

**SOLUTIONS THAT WORK:
WHAT THE EVIDENCE
AND OUR PEOPLE TELL US**

**Aboriginal and Torres Strait Islander
Suicide Prevention Evaluation Project Report**



ATSIPEP



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Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report

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Acknowledgement

The ATSIPEP team acknowledges all Aboriginal and Torres Strait Islander peoples who contributed their time and shared their stories for this project.

The ATSIPEP team also acknowledges the support of our partner organisations, the Telethon Kids Institute and the Healing Foundation.



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Aboriginal and Torres Strait Islander readers are advised that this publication may contain images or information on deceased persons.

30 June 2016

Minister the Hon. Nigel Scullion
Minister for Indigenous Affairs
Parliament House
Canberra ACT 2600

Dear Minister,

We are pleased to present this Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Final Report in accordance with the contractual agreement between the University of Western Australia and the Commonwealth Department of the Prime Minister and Cabinet.

The Report summarises the evidence-base for what works in Indigenous community-led suicide prevention, including responses to the social determinants of health that are 'upstream' risk factors for suicide. It also presents tools to support Indigenous suicide prevention activity developed by the project. Through these, we hope you agree that ATSISPEP has placed Indigenous suicide prevention activity on a firm foundation. The ATSISPEP Team believes that this Report should be considered by all Government agencies, particularly in relation to social and cultural determinants of health. The tools related to planning, assessment and evaluation should be considered by all parties involved in suicide prevention, including the Primary Health Networks, particularly in relation to the implementation of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

In closing, the ATSISPEP team extends thanks and appreciation to you and your staff for support during development stages and throughout the project. The team also would like to acknowledge the support provided by the staff of the Department of the Prime Minister and Cabinet.

Yours sincerely,

the ATSISPEP Senior Management Team



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GLOSSARY

AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ACCHSs	Aboriginal Community Controlled Health Services
AMHFA	Aboriginal Mental Health First Aid
ATAPS	Access to Allied Psychological Services
ATSIMHSPAG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
ATSISEPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
Cultural determinants	Promote a strength based approach using strong connections to culture and country to build identity, resilience and improved outcomes
Cultural safety	An environment which is safe for Indigenous people with shared respect, shared meaning, shared knowledge and experience, and dignity
Healing Foundation	Aboriginal and Torres Strait Islander Healing Foundation
IAS	Indigenous Advancement Strategy
Indicated interventions	Activities aimed at individuals who have been identified as at risk of suicide, or who have attempted suicide
Indigenous	Used in this report predominantly to refer to Aboriginal and Torres Strait Islander people. Where used to refer to Indigenous people of other nations, this is specifically addressed
Intervention	An action or provision of a service to produce an outcome or modify a situation
LGBTQI	People identifying as Lesbian, Gay, Bisexual, Transsexual, Queer or Intersex
LiFE Framework	Living is For Everyone (LiFE) Framework
NATSILMH	National Aboriginal and Torres Strait Islander Leadership in Mental Health
NATSISPS	National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
NGO	Non-government Organisation
NHLF	National Health Leadership Forum
NMHC	National Mental Health Commission
NSPS	National Suicide Prevention Strategy
PHN	Primary Health Network
Postvention	Interventions to support and assist those bereaved by suicide
Primary prevention	Activity to prevent a completed suicide or a suicide attempt occurring but in the context of an Indigenous community-wide approach
Primordial prevention or interventions	Aim to prevent the risk factors for suicide and include interventions addressing upstream risk factors
PTSD	Post Traumatic Stress Disorder
QAIHC	Queensland Aboriginal and Islander Health Council
Selective interventions	Activities aimed at groups who are identified as being at higher risk of suicide
SEWB	Social and Emotional Wellbeing
Social determinants of health	The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life (WHO)
SPA	Suicide Prevention Australia
TATS	Taking Action to Tackle Suicide
TKI	Telethon Kids Institute
Trauma informed care	Strengths based framework grounded in an understanding of and responsiveness to the impact of trauma, emphasising physical, psychological and emotional safety for providers and survivors
Universal interventions	Usually refers to a suicide prevention activity aimed at the whole and 'well' population. In this report, 'universal' activity and interventions are defined as Indigenous community-wide activity and preventions (rather than those targeting the whole Indigenous population)
WHO	World Health Organisation

EXECUTIVE SUMMARY

Indigenous suicide is a significant population health challenge for Australia. Suicide has emerged in the past half century as a major cause of Indigenous premature mortality and is a contributor to the overall Indigenous health and life expectancy gap. In 2014 it was the fifth leading cause of death among Indigenous people, and the age-standardised suicide rate was around twice as high as the non-Indigenous rate.¹ In this report, the term 'Indigenous' is predominantly used to refer to Aboriginal and Torres Strait Islander people. Where used to refer to Indigenous people of other nations, this is specifically addressed.

Indigenous children and young people are particularly vulnerable,² comprising 30% of the suicide deaths among those under 18 years of age.³ In addition, Indigenous 15–24 year olds are over five times as likely to suicide as their non-Indigenous peers.⁴ 'Suicide clusters', or a series of suicide completions and/or self-harming acts that occur within a single community or locale over a period of weeks or months, is also a significant concern, particularly among younger people.⁵

As males represent the significant majority of completed Indigenous suicides, gender can also be understood as a risk factor. However, the number of suicides and increasing self-harm among Indigenous females is an ongoing concern.⁶

National responses to general population suicide began in the 1990s and include the current *1999 National Suicide Prevention Strategy* (NSPS).⁷ Within the latter, the *Living is For Everyone (LiFE) Framework* is an evidence-based national strategic policy framework for suicide prevention. In May 2013, the first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (NATSISPS) was launched.⁸

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) arose from Indigenous community members, leaders in mental health and suicide prevention and the Australian Government who shared an intention that the implementation of the NATSISPS, and the funds pledged towards it, should be impactful and should reduce suicide in Indigenous communities. The parties also shared concern that more formal approaches should be adopted to identify a sufficiently robust evidence-base on which NATSISPS implementation could proceed.

There is surprisingly little evidence about what works in general population suicide prevention, let alone an Indigenous-specific prevention. In 2013 following an extensive literature review, the National Mental Health Commission (NMHC) noted in its *National Report Card on Mental Health Services and Suicide Prevention* that, "in terms of what works for suicide prevention, we are only just starting to scratch the surface."⁹ This is further magnified in an Indigenous context. The 2013 Close the Gap Clearinghouse's *Strategies to Minimise the Incidence of Suicide and Suicidal Behaviour*, which focused on Indigenous suicide prevention programs, showed that few programs had been suitably evaluated. The publication concluded that there was a need for significant further research into Indigenous suicide prevention and for service and program evaluation.¹⁰

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) is an important Australian Government response to the above. This report summarises the work of ATSISPEP in expanding the evidence-base for what works in Indigenous community-led suicide prevention and is based on:

- Twelve Indigenous community, risk group and subject-matter-specific suicide prevention Roundtable Consultations that took place across Australia over March 2015 – April 2016
- A literature review on what works in community-led Indigenous suicide prevention
- An analysis of 69 previous consultations on Indigenous suicide prevention that took place across Australia between the years 2009 and 2015, and that involved 1,823 participants¹¹
- An analysis of other credible and relevant sources, including the *Access to Allied Psychological Services (ATAPS) Operational Guidelines for Indigenous Suicide Prevention Services*, and state and territory general population suicide prevention strategies
- Key themes and recommendations from the inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference held in Alice Springs on 5–6 May 2016.

A potential set of success factors was identified from the above activities and provided a foundation for a major project deliverable: a meta-evaluation of evaluated, community-led, Indigenous suicide prevention programs. A summary of the success factors identified by ATSISPEP is set out on page three of this report.

Consistent with the LiFE Framework, the success factors are organised into three levels of activity or intervention (universal, selected and indicated) and then further categorised to indicate responses for particular risk groups.

The three levels of intervention are:

- **Universal interventions** Usually aimed at the whole and 'well' population, this report defines 'universal' activity and interventions as Indigenous community-wide activity and preventions (rather than those targeting the whole Indigenous population). Within this level **primordial prevention**, or interventions that aim to prevent the risk factors for suicide, is critical. These approaches address the 'upstream' risk factors for suicide such as alcohol and drug use reduction, family dysfunction, and other challenges to wellbeing that might face communities. These 'upstream' responses might also involve promoting healing and strengthening resilience in individuals, families and communities by strengthening social and emotional wellbeing and culture. **Primary prevention** aims to prevent a completed suicide or a suicide attempt occurring but in the context of this report it is from an Indigenous community-wide approach. Primary prevention can, for example, include community education to support help-seeking behaviour among those in the community who suffer with problems that affect their mental health and wellbeing.
- **Selective interventions** These interventions are aimed at groups who are identified as being at higher risk of suicide. As already outlined above, Indigenous children and young people accounted for 30% of the total (Indigenous and non-Indigenous) suicide deaths under 18 years of age over 2007–2011.¹² In addition, Indigenous 15-24 year olds are more than five times as likely to suicide as their non-Indigenous peers.¹³ As such it is important to tailor selective responses to the right age groups.
- **Indicated interventions** These interventions are aimed at individuals who have been identified as at risk of suicide, or who have attempted suicide. For these people, the accessibility of services could be a life-saving issue. Optimally, support should be available 24 hours a day, 7 days a week to ensure a person receives therapeutic treatment as soon as possible. In addition to time protocols, a culturally safe service environment and access to Indigenous or culturally competent staff for Indigenous people in a vulnerable state may also be important to the success of an intervention or response.

A common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and 'lived experience' elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers. In addition, the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time.

The ATSIPEP project generated the following tools and resources for use by Indigenous communities along with stakeholders, government, organisations and funding agencies such as Primary Health Networks, to support Indigenous suicide prevention activity:

- An Evaluation Tool for evaluating proposals for Indigenous suicide prevention activity
- A Community Tool to support the development of Indigenous suicide prevention activity
- An Evaluation Framework for Indigenous suicide prevention activity for use by communities, government and Primary Health Networks
- Interactive maps showing Indigenous suicide numbers and rates by postcode
- Fact Sheets
- Discussion papers

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

In practice, the involvement of Elders cannot be separated from community leadership and this is particularly so for cultural elements in responses. Elders are best placed to ensure that interventions meet cultural governance and that responses in general are delivered within a cultural framework.

Generally, suicide prevention activity should aim to employ community members. Peer-to-peer context is a common feature of several successful programs, particularly those aimed at young people. Such an approach provides an opportunity for suicide prevention activity to address community unemployment rates and to create culturally relevant jobs and long-term employment for community members.

The success factors identified by ATSIPEP are summarised in the following table, organised by level of intervention as discussed above. All of the ATSIPEP reports can be accessed at www.atsispep.sis.uwa.edu.au

SUMMARY TABLE OF SUCCESS FACTORS IDENTIFIED BY ATSIPEP

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

UNIVERSAL/ INDIGENOUS COMMUNITY- WIDE In this report 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates	Primordial prevention	<ul style="list-style-type: none"> Addressing community challenges, poverty, social determinants of health Cultural elements – building identity, SEWB, healing Alcohol /drug use reduction
	Primary prevention	<ul style="list-style-type: none"> Gatekeeper training – Indigenous-specific Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy Reducing access to lethal means of suicide Training of frontline staff/GPs in detecting depression and suicide risk E-health services/internet/crisis call lines and chat services Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	School age	<ul style="list-style-type: none"> School-based peer support and mental health literacy programs Culture being taught in schools
	Young people	<ul style="list-style-type: none"> Peer-to-peer mentoring, and education and leadership on suicide prevention Programs to engage/divert, including sport Connecting to culture/country/Elders Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	Clinical elements	<ul style="list-style-type: none"> Access to counsellors/mental health support 24/7 availability Awareness of critical risk periods and responsiveness at those times Crisis response teams after a suicide/postvention Continuing care/assertive outreach post ED after a suicide attempt Clear referral pathways Time protocols High quality and culturally appropriate treatments Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	Community leadership/ cultural framework	<ul style="list-style-type: none"> Community empowerment, development, ownership – community-specific responses Involvement of Elders Cultural framework
	Provider	<ul style="list-style-type: none"> Partnerships with community organisations and ACCHS Employment of community members/peer workforce Indicators for evaluation Cross-agency collaboration Data collections Dissemination of learnings

This Report concludes with recommendations for government and other activity pertaining to Indigenous suicide prevention. It is relevant to a range of stakeholders working in Indigenous suicide prevention including (but not limited to) Indigenous communities, Aboriginal Community Controlled Health Services, Aboriginal Medical Services, Community Mental Health Services and Primary Health Networks.

ATSISPEP RECOMMENDATIONS

(see full details on page 56)

General recommendations for future Indigenous suicide prevention activity	1 All future Indigenous suicide prevention activity should: <ul style="list-style-type: none"> utilise and/or build upon the range of success factors identified by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project include a commitment to, and a provision for, the evaluation of the activity and the dissemination of findings to further strengthen the evidence-base.
	2 All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.
	3 Justice reinvestment principles should be used to secure additional funding for a range of upstream diversionary activity for Indigenous young people away from the criminal justice system. This could include programs to support young people and families, sport or other activities, or by enhancing access to quality education and employment. Justice reinvestment principles should also be used to fund improvements to Indigenous mental health and alcohol and other drug services and programs.
	4 Governments should support the training, employment and retention of Indigenous community members/people as mental health workers, peer workers and others in suicide prevention activity. In particular, Indigenous young people should be supported and trained to work in suicide prevention activity among their peer group.
	5 All mental health service provider staff working with Indigenous people at risk of suicide and within Indigenous communities should be required to achieve Key Performance Indicators (KPIs) in cultural competence and the delivery of trauma informed care. These services should also be required to provide a culturally safe environment.
	6 Preparatory work should immediately commence to develop suicide prevention activities specific to the needs of those who have suffered child sexual abuse, and specifically in preparation for the release of the findings of the Royal Commission into Institutional Responses to Child Sexual Abuse.
	7 Indigenous people identifying as LGBTIQI should be represented on all Australian Government and other Indigenous mental health and suicide prevention advisory forums.

Recommendations on the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy	8 A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan should be developed and funded, utilising the findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.
	9 Service agreements between the Australian Government and the Primary Health Networks should contain Key Performance Indicators that require demonstration of cultural capabilities and standards, and representation of Indigenous communities on boards, community advisory committees and clinical councils. This is in part to facilitate effective engagement and partnership with Indigenous communities at key junctures of the NATSISPS implementation process and including the development of suicide prevention needs assessments, commissioning of services and programs, and evaluation of existing programs.
	10 Aboriginal Community Controlled Health Services remain the preferred facilitators of suicide prevention activity to their communities, including the provision of primary mental health care services. This includes the delivery of programs and services funded to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy through the Primary Health Networks.
	11 The ATSIPEP Assessment Tool for assessing Indigenous suicide prevention activity should be used to support the evaluation of applications for National Aboriginal and Torres Strait Islander Suicide Prevention Strategy funding to ensure conformity with the findings of the ATSIPEP.
	12 The Success Factors identified by ATSIPEP should be included in the systems approach to suicide prevention when applied in Indigenous community settings. This should occur in consultation with Indigenous mental health and suicide prevention leaders, and in partnership with the communities concerned.
Disseminating and building on the findings of ATSIPEP	13 The ATSIPEP findings, tools and resources should be broadly disseminated and included in Australian Government portals.
	14 An Indigenous-led national clearinghouse for best practice in Indigenous suicide prevention activity should be established. This should be tasked to maintain the currency of ATSIPEP tools and resources over time.
	15 Participatory action research is the preferred methodology for future suicide prevention research in Indigenous communities.
	16 A National Aboriginal and Torres Strait Islander Suicide Prevention Conference should be funded and held every two years.
	17 Resources should be made available to enable local Aboriginal and Torres Strait Islander communities to undertake critical response activities for their local communities with relevant stakeholders. Outcomes of the UWA Critical Response Project can inform these approaches.

INTRODUCTION: WHY ATSIPEP?

Indigenous suicide as a national concern

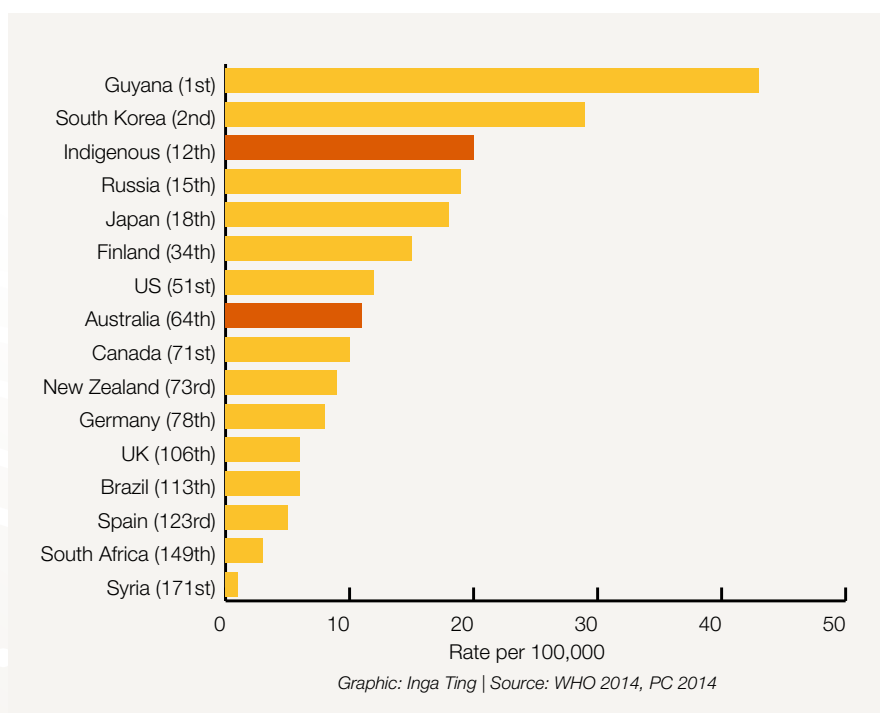
ATSIPEP is an Australian Government funded initiative to identify the success factors that underpin successful Indigenous suicide prevention activity. It addresses the concerning emergence of suicide in the past half century as a major cause of Indigenous premature mortality and a contributor to the overall health and life expectancy gap.

Indigenous suicide was almost unheard of prior to the 1960s.¹⁴ Yet in 2014 it was the fifth leading cause of death among Indigenous people, and the age-standardised suicide rate was around twice as high as the non-Indigenous rate.¹⁵ To place this in a wider context, Chart 1 (below) shows that in 2012 the World Health Organisation (WHO) ranked Indigenous Australian suicide (shown as 'Indigenous') as 12th highest when compared to the world's nations, while Australia (which includes Indigenous and non-Indigenous) ranked 64th.¹⁶ It should be noted that Chart 1 does not distinguish the rankings of Indigenous people of other nations.

Critically, there has been no significant improvement between 1998 and 2012 in the formally recorded rates in New South Wales (NSW), Queensland (Qld), Western Australia (WA), South Australia (SA) and the Northern Territory (NT) (where data is deemed reliable).¹⁷ From 2001 to 2010, approximately 100 Indigenous people died by suicide each year in Australia¹⁸, and the situation appears to be getting worse. In 2012, 117 Indigenous suicides were reported;¹⁹ in 2013 the number was 138;²⁰ and in 2014 it was 143.²¹

Indigenous suicide is a significant population health challenge for Australia.

CHART 1: Global suicide rates with Indigenous Australia and Australia ranked separately against selected countries

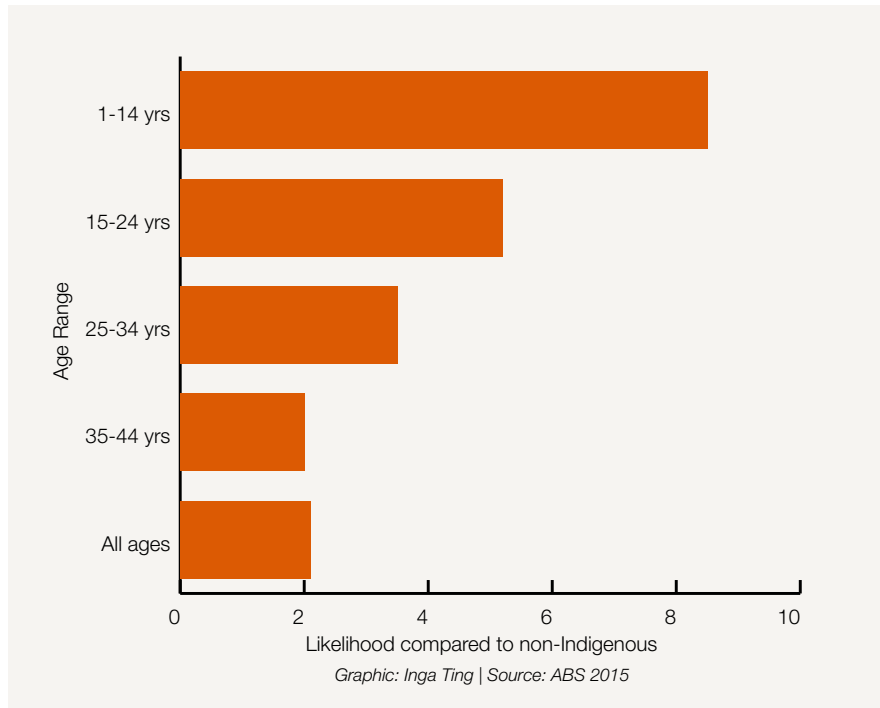


Source Hunter and Ting, 2016

What is known about Indigenous suicide?

