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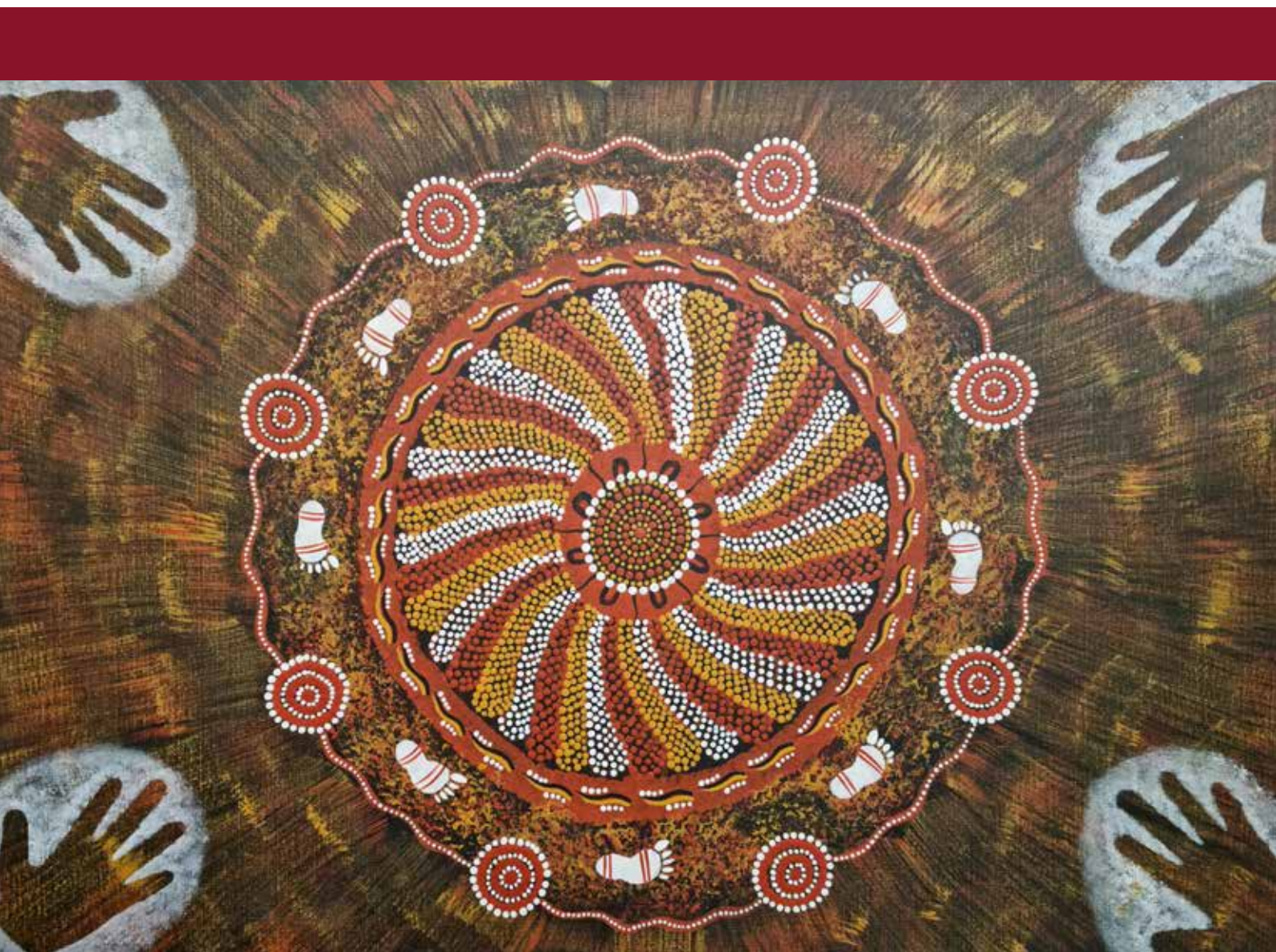
Indigenous self-governance for mental health and suicide prevention

Kimberley Groves, Mark Moran and Josephine Bourne



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About the cover artwork:

Artist: Linda Huddleston

Title: The journey towards healing

At the centre of the artwork is the Clearinghouse. The black half-circles are the people who come to the Clearinghouse for information about mental health and suicide prevention.

The waves of red, yellow and white dots surrounding the inner circle represent strength and healing.

The footprints represent the journey towards healing.

The red and white circles around the edge represent different programs and policies aimed at helping people heal.

The hands represent success and wellbeing.



Summary

Indigenous self-governance for mental health and suicide prevention

What we know

- Aboriginal and Torres Strait Islanders (Indigenous Australians) experience a much higher rate of suicide than that of non-Indigenous Australians. They also experience considerable barriers to accessing and engaging with mental health and suicide prevention services.
- Poor mental health outcomes and suicide in Indigenous communities are related to collective trauma, disempowerment, and the enduring effects of colonisation.
- A mainstream health system that is based on over-reliance on individual-centred, biomedical explanatory and intervention treatment models is not having an impact on Indigenous suicide.
- Indigenous communities have shown historical and ongoing capability in organising to empower and protect the interests of their people and to provide services that correspond to their needs.
- There is evidence that Indigenous communities that have secured a level of self-governance have less or no instances of youth suicide.
- There is a documented trend towards policies that support self-governance across all levels of government in Australia. These policies increasingly recognise the importance of Indigenous leadership and cultural competency in mental health and suicide prevention services.

What works

- Indigenous organisations make unique contributions to mental health and suicide prevention through processes, structures, institutions, and control associated with self-governance.
- Indigenous organisations provide Indigenous Australians with improved access to services and continuity of care within holistic mental health and suicide prevention models.
- Indigenous organisations conceptualise and apply culturally appropriate models of wellbeing.
- Indigenous organisations use cultural knowledge and principles in culturally responsive and trauma-informed healing.
- Indigenous organisations promote personal and community empowerment for Indigenous Australians.
- Indigenous organisations advocate for recognition of the social determinants of health and enable connectivity within complex government systems.



What doesn't work

- Imposing non-Indigenous conceptualisations of mental health on Indigenous services and programs is inappropriate and ineffective.
- Using program performance measures that have not been jointly negotiated with Indigenous organisations makes it difficult to recognise, achieve or monitor wellbeing.
- Expecting Indigenous organisations to perform in the absence of government funding or other financial support (such as mining royalties) is unrealistic.
- Overloading Indigenous organisations with multiple programs and reporting frameworks distracts them from their primary tasks of innovation and implementation.

What we don't know

- Although formal organisations are the most visible, Indigenous self-governance takes many other forms such as social enterprises, family, and community networks. Little is known about the relative effectiveness of these different forms of self-governance.
- There is a gap in the evidence base. There are no programs that explicitly cite self-governance as a way to achieve mental health and suicide prevention.
- The factor of gender in Indigenous mental health and suicide prevention is not well understood. Similarly, more work and research need to be done to address gender in Indigenous self-governance.



1



Introduction



1 Introduction

Indigenous suicide is a complex problem. Finding ways to improve mental health and prevent suicide in Aboriginal and Torres Strait Islander (hereafter Indigenous Australian) populations demands multiple entry points. Self-governance is an important entry point to consider.

Communities that have attained self-governance have fewer or no instances of youth suicide (Chandler and Lalonde 1998). In Australia, Prince (2018) found that 2 Indigenous Australian communities that took back governance of their own affairs experienced a reduction in suicides and increased community capacity to deal with associated social and cultural issues. Before taking action, they had faced devastatingly high suicide rates.

Indigenous Australian self-governance is understood as:

- processes (how things are done)
- structures (the ways people organise themselves and relate to each other)
- institutions (the rules for how things should be done), and
- control (including Indigenous direction and leadership) (AIGI n.d.; Dudgeon et al. 2018).

This article's discussion of self-governance includes these broader forms; however, the focus is on Indigenous Australian organisations and the potential contribution they make to Indigenous mental health and suicide prevention. This is in recognition of Indigenous organisations as important mechanisms of self-governance that provide multiple points of engagement across various sectors and levels of government (Bourne 2017). The discussion sits within a broad context of continued Indigenous advocacy for politically recognised Indigenous self-governance in Australia. It is also contextualised by the increasing (re)acknowledgement in research and policy of Indigenous organisations as being best placed to provide leadership and service delivery for mental health and suicide prevention.

This article adopts a social determinants of health approach that integrates a strength-based cultural determinants approach in its examination of mental health and suicide prevention in the context of self-governance.

Through a discussion of key issues, policies, frameworks and program evaluations, this article provides a synthesis of the information about Indigenous self-governance in relation to mental health and suicide prevention. It explores the ways in which Indigenous organisations embody and enable processes, structures, institutions, and control associated with self-governance and how these contribute to Indigenous wellbeing and suicide prevention.



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Background



2 Background

Suicide was a rare occurrence in Indigenous Australian communities before 1970 (Tatz and AIATSIS 2005). By 2019, suicide was the second leading cause of death for Indigenous males and the seventh leading cause of death for Indigenous females (ABS 2019a). Males account for 70.3% of completed suicides in the Indigenous population (ABS 2019a). Indigenous Australians now experience a suicide rate double that of other Australians (ABS 2019b; Productivity Commission 2020a).

The Overcoming Indigenous Disadvantage Key Indicators report (SCRGSP 2020) points to a several interrelated factors contributing to suicide, including:

intergenerational trauma attributable to colonisation and dispossession, exposure to multiple and cumulative life stressors, higher levels of psychological distress, exposure to suicide of other family members, poorer access to mental health services for people who are at risk of suicide, higher rates of alcohol use, and the use of illicit substances.

Indigenous Australians are not accessing mental health and suicide prevention services at a comparable rate to non-Indigenous Australians, nor at a rate commensurate with need (AIHW 2021). Sveticic et al. (2012) found that Indigenous Australians who died of suicide were less than half as likely to have sought help than their non-Indigenous Australian counterparts. When Indigenous Australians do engage with mental health services, it tends to be more reactive, at a chronic level and for shorter time periods (Westerman 2004). In accessing mainstream health services, Indigenous Australians regularly report racism, and many expect not to be helped or treated well (Fielke et al. 2009; Freeman et al. 2016; Royal Commission into Victoria's Mental Health System 2019). Despite decades of attention to the problem, national rates of Indigenous suicide continue to increase (ABS 2019b).

Conceptual approach to mental health and suicide prevention

At every stage of a person's life, there are multiple social, psychological, and biological risk factors that impact on mental health (WHO 2018) and act in combination to increase a person's vulnerability to suicidal behaviour (WHO 2014). These include the socioeconomic and political contexts in which people live, and these contexts are shaped through macro-governance structures and policies, as well as societal values (Pearson et al. 2020). They are understood as social determinants.

In this article, mental health and suicide prevention is considered in the context of a social determinants of health approach (WHO and Calouste Gulbenkian Foundation 2014:9), which acknowledges that:

certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender.

For example, inadequate housing, high rates of incarceration, lack of educational and employment opportunities, and problems of youth disengagement, community justice and conflict resolution can be considered social determinants, as contributing factors to distress, and as barriers to (re)gaining acceptable levels of mental health.



The social determinants of health approach brings value to this complex problem by drawing attention to the impact of the constructed social environments that people live in and the advantages and disadvantages that characterise them. This approach can, however, become a ‘deficiency discourse’—a narrative of ‘deficiency’, ‘absence, lack or failure’ (Fogarty et al. 2018:vi) that causes policy and advocacy to be concentrated on alleviating disadvantage and poor mental health. The result can be that Indigenous Australians experiencing the disadvantage and poor mental health become the problem (Fogarty et al. 2018). It excludes Indigenous Australians from possible solutions or approaches and also limits what approaches are possible (Dudgeon et al. 2020; Fogarty et al. 2018).

A strength-based cultural determinants approach mitigates this risk. A strengths-based approach is associated with what Indigenous Australian communities and organisations ‘have’ (rather than what they ‘lack’ in comparison with a non-Indigenous standard) (Fogarty et al. 2018). It is associated with asset-based approaches, resilience, empowerment, wellness and wellbeing, positive psychology, and decolonisation methodology, among other approaches (Calma et al. 2017; Fogarty et al. 2018).

