traditional medical practice. It focuses on providing mental health and SEWB support for Indigenous patients and consumers. Referrals are made through SA Health sites including hospitals, health services and clinics.⁶⁴

- Addressing challenges associated with social determinants

In many Indigenous communities, SEWB and mental health challenges and associated behaviours associated with social determinants (for example, poverty, unemployment and overcrowded and sub-standard housing) persist, and the impact of these can be exacerbated by increased exposure to stressful and traumatic life events. This is discussed further in Appendix 1 at (page 43).

An example of a response to these cumulative challenges is the National Empowerment Project (NEP), an Indigenous-led community empowerment project that has the dual aim of building on resilience and the cultural determinants of good mental and physical health while also reducing a community's exposure to challenges to SEWB and mental health, including suicide. The NEP supported eight Indigenous communities across Australia in 2012–13, and a further three sites in 2013–14. It is carried out with strong Indigenous governance using a community-led and community-based model.⁶⁵

- Addressing challenges associated with alcohol and drug misuse

As noted previously in this report, alcohol use is associated with Indigenous suicide. While in some cases it may be used to assist suicide, indications are that at least some suicide deaths were associated with alcohol dependence.⁶⁶ Alcohol abuse and the misuse of other drugs are a symptom of wider challenges facing Indigenous communities. Reducing alcohol and drug use features as major elements of the following responses to Indigenous suicide deaths (from ATSISEPP's *Solutions That Work* report):

- In the Yiriman Project in Western Australia, the experience of walking on country allows young people to get out of the towns and be exposed to a different environment. On country, they are provided with the opportunity to reconnect with their Elders, Aboriginal culture and the land of their family. The experience can also divert their attention away from alcohol and drugs, antisocial activities and general unhealthy lifestyle choices and behaviour. On these trips, young people eat healthy food, are free of alcohol and other drugs, live without violence, enjoy themselves, spend time with knowledgeable and respected members of their community and take on new and exciting roles. This provides a healing space in which participants can reflect on their use of alcohol or drugs outside of the project.
- Cannabis misuse is a significant suicide risk for Warlpiri young people and is addressed in the Warra-Warra Kanyi: Mt Theo Program in the Northern Territory. The physical place, Mt Theo (Puturlu), has significance as a cultural site among Warlpiri people, containing powerful Jukurrpa (Dreaming) sites and stories. Young people misusing cannabis have the opportunity to undergo cultural rehabilitation and a period of detoxification supported by experienced Warlpiri carers. Respite from the pressures, demands and temptations of community life assists young Warlpiri people to deal with their cannabis misuse. Mt Theo fosters a strong link with Warlpiri culture and with all the inherent benefits embedded in that culture. It is a place where strong, positive, healthy Warlpiri identity is forged, promoted, practiced and imparted.

(c) Greater focus on preventing suicide among younger people

As discussed, young people in Indigenous communities are particularly challenged by suicidal behaviours in when compared to their non-Indigenous peers. Not surprisingly, the focus of many Indigenous communities is on preventing suicide among younger people.

When developing suicide prevention initiatives, working in partnership with younger people to co-design and co-implement these programs is critical. For example, a Youth Advisory Group was established to guide the headspace in Inala (Qld). It consists of local Indigenous young people who are already associated with either headspace Inala, or are future leaders with the Inala Elders Suicide Prevention and Mental Health Program. This group of young people provides feedback on processes and approaches to engaging with and supporting project participants. Approaches to consider include:

- Connecting young people to culture, country and Elders

There are several promising examples of Elder-driven, on-country healing programs to help youth become stronger and think differently about themselves and their connection with culture and community. These include (from ATSISEPEP's *Solutions That Work* report):

- The Yiriman Project (WA), which aims to build stories in young people and keep them alive and healthy by reacquainting them with country. It hosts 'back to country trips' where young people, Elders, community members and stakeholder groups are brought together. Stakeholder groups include land care workers, educationalists, health practitioners, researchers and government officials. The Yiriman model provides young people with opportunities to participate more fully in life through community and other events.
- The Warra-Warra Kanyi: Mt Theo Program, again, where Elders play an important outreach and support role, including as cultural advisors, to the Mt Theo Outstation and other Warlpiri communities and in the development of culturally relevant Warlpiri mentoring and counselling resources.
- Peer-to-peer mentoring

Several ATSISEPEP programs described in *Solutions That Work* highlight the importance of peer-to-peer support in Indigenous suicide prevention among younger people, both in the context of gatekeeper training and more broadly. Unlike peer support programs in the general population, those in Indigenous communities have the added potential of being able to leverage peer-to-peer cultural obligations, and responsibilities of care and support.

An example is the Warra-Warra Kanyi: Mt Theo Program, mentioned previously. Here, youth mentors are active collaborators in the care of clients (primary care responsibilities remain with the program's counsellor). Youth mentors will often have genuine, direct, honest and insightful advice on preventative behaviours, coping strategies and positive pathways. Peer status is particularly powerful and important in Warlpiri youth culture. Through kinship and ceremonial systems, Warlpiri young people have formal obligations and responsibilities of care and protection towards certain other young people. Each person develops a specific relationship with an appropriate peer to provide validated and skillful support. The same kind of support may not be accepted from a different peer (or indeed an older person, or other mental health professional) because they are not a trusted or appropriate person to deliver this support. Several other programs described by ATSISEPEP utilise peer-to-peer support, such as GREATS Youth Services, Maningrida, NT; Alive and Kicking Goals! WA; EK Youth Services Network, WA.

- Programs to engage/divert young people, including sport

Sport as a mechanism to engage young people and divert them from potentially negative influences and behaviours, including those associated with elevated risk of suicide, is a success factor across a range of programs considered by ATSISEPEP. Sport can also be used to promote teamwork and respect for rules, and to maintain physical fitness and enhance self-esteem including by directly connecting young people with their sporting role models, both locally and nationally. A good example is Alive and Kicking Goals! (WA), which aims to prevent Indigenous youth suicide through football and peer education. Volunteer youth leaders who are well-respected community sportsmen undertake training to become peer educators. In the broader coaching and training context, they educate young people about suicide prevention and lifestyle, and demonstrate that seeking help is not a sign of weakness.

Diverting young people from potentially negative influences and behaviours, including those associated with elevated risk of suicide, is also a strategy used in the programs developed by the Warra-Warra Kanyi: Mt Theo Program and in GREATS (Great Recreation, Entertainment, Arts, Training and Sport) Youth Services, Maningrida NT (in partnership with the NT Juvenile Justice Department and including a school holiday program).

- Use of e-health services and technology

Given that internet, smartphone and social media use is widespread among many Indigenous young people, there has been increasing interest in whether mental health interventions can be successfully delivered via these platforms. Internet-delivered therapy in the general population has been found to be as effective as face-to-face therapy for issues such as depression and anxiety, which are both risk factors for suicide⁶⁷, and addiction. The iBobbly smartphone app was developed by the Black Dog Institute to specifically target young Indigenous people at risk of suicide and highlights the potential of such innovative, technology based approaches.

(d) Significant additional focus on critical responses and postvention

Traumatic events, suicide risk and suicide are all critical events that require robust response and postvention support, referred to as 'critical response'. In particular, after a suicide, family, kin and the community of the deceased might be challenged by suicidal ideation or imitative behaviours;⁶⁸ therefore, an effective postvention response can be a form of suicide prevention.

The July 2017 ATSISEPEP *Report of the Critical Response Pilot Project* provides further information about crisis and postvention responses in Indigenous communities.