As illustrated by Charts 2 and 3 (below) Indigenous children and young people are significantly more vulnerable to suicide when compared to the non-Indigenous population. When examining suicide deaths among combined Indigenous and non-Indigenous people under 18 years of age over 2007–11, Indigenous children and young people accounted for 30% of the suicide deaths despite comprising only 3 to 4% of the population of that age group.²² Indigenous 15–24 year olds are over five times as likely to suicide as their non-Indigenous peers.²³

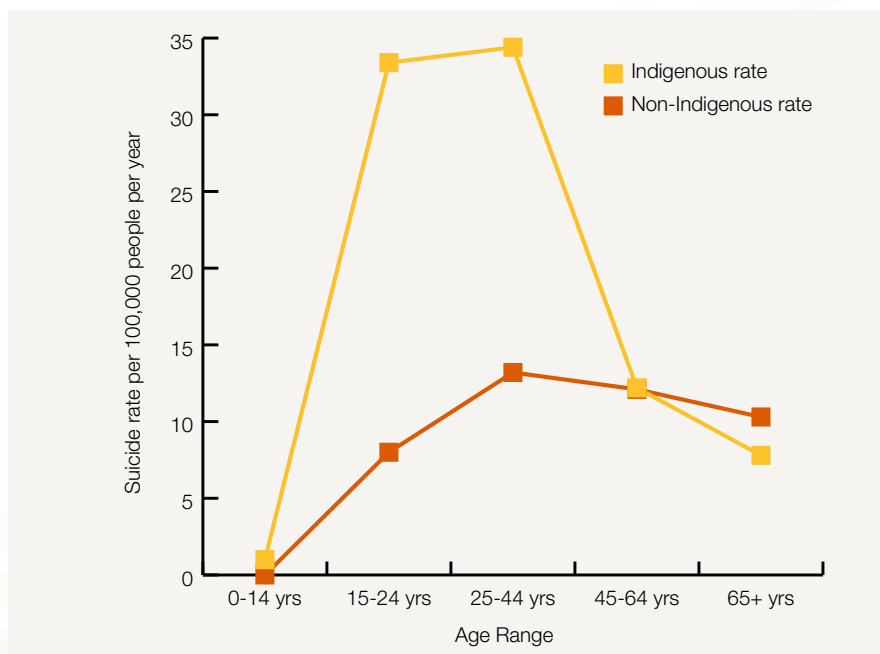
CHART 2: Likelihood of Indigenous Australians dying by suicide when compared to non-Indigenous persons, by age groups, 2008–12



Source Hunter and Ting, 2016²⁴

Overall, the peak age range for suicide is 30–34 years for Indigenous males and 20–24 years for Indigenous females.²⁵

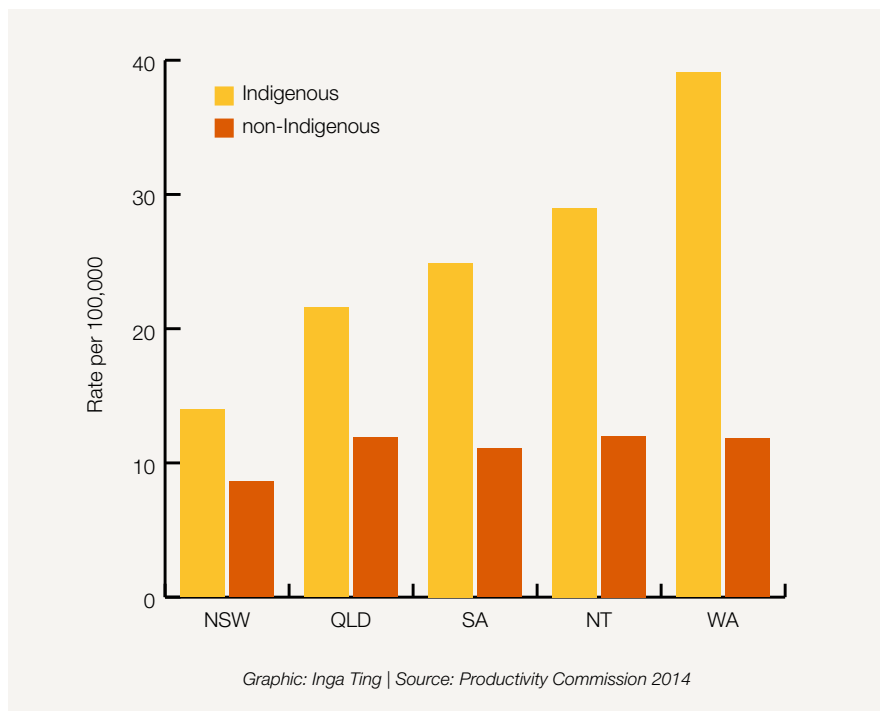
CHART 3: Rate of suicide per 100,000 – Indigenous compared to non-Indigenous persons, by age groups, 2001–12



Source: ATSIPEP²⁶

The national Indigenous suicide rate obscures significant differences between states and territories, as well as age groups. Chart 4 (below) shows that Western Australia had the highest suicide rate in Australia between 2008 and 2012, with 35.2 suicides per 100,000, compared with 11.4 per 100,000 in NSW.²⁷ But a further breakdown by jurisdiction shows the Northern Territory's Indigenous 25 to 34-year-olds had the nation's highest suicide rate over 2008 to 2012. Among this age group in the Northern Territory, the suicide rate was 68.9 per 100,000.²⁸

CHART 4: Indigenous and non-Indigenous suicide by jurisdiction, 2008–12



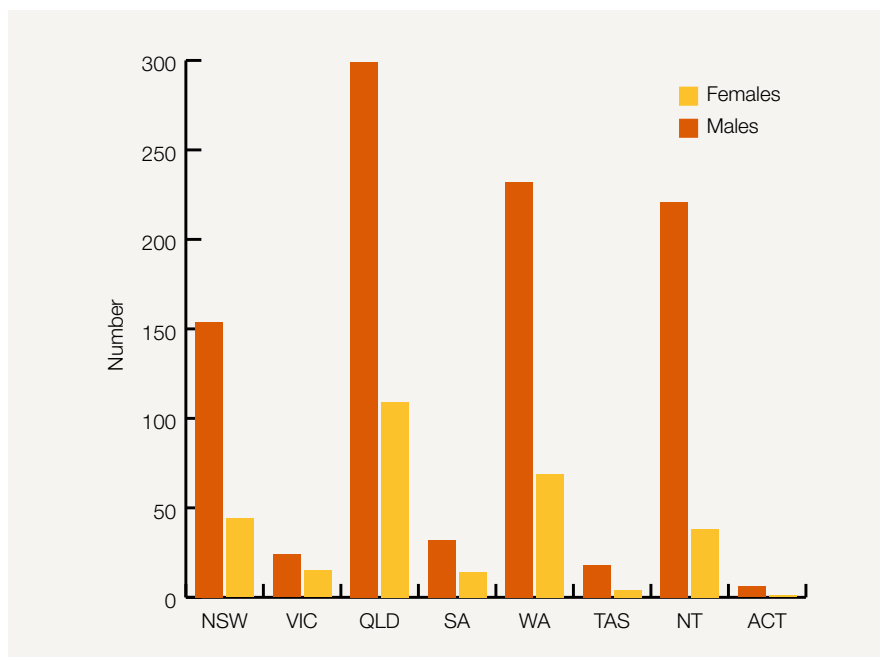
Source: Hunter and Ting, 2016²⁹

Chart 5, developed on the basis of a statistical analysis undertaken by ATSISEEP, illustrates Indigenous suicides over 2001–12 by state and territory and by gender. The significant majority of completed Indigenous suicides by males suggests that gender can be understood as a risk factor.³⁰ Overall, males accounted for 77% of Indigenous suicide deaths. However, this ratio varied quite considerably across the states and territories, from 61.5% male in Victoria to over 85% male in the Northern Territory and the Australian Capital Territory.

The number of suicides among Indigenous females is also an ongoing concern. Of the 143 deaths of Indigenous people due to suicide in 2014, 102 were male and 41 were female (approximately 28%), with girls as young as ten having completed suicide in recent years.³¹ The age-standardised death rate for suicide was approximately twice as high for both males and females when compared to their non-Indigenous peers (rate ratios of 1.9 and 2.1 respectively).³² As noted over 2001–10, the highest rate of suicide among Indigenous females was in the 20–24 age group (21.8 deaths per 100,000 population), five times the non-Indigenous female rate for that age group.³³ Hospitalisation rates for intentional self-harm for Indigenous people increased by almost 50% from 2004–05 to 2012–13, while the rate for other Australians remained relatively stable. Rates are significantly higher among Indigenous females than males; in 2012–13, 1502 Indigenous women were hospitalised compared to 1034 Indigenous males.³⁴

It should be noted that these numbers are likely to significantly under-represent the rates of self-harm among Indigenous young people. A 2004 general population study into self-harm among year 10 and 11 school students reported that only 10.3% of acts of self-harm resulted in hospitalisation, and that otherwise adolescents under-reported or failed to recognise behaviour as self-harm. The study also provided strong evidence for the prevalence of contagion or 'copycat' self-harm.³⁵

CHART 5: Indigenous suicide by jurisdiction, by gender, 2001–12



Source: ATSIPEP

As discussed in the ATSIPEP Literature Review, Hunter and Harvey offer two compounding explanations for the preponderance of suicide in young Indigenous males – first, they are overrepresented as vulnerable to suicide risk factors (e.g. alcohol abuse and traumatic exposure, as discussed below) and second, they are the product of wider disadvantage and carry deeper issues of loss of cultural identity and cultural continuity (which would otherwise be a protective factor against suicide) as described below.³⁶

The ATSIPEP Literature Review also discusses the phenomenon of ‘suicide clusters’ in remote Northern Queensland Indigenous communities as described by Hunter et al. The term refers to a series of suicide completions and/or self-harming acts that occur within a single community or locale over a period of weeks or months. What is driving such events is believed to be ‘copycat’ phenomena where a single suicide inspires peers to model this behaviour.³⁷

Hanssens’ investigation into suicide clusters in the Northern Territory from 1996–2006 identified contagion as a strong predictor of Indigenous suicide in Indigenous communities – with hanging, in particular, as a behavioural contagion. Hanssens urged for intervention to address the potential for suicide clusters in communities as she recognised it as an important aspect of any overall response to Indigenous suicide.³⁸ The 2010 Hidden Toll Report of the Senate Community Affairs References Committee into Suicide in Australia recommended the ‘timely distribution of suicide data from coroners’ offices regarding suicides to allow early notification of emerging suicide clusters to public health authorities and community organisations’³⁹, and this also a recommendation of the ATSIPEP Discussion Paper on the topic. The Hidden Toll Report also referred to the need to implement postvention services to Indigenous communities following a suicide to reduce the risk of further suicides occurring.⁴⁰

Of significant concern is the high level of suicidality among those who have experienced child sexual abuse. The Hon. Justice Peter McClellan, Chair of the Royal Commission into Institutional Responses to Child Sexual Abuse, has spoken of the high proportion (around 45%) of child sexual abuse occurring in out of home care including orphanages, children’s homes or foster care,⁴¹ and this has likely affected a high proportion of Indigenous children. The impacts of child sexual abuse are lifelong and include ‘suicide, ... parenting difficulties and intergenerational trauma’⁴².

The lifelong risk of suicide associated with child sexual abuse (40 times higher for females and 14 times higher for males compared with those who have not experienced child sexual abuse⁴³) indicates that no single preventative strategy will be sufficient, rather there is a need for ongoing access to services. Early intervention is essential, and may be assisted by the addition of trauma modules to parenting programs.

Child sexual abuse impacts determinants of health which can also contribute to suicidality. Whilst a complex connection, child sexual abuse is associated with poor educational outcomes⁴⁴ and hence lowered employability, alcohol and other substance misuse⁴⁵, re-victimisation⁴⁶ and high rates of criminal offences and subsequent custodial sentences. Female victims of child sexual abuse have been shown to be 6.71 times more likely to be charged with an offence than those who have not experienced child sexual abuse, and male victims 4.34 times more likely.⁴⁷

Also of concern is suicide among Indigenous lesbian, gay, bisexual, transgender, queer-identifying and intersex (LGBTQI) people. While there is little specific data available, the ATSIPEP LGBTQI Roundtable Consultation highlighted the intersection of Indigenous and LGBTQI status, both known risk factors for suicide, and suggests this group is particularly vulnerable. While further research is needed, a 1998 national report on youth mental health services and Indigenous lesbian, gay, bisexual and transgender clients reported mental health issues associated with increased HIV infections, suicide and alcohol and drug use among this group.⁴⁸

POLICY CONTEXT – RESPONSES TO SUICIDE AND INDIGENOUS SUICIDE

National responses to general population suicide began with the 1995 *Here for Life* national youth suicide strategy and the current 1999 *National Suicide Prevention Strategy* (NSPS). Within the latter, *Living is For Everyone* (LiFE) is an evidence-based national strategic policy framework for suicide prevention. It identifies eight domains of suicide prevention activity at three levels of intervention:

- **universal** – aimed at the whole population
- **selective** – aimed at groups and communities who are identified as being at higher risk of suicide
- **indicated** – aimed at individuals at risk of suicide.⁴⁹

'Universal' defined in this report

In this report, 'universal' responses are defined as Indigenous community-wide responses rather than a response targeting the whole Indigenous population.

There are specific outcomes, action areas, measures and indicators in the LiFE framework.⁵⁰

In accordance with the NSPS, the National Suicide Prevention Program funds dedicated suicide prevention activities. In 2011–12 the Taking Action to Tackle Suicide (TATS) package to enhance the NSPS was announced. To 2015–16, the total TATS investment is \$292.4 million.⁵¹ The main elements of the package were to:

- Provide more services to those at greatest risk of suicide – including psychological and psychiatric services through the Access to Allied Psychological Services (ATAPS) program as well as non-clinical support to assist people with severe mental illness and their carers with their day-to-day needs
- Invest more in direct suicide prevention and crisis intervention, including through boosting the capacity of counselling services such as Lifeline and providing funding to improve safety at suicide 'hotspots'
- Provide more services and support to men – who are at greatest risk of suicide but least likely to seek help
- Promote good mental health and resilience in young people, to prevent suicide later in life.⁵²

The 2014 National Mental Health Commission Review of Mental Health Programs and Services identified \$68.8 million Commonwealth funding provided for suicide prevention in 2012–13. Around 12.7% (\$8.7 million) was for Indigenous suicide prevention.⁵³ This included dedicated funding provided through the ATAPS program as discussed in Text Box 1 (below).

TEXT BOX 1: ATAPS Tier 2 programs for Indigenous people, including for suicide prevention

Under ATAPS, funds were provided to Medicare Locals (now Primary Health Networks or PHNs) to contract with, or employ, local allied mental health professionals to provide Focused Psychological Strategies on a fee-for-service basis. The expanded ATAPS program referred to in the text was funded by \$36.5 million over five years to support an additional 18,000 Indigenous clients overall. Through this, ATAPS became a two-tier scheme that included Indigenous-specific referral pathways to:

- *Culturally competent mental health services.* Cultural competence training is provided by the Australian Indigenous Psychologists Association as part of this component of the program.
- *Culturally competent suicide prevention services.* In addition to other requirements, allied mental health service providers are required to have completed training in providing culturally acceptable suicide prevention counselling to Aboriginal and Torres Strait Islander people to qualify as providers for these services.

The Aboriginal and Torres Strait Islander Mental Health Advisory Group (now subsumed into the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group – ATSIMHSPAG) worked with the then Department of Health and Ageing to develop Operational Guidelines for Indigenous-specific Tier 2 ATAPS services.⁵⁴

In 2012–13, the age-standardised rate of ATAPS consumers among Aboriginal people was 831 per 100,000 population, which was over 3 times that of non-Indigenous Australians, suggesting the success of the program at least in terms of accessibility.⁵⁵ The National Mental Health Commission's (NMHC) national review of mental health services and programs described the model as having great promise, although more work at promoting the ATAPS Tier 2 program was required.⁵⁶

In the Australian Government's 2015 response to the NMHC national review, it was announced that ATAPS funding was to be pooled for the commissioning of primary mental health services by Primary Health Networks.

In May 2013, the first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (NATSISPS) was launched. NATSISPS was developed by the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group (now subsumed into a Commonwealth ministerial advisory body: the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG)). The Australian Government pledged \$17.8 million over four years to the Strategy. NATSISPS identifies six broad action areas:

- Building strengths and capacity in Aboriginal and Torres Strait Islander communities
- Building strengths and resilience in individuals and families
- Targeted suicide prevention services
- Coordination of approaches to prevention
- Building the evidence-base and disseminating information
- Standards and quality in suicide prevention.⁵⁷

NATSISPS complemented the National Suicide Prevention Strategy (NSPS) by providing a framework for Indigenous-specific responses to suicide that account for Indigenous experiential and cultural differences, and for ensuring general population responses were respectful of such differences.

In the Australian Government's 2015 response to the National Mental Health Commission Review of Mental Health Programs and Services, a renewed approach to suicide prevention was signalled, which included refocused efforts to prevent suicide in Indigenous communities. Further, Primary Health Networks (PHNs) were given a key role in the planning and commissioning of community-based mental health and suicide prevention activity. In particular, PHNs have been tasked with identifying Indigenous communities within their region that may be at high risk of suicide, and to liaise with local Indigenous-specific organisations, as well as mainstream service providers at a regional level, to help plan, integrate and target local mental health and suicide prevention funding. It is also expected that PHNs will support the implementation of culturally appropriate activity, guided by the goals and actions identified within the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.⁵⁸

Funding for Indigenous-specific suicide prevention activity is an ongoing component of Commonwealth suicide prevention investment under the new National Suicide Prevention Strategy, announced as part of the Government's response to the National Mental Health Commission Review of Mental Health Programs and Services. The funding, originally pledged to implement the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, is now an ongoing commitment and equates to approximately \$6.3 million per annum, to be rolled out from 2016–17. The sum comprises approximately \$5.6 million per annum allocated to the PHN mental health and suicide prevention flexible funding pool and approximately \$0.7 million per annum for national Indigenous-specific activity.⁵⁹

BACKGROUND TO ATSIPEP

ATSIPEP arose from Indigenous community members, leaders in mental health and suicide prevention and the Australian Government who shared an intention that the implementation of the NATSISPS, and the funds pledged towards it, should be impactful and should reduce suicide in Indigenous communities.

While NATSISPS was developed on the basis of a nationwide consultation with Indigenous community members, experts and stakeholders (this is discussed further in this report), parties agreed that more formal approaches should be adopted to identify a sufficiently robust evidence-base on which NATSISPS Implementation could proceed.

There is surprisingly little evidence about what works in general population suicide prevention, let alone in Indigenous-specific prevention. In 2013 following an extensive literature review, the National Mental Health Commission (NMHC) noted in its National Report Card on Mental Health Services and Suicide Prevention that, 'in terms of what works for suicide prevention, we are only just starting to scratch the surface.'⁶⁰

This evidence-base gap is only magnified in an Indigenous context. Prior to ATSIPEP, the 2014 *Elders' Report into Preventing Indigenous Self-harm & Youth Suicide*⁶¹ and the 2013 Menzies School of Health Research paper *Towards a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy – Consultation Paper for Community Forums*,⁶² commissioned by the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group to the then Commonwealth Minister of Health and Ageing, listed several dozen examples of Indigenous suicide programs, most generated by Indigenous communities in response to suicide among their members, and young people. The 2013 Close the Gap Clearinghouse's *Strategies to Minimise the Incidence of Suicide and Suicidal Behaviour*, which focused on Indigenous suicide prevention programs, showed that few programs had been properly evaluated. The publication concluded there was a need for significant further research into Indigenous suicide prevention and for service and program evaluation.⁶³

A further challenge was posed by the studies of Chandler and Lalonde who examined suicide among British Columbian (Canadian) First Nations' young people. Their findings have been broadly considered to be applicable in an Indigenous Australian context. Two Chandler and Lalonde studies, which focus on the protective effects against suicidal behaviours of what was coined 'cultural continuity', are discussed in Text Box 2 (below).

TEXT BOX 2: Cultural continuity and the research of Chandler and Lalonde

Chandler and Lalonde examined cases of suicide among young First Nations people of British Columbia and the protective effects of 'cultural continuity' against suicide.

In their first study (1987–92) cultural continuity was defined according to six key indicators of self-determination and cultural maintenance:

- Achievement of a measure of self-government
- Have litigated for Aboriginal title to traditional lands
- Accomplished a measure of local control over health
- Accomplished a measure of local control over education
- Accomplished a measure of local control over policing services
- Had created community facilities for the preservation of culture.

Chandler and Lalonde mapped suicides in all 197 communities or 'bands' in British Columbia and found that communities that achieved all six markers had no cases of suicide among young First Nations people. Conversely, where communities achieved none of these protective markers, youth suicide rates were many times higher than the national average (Chandler and Lalonde, 1998).

A second study (1993–2000) included two other indicators and found similar results to those of the first study. The additional indicators were:

- A measure of local control over child welfare services
- That they are characterised by having elected band councils composed of more than 50% women (Chandler and Lalonde, 2008).

If thematic elements can be drawn from the Chandler and Lalonde studies, the first is community empowerment: supporting communities' agency to make real choices and change their experience for the better. This could be through education and awareness raising, the emergence of leadership and decision-making structures, the devolution of decision-making power to such structures, and the presence of services and support organisations to assist in achieving goals and/or the provision of resources. Cultural maintenance and renewal was another thematic element. More broadly, the studies suggested that primordial prevention – upstream interventions that may have little directly to do with suicide as such – had an important place in Indigenous suicide prevention.

In fact, the work of Chandler and Lalonde has already influenced suicide prevention activity in Australian Indigenous communities. In particular, the ongoing National Empowerment Project (NEP) that aims to empower communities through education in identifying and addressing challenges (including those associated with suicide) and supporting community capacity for self-governance and organisation to address those challenges. Echoing Chandler and Lalonde's work, the NEP also places a strong emphasis on leveraging cultural strengths and supporting a community's cultural renewal on its own terms.^{64,65}

NATSISPS also reflected the above. It highlighted the need for investment in upstream prevention efforts in addition to the universal, selective and indicated responses in general population suicide prevention for those at risk of suicide.⁶⁶ In particular, it promoted community-led, empowerment-based approaches to Indigenous suicide prevention, as well as Indigenous culture as a source of protection against suicide risk.

ATSISPEP's primary aim then was to identify the success factors in the approaches promoted in NATSISPS and that were already being utilised in Indigenous suicide prevention activities around Australia. From this, two deliverables were to be developed:

- Tools for communities, stakeholders and governments to use when evaluating suicide prevention activity, or proposal assessment, to ensure that NATSISP implementation pledged funding was optimally invested
- A suite of Indigenous community resources for suicide prevention including a tool to support the development of suicide prevention activities.

To that end, the ATSIPEP project description is presented in Text Box 3 (below).

TEXT BOX 3: ATSIPEP Project Description

1. The development of an evidence-base for what works in (Indigenous) suicide prevention. This will be achieved through an evaluation of suicide prevention programs identified through this project and community consultations
2. The development of a culturally appropriate evaluation framework, including interactive maps of places experiencing high rates of suicide and the availability of services
3. The development and testing of a community resource tool. It will be tested in selected communities and submitted for endorsement by the ATSIPEP National Advisory Committee
4. A final report that will summarise the Project and make recommendations to Government
5. A National Suicide Prevention Conference.