Culture is an important feature of this strength-based approach. Cultural connectivity and social inclusion are known social determinants of health, including mental health (Zubrick et al. 2014). Lindheim and Syme (1983:335) found that:

disease occurs more frequently ... among those with fewer meaningful social relationships ... [and] those disconnected from their biological and cultural heritage.

In the context of Indigenous health, it is worth distinguishing culture from other social determinants by recognising cultural determinants (Lowitja Institute 2020). There is ample evidence, collected over decades and across Indigenous contexts, that demonstrates the critical importance and protective role of culture to health and wellbeing (Bourke et al. 2018; Colquhoun and Dockery 2012). For example, increased connections to land and cultural caring for country have been associated with better health outcomes (Burgess et al. 2009; Garnett et al. 2008).

Defining self-governance

As one of the world’s oldest peoples, Indigenous Australians have always had their own governance (AIGI n.d.). Governance is understood by the Australian Indigenous Governance Institute (AIGI n.d.) in the following way:

It is an ancient jurisdiction made up of a system of cultural geographies (‘country’), culture-based laws, traditions, rules, values, processes and structures that has been effective for tens of thousands of years, and which nations, clans and families continue to adapt and use to collectively organise themselves to achieve the things that are important to them.

With the British colonisation of Australia, the freedom of Indigenous Australians to self-determine how to live and organise was denied or curtailed, and Indigenous governance was disrupted (AIGI n.d.; Vivian et al. 2017).

The concept of self-determination, as the right of peoples to ‘freely determine their political status and freely pursue their economic, social and cultural development’ (UN 2007), has its legal roots in the Charter of the United Nations (1945) (UN n.d.), the International Covenant on Economic, Social and Cultural Rights (1966) (OHCHR n.d.(a)) and the International Covenant on Civil and Political Rights (1966) (OHCHR n.d.(b)).



Article 4 of the United Nations Declaration of the Rights of Indigenous People (UN 2007) states (emphasis added) that:

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or *self-government* in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

Originally, Australia voted against the Declaration (along with Canada, New Zealand and the United States). All 4 nations have since supported the non-legally binding Declaration.

Joe DeLaCruz, of the Quinault Indian Nation, expressed succinctly the relationship between Indigenous self-determination and self-governance (quoted in Caldbick 2011):

No right is more sacred to a nation, to a people, than the right to freely determine its social, economic, political and cultural future without external interference. The fullest expression of this right occurs when a nation freely governs itself. We call the exercise of this right self-determination. The practice of this right is self-government.

Indigenous Australians have long sought and struggled for self-determination and the inherent right to self-governance (Vivian et al. 2017). Efforts are ongoing, most recently through constitutional recognition (Parliament of Australia 2018). Other important features in the context of Indigenous self-determination and self-government are:

- the Yirrkala bark petitions (1963) (Museum of Australian Democracy n.d.)
- the Aboriginal Tent Embassy (1972) (National Museum of Australia n.d.)
- the Barunga Statement (1988) (AIATSIS 2018)
- the establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC) (1989) (Pratt 2003)
- the Mabo decision (1992) (AIATSIS n.d.)
- the Native Title Act (1993) (AHRC 2015)
- the Uluru Statement from the Heart (2017) (First Nations National Constitutional Convention 2017)
- the state-level 'Path to Treaty' documents, for example, the Queensland Government Treaty Statement of Commitment (Queensland Government 2020), and the Advancing the Treaty Process with Aboriginal Victorians Act 2018 (State of Victoria 2018).

The Australian Government believes that Indigenous Australians 'have the right to preserve their group identity and culture', and that they 'should be consulted about decisions likely to impact on them' (AGD n.d.). It understands Indigenous self-determination 'in a manner that preserves the territorial integrity, political unity and sovereignty of a country' (AGD n.d.). That is, concerned with governing one Australian state, the Australian Government does not legally recognise Aboriginal and Torres Strait Islander people in terms of a distinct nation (or any other form of political unit or collective), nor does it acknowledge inherent rights to Indigenous self-governance (Vivian et al. 2017).

This lack of legal status has considerable impact on the means, scope, and capacity of Indigenous Australians to advocate and organise within the system of Australian Federation (Vivian et al. 2017). Nevertheless, Indigenous Australians continue to informally and formally employ self-governing mechanisms to protect the interests of their people and to provide services that correspond to their



needs (Campbell et al. 2017:218). Today, Indigenous self-governance can take a multitude of forms, including formal organisations, social enterprises, for-profit companies, leadership groups, family and community networks and other informal arrangements.

This article draws on the definition of Indigenous governance as understood by the Australian Indigenous Governance Institute (AIGI n.d., emphasis added):

What makes it Indigenous governance is the role that Aboriginal and Torres Strait Islander social and philosophical systems, cultural values, traditions, rules and beliefs play in the governance of: *processes*—how things are done; *structures*—the ways people organise themselves and relate to each other; [and] *institutions*—the rules for how things should be done.

In the context of suicide prevention, the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (Dudgeon et al. 2018:5, emphasis added) understands that Indigenous governance is:

about Indigenous communities' *control* of the design and implementation of suicide prevention activity taking place within them; or direction and leadership guiding external organisations to the same end.

This article draws on these understandings of Indigenous governance as continuing, complex, and multidimensional. It seeks to explore the ways in which Indigenous organisations embody and enable processes, structures, institutions, and control (including direction and leadership) associated with self-governance in ways that contribute to Indigenous wellbeing and suicide prevention.

Self-governance as an entry point to suicide prevention

National suicide rates can obscure significant variations across communities and regions (Clifford et al. 2013). Variations indicate differences in how people and communities are organising through processes, structures, institutions, and control towards preventing suicide.

In the absence of comparable research in Australia, it is useful to look to other contexts to gain insight into these variations. Chandler and Lalonde's (1998) study in Canada has been extensively cited as relevant and important across a range of Indigenous contexts (Dudgeon et al. 2020). They pointed out that, across nearly 200 First Nations groups in British Columbia in Canada, some communities had youth suicide rates that were 800 times the national average, while suicide never occurred in other communities. Chandler and Lalonde (1998:13) explain this stark difference by first suggesting that:

people end up being at special risk to suicide whenever they are unable, for whatever reason, to successfully count themselves as continuous.

They then compare community-level markers of 'cultural continuity' to rates of youth suicide. They present evidence to demonstrate that a range of cultural factors or markers, if present in a community, function to maintain or regain a more robust sense of cultural continuity and therefore 'insulate' First Nations youth from the risk of suicide (Chandler and Lalonde 1998:13). They argue that for the First Nation youth, cultural continuity is 'essential to understanding themselves as connected to their own past and building future' (Chandler and Lalonde 1998:13).



The community-level markers were those that indicated a 'collective effort to rehabilitate and vouchsafe the cultural continuity' of the First Nation groups (Chandler and Lalonde 1998:1). One of these markers, and the one found to have the most protective value against youth suicide, is self-governance. The Chandler and Lalonde (1998:15) study found 'an estimated 102.8 fewer suicides per 100,000 youth within communities that have attained self-government against those that have not'.

In Canada, First Nations' inherent right to self-government is protected in the Canadian Constitution and is recognised in federal government policy (Government of Canada 2020; Minister of Justice 2021). The study considered self-government to exist where First Nation communities had successfully negotiated with federal and provincial governments to establish their 'right in law to a large measure of economic and political independence within their traditional territory' (Chandler and Lalonde 1998:14).

Although there is no equivalent research to Chandler and Lalonde's (1998) Canadian study in the Australian context, Prince's (2018) case studies of Indigenous Australian communities in Yarrabah (Queensland) and the Tiwi Islands (Northern Territory) draw comparable conclusions about self-governance and suicide prevention. Both communities saw a dramatic reduction in suicide rates from the high rates experienced in the 1990s by taking control of how things were done, the way people organised themselves, and the values that their responses were based on (Prince 2018).

There was no word for suicide in the Tiwi language when the first suicide was understood to have occurred in 1989 in the Tiwi Islands. By 2006, the community had one of the highest suicide rates in the world (Prince 2018:6). Through interviews with the community, Prince (2018) gathered reflections on why suicide was occurring among their youth. Themes of 'disempowerment' and 'loss of control' were common. There was reportedly a collective understanding that the community had lost its ability to 'govern' its own affairs, including its 'control over traditional lands, health, education and the passing on and preservation of culture' (Prince 2018:6). Faced with unimaginable levels of grief, and an ongoing crisis, the community decided in a series of meetings to 'take control of processes, systems and services, which they recognised at the time were out of their control' (Prince 2018:18). A range of community-led initiatives was launched, and it was agreed that responses were to be based on cultural knowledge, traditions, and systems (Prince 2018:18).

Prince's (2018) second case study is focused on the community of Yarrabah, which experienced a devastating period of suicides and attempted suicides. From a community of just 2,500 people, 22 people reportedly completed suicide in the 10 years between 1986 and June 1996 (McCalman et al. 2005:5). The Yarrabah community acknowledged that change had to come through taking control and identifying their own culturally appropriate solutions (Prince 2018:23). They requested funds for a feasibility study. After extensive consultation, the community decided on important community-based suicide intervention and prevention strategies, including the Family Wellbeing program (Prince 2018:23). It also resulted in the establishment of the community-controlled health service in 1998—the Gurriny Yealamucka Health Service—which supported the Yaba Bimbie Men's Group (Prince 2018:24). In the following 9 years, there were reportedly only 2 completed suicides in Yarrabah (McCalman et al. 2005:15).

Both communities in Prince's (2018) case studies still face challenges, including renewed concerns for suicidal ideation (thoughts of attempting suicide or self-harm) in Yarrabah at the time of their research. The case studies clearly associate self-governance with a reduction in suicide and an empowerment of community capacity to deal with future issues.



Chandler and Lalonde's (1998) Canadian research and Prince's (2018) Australian case studies indicate that a sense of 'cultural continuity' was achieved through Indigenous self-governance, and that this is a protective factor against suicide. They also both suggest that this cultural continuity can be achieved and articulated by:

- the processes (how things are done)
- structures (the ways people organise themselves and relate to each other)
- institutions (the rules for how things should be done)
- control (including Indigenous direction and leadership) (AIGI n.d.; Dudgeon et al. 2018).

Cultural identification, or self-determination alone was not the deciding factor. In combination with cultural continuity, it was the autonomous action of self-government that saw the positive impact on suicide (Hunter and Harvey 2002).



3



Methods



3 Methods

This article draws on a literature review that looked at the following research questions in relation to Indigenous Australian organisations in the context of self-governance:

- What value do Indigenous organisations bring to the formal delivery and improved effectiveness of mental health and suicide prevention services?
- What value do Indigenous organisations bring to the empowerment and connectivity of Indigenous people as a determinant of mental health and suicide prevention?
- What are the success factors that might be adapted from other contexts in Australia and internationally, which could improve the effectiveness of Indigenous organisations in bringing this value?

This article does not seek to canvas, review or assess the strengths or weaknesses of Indigenous organisations across different types of leadership or service delivery. It does not consider the concepts of ‘efficiency’ and ‘effectiveness’ of Indigenous organisations in terms of achieving outcomes (whether set by funding agencies or their constituencies). Nor are these concepts compared to mainstream health service providers.

Indigenous organisations are not homogenous. They have unique histories and capabilities, so it is unrealistic to expect Indigenous organisations to be fully representative of a neatly bounded constituency (Rowse 2001). Indigenous communities are often defined by their plurality of self-governing entities, in which constituents self-select or newly establish themselves (Sanders 2014). As a result, it is not easy to draw generalisations.

For example, Aboriginal Community Controlled Health Organisations (ACCHOs) are one type of Indigenous organisation, which plays an important role in Indigenous mental health and suicide prevention. The contemporary national peak body for all ACCHOs, the National Aboriginal Community Controlled Health Organisation (NACCHO), defines an ACCHO as:

a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management. (NACCHO 2021a:n.p.)

The literature review identified important policies and frameworks along with relevant program evaluations and descriptions of Indigenous organisations, self-governance, mental health, and suicide prevention (see Appendix C for a discussion of the search strategy). Despite support and mention of principles of self-governance in relation to mental health in Indigenous advocacy and policy, we could not find any programs that use self-governance as an explicit method, or ‘theory of change’, to address Indigenous mental health and suicide prevention. The review found that that Indigenous organisations embody and enable self-governance in ways that contribute to Indigenous wellbeing and suicide prevention. Twelve programs and studies were identified in relation to this contribution.