TABLE 5: Correlating elements of the Fifth Plan, LifeSpan and EEAD integrated approach models, and the ATSIPEP Solutions That Work report success factors and Critical Response Project report

ATSIPEP <i>* indicates a success factor supported by program meta-evaluation</i>	LifeSpan integrated approach <i>Implementation methodology</i>	Elements of the Fifth Plan	EEAD four levels of intervention
UNIVERSAL – POPULATION WIDE			
In the CRP report, surveillance systems, including a national ‘real time’ suicidal behaviours surveillance system, are recommended.		Surveillance – increase the quality and timeliness of data on suicide and suicide attempts.	
Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy*	Engaging the community and providing opportunities to be part of the change <i>R U OK?</i>	Awareness – establish public information campaigns. Stigma reduction – promote the use of mental health services.	EEAD Level 2: <i>The broad public</i> Large-scale public awareness campaigns to improve knowledge about adequate treatments of depression in general and to reduce stigma.
Responsible suicide reporting by the media	Encouraging safe and purposeful media reporting <i>Mindframe</i>	Media reporting guidelines	Media guidelines (under level 4)
UNIVERSAL – COMMUNITY FOCUS			
Promotion/primordial prevention/preparatory work for an integrated approach			
Cultural elements – building identity, SEWB, healing*			
Addressing community challenges, poverty, social determinants of health*			
Alcohol/drug use reduction*			
Primary prevention, detection and early treatment of mental health difficulties associated with suicidal behaviours			
Reducing access to lethal means of suicide	Improving safety and reducing access to means of suicide	Means restriction	
Gatekeeper training – Indigenous-specific*	Training the community to recognise and respond to suicidality <i>Applied Suicide Intervention Skills Training</i> <i>Question, Persuade, Refer</i>	Training and education – maintain comprehensive training programs for identified gatekeepers.	EEAD Level 4: <i>Community facilitators and stakeholders</i> Educational workshops will be held to various target groups playing an important role in disseminating knowledge about depressive disorders.
Training of frontline staff/GPs to detect depression and suicide risk	Improving the competency and confidence of frontline workers to deal with suicidal crisis <i>Targeted training for paramedics, police and mental health workers</i>		

TABLE 5 CONTINUED.

Primary prevention, detection and early treatment of mental health difficulties associated with suicidal behaviours			
Access to counsellors/mental health support*	Equipping primary health care providers to identify and support people in distress.	Access to services – promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.	EEAD Level 1. <i>Primary care and mental health care</i> – Invite GPs and pediatricians to educational workshops on how to recognise and treat depression and explore suicidal tendency in the primary care setting.
SELECTIVE – YOUNGER PEOPLE			
Indicated			
High quality and culturally appropriate treatments	Using evidence-based treatment for suicidality • <i>StepCare</i> • <i>Collaborative Assessment and Management of Suicidality (CAMS)</i>	Treatment – improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.	EEAD Level 3. <i>Patients, high-risk groups and relatives</i> ‘Emergency Cards’ will be handed out to high-risk groups (first of all young people in adolescent crisis and people after suicide attempt), guaranteeing direct access to professional help in a suicidal crisis. Initiatives will be started to found regional self-help groups.
24/7 availability*	Improving emergency and follow-up care for suicidal crisis		
Awareness of critical risk periods and responsiveness at those times*	<i>Guidelines for integrated, suicide-related crisis and follow-up care</i>		
Clear referral pathways			
Time protocols			
Continuing care/assertive outreach post ED after a suicide attempt			
POSTVENTION/COMMUNITY CRISIS			
Crisis response teams after a suicide/postvention*	Aftercare service	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 attempts.	

6.0 CO-INSTALLATION AND CO-IMPLEMENTATION

(a) Installation

From the LifeSpan Implementation Framework

The focus within the installation phase is on 'getting ready' for applying the different elements and recommended interventions of a particular integrated approach to suicide prevention and conducting relevant activities.

The first steps in this process focus on creating collaborative governance structures that can help a site to progress implementation over time. The *LifeSpan Implementation Framework's* multi-agency governance framework mandates that local collaboratives must include representation from Public Health Networks (PHNs) and/or Local Health Departments (LHDs), as well as Lived Experience.

Furthermore, a local collaborative should include as many local stakeholders and representatives from priority populations as possible.

Furthermore, in preparing for implementing a particular integrated approach to suicide prevention, new staff may need to be hired, different trainings will need to be delivered, new organisational and community structures developed, and data systems built. In this sense, installation can be a rather *technical* phase that requires strong communication and good organisational skills from participants given the many interventions that may be required.

However, this phase also needs to have a strong awareness of the *adaptive* aspects of an implementation process. Implementing a particular integrated approach to suicide prevention implies to initiate an organisational and system change that requires individuals to change their behaviour. Such behaviour change depends on the individual readiness of staff in the different organisations involved in the LifeSpan implementation – general practitioners, school teachers, social workers, volunteers, gatekeepers.

6.1 COLLABORATIVE GOVERNANCE ARRANGEMENTS AND IMPLEMENTATION TEAMS

Effective co-installation and co-implementation might involve several layers of governance and community leadership and involvement in governance as follows.

- An Indigenous Health Council

As discussed in section 2.

- A multi-agency governance group

As discussed in section 3, the exploration phase should involve a PHN working under community direction to bring together a stakeholder group that could, in the installation and implementation phases, also function as a multi-agency governance group.

The installation and implementation of an integrated approach to suicide prevention should be initiated and driven by a consortium of collaborating agencies. Leading roles, of course, are played by the Indigenous Health Council (above) at the regional level, and community governance bodies as at the community level. PHNs and LHDs are key players, but with decision-making power transferred to the Indigenous Health Council and community governance bodies.

POINTERS TO ACTION

- Indigenous community leadership and 'ownership' of multi-agency governance groups and their activities is essential for the successful delivery of systems approaches across regions. Community leadership and direction in multi-agency governance group activity at the community level will, similarly, be key to the success of installing and implementing in communities.

- Implementation teams

In the *LifeSpan Implementation Framework*, implementation teams are described as an internal structure to move selected programs and practices through the stages of implementation in organisations and systems.

With this in mind, a critical step of a local LifeSpan installation and implementation process is developing a team and governance structure, including:

- community implementation teams under community leadership with representatives from multi-agency governance group key agencies, who are charged with guiding the overall implementation of tailored integrated approaches in communities.
- practice implementation teams, responsible to the multi-agency governance group, with focused tasks across regions and in communities – such as ongoing evaluation – as the integrated approach is implemented.

For further information on this team structure, please refer to the *LifeSpan Implementation Framework*.

- Establishing cultural governance

As noted, a separate cultural governance framework for integrated approaches to suicide prevention is currently being developed by the Black Dog Institute and the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

Cultural governance of integrated approaches should be an integral part of overarching governance processes. In practice, the involvement of Elders cannot be separated from cultural governance. Elders are best placed to ensure that systems approach elements are culturally acceptable and that systems approaches overall are delivered within a cultural framework. In many ATSISEPP programs described in *Solutions That Work*, Elders are involved as support persons, and in some cases employed as Senior Cultural Advisors.

headspace Inala (Qld), for example, is located in a region with a significantly large and culturally strong Indigenous community. There is strong local leadership within the community from the Inala Elders. Historically, there has been a proportionally high rate of Indigenous youth suicide. To ensure its accessibility to Indigenous young people, headspace Inala was required to adopt a partnership approach with local communities and develop a cultural governance mechanism. In addition to improving accessibility, this approach demonstrated to local Indigenous communities that the knowledge and wisdom of the community and its Elders was valued. Governance processes were designed to fit with existing community oversight structures. Taking a cultural governance approach also increased the commitment from the community to the project.

- Empowering community members with lived experience

As noted in the *LifeSpan Implementation Framework*, ‘the involvement and contributions of those with a lived experience of suicide is embedded across all LifeSpan recommended interventions. This puts the core lived experience principles of ‘nothing about us without us’ and ‘doing with, not for’ to action and is manifested in several key activities and outcomes’. A further complementary Indigenous lived experience framework will be developed by the authors of this document to guide PHNs in this area.

A critical part of the installation stage is creating governance arrangements for an integrated approach that ensure the self-determination of Indigenous communities is respected and preserved throughout the implementation process.

6.2 EMPLOYMENT OF NEW STAFF

In general, when commissioning suicide prevention activity, a PHN should aim to employ local and community people where possible.

As discussed, peer-to-peer mentoring and work is a common feature of successful Indigenous suicide prevention programs, particularly those aimed at young people. As such, the employment of young community people, particularly those with lived experience of suicide, should be a key part of the installation stage.

Such an approach also provides an opportunity for suicide prevention activity that addresses unemployment and creates culturally relevant long-term employment for community members – these in themselves are likely to be protective factors against suicide.

The advantage of workforce ratios (as discussed in section 3) is that they can be used to support the training and employment of an Aboriginal and Torres Strait Islander mental health workforce, and more generally a mental health workforce. By linking programs to evidence-based training and employment targets, these workforce initiatives can meet the needs of Aboriginal and Torres Strait Islander people.