The ATSIPEP project will include community consultations and/or targeted forums with the following:

- Indigenous communities in the Kimberley (Western Australia), Darwin (Northern Territory), Mildura (Victoria), Cairns (Queensland), Adelaide (South Australia), Shoalhaven area (New South Wales) and other regions agreed to by the Commonwealth.
- Targeted national cohorts including (Indigenous) youth, people recently re-entering communities following incarceration, people identifying as gay, lesbian, bisexual, transgender, queer and intersex, and targeted forums to include crisis response experts, clinical experts (psychologists, AOD experts, etc.), statistics and data experts.

This final report, identified as a deliverable in point 4 above, summarises the success factors and what works in Indigenous suicide prevention (point 1). It also collates the tools and resources developed by ATSIPEP including those mentioned at points 2 and 3. It concludes with recommendations for future Indigenous suicide prevention activity.



PART **1**

**SUCCESS FACTORS FOR
INDIGENOUS SUICIDE PREVENTION**

Summary table of success factors identified by ATSIPEP

Success factors for Indigenous suicide prevention, with those identified in the meta-evaluation of evaluated community-led Indigenous suicide prevention programs in [blue font](#).

UNIVERSAL/ INDIGENOUS COMMUNITY- WIDE In this report 'universal' is used to indicate community-wide responses, not population-wide or responses as the term usually indicates	Primordial prevention	<ul style="list-style-type: none"> Addressing community challenges, poverty, social determinants of health Cultural elements – building identity, SEWB, healing Alcohol/drug use reduction
	Primary prevention	<ul style="list-style-type: none"> Gatekeeper training – Indigenous-specific Awareness raising programs about suicide risk/use of DVDs with no assumption of literacy Reducing access to lethal means of suicide Training of frontline staff/GPs in detecting depression and suicide risk E-health services/internet/crisis call lines and chat services Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	School age	<ul style="list-style-type: none"> School-based peer support and mental health literacy programs Culture being taught in schools
	Young people	<ul style="list-style-type: none"> Peer-to-peer mentoring, and education and leadership on suicide prevention Programs to engage/divert, including sport Connecting to culture/country/Elders Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	Clinical elements	<ul style="list-style-type: none"> Access to counsellors/mental health support 24/7 availability Awareness of critical risk periods and responsiveness at those times Crisis response teams after a suicide/postvention Continuing care/assertive outreach post ED after a suicide attempt Clear referral pathways Time protocols High quality and culturally appropriate treatments Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	Community leadership/ cultural framework	<ul style="list-style-type: none"> Community empowerment, development, ownership – Community-specific responses Involvement of Elders Cultural framework
	Provider	<ul style="list-style-type: none"> Partnerships with community organisations and ACCHS Employment of community members/peer workforce Indicators for evaluation Cross-agency collaboration Data collections Dissemination of learnings

OVERVIEW OF METHODOLOGY

Descriptions of methodology and specific success factors identified in each process can be found in the Appendices. Appendix 3 covers success factors identified in the Roundtables, Literature Review, previous consultations, National Conference and other credible sources. Appendix 4 covers the meta-evaluation process. From this, a synthesis of success factors were identified as set out in Appendix 1 and upon which the summary table of success factors is based. Success factors that were indicated in the meta-evaluation presented in the Summary Table in blue font for ease of identification.

Consistent with the LiFE Framework, the success factors are organised into three levels of activity or intervention (universal, selected and indicated) and then further categorised to indicate responses for particular risk groups. In addition, common elements are included that are relevant at all three intervention levels.

DISCUSSION ABOUT THE SUCCESS FACTORS IDENTIFIED IN THE META-EVALUATION

Universal (Indigenous community-wide) approaches

Primordial prevention

Critical to preventing Indigenous suicide is understanding the traumatic disruption of colonisation on communities, cultures and families which are sources of social and emotional wellbeing⁶⁷ to Indigenous people.

Whilst 'decolonisation' may not be considered complete by many Indigenous Australians, it is in the decades in which the process toward decolonisation began that rates of Indigenous suicide increased. As discussed in the ATSISEPP Literature Review, the process can be dated to the 1950s and 1960s with the closing of reserves, and the end of formal legally encoded racial discrimination.

So why would this result in increased suicide? Firstly, because, in practice, Indigenous people remained excluded from the benefits of social and economic life and the material and other resources available to the wider population (in particular, housing, employment, education, health services and political influence). In other words, the end of legally supported discrimination did little to practically improve the desperate conditions of many Indigenous Australians. On the other hand, it did enable Indigenous people to access welfare and alcohol without restriction.

In particular, Hunter and Milroy⁶⁸ contend this combination led to widespread dysfunction in Indigenous communities. This period preceded the rapid increase in suicide rates of Indigenous people in the 1980s who were born into a state of what they describe as 'normative instability', where alcohol abuse and dysfunction were layered upon trauma and distress in a broader context of deep poverty and social, economic and political exclusion.

This summary provides the background for discussing universal (community-wide) primordial suicide prevention in relation to three interrelated challenges:

- specific community challenges, poverty, social determinants of health
- cultural factors – building identity, SEWB, healing
- alcohol/drug use reduction

These three interrelated issues can be compounding. For example, without the protective factors provided by social and emotional wellbeing, negative cycles involving exposure to social determinants, mental health problems, and at-risk health behaviours (such as alcohol and other drug use) are evident among too many Indigenous communities. All are risk factors for suicide.

Addressing community challenges, poverty, social determinants of health

'Deep and persistent disadvantage' characterises a disproportionate number of Indigenous communities today. It is a term coined by the Productivity Commission to classify the socioeconomic status of population groups in relation to 29 indicators across seven key life domains (including material resources, employment, education and skills, health and disability, social connection, community and personal safety). The Productivity Commission found that in 2010, 9.1% of Indigenous people were estimated to suffer deep and persistent social exclusion in Australia, compared to approximately 5% in the general population.⁶⁹

Social and emotional wellbeing (SEWB)

For Indigenous peoples, health itself is not understood as the concept often assumed by non-Indigenous people, rather it is a culturally informed concept, conceived of as 'social and emotional wellbeing' – a term that is increasingly used in health policy but in this context carries a culturally distinct meaning: it connects the health of an Indigenous individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine.

Australian governments have responded with affirmative action policies since the 1970s. Of note are the 2008 *Closing the Gap Strategy* and the *Indigenous Advancement Strategy* (IAS) that operate out of the Department of the Prime Minister and Cabinet. The IAS aims to support the Closing the Gap Strategy with a particular focus on increasing school attendance, employment and community safety.

Detrimental social determinants of health and disadvantage, however, persist. In Indigenous communities such conditions are associated with poorer mental health and higher exposure to traumatic and stressful life events with resulting psychological distress and trauma (as described in points directly below) that is, in turn, associated with suicide:

- In the Australian Bureau of Statistics (ABS) 2012–13 *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS), 73% of respondents reported that they, their family or friends had experienced one or more stressful life events in the previous year,⁷⁰ being 1.4 times the rate reported by the non-Indigenous population.⁷¹ The most frequently reported stressful life events were death of a family member or friend (37% of respondents), serious illness (23%), inability to get a job (23%).⁷²
- Researchers report that 1.9 – 2.6 overlapping stressful life events are associated with mild or moderate psychological distress, with between 2.6 and 3.2 events associated with high or very high psychological distress.⁷³
- Of the AATSIHS respondents, 30% were assessed with having high or very high psychological distress levels in the four weeks before the survey using the Kessler K-5 assessment,⁷⁴ a modified version of the K-10 assessment.⁷⁵ The rate was nearly three times the non-Indigenous population rate from comparable surveys.⁷⁶
- A 2009 study reported that those with high and very high psychological distress measured by the Kessler K-10 scale were 21 and 77 times more likely, respectively, to be experiencing suicide ideation.⁷⁷

Upstream approaches that aim to address detrimental social determinants are an important foundation response to suicide. Examples are discussed in Text Box 4 (below).

TEXT BOX 4: Addressing specific community challenges, poverty, social determinants of health

- The *Family Wellbeing* program in Queensland supports Indigenous people's capacity to regain social and emotional wellbeing and begin to rebuild the social norms of their families and community. It successfully operationalises the links between empowerment at the personal/family, group/organisational and community/structural levels and provides mechanisms to address Indigenous social and emotional wellbeing issues such as family violence and abuse, suicide prevention and incarceration.
- The *National Empowerment Project (NEP)* is an Aboriginal-led community empowerment project that works with Indigenous communities to develop, deliver and evaluate a program to promote positive social and emotional wellbeing (SEWB), address some social determinants of health and reduce suicide. Using participatory action research, the NEP engaged eight Indigenous communities across Australia in 2012–13, and a further three sites in 2013–14, to identify risk and protective factors influencing mental health and social and emotional wellbeing; and to develop strategies to respond to these issues through a focus on individuals, families and communities, using a SEWB reference framework.

The NEP has a dual aim of increasing resilience and reducing the instances of psychological distress and suicide among Indigenous people by the promotion of positive SEWB factors, and empowering communities to take affirmative action to address the social determinants that contribute to psychological distress, suicide and self-harm. This is carried out with strong Aboriginal governance using a community-led and community-based model.

Cultural elements – building identity, SEWB, healing

According to Milroy, Dudgeon and Walker⁷⁸ the first step in re-establishing strong healthy communities is to acknowledge and understand the devastating and enduring impact of the colonial legacy on Indigenous people's contemporary lives. It also requires an understanding of the various pathways necessary for healing from historical trauma, using both cultural and contemporary understandings and processes to support social and emotional wellbeing. This includes dealing with loss, grief and disconnection, trauma and helplessness, powerlessness and lack of control. It requires self-determination and community governance, reconnection and community life, restoration and community resilience. Examples are discussed in Text Box 5.

TEXT BOX 5: Cultural elements – building identity, SEWB, healing

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

Alcohol/drug use reduction

Researchers estimate that men with alcohol dependence and those who drink at levels of risk have 6 times increased risk of suicide, and similar drinking levels for women results in an even higher risk of suicide.⁷⁹ Among Indigenous Australians, Chikritzhs et al. found suicide to be the most common cause of alcohol-related deaths among Indigenous males and the fourth most common cause among females.⁸⁰

Alcohol abuse is a symptom of wider Aboriginal and Torres Strait Islander disadvantage which Hunter et al. describe as a 'lifestyle of risk'.⁸¹ In 2012–13, 14% of Indigenous Australians reported experiencing a family stressor related to alcohol problems. After adjusting for differences in the age structure of the two populations, Indigenous Australians were 3.6 times more likely to report a stressor relating to alcohol or drug-related problems than non-Indigenous Australians. In 2012–13, 54% of Indigenous Australians exceeded the single occasion guidelines (binge drinking) at least once in the last twelve months (19% weekly and 35% less than weekly). After adjusting for differences in the age structures of the two populations, this was 1.1 times the non-Indigenous rate. Rates of binge drinking were higher for Indigenous males (64%) than females (44%). Indigenous Australians living in non-remote areas were more likely to binge drink at least once in the last 12 months than those living in remote areas (55% compared with 48%); while rates for binge drinking at least once per week were 20% in remote areas and 18% in non-remote areas.⁸²

Using the 24 hour dietary recall data from the AATSIHS, we can see a lower proportion of Indigenous adults in remote areas reported consuming alcoholic beverages compared with Indigenous adults in non-remote areas (14% compared with 20%). However, the median amount of alcoholic beverages consumed by Indigenous adults was higher in remote areas (1,717 grams) than non-remote areas (1,007 grams). So while a lower proportion of Indigenous people in remote areas consumed alcoholic beverages compared to Indigenous people in urban areas, Indigenous people in remote areas were more likely to drink larger amounts when they did consume alcoholic beverages.⁸³ Indigenous people were admitted to hospital for acute intoxication at around 12.1 times the rate for the non-Indigenous population – with the highest rates in remote and very remote areas.⁸⁴ Examples of reduction in alcohol and drug use in the context of suicide prevention are discussed in Text Box 6.

TEXT BOX 6: Reducing alcohol and drug use

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

Primary prevention

Gatekeeper training

Gatekeeper training has been implemented and studied in many populations including military personnel, public school staff, peer helpers, clinicians, and with Indigenous people. It involves teaching specific groups of people in the community how to identify and support individuals at high risk of suicide and has been evaluated in several systematic studies. In particular, Clifford *et al.* identified four studies that had evaluated gatekeeper training. Three of the studies reported post-training increases in knowledge of suicidal risk behaviours, and confidence and/or willingness to assist individuals at risk of suicide. Measuring the long-term effects of gatekeeper training two years later, Deane *et al.* found improvements in knowledge and confidence were sustained, however, the relationship between intention and actually helping at-risk people was weak after this time period. None of the studies evaluating gatekeeper training measured changes in suicide or suicidal behaviour.⁸⁵

Examples of Indigenous gatekeeper training are discussed in Text Box 7.

TEXT BOX 7: Gatekeeper training

- *Suicide Story* in the Northern Territory, was adapted from the Mental Health Association of Central Australia's Life Promotion Program (LPP) and in particular its two-day Living Works ASIST workshop (Applied Suicide Intervention Skills Training). In consultation with Aboriginal people and other related services, the LPP team developed Indigenous-specific resources and a training known as *Suicide Story*. Over seven years the content and delivery of the program has been reworked and adjusted through a continuous cycle of participatory action research and quality improvement processes based on feedback from facilitators and participants. The program incorporates the use of a DVD consisting of short films that feature the voices of Indigenous people, combined with animation, artwork, music, pictures/posters to generate scenarios, and a focus on conversations/discussion.
- *Aboriginal Mental Health First Aid (AMHFA)*, a National training program, has been shown to be effective in developing knowledge about symptoms and behaviours linked with help seeking. This has been used in many contexts. For example, a critical part of the National Empowerment Project facilitator training was in AMHFA.⁸⁶

Awareness-raising programs about suicide/use of DVDs with no assumption of literacy

A systematic review by Clifford *et al.* examined interventions aimed at increasing public awareness of suicide to reduce suicide in various contexts. One approach was to deliver awareness-raising material to Indigenous people across varying age groups and from different social backgrounds via multimedia technology. This resulted in modest improvements in participant knowledge of suicide risk factors but did not measure changes in behaviour.⁸⁷

Some of the programs used awareness raising and the use of DVDs as part of a range of responses in addressing suicide in communities. Examples are discussed in Text Box 8.

TEXT BOX 8: Awareness raising /use of DVDs with no assumption of literacy

- The Queensland Aboriginal and Islander Health Council (QAIHC) Suicide Prevention Project: *Lighting the Dark* worked with local communities to raise individual, family and community capacity to be able to identify and respond to suicide. QAIHC identified the importance of increasing knowledge and awareness of suicide, its risk factors and symptoms, and appropriate strategies and interventions to assist people at risk.
- Part of *Alive and Kicking Goals* training in Western Australia involves a DVD. In evaluation, many of the participants reported that the narrators of the DVD were people they could identify with and that the content was relevant to their communities. While struggling with literacy, all participants noted positive changes occurred for the questions to varying degrees indicating the DVD's impact on attitudes and knowledge.
- Many programs use DVDs to convey information to a specifically Indigenous audience (e.g. *Suicide Story*, *UHELP*, *Aboriginal Mental Health First Aid*).

Selective – at-risk groups focusing on young people

Peer-to-peer mentoring

Several evaluated Indigenous Australian programs highlight the importance of peer-to-peer support in suicide prevention – both in the context of gatekeeper training and more broadly. Unlike peer support programs in the general population, those in an Indigenous community are able to leverage peer-to-peer cultural obligations and responsibilities of care and support. Examples are discussed in Text Box 9 (below).

TEXT BOX 9: Peer-to-peer mentoring

In the *Warra-Warra Kanyi (WWW): Mt Theo Program*, the youth mentor is an active collaborator in the care of appropriate clients (with primary care responsibilities remaining with the WWW counsellor). Youth mentors will often have genuine, direct, honest and insightful advice on preventative behaviours, coping strategies and positive pathways. Peer status is particularly powerful and important in Warlpiri youth culture. Through kinship and ceremonial systems, Warlpiri youths have formal obligations and responsibilities of care and protection towards certain other youth. Each person is in a particular relationship with another and there is an appropriate peer to provide validated and skilful support. The same kind of support may not be accepted from a different peer (or indeed an older person, or other mental health professional) because they are not a trusted or appropriate person to deliver this support.

- Several programs utilise peer-to-peer support (e.g. *GREATS Youth Services (GYS)* Maningrida, NT; *Alive and Kicking Goals!* WA, *EK Youth Services Network*, WA).

Programs to engage/divert including sport

Sport as a mechanism to engage youth has demonstrated success across a range of programs. Sport can be used to promote teamwork and respect for rules, maintain physical fitness and enhance self-esteem. Such programs can also provide an opportunity to directly connect youth with their sporting role models, locally and nationally in some instances. Examples are discussed in Text Box 10 (below).

TEXT BOX 10: Programs to engage/divert including sport

- *Alive and Kicking Goals!* (WA), aims to prevent Indigenous youth suicide through use of football and peer education. Volunteer youth leaders, who are well-respected sportsmen, undertake training to become peer educators. In a sporting context, they educate young people about suicide prevention and lifestyle, and demonstrate that seeking help is not a sign of weakness.
- An important step in developing the *Warra-Warra Kanyi: Mt Theo Program* in the early 1990s was creating a seven day and night youth diversionary service in Yuendumu offering sports, art, bush trips and discos to keep Warlpiri youth entertained and engaged. In 2003 there was a deepening of the basic youth program beyond an entertainment and diversion focus incorporating education, training, cultural activities, mentoring, leadership and career pathways. The success of these activities stimulated youth diversionary programs in Willowra (2005), Nyirripi (2008) and Lajamanu (2009). Similar to the growth of the Yuendumu youth program, these services grew from an initial solid diversionary base to broader, more comprehensive youth development programs including training, education, employment and leadership outcomes as well as crisis response, education, group project work and bush trips.
- Diversion elements are also used in the programs developed by the GREATS (Great Recreation, Entertainment, Arts, Training and Sport) Youth Services, Maningrida NT (in partnership with the NT Juvenile Justice Department and including a school holiday program).

Connecting to culture/country/Elders

There are several promising examples of Elder-driven, on-country healing programs for youth to help them become stronger and think differently about themselves. Such examples highlight the need for continued support for Elders in maintaining and passing on their cultural knowledge to young people. These are discussed in Text Box 11 (below).

TEXT BOX 11: Connecting to culture/country/Elders

- The *Yiriman Project* (WA) aims to 'build stories in young people' and keep young people alive and healthy by reacquainting them with country. It hosts 'back to country trips' where young people, Elders, community members and stakeholder groups are brought together. Stakeholder groups include land care workers, educationalists, health practitioners, researchers and government officials. The Yiriman model is a means of providing young people with opportunities to participate more fully in life through community events and a range of other events.
- In the *Warra-Warra Kanyi: Mt Theo Program*, (NT) Elders are involved as support persons. An Elder – Senior Cultural Advisor plays an important outreach and support role to the Mt Theo Outstation and to other Warlpiri communities including the development of culturally relevant Warlpiri mentoring and counselling resources.

Indicated – at risk individuals

Access to counsellors/mental health support

There are associations between mental health problems such as high and very high psychological distress, trauma and depression:

- Trauma refers to experiences and symptoms associated with particularly intense and stressful life events (including natural disasters, injuries, child sexual abuse or violent assault) that overwhelm a person's ability to cope.⁸⁸ Responses can range from chronic disassociation to psychotic breakdown and post-traumatic stress that can be diagnosed as Post Traumatic Stress Disorder (PTSD).⁸⁹ As covered in the ATSIPEP Literature Review, a 2012 study of 271 WA Indigenous community residents found that almost all (97.3%) participants had been exposed to traumatic events. The same group of participants also had a lifetime prevalence of 55.2% for PTSD, 20% for depression, and 73.8% of participants met diagnostic criteria for alcohol abuse or dependence.⁹⁰ Trauma is also associated with suicide. A 2006 study associated trauma and suicidal ideation in a sample of approximately 750 West Kimberley Indigenous adolescents and young people. The study found that in comparison to the non-Indigenous sample, Indigenous adolescents reported significantly increased exposure to direct trauma (trauma occurring to self) and secondary trauma (witnessing trauma occurring to others). Indigenous adolescents were four times more likely than non-Indigenous adolescents to have a family member die by suicide (29% Indigenous compared to 8% non-Indigenous). Multiple regression analysis revealed suicidal ideation and previous suicide attempts were significantly predicted by exposure to direct trauma and PTSD.⁹¹
- Researchers estimate that people with major depression have a 20 times increased risk of suicide.⁹² In the AATSIHS, 12% of respondents reported feeling depressed or having depression as a long-term condition compared to 9.6% in the general population.⁹³ Over 2008–13, depression was the most frequently reported mental health related problem managed by GPs for Indigenous clients, followed by anxiety, and then use of tobacco, alcohol and other drugs.⁹⁴

Due to associations between trauma, depression and mental health issues, the indicated programs that were the subject of the meta-evaluation necessarily involved a counselling or mental health support element. However, gatekeeper training, peer-to-peer mentoring programs and other universal (primary prevention) and selective programs require participants to be able to connect at-risk individuals to mental health and support services. Some incorporate counselling as a key program element – as discussed in Text Box 12 (below).

TEXT BOX 12: Access to counsellors/mental health support

- A success factor in the *Warra-Warra Kanyi: Mt Theo Program* is the engagement of a permanent, locally based, qualified counsellor with tertiary qualifications. The counsellor's role includes the development of client care plans, identifying and implementing coping strategies, identifying and accessing sources of support, monitoring and managing risk, and exploring the deeper causes and triggers for the issues in a young person's life.
- *UHELP* (Inala, QLD) Action Learning Model provides culturally appropriate counselling and culturally safe places to deliver services at headspace Inala. There has been a significant increase in referral rates to headspace Inala since the UHELP program began.

24/7 availability and awareness of critical risk periods and responsiveness

The *Warra-Warra Kanyi: Mt Theo Program* is an example of a service that is built around patterns of suicidal behaviour at the community level and so does not operate as a standard 9 to 5 business.

- A counsellor is expected to be available to community members at all times, day or night, weekends, and public holidays (with clear on-call protocols covered by other appropriate staff members during periods of annual leave).
- Critical periods or situations when suicide risk is likely to be present have been identified over many years of work in the community. This predictive knowledge is crucial in developing an understanding of a 'local calendar' for suicidal behaviours. It also supports the effective allocation of staff, resources, and preventive activity with families and peers and external agencies such as the police.