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Key issues



4 Key issues

Indigenous organisations make unique contributions to mental health and suicide prevention. The review pointed to 5 key issues that will be discussed in this section:

- Indigenous organisations provide Indigenous Australians with improved access to services and continuity of care within holistic mental health and suicide prevention models.
- Indigenous organisations conceptualise and apply culturally appropriate models of wellbeing.
- Indigenous organisations utilise cultural knowledge and principles in culturally responsive and trauma-informed healing.
- Indigenous organisations promote personal and community empowerment for Indigenous Australians.
- Indigenous organisations drive action on the social determinants of health through advocacy and enable connectivity within complex government systems.

Each of these key issues (key areas of contribution) are understood in terms of underlying and interrelated processes, structures, institutions, and control associated with self-governance.

Access to services and continuity of care

Indigenous organisations provide Indigenous Australians with improved access to services and continuity of care within holistic mental health and suicide prevention models.

Indigenous Australians have long identified the value of creating organisations that can provide their communities with the health services that they need. Some of the earliest pioneers were ACCHOs that were created to provide culturally safe spaces and deliver a range of health services, including services for wellbeing, mental health, and suicide prevention.

The first ACCHO was the Redfern Aboriginal Medical Service, which was established in 1971 and operated without any government funding. It was a direct response to ‘the inability of mainstream health services to effectively engage Aboriginal communities with their services’ (NACCHO 2021a:n.p.). Since their inception, ACCHOs have championed mental health responses under a model of comprehensive and community-controlled primary health care (Baba et al. 2014; NACCHO 2021a). Primary health care is understood to be a ‘people-centred rather than disease-centred’ and ‘whole-of-society approach’ to health (WHO 2021).

ACCHOs have survived comparatively unscathed during major policy shifts away from Indigenous self-governance (Moran et al. 2014). Key factors in their success are that they:

- provide improved access to services and continuity of care to Indigenous Australians
- wrap services around Indigenous Australians through a holistic model that addresses their physical, mental and social wellbeing.

There are now more than 140 ACCHOs operating across Australia (NACCHO 2021a). Indigenous Australian clients favour ACCHOs and access these services more than mainstream services when possible (Panaretto et al. 2014). More than half of ACCHOs report depression and anxiety as the most frequent issues their clients experience (Royal Commission into Victoria’s Mental Health System 2019).



ACCHOs have the following characteristics:

- They are more likely to have an Indigenous and culturally capable workforce, which helps to reduce discrimination and create culturally safe spaces for suicide prevention services that many Indigenous Australians (though not all) will feel more comfortable accessing (Baba et al. 2014; Hepworth et al. 2015).
- They provide an organisational network that assists clients to navigate complex health and social sectors.
- They deliver a variety of different services from a single base and often work in partnership with other organisations in the community. The approach has been found to provide clients with good continuity of care in mental health services (Royal Commission into Victoria's Mental Health System 2019).

Culturally appropriate models of wellbeing

Indigenous organisations conceptualise and apply culturally appropriate models of wellbeing.

Many issues affect a person's ability to access mental health and suicide prevention services. A lack of culturally appropriate services is believed to be a main reason that Indigenous Australians have a low level of access to, and engagement with the services they need (Productivity Commission 2020a).

At the heart of this issue is the tension between non-Indigenous and Indigenous understandings and measurements of health and wellbeing. The aspects of 'a good life' that Indigenous people value are not recognised by frameworks, policies and programs for health and wellbeing that are based primarily on non-Indigenous models. Neither are the indicators relevant to (re)attaining this 'good life' recognised (Yap and Yu 2016:8). The Indigenous conceptualisation of wellbeing is 'grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community' (Gee et al. 2014:57).

Mainstream biomedical explanatory models for mental illness can be detrimentally at odds with an Indigenous understanding of mental health. For example, the Royal Commission into Victoria's Mental Health System found evidence of the misinterpretation of behaviour and symptoms in Indigenous patients, including those linked to grief and trauma. This lack of understanding led to high levels of disengagement and mistrust (Royal Commission into Victoria's Mental Health System 2019).

Indigenous organisations make a unique contribution to mental health and suicide prevention through the conceptualisation and application of culturally appropriate models of wellbeing in their own activities and service provision. Indigenous models of wellbeing influence policies and frameworks at all levels of government. They have brought widespread value to suicide prevention by bringing Indigenous worldviews into operationalised health paradigms and through their use in program planning and implementation (McEwan et al. 2008). Indigenous wellbeing frameworks are also contributing to the creation and influence of culturally appropriate forms of evaluation in Indigenous-specific programs (Chouinard and Cram 2019; Lawton et al. 2020; McCausland 2019; Productivity Commission 2020b; Tiwari et al. 2019; Williams 2018).



Culturally responsive and trauma-informed healing

Indigenous organisations utilise cultural knowledge and principles in culturally responsive and trauma-informed healing.

A significant part of Indigenous social and emotional wellbeing models is being and feeling culturally safe through connections to family, community and country (Anthony et al. 2020; Black et al. 2019; Department of Health and Human Services 2017; Gurm et al. 2020; Murrup-Stewart et al. 2020). This is significant in the context of disconnection to culture, land dispossession and child removal (Krieg 2009; Swan and Raphael 1995). Forced cultural assimilation through systemic and institutionalised practices has resulted in Indigenous people being born into cultural and social settings that are plagued with intergenerational and transgenerational trauma. In considering Indigenous suicide in connection to ‘cultural wounds’ (Dudgeon et al. 2020:238), the concept of ‘culture as treatment’ in mental health and suicide prevention is increasingly acknowledged (Barker et al. 2017).

A resurgence of Indigenous cultural knowledges and practices has occurred in recent decades, including an emphasis on (re)connecting to language, country, and Elders (Dudgeon et al. 2014:4). There is a growing body of work on Indigenous theory research and practice applied in Indigenous programs that utilise cultural knowledges and principles to provide healing services that are culturally responsive and trauma informed, including those related to suicide prevention (Barudin 2021; Green 2011; Hill et al. 2010; Sasakamoose et al. 2017). There is a recognition that organisations and practitioners in human services and the health sector need to be trauma informed and aware (Bent-Goodley 2019; Duran 2019; Gerber 2019; Levenson 2020; Raja et al. 2015).

Indigenous organisations understand how services are experienced by Indigenous clients. For example, ACCHOs acknowledge that Indigenous clients have had specific harmful experiences resulting from past and ongoing colonisation. The organisations strive to mitigate against further trauma and ensure that Indigenous clients receive a high standard of health and wellbeing services. The Aboriginal and Torres Strait Islander Healing Foundation is leading the way in growing awareness in how organisations can be trauma-informed through their policies and practices, particularly in relation to the delivery of wellbeing and healing services to Indigenous people (Healing Foundation 2015). Australian Indigenous organisations have an essential role in providing and connecting people to services and activities that utilise culture as a preventative or healing force in mental health and suicide prevention strategies. The examples of the Akeyulerre Healing Centre, Yaba Bimbie, and the Mibbinbah Indigenous Men’s Spaces Project are discussed in the later section on relevant programs and initiatives.

Personal and community empowerment

Indigenous organisations promote personal and community empowerment for Indigenous Australians.

Mental health is ‘more than the absence of mental disorders’ (WHO 2018). It is about feeling in control of one’s life. As understood by the World Health Organization (WHO 2018):

Mental health is a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.



Epidemiologists and other researchers have long established the health risks associated with low hierarchical positions, loss of authority, low self-esteem, powerlessness, lack of control over one's life, and absence of meaningful participation (Daniel et al. 2006; Lindheim and Syme 1983; Marmot et al. 1978; Marmot et al. 1991; Syme 2003; Tiessen et al. 2009). The everyday struggles of life, over time, affects a person's mental health (Tsey et al. 2003). Syme (1998) uses the terms 'control of destiny' and 'mastery' to describe having the problem-solving skills and resources needed to deal with the daily struggle.

To aid people in this struggle, or to (re)attain 'mastery', Garvey (2000:34) recommends that, in addition to clinical service provision, there is potential for engagement with Indigenous Australians along the lines of 'provision of information and skills, provision of human and material resources', and 'assistance in the development of suicide response action plans and postvention strategies'. This is where Indigenous organisations can play an important role. They can empower Indigenous Australians at a personal and community level—providing information, skills, and resources that Indigenous Australians require to manage stressors and take control of their lives.

In contemporary Indigenous bi-cultural realities, the collective nature of Indigenous cultural and political practices creates tension for individuals on a day-to-day basis. Indigenous clients can struggle to move between different cultural spaces to access the services they need. Therefore, organisations and programs that simultaneously address the capacity-building and empowerment of the individual, and the collective, can achieve beneficial outcomes for various stakeholders. Indigenous organisations that have the capacity to design and deliver programs that focus on building Indigenous clients' bi-cultural capabilities contribute to increasing help-seeking behaviour, especially among young people (Farrelly 2008; Lumby and Farrelly 2009; Price and Dalglish 2013). This capacity development also strengthens Indigenous leadership, which is so crucial to engagement in formal and informal contexts and directly associated with self-governance.

Pearson (2000) emphasises the important factor of responsibility, at both the personal and community level. In their attempts to (re)establish good health outcomes, Indigenous Australians need to take control of their own affairs. In suicide prevention and other health issues, a focus on personal agency does not deny the magnitude of social disadvantage that is outside the control of the individual. Rather, as Garvey (2000:34) states:

promoting mental health should include optimising individuals' capacities to contend with the challenges of their world, particularly when that world remains less than ideal.

Advocacy and connectivity

Indigenous organisations drive action on the social determinants of health through advocacy and enable connectivity within complex government systems.

As well as empowering people on a personal and community level to manage the stressors of life, Indigenous organisations seek to address some of the social and political origins of the stressors. Taking a social determinants of health approach to reduce physical and mental health inequalities means taking action to improve the context and conditions of everyday life, in every stage of life, across multiple sectors (WHO 2014). To prevent suicide and promote wellbeing, Indigenous-controlled organisations are well-placed to drive this action through advocacy and connectivity.



Given the effects of colonisation on Indigenous mental health and suicide, many Indigenous organisations sensibly look to processes of decolonisation to form part of the solution (Prince 2018; Trout et al. 2018). ACCHOs have a particularly strong history of advocacy on behalf of their clients, beginning with the Redfern Aboriginal Medical Service in 1971. The service recognised that 'Aboriginals suffer economic, social, nutritional and housing disadvantages which cause or accentuate medical problems beyond those of the general community' (Foley n.d.:2). Many Indigenous organisations do not limit their role to providing mental health services to their clients. They also work to change the system.

Indigenous organisations also play a key role in connecting Indigenous people to bewilderingly complex administrative system. An in-depth study in a remote settlement in Central Australia (Moran et al. 2007) found that community members viewed external institutions as a monolithic entity, which they simply referred to as 'the government'. The study showed that people had little awareness of the many different jurisdictions, levels and departments of government and which part of government provided the funding and services needed. This was not deemed to be indicative of a lack of interest, since people expressed how vulnerable they felt to the withdrawal of government-backed funding and services.

Moran and Elvin (2009) similarly found that, although Indigenous groups had good connectivity 'horizontally' to other organisations in their region, their 'vertical' connectivity into the mainstream government systems was much weaker. Vertical connectivity tended to be dominated by hierarchical power relationships of different government departments and other providers, who tended to prioritise working upwards to their chief executive officers and government ministers, rather than downward to their end users. As this example illustrates, a key contribution of Indigenous organisations is in challenging power relationships to ensure that their constituents are better served.



5



Policy context



5 Policy context

By examining how Australian policy on Indigenous mental health and suicide prevention is linked to self-governance, it is evident that cultural identification and self-determination are established elements. Since the abolition of ATSIC in 2004, the collective policies across all levels of government that apply to Indigenous Australians have seldom explicitly supported an extension to self-governance. Recent features of the policy landscape signal a mainstream political recognition of (or return to) the principles of Indigenous self-governance. The following list of key policies and frameworks demonstrates just some aspects of the connection between self-governance, Indigenous wellbeing and suicide prevention. More information is in Appendix A.