POINTERS TO ACTION

- When commissioning elements of integrated approaches, a PHN should aim to employ local and community people as much as possible.

6.3 PARTNERING WITH, AND SUPPORTING THE DEVELOPMENT OF ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES

Studies have found that for Indigenous people, 'access to health services is critical and, where ACCHSs exist, the community prefers to and does use them.'⁶⁹ With appropriate resources, an ACCHSs is able to implement a culturally competent and comprehensive primary health care model based on the culturally shaped, holistic concepts of health understood by the communities they serve.⁷⁰

ACCHS are ideally placed to support the delivery of integrated approaches to suicide prevention. Not only are they located in communities, or close to communities, they provide a single platform through which the integration of the elements or recommended interventions can be coordinated. Further, they are usually directly connected to community's governance and leadership mechanisms. Where available, ACCHSs were used as such platforms by the National Empowerment Project and the ATSIPEP *Report of the Critical Response Pilot Project*.¹⁰¹

Many ACCHS have an increasingly significant mental health capacity that can enhance a systems approach to suicide prevention. The 1997 *Bringing Them Home* report highlighted the mental health challenges associated with the historical practice of forcibly removing Aboriginal infants and children from their families in order to assimilate them into non-Indigenous society. Elements of a national response include mental health (counselling), SEWB support, and family reconnection services largely delivered through ACCHSs. Since then, supports offered by ACCHS include yarning circles, healing camps, outreach services and case management in communities for the delivery of SEWB promotion and suicide prevention programs. Increasingly today, ACCHS enable community access to mental health professionals through outreach from LHNs, although significant gaps have been identified and remain.⁷¹

A major focus of the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023* as it guides the implementation of the *Fifth National Mental Health and Suicide Prevention Plan* in an Indigenous context is building on this existing capacity of the ACCHS to deliver primary mental health services. These services are delivered by multidisciplinary SEWB and mental health teams that integrate physical and mental health care, alcohol and other drug services, and suicide prevention capabilities. Integrated approaches should contribute to this wider goal wherever possible.

POINTERS TO ACTION

- Where service gaps are identified and when commissioning suicide prevention activity, a PHN should aim to build community capacity (including ACCHS and other community-controlled organisational capacity) as much as possible, including as an important part of committing to the empowerment of communities in the context of suicide prevention.

(b) Initial and full co-implementation

From the LifeSpan Implementation Framework

Initial implementation is a fragile phase. The new integrated approach to suicide prevention intervention will be implemented in different areas and organisations of the community and applied for the first time. To begin with, even highly experienced clinicians, educators or administrators may feel slightly awkward because new behaviours and routines need to be learned, and old habits unlearned. This may lead to a feeling of 'incompetence' or 'loss of control' that has to be accepted for a while.

This also explains why the focus of this phase is on quality assurance and improvement. As soon as new practices and interventions are taken in use, data collection should begin, and their information be assessed regularly to understand where to find the most immediate and crucial local or central implementation barriers and facilitators.⁷²

After having become familiar with applying different elements and recommended interventions of any particular integrated approach to suicide prevention and tailor them to different situations, contexts and target populations, a process of routinisation sets in and will lead a site into 'full implementation'. The focus in this phase is on consolidating the different interventions further, and on enhancing their skillful implementation among relevant clinicians and agencies. Full implementation may also imply that an implementation that has been contained to a single team, clinic, school or agency now is expanded to also entail other teams, units or organisations because the confidence gained in the intervention leads a community to expand its use.⁷³

- **Improvement cycles**

An effective way of exploring potential untested elements in any integrated approach is by PAR methodologies. These have points in common with what the *LifeSpan Implementation Framework* refers to as ‘improvement cycles’ that rely on a ‘plan-do-study-act’ logic, as outlined in section 1, and enable the provider of an intervention to establish purposeful continuous quality improvement processes. Through these processes, an intervention can respond to feedback and thereby improve consistently.

PAR is an empowerment-based approach to research that seeks to empower those who are affected by it. The participatory nature of PAR requires the active involvement of clients, staff, and community members involved in systems approaches overall, as well as those involved in elements of a systems approach, in ongoing review and improvement cycles. Such should also include funders, researchers and program managers.

A key element of a PAR process is collective, self-reflective inquiry. Stakeholders use this process to understand and – as rapidly as possible – improve upon those practices being ‘researched’ or explored as they are implemented. As a part of PAR-based methodologies, it is important for everyone involved to examine what worked, what didn’t, and the resulting impact (good or bad). It is particularly important that people with lived experience of the activity have an opportunity to contribute to the ongoing evaluation process and any subsequent decision making about whether the activity should be trialed further; should be discarded, refined, adapted, substituted; or should otherwise be risk-managed effectively.⁷⁴

As noted in the *ATSISEEP Solutions That Work* report, evaluating Indigenous suicide prevention activity is critical to reducing Indigenous suicide across Australia and to ensuring the finite resources allocated to it support the highest quality activities. The foundation of activity evaluation is assessing process, impact and outcomes – in short, what happened as a result of the activity, and what impact and outcomes flowed on from what happened.

In relation to PAR methodology, and as the *LifeSpan Implementation Framework* stipulates, as soon as new elements of system approaches are commenced, data collection should begin, and information should be assessed regularly to understand where to find the most immediate and crucial implementation barriers and/or facilitators. In this way, the best systems approach ‘element fits’ for a community should be identified quickly and PAR-based activities further supported.

An example of PAR-based adaptation of a mainstream suicide prevention activity, extracted from the *ATSISEEP Solutions That Work* report, is provided in Text Box 9 on (page 32).

Elements of systems approaches may function effectively but still require improvement, or the focus of an activity may change over time. Ongoing evaluation can identify these issues. This information should then be disseminated as appropriate and contribute to an expanding evidence base for Indigenous suicide prevention including, but not limited to, systems approaches.

The *ATSISEEP Solutions That Work* report contains a framework to guide communities or stakeholders in developing an evaluation plan as part of a systems approach. In the exploration phase, it also supports the development of evaluation plans for existing activity when programs are being evaluated.

POINTERS TO ACTION

- An effective way of exploring potential untested elements in any integrated approach is by Participatory Action Research (PAR) methodologies.
- PAR-based evaluations and processes should be disseminated to help build an increasing evidence base for Indigenous systems approaches to suicide prevention and suicide prevention in general, and should support the expansion of integrated approaches to suicide prevention in Indigenous communities across Australia.

APPENDIX 1: INDIGENOUS SUICIDE DEATHS IN HISTORICAL, POLITICAL AND SOCIAL CONTEXT

Some significant differences between Indigenous and non-Indigenous suicide patterns include:

- that the present-day Indigenous suicide rate is about double that of the non-Indigenous population and likely to be increasing⁷⁵, suggesting the urgent need for effective action
- that younger age groups affected by suicide in Indigenous communities suggest the need for a particular focus on young Indigenous people
- that the above are believed to be a relatively recent phenomenon and have been associated with challenges to community functioning. This suggests the need for community-wide approaches and activities that builds on community strengths as an important element of Indigenous suicide prevention activity.

Indigenous suicide rates are often considered narrowly as a contemporary mental health challenge. In fact, they are the contemporary manifestations of historical, social and political determinants that have (in some cases, deliberately) weakened the connections of Indigenous people to the cultural determinants of good physical and mental health and sources of SEWB.

While the situation of each Indigenous individual, family and community is unique, this section of the report explores the broad historical, political and social context of Indigenous suicide. This exploration will highlight the differences between Indigenous and non-Indigenous suicide at the population level, and demonstrate how and why Indigenous systems approaches to suicide prevention may also differ from those developed for non-Indigenous groups.