Crisis Response teams after a suicide/postvention

In the ATSISEPP Literature Review, Hunter *et al.* describe the phenomenon of suicide clusters in remote Northern Queensland Indigenous communities (although the phenomena is not restricted to communities there). This term refers to a series of suicide completions and/or self-harming acts that occur within a single community or locale over a period of weeks or months. What is driving such events is believed to be a 'copycat' phenomena where a single suicide – usually by hanging – inspires peers to model this behaviour.⁹⁵

Addressing the potential for suicide clusters in communities is an important aspect of any overall response to Indigenous suicide and is discussed in Text Box 13 (below).

TEXT BOX 13: Crisis response teams after a suicide/postvention

- The *National StandBy Response Service* is a postvention program located in 17 Australian regions. It provides postvention support to communities impacted by suicide. StandBy has also developed a short-term Critical Postvention Response (CPR). This brief rapid response model is intended for communities where there are concerns about the high incidence of suicide and its effects on the community. ATSISEPP is currently trialling a CPR model in Aboriginal communities in Western Australia as part of the Critical Response Project.

Common elements

Community empowerment, development, ownership – Community specific responses

Responses to Indigenous suicide require Indigenous leadership and family and community engagement to be effective. Responses need to address cultural and 'lived experience' elements, and involve Indigenous people in service design and delivery as mental health consumers. Indigenous people's right to self-determination (or self-governance) in matters that impact upon them, including suicide prevention, must be respected.

For Indigenous people, empowerment has come to be recognised as an important element of any strategic response that aims to address community challenges. Empowerment can counteract the pervasive disempowerment that followed colonisation, and it is an important intermediate step in addressing community challenges. Its potential in enabling multiple flow-on benefits that go beyond addressing a particular issue is also recognised.

Ensuring the community initiates and/or drives the process is important if particular outcomes are to be achieved. Empowerment can occur only as communities create their own momentum, gain their own skills, and advocate for their own changes. For this reason, initiatives such as the National Empowerment Project have a strong foundation in community education on social and emotional wellbeing as they give communities the tools to organise their thinking about their situation and respond to it. Providing places and ways for people to physically come together to support this capability may also be required. In a feuding community this will necessitate other steps to ensure the parties are able to meet and communicate in a constructive manner.

Governments and service providers must be able to respond, in turn, to a community's priorities with the necessary programs and services. In some cases this might simply be a case of connecting communities to existing programs, in other instances working across sectors and pooling resources to establish new programs may be required.

Further, governments must accept that empowering interventions cannot be fully shared or standardised across communities as interventions need to reflect local needs. This requires that Government operates in a new way of thinking and working with communities if it is to appropriately support communities. A commitment to funding over the longer term is also required for cumulative impact to accrue without interruption, and for that impact to be sustained.

The National Empowerment Project and Family Wellbeing programs are described in Text Box 4 and are examples of empowerment-based approaches.

Involvement of Elders

In practice, the involvement of Elders in programs cannot be separated from community empowerment-based approaches, provision of cultural elements in programs, or cultural governance of programs within a cultural framework. Two examples of Elder involvement in program design and delivery are discussed in Text Box 14 (below).

TEXT BOX 14: Involvement of Elders in suicide prevention activity

- The *Mowanjum Connection to Culture* program (WA) was a response by the Elders of the Mowanjum community to address their concern for their young people, with the belief that connection to culture and country and a strengthening of Indigenous identity would be a source of wellbeing and resilience.
- In the *Warra-Warra Kanyi: Mt Theo Program*, (NT) Elders are involved as support persons, by the employment of an Elder as a Senior Cultural Advisor. The role provides cultural supervision and advice, particularly for the non-Warpiri staff. Elders also play an important role in the development of culturally relevant Warpiri mentoring and counselling resources.

Cultural framework / partnership approaches

One advantage of community-led approaches is the knowledge that activity will be developed within a cultural framework. For general population programs that wish to be more responsive to Indigenous community needs, working within a cultural framework under cultural governance is a positive step as illustrated by examples in Text Box 15 (below).

TEXT BOX 15: Operating in partnership/in a cultural framework

- The *Wesley LifeForce Suicide Prevention Training for Indigenous Community Workers* (National) is an adaptation of an existing mainstream suicide prevention program led by experienced Aboriginal community consultants using culturally responsive and reciprocal learning processes.
- *Headspace Inala* (QLD) is located in a region with a significantly large and culturally strong Indigenous community. There is strong local leadership within the community from the Inala Elders. Historically, there has been a proportionally high rate of Indigenous youth suicide. To ensure accessibility to Indigenous young people, Headspace Inala was required to adopt a partnership approach with local communities and develop a cultural governance mechanism. In addition to improving accessibility, this approach demonstrated to local Indigenous communities that the knowledge and wisdom of the community and its Elders was valued. Governance processes were designed to fit with existing community oversight structures. Taking a cultural governance approach also increased the commitment from the community for the project. A Youth Advisory Group (YAG) was established to guide the project that consisted of local Indigenous young people who were already associated with either headspace Inala, or were Future Leaders with the Inala Elders Suicide Prevention and Mental Health Program. This group participated in and provided feedback into the SEWB group program content including processes and approaches to engaging with and supporting project participants.

Employment of community members/peer workforce

The importance of peer-to-peer support in the context of Indigenous youth suicide prevention is discussed above. Generally, suicide prevention activity should aim to employ community members and provide them with training (and/or upskilling) as appropriate. For example, in the *Mowanjum Connection to Culture* program (referred to above) a community member is trained and employed to manage the digital archive. In this way, suicide prevention activity can also be used to address community unemployment rates and to create culturally relevant jobs and long-term employment for community members. See Text Box 16 (below) for an example.

TEXT BOX 16: Employment of peer workforces

Alive and Kicking Goals! (AKG!) (WA) aims to prevent Indigenous youth suicide through use of football and peer education. The program was developed in response to high rates of suicide experienced among young people in the Kimberley, Western Australia. It is community-developed and led, and was built on the popularity of football and the peer relationships that can develop from playing the game. In this context, AKG! enhances the capacity of community members to address suicide and its risk factors through suicide awareness and prevention education.

Volunteer youth leaders, who are well-respected sportsmen, undertake training to become peer educators. They educate young people in communities about suicide prevention and lifestyle, and demonstrate that seeking help is not a sign of weakness.

TEXT BOX 17: Aboriginal Community Controlled Health Services as platforms for universal suicide prevention programs and indicated services

Aboriginal Community Controlled Health Services (ACCHSs) initiated, operated and controlled by Aboriginal communities were established to deliver holistic, comprehensive, and culturally appropriate health care, aligned to the social and emotional wellbeing concept. The health services are now largely funded by the Commonwealth Department of Health. In 2013–14, ACCHSs had 323,000 Indigenous clients against an estimated resident Aboriginal population of 713,300 (in June 2014).⁹⁶ This suggests that services provided by ACCHSs were accessed by almost half (about 40–45%) of the Aboriginal and Torres Strait Islander population.⁹⁷

The 1997 *Bringing Them Home Report* highlighted the mental health impacts of the historical practice of forcibly removing mixed race Aboriginal infants and children from their families in order to assimilate them into non-Indigenous society.⁹⁸ Elements of a national response include mental health (counselling), social and emotional wellbeing, and family reconnection services largely delivered through ACCHSs.

In the 2011–12 Federal Budget, the Australian Government announced that a single Social and Emotional Wellbeing (SEWB) Program would be created to consolidate these activities.⁹⁹ This is now delivered under the Department of the Prime Minister and Cabinet's *Indigenous Advancement Strategy*. The revised *SEWB Program: Handbook for Counsellors* highlights that counselling is just one type of healing activity that may be provided to consumers, with other supports including yarning circles, healing camps, outreach services and case management.¹⁰⁰

ACCHSs increasingly enable access to mental health professionals at the same time as providing ideal platforms for the delivery of universal suicide prevention programs, such as the National Empowerment Project.¹⁰¹

When properly funded, ACCHSs are also in a position to provide indicated responses. In 2013–14, 40.9% of services reported self-harm and suicide as an issue that was presenting at their services.¹⁰² Yet from these services only 38.1% were able to offer onsite access to psychiatrists and 64.7% access to offsite psychiatrists; 56.8% offered onsite access to psychologists and 48.2% offsite.¹⁰³ Of the 206 Australian Government funded Indigenous primary health care organisations, including ACCHSs, that reported in 2013–14, 55% reported service gaps for mental health and social and emotional wellbeing needs.¹⁰⁴



PART **2** **A**

**TOOLS TO SUPPORT INDIGENOUS
SUICIDE PREVENTION ACTIVITY**

1. A TOOL FOR ASSESSING INDIGENOUS SUICIDE PREVENTION ACTIVITY

This tool, presented in the form of a five-part flow chart, is designed to be used in the evaluation of proposals for Indigenous suicide prevention activity including, but not limited to, the work of the Primary Health Networks and state- and territory-level activity as appropriate. It is also designed to empower Indigenous communities to assess proposals for suicide prevention activity in their communities and ensure activity is aligned with the success factors identified in this report and the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. It is based on the Quality Indicators set out in Appendix 2.

1. HAS A STRONG/URGENT, UNMET NEED FOR SUICIDE PREVENTION ACTIVITY BEEN ESTABLISHED IN A COMMUNITY SETTING?

This is a primary evaluative measure and overriding consideration. If there is a high need for suicide prevention activity, the *high risk of not funding responses against the risk of funding a less than optimal response* based on a rigid application of the indicators in the other parts of the framework should be considered.

ASK THE FOLLOWING QUESTIONS:

1. IS THERE EVIDENCE OF NEED/ ONGOING NEED FOR SUICIDE PREVENTION ACTIVITY?

CONSIDER THE EVIDENCE FOR:

- suicide
- suicide clusters
- suicide attempts
- suicidal thinking
- self-harm
- risk factors for suicide (e.g. mental illness, depression, drug and alcohol use)
- concentrations of high-risk groups for suicide and corresponding risk factors for suicidal behaviours (i.e. young people, LGBTQI)

The evidence that is required should be approached flexibly – data, anecdotal reports, coronial inquests, community identification of need should all be considered.

2. IS THERE A COMMUNITY CONSENSUS THAT SUICIDE PREVENTION-ACTIVITY IS REQUIRED?

CONSIDER:

- Is there a representative governance structure/ health service or other body that is in a position to provide a consensus opinion?

3. ARE THERE SERVICES AND PROGRAMS ALREADY RESPONDING APPROPRIATELY TO THE SITUATION?

CONSIDER:

- What is the community's assessment of these services? Have you asked?
- Are you able to assess if a service is likely to be adequate or not? A major consideration should be whether it is culturally appropriate for the community. Otherwise refer to the quality indicators below.
- If the community does not believe the service to be adequate, could the service be improved in partnership with the community?

TAKING ALL THE ABOVE INTO ACCOUNT

IF A STRONG/URGENT, UNMET NEED FOR SUICIDE PREVENTION ACTIVITY HAS BEEN ESTABLISHED

PROCEED



IF THERE IS NO STRONG/URGENT, UNMET NEED FOR SUICIDE PREVENTION ACTIVITY THAT CAN BE ESTABLISHED

DO NOT PROCEED

2. ESTABLISH THAT THE COMMUNITY IS LEADING THE DEVELOPMENT OF RESPONSES WITH AN APPROPRIATE RANGE OF STAKEHOLDER INVOLVEMENT

'Community' could be of the members of a high-risk group e.g. LGBTQI

ASK: IS THE COMMUNITY INITIATING AND LEADING THE DEVELOPMENT PROCESS?

IF YES, CONSIDER:

Who is claiming to represent the community?
Is there a representative governance structure/health service or other body that is in a position to confirm this, or otherwise represent the community?

IF NO, IS AN ORGANISATION WORKING IN PARTNERSHIP WITH THE COMMUNITY?

CONSIDER:
How is that being demonstrated?
How is decision-making power being shared?
What does the community say about it?

IF THE COMMUNITY IS NOT LEADING THE PROCESS

DO NOT PROCEED

REQUIRE GENUINE COMMUNITY REPRESENTATION BEFORE PROCEEDING

IF THE COMMUNITY IS LEADING THE PROCESS

PROCEED

IF THE COMMUNITY IS A PARTNER IN THE PROCESS

IF THE COMMUNITY IS NOT A PARTNER IN THE PROCESS

DO NOT PROCEED

REQUIRE A PARTNERSHIP AGREEMENT TO BE MADE BEFORE PROCEEDING

ASK FURTHER: HAVE A RANGE OF APPROPRIATE STAKEHOLDERS BEEN INVOLVED IN THE ACTIVITY-DEVELOPMENT PROCESS?

Community stakeholders include, as appropriate, Elders, men's and women's groups, families, cultural and community leaders, survivors, bereaved families, etc. Other stakeholders include, as appropriate, mental health services, health services, schools, police, media, etc.

IF YES, PROCEED

IF NO, DO NOT PROCEED

REQUIRE THAT A RANGE OF APPROPRIATE STAKEHOLDERS ARE INVOLVED IN THE ACTIVITY-DEVELOPMENT PROCESS AS A CONDITION OF FURTHER CONSIDERATION OF THE PROPOSAL

3. ESTABLISH THAT ADEQUATE PLANNING FOR THE ACTIVITY HAS TAKEN PLACE

ASK:

IS THE DEVELOPMENT OF THE ACTIVITY BASED ON A SITUATIONAL ANALYSIS?

This could include consideration of:

What levels of intervention are needed? Universal, selective, indicated? If selective, which group(s) in particular? If indicated, how will the community work to ensure its presence?

What are the immediate, medium-term and longer-term priorities? Is self-harm an issue?

What are the main causes of suicide/risk factors for suicide in the community? Do they vary for different vulnerable groups, or different age ranges?

What lethal means are being employed by those who attempt suicide or suicide?

What resources are already available to the community that could be used in suicide prevention activity?

What is the appropriate balance of cultural and clinical approaches, and will this change over time?

What are the gaps? Of these, what are the priorities?

What are the barriers to the effective and efficient operation of the activity? How can these be addressed?

What are the main risks to the activity and what management strategies should be in place?

**IF YES,
PROCEED**



**IF NO,
DO NOT PROCEED**

REQUIRE A SITUATIONAL ANALYSIS IS UNDERTAKEN AS A CONDITION OF FURTHER CONSIDERATION OF THE PROPOSAL

ASK:

1. IS A COMMUNITY ACTION OR OTHER APPROPRIATE PLAN TO SUPPORT THE ACTIVITY IN PLACE?

This could include consideration of whether:

- success factors identified in Indigenous suicide prevention to date are included in the plan
- the program logic is clearly articulated
- a causal relationship between desired outcomes and activity is clearly articulated
- an evaluation component is built into the plan with evaluation questions identified
- articulated, agreed goals are set at appropriate milestones

2. DOES THE PLAN CONNECT WITH, AND IS INTEGRATED WITH, REGIONAL LEVEL PLANNING UNDERTAKEN BY THE PHN?

IN RELATION TO BOTH THE ABOVE:

**IF YES,
PROCEED**



**IF NO,
DO NOT PROCEED**

REQUIRE AN INTEGRATED PLAN BE DEVELOPED AS A CONDITION OF FURTHER CONSIDERATION OF THE PROPOSAL

4. A CHECKLIST FOR ASSESSING THE ACTIVITY FOR QUALITY INDICATORS

ASK:

1. WILL THE PROGRAM PROACTIVELY ENGAGE WITH TARGET CLIENTS/ CLIENT GROUPS?

2. ARE CULTURALLY INFORMED/HEALING ELEMENTS PRESENT, AND DESIGNED AND DELIVERED BY THE COMMUNITY/CREDIBLE CULTURAL LEADERS?

3. DOES THE PROGRAM SUPPORT COMMUNITIES AND FAMILIES TO ADDRESS THE IMPACT OF NEGATIVE SOCIAL DETERMINANTS INCLUDING THOSE OF SUICIDE, FOR EXAMPLE BY CONNECTING THEM TO A RANGE OF SOCIAL SUPPORT AGENCIES?

4. DOES THE PROGRAM BUILD INDIVIDUAL, FAMILY AND COMMUNITY CAPABILITIES TO RESPOND TO SUICIDE AND ITS RISK FACTORS?

Consider whether the program:

- includes gatekeeper/mental health literacy training/reduces stigma
- promotes e-mental health and Indigenous suicide prevention apps (e.g. iBobbly)
- works with or helps establish family, youth, at-risk groups, peer-support networks
- supports community to access postvention support

5. DOES THE PROGRAM WORK WITH THE COMMUNITY TO MONITOR AND PROACTIVELY RESPOND TO CHANGING PRIORITIES AND NEEDS OVER TIME?

Consider its capacity to respond to:

- potential crisis situations
- high-risk periods for suicide (e.g. Christmas, wet season)

6. IS THE ACTIVITY INTEGRATED WITH OTHER RELEVANT COMMUNITY SERVICES AND ACTIVITIES?

7. IS THE ACTIVITY ABLE TO DEMONSTRATE WIDER COMMUNITY BENEFITS?

8. IS THE PROGRAM ABLE TO PRIORITISE, AND FLEXIBLY AND APPROPRIATELY RESPOND TO AND/OR REFER THOSE SELF-HARMING AND OTHERWISE AT RISK OF SUICIDE, OR WITH MENTAL HEALTH OR ALCOHOL AND DRUG PROBLEMS TO THE APPROPRIATE CLINICAL SERVICES WITHIN APPROPRIATE TIMEFRAMES/ACCESS POSTVENTION SUPPORT SERVICES?

**IF YES TO ALL OF THE ABOVE,
PROCEED**



**IF THE ANSWER WAS 'NO'
TO ANY OF THE ABOVE
PROCEED, BUT WITH CAUTION**

REQUIRE THE PROPOSAL TO ADDRESS THESE FACTORS. A PROPOSAL MAY PROCEED WITHOUT THESE FACTORS, BUT IF THEY ARE NOT INCLUDED A SOUND REASON SHOULD BE PROVIDED.

USE THE CHECKLIST TO ASSESS COMPETING PROPOSALS

2. A COMMUNITY TOOL TO SUPPORT THE DEVELOPMENT OF INDIGENOUS SUICIDE PREVENTION ACTIVITY

The Community Tool is a five-part process that guides communities in the development and implementation of a community suicide prevention plan. It utilises the same quality indicators (found in Appendix 2) that are used in the Assessment Tool for Indigenous suicide prevention activity. The Community Tool is designed to support the empowerment of Indigenous communities by supporting them to:

- develop programs and activity to implement the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*
- evaluate the suitability of proposals for suicide prevention activity in the community from external organisations, as well as the suitability of the organisations
- improve existing suicide prevention activities.

As with the Assessment Tool, the development of indicated services is not covered by the Community Tool as these will, in practice, be generated at the state and territory level, and within the context of the mental health and health systems. Otherwise, indicators for these can be found in Appendix 2.

However, the Community Tool does draw attention to the need for a community with members at immediate risk of suicide to be able to access indicated services. Whilst not part of this tool, such indicated services should also be developed through engagement with the Indigenous consumers and communities that are intended to use them.

To meet the needs of those who will be using it, the Community Tool was:

- workshopped with a group of community representatives from across Australia to test relevance (this precipitated minor changes)
- tested with Ngoonbi Community Services Indigenous Corporation including meetings with various managerial staff members and a community consultation with people of various age groups and occupations
- discussed in depth with a meeting of the National Empowerment Project, including 36 people representing twelve communities across the country, and key organisations such as the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) and Telethon Kids Institute
- included in delegate bags at the inaugural Aboriginal and Torres Strait Islander Suicide Prevention Conference from 5–6 May, 2016, with a request for feedback
- discussed at a meeting of the Governance Committee and Key Partner Organisations for the Critical Response Project with the Tool provided to all participants and feedback requested offline
- the focus of a consultation with clinicians, management and other staff of the Winnunga Nimmityjah Aboriginal Health Service, who provide numerous services designed to improve the social and emotional wellbeing of their community.

The overarching feedback from the consultation was positive, and it was telling that while the Community Tool is designed to first ensure that there is a need for suicide prevention activity, there was strong consensus that every community will have such a need.

Other points of feedback included:

- Many communities already develop Community Wellbeing Plans. It is important that these include a plan to develop a suicide prevention plan or strategy.
- Resources available locally and at a regional level to assist with suicide prevention should be centrally located, regularly updated, and easily accessible.
- It would be valuable when initially disseminating the Community Tool to communities that facilitators be funded and provided to trial the process.
- The instructions should draw attention to the need for good governance, and to encourage communities to evaluate their processes and programs as they proceed, and then to utilise these results for ongoing improvements and further funding applications.

Part 1: Establish the foundation for planning for suicide prevention activity

Are the community's prior needs to plan effectively for suicide prevention activity being met?

1 Is there agreement in the community of the need for suicide prevention activity?

Consider suicides, suicide attempts and self-harm, the risk of suicide associated with mental health issues, alcohol and drug use, and whether the community is able to use existing local suicide prevention activity or other services to meet needs in these areas.

2 Is education of community members on social and emotional wellbeing, mental health, risks for suicide (including alcohol and drug use) and suicide prevention required before activity planning starts? If yes, are there arrangements in place?

If not, please contact your closest Aboriginal Community Controlled Health Service, Primary Health Network, health or mental health service to work out the best way to provide this community education. Your community may also want to consider contacting the National Empowerment Project: <http://www.nationalempowermentproject.org.au>

Is the community in control of the activity development process and are all relevant parties contributing to it?

3

- **Has the community initiated the response to suicide?**
- **Is the community trying to evaluate a proposed suicide prevention activity from an external organisation, or identify the best choices available to it from outside the community?**

If it is the latter:

- at this stage, use Part 4 of this tool to evaluate the suitability of the organisation(s) for the role (and ignore Part 5)
- then proceed with steps 4 – 24 in Part 2, adapted accordingly, to help evaluate the activity proposed by each organisation.

4 Are the community's wishes determining the activity planning process?

Are Elders, governing bodies, men's and women's groups, families, cultural and community leaders, survivors, and/or bereaved families (as appropriate) involved?

5 Are mental health services, health services, youth services, family support services, schools, police and any other bodies involved with the community that might have a role to play in suicide prevention involved in the planning process?