An early development was the Australian Aboriginal delegation that directly influenced the World Health Organization's 1978 Declaration of Alma-Ata (NACCHO 2021b). The Declaration was a recognition by many representative parties that health was not just the absence of disease or illness, but was related to 'complete physical, mental and social wellbeing', and that optimal health outcomes result from community operation and control of primary health care (WHO 1978).

The landmark 1995 Ways Forward National Aboriginal and Torres Strait Islander Mental Health Policy (the Ways Forward report) was the first assessment of Indigenous Australian mental health that supported culturally appropriate and community-led primary mental health services, as well as principles of self-determination (Swan and Raphael 1995). Importantly, the Ways Forward report discussed key principles of social and emotional wellbeing that were later summarised in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, first established for the period 2004–2009 (NATSIHC and NMHWG 2004) and was updated in 2017 to extend to 2023 (PM&C 2017). It established that the ability to conceptually articulate and practically apply culturally relevant models of wellbeing is essential to Indigenous self-determination and self-governance. The frameworks states that (PM&C 2017:6):

social and emotional wellbeing is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. It is a holistic concept which results from a network of relationships between individuals, family, kin and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual.

Indigenous models of wellbeing have also been similarly recognised at the state level, for example, in Victoria, the Balit Murrup (Strong Spirit): Aboriginal social and emotional wellbeing framework 2017–2027 (Department of Health and Human Services 2017a), promotes the delivery of services in ways that incorporate culturally appropriate models of social and emotional wellbeing, supported by Aboriginal leadership.

In 2015, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) developed the Gayaa Dhuwi (Proud Spirit) Declaration, which connected Indigenous values-based social and emotional wellbeing frameworks, leadership and empowerment to mental health and suicide prevention (NATSILMH 2015). Similarly, from 2016, the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP), worked to evaluate the effectiveness of existing suicide prevention services and programs in accordance with Indigenous values-based frameworks.



Their findings in the Solutions That Work report (ATSISPEP 2016) pointed to Indigenous leadership and partnership with Indigenous communities as an important success factor. The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSIISP) built on these findings to argue that ‘effective suicide prevention requires design and implementation processes under Indigenous governance’ (Dudgeon et al. 2018:5).

The first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was launched in 2013. It recognised that an Indigenous-specific interpretation and approach to suicide was needed in the health system. Without using the terminology of ‘self-governance’, it pointed to the need to conduct research on how ‘community governance’ could be leveraged to improve community-level indicators and services for suicide prevention (DoHA 2013).

Similarly, the Royal Commission into Victoria’s Mental Health System (2019:472) used the terminology of ‘self-determination’ (rather than ‘self-governance’) when discussing the importance of ‘transferring power and resources to Aboriginal communities to design and deliver their own mental health services while drawing on the skills and expertise of others where needed’.

This understanding is reflected in Victoria’s Korin Korin Balit-Dja [Growing very strong]: Aboriginal health, wellbeing and safety strategic plan 2017–2027, that directly links Indigenous self-determination to health, wellbeing and safety (Department of Health and Human Services 2017b).

During 2018–19, the Coalition of Peaks formed a representative body of 50 Aboriginal and Torres Strait Islander community-controlled peak organisations (Coalition of Peaks 2020). This led to a Partnership Agreement with the Council of Australian Governments (COAG), and then to a National Agreement on Closing the Gap and the inclusion for the first time of ‘Outcome 14’ for Indigenous social and emotional wellbeing. This had the target of ‘significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero’ (CATSIPO and Australian Governments 2020:33). This partnership between Indigenous Australians and Australian governments on Closing the Gap, as well as the co-design of the Indigenous Voice (NIAA 2020), argued for shared and decentralised decision-making across a range of health and wellbeing outcomes.

The 2020 Productivity Commission inquiry report on mental health (Productivity Commission 2020a:23) argued for a new standard of Indigenous leadership and cultural competency in health services. It made the case that Indigenous-controlled organisations should be the preferred providers of suicide prevention activities for Indigenous people, stating that:

stronger connections of individuals with their culture and control over services have reduced suicide risk and improved social and emotional wellbeing in some communities.

Within these policies and frameworks for mental health and suicide prevention, the level of recognition, scope and language around Indigenous self-determination and self-governance varies. There is more and more evidence of an encouraging evolution and trajectory in the policy context that places increased emphasis and importance on self-governance for improving mental health and suicide prevention.



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Relevant programs and initiatives



6 Relevant programs and initiatives

The review undertaken for this article found no known programs that use self-governance as an explicit method, or ‘theory of change’, to address Indigenous mental health and suicide prevention. We were able to identify 12 program evaluations and descriptions that are relevant to self-governance as an entry -point to Indigenous mental health and suicide prevention. The evaluations and descriptions of the programs are based on varied methodologies. Rigour, standardisation, and generalisability is mixed.

The programs are considered in terms of how they relate to the key issues, or areas of contribution, that Indigenous organisations make to Indigenous mental health and suicide prevention. Their contributions are considered in terms of:

- self-governance processes (how things are done)
- structures (the ways people organise themselves and relate to each other)
- institutions (the rules for how things should be done)
- control (including Indigenous direction and leadership) (AIGI n.d.; Dudgeon et al. 2018).

The program evaluations are summarised in Appendix B.

ACCHOs and social determinants of health

Relevant key issues: Advocacy and connectivity; Access to services and continuity of care

Pearson et al. (2020) analysed 67 annual reports (those closest to the 2015–16 financial year) of 122 ACCHOs to identify which of their activities (and how many) were related to the social determinants of health. A key finding of the study was the contribution of Indigenous organisations in terms of advocacy and connection to complex government systems. Specifically:

- ACCHOs regularly engage in advocacy, collaborations and partnerships, capacity-building, community empowerment, and legal and justice services.
- ACCHO leaders and workforce contribute to debates on public policy related to the broad social determinants of health by their participation on committees and efforts to influence Parliamentary Joint Committees.
- ACCHOs and their peak state and national bodies invest significant energies at local, state and Commonwealth levels into advocating for policy and programs that address social determinants and health inequities for Indigenous people.

This study also identified the contribution of Indigenous organisations to improving access to services and continuity of care. This contributes to the provision of a culturally safe space that Indigenous people will be more likely to access. Specifically, ACCHOs:

- employ a high proportion of Indigenous peoples in the organisation’s workforce
- provide opportunities for workers to pursue important training and qualifications both in and outside the organisation.



ACCHOs also reportedly support Indigenous clients to access and navigate complex health and social sectors. The study described activities that sought to increase contact with social services (for example, Centrelink, Housing and Human Services) and highlighted the way that ACCHOs routinely connect people to services, including those related to community and cultural engagement, drug, alcohol and addiction and mental health.

The sample in this study was not nationally representative and relied on reports from organisations that generally experience challenges in terms of resourcing and reporting burden. Even so, this study gives important insight into the extent of the contribution that ACCHOs are making to health outcomes, through processes, structures, institutions and control associated with self-governance.

Central Australian Aboriginal Congress

Relevant key issues: Access to services and continuity of care; Advocacy and connectivity

In a case study of the Central Australian Aboriginal Congress, Freeman and others (2016) discuss an Indigenous organisation formed in Alice Springs in 1973. The aim of the 5-year research project was to explore the strengths of the organisation as a comprehensive primary health care provider. The authors drew on 2 rounds of interviews, surveys, and workshops with staff as well as regular reports on service implementation and changes.

The findings indicate that Congress achieved improved accessibility to services in 4 important ways (Freeman et al. 2016:102):

- Availability through the provision of a free transportation service to all its service areas, outreach, home visitation, and a hybrid appointment system that allowed for walk-ins.
- Affordability through the provision of all services and medicines free of charge.
- Acceptability through the design of spaces to make the service welcoming and culturally respectful, the employment of local Aboriginal staff, and a consideration of cultural protocols.
- Engagement through interactions with the local community, including campaigns, awareness raising, and informal community development activities (such as cultural days that acted as entry points into the service).

While the Congress was contributing to improved access to services and continuity of care, the case study reveals that it was also concerned with advocacy and connection. The Congress founders, as part of their calls for a more comprehensive approach to health, initially lobbied for access to economic opportunities and nutrition. A small medical service expanded to include an:

alcohol rehabilitation center [sic], a childcare facility, a women's health and maternity service, family support services, and outreach health promotion programs in remote areas. (Freeman et al. 2016:96)

The Congress' capacity to connect and advocate was important; this was also seen as the 'space for action' for addressing the social determinants of health. It was involved in an anti-violence campaign, as well as a plan that brought attention to housing issues, and lobbied for alcohol supply restrictions in collaboration with other organisations and sectors. Participation and engagement strategies included:



... taking community members to external forums to provide a voice for the local community, consulting community members about new programs, employing local Aboriginal health practitioners, and having cultural advisory committees which provided advice and guidance on cultural protocols (Freeman et al. 2016:99).

While the case study does not give reference or cite data regarding the impact on mental health or suicide in the relevant community, it suggests that through processes, structures, institutions, and control associated with self-governance, the Congress provided improved access to services and continuous care as well as advocacy and connection within the primary health care model.

Family Wellbeing

Relevant key issues: Personal and community empowerment

The Family Wellbeing program incorporates techniques of meditation and creative visualisation in a series of workshops and meetings to open safe discussions and directly addresses control and power relations at a personal level (Tsey et al. 2003). McEwan et al. (2008:1) note that it:

focuses on social and emotional wellbeing and the development of self-worth, communication and problem-solving skills, conflict resolution, and other personal qualities that enable the individual to take greater control and responsibility for themselves and their family, work and community life.

The Family Wellbeing framework was adopted as a foundational program when the Gurriny Yealamucka ACCHO was established in response to a crisis of suicides in Yarrabah, an Indigenous community south of Cairns (McEwan et al. 2008; Prince 2018). The community had previously identified a list of factors contributing to suicide including, drugs and alcohol; unresolved grief; conflict; depression; domestic violence; unemployment; and parental neglect (McEwan et al. 2008:18).

An evaluation of the program was made in 2005 in Yarrabah by The University of Queensland, and James Cook University in partnership with the Gurriny Yealamucka Health Service (McEwan et al. 2008). Another case study by Prince (2018) is discussed elsewhere in this article (see 'Background').

The evaluation drew on data collected from 38 semi-structured interviews in 2003 and 2005. Program participants were asked about their experiences, and observations of participants were gathered from the program implementation team and stakeholders. Evaluators sought to explore the relationship between the community context, the implementation of the program, and the outcomes of the program (in the form of self-reported changes) (McEwan et al. 2008).

Though the program's impact on actual rates of suicide in the community could not be measured due to the lack of specific data, evaluators reported an 'improved understanding of emotions, relationships and life circumstances' among participants, and that this had 'led to improved communication with family members and a better ability to avoid or manage conflict in a constructive manner' (McEwan et al. 2008:18). In terms of (re)attaining mastery or control of destiny, evaluators reported that 'participants saw the possibility of change—it [the program] enlivened their creativity and ignited their hope for the future' (McEwan et al. 2008:2).



National Empowerment Project

Relevant key issues: Personal and community empowerment; Advocacy and connectivity

The Indigenous-led National Empowerment Project has a focus on community engagement and empowerment processes (Cox et al. 2014). To combat psychological distress and suicide, the aims of the program are to promote wellbeing, increase resilience and to empower communities to address the contributing social determinants (Cox et al. 2014). Individuals are engaged by building 'resilience against the forces of racism and internalised shame; and for connection to the esteem building opportunities of employment and education' (Dudgeon et al. 2015:6).

At a community level, a focus is on empowering leaders and promoting control over services. At the family level, there is training in relationships, parenting and programs for Stolen Generation Survivors.

There have been multiple evaluations of the Project in different locations. A 2017 evaluation of the Project in Kuranda and Cherbourg communities drew on summaries of 153 'stories of most significant change' and 30 interviews with program participants. The evaluation reported 'increased levels of wellbeing, strengthened resilience, and capacity to address and resolve many of the issues impacting on families both individually and collectively' (Mia et al. 2017:43).