This section also examines causes that have been associated with the suicide of Indigenous individuals. However, as discussed, the Indigenous SEWB concept includes a strong association between *collective* and *individual* experience. As such, Indigenous suicidal behaviours should be understood to reflect internal states informed by both individual and collective circumstance.⁷⁶

1.1 HISTORICAL AND CONTEMPORARY COLLECTIVE EXPERIENCE

Colonisation, intergenerational trauma and contemporary challenges

Indigenous history since colonisation has been a story of resilience and survival. Indigenous populations were subjected to a process of colonisation that has been characterised as genocidal and was collectively traumatic.⁷⁷ This process occurred within only three to eight generations of Indigenous people living today, depending on their country. A second wave of colonisation involved the dispossession of Indigenous people onto reserves and missions, or their confinement to ‘fringe dwellings’ outside of towns. Indigenous people there were subject to legislation that controlled all aspects of their lives.⁷⁸

- The peak age for Indigenous suicide deaths is lower than for non-Indigenous people: at 30-34 years for males and 20-24 years for females;⁷⁹ three times the rate for non-Indigenous people of the same ages.⁸⁰ Further, when considering all suicide deaths under 18 years, Indigenous people accounted for 30 per cent of deaths over 2007–2011, despite comprising only three to four per cent of the total age group population.⁸¹ Indigenous 15–24 year olds are over five times as likely to suicide as their non-Indigenous peers.⁸²

Against this background, the forcible removal of tens of thousands of Indigenous children for assimilation with the non-Indigenous occurred.⁸³ In the Australian Bureau of Statistics (ABS) 2008 *National Aboriginal and Torres Strait Islander Social Survey*, 12 per cent of respondents aged 45 years and over had personally experienced separation from their family.⁸⁴ Tracing one family line across six generations, one researcher has mapped an intergenerational progression of the transmission of trauma that links the historical events of colonisation to many challenges facing Indigenous individuals, families and communities today.⁸⁵ However, the association between intergenerational trauma and suicide, including by mediating factors, is yet to be significantly explored and should be the subject of further research, including in the context of Indigenous suicide prevention.⁸⁶

- Impacts of colonisation on communities

The deliberate breaking up, dispossession and marginalisation of Indigenous communities, including by legally enforceable segregation, was a tactic of colonisation. This resulted in weakened community governance and other forms of cultural practice that support SEWB.

Today, these direct historical legacies of the colonisation are compounded by alcohol and other drug use and other challenges associated with suicide. It is noteworthy that prior to the 1950s and 1960s, there are few, if any, reports of Indigenous suicides. Paradoxically perhaps, its emergence as a population health issue has been connected, in particular, to the closing of reserves and missions, and the ending of legally encoded racial discrimination.⁸⁷

Why is this so? First, because while legal change was right and necessary, alone it was not enough to redress the deep poverty and lack of even basic health and associated services that characterised much Indigenous life on the reserves and missions. There was no additional ‘closing the gap’ response to truly redress this historical injustice. Indeed, while many Indigenous communities today have restored governance structures and revitalised culture to be sources of strength, resilience and SEWB to their members, others remain challenged by the legacies of colonisation. A good source of information and an Indigenous perspective on these challenges can be found in *The Elders Report into Preventing Indigenous Self-harm & Youth Suicide* (summarised in Appendix 8).⁸⁸

As discussed in Text Box 1, some research strongly implies that the weakening of community self-governance could, in itself, underpin high contemporary Indigenous youth suicide rates.

TEXT BOX 1: Community empowerment, culture and suicide

Chandler and Lalonde's studies among almost 200 British Columbian (Canadian) First Nations' communities are particularly influential in explaining the relationship between culture, SEWB, the collective functioning of contemporary Indigenous communities and suicide rates among their young people. The studies focused on community-level protective factors against suicidal behaviours; in particular, community empowerment and cultural continuity defined according to key indicators:

- A measure of self-government
- Litigation for Aboriginal title to traditional lands
- A measure of local control over health, education, policing and child welfare services
- Community facilities for the preservation of culture
- Elected band councils composed of more than 50 percent women.⁸⁹
- The studies found that communities where all of these protective factor indicators were present had no cases of suicide. Conversely, where communities had none of these protective markers, youth suicide rates were many times the national average.⁹⁰
- A ‘cultural continuity’ theory has emerged from Chandler and Lalonde's and other studies, which proposes that Indigenous people (and particularly young people) who have a sense of their past and their cultures will draw resilience-building pride and identity from them, as well an awareness that strengthens their sense of connectedness with family and community.⁹¹ Further, by extension, potentially vulnerable younger people will also conceive of themselves as having a future as bearers of that culture.⁹²

- Contemporary legacies of colonisation: Social exclusion and intergenerational poverty

Many remote Indigenous communities remain socially excluded from the benefits of Australian social and economic life. Today, intergenerational poverty – some of the unfinished business of colonisation – remains a challenge. One researcher who analysed 2011 Census data has reported that across Australia, nowhere does the Indigenous population have better or even relatively equal socio-economic status compared with the non-Indigenous population.⁹³ In 2013, the Productivity Commission assessed that the Indigenous people were, on a population basis, not only experiencing deeper or multiple forms of disadvantage than other Australians, but were also significantly over-represented in other cohorts that were considered disadvantaged, such as those who are dependent on income support.⁹⁴

1.2 CHALLENGES FACING INDIGENOUS INDIVIDUALS THAT ARE ASSOCIATED WITH SUICIDE

Many of the challenges discussed below have their ultimate origin in the historical and present-day collective experience of Indigenous people, as discussed above. However, here they are considered as challenges to individuals.

- Exposure to stressful and traumatising incidents

In the 2012–13 ABS *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS), 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life event(s) in the previous year. That rate is 1.4 times that reported by the non-Indigenous population. For Indigenous respondents, the most frequently reported stressful life events in the year prior to the survey were the death of a family member or friend (reported by 37 per cent), followed by serious illness and inability to get a job.⁹⁵

Stressful life events can cause psychological distress and trauma, and, in some cases, can overwhelm a person's resilience and ability to cope, even leading to suicide.⁹⁶

- Researchers have reported that 1.9–2.6 overlapping stressful life events are associated with low or moderate psychological distress, with between 3.2 and 3.6 events associated with high or very high psychological distress.⁹⁷ Further, those with high and very high psychological distress measured by the Kessler K-10 scale have been assessed by some researchers as 21 and 77 times more likely, respectively, to be experiencing suicidal ideation.⁹⁸ This is concerning; in the AATSIHS, 30 per cent of Indigenous respondents over 18 years of age reported experiencing high or very high psychological distress levels in the four weeks before the survey – nearly three times the non-Indigenous rate.⁹⁹
- Trauma is not a mental illness, but the result of exposure to traumatic – often violent – stressful life events and can result, as discussed, in intergenerational impacts. Research indicates an association between suicide and an individual's weakened resilience and ability to cope as a result of untreated trauma. Certainly, among soldiers exposed to violence, suicide rates are significantly higher than in other population groups.¹⁰⁰

Sources of trauma and psychological distress that could contribute to, or are associated with, to Indigenous suicide deaths include:

- *Adverse childhood experiences.* All forms of child abuse are believed to significantly increase the lifetime risk of suicidal ideation and suicide attempts, particularly child sexual abuse.¹⁰¹ Young people leaving care are also reported to be at significantly higher risk of suicide.¹⁰² This highlights the need to support parental and Indigenous family strengths as a part of addressing youth suicide.
- *Racism.* The association between interpersonal and other experiences of racism and psychological distress are well documented.¹⁰³ The AATSIHS, among many other surveys, reports racism to be a common experience in many Indigenous people's daily lives, and is a factor that can undermine resilience and cause psychological distress. Some researchers believe that regular exposure to racism may result in traumatisation.¹⁰⁴
- *Lateral violence.* Lateral violence is a challenge associated with oppression. It describes the way members of groups challenged by oppression can treat each other badly, including by gossiping, jealousy, bullying, shaming, ostracism, family feuding, intra-organisation conflict and, ultimately, physical violence. It has been identified as a challenge in some Indigenous communities.¹⁰⁵
- *Contact with the criminal justice system.* Indigenous people now comprise over one quarter of all Australian prisoners. Incarceration can result from behaviours associated with trauma, as well as potentially exposing people to traumatising incidents. While further research is needed, a 2008 Queensland study reported 12.1 per cent of Indigenous male prisoners and 32.3 per cent of female prisoners as having post-traumatic stress disorder.¹⁰⁶ Studies have also reported stronger associations between criminal history and suicide for Indigenous people compared to non-Indigenous people.¹⁰⁷ Pending legal issues prior to death by suicide have also been reported at elevated levels among young Indigenous men.¹⁰⁸
- *Relationship and related challenges.* Studies have strongly associated Indigenous suicide deaths with intimate partner conflict or relationship challenges including separation, but not at elevated levels compared to non-Indigenous suicide deaths.¹⁰⁹ On the other hand, elevated rates of suicide deaths among Indigenous young people have been associated with family conflicts and interpersonal conflict of some kind, as well as with bereavement.¹¹⁰
- *Unemployment/inability to get a job.* Unemployment is associated with both Indigenous and non-Indigenous suicide deaths. However, because rates of Indigenous unemployment are significantly higher than non-Indigenous unemployment, it is not clear whether rates of associated suicide deaths are actually elevated for Indigenous people when compared to the non-Indigenous at the population level.¹¹¹
- Mental health difficulties/depression