Identify people in the community who need immediate professional help and, as a priority, make sure they are being helped

6 Are there people in the community at immediate risk of suicide and in need of help straight away? Are there families and people in the community who have recently experienced a suicide among their members/kin, and are in distress and in need of help straight away?

If yes, ensure that established protocols are followed to refer these people to the appropriate service or please contact your closest Aboriginal Community Controlled Health Service, health, mental health or family support service straight away and work out the best way to help these people as a priority.

Part 2: Develop a community plan to prevent suicide that includes the activities the community would like to see happen

Ensure a shared community understanding of the reasons why suicide is occurring, what resources the community already has to reduce suicide, and what the community's priorities are.

In particular, has the community considered the following (7–15):

7 What are the main causes of suicide/risk factors for suicide in the community?

What activity is required to address them?

8 How are people dying by suicide or attempting suicide?

Could suicide be reduced by restricting people's access to these means?

9 Are resources already available to the community, including at the regional level, that could be used in suicide prevention activity? Conversely, what are the gaps and what are the priorities that the community needs to ask for assistance with?

This should include particular focus on mental health services, but include health services, youth services, family services, employment services, schools, and other appropriate services. If the community is not sure, please contact your closest Aboriginal Community Controlled Health Service, Primary Health Network, health, mental health or family support service to help work it out.

In particular, the community might want to consider success factors identified by ATSISEPP from other community suicide prevention activities:

- Addressing community challenges, poverty, social determinants of health
 - Cultural elements – building identity, SEWB, healing
 - Alcohol/drug use reduction
 - Gatekeeper training – Indigenous-specific
 - Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy
 - Peer-to-peer mentoring, and education and leadership on suicide prevention
 - Programs to engage/divert young people, including sport
 - Connecting young people to culture/country/Elders
 - Access to counsellors/mental health support
 - 24/7 availability
 - Awareness of critical risk periods and responsiveness at those times
 - Crisis Response teams after a suicide/postvention
 - Community empowerment, development, ownership – community-specific responses
 - Involvement of Elders
 - Cultural framework
 - Partnerships with community organisations and ACCHS
 - Employment of community members/peer workforce
-

10 How could the community's culture and cultural practices help with suicide prevention? What is the possible role of families in preventing suicide? Could existing family, men's and women's, youth and at-risk group peer-support networks in the community be harnessed to help prevent suicide in the community?

How can these strengths be harnessed to reduce suicide?

11 What are the priority groups for suicide: men, young women, young people, gay and lesbian people, brother-boys and sister-girls, and so on?

How will activities target and reach these groups?

12 What types of crisis situations trigger suicide or suicide attempts, and among which groups? Are there high-risk periods for suicide (e.g. Christmas, wet season)?

How can these be anticipated and addressed?

Part 2: Develop a community plan to prevent suicide that includes the activities the community would like to see happen (continued)

13 Is violence, or alcohol and drug use contributing to suicide?

How can these influences be reduced? What specific activities need to happen?

14 Are there things the community could do without outside assistance and that would reduce the risk of suicide among its members?

For example, stopping family feuding, lateral violence, discrimination against families or people of various sexualities, or other behavioural changes.

15 What are the main things that could go wrong in the activities proposed, and how is the community planning to address these before they happen?

As a community, demonstrate you have considered good practice in developing suicide prevention activities.

In particular, has the community considered the following:

16 How will the suicide prevention activities be publicised and how will the community maximise participation?

For example, using local media, school based programs, youth services, men's and women's groups/existing community structures. Is transport for participants required for the activities to work? If so, who will provide it?

17 Are the activity providers able to respond flexibly and prioritise people who are self-harming and otherwise at risk of suicide or with mental health or alcohol and drug problems, by connecting them to the appropriate health, mental health and other services quickly and as a priority?

If the community is not sure how this should occur, please contact your closest Aboriginal Community Controlled Health Service, health, mental health or family support service to work out the best way to make this happen.

18 How will support agencies be involved? How will community members be supported to seek help in times of crisis or stress? If a suicide occurs, how will the community access support services to help those grieving and help prevent 'copycat' suicide deaths?

How are postvention, health, mental health, housing, employment, education and other services to be involved in suicide prevention activities, and to what degree? If the community is not sure, please contact your closest Aboriginal Community Controlled Health Service, Primary Health Network or the agencies listed above to work out the best way to make this happen.

19 Is Mental Health First Aid and other gatekeeper training important, and who in the community should be prioritised for training?

If the community is not sure, please contact your closest Aboriginal Community Controlled Health Service, Primary Health Network, health, mental health or family support service to work it out.

20 Could the community utilise the internet and special suicide prevention and mental health websites and mobile phone apps in its suicide prevention activity?

If the community is not sure, please contact your closest Aboriginal Community Controlled Health Service, Primary Health Network, health, mental health or family support service to work out the best way to make this happen.

21 What other benefits could suicide prevention activities bring to the community?

For example, employment of community members, life skills, building individuals to be strong and resilient, supporting the community's efforts to govern itself, communication skills, relationship skills, conflict resolution, dealing with racism.

Plan to evaluate the results of suicide prevention activities before they get underway.

In particular, has the following occurred:

22 Building milestones into the community plan, and agreeing on ways to measure how they have been achieved.

This could include (for example) the number of participants in various activities per year/as a percentage of your community's population.

23 Arranging for an outside organisation to conduct an independent review of activities after an appropriate time period.

This includes seeking funding for that purpose as a part of the community plan.

Part 2: Develop a community plan to prevent suicide that includes the activities the community would like to see happen (continued)

24 Arrangements to collect data to support the evaluation of the impact of the plan and associated activities. This could include:

- data about suicidal behaviours prior to the plan implementation in order to be able to measure its impact
- recording the numbers of suicides, attempted suicides and any measures of suicide ideation among community/group at higher risk members over the short and long term
- recording data about the risk factors for suicide/changes in at-risk behaviours including self-harm, cannabis and alcohol use – short and long term
- recording data about the social and emotional wellbeing of the community/higher risk groups with a focus on cultural activity, physical health, employment, community safety and school attendance – short and long term
- recording help-seeking behaviour/the use of mental health services and improved mental health outcomes – short and long term.

Not all the above might be possible and the community may need to work with other agencies to get this data over time. If the community is not sure, please contact your closest Aboriginal Community Controlled Health Service, Primary Health Network, health, mental health or family support service to work out the best way to make this happen.

Part 3: Write up the above as a community suicide prevention plan. This should clearly identify the causes of suicide and the activities the community would like to see in addressing those causes. It should show clearly and logically how the activities proposed will contribute to reducing the risk of suicide in the community.

Part 4: Identify a community organisation that is willing to be legally and otherwise responsible for the plan activities, including the employment of people and holding any funds that may be provided to support the activity.

Make sure the organisation agrees to the following:

- 25 To support community governance/engagement including putting in place appropriate cultural governance mechanisms for cultural activities that are a part of suicide prevention activity and clinical governance mechanisms if appropriate.
-
- 26 To employ community members and to ensure the staff profile of those employed in the activities reflect the community and/or targeted high-risk groups.
-
- 27 To hold funds and be financially accountable.
-
- 28 To provide an office for the activity and the capacity to secure vehicles, computers, records and so on.
-
- 29 To manage confidential participant/consumer information and data appropriately.
-
- 30 To connect with other elements of suicide prevention and related activity at the local and regional level through local Aboriginal Community Controlled Health Services and the Primary Health Network.

Make sure that the community supports the organisation taking on this role

Part 5: If you have identified an organisation that is willing to take legal responsibility for suicide prevention activity in your community plan and has community support in that role, work through the organisation to talk to your Primary Health Network and/or local health and mental health services about your community's needs and plan and how to go about getting funding for the activity.

If your community is not able to identify a suitable organisation, it should consider establishing a new organisation specifically for overseeing suicide prevention activity. Contact the Office of the Registrar of Indigenous Corporations for further information: free call 1800 622 431.

3. AN EVALUATION FRAMEWORK FOR INDIGENOUS SUICIDE PREVENTION ACTIVITY FOR USE BY COMMUNITIES, GOVERNMENTS AND PRIMARY HEALTH NETWORKS

The Evaluation Framework is designed to evaluate suicide prevention activities that are already underway, and to provide guidance around evaluation while in the planning stages. The Evaluation Framework can be utilised by governments, communities and funders such as PHNs. It is based on the same quality indicators found in Appendix 2 which underpin both the Assessment Tool for Indigenous suicide prevention activity and the Community Tool.

Aim

The Evaluation Framework aims to:

- provide a step-by-step approach to undertaking the quality evaluation of Indigenous community-based suicide prevention activities
- provide guidance on how to write an evaluation plan.

Scope

The Framework's intended audience is varied, and has been designed for use in different contexts and at different stages of activity development, therefore not all of the Framework will be relevant in all circumstances. The reader is asked to take from this Framework what is most useful to the activity they are seeking to evaluate.

Why evaluate Indigenous suicide prevention activity?

Evaluating Indigenous suicide prevention activity (whether that activity can be described as a project¹⁰⁵, a program¹⁰⁶ or even a service) is critical to reducing Indigenous suicide across Australia, and ensuring the finite resources allocated to it support the highest quality activities.

The foundation of activity evaluation is assessing process, impact and outcomes. In short, what happened as a result of the activity, and what impact and outcomes flowed on from what happened.

Evaluations are useful for several reasons:

- **Getting the best 'activity fit' for a community.** For example, an otherwise high-quality activity that was developed to reduce suicidal behaviours in girls and young women might have no measurable impacts or outcomes in a community where it operates. An evaluation can help demonstrate this, and help a community understand why. It might be because the main risk group in that community is boys and young men. If so, a community and/or funder need to know this and recalibrate their response to meet the needs of boys and young men in that community.
- **Improving activities or changing activities to meet changing needs.** Ongoing evaluation should be used as the basis of continually improving a suicide prevention activity. An activity may be working effectively but still have room to improve. An evaluation might identify what these areas are. Alternately, the focus required of an activity may change over time and an evaluation can help pick this up. For example, it might be entirely appropriate for an activity to focus its impact on reducing alcohol and drug use by young people in its early years. However, five years later, the required focus might be on something else.
- **Proposing new activities and expanding the evidence-base.** Recommendation 1 of the ATSIPEP Final Report includes a reference to the importance of the dissemination of the findings. No matter how long an activity might last, an evaluation means it can be of enduring usefulness by informing other communities on what has worked or not worked – at least for that community. In that way, communities can support other communities to develop activities that fit their needs and contribute to reducing the Indigenous suicide rate nationwide for many decades to come. For example, if there are two competing suicide prevention activities that could be chosen by a community, evaluations of both will help a community decide which is preferable. Alternatively, a new activity may be developed in one community, and an evaluation might suggest it offers real advantages over existing activity occurring in another community.
- **Evaluations help protect communities and activities.** An evaluation that demonstrates that an activity is high quality and is utilising effective risk-management procedures can help provide protection to communities and those delivering activities.

Using this Evaluation Framework

This Framework aims to guide communities or stakeholders in developing an evaluation plan alongside an activity plan or proposal for Indigenous suicide prevention. It also supports the development of evaluation plans for existing activity.

Developing an evaluation plan as a prerequisite, however, may not be appropriate in all circumstances. In particular, in communities where lives may be at immediate risk without suicide prevention activity in the short term. The need to save lives in the short term should be the overriding concern and an activity should not be excluded from consideration simply because it has not been possible to develop an evaluation plan for it. An evaluation guided by this Framework should occur over the longer term.

It is also critical that evaluation planning and processes build on commitment from community groups and activity providers to use the results of evaluations so that existing activity can improve and contribution can be made to the evidence-base for Indigenous suicide prevention. As discussed in the following parts of this Framework, partnership with communities in Indigenous suicide prevention activity and evaluation, is a key indicator of quality and effectiveness.

The five steps outlined in this framework are:

1. The foundation for effective evaluations: community partnerships
- 2: Setting the parameters for evaluation planning
- 3: Developing an evaluation plan using program logic
- 4: Implementing an evaluation plan
- 5: Disseminating the lessons learned

Step 1: The foundation for effective evaluation: community partnership

Community-based Indigenous suicide prevention activity requires Indigenous community ownership, partnership and engagement to be effective,¹⁰⁷ and includes activity evaluations. For organisations wanting to support Indigenous communities in preventing suicide, the development of activity and evaluation plans should be complemented by the following:

- An effective Indigenous community partnership and engagement strategy that places communities in a leadership role
- A commitment from the community to develop evaluation plans and processes along with activity planning.

Partnership is more than a 'foundation element' for evaluations. Partnership is also a key indicator of an effective process and a primary focus of evaluation: without community partnership and engagement, an activity cannot be said to be a high-quality program. This is because of the need for activities to respond to the specific needs of communities – whether these relate to primordial factors, specific risks, or at-risk groups. In addition, the community is the only appropriate means for the governance and delivery of any cultural elements of the activity, or the ability to advise on any cultural parameters that should be observed in the activity.¹⁰⁸

Engagement and partnership with Indigenous communities

Identifying legitimate, community-supported and representative leaders and governance mechanisms for engagement and partnership can be a challenge and should be undertaken with care. However, in general terms, Indigenous communities' preferred approach to engagement is often through their community controlled organisations. Where they exist, Aboriginal Community Controlled Health Services can be the most visible expressions of governance in communities and have the potential to be key points of 'engagement' – although this may vary from community to community.¹⁰⁹

Guidance as to effective engagement and partnership is provided by the following Closing the Gap Clearinghouse resource papers:

- Hunt, J, 2013, *Engaging with Indigenous Australia—exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities*. Issues paper no. 5. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.
- Hunt, J, 2013, *Engagement with Indigenous communities in key sectors*. Resource sheet no. 23. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

Step 2: Setting the parameters for evaluation planning

The main tasks at this stage are to:

- **Identify what resources are available to support evaluation planning and processes.** An evaluation can be onerous, and a key part of the evaluation involves analysis and writing: identifying and summarising the key findings, themes and information that the evaluation process has revealed. This may require employment of an outside body or consultant and funding for such should be included as a key element of activity planning.
- **Identify indicators or measures, reliable information sources and data collection tools.** A good evaluation involves measurement, however, what to measure must be decided. There is, for example, little point in aiming to measure something against which no data is collected. From the start, consider what resources and data are available to support evaluations and whether data collections (for example, activity user questionnaires) or other means need to be incorporated into activity and evaluation planning. Further, it should be possible to measure whatever you decide to measure before and after the activity. In this way, an evaluation can help ensure that changes for the better can be attributed to the activity. To gather community-specific data, special arrangements may be needed with the health services or hospitals, and Primary Health Networks may be able to help with this.
- **Based on the above, clarify the scale of the evaluation.** Consider the scale, resources and capacity of the activity in question. Large scale evaluations are not required for all, particularly small scale, programs. Clarify what is going to be evaluated within the activity. The evaluation should include, at a minimum impact, outcomes and process, in addition to the broader outcomes (apart from those directly relating to suicide).

What to evaluate?

Assessing process, impacts and outcomes is a primary consideration in Indigenous suicide prevention activity evaluation. If an activity cannot demonstrate it proceeded on the basis of partnership with a community or communities, or as planned, and had relevant impact or outcomes, then its continuation is hard to justify. Activity planners should consider how they will evaluate process, impacts and outcomes of activity at the development stage. In short:

- An **impact** is the direct, shorter-term effect of an activity. For example, 200 sessions of informal counselling offered by peer-to-peer mentors within a suicide prevention activity.
- An **outcome** is the longer term result and should, as much as possible, coincide with the intended purpose of the activity. For example, the 200 sessions of peer-to-peer mentoring (in the example above) resulted in X fewer completed suicides and X fewer attempted suicides over time. However, in small community settings, this may not be an appropriate indicator. In this context, **broader outcomes** might be considered as a complementary measure. These might include increased use of mental health services, reduced alcohol and drug use, or improvements in other areas that are risk factors for suicide.
- A **process** involves the steps taken in achieving an outcome. As noted, community partnership and participation in activity and evaluation planning is a key process measure or indicator and is likely to be a determining factor of an activity's impact and outcomes. Hence in this Framework, process (partnerships with communities) and impact/outcomes are assumed to be 'two sides of one coin'. However, elements of process can also be evaluated as a distinct evaluation objective in this context. Importantly, this includes how closely the implemented activity conforms to the plans for the activity that was resourced in the first place.

Other considerations that an evaluation might seek to determine include **other kinds of broader outcomes**. Did the activity result in other benefits, perhaps unintended or unforeseen at the developmental stage? For example, did the capacity of the local health service increase by hosting the activity? Did the activity help strengthen community governance overall, or strengthen the role of Elders in community governance? Was the activity a facilitator of cultural renewal?

A further consideration might be an activity's **cost effectiveness**. Every activity requires resources. A primary input will be funding, but just as important might be the person hours needed to operate it (both paid hours and voluntary support might be relevant). The task here is to determine whether resources required for the activity are justifiable and appropriate when compared to the impact and outcomes. This includes in the broader context of limited resources, competing priorities overall, and competing Indigenous suicide prevention activity.

When considering evaluation planning for an activity that is new and innovative, it may be necessary to evaluate it more intensively, using a stronger evaluation plan. This may also be necessary if the activity is being implemented in a new site or setting, or if the evaluation is being used to support applications for additional funding.

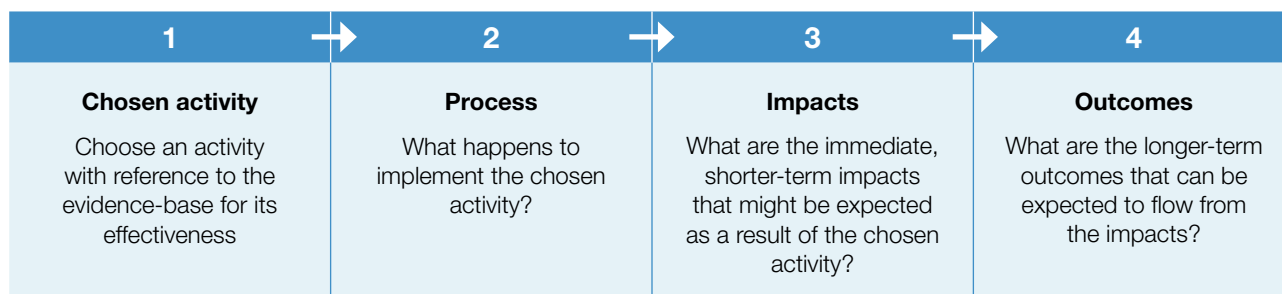
If an activity has been evaluated already and has been shown to be effective, performance monitoring is likely to be sufficient rather than an evaluation plan as such. For these programs, a few agreed indicators of process, impact and outcome could be identified for use in performance agreements (for example, service agreements).

Evaluation plans should be developed to measure the program logic that determined activity planning. That is, in a way that measures or describes the chain of causation of the activity from process, to short-term impacts, and then longer-term outcomes. This is discussed further in Step 3.

Step 3. Developing an evaluation plan using program logic

Evaluation planning should be informed by the same program logic that underpinned activity planning. Program logic then underpins both activity and evaluation planning and ensures an alignment of the two. Program logic can be thought of as four steps that must flow 'logically' from each other in a chain of cause and effect to achieve a particular outcome, as illustrated below.

The four-step chain of program logic – from chosen activity to outcomes



A basic evaluation examines steps 2, 3 and 4. It aims to measure at each stage as discussed below.

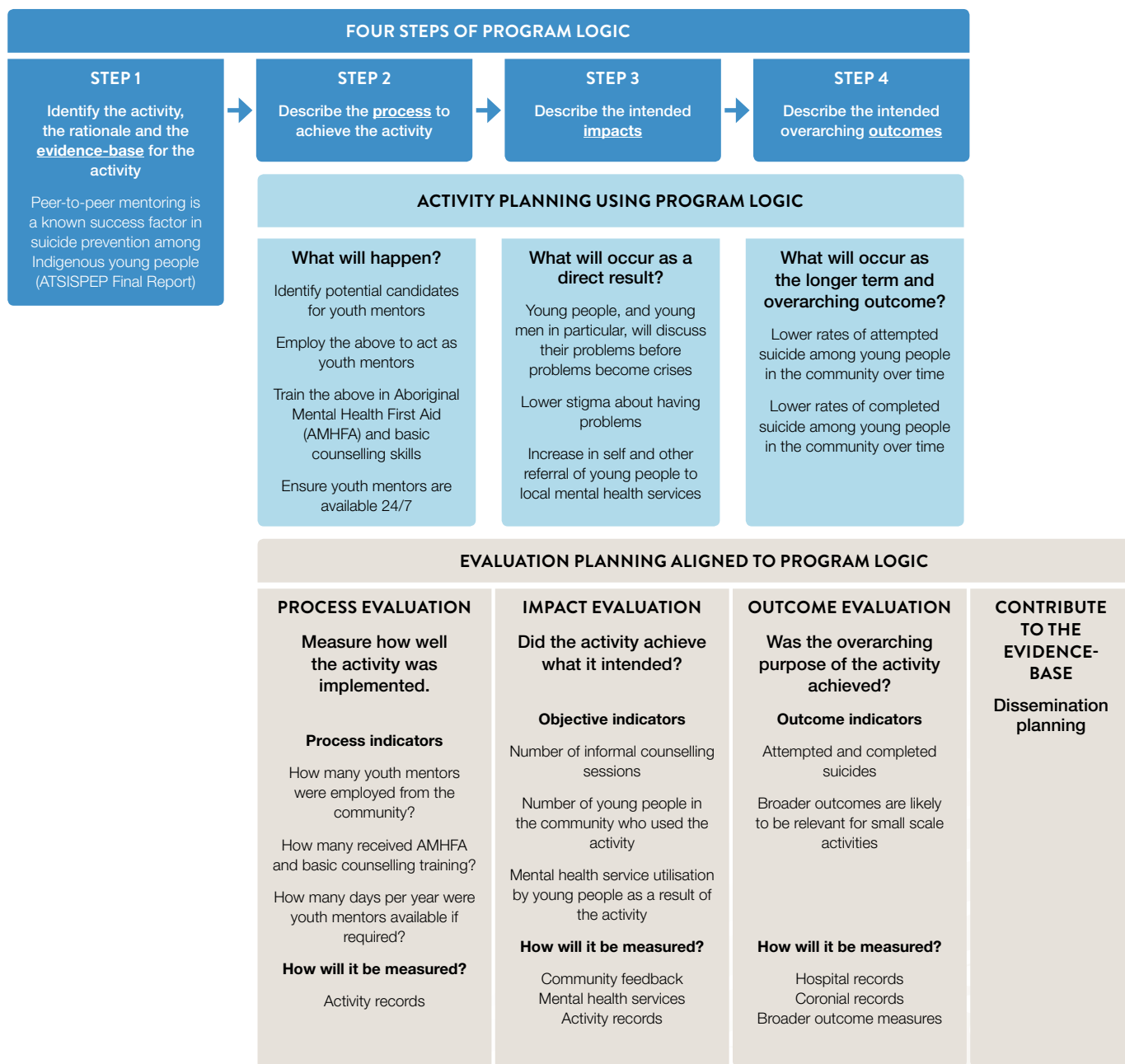
- Evaluating process** takes as its starting point the activity plan. What did the activity plan say the activity was going to do; and did it happen? And if not, why not? This step might also involve a review of contracts and progress reports. As discussed, a critical question is: Were the Indigenous community/ies involved as partners in the activity development process?
- Evaluating impact** requires choosing measures or indicators of impact, and ensuring that the relevant data is gathered as a part of the activity's operations. Key measures will include the number of participants in various elements of the activity per year/and as a percentage of relevant Indigenous community population or target group. (As a general rule, this is a good indicator of the activity's effectiveness, acceptability and accessibility in any given setting). It is also important to develop more focused impact measures such as with peer-to-peer mentoring used as an example on page 43, and indicators might include referrals to mental health services, and the number of informal counselling sessions delivered through the activity. In terms of data gathering, options include the collection of data from client records or through community or client questionnaires. In fact, ensuring the community's voice is heard is an important part of evaluating impact in this context.
- Evaluating outcomes** depends on the scale of the activity and outcome indicators could include measurable reductions in suicide, attempted suicide and suicide ideation across a defined area by comparing 'before and after activity' data. As discussed, because the numbers of people who complete suicide is relatively small, and particularly for activity in a single community, this might not be suitable for evaluating outcomes. In this case, broader outcomes assessment may need to be considered. This could include measurable reductions in risk factors for suicide such as changes in at-risk behaviours including reductions in self-harm, alcohol and drug use. In addition, measurable improvements to the social and emotional wellbeing of the community with a focus on self-governance, cultural activity, physical health, employment, community safety and school attendance might also be relevant.