Promoting Community Conversations About Research to End Suicide

Relevant key issues: Personal and community empowerment; Culturally responsive and trauma-informed healing

A health intervention described called Promoting Community Conversations About Research to End Suicide (PC CARES) was co-developed and delivered by a 'tribally-governed' Indigenous organisation, Maniilaq Association, in rural Alaska, USA, the University of Massachusetts-Amherst and the University of Alaska-Fairbanks (Trout et al. 2018). Evaluators describe how teams of 2 to 3 local facilitators, across 10 villages in rural Alaska, invited community stakeholders to attend 'learning circles', where suicide research was presented in a straightforward way and the community asked to discuss, share and provide analysis on the situation based on 'what we know', 'what we think' and 'what we want to do' (Trout et al. 2018:399). Acknowledging the community as best placed to determine 'next steps' and create their own self-determined suicide prevention strategies, the primary aim of the program is to practically translate research and 'invite community action' (Trout et al. 2018:401–402).

The purpose of the Trout et al. (2018) evaluation was to assess the acceptability of the program and its role as a decolonial process. It does not offer evidence about impacts on youth suicide rates. Its importance is in the direct connections it makes to self-governance and self-determination in decision-making. It reports that participants:

- felt respected as capable leaders in the process
- showed collective responsibility and commitment
- felt that their Indigenous knowledge and understanding of the problem was legitimised.

Combined, these 3 factors resulted in increased sense-making of the complex problem and the arrival at appropriate and practical strategies to address it.



Elders program

Relevant key issues: Culturally responsive and trauma-informed healing

In their evaluation of an Elders program in Canada, Hadjipavlou et al. (2018:613) describe a 'cultural intervention' undertaken at an inner-city primary care clinic. The clinic had established a partnership with First Nation Elders. Between 2014 and 2016, more than 300 First Nation clinic patients had interacted with Elders through 'one-on-one visits, group cultural teaching circles and seasonal land-based ceremonies' in association with other types of mental health care (Hadjipavlou et al. 2018:609).

To explore the Indigenous patients' experiences and perceptions of the Elders program, the evaluation collected quantitative measures (at baseline, 1, 3 and 6 months) and conducted qualitative semi-structured interviews over a 4-month period with 37 patients. Analysis included a presentation and discussion of initial themes with patients, community members, clinic staff and Elders.

The perceived benefits of the program were grouped into 5 themes:

1. finding a place of healing after a prolonged period of seeking and desperation
2. strengthening cultural identity and belonging
3. developing trust and 'opening up'
4. coping with losses
5. engaging in ceremony and spiritual dimensions of care as a resource for hope.

Quantitative analysis showed substantial reductions in depression and suicidal ideation (thoughts of committing suicide or self-harm). This trend was linked to factors of strengthening cultural identity and re-establishing cultural connections.

Akeyulerre Healing Centre

Relevant key issues: Culturally responsive and trauma-informed healing

Arnott et al. (2010) made a descriptive evaluation of Akeyulerre Healing Centre in Alice Springs. Incorporated in 2000, the Aboriginal owned and controlled organisation was self-described as a place where:

older people can teach younger people, where people who are feeling lost from grief can sit down and have company, where the spirit of the community could be healed through 'the old ways' (Arnott et al. 2010:1).

In terms of mental health, it partnered with other organisations and worked with mainstream health providers, often making assessments or referrals to other services. Evaluators found the existence of important elements of healing through increased connection to culture (Arnott et al. 2010:vi):

Healing is achieved through a combination of what on the surface may seem to be simple activities, such as bush trips, collecting bush medicines and bush tucker, barbecues, story-telling, singing and dancing. However, surrounding these activities is a spiritual dynamic that is expressed through the work of Angangkernes [traditional healers], in ceremonies, and in the transmission of knowledge from one generation to the next. It is about keeping culture strong, reconnecting with country, and building a sense of belonging.



Yaba Bimbie

Relevant key issues: Culturally responsive and trauma-informed healing; Personal and community empowerment

The Yaba Bimbie [father son] Men's Group started in 1998 in the context of a period of high suicide rates and suicide attempts in the community of Yarrabah, Queensland (McCalman et al. 2005). Supported by Yarrabah's community-controlled health service, its aim was to assist men to 'take their rightful role in the community, encompassing the spiritual, mental, emotional and physical aspects of life' (McCalman et al. 2005:4).

Due to challenges in data collection, including lack of routine attendance statistics, evaluators found it difficult to determine the effect that the men's group had in the community. From interviews with 13 people, participant observations, reflections from project workers, and community-level statistical data, the evaluators concluded that, by tackling some of the underlying psychological determinants of health, Yaba Bimbie made an important contribution to 'addressing suicide and related issues of self-esteem and identity at community level' (McCalman et al. 2005:4).

Mibbinbah Indigenous Men's Spaces Project

Related key issues: Culturally responsive and trauma-informed healing

The Mibbinbah Indigenous Men's Spaces Project centred on providing safe spaces for men dealing with depression and anxiety to find connection to culture, Elders and 'Spiritual Healing'. Among a range of other topics, mental health was a featured focus within Men's Spaces, including through partnerships with beyondblue (Bulman and Hayes 2011).

Through the transfer of cultural knowledge, the program reportedly fostered 'life-saving' hope and a 'shared vision of the future' (Bulman and Hayes 2011:14). Although there are no data on the impacts on suicide prevention, there is a description of increased levels of self-confidence and trust in others, which Bulman and Hayes (2011) argued was essential for Indigenous men to feel more comfortable and able to access important health services.

Uti Kulintjaku Project

Relevant key issues: Culturally appropriate models of wellbeing

The Aboriginal-led Uti Kulintjaku Project, meaning 'to think and understand clearly', was conceived and led from within the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) in Central Australia (Togni 2016:269).

The Project came in response to an increase in youth suicides in the region, and the concern that young people were not able to adequately express their feelings or understand how they might relate to Indigenous social and wellbeing models.



The women in the Council identified a need for ‘increased bi-cultural understanding, with a focus on language’, or a way to draw on the relevant Indigenous knowledge systems as well as those of non-Indigenous health professionals to bring about positive mental health outcomes (Togni 2016:269). A series of workshops on mental health and culturally relevant wellbeing was developed and delivered by the women. Participants included both Indigenous and non-Indigenous community members, internal and external service providers, and stakeholders. Much of the discussion took place in Aboriginal languages, and all words relating to mental health and wellbeing were discussed at length and recorded along with their English translations.

Although the project description offers no data to determine impacts on suicide rates in the community, evaluators reported that participants had increased understandings of mental health from both Indigenous and non-Indigenous perspectives as well as more confidence in responding to mental health challenges in the community (Togni 2016:270). Importantly, the constantly evolving repository of language has reportedly been used in the creation of successful community outreach resources like the ‘words for feelings map’ poster (see Appendix C) that was reportedly mentioned in the National Children’s Commissioner’s 2014 Report ‘as an effective resource to overcome language barriers for young people seeking help around mental health’ (Togni 2016:274). Evaluators assessed the program as being consistent with wider efforts to enhance social and emotional wellbeing and ‘suicide proofing’ of Indigenous communities (Togni 2016:268).

Yawuru Wellbeing Project

Relevant key issues: Culturally appropriate models of wellbeing; Personal and community empowerment

Yap and Yu (2016) offered a description of the Yawuru Wellbeing Project that aimed to articulate and develop community wellbeing ‘from the ground up’. Although the Project did not come about as an explicit response to suicide, it is described as a means for the community to take ‘self-determination in their own hands to conceptualise, define and measure their wellbeing’, which included considerations of mental health (Yap and Yu 2016:24). The Project involved a process of developing wellbeing indicators specific to the Yawuru people in Broome and exploring how these relate to non-Indigenous concepts in reporting frameworks of government and statistical agencies.

Qualitative data were collected from interviews and focus groups to explore how wellbeing was experienced and defined by the community. This information was then used to create a quantitative tool, the Yawuru Wellbeing Survey. The Survey was designed to measure elements of culture, identity, and wellbeing, as well as provide baseline information about personal circumstances. The Survey was used to make a contextually relevant set of wellbeing indicators, as well as a series of situating social and emotional wellbeing statements that the community could use as tools to address their own health issues, including in policy and program design.

The Yawuru Wellbeing Project confirmed that the notion of *liyan* is central to the community’s understanding of wellbeing, and ‘is expressed through relationships beyond the individual: it is a model of living well in connection with country, culture, and others as well as with oneself’ (Yap and Yu 2016:29). Self-determination was identified as a constituent element necessary to achieve wellbeing. It was associated with ‘feeling respected, enjoying basic human rights afforded to all citizens and autonomy or control over one’s life’ (Yap and Yu 2016:72).



United Health Education and Learning Program

Relevant key issues: Culturally appropriate models of wellbeing; Personal and community empowerment

The United Health Education and Learning Program (UHELP) was a partnership between 2 groups:

1. headspace, Inala, Brisbane (the National Mental Health Foundation), and
2. the Suicide Prevention and Mental Health Program (SPAMHP), a community group of Elders, Indigenous leaders, and stakeholders (Skerrett et al. 2018).

Its aim was to use culturally appropriate social and emotional wellbeing models to address high levels of suicide and psychological distress in the community's youth. The focus was on a wellbeing model that explored 'social, environmental, behavioural, and emotional contributors towards ill health and engaged participants in information-sharing and skill-building to address these holistic factors' (Skerrett et al. 2018:20).

UHELP was evaluated by a team from Griffith University using a mixed-methods approach to assess whether there had been a change in suicidal ideation among the participants. The program was delivered in weekly sessions with an extra hour of physical activity, as well as the sharing of a nutritious meal. Over a one-year period, 61 Indigenous Australians aged 11–21 years completed the program. Focus groups made up the qualitative approach. Quantitative data, based on established psychological measurement frameworks, were collected from 49 of the participants 2 months after completion of the program.

The evaluation found a statistically significant decrease in suicidal ideation (measured by self-reporting standardised questions about a person's intent to self-harm or attempt suicide). Importantly, the number of referrals to headspace increased, reflecting a rise in awareness from the participants and community about sources for help as well as increased connections made by the program with associated organisations, including justice services.

There are limits to generalisability:

1. the initially small sample size
2. a low retention rate at the 2 months' follow-up.

The decrease in suicidal ideation in the participating youth is important, especially given the focus was on Indigenous self-determined holistic wellbeing models rather than standard mainstream suicide prevention frameworks (Skerrett et al. 2018).



7



Overarching approaches and best practice



7 Overarching approaches and best practice

The literature reviewed for this article has shown 4 approaches that can be considered to be best practice for improving mental health and suicide prevention:

- strengths-based cultural determinants approaches
- culturally responsive trauma-informed approaches
- interface approach
- decolonisation approaches.

Strengths-based cultural determinants approaches

To move beyond entrenched deficit discourses about Indigenous people, mental health and suicide prevention approaches must be based on the understanding that Indigenous communities have strengths and knowledge to (re)implement solutions, including program design and delivery. Many communities face a range of challenges, including those related to capacity to (re)build mental health and suicide prevention programs and initiatives. The experience of multiple suicides in a community can compound distress and frustrate progress (AIPA 2009).

Communities have innate strengths that can be built on as the basis of recovery. Surfacing and communicating these strengths is key to achieving progress, as is the integration of Indigenous knowledges into mainstream health institutions. This requires genuine support and collaboration.

Culturally responsive trauma-informed approaches

By taking a culturally responsive trauma-informed approach, programs and organisations can mitigate against further Indigenous intergenerational and transgenerational trauma. They can provide sites and ‘holding places’ for healing, which:

- allow positive intergenerational knowledge to be transferred and so contribute to building bi-cultural skills
- enable individuals, families and communities to negotiate within and among themselves how they can and will deal with the ongoing realities of forced cultural assimilation through engagement with mainstream organisations and institutions.

The approach also involves building the capacity of mainstream service providers to give Indigenous clients a wider range of entry points to access culturally responsive trauma-informed services.

Interface approach

Indigenous organisations are situated at the interface between Indigenous groups and non-Indigenous structures and agents. As noted by Sullivan (1988), Indigenous organisations bridge between 2 distinct domains:

- the Indigenous domain and expressions of self-determination and self-governance
- the non-Indigenous domain and its mechanisms of administrative control.



Taking an interface approach in self-governance, Indigenous organisations can be effective mechanisms to engage constituents, make sense of problems, express community aspirations, exercise community control, mobilise local resources and activities, connect to other organisations and to higher levels of government and the private sector, and significantly challenge external power influences.