In addition to psychological distress and trauma, suicide and depression are significantly associated in studies¹¹² and are likely to be so in Indigenous suicide deaths. In the AATSIHS, 12 per cent of Indigenous respondents reported feeling depressed or having depression as a long-term condition compared to 9.6 per cent in the total population.¹¹³

- Challenges related to alcohol and drug use

Challenges related to alcohol and drug use have been associated with Indigenous deaths by suicide.¹¹⁴ Further, some studies have proposed that particular causes may be prompting impulsive suicidal reactions in Indigenous people under the influence of alcohol or drugs.¹¹⁵ However, impulsivity and its relationship to suicidal behaviours is a complex issue that cannot be simply attributed to alcohol and drug use, and Indigenous suicide deaths should not be described as impulsive overall.

Research suggests that many Indigenous suicide deaths involve premeditation, with alcohol used to assist.¹¹⁶

1.3 ACCESS TO MENTAL HEALTH, HEALTH AND RELATED SERVICES ACCORDING TO NEED

An important part of Indigenous suicide prevention is access to mental health, health and related services. Of particular concern is that an Indigenous person whose resilience and coping ability is challenged, and who may be in suicidal ideation, is less likely to be able to access the mental health services they need than a non-Indigenous person in the same position.

Access is particularly important to people who have already attempted suicide. People who have already attempted suicide are considered to be at the highest risk of suicide (up to 40 times more likely) than any other population group.¹¹⁷ Further, increased risk is related to the recency of a previous attempt, the frequency of previous attempts, and isolation.¹¹⁸

The available evidence suggests that the majority of Indigenous suicides are pre-meditated and, in many cases, that intent is communicated prior to death. Further, many of the people who die by suicide are, to some degree, identifiable as being suicidal to friends, family and mental health and suicide prevention service providers.¹¹⁹ There is also evidence to support the proposition that greater numbers of Indigenous people who later died by suicide were unable to (or otherwise did not) access support and/or services immediately prior to their deaths when compared to non-Indigenous people in the same position.¹²⁰ Lower access to and use of mental health services in general is also reported in the AATSIHS. In this, only about one in four (27 per cent) of the Indigenous adults with high/very high levels of psychological distress (as discussed, a known risk factor for suicide) had seen a health professional in response to that distress in the previous four weeks.¹²¹

The development of Aboriginal Community Controlled Health Services (ACCHSs) and other dedicated services for Indigenous peoples is critical to supporting Indigenous peoples' access to health and mental health assistance. ACCHSs provide a more accessible service by being based in Indigenous communities and by providing a culturally safe service environment and a culturally competent service experience (these concepts are discussed in Text Box 6 on page 27 of the text).

In contrast, other services tend to lack these community/cultural connections, which are essential for promoting access to services. Indeed, studies have found that for Indigenous people, *'access to service is critical and, where ACCHSs exist, the community prefers to and does use them.'*¹²²

However, at time of writing, many ACCHSs are not funded to provide mental health, SEWB and related services according to need. Further, only about four in 10 Indigenous people can access (or choose to use) ACCHSs.¹²³ Where such services do not exist, Indigenous people are obliged to rely on general population mental health, health and related services.

1.4 SUICIDE CLUSTERS

Suicide clusters need to be addressed in this report. Some researchers have reported that imitation, normalisation and even glamorisation of suicidal behaviours appears to play an elevated role in Indigenous suicide cases when compared to non-Indigenous cases. At times, factors that can increase the risk of suicide among Indigenous young people are considered to include viewing suicide as a way to end psychological pain, the desensitisation of young people towards death and suicide, the visibility of suicides occurring in the communities, and/or communication about these deaths via media or word of mouth.¹²⁴

It should be stressed, however, that imitative suicidal behavior is not unique to Indigenous communities. Internationally, it has been estimated that between one and five per cent of all suicides by young people occur in the context of a cluster.¹²⁵ While cluster suicides are most commonly documented in Indigenous communities in Australia, they also occur in the non-Indigenous population.¹²⁶

The prevalence and reasons for suicide clusters require further research for the phenomena to be properly understood in an Indigenous context. At present, the risk of suicide clusters is already being addressed through postvention and responses to suicide or traumatic crisis that are discussed further on, and are likely to be an important part of a systems approach to suicide prevention in Indigenous communities.

headspace School Support have also created some useful fact sheets on Indigenous suicide, including one on suicide clusters in Indigenous communities.¹²⁷

APPENDIX 2: EUROPEAN ALLIANCE AGAINST DEPRESSION (EAAD) MODEL

Extracts from the European Alliance Against Depression website: <http://www.eaad.net/home> [Accessed 6 February 2018].

The European Alliance Against Depression (EAAD) is an international non-profit organisation based in Leipzig, Germany, with several members and more than 100 regional network partners in Europe, Canada, Chile and Australia.

The main focus of the EAAD project was to initiate community-based intervention programs using the 4-level approach on a regional and national level in 17 European countries... All EAAD project partners get together in regular meetings in order to coordinate the activities in the different countries, to exchange the practical experiences in a “knowledge pool” and to combine forces Europe-wide.

The 4-level approach that has been implemented in different regions in 17 European countries comprising the following four levels:

- 1. Primary care and mental health care:** GPs and pediatricians will be invited to educational workshops on how to recognize and treat depression and explore suicidal tendency in the primary care setting. Information materials (e.g. video tapes) will be distributed to GPs who can hand them out to their patients.
- 2. General public depression awareness campaign:** The broad public will be addressed by large-scale public awareness campaigns including posters, cinema spots, information leaflets, brochures, public events and web presence. The aim is to improve knowledge about adequate treatments of depression in general and to reduce the stigmatization of the topic “depression” and the affected individuals.
- 3. Patients, high-risk groups and relatives:** “Emergency Cards” will be handed out to high risk groups (first of all young people in adolescent crisis and persons after suicide attempt) guaranteeing direct access to professional help in a suicidal crisis. Initiatives will be started to found regional self-help groups and support them with expert advice. Partnerships with patient associations will be established and intensified.
- 4. Community facilitators and stakeholders:** Educational workshops will be held to various target groups playing an important role in disseminating knowledge about depressive disorders (e.g. health care professionals, priests, counselors, police). Particular emphasis can be put, e.g. on special offers for parents, youth workers and teachers in order to reach children and adolescents suffering from depression, deliberate self-harm and suicidal behaviour (e.g. information sessions and prevention programs in schools). A close co-operation with the media is crucial to trigger the public discussion. Special guidelines on media coverage of suicidal tendency will be distributed to prevent copycat suicides.

APPENDIX 3: NATIONAL STRATEGIC FRAMEWORK FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE'S MENTAL HEALTH AND SOCIAL AND EMOTIONAL WELLBEING 2017–2023

Extract: Summary Table at page 16. Available online at: <https://pmc.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23>

The Mental Health and Social and Emotional Wellbeing Framework in Action

Vision

For Aboriginal and Torres Strait Islander people, families and communities to achieve and sustain the highest attainable standard of social and emotional wellbeing and mental health supported by mental health and related services that are effective, high quality, clinically and culturally appropriate, and affordable.

Actions Area and Outcomes

These Action Areas and Outcomes are based on a stepped care model of primary mental health care service delivery.

ACTION AREA 1 – Strengthen the Foundations

Outcome 1.1: An effective and empowered mental health and social and emotional wellbeing workforce.

Outcome 1.2: A strong evidence base and a social and emotional wellbeing and mental health research agenda under Aboriginal and Torres Strait Islander leadership.