A table correlating program logic and evaluation planning is set out below.

Program logic	Activity planning	Evaluation planning
Step 1: Activity	Choose the activity based on the evidence-base for its effectiveness. (Consider the success factors identified in the ATSIPEP Final Report. A summary table is included as Appendix 1 to this Framework).	
Step 2: Process	What will happen to implement the chosen activity?	Evaluation of process. How was the activity implemented, and how effectively? Did all or only some of the intended elements take place? Were the Indigenous community or communities involved as partners in the activity development process?
Step 3: Impacts	What are the immediate shorter term impacts that might be expected?	Evaluation of impact. What were the immediate results of the activity? What are the measures or indicators of these impacts?
Step 4: Outcomes	What are the longer term outcomes that can be expected to flow from the impacts?	Evaluation of outcomes. Was it possible to measure whether the activity achieved any of its overarching goals (reductions in suicidal behaviours)? Should broader outcomes be considered?
		Write up and dissemination. How will the evaluation be written up, disseminated and otherwise contribute to the evidence-base (i.e. back to Step 1).

The information below uses the example of peer-to-peer mentoring – a known success factor in suicide prevention among Indigenous young people – to demonstrate a coordinated approach to activity and evaluation planning as discussed in this Framework.

USING PROGRAM LOGIC TO COORDINATE ACTIVITY AND EVALUATION PLANNING



Key:

Program logic provides the framework for the two types of planning

Activity planning

Evaluation planning

Step 4: Implement the evaluation plan

To do this, it is necessary to identify within the evaluation plan itself:

- What tasks need to be completed?
- Who will undertake the tasks?
- When should the tasks should be undertaken?
- What resources are required?

Implementation is the process of ensuring that these steps are undertaken.

An important part of the evaluation process is writing an evaluation report in which the data gathered in the evaluation process is evaluated. This involves identifying and summarising the key findings, themes and information that the evaluation process has revealed. As noted previously, this may require funding an outside body or consultant to help with evaluation and completing the Report.

As a general rule an independent evaluation is preferred over an in-house evaluation given the potential for conflicts of interest.

Step 5: Disseminate the lessons learned

The dissemination of evaluation findings is crucial in strengthening the evidence-base for Indigenous suicide prevention. It is important for the future to know what works, what does not work, and why.

Key chapters for an evaluation report should include:

- **Background** – What was the problem the activity sought to change for the better?
- **Evaluation method** – What was the program logic of the activity (as discussed in Step 3) and how was it implemented? Did the evaluation assess the effectiveness of the program logic in this instance, and what indicators of process, impact and outcome were chosen? How was the data collected to assess these?
- **Evaluation results** – What did the evaluation find? Did the activity work? How well? How could it be improved? How does it compare to other activities? Was it cost effective?
- **Conclusions** – What are the implications for existing or future Indigenous suicide prevention activity?

The dissemination of evaluation findings is crucial in establishing a strong evidence-base for Indigenous suicide prevention. A mix of dissemination strategies can be used, including:

- summary reports for different audiences
- publishing the evaluation/summary reports in print and on the internet
- writing or commissioning peer-reviewed academic journal articles based on the evaluation
- making presentations to the community at forums and conferences.

Make time and allocate a budget for dissemination activities in evaluation planning.

SUCCESS FACTORS FROM THE ATSIPEP FINAL REPORT

The following table is provided to assist those developing activity plans to show factors for which program logic is evident as determined by ATSIPEP. As discussed in Step 3, program logic shows the cause and effect relationship between a chosen activity and its intended impact and outcomes.

Summary table of success factors identified by ATSIPEP

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

UNIVERSAL/ INDIGENOUS COMMUNITY- WIDE In this report 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates	Primordial prevention	<ul style="list-style-type: none"> Addressing community challenges, poverty, social determinants of health Cultural elements – building identity, SEWB, healing Alcohol/drug use reduction
	Primary prevention	<ul style="list-style-type: none"> Gatekeeper training – Indigenous-specific Awareness-raising programs about suicide risk/use of DVDs with no assumption of literacy Reducing access to lethal means of suicide Training of frontline staff/GPs in detecting depression and suicide risk E-health services/internet/crisis call lines and chat services Responsible suicide reporting by the media
SELECTIVE – AT RISK GROUPS	School age	<ul style="list-style-type: none"> School-based peer support and mental health literacy programs Culture being taught in schools
	Young people	<ul style="list-style-type: none"> Peer-to-peer mentoring, and education and leadership on suicide prevention Programs to engage/divert, including sport Connecting to culture/country/Elders Providing hope for the future, education – preparing for employment
INDICATED – AT RISK INDIVIDUALS	Clinical elements	<ul style="list-style-type: none"> Access to counsellors/mental health support 24/7 availability Awareness of critical risk periods and responsiveness at those times Crisis response teams after a suicide/postvention Continuing care/assertive outreach post ED after a suicide attempt Clear referral pathways Time protocols High quality and culturally appropriate treatments Cultural competence of staff/mandatory training requirements
COMMON ELEMENTS	Community leadership/ cultural framework	<ul style="list-style-type: none"> Community empowerment, development, ownership – community-specific responses Involvement of Elders Cultural framework
	Provider	<ul style="list-style-type: none"> Partnerships with community organisations and ACCHS Employment of community members/peer workforce Indicators for evaluation Cross-agency collaboration Data collections Dissemination of learnings



PART **2** **B**

**RESOURCES TO SUPPORT
INDIGENOUS SUICIDE
PREVENTION ACTIVITY**

INTERACTIVE MAPS TO ASSIST WITH PLANNING

Interactive maps are available on the ATSI S PEP and TKI websites <http://www.Indigenoussuicidepreventionmaps.com.au>. The maps provide a visual insight into how the numbers and rates of Indigenous suicides can vary across different regions of Australia. They are intended for use by communities, policy makers, service providers (for example, the Primary Health Networks) and researchers. The maps and their features are illustrated below.

Diagram 1 is a screen shot of the map that shows the Indigenous suicide rate (the rate per 100,000 Indigenous people) per year across Australia over 2001–12 by postcode.

DIAGRAM 1: Screen shot of interactive map showing Indigenous suicide rates in Australia, over 2001–12, by postcode

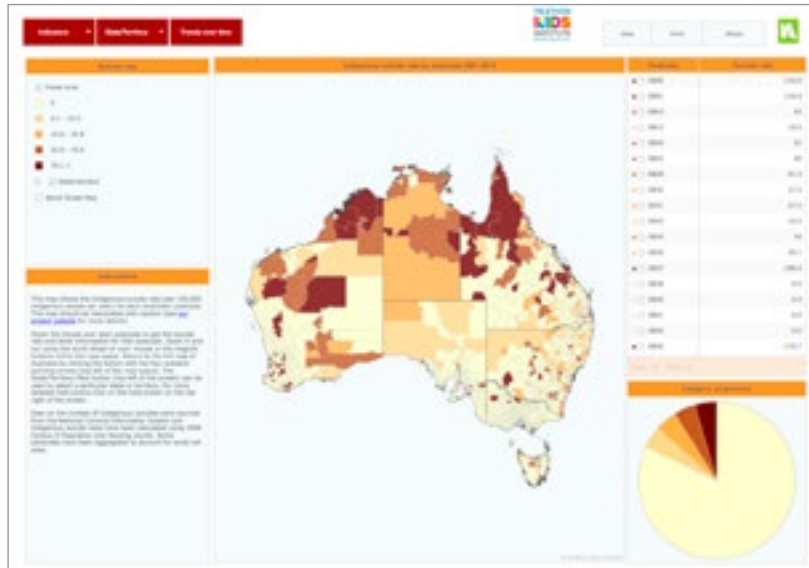


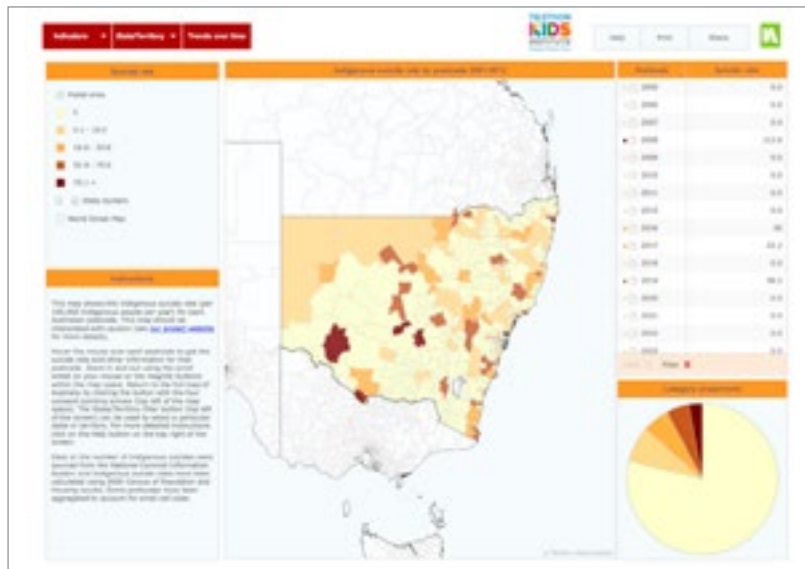
Diagram 2 illustrates that by hovering the mouse over a particular postcode it is possible to get the suicide rate for that specific area.

DIAGRAM 2: Screen shot of data shown when the user's mouse hovers over a particular postcode



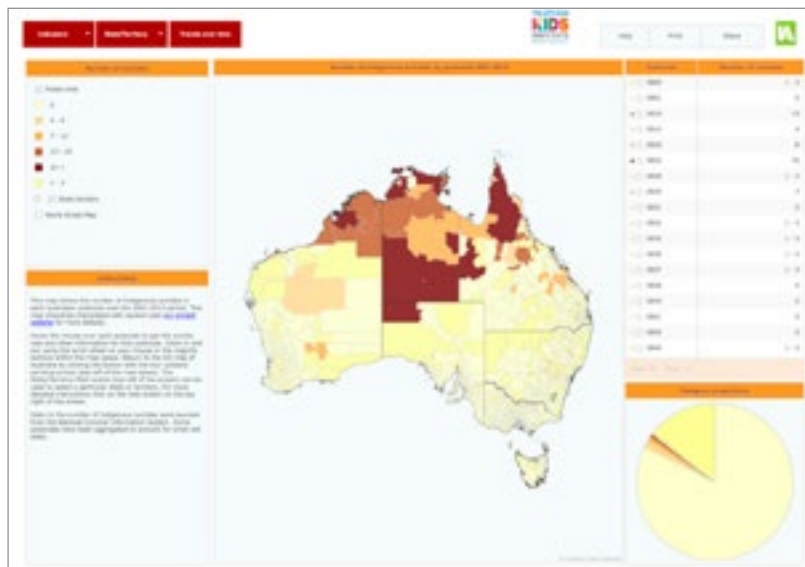
Diagram 3 illustrates how it is also possible to filter the map to show the rates in particular jurisdictions (in this case, NSW).

DIAGRAM 3: Screen shot of map showing Indigenous suicide rates in Australia, over 2001–12, by postcode, NSW filter selected



Similar capabilities are included in the second map showing the number of Indigenous suicides by postcode over 2001–12 and illustrated by Diagram 4.

DIAGRAM 4: Screen shot of map showing the number of Indigenous suicides in Australia, by postcode, over 2001–12



A further map shows Indigenous suicide trends over time, by the Australian Bureau of Statistics (ABS) Statistical Division (a primary ABS Australian Standard Geographical Classification Area), with 4 filters – for 2001–03, 2004–06, 2007–09, and 2010–12. Diagram 5 shows the filter set for 2007–09.

DIAGRAM 5: Screen shot of map showing the number of Indigenous suicides in Australia, by Statistical Division, 2007–09 filter selected

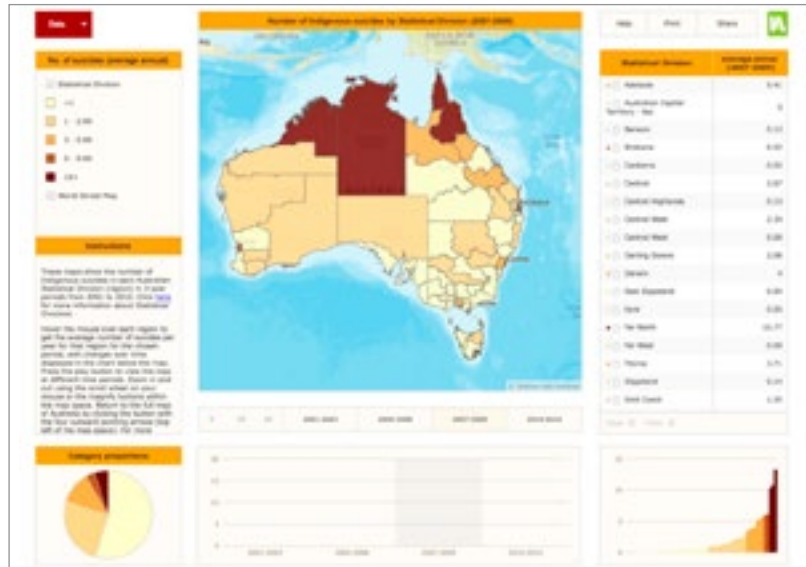
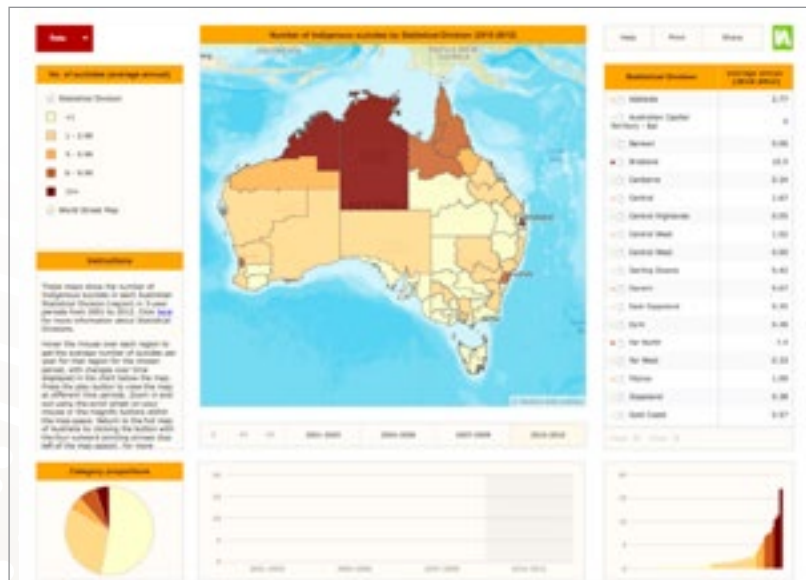


Diagram 6 shows the same map with the 2010–12 filter selected.

DIAGRAM 6: Screen shot of map showing the number of Indigenous suicides in Australia, by Statistical Division, 2010–12 filter selected



See: <http://www.Indigenoussuicidepreventionmaps.com.au/suicides/> for the maps.

Further maps of previous consultations on Indigenous suicide prevention were also created and are discussed under section 7.

FACT SHEETS

A series of Fact Sheets have been prepared based on extensive research from our Literature Review and Roundtable Consultations undertaken during 2014–15.

The Fact Sheets are designed to be read individually but also as a set to form a comprehensive guide to promising practice and directions in Indigenous suicide prevention, including key principles to guide services and programs.

Fact Sheet 1: What we know about suicide prevention

Fact Sheet 1 sets out current data on Indigenous suicide and suicide among particular groups within the Indigenous population. It identifies that there is a significant gap in suicide rates between Indigenous and non-Indigenous Australians, and that there has been little change in the rate of Indigenous suicide in the past decade. It examines the known risk factors for Indigenous suicide. It concludes by identifying strategies to close the suicide gap, and implement effective programs and services. It lists promising programs and the principles they operate by, including the importance of community leadership and culturally informed approaches.

See: http://www.sis.uwa.edu.au/data/assets/pdf_file/0005/2790932/Fact-Sheet-No.-1.pdf

Fact Sheet 2: The valuing of upstream approaches across the life course

Fact Sheet 2 discusses the importance of preventive ‘upstream’ approaches to suicide prevention. In particular, those that are strengths based, culturally informed, that empower communities and contribute to the wellbeing of children and young people, and promote resilience. These approaches allow for a reduction in susceptibility to risk factors for suicide and self-harm. The Fact Sheet concludes by identifying promising programs.

See: http://www.sis.uwa.edu.au/data/assets/pdf_file/0006/2790933/Fact-Sheet-No.-2.pdf

Fact Sheet 3: Suicide prevention for Aboriginal and Torres Strait Islander young people

Fact Sheet 3 sets out current data on suicide among young Indigenous people and the stressors and risk factors that can lead to suicide. It highlights the importance of suicide prevention activity for this group not only focusing on those immediately at risk of suicide, but also on the developmental factors for suicide. It highlights the importance of community-led upstream approaches that promote young people’s connectedness to culture and community, sense of belonging, stability, hope and control over their life and future. It also highlights the place of peer leadership, technology, and 24/hour services (among other factors) when working with this group.

See: http://www.sis.uwa.edu.au/data/assets/pdf_file/0007/2790934/Fact-Sheet-No.-3.pdf

Fact Sheet 4: The social determinants of Aboriginal and Torres Strait Islander people’s suicide

Fact Sheet 4 discusses the social determinants of Indigenous suicide and the mediating role of life stressors, psychological distress and mental health conditions associated with negative social determinants. It highlights the need for effective holistic approaches to Indigenous suicide prevention in order to reduce the impact of social determinants. Such approaches can include working in partnership with communities to address issues such as child welfare, housing and the contact of community members with the criminal justice system (among other risk factors).

See: <http://www.sis.uwa.edu.au/data/assets/file/0008/2790935/Fact-Sheet-No.-4.pdf>

Fact Sheet 5: Examining the risk factors for suicidal behaviour in Aboriginal and Torres Strait Islander children

Fact Sheet 5 sets out the data for suicidal behaviour among Indigenous children and the often compounding stressors and risk factors that may trigger such behaviour – including peer rejection, relational conflict, racism, bullying, family stress, and alcohol and cannabis use. It discusses the need for family support and school-based programs as the best ways of addressing these issues. It highlights promising programs.

See: http://www.sis.uwa.edu.au/data/assets/pdf_file/0010/2790937/Fact-Sheet-No.-5.pdf

Fact Sheet 6: Addressing the relationship between racism and inequality in suicide

Fact Sheet 6 discusses the interpersonal and institutional racism, and the associated health impacts, that is faced by Indigenous people. In particular, it looks at the association of risk-taking behaviours (such as smoking, and alcohol and other drug use) and the experience of racism and its impact on the self-esteem of young Indigenous people. It highlights the need for all government services and programs, but particularly those focused on Indigenous suicide prevention, to be culturally safe and established on principles of cultural respect.

See: http://www.sis.uwa.edu.au/data/assets/pdf_file/0009/2790936/Fact-Sheet-No.-6.pdf

Further Fact Sheet development

The Community Roundtable that was dedicated to the needs of Indigenous people identifying as being sexuality diverse recommended that a further Fact Sheet specific to LGBTQI issues be developed. A workshop was held adjacent to the Inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference to develop this Fact Sheet.

It is also considered vital that a further Fact Sheet be developed to address the impact of child sexual abuse on Indigenous suicide.

DISCUSSION PAPERS

1. The persistence of institutional racism in the Australian health and mental health systems, and anti-racist interventions

The paper presents the evidence for the operation of historical and persisting institutional racism in the Australian health and mental health systems. This includes:

- the ten year Indigenous and non-Indigenous life expectancy gap, and the underlying gaps in death rates associated with a range of health conditions
- the relatively high rates of interpersonal racist actions from health services staff as reported by Indigenous people which contribute to an institutional barrier in seeking help
- the widely different hospital treatment outcomes for the same health conditions between Indigenous and non-Indigenous people
- the particular issues reported with hospitals, and the disproportionate rate of self-discharge reported for Indigenous patients when compared to non-Indigenous (ten times higher)
- the lack of need-based funding for the Aboriginal Community Controlled Health Services who report significant mental health related service gaps (see Text Box 17)
- the apparent barriers to primary mental health services offered by or through GPs, based on the proposition that to meet recorded higher need, Indigenous people would need to be using these services at about double that of the non-Indigenous population, instead of at current parity.