Decolonisation approaches

In the face of the lasting impacts of colonisation, mental health and suicide prevention approaches must fall under wider processes of decolonisation. To be consistent with the principle of subsidiarity, this should involve shifting decision-making powers, so decisions are taken at the lowest level possible, closest to where they will have their effect, with appropriate level of finances and support.

Through self-governance, Indigenous organisations can counter power imbalances from past and ongoing colonial practices that contribute to social determinants of poor mental health and suicide. This can take multiple forms, including advocacy for the understanding of Indigenous experiences, and a voice to governments and other state mechanisms. Strategies must address power on both the micro or interpersonal level and the macro level, meaningfully considering personal and social barriers.



8



Gaps and limitations



8 Gaps and limitations

In the context of mental health and suicide prevention, this article discusses programs in terms of the contributions that Indigenous organisations make through processes, structures, institutions and control associated with self-governance. It shows that there is a complete absence of programs or studies that use self-governance as an explicit ‘theory of change’. There is an obvious need for new research—co-designed by Indigenous researchers, communities, and stakeholders—to produce quality evidence about self-governance and suicide prevention. To do this effectively, it is necessary to address the limitations of the existing research in the field.

Generally, there is a recognised lack of suitably evaluated Indigenous-specific suicide prevention programs in Australia that could inform Indigenous suicide prevention policy and practice (AIHW 2013; Skerrett et al. 2018). This is clear from the small number of program evaluations featured in this article, as well as the lack of programs that would meet the highest levels of standardised rigour. Indigenous organisations and other community-led initiatives generally have insufficient resources or capacity to do complex evaluations, especially rigorous quantitative and experimental evaluation methodologies. Governments typically shy away from this expense, as well as the difficulties and ethical dilemmas in finding a valid control (Cobb-Clarke 2009).

The reported outcomes or impacts described in the programs featured in this article are not fully reflective of what is achieved in practice. The administrative system that presents at the interface between Indigenous groups and non-Indigenous structures and agents is beset by major problems of fragmentation and overburden (Dwyer et al. 2009), leading to a marked mismatch between policy and practice. Indigenous organisations are beholden to multiple reporting requirements, which often do not correlate with the daily activity and politics of achieving success and coping with failures (Moran et al. 2014). Meeting internal demands is often more critical to the daily survival of Indigenous organisations than reporting against externally set (and potentially culturally inappropriate) benchmarks.

The lack of evidence for impacts may suggest a bias in limiting evaluations to current government programs rather than capturing the realities that Indigenous organisation face daily. It follows that evaluations tend to focus on the perceived problems and deficits that exogenous programs are designed to tackle, rather than capturing endogenous progress and strengths. There can also be resistance by Indigenous organisations in reporting due to scepticism about the value of evaluation and whose interest it serves. However, Indigenous organisations are becoming more assertive in establishing their own internal performance measures (see, for example, Empowered Communities 2015).



9



Recommendations for further research



9 Recommendations for further research

There is a recognition that research and reporting needs to be led by Indigenous organisations and community rather than by external agents, and only by taking control of data, and monitoring and evaluation will it be possible to understand and improve the impact of mental health and suicide prevention programs (Dudgeon et al. 2020). The processes involved in taking this control and designing future research are clearly linked to those of Indigenous self-determination and self-governance.

There is a compelling need to look beyond the currently favoured public finance modality—the ‘program’, with its ubiquitous ‘Key Performance Indicators’—to more decentralised performance measurement frameworks with indicators that are built up around Indigenous organisations.

Indigenous organisations that are active in delivering mental health and suicide prevention services are beholden to many separate reporting requirements under multiple funding contracts, which are typically short term and subject to a high turnover. This undermines the effectiveness of these organisations and negatively impacts staff performance and retention, especially that of Indigenous workers (Moran et al. 2014). When the real work of engaging people and achieving progress is not reported, it cannot be understood or valued by external stakeholders (Moran et al. 2014). Further research is required to distil and document actual ‘Indigenous Indicators’ of progress and success, which report performance at the organisation level from the ground up, over the long term, as capacity builds. Crucially, these Indigenous Indicators should also capture effective partnerships between an Indigenous organisation and other Indigenous organisations, as well as with non-Indigenous organisations and mainstream service providers.

More space must be given to understand the factor of gender in Indigenous mental health and suicide prevention. There is a difference in rates of suicide between Indigenous women and men—males comprise the majority of completed suicides in the Indigenous population (ABS 2019a). More research must be done to understand this difference and the risk and protective factors associated with gender roles and constructs in Indigenous communities. Similarly, research is needed towards understanding the different impacts of mental health and suicide prevention strategies and interventions on Indigenous women and men.

It is also essential to understand the risk factors for those Indigenous persons that identify differently, or are seen differently by their communities, in terms of gender. For example, the ‘sista girls’ in the Tiwi Islands who struggled to be accepted by their families and community and to connect to their culture was a group that experienced disproportionate trauma and grief related to suicide (Prince 2018). Gender diverse groups have not been adequately included in strategies to prevent Indigenous suicide. For example, gender diverse people were not mentioned in the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy of 2013 (GDPSA 2020). Importantly, there is the intention that ‘Indigenous Lesbian, Gay, Bisexual, Transgender, Queer identifying and Intersex people + and Sistergirls and Brotherboys (LGBTQI+SB) people’ will be directly referenced and supported in the new Strategy for 2021–2031 (GDPSA 2020:13). Gender must be considered in all mental health and suicide prevention strategies, including those that adopt culturally responsive trauma-informed healing.



Gender is also a critical driver of change in leadership and governance (Coles et al. 2015; Kangas et al. 2014). The UN Permanent Forum on Indigenous Issues has highlighted the significance of gender in Indigenous contexts (UNPFII 2010). This includes not only the importance of having women in formal leadership roles, but also in ensuring that their influence and involvement is integrated in all levels of decision-making.

In efforts to strengthen Indigenous self-governance, gender must be adequately addressed. Indigenous organisations, like all social institutions, are gendered. There needs to be more space given to understanding and interrogating gender roles and constructs in Indigenous communities and at different levels of Indigenous governance. This needs to be done at the same time as decolonising processes and strength-based cultural determinant approaches.

There is a danger in assuming that once 'self-governance' is 'achieved' or once reconnection to culture is established, that 'harmony', including traditional roles of women and men, will result (Kuokkanen 2019). If gender is not considered at the very foundation of Indigenous self-governance, then there is a risk that Indigenous women's voices, needs and experiences are not integrated, and worse, that problems of sexism, discrimination, oppression or violence become entrenched in the processes and institutions that are established (Kuokkanen 2019).



10



Conclusions



10 Conclusions

Finding ways to improve mental health and prevent suicide in Australian Indigenous populations demands multiple entry points, both in research and in policy. There is limited, yet compelling, evidence from Canada (Chandler and Lalonde 1998) and Australia (Prince 2018) that draws a link between Indigenous self-governance and improved mental health and suicide prevention outcomes.

Indigenous Australian self-governance is best understood as processes (how things are done), structures (the ways people organise themselves and relate to each other), institutions (the rules for how things should be done), and control (including Indigenous direction and leadership) (AIGI n.d.; Dudgeon et al. 2018). It can take many forms, including formal organisations, social enterprises, for-profit companies, leadership groups, family and community networks, and other informal arrangements that collectively organise for the benefit of their constituents.

A review of program evaluations and descriptions revealed that self-governance has not been explicitly referenced as a means to achieve mental health and suicide prevention outcomes. However, the review highlighted the ways in which Indigenous organisations contribute to mental health and suicide prevention in ways that are enabled by processes, structures, institutions and the control associated with self-governance:

Indigenous organisations provide Indigenous Australians with improved access to services and continuity of care within holistic mental health and suicide prevention models by:

1. conceptualising and applying culturally appropriate models of wellbeing
2. using cultural knowledge and principles in culturally responsive and trauma-informed healing
3. promoting personal and community empowerment for Indigenous Australians
4. driving action on the social determinants of health through advocacy and enabling connectivity within complex government systems.

Indigenous self-governance is a concept that is as politically charged as it is continuing, complex and multidimensional. Indigenous Australians have a protracted history of struggle for self-determination and the inherent right to self-governance. In this context, it is promising that there appears to be a mainstream political recognition of (or return to) the principles of self-governance in the context of policy and programs for Indigenous Australians. It remains to be seen how this will translate for Indigenous organisations and their constituents, who have long been working to achieve frontline change. More work is needed to determine what resources will be needed to support them in that context, as well as the appropriate role for outsiders who come to their aid.

We need to increase our understanding of the current limitations and challenges to research. In general, there is a lack of suitably evaluated Indigenous-specific suicide prevention programs that could inform Indigenous suicide prevention policy and practice in Australia. In the specific link between self-governance and suicide prevention, there is an absence of standardised or rigorous studies. The role of gender in relation to both suicide prevention and self-governance is not well understood and requires extensive and targeted research. Indigenous researchers, communities, and other stakeholders must lead and take control of research processes to produce evidence that is reflective of lived realities and relevant to design, implementation, and evaluation of programs.



Indigenous communities have the capacity and the strengths to (re)implement solutions. Culture is a vitally important aspect of this strength. Taking a culturally responsive trauma-informed approach can mitigate against further Indigenous intergenerational and transgenerational trauma and provide sites for healing. Indigenous organisations can play essential roles in bridging domains and challenging power constructs, including in advocacy and decolonisation processes. These reflect important crosscutting principles to guide and progress action towards meaningfully improving mental health and prevent suicide in Indigenous Australian communities.



Appendixes

Appendix A: Policies and frameworks

Table A1: Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
Declaration of Alma-Ata (1978)	The declaration is considered a 'major milestone of the twentieth century in the field of public health' (WHO n.d.). It resulted from an International Conference on Primary Health Care, in Alma-Ata, USSR, in 1978. An Australian Aboriginal delegation was in attendance (NACCHO 2021b). 134 national government members of the WHO signed the Alma-Ata Declaration, making Primary Health Care (PHC) the official health policy of all members countries (Rifkin 2018).	Primary health care is the best way to achieve health for all Health as a human right—and understood not just as the absence of disease or illness, but related to 'complete physical, mental and social wellbeing' (WHO 1978:n.p.) Principles of equity, community operation and control in health care	Globally, there are challenges in implementation, including in defining and institutionalising community operation and control of primary health care (Rifkin 2018) Implementation measures unidentified
Ways Forward National Aboriginal and Torres Strait Islander Mental Health Policy (1995)	It was the first to report specifically on Indigenous Australian mental health. It was followed by a consultancy process with providers and consumers of mental health services.	Self-determination is central to mental health and the provision of mental health services Aboriginal concept of health is holistic and so should be the approaches to provide health services (encompassing mental, physical, cultural, and spiritual health)	The policy is intended to be implemented over 5 years. The report influenced further policy development. It led to activities related to suicide, trauma and grief, research and data, and mental health workforce training and development (PM&C 2017). It also supported the development of strengths-based, culturally appropriate, community-led primary mental health and social and emotional wellbeing services (PM&C 2017).
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy	Australian Government (Department of Health and Aging) strategy that recognised that an Indigenous-specific interpretation and approach to suicide was needed in the health system. This includes a commitment to addressing social determinants.	Pointed to the need to conduct research on how 'community governance' could be leveraged to improve community-level indicators and services for suicide prevention (DoHA 2013:40)	Relevant across levels and portfolios of the Australian Government Implementation measures unidentified A new Strategy for the period of 2021 to 2031 is being drafted under consultation from stakeholders (GDP&A 2020).