Outcome 1.3: Effective integration and partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services and other health services.

ACTION AREA 2 – Promote Wellness

Outcome 2.1: Aboriginal and Torres Strait Islander communities and cultures are strong and support social and emotional wellbeing and mental health.

Outcome 2.2: Aboriginal and Torres Strait Islander families are strong and supported.

Outcome 2.3: Infants get the best possible developmental start to life to support good mental health and wellbeing.

Outcome 2.4: Aboriginal and Torres Strait Islander children and young people get the services and support they need to thrive and grow into mentally healthy adults.

ACTION AREA 3 – Build Capacity and Resilience in People and Groups at Risk

Outcome 3.1: Access to traditional and contemporary healing practices.

Outcome 3.2: Equality of mental health outcomes is achieved across the Aboriginal and Torres Strait Islander population.

Outcome 3.3: Mental health and related problems are detected at early stages and their progression prevented.

ACTION AREA 4 – Provide Care for People who are Mildly or Moderately Ill

Outcome 4.1: Aboriginal and Torres Strait Islander people living with a mild or moderate mental illness are able to access culturally and clinically appropriate primary mental health care according to need.

Outcome 4.2: Culturally and clinically appropriate specialist mental health care is available according to need.

Outcome 4.3: Effective client transitions across the mental health system.

ACTION AREA 5 – Care for People Living with a Severe Mental Illness

Outcome 5.1: That the human rights of Aboriginal and Torres Strait Islander people living with severe mental illness are respected.

Outcome 5.2: Aboriginal and Torres Strait Islander people in recovery are able to access support services in an equitable way, according to need, within a social and emotional wellbeing framework.

Outcome 5.3: Aboriginal and Torres Strait Islander people living with psychosocial disability are able to access the National Disability Insurance Scheme and other support services in an equitable way, according to need, and within a social and emotional wellbeing framework.

16

APPENDIX 4: GAYAA DHUWI (PROUD SPIRIT) DECLARATION

Extract – body of the declaration. Source: National Aboriginal and Torres Strait Islander Leadership in Mental Health Ltd website. Available online at: <http://natsilmh.org.au/pledge-support-for-the-gayaa-dhuwi-proud-spirit-declaration>.

Leadership strong together Gayaa Dhuwi outcomes Declaration National mental health proud spirit Aboriginal and Torres Strait Islander

The Gayaa Dhuwi (Proud Spirit) Declaration

On Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples

1: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

- The holistic concept of social and emotional wellbeing in combination with clinical approaches should guide all Aboriginal and Torres Strait Islander mental health, healing and suicide prevention policy development and service and program delivery.
- Across their lifespan, Aboriginal and Torres Strait Islander people with wellbeing or mental health problems must¹⁰ have access to cultural healers and healing methods.
- Across their lifespan, Aboriginal and Torres Strait Islander people should have access to affordable, appropriate and culturally safe and competent mental health and suicide prevention programs, services and professionals without direct or indirect discrimination.

2: Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

- All parts of the Australian mental health system should be guided by Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing in combination with clinical approaches when working to heal and restore the wellbeing and mental health of Aboriginal and Torres Strait Islander people.
- It is the responsibility of all mental health professionals and professional associations, and educational institutions and standard-setting bodies that work in mental health (and also those in areas related to mental health, particularly suicide prevention) to make their practices and/or curriculum respectful and inclusive of the mental health and suicide prevention needs of Aboriginal and Torres Strait Islander peoples, as outlined in this Declaration.

3: Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

- Led by Aboriginal and Torres Strait Islander peoples, all parts of the Australian mental health system should use Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical measures when developing evaluation frameworks for Aboriginal and Torres Strait Islander mental health and suicide prevention services and programs. This also applies to the development of an evidence base for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention.

Leadership strong together Gayaa Dhuwi outcomes Declaration National mental health proud spirit Aboriginal and Torres Strait Islander

APPENDIX 4: GAYAA DHUWI (PROUD SPIRIT) DECLARATION

Leadership strong together Gayaa Dhuwi outcomes *Declaration National mental health proud spirit Aboriginal and Torres Strait Islander*

- Led by Aboriginal and Torres Strait Islander peoples, Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health targets in combination with clinical targets should be adopted across all parts of the Australian mental health system.

4: Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

- Aboriginal and Torres Strait Islander people should be trained, employed, empowered and valued to work at all levels and across all parts of the Australian mental health system and among the professions that work in that system.
- Aboriginal and Torres Strait Islander people should be trained, employed, empowered and valued to lead across all parts of the Australian mental health system that are dedicated to improving Aboriginal and Torres Strait Islander wellbeing and mental health and to reducing suicide, and in all parts of that system used by Aboriginal and Torres Strait Islander peoples.
- Aboriginal and Torres Strait Islander people should be trained, employed, empowered and valued to lead in all areas of government activity in Australia that affect the wellbeing and mental health of Aboriginal and Torres Strait Islander people.

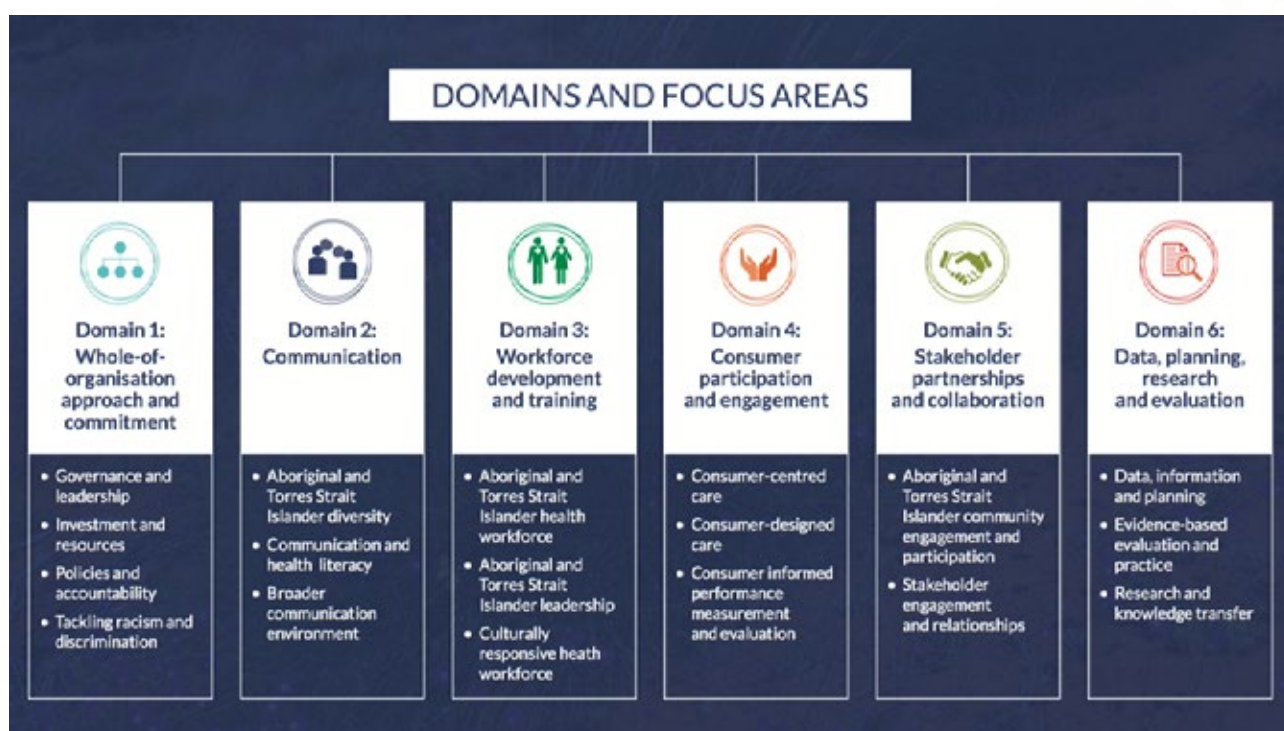
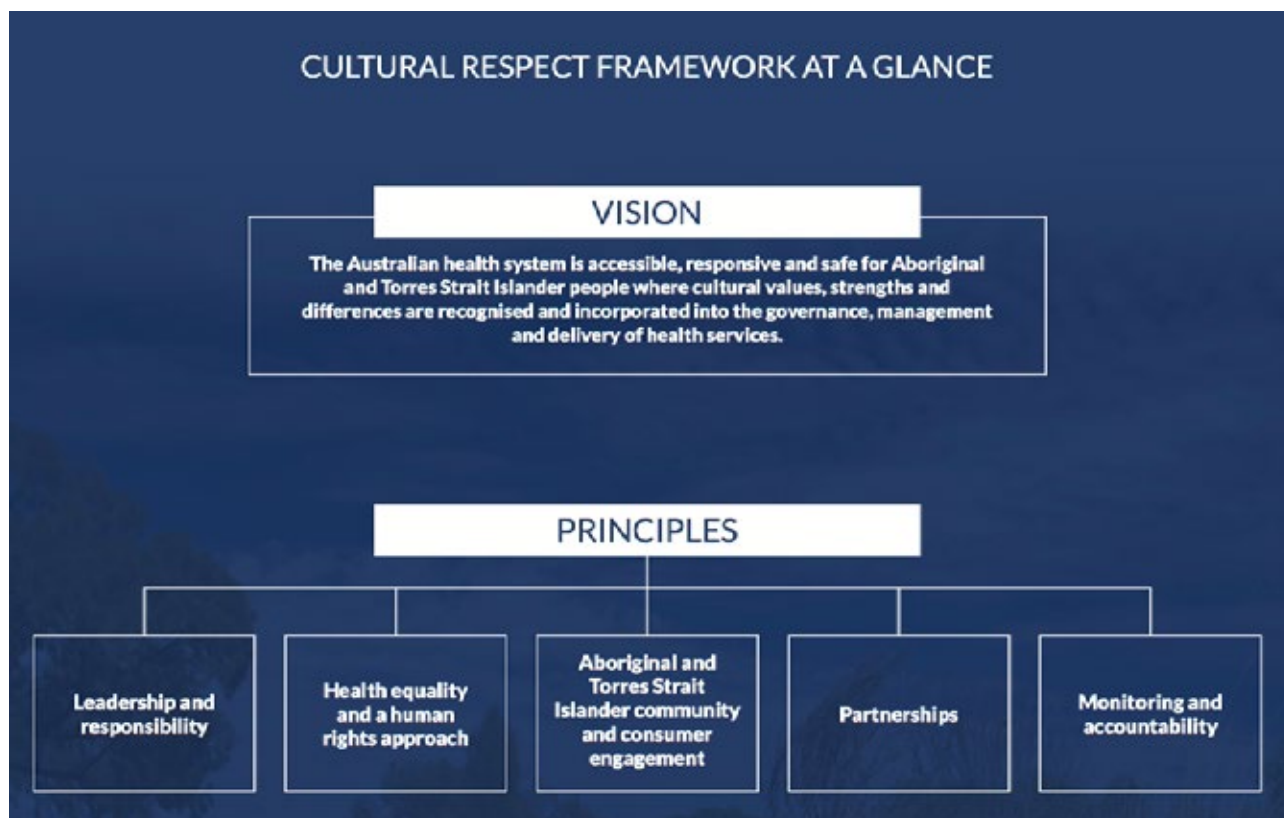
5: Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