The paper unpacks the mediating elements that amount to institutional racism in Australia as:

- A power imbalance between co-existing cultural groups, in particular, the inconsistent application of the self-determination principle in the broader health system and the overarching political and policy development spaces. Australia, as a nation state, needs to share power with Indigenous Australians when making decisions that effect them.
- Racist ideology and racist actions by health system staff.
- Cultural racism whereby the 'cultural assumptions of the dominant group, so that the practices of that group are seen as the norm to which other cultural practices should conform...'¹¹⁰ These practices have also been described as 'the observance and administration of policies, rules and procedures that purport to treat everybody equally, but are unfairly or inequitably administered or applied in dealings with people belonging to a particular racial, ethnic, religious or cultural group'.¹¹¹ For example, a service might purport to work with families, but is only able to work with nuclear families rather than Indigenous extended family structures.

While highlighting some positive current initiatives, the paper proposes the following anti-racist interventions to counter the above three elements of institutional racism:

- Aboriginal Community Controlled Health Services (ACCHSs) Researchers have demonstrated that ACCHSs are the preferred providers of services to their communities. ACCHSs provide a culturally safe and competent service, countering cultural racism.¹¹² As well as addressing an imbalance of power in the health system, at least at a local level, they are also manifestations of Aboriginal and Torres Strait Islander people's right to self-determination.¹¹³ The National Aboriginal Community Controlled Health Organisation, the peak body for ACCHSs, and its predecessor bodies have been effective in advocating for the support and expansion of community controlled health service delivery since the 1970s.¹¹⁴
- Support for collective action and advocacy on the part of independent Aboriginal and Torres Strait Islander health and mental health bodies to address power imbalances in the system. This includes the:
 - Close the Gap Campaign for Indigenous Health Equality.
 - National Health Leadership Forum (NHLF) that comprises the peak national Indigenous health and health professional bodies working as a collective.¹¹⁵

- National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) comprising a core group of senior Aboriginal and Torres Strait Islander people working in the areas of social and emotional wellbeing, mental health and suicide prevention.
- The development of institutional racism measurement tools such as the Marrie Institutional Racism Matrix (MIRM). While yet to be validated, the MIRM promises to enable institutional racism to be measured across Australian hospitals. Its significant focus is on Aboriginal and Torres Strait Islander participation in hospital leadership and governance.¹¹⁶ This could be connected to KPIs over time.
- ‘Zero tolerance’ attitude to interpersonal racism by health system staff, combined with anti-racism education as a part of professional development. A ‘zero tolerance’ attitude should be used to eliminate any instances of racist actions by health services staff occurring as a priority. Supporting and encouraging complaints and investigation by monitoring agencies independent of health system institutions could support the elimination of racist practice in this context.
- Dedicated Indigenous health and mental health planning and plan-implementation partnerships to help overcome cultural racism, and to address power imbalances in the health and mental health systems. An important milestone was the NHLF’s recognition as a partnering body of the Australian Government in the development of the National Aboriginal and Torres Strait Islander Health Plan 2013–23 and the National Aboriginal and Torres Strait Islander Health Plan Implementation Plan that is itself significantly concerned with institutional racism in the health system. Other examples include the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2004–09 (currently being renewed), the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014–19.
- Cultural safety in health and mental health institution service environments and cultural competence among health and mental health professionals and workers. Examples include AHMAC’s Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–09, and cultural competence training from training onwards such as that developed by the Leaders in Indigenous Medical Education (LIME) Network that has been instrumental in ensuring curriculum changes within Australian medical schools designed to ensure practitioners emerge with cultural competence skills.¹¹⁷
- Increase of the Aboriginal and Torres Strait Islander health and mental health workforce.

Building on existing efforts to increase and upskill the Aboriginal and Torres Strait islander workforce and employing staff across the health system has been demonstrated to have an acculturating effect on services.¹¹⁸

In its conclusion, the paper notes that addressing interpersonal racist actions within the health and mental health system is important and requires ongoing vigilance, but the overarching challenge remains in addressing the power imbalance and cultural racism within the Australian health and mental health systems and their institutions.

While continuing support for already successful interventions is important, shifting power imbalances in the health and mental health systems requires continued advocacy and collective action on the part of Aboriginal and Torres Strait Islander health and mental health leaders. Conversely, Australian governments and the health and mental health systems must embrace power sharing – as much as anti-racist cultural interventions such as cultural competence training are an increasingly familiar part of the health policy landscape. In this regard, a particular challenge was identified in relation to the operation of the Primary Health Networks.

2. Real Time Suicide Data

The paper identifies three main challenges to data collections about Indigenous suicide:

- There is variable quality of Aboriginal and Torres Strait Islander identification at the state, territory and national levels, resulting in an expected under-reporting of Aboriginal and Torres Strait Islander suicides.
- There is a lack of reporting on suicide due to questions regarding intent, especially in the case of childhood suicides. Similarly, it can be demonstrated that there may be a reluctance to classify adult deaths as suicides for a variety of reasons.
- There are delays in reporting data, whereby incidences of Aboriginal and Torres Strait Islander suicide might not be known for months and often years afterwards.

The paper's focus, however, is on the delay between the timing of suicide events and the reporting of suicide events which hinders early detection of systematic trends (including suicide hotspots and clusters) and intervention responses aimed at preventing further suicides. The paper notes that accessibility of real time data is an essential component in efforts to ensure that bereaved families and communities can access the services they need. Accessibility of real time data will also enable targeted interventions to prevent the development of suicide clusters.

The paper concludes that without comprehensive, meaningful, timely and accessible data, all jurisdictions lack a clear understanding of the scope of suicide behaviours and lack the ability to take appropriate and targeted action in preventing suicides. It is imperative that policies aimed at preventing suicide are developed based on good quality information and evidence. The design and implementation of effective preventive measures will be greatly enhanced by timely information on the characteristics of those who have suicided and the identification of possible current causative influences in specific populations in each state and territory.



CONCLUSION AND RECOMMENDATIONS

The Report sets out success factors in Indigenous suicide prevention based on an analysis of multiple sources, including a meta-evaluation of evaluated Indigenous suicide prevention programs. The ATSIPEP Project Team believes that these identified success factors place future activity for Indigenous suicide prevention on a firmer foundation.

ATSIPEP Recommendations

General recommendations for future Indigenous suicide prevention activity	1	All future Indigenous suicide prevention activity should: <ul style="list-style-type: none"> utilise and/or build upon the range of success factors identified by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project include a commitment to, and a provision for, the evaluation of the activity and the dissemination of findings to further strengthen the evidence-base.
	2	All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.
	3	Justice reinvestment principles should be used to secure additional funding for a range of upstream diversionary activity for Indigenous young people away from the criminal justice system. This could include programs to support young people and families, sport or other activities, or by enhancing access to quality education and employment. Justice reinvestment principles should also be used to fund improvements to Indigenous mental health and alcohol and other drug services and programs.
	4	Governments should support the training, employment and retention of Indigenous community members/people as mental health workers, peer workers and so on in suicide prevention activity. In particular, Indigenous young people should be supported and trained to work in suicide prevention activity among their peer group.
	5	All mental health service provider staff working with Indigenous people at risk of suicide and within Indigenous communities should be required to achieve Key Performance Indicators (KPIs) in cultural competence and the delivery of trauma informed care. These services should also be required to provide a culturally safe environment.
	6	Preparatory work should immediately commence to develop suicide prevention activities specific to the needs of those who have suffered child sexual abuse, in preparation for the release of the findings of the Royal Commission into Institutional Responses to Child Sexual Abuse.
	7	Indigenous people identifying as LGBTQI should be represented on all Australian Government and other Indigenous mental health and suicide prevention advisory forums.
Recommendations on the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy	8	A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan should be developed and funded, utilising the findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.
	9	Service agreements between the Australian Government and the Primary Health Networks should contain Key Performance Indicators that require demonstration of cultural capabilities and standards, and representation of Indigenous communities on boards, community advisory committees and clinical councils. This is in part to facilitate effective engagement and partnership with Indigenous communities at key junctures of the NATSIPEP implementation process including the development of suicide prevention needs assessments, commissioning services and programs, and evaluation of existing programs.
	10	Aboriginal Community Controlled Health Services remain the preferred facilitators to their communities of suicide prevention activity to their communities, including the provision of primary mental health care services. This includes delivery of programs and services funded to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy through the Primary Health Networks.
	11	The ATSIPEP Assessment Tool for assessing Indigenous suicide prevention activity should be used to support the evaluation of applications for National Aboriginal and Torres Strait Islander Suicide Prevention Strategy funding to ensure conformity with the findings of the ATSIPEP.
	12	The Success Factors identified by ATSIPEP should be included in the systems approach to suicide prevention when it is applied in Indigenous community settings. This should occur in consultation with Indigenous mental health and suicide prevention leaders, and in partnership with the communities concerned.

13	The ATSIPEP findings, tools and resources should be broadly disseminated, and included in Australian Government portals.
14	An Indigenous-led national clearinghouse for best practice in Indigenous suicide prevention activity should be established. This should be tasked to maintain the currency of ATSIPEP tools and resources over time.
15	Participatory action research is the preferred methodology for future suicide prevention research in Indigenous communities.
16	A National Aboriginal and Torres Strait Islander Suicide Prevention Conference should be funded and held every two years.
17	Resources should be made available to enable local Aboriginal and Torres Strait Islander communities to undertake critical response activities for their local communities with relevant stakeholders. Outcomes of the UWA Critical Response Project can inform these approaches.

The Report's recommendations were distilled over the life of the Project and from all its elements – including the Roundtable Consultations, the findings of the meta-evaluation, and the inaugural Aboriginal and Torres Strait Islander National Suicide Prevention Conference in May 2016, Alice Springs (National Conference). The recommendations were considered and approved by the ATSIPEP National Advisory Committee.

The final recommendations are grouped as:

- General recommendations for future Indigenous suicide prevention activity
- Recommendations on the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- Disseminating and building on the findings of ATSIPEP.

(a) General recommendations for future Indigenous suicide prevention activity

ATSIPEP recognises that growing the evidence-base for what works in Indigenous suicide prevention is an ongoing process requiring continued focus on evaluation of programs and services.

This leads to the first recommendation of this report.

1. All future Indigenous suicide prevention activity should:

- **utilise and/or build upon the range of success factors identified by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project**
- **include a commitment to and a provision for the evaluation of the activity and the dissemination of findings to further strengthen the evidence-base.**

Australian governments and agencies should not assume general population suicide prevention activity is enough to meet the needs of Indigenous communities. While some communities can, and should be able to benefit from general population suicide prevention activity, this is unlikely to meet the full range of their needs.

In particular, the need for primordial prevention or upstream measures that address the historical and present day impacts of colonisation on Indigenous communities, many of which are problems not generally faced by other Australian communities, requires dedicated and Indigenous community-specific and led responses. Further, as ATSIPEP has underscored, dedicated suicide prevention activity is needed to account for cultural differences between diverse Indigenous communities and the general population. This includes differences in:

- community and family organisation and governance
- understandings of health as social and emotional wellbeing¹¹⁹
- health-supporting practices, such as those provided by cultural healers.

The Roundtable Consultations in particular identified a set of common concerns about the ongoing effects of colonisation and its relationship to the high suicide rates among contemporary Indigenous people. Notably, what was described by one participant as 'theft of identity and spirit' – against which the development of a strong cultural identity and strengthening culture were important remedial activities.

Other common concerns were the social determinants of health associated with suicidal behaviours, in particular trauma and intergenerational trauma stemming from forced child removal resulting from and associated with practices of the 'Stolen Generations', and contemporary family dysfunction, violence, sexual abuse, substance misuse and high incarceration rates among youth and adults.

While communities share many of these problems, the context in which they are experienced and the priorities among them for any given community will vary. Because of this, a 'one size fits all' approach to suicide prevention in Indigenous communities should be avoided, and communities should be empowered to lead in the design and delivery of programs to meet their specific needs. As well as resulting in the identification of better responses to challenges, empowerment based approaches strengthened agency, brought hope and, if needed, supported communities to regain a sense of control over their affairs.

Differences in cultural practices and beliefs between communities only serve to underscore the need to empower communities and their cultural leaders to develop community-specific responses to suicide.

2. All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.

Community-based and youth Roundtable Consultations, and the national conference, highlighted the impact of the high rates of Indigenous imprisonment on suicidal behaviours. A common observation was that imprisonment and contact with the criminal justice system was part of a matrix of factors that collectively contributed to suicidal behaviours (among other problems) in Indigenous young people.

Further, these forums advocated for the broader need to redirect resources from imprisonment to mental health and other support services, particularly youth and family support services. Additional funding that supported access to quality education and employment for Indigenous young people was also seen as critical to primordial suicide prevention – even though a causal relationship to reduced suicidal behaviors may not be easily established.

In 2014, the imprisonment rate for Indigenous people was 13 times greater than for non-Indigenous Australians.¹²⁰ In 2012–13, Indigenous 10 to 17 year olds comprised about 40% of that cohort under youth justice supervision, and 50% of all young people in detention.¹²¹ Overall, they were 17 times as likely as non-Indigenous young Australians to have been under youth justice supervision.¹²² This gap has increased over recent years.¹²³ ATSIPEP encountered the impact of these unacceptably disproportionate imprisonment rates in real communities, on actual families and their children.

A major theme from the community consultations was to 'keep out of prison those who should not be there', principally Indigenous people and young people with mental health and substance abuse disorders. As is well documented, there are clear associations between mental health disorders and alcohol and drug problems, along with high imprisonment rates, for Indigenous people.^{124,125}

Justice reinvestment refers to policies that divert funds for imprisonment to local communities where there is a high concentration of offenders. The money that would have been spent on imprisonment is reinvested into services that address the underlying causes of crime in these communities.¹²⁶ In 2011, the Senate Legal and Constitutional Affairs Committee reported on its inquiry into the value of a justice reinvestment approach to criminal justice in Australia. Highlighting the potential of such an approach it recommended: 'that the Commonwealth commit to the establishment of a trial of justice reinvestment in Australia in conjunction with the relevant states and territories, using a place-based approach, and that at least one remote Indigenous community be included as a site.'¹²⁷

The need for Indigenous youth diversion activity and for better access to mental health and drug and alcohol services as a part of upstream, primordial suicide prevention activity gave rise to Recommendation 3. It also proposes justice reinvestment principles be used to fund such activities.

3. Justice reinvestment principles should be used to secure additional funding for a range of upstream diversionary activity for Indigenous young people away from the criminal justice system. This could include programs to support young people and families, sport or other activities, or by enhancing access to quality education and employment. Justice reinvestment principles should also be used to fund improvements to Indigenous mental health and alcohol and other drug services and programs.

As identified by ATSIPEP, the composition and skillset of the Indigenous suicide prevention workforce is critical. Trained Indigenous youth peer workers from the community, Elders and cultural mentors all have critical roles to play in Indigenous suicide prevention activity – bringing knowledge and understanding of community and family life, along with cultural support through the leveraging and building on cultural strengths, in addition to clinical skills.

A further observation, made particularly in the community Roundtable Consultations was that the mental health system and primary mental health care providers lacked the capacity to deal effectively with Indigenous clients with mental health problems, including those at risk of suicide. In particular, responses were not always culturally appropriate and it was becoming more evident that there was an increasing disconnection between service providers and communities. To counter this and otherwise meet service gaps, the training, employment and retention of Indigenous community members and Indigenous people as mental health workers, peer workers and so on was also seen as critical to building service capacity.

The Roundtable Consultations and the National Conference further highlighted the importance of an appropriately composed, skilled and trained workforce in all areas of Indigenous suicide prevention activity, which resulted in the development of the following two recommendations.

4. Governments should support the training, employment and retention of Indigenous community members/people as mental health workers, peer workers and others in suicide prevention activity. In particular, Indigenous young people should be supported and trained to work in suicide prevention activity among their peer group.

5. All mental health service provider staff working with Indigenous people at risk of suicide and within Indigenous communities should be required to achieve Key Performance Indicators (KPIs) in cultural competence and the delivery of trauma informed care. These services should also be required to provide a culturally safe environment.

The Royal Commission into Institutional Response to Child Sexual Abuse will deliver its final report by December 31, 2017. To date, over 32,000 cases have been handled and close to 20,000 letters and emails received. The Royal Commission has made a specific effort to target the needs of Indigenous Australians, recognising their overrepresentation in out of home care. Given the close relationship between child sexual abuse and suicide, preparation is needed now to address the outcomes of the Royal Commission.

6. Preparatory work should immediately commence to develop suicide prevention activities specific to the needs of those who have suffered child sexual abuse, in preparation for the release of the findings of the Royal Commission into Institutional Responses to Child Sexual Abuse.

The following recommendation was identified at the LGBTQI Roundtable. Placing Indigenous LGBTQI at the centre of responses was highlighted as a critical principle to guide future suicide prevention activity among this population sub-group at higher risk of suicide.

7. Indigenous people identifying as LGBTQI should be represented on all Australian Government and other Indigenous mental health and suicide prevention advisory forums.

(b) Recommendations on the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

Indigenous leaders in mental health and suicide prevention and the Australian Government agree that the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS), and the funds pledged towards it, should have impact. ATSIPEP evolved from this intention, with the aim of achieving a reduction in suicide and suicidal behaviours in Indigenous communities.

In the 2015 Australian Government response to the National Mental Health Commission's national review of mental health services and programs, it was announced that the NATSISPS will be implemented over 2016–20 predominantly through the dispersal of funds through the Primary Health Networks (PHNs). Hence the NATSISPS implementation is now inexorably bound to the work of the PHNs and it is important that as agencies they are able to respond appropriately. Many of the following recommendations therefore also go to the way PHNs operate as a necessary precondition for successful NATSISPS implementation.

The first recommendation is that the implementation of the NATSISPS not occur without a mediating Implementation Plan that uses the findings of ATSIPEP and guides work through PHNs and others with Indigenous communities to maximise the impact of implementation and limited NATSISPS resources. This recommendation was strongly supported at the National Conference.

8. A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan should be developed and funded, utilising the findings of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.

ATSIPEP has highlighted that critical to the success of PHN suicide prevention activity in Indigenous communities will be that PHNs ensure that community members are not only engaged with, but partnered. Critical points of engagement are likely to include:

- when PHNs are undertaking needs assessments regarding both the prevalence of suicidal behaviours and service/response gaps
- when a PHN is commissioning a service or program that addresses Indigenous issues including suicide prevention. Such service or program must be acceptable to the Indigenous communities it is intended to serve.
- when a PHN is evaluating a service or program. Indigenous communities that the service or program is intended to serve should be engaged in the evaluation process and their views given priority.

Such concerns go to the way PHNs operate and the following recommendation reflects further concerns that while some PHNs will likely be exemplars of good partners with Indigenous communities, others will fall short. A further recommendation then is that the service agreements between the Australian Government and the PHNs should ensure that the latter are accountable to the Indigenous communities they serve by virtue of ensuring Indigenous representation on key PHN governance and advisory forums and by formally requiring effective engagement and partnership with Indigenous communities at key junctures of the NATSISPS implementation process.

9. Service agreements between the Australian Government and the Primary Health Networks should contain Key Performance Indicators that require demonstration of cultural capabilities and standards, and representation of Indigenous communities on boards, community advisory committees and clinical councils. This is in part to facilitate effective engagement and partnership with Indigenous communities at key junctures of the NATSISPS implementation process including the development of suicide prevention needs assessments, commissioning services and programs, and evaluation of existing programs.

A focus for the above group is mental health problems in Indigenous communities that have particular relevance for suicide prevention. In particular, the rates of high and very high psychological distress are reported at three times the rate among Indigenous people when compared to the rate in the general population.¹²⁸ In fact, there is a broader mental health 'gap' across many indicators.¹²⁹ Suicide is only part of this bigger picture.

This is compounded by Indigenous people's lesser access to primary mental health services.¹³⁰ This might be due to services being inaccessible to Indigenous people for financial and/or geographical reasons, or for a reluctance to use those services available because they are not culturally safe environments, or because the staff are not culturally competent in service delivery. In the 2012–13 Australian Bureau of Statistics (ABS) Aboriginal and Torres Strait Islander Health Survey (AATSIHS), only about one in four (27%) of adults with high/very high levels of psychological distress had seen a health professional in response in the previous four weeks.¹³¹ ¹³² Primary mental health care is particularly important for treating depression and can be a gateway to specialist mental health care in severe cases.¹³³

Historically and to the present day, Indigenous people are largely obliged to rely on a health system and services that they have not developed and that they do not control, and that are based on concepts of health they do not share. In response, Aboriginal Community Controlled Health Services (ACCHSs) initiated, operated and controlled by Aboriginal communities were established to deliver holistic, comprehensive, and culturally appropriate health care, aligned to the social and emotional wellbeing concept.¹³⁴ These are now largely funded by the Commonwealth Department of Health.

ACCHSs have gradually begun to deliver mental health services. The 1997 *Bringing them home Report* highlighted the mental health impacts of the historical practice of forcibly removing mixed race Aboriginal infants and children from their families in order to assimilate them into non-Indigenous society.¹³⁵ Elements of a national response included mental health (counselling), social and emotional wellbeing and family reconnection services for removed Aboriginal people and their descendants largely delivered through ACCHSs.¹³⁶

Today, many ACCHSs and other Australian Government funded Indigenous-specific primary health care services (i.e. that are not community controlled) provide or connect Indigenous people to mental health and alcohol and drug services, including those provided by GPs working in them, and visiting mental health professionals. However in 2013–14, ACCHSs had 327,000 Indigenous clients against an estimated resident Indigenous population of 713,300 in June 2014.¹³⁷ This suggests ACCHSs were only accessible to, or used by, approximately about 40–45% of the Indigenous population.¹³⁸

Studies have found that for Indigenous people ‘where ACCHSs exist, the community prefers to and does use them.’¹³⁹ With appropriate resources, an ACCHS is able to implement a culturally safe, competent and comprehensive primary health care model based on the social and emotional wellbeing concept and that can optimally include mental health and related services.¹⁴⁰ However, in the Australian Government 2015 Service Reports, of the 203 Indigenous Primary Health Care Organisations including ACCHSs, 55% reported service gaps for mental health and social and emotional wellbeing; and 47% – alcohol, tobacco and drug service gaps.¹⁴¹

Recommendation 10 of this report supports building the existing primary mental health care and suicide prevention capacity and reach of the ACCHSs wherever possible when using funds pledged to NATSISPS rather than relying on mainstream mental health services. This again was a recommendation strongly supported by the ATSIPEP National Conference.