(continued)

Table A1 (continued): Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023	Codified by the Australian Government for the period 2004–2009 and updated for 2017 to 2023, the policy was 'intended to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms' (PM&C 2017:2).	Concept of social and emotional wellbeing codified by the Australian Government 'Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services' (PM&C 2017:3)	It is part of ongoing reform to the mental health system and is connected to several other frameworks: • Fifth National Mental Health and Suicide Prevention Plan • National Aboriginal and Torres Strait Islander Health Plan 2012–2023 • 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
Balit Murrup (Strong Spirit): Aboriginal social and emotional wellbeing framework 2017–2027	A state-level framework aiming to achieve the 'highest attainable standards of social emotional wellbeing and mental health' (Department of Health and Human Services 2017a:8). Four domains: 1. Improving access to culturally responsive services 2. Supporting resilience, healing and trauma recovery 3. Building a strong, skilled and supported workforce 4. Integrated and seamless service delivery.	Key principles: • Self-determination and community control • Embedding healing and protective factors • Culturally capable services • Person-centred care • Community engagement • Partnerships	Aligns with the state of Victoria's 10-year mental health plan (Department of Health and Human Services 2015) and Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027 (Department of Health and Human Services 2017b) Implementation measures unidentified

(continued)

Table A1 (continued): Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
Korin Korin Balit-Dja [Growing very strong]: Aboriginal health, wellbeing and safety strategic plan 2017–2027	State of Victoria Government plan that 'articulates Victorian Aboriginal people's aspirations for health, wellbeing and safety' (Department of Health and Human Services 2017b:7) Reportedly reflects consultation and partnership between Aboriginal communities and community organisations, mainstream services and government departments	Five priority domains with Indigenous self-determination at centre: • Aboriginal community leadership • Prioritising Aboriginal culture and community • System reform across the health and human services sector • Safe, secure, strong families and individuals • Physically, socially and emotionally healthy Aboriginal communities.	Designed to be useful for government and other service providers. Aligns with Balit Murrup (Strong Spirit): Aboriginal social and emotional wellbeing framework 2017–2027 (Department of Health and Human Services 2017a) Implementation measures unidentified
Gayaa Dhuwi (Proud Spirit) Declaration (NATSILMH 2015)	Undertaken by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)	Indigenous leadership and presence in all levels of the Australian mental health system Indigenous concepts of social and emotional wellbeing, mental health and healing should be recognised and integrated into the system	A companion declaration to the Wharerātā Declaration Implementation measures unidentified
Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISEP)	The body is funded by the Australian Government through the Department of Prime Minister and Cabinet. It worked to evaluate the effectiveness of existing suicide prevention services and programs in accordance with Indigenous values-based frameworks.	Solutions That Work report pointed to Indigenous leadership and partnership with Indigenous communities as an important success factor in suicide prevention (ATSISEP 2016).	Cites tools related to planning, assessment and evaluation Implementation of these tools unidentified Relates to addressing social determinants of mental health Informed the Fifth National Mental Health and Suicide Prevention Plan (Dudgeon et al. 2021)
Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSIISP)	Body funded by the Australian Government through the Department of Health's National Suicide Prevention Leadership and Support Program Understood as 'Australia's leading authority on Indigenous suicide' (CBPATSIISP 2021)	Recognises that 'effective suicide prevention requires design and implementation processes under Indigenous governance' (Dudgeon et al. 2018:5)	Promotes 'evidence-based suicide prevention practice that empowers individuals, families and communities and respects their culture' (CBPATSIISP 2021) Implementation measures unidentified

(continued)

Table A1 (continued): Description and key recommendations of policies and frameworks

Name	Details	Key recommendations	Implementation
Coalition of Peaks (2018) and National Agreement on Closing the Gap	During 2018–19, the Coalition of Peaks formed as an ‘act of self-determination’—it is a representative body of 50 Aboriginal and Torres Strait Islander community-controlled peak organisations (Coalition of Peaks 2020). It is a formal partner with Australian governments on the National Agreement on Closing the Gap—‘to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians’ (CATSIPO and Australian Governments 2020:3).	Closing the Gap ‘Outcome 14’ pertaining to Indigenous social and emotional wellbeing, with the Target of ‘significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero’ (CATSIPO and Australian Governments 2020:33).	Parties of the Agreement have implementation plans and related activities to close the gap. The Agreement is a commitment to shared decision-making, building the community-controlled sector, improving mainstream institutions, and Aboriginal and Torres Strait Islander-led data (CATSIPO and Australian Governments 2020:3).
Royal Commission into Victoria’s Mental Health System (2019) (Interim report)	State of Victoria called Royal Commission to report on ‘how Victoria’s mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future’ (Royal Commission into Victoria’s Mental Health System 2019:11).	Discussed the importance of ‘transferring power and resources to Aboriginal communities to design and deliver their own mental health services while drawing on the skills and expertise of others where needed’ (Royal Commission into Victoria’s Mental Health System 2019:472).	Potential for policy influence and reform
Indigenous Voice	The co-design process for the Indigenous Voice began in 2019. Proposals are to be made to the Australian Government on the best way to ‘provide advice to the Parliament on national issues impacting Aboriginal and Torres Strait Islander peoples’ (NIAA 2020:7).	The Voice would include ‘advise on nationally significant matters of critical importance to the social, spiritual and economic wellbeing’ of Indigenous Australians (NIAA 2020:8).	Co-design groups have developed proposals of how shared decision-making could work at the local and regional level. The proposals have received feedback towards finalising a report to the Australian Government (NIAA 2020).

Appendix B: Programs

Table B1: Program descriptions, methods and evaluations

Program	Program details			Evaluation	Evaluation details			Evaluation outcomes
ACCHOs and social determinants of health research Indigenous-led research team analysed 67 annual reports (those closest to the 2015–16 financial year) from ACCHOs	Location(s)	n.a.		Pearson et al. (2020) The activities of the ACCHOs were coded using the WHO framework on the determinants of health (intermediary, socioeconomic and sociopolitical contexts) (Pearson et al. 2020).	Location(s)	n.a.		• ACCHO sector found to use a comprehensive model of primary health care—providing services, and at the same time addressing the social determinants of health. • All reports described activities that sought to increase access to social services (for example, Centrelink, Housing and Human Services) • ACCHOs employ a high proportion of Indigenous peoples in their workforce, as well as provide opportunities for workers to pursue important training and qualifications both within and outside the organisation. • ACCHOs regularly conduct activities related to advocacy, as well as collaborations and partnerships, capacity building and community empowerment, and legal and justice services (Pearson et al. 2020:6). • Sample is not nationally representative and may bias those ACCHOs that had sufficient administrative resourcing—those that are more able to deal with the ‘reporting burden’.
	Participants	n.a.			Participants	n.a.		
	Duration	n.a.			Duration	n.a.		
	Indigenous specific	Yes			Indigenous specific	Yes		
	Focus	ACCHOs			Focus	To ascertain the number and type of activities they undertook related to the social determinants of health		

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Evaluation outcomes
Central Australian Aboriginal Congress Case study of an ACCHO Part of findings from a five-year research project on the implementation of comprehensive primary health care (PHC) in South Australia and the Northern Territory in the context of universal health coverage (UHC).	Location(s)	South Australia and Northern Territory	Freeman et al. (2016) Two rounds of interviews, surveys, and workshops with staff as well as regular reports on service implementation and changes	Location(s)	Northern Territory	- The organisation was found to have achieved improved accessibility to services in 4 ways: <i>Availability, Affordability, Acceptability and Engagement</i> - Beyond providing access to primary health care service, the organisation addressed social determinants and health equity factors—through advocacy and connection to social programs. - Study did not gather comparative health outcome data.
	Participants	n.a.		Participants	Central Australian Aboriginal Congress	
	Duration	n.a.		Duration	5-year case study (2009–2014)	
	Indigenous specific	n.a.		Indigenous specific	Yes	
	Focus	Primary Health Care (PHC)		Focus	Strengths of the ACCHO as a comprehensive PHC model for UHC compared to state-funded and state-managed PHC services.	

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Evaluation outcomes
Family Wellbeing Developed in early 1990s by Indigenous leaders and members of the Stolen Generation Five stages of workshops and meetings Incorporates techniques from psychosynthesis, including meditation and creative visualisation Conducted in several locations within Australia On completion of the program, participants gain a nationally accredited qualification in counselling.	Location(s)	Yarrabah, an Indigenous community south of Cairns	McEwan et al. (2008) Participatory action research Drew upon ethnographic methods 38 semi-structured interviews and participant observation	Location(s)	Gurriny Yealamucka Health Service (ACCHO), Yarrabah	- Reported an 'improved understanding of emotions, relationships and life circumstances' among participants, and that this had 'led to improved communication with family members and a better ability to avoid or manage conflict in a constructive manner' (McEwan et al. 2008:18). - Reported perceptual changes at personal, family and community level that are relevant to social and emotional health. Emergent themes: 'understanding', 'calm and peace', 'recognition of personal potential', 'unity', 'healing', 'spirituality', 'self-reflection', 'empathy', and 'family relationships'. - Increased 'control' and 'mastery' was associated with 'greater capacity to deal with day-to-day challenges of life without being overwhelmed by them' (McEwan et al. 2008:18).
	Participants	n.a.		Participants	122	
	Duration	5 years (2001–2005)		Duration	Evaluations in 2003 and 2005	
	Indigenous specific	Yes		Indigenous specific	Yes	
	Focus	Self-worth, communication and problem-solving skills, conflict resolution		Focus	Evaluating program relevance and acceptability (as well as Personal Level Change, Community Level Change, Building Facilitator Capacity, and Spirituality and Religious Beliefs)	

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Evaluation outcomes
National Empowerment Project (NEP) Aboriginal-led and based on extensive community consultations and Participatory Action Research Delivered in 6 weeks, over a 12-month period Developed in partnership between Department of Health and the School of Indigenous Studies at the University of Western Australia	Location(s)	Various locations in Australia	Mia et al. (2017) Summaries of stories of most significant change (SMSC)	Location(s)	Kuranda/ Mt Garnet and Cherbourg communities, Queensland	Eight key themes present within the participating communities: 1. Personal strengths <i>(reported increased self-esteem and confidence, encouraged positive thoughts)</i> 2. Healthcare and healthier lifestyle choices <i>(reported more conscious of their physical and mental health)</i> 3. Relationships: children, partners, family, and community <i>(reported resolve to nurture more positive relationships)</i> 4. Family/domestic violence and incarceration <i>(reported more skills to deal with family/domestic violence, and family breakdown)</i> 5. Life skills and life planning <i>(tools for self-assessment of their behaviours and actions)</i> 6. Education, training, and employment <i>(reported interest in personal and professional development)</i> 7. Cultural, social, and emotional wellbeing <i>(reported positive benefits from feeling a sense of belonging)</i> 8. Cultural reconnection, identity, pride, and community <i>(reported increased hope and commitment)</i>
	Participants	199 commenced 159 completed	One-on-one interviews Review of the NEP Site Reports	Participants	30 interviewees 153 participants completed the SMSC process	
	Duration	2014–2016		Duration	2017	
	Indigenous specific	Yes		Indigenous specific	Yes	
	Focus	Addressing psychological distress and suicide through the empowerment of individuals, families and communities to identify and navigate challenges.		Focus	Assessment of if, and how, the program contributed to strengthening the cultural, social, and emotional wellbeing of participants, their families and communities.	