- All parts of the Australian mental health system should support Aboriginal and Torres Strait Islander leaders to practice culturally informed concepts of leadership.
- All parts of the Australian mental health system should support and value the presence and visibility of Aboriginal leaders across all parts of that system, and further support them to be influential in all parts of it.
- All parts of the Australian mental health system should support Aboriginal and Torres Strait Islander leaders to exercise self-care, and to meet and to support each other, and to further develop and articulate Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing.
- All parts of the Australian mental health system should support the accountability of Aboriginal and Torres Strait Islander leaders to their communities and to the wider Aboriginal and Torres Strait Islander population, including by allowing them the time required to meet and listen to their communities and wider constituents and exercise culturally informed leadership among them.

National Aboriginal and Torres Strait Islander
Leadership in Mental Health
Together we are strong

APPENDIX 5: THE CULTURAL RESPECT FRAMEWORK FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH 2016–2026

Extracted summary diagrams. Available online at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/indigenous-crf>



APPENDIX 6: NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION STRATEGY

Executive Summary (extract). Available online at: <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pub-atsi-suicide-prevention-strategy>

The suicide rates of Aboriginal and Torres Strait Islander peoples for the period 2001–2010 were twice that of non-Indigenous Australians (ABS, 2012). The high rates of suicide among Aboriginal and Torres Strait Islander peoples are commonly attributed to a complex set of factors which not only includes disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic determinations that impact on Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health.

In June 2010 the Senate Community Affairs References Committee recommended, in its report into suicide amongst Aboriginal and Torres Strait Islander peoples, that “...the Commonwealth government develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy...” (SCARC, 2011).

In response the Australian Government agreed to develop Australia’s first national Aboriginal and Torres Strait Islander Suicide Prevention Strategy and established the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group (the Advisory Group) to guide its development. A list of the members for the Advisory Group can be found at Appendix 1.

The Strategy has been informed by extensive community consultation across Australia and by the Aboriginal and Torres Strait Islander peoples’ holistic view of health that encompasses mental health, physical, cultural and spiritual health. Participants at the community consultations consistently called for community-focused, holistic and integrated approaches to suicide prevention with an emphasis on investment in “upstream” prevention efforts to build community, family and individual resilience and on restoring social and emotional wellbeing.

The overarching objective of the Strategy is to reduce the cause, prevalence and impact of suicide on individuals, their families and communities.

Six goals underpin this objective:

1. Reduce the incidence and impact of suicide and suicidal behaviour in the Aboriginal and Torres Strait Islander population and in specific communities affected by suicide.
2. Ensure that Aboriginal and Torres Strait Islander communities and populations are supported within available resources to respond to high levels of suicide and/or self-harming behaviour with effective prevention strategies.
3. Implement effective activities that reduce the presence and impact of risk factors that contribute to suicide outcomes in the short, medium and long term and across the lifespan.
4. Build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels.
5. Build the evidence base to support effective action and to evaluate the outcomes of suicide prevention activity at local, regional and national levels.
6. Make high quality resources, information and methods to support suicide prevention for Aboriginal and Torres Strait Islander peoples available across all contexts and circumstances.

The objectives and goals will be achieved through the six action areas of the Strategy, which set out how these will be achieved in terms of areas of need, intervention and expected outcomes.

The action areas focus on early intervention and building strong communities through more community-focused, holistic and integrated approaches to suicide prevention. In implementing the activities listed under the action areas the focus should, where possible, be on providing the widest possible benefit to Aboriginal and Torres Strait Islander peoples, with additional effort focussed on those at greater risk or disadvantage. Each action area is supported by a number of outcomes and associated strategies through which the outcomes are intended to be achieved.

The action areas are as follows:

Action area 1: *Building strengths and capacity in Aboriginal and Torres Strait Islander communities.*

This action area focuses on strategies to address two key areas: the encouragement of leadership, action and responsibility for suicide prevention on the part of communities; and the development, implementation and improvement of preventive services and interventions for communities and their members. The actions reflect the importance of organisations understanding communities, respecting local cultures, strengths and histories and recognising differences in social relationships and possibilities for action in rural, urban and remote settings.

Action area 2: *Building strengths and resilience in individuals and families.*

Suicide risk is associated with adversity in early childhood. This action area focuses on work with universal services—child and family services, schools, health services—to help build strengths and competencies and to protect against sources of risk and adversity that make children vulnerable to self-harm in later life. The focus is also on activity across the lifespan, directly with families or with children in schools to ensure that all Aboriginal and Torres Strait Islander children are supported to develop the social and emotional competencies that are the foundations of resilience throughout life.

Action area 3: *Targeted suicide prevention services.*

Targeted services are provided to individuals and families at a higher level of risk including those with mental illness, particularly those with a prior history of attempted self-harm; people in, or discharged from, custody; those with histories of alcohol and drug abuse or of domestic violence; and some people with histories of neglect and abuse. It is critically important that targeted services are well-coordinated and culturally appropriate and have access to or are followed up by culturally competent community-based preventive services. A number of strategies to address these issues are identified under this action area.

Action area 4: *Coordinating approaches to prevention.*

This action area relates to the importance of coordinated action of Commonwealth and state or territory governments, coordination between different departments—health, schools, justice, child and family services, child protection and housing—and coordination with the community sector to ensure that there is capacity within local Aboriginal and Torres Strait Islander organisations to provide preventive services. This will help to reduce duplication and overlap of services and to improve infrastructure and resources.

Action area 5: *Building the evidence base and disseminating information.*

It is important that activities to prevent suicide are founded on evidence and that services are professionally and ethically sound and do not add to the risk and vulnerability of Aboriginal and Torres Strait Islander clients. Developing a body of research in this area is a high priority. Also important are adequate data on self-harm and suicide in communities to address the gaps in the availability and accuracy of information in these areas. This action area recommends a number of strategies to address these issues.

Action area 6: *Standards and quality in suicide prevention.*

This action area focusses on strategies to ensure consistency in standards of practice and high quality service delivery. The three key components are: 1) Measures to improve Aboriginal and Torres Strait Islander participation in the workforce through access to training and qualifications at all levels; 2) Implementing quality controls to strengthen uptake and embedding of preventive activity in primary health care and other service sectors; and 3) Strengthening the role of evaluation to support quality implementation of programs and to evaluate their outcomes.

The Strategy has been developed to complement the National Suicide Prevention Strategy. The strategic platform of the National Suicide Prevention Strategy is expressed in the LIFE Framework, an evidence-based strategic framework that sets out a population approach to suicide prevention and provides a guide for developing suicide prevention initiatives, as well as identifying resources to assist their implementation. It aims to provide information and resources to researchers, policy makers, professionals and community members...

APPENDIX 7: THE ELDERS REPORT INTO PREVENTING INDIGENOUS SELF HARM AND YOUTH SUICIDE

Extracts from the Report Summary. Available online at: <http://www.cultureislife.org/wp-content/uploads/2015/10/Elders-Report.pdf>

The Elders' Report into Preventing Indigenous Self-harm & Youth Suicide was produced between 2012 and 2014 by Indigenous led social justice organisation People Culture Environment in partnership with Our Generation Media. It was developed in response to a massive and unprecedented increase in Indigenous youth self-harm and suicide that has occurred over the past 20 years across Australia's Top End...

The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide brings together the voices of Elders and community leaders from across affected communities that wished to speak publicly about the causes and solutions needed to address this issue.

The reason for creating the Report is that too often, the voices of community leaders are lost amongst the views of professionals, bureaucrats and other people in positions of power who bring their own perspectives to consulting with communities, analysing problems, developing policies and prescribing solutions. In this Report the voices and views of speakers are unaltered.

The Report is a transcription of interviews held with 31 Elders and Community representatives from over 17 communities. Each speaker was asked two primary questions: why is self-harm and suicide happening? what is the solution?

In response to the first question there was a high level of agreement between the speakers about the role culture and loss of cultural connection plays in making young people vulnerable to self-harm.

"If we lose our culture we are lost, without it we are finished as a people."

Andrew Dowadi, Maningrida, N.T.

"There is no balance for young people they are more adapted to non-Aboriginal culture than their own. This is happening because we have been forced into one place into towns and away from our traditional homelands our outstations."

Lorna Hudson OAM Derby WA

"They are forcing our kids to attend school but they got to realise there is another education too and it's our old system our culture that our kids are missing out on."

James Gaykamangu Millingimbi, N.T.

"If they lose language and connection to culture they become a nobody inside and that's enough to put them over the edge."

Joe Brown – Fitzroy Crossing, W.A

The Elders are the ones that hold on to the culture and the lore, they are the most important aspect of healing our people. And when we lose that, we lose who we are and when you lose who you are what do you have to live for. And many of our people are giving up; many of our people are suffering because of that loss of spirit loss of identity."

David Cole – Central Desert.

In response to the second question there was an equally high level of agreement amongst speakers about the role culture can play in healing and protecting young people.

While some details of people's experience differed, the message was unanimous: while most non-Indigenous involvement with the issues in these communities is well meaning, it is not working; give power back to the Elders of each region to build programs that take Indigenous young back to country to reconnect with their land and their spirit; and direct funds and programs for ending suicide and self-harm to the Elders and community leaders to lead in the healing process.

"We haven't been funded because the Government haven't been listening to the people on the ground, they do come and do consultations but they go away and the bureaucracy gets a hold of that document and when it comes back its probably unrecognisable from the interview that was done on the ground. ...So we end up again with ideas, with suicide prevention that come from Canberra that bears no resemblance to what is needed in the community and on the ground. And that is a big frustration that there is funding but the Government says this is how we are going to spend it."

Dean Gooda, Fitzroy Crossing, W.A.

"Aboriginal people need to be involved in solving our own problems, bringing in outsiders into the Kimberley will not create succession, the legacies of change we need."

Wayne Bergmann, Kimberley, N.T.

"We want Government to support the Elders so we can teach culture to our young people – when they have culture first they have the very thing that will hold them strong through their lives no matter what they choose to do or where they choose to do it."

Eustice Tipiloura, Tiwi Islands

"Support us to take our people out on country. All we ask is to help us so we can change things, we are losing our own countrymen, we are losing our lives. What is happening is a Balanda (non-Indigenous) problem that gave us the bad things. Stop thinking blackfella doesn't know anything about healing, we living with these problems, we the best informed to deal with it."

Andrew Dowadi, Maningrida, N.T.

"The only way to stop suicide is to fulfill our cultural obligation to teach our young people because that's what we have been brought up with, strength of character through strength of culture, not by white man's cultural obligation, we need to educate our young ones culturally. The Government doesn't see that we need to build something culturally strong for our people to be healthy and survive."

George Gaymarrangi Pascoe, Maningrida N.T.

What needs to happen and how you can help

In respect to the actions and next steps that should be taken to address youth self-harm and suicide in Indigenous communities this report calls for Governments, professionals in the health and justice systems and others to acknowledge and accept:

The links between cultural strength, cultural identity and young Indigenous people's vulnerability to suicide and self-harm;

- That preventing suicide and self-harm involves supporting Elders to maintain and pass on their cultural knowledge to young people - and that this involves taking young people onto country so they can reconnect with who they are as the basis for building self-belief, self-confidence and self-respect;
- That the way forward is to adopt a 'community centred' approach to healing that is led by local Elders and which involves building community and cultural strength as a foundation for helping Indigenous youth be stronger, more resilient and more positive about their future.

APPENDIX 8: FURTHER READING

Background material on the National Suicide Prevention Trial

- <https://blackdoginstitute.org.au/news/news-detail/2017/05/29/black-dog-institute-to-support-national-suicide-prevention-trials>
- <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-hunt003.htm>

On Indigenous servicemen and servicewomen

- <https://www.dva.gov.au/i-am/aboriginal-and-or-torres-strait-islander/indigenous-australians-war>
- <https://www.dva.gov.au/i-am/aboriginal-and-or-torres-strait-islander/indigenous-veterans-liaison-officers-network>
- <https://www.dva.gov.au/i-am/aboriginal-and-or-torres-strait-islander/our-mob-serving-country-100-years-and-beyond>

Anger inoculation programs/youth programs connected with Ex ADF Mentoring

- <http://kapani.com.au>

Exposure to Lateral Violence for Youth through Social Media

- <https://www.creativespirits.info/aboriginalculture/media/aboriginal-use-of-social-media#axzz4qoxfVreq>

Mentoring and suicide risk in boarding schools CQU

- <https://www.ncbi.nlm.nih.gov/pubmed/26833339>
- https://www.researchgate.net/publication/292677128_Psycho-social_resilience_vulnerability_and_suicide_prevention_impact_evaluation_of_a_mentoring_approach_to_modify_suicide_risk_for_remote_Indigenous_Australian_students_at_boarding_school
- <http://www.cairnsinstitute.jcu.edu.au/research/research-projects/indigenous-projects/>

Certificate IV in Indigenous Mental Health (Suicide Prevention) – Research

- <https://researchonline.jcu.edu.au/41155/>

Here and Now Aboriginal Assessment (HANAA) UWA – SEWB in clinical or psychosocial settings

- http://www.wpro.who.int/whocc_forum/agenda/whocc2_poster_austr-77_research_and_training_hanaa.pdf

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