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details			Evaluation	Evaluation details			Evaluation outcomes
Promoting Community Conversations About Research to End Suicide (PC CARES) Developed and delivered by 'tribally-governed' organisation Maniilaq Association, Alaska, the University of Massachusetts-Amherst and the University of Alaska-Fairbanks	Location(s)	10 villages in rural Alaska, USA	Trout et al. (2018) Case study tracking community response to program Workshops were audio recorded, analysed and coded	Location(s)	10 villages in rural Alaska, USA	- Participants reportedly felt respected as capable leaders in the process, that they showed collective responsibility and commitment. Indigenous knowledge and understanding of the problem was legitimised, resulting in increased sense-making of the complex problem and the arrival at appropriate and practical next steps to address it. - Does not offer evidence relating to impacts on youth suicide rates.		
	Participants			Participants	Not specified			
	Duration			Duration				
	Indigenous specific	Yes		Indigenous specific	Yes			
	Focus	Participatory Action Research		Focus	To assess the acceptability of the program and its role as a decolonial process			
Elders program Partnership with First Nation Elders	Location(s)	Inner-city primary care clinic, Canada	Hadjipavlou et al. (2018) Quantitative measures (at baseline, 1, 3 and 6 months) and qualitative semi-structured interviews over a 4-month period.	Location(s)	Inner-city primary care clinic, Canada	- The perceived benefits of the program were grouped into five themes: 1. Finding a place of healing after a prolonged period of seeking and desperation 2. Strengthening cultural identity and belonging 3. Developing trust and 'opening up' 4. Coping with losses - Engaging in ceremony and spiritual dimensions of care as a resource for hope. - Quantitative analysis showed substantial reductions in depression and suicidal ideation.		
	Participants	More than 300 patients		Participants	37 patients			
	Duration	2014-2016		Duration				
	Indigenous specific	Yes		Indigenous specific	Yes			
	Focus	Addressing suicide through culture/ connection to Elders		Focus	To explore the Indigenous patients' experiences and perceptions of the Elders program.			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details			Evaluation	Evaluation details			Evaluation outcomes
Akeyulerre Healing Centre Established by Arrernte Elders and community members	Location(s)	Alice Springs	Arnott et al. (2010) Formative, mixed methods approach. Local researchers worked with Charles Darwin University team. 20 interviews, review of over 450 photographs and videos and relevant documentation provided by Akeyulerre.	Location(s)	Alice Springs	• The project found existence of important elements of healing through increased connection to culture. • Activities included: 'bush trips, collecting bush medicines and bush tucker, barbecues, storytelling, singing and dancing' associated with healing (Arnott et al 2010:vi). • Outcomes were described in terms of 'improved mental health, engaged processes of education and learning for young people and adults, social inclusion, support for aged care and disability services as well as crime prevention and prevention of substance abuse' (Arnott et al 2010:vi).		
	Participants			Participants	unspecified			
	Duration			Duration	September 2009–April 2010			
	Indigenous specific	Yes		Indigenous specific	Yes			
	Focus	Healing, wellbeing, traditional knowledge use		Focus	How Akeyulerre supports health and wellbeing for Arrernte people			
Yaba Bimbie Men's Group started in February 1998 in the context of a period of high suicide rates and suicide attempts in the community	Location(s)	Yarrabah, Queensland	McCalman et al. (2005)	Location(s)	Yarrabah, Queensland	• Evaluators conclude that by tackling some of the underlying psychological determinants of health, the program is an important feature in 'addressing suicide and related issues of self-esteem and identity at community level' (McCalman et al. 2005:4). • Challenges in data collection included a lack of routine attendance statistics.		
	Participants		Interviews, participant observations, reflections from project workers, and community-level statistical data	Participants	13 people			
	Duration			Duration				
	Indigenous specific	Yes		Indigenous specific	Yes			
	Focus	Men's mental health and suicide prevention		Focus	Impact of program on men's mental health			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details			Evaluation	Evaluation details			Evaluation outcomes
Mibbinbah Indigenous Men's Spaces Project Centres on providing safe spaces for men dealing with depression and anxiety to find connection to culture, Elders and 'Spiritual Healing' Partnerships with <i>beyondblue</i>	Location(s)	Various locations in Australia	Bulman and Hayes (2011) Program description —authors impressions of various interactions with program and participants.	Location(s)	n.a.	• Description of increased levels of self-confidence and trust in others which authors argue is essential for Indigenous men to feel more comfortable and able to access important health services. • No data provided on the impacts on suicide prevention		
	Participants			Participants	n.a.			
	Duration			Duration	n.a.			
	Indigenous specific	Yes		Indigenous specific	Yes			
	Focus	Men's mental health and suicide prevention		Focus	Program description			
Uti Kulintjaku Project Meaning "to think and understand clearly". Conceived and led from within the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) in Central Australia. A series of workshops on mental health and culturally relevant well-being	Location(s)	Central Australia	Togni (2016) Developmental evaluation Data collected through ten 3- to 4-day workshops, as well as reflective practice, participant observation, and focussed discussion groups with participants, and 21 semi-structured, in-depth key stakeholder interviews.	Location(s)	Central Australia	• The program model was found to be useful in the way that it 'facilitates clear thinking, enables safe ways to talk about difficult issues related to mental health and wellbeing, and develops capacity to find new ways to respond to and address these issues' (Togni 2016:271). • Reported increased community control in addressing health outcomes. • Innovative community resources were developed, including the 'words for feelings map' poster that was mentioned in the National Children's Commissioner's 2014 Report 'as an effective resource to overcome language barriers for young people seeking help around mental health' (Togni 2016:274). • No data were provided on the impacts on suicide prevention, but evaluators deemed the program consistent with effort to 'suicide proof' Indigenous communities.		
	Participants			Participants	No specified			
	Duration			Duration	3 years			
	Indigenous specific	Yes		Indigenous specific	Yes			
	Focus	Bi-cultural understanding of mental health with a focus on language		Focus	Understanding the program model, exploring program outcomes and lessons learned			

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Evaluation outcomes
Yawuru Wellbeing Project Involved a process of developing specific wellbeing indicators and how these relate to non-Indigenous concepts in reporting frameworks of government and statistical agencies	Location(s)	Yawuru community, Broome	Yap and Yu (2016)	Location(s)	Yawuru community, Broome	Emergent themes of well-being: - Family and relatedness - Involvement in community - Connection to culture and country - Self-determination, rights and autonomy - Health and material well-being (including security and basic living standards) • The co-production of knowledge processes of the project resulted in increased community control in addressing health outcomes. • Creation of a community owned tool, the <i>Yawuru Wellbeing Survey</i>, with indicators specific to the community. • No data provided on the impacts on suicide prevention.
	Participants		Partnership between the Bankwest	Participants	Initial sample 200 persons (156 participated in the survey (63% women, 37% men)	
	Duration		Curtin Economics Centre, the ANU's Centre for Aboriginal Economic	Duration		
	Indigenous specific	Yes	Policy Research, the Kimberley Institute, and the Yawuru community	Indigenous specific	Yes	
	Focus	Culturally appropriate models of wellbeing	Interviews, focus groups, survey and presentation of research back to community.	Focus	Synthesis of experiences into wellbeing model and indicators.	

(continued)

Table B1 (continued): Program descriptions, methods and evaluations

Program	Program details		Evaluation	Evaluation details		Evaluation outcomes
United Health Education and Learning Program (UHELP) Partnership between headspace, Inala, Brisbane (the National Mental Health Foundation), and the SPAMHP. Developed under a community-based participatory research (CBPR) framework and with reportedly high levels of community oversight and cultural governance structures.	Location(s)	Inala, Brisbane	Skerrett et al. (2018) Griffith University. Mixed methods approach 14 pre and post session focus groups and Psychological measurements: K10, GHQ-28 Suicide items (GHQ-Suicide), RSES, and the WASC	Location(s)	Inala, Brisbane	- A statistically significant decrease in suicidal ideation was observed. - Participants reported or demonstrated an increased understanding of health (including holistic concepts). - There was an increase in referrals to headspace (service delivery centre). 'In the period immediately prior to the project (February to May 2013), the proportion of headspace Inala young people identifying as Aboriginal and/or Torres Strait Islander was 8.9%, this rose to 16.4% for the period following the program' (Skerrett et al. 2018:18).
	Participants	Delivered to nine groups of young people		Participants	61 participants completed the program. Data collected for 49 participants at 2 months after program completion.	
	Duration	1 year		Duration	1 year	
	Indigenous specific	Yes		Indigenous specific	Yes	
	Focus	Social and emotional wellbeing models and youth mental health and suicide		Focus	Assess impact of program on suicidal ideation	

Appendix C: Methods

See Table 1 for the PICO (participant, intervention, comparator, and outcome elements) criteria for considering programs in the literature review. See Table 2 for the databases and search terms used. Further programs and references were located through the reference lists of sources found in the search strategy, via a 'snowballing' process.

Table C1: Search strategy based on (PICO) elements

PICO elements	Description	Key words
Population (P)— Types of Participants	<i>Indigenous Australians.</i> The search strategy focused on programs in the Australian context. Sources from the United States, Canada, and New Zealand were found in the snowballing process. However, no programs from New Zealand appear in this article.	Australia Aboriginal Torres Strait Island*
Intervention (I)	<i>Programs that reported on aspects/factors of self-governance and self-determination.</i> Interventions conducted by non-Indigenous controlled or mainstream providers were included in cases where Indigenous direction and leadership was evident, through partnership or other arrangement. No exclusions were made regarding the methodologies used in the program evaluations/ descriptions.	Indigenous community control self determination self-governance community-controlled service organisation
Comparison (C)	No comparison or control was undertaken of programs that did not report on aspects/ factors of self-governance.	Not applicable
Outcomes (O)— Types of outcome measures	<i>Mental health and suicide prevention.</i> Outcomes of increased wellbeing, reductions in suicide and suicidal ideation, personal and community empowerment were considered. Though aspects of self-governance could be associated with a range of interventions, they were only considered and discussed in this article if they were explicitly related to Indigenous-specific mental health and suicide prevention.	suicide suicide prevention mental health Social and emotional wellbeing

Table C2: Databases and search terms

Database searched	Date run	Search terms (title, abstract or keywords)	Number returned
Web of Science	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" self determination	2
Web of Science	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community control	3
Web of Science	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community	18
Web of Science	27-Jan-21	indigenous "mental health" "suicide" community control service	6
Scopus	27-Jan-21	indigenous "mental health" "suicide" community AND control AND service	6
Scopus	27-Jan-21	indigenous "mental health" "suicide" community-control* AND service	1
Scopus	27-Jan-21	australia AND aboriginal "torres strait island*" "mental health" "suicide" community	20
Scopus	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community control	1
Scopus	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" self determination	1
Scopus	27-Jan-21	indigenous "mental health" "suicide" community-controlled AND organi*ation	1
Journal Storage (JSTOR)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" self determination	2
Journal Storage (JSTOR)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community control	5
Journal Storage (JSTOR)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community	5
Journal Storage (JSTOR)	27-Jan-21	indigenous "mental health" "suicide" community control service	1098
Journal Storage (JSTOR)	27-Jan-21	indigenous "mental health" "suicide" community-controlled service organi*ation "self-governance"	15
Australian Public Affairs Full Text (APA-FT)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" self determination	10
Australian Public Affairs Full Text (APA-FT)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community control	15
Australian Public Affairs Full Text (APA-FT)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community	23
Australian Public Affairs Full Text (APA-FT)	27-Jan-21	indigenous "mental health" "suicide" community control service	1071

(continued)

Table C2 (continued): Databases and search terms

Database searched	Date run	Search terms (title, abstract or keywords)	Number returned
Australian Public Affairs Full Text (APA-FT)	27-Jan-21	indigenous "mental health" "suicide" "community-controlled" program	949
Australian Public Affairs Full Text (APA-FT)	27-Jan-21	indigenous "mental health" "suicide" community-controlled service organi*ation "self-governance"	562
Informit	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" self determination	10
Informit	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community control	15
Informit	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community	23
Informit	27-Jan-21	indigenous "mental health" "suicide" community control service	1071
Informit	27-Jan-21	indigenous "mental health" "suicide" "community-controlled" program	949
Informit	27-Jan-21	indigenous "mental health" "suicide" community-controlled service organi*ation "self-governance"	562
PsychINFO (APA)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" self determination	3
PsychINFO (APA)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community control	2
PsychINFO (APA)	27-Jan-21	australia aboriginal "torres strait island*" "mental health" "suicide" community	19
Science Direct	1-Feb-21	Aboriginal OR Indigen OR "Torres Strait"; "mental health" AND "self-governance"	9
The Lowitja Institute	1-Feb-21	suicide	8



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Abbreviations

ACCHOs	Aboriginal Controlled Community Health Organisations
ABS	Australian Bureau of Statistics
AI GI	Australian Indigenous Governance Institute
AIHW	Australian Institute of Health and Welfare
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CBPATSI SP	Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
COAG	Council of Australian Governments
GHQ-28	General Health Questionnaire—28
GHQ-Suicide	General Health Questionnaire—Four-item suicidal ideation subscale
K10	Kessler-10
LGBTQI+SB	Lesbian, Gay, Bisexual, Transgender, Queer identifying and Intersex people + and Sistersgirls and Brotherboys
PHC	Primary Health Care
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSILMH	National Aboriginal and Torres Strait Islander Leadership in Mental Health
NPYWC	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council
PC CARES	Promoting Community Conversations About Research to End Suicide
RSES	Rosenberg Self-Esteem Scale
SMSC	Stories of most significant change
SPAMHP	Suicide Prevention and Mental Health Program
UHC	Universal health coverage
UHELP	United Health Education and Learning Program
UN	United Nations
WASC	Westerman Aboriginal Symptom Checklist
WHO	World Health Organization

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This paper provides a synthesis of relevant information on Aboriginal and Torres Strait Islander self-governance in relation to mental health and wellbeing. It also explores the ways in which self-governance is enabled by Indigenous organisations and how this also contributes to Indigenous wellbeing.



Stronger evidence,
better decisions,
improved health and welfare