10. Aboriginal Community Controlled Health Services remain the preferred facilitators of suicide prevention activity to their communities, including the provision of primary mental health care services. This delivery of programs and services funded to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy through the Primary Health Networks.

The penultimate recommendation in this group is that the ATSIPEP Assessment Tool be used to guide the implementation of the NATSISPS, whether by PHNs or other bodies.

11. The ATSIPEP Assessment Tool for assessing Indigenous suicide prevention activity should be used to support the evaluation of applications for National Aboriginal and Torres Strait Islander Suicide Prevention Strategy funding to ensure conformity with the findings of the ATSIPEP.

Finally, the ATSIPEP Team is aware of the promotion of the ‘systems approach’ to suicide prevention currently being pioneered in Australia by the Black Dog Institute. While not yet tested in Indigenous community settings, the ‘systems approach’ involves nine evidence-based activities taking place simultaneously in any given community setting, with the understanding that they will have a cumulative effect in reducing suicide.

Because of this current focus on the ‘systems approach’ and the likelihood of Australian suicide prevention trial sites occurring at the same time the NATSISPS is implemented, the ATSIPEP team strongly recommends that any application to Indigenous communities ensures accountability for Indigenous cultural and experiential differences. Hence Recommendation 12.

12. The Success Factors identified by ATSIPEP should be included in the systems approach to suicide prevention when it is applied in Indigenous community settings. This should occur in consultation with Indigenous mental health and suicide prevention leaders, and in partnership with the communities concerned.

Recommendation 2 also applies in the above context.

(c) Disseminating and building on the findings of ATSIPEP

As stated, a major aim of ATSIPEP is to build the evidence-base for Indigenous suicide prevention. The Project has also generated a number of tools and resources for use in Indigenous suicide prevention activity.

13. The ATSISEPE findings, tools and resources should be broadly disseminated, and included in Australian Government portals.

Further to the above, Recommendation 14 is for the establishment of a national clearinghouse for Indigenous suicide prevention. This could be located in a university or other setting. Building on the work of ATSISEPE, the clearinghouse could be tasked with maintaining a cumulative evidence-base for what works in Indigenous suicide prevention and disseminating it through a searchable website, publications and a helpdesk. It would aim to improve the access of Indigenous communities, PHNs, policy makers, service providers and the general public to evidence on best practice and success factors.

The clearinghouse could be also tasked with rigorously assessing future evidence for policies and interventions by use of subject specialists, and maintain an online register of research and evaluation projects across Australia. It could also identify gaps in the available evidence on what works in Indigenous suicide prevention, with recommendations for addressing those gaps.

14. An Indigenous-led national clearinghouse for best practice in Indigenous suicide prevention activity should be established. This should be tasked to maintain the currency of ATSISEPE tools and resources over time.

Recommendation 15 supports participatory action research (PAR) as preferred methodology for future community based research into Indigenous suicide prevention and indeed in research in relation to many of the challenges facing Indigenous communities. PAR based research not only empowers communities to lead and tailor and trial their own responses to challenges, but communities also benefit directly from any data or findings generated in a positive feedback cycle. In this, learnings can be immediately adopted and incorporated into community practice as soon as they are evident. Findings of wider benefit are disseminated from the same foundation.

15. Participatory action research is the preferred methodology for future suicide prevention research in Indigenous communities.

The inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference was recognised for its success and value, and participants recommended that this become a regular bi-annual event for sharing and disseminating information and best practice as well as an opportunity to develop support and professional networks.

16. A National Aboriginal and Torres Strait Islander Suicide Prevention Conference should be funded to be held every two years.

(d) Recommendations on specific activity and programs

The ATSISEPE Perth Critical Response Roundtable was a response not only to the high Indigenous suicide rate in Western Australia, but also to suicide clusters (or spates of 'copycat' suicides) in WA communities. In this context, the Roundtable considered whether a highly mobile team that is able to identify and rapidly respond to suicide crisis situations in Indigenous communities would be an important complementary response to existing services and programs.

The recommendations of the Roundtable led to the establishment of the ATSISEPE Critical Response Project in December 2015 which will operate on a trial basis in WA until December 2016. A recommendation that builds on this is:

17. Resources should be made available to enable local Aboriginal and Torres Strait Islander communities to undertake critical response activities for their local communities with relevant stakeholders. Outcomes of the UWA Critical Response Project can inform these approaches.



APPENDICES

APPENDIX 1: SYNTHESIS OF SUCCESS FACTORS

This table contains a synthesis of success factors as identified by ATSIPEP across the range of its work (see along the top row for the activity in question). Information about the methodology can be found in other Appendices: Appendix 3 covers success factors identified in the Roundtables, Literature Review, previous consultations, the National Conference and other credible sources. Appendix 4 covers the meta-evaluation process.

TABLE A1:1 Synthesis of success factors

			ATSIPEP GENERATED						GENERAL POPULATION	
			INDIGENOUS						Synthesis of multiple sources	Systems approach
			ATAPS	Literature Review	Roundtable Consultations	National Conference	Analysis of previous consultations	Meta-evaluation of program evaluations		
UNIVERSAL/INDIGENOUS COMMUNITY WIDE	PRIMORDIAL PREVENTION	Addressing community challenges – poverty, social determinants		✓	✓	✓	✓	✓	✓	
		Cultural elements – building identity, SEWB, healing	✓	✓	✓	✓	✓	✓	✓	
		Alcohol/drug use reduction		✓	✓	✓		✓		
	PRIMARY PREVENTION	Gatekeeper training – Indigenous-specific		✓				✓	✓	
		Reducing access to lethal means of suicide								✓
		Awareness raising programs about suicide/use of resources/use of DVDs with no assumption of literacy					✓	✓	✓	✓
		Training of front line staff/GPs in detecting depression and suicide risk								✓
		E-health services/Internet/crisis call lines and chat services								✓
Responsible suicide reporting by the media							✓			
SELECTIVE – AT RISK GROUPS	SCHOOL	School-based peer support and mental health literacy programs							✓	
		Culture being taught in schools			✓					
	YOUNG PEOPLE	Providing hope for the future, education – preparing for employment			✓				✓	
		Peer-to-peer mentoring and education and leadership on suicide prevention			✓			✓		
		Programs to engage/divert including sport				✓		✓		
		Connecting to culture/country/Elders		✓	✓	✓	✓	✓		
INDICATED	CLINICAL ELEMENTS	Continuing care/assertive outreach post ED after a suicide attempt							✓	
		Clear referral pathways							✓	
		Time protocols	✓							
		Access to counsellors/mental health support						✓		
		24/7 availability			✓			✓	✓	
		Awareness of critical risk periods and responsiveness at those times			✓			✓		
		High quality and culturally appropriate treatments							✓	
		Crisis response teams after a suicide/postvention				✓		✓	✓	
Cultural competence of staff/mandatory training requirements	✓						✓			
COMMON ELEMENTS	COMMUNITY LEADERSHIP/ CULTURAL FRAMEWORK	Community empowerment development/ownership		✓	✓	✓	✓	✓	✓	
		Involvement of Elders		✓	✓	✓	✓	✓	✓	
		Cultural framework		✓	✓	✓	✓	✓	✓	
		Community-specific responses		✓	✓	✓	✓	✓	✓	
	PROVIDER	Partnerships with community organisations and ACCHS			✓			✓	✓	
		Employment of community members/peer workforce			✓		✓	✓	✓	
		Indicators for evaluation							✓	
		Cross-agency collaboration							✓	
		Data collections							✓	
		Dissemination of learnings				✓			✓	

APPENDIX 2: QUALITY INDICATORS FOR INDIGENOUS SUICIDE PREVENTION ACTIVITY

Presented here is a six-part set of quality indicators for Indigenous suicide prevention activity generated from the success factors discussed in Part One of the Report and summarised in Appendix 1. Two project tools, including the Indigenous Suicide Prevention Activity Assessment Tool and the Community Tool to Support the Development and Assessment of Indigenous Suicide Prevention Activity, were generated from this set of quality indicators.

The six parts comprise:

1. A need assessment component. This is a primary evaluative measure and overriding consideration but should be considered alongside quality indicators in other parts.
2. Quality indicators for the development process for universal and selective suicide prevention activities. These place value on community control and/or engagement and also requires a situational analysis and community action plan as the foundation for responses to suicide.
3. Quality indicators for universal and selective suicide prevention activity including those for service/program models.
4. Quality indicators for indicated services. These include non-negotiable clinical standards.
5. An outcomes assessment component that reflects the measures of the LiFE Framework.
6. Requirements and quality indicators for organisations involved in Indigenous suicide prevention activity. These include standard Australian Government requirements for contracting with organisations and cover quality indicators for how organisations are governed, their staff, and their connection to the spectrum of suicide prevention activity that may be occurring at the local, Primary Health Network-regional and national levels. These include requirements that suicide prevention activity be better integrated with responses to mental health problems and alcohol and other drug use found in the 2015 Australian Government response to the National Mental Health Commission's report of its National Review of Mental Health Services and Programs.

The indicators are also cross referenced to outcomes in the LiFE Framework and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

TABLE A2:1 Quality indicators for Indigenous suicide prevention activity

LiFE Outcomes	1. ASSESSMENT OF THE NEED FOR SUICIDE PREVENTION ACTIVITY	NATSISPS Outcomes
5.1 5.2 (i) 5.3 (i, ii)	<p>(i) Evidence of need/ongoing need/for suicide prevention activity in any given context</p> <ul style="list-style-type: none"> • evidence of suicide • evidence of suicide clusters • evidence of suicide attempts • evidence of suicidal thinking • evidence of self-harm • evidence of risk factors for suicidal behaviours (e.g. mental illness, depression, drug and alcohol use) • evidence of concentrations of high risk groups for suicide and corresponding risk factors for suicidal behaviours 	1.1 (i) 1.2 (i)
	(ii) Demonstrated lack of other activity in response	

LIFE Outcomes	2. QUALITY INDICATORS TO EVALUATE THE DEVELOPMENT PROCESS OF UNIVERSAL AND SELECTIVE ACTIVITY	NATSISPS Outcomes
2.1 (ii) 2.2 (i) 3.1 (i) 3.3 (i) 4.2 (i) 5.1 5.2 (i, ii), 5.3 (i, ii, iv)	<p>(i) The community shapes the activity within cultural frameworks</p> <ul style="list-style-type: none"> the community initiates, leads or supports and is appropriately engaged with the activity design process. ('Community' could comprise members of a high risk group e.g. LGBTQTI) activity is designed on the basis of community capacity building: proactive education about and promotion of social and emotional wellbeing, mental health and suicide prevention 	
	<p>(ii) A range of appropriate stakeholders are involved in the activity development process</p> <ul style="list-style-type: none"> community stakeholders include, as appropriate, Elders, men's and women's groups, families, cultural and community leaders, survivors, bereaved families, etc other stakeholders include, as appropriate, mental health services, health services, schools, police, media, etc 	1.1(ii, iii), 1.2(iii), 2.2(iii)
5.2 (i) 5.3 (ii)	<p>(iii) The development of the activity is based on a situational analysis</p> <p>This could include consideration of:</p> <ul style="list-style-type: none"> What levels of intervention are needed? Universal, selective, indicated? If selective, which groups in particular? If indicated, how will the community work to ensure its presence? What are the immediate, medium term and longer term priorities? What are the main causes of suicide/risk factors for suicide in the community? What lethal means are being employed by those who suicide or attempt suicide? What resources are already available to the community that could be used in suicide prevention activity? What is the appropriate balance of cultural and clinical approaches, and will this change over time? What are the gaps? Of these, what are the priorities? What are the barriers to the effective and efficient operation of the activity? How can these be addressed? What are the main risks to the activity and what management strategies should be in place? 	1.1(iv)
	<p>(iv) A community action or other appropriate plan to support the activity is in place</p> <ul style="list-style-type: none"> the plan includes appropriate success factors identified in Indigenous suicide prevention to date the program logic is clearly articulated the causal relationship between desired outcomes and activity is clearly articulated an evaluation component is built into the plan with evaluation questions identified articulated, agreed goals are set at appropriate milestones 	
	<p>(v) Plan connects with and is integrated with regional level planning undertaken by the PHNs, ACCHSs and other health and mental health services</p>	
	<p>(vi) When required, appropriate materials are included as a part of the activity</p> <ul style="list-style-type: none"> this is designed with community control/culturally appropriate/inclusive of genders/ language groups/clans/higher risk groups and others 	

LIFE Outcomes	3. QUALITY INDICATORS TO EVALUATE UNIVERSAL AND SELECTIVE ACTIVITY/ SERVICE MODELS	NATSISPS Outcomes
3.3 (iii, iv) 5.1 (i) 5.3 (i, iii) 2.1 (iv) 3.1 (iii)	<p>(i) Proactively engages with target client groups</p> <ul style="list-style-type: none"> activity is appropriately publicised – use of local media proactive engagement and outreach including to young people through providing or facilitating sports and other purposeful/ social and cultural activities resource materials developed and available as appropriate (culturally informed/in language/age appropriate/not assuming English literacy) works with/through school-based programs, youth services, men's and women's groups/existing community structures able to provide transport for participants 	1.5 (ii) 2.1 (iii) 2.1 (iv) 2.2 (i, ii)
	<p>(ii) Activity is able to prioritise and flexibly and appropriately respond to and/or refer those self-harming and otherwise at risk of suicide or with mental health or alcohol and drug problems to the appropriate clinical services within appropriate time frames/access postvention support services</p>	1.1 (iii)
	<p>(iii) Culturally informed/healing elements are present, and designed and delivered by the community/credible cultural leaders</p> <ul style="list-style-type: none"> on country activities connecting young people with Elders 	
	<p>(iv) Activity supports communities and families to address the impact of negative social determinants including those of suicide including by connecting them to a range of social support agencies</p>	
2.1 (iv) 2.2 (ii) 5.4 (iii) 2.1 (iv) 2.2 (iii)	<p>(v) Builds individual, family and community capabilities to respond to suicide and its risk factors</p> <ul style="list-style-type: none"> counselling/ safe spaces for people to discuss their concerns actively promotes and supports help-seeking behaviours gatekeeper/mental health literacy training provided to community members and identified natural helpers/reduces stigma promotes e-mental health and Indigenous suicide prevention apps (e.g. iBobbly) works with or helps establish family, youth, at-risk groups, peer support networks including peer-to-peer mentoring on suicide prevention supports community to provide postvention support 	2.2 (i) 1.3 (i, ii)
	<p>(vi) Works with the community to monitor and proactively respond to changing priorities and needs over time</p> <p>This could include responding to:</p> <ul style="list-style-type: none"> emerging groups at high risk of suicide potential crisis situations high risk periods for suicide (e.g. Christmas, wet season) 	
3.2 (ii) 3.3 (iv) 5.2 (ii) 2.1 (iii) 3.2 (iv) 4.1 (iii, iv) 4.2 (iv) 4.3 (v) 5.4 (i)	<p>(vii) Activity is integrated with other relevant community services and activities:</p> <ul style="list-style-type: none"> community based media outlets on responsible suicide reporting/promotion of activities community controlled and general population health services schools/youth services to address at-risk behaviours for young people – diversion programs prison health services a range of community support services including for those bereaved by suicide safe houses including women's shelters 	1.3 (iii) 1.4 (ii) 2.4 (ii) 2.5 (iii) 4.4
2.1 (i) 3.2 (iv) 3.3 (i) 4.1 (i) 4.3 (v)	<p>(viii) Activity is able to demonstrate wider community benefits</p> <ul style="list-style-type: none"> contributes to capacity for self-governance and other forms of empowerment employs community members builds life skills as appropriate including communication skills, relationship skills, conflict resolution, dealing with racism 	4.3 (i) 4.4

LIFE Outcomes	4. QUALITY INDICATORS TO EVALUATE INDICATED SERVICE MODELS (All indicators optimal)	NATSISPS Outcomes
	(i) Community engagement mechanisms in place <ul style="list-style-type: none"> • service is appropriately publicised – use of local media 	
2.1 (i) 4.1 (iii)	(ii) Consumer centred <ul style="list-style-type: none"> • consumer-centred - focus on whole of person wellbeing with a social and emotional wellbeing framework • develops mental health or other action plan for each consumer • maximises use of ATAPS/MBS subsidised services 	3.2 (iii)
4.1 (v)	(iii) Clinical capabilities/standards <ul style="list-style-type: none"> • 24/7 outreach • time protocols in place: contact with person at risk must be made within 24 hours, first clinical session with 48 - 72 hours. If not possible, support must be proactively provided to the person at risk while in the community • suicide risk and mental health assessments • provides high quality, evidence-based clinical mental health treatments, including mental health medications as appropriate • provides counselling and therapeutic postvention support for bereaved families and community members 	3.2 (iii) 3.2 (iii) 1.6 (i)
5.1 (ii)	(iv) Cultural safety <ul style="list-style-type: none"> • engaged with Indigenous consumers/communities to ensure a culturally safe and approachable service environment • access to translators for local language groups at short notice • option for client to be seen by an Indigenous staff member/person of their gender 	
	(v) Cultural elements <ul style="list-style-type: none"> • culturally informed treatment and cultural healers are available as appropriate • delivered in partnership with communities and subject to their cultural governance 	
2.1 (iv) 3.2 (i, iii) 3.3 (v) 4.1 (iv) 5.1 (iii) 5.4 (ii, iii)	(vi) Continuing care <ul style="list-style-type: none"> • ongoing, proactive and regular monitoring of person at risk of suicide after they have left the service, including outreach, particularly within 28 days of a suicide attempt • working in partnership with GPs, mental health and social support services to ensure long-term support in the community/or alternatives to the community if return is not possible • involves carers, family and kin in treatment as appropriate/support for carers, family and kin including by developing materials/builds the capacity of potential gatekeepers and natural helpers among them • supports the development of community and group support networks for those with the lived experience of suicide including those who have attempted suicide and those who have been bereaved by suicide • supports help seeking behaviour among those at risk of/who have attempted suicide 	3.2 (iii) 3.5 (iii)
2.1 (iii) 3.2 (iv) 3.3 (i) 4.1 (iii, vi) 4.3 (v) 5.4 (i, iv)	(vii) Connected to other services to enable the rapid referral for people at risk of suicide, and increasing other services' capacity to detect people at risk of suicide, including <ul style="list-style-type: none"> • universal and selective suicide prevention programs/postvention support services • hospital emergency departments to ensure continuity of care for those who have attempted suicide • community controlled and general population health services/GPs • frontline services • alcohol and drug services • wider support services – housing/employment/schools, etc. 	1.5 (v, vi) 3.1 (iii) 3.2 (iii) 3.3 (iii) 3.5 (ii) 3.6 (i)

LiFE Outcomes	5. ASSESSMENT OF OUTCOMES	NATSISPS Outcomes
	<p>(i) Measurable reductions in suicidal behaviours</p> <ul style="list-style-type: none"> measurable reductions in suicide, attempted suicide and suicide ideation among community/group at higher risk members – short and long term for indicated services – measurable reductions in suicide/suicide attempts within 28 days of initial attempt/discharge from care measurable reductions in risk factors for suicide/changes in at-risk behaviours including reductions in self-harm, alcohol and drug use – short and long term number of participants in various elements of the activity per year/as a percentage of relevant Indigenous population measurable increases in help-seeking behaviour/the use of mental health and related goods and services /improved mental health outcomes – short and long term measurable improvements to the social and emotional wellbeing of the community/ higher risk group with a focus on self-governance, cultural activity, physical health, employment, community safety and school attendance – short and long term 	
	<p>(ii) An assessment that the activity worked – for universal and selective activity, community action plan goals at various milestones achieved</p>	
<p>1.1 (i, ii) 1.2 (i, iii, v) 1.4 3.1 (ii) 4.1 (ii) 4.3 (iv) 6</p>	<p>(iii) Generation of agreed data and articulation/dissemination of learnings to contribute to the evidence-base for Indigenous suicide prevention</p> <ul style="list-style-type: none"> triangulation of data as possible support that the activity is effective in reducing suicidal behaviours and risk factors as above maximum dissemination of learnings – journal articles/conference papers, etc 	<p>4.2 (i) 5 6.2</p>
	<p>(iv) Ongoing community/consumer support for the activity</p>	
	<p>(v) Demonstrated ‘value for money’ and return on investment</p> <ul style="list-style-type: none"> demonstration of efficient use of human and other capital – short and long term 	

LIFE Outcomes	6. REQUIREMENTS AND QUALITY INDICATORS TO EVALUATE ORGANISATIONS INVOLVED (OR PROPOSED TO BE INVOLVED) IN SUICIDE PREVENTION ACTIVITY	NATSISPS Outcomes
	(i) Activity is supported by an appropriate legal structure	
	(ii) Fund holding and financial accountability mechanisms in place	
	(iii) Organisational risk analysis has taken place and management strategies in place <ul style="list-style-type: none"> • staff retention strategies including those working in remote locations, and including mental health support and other strategies to prevent burn out • public liability insurance as appropriate 	
	(iv) Demonstrated community support	
	(v) Effective governance in place <ul style="list-style-type: none"> • community control or engagement mechanisms in place • clinical governance mechanisms in place when required 	
	(vi) Appropriate cultural governance mechanisms in place for cultural activities that are a part of suicide prevention activity	
	(vii) Required infrastructure and consumables are accounted for <ul style="list-style-type: none"> • secure premises • consumables including vehicles, computers and other valuables are secure/insured 	
	(viii) Able to manage confidential participant/consumer information and data appropriately <ul style="list-style-type: none"> • secure place to keep records 	
5.4 (v)	(ix) Staff appropriately trained and/or qualified for their role/for the type of response <ul style="list-style-type: none"> • proactive upskilling of Indigenous workforce over time • clinical staff are appropriately qualified • non-Indigenous staff have received recognised cultural competence training • professional indemnity insurance as appropriate 	4.2
5.4 (v)	(x) Staff profile reflects (as appropriate) the genders/ages/clan and language groups of participants/consumers <ul style="list-style-type: none"> • maximum employment of community members/Indigenous people • capacity to deliver gender-specific activity/service • at-risk groups are represented in staff in activities that are aimed at these groups 	3.3 (i, ii) 6.1
3.3 (i) 4.1 (i, iii, iv, vi) 4.2 (i) 4.3 (i, ii, iii, v)	(xi) Connected with other elements of suicide prevention and related activity at the local, regional and national level/works to contribute to better patient transitions This could include activity with: <ul style="list-style-type: none"> • community controlled health services • e-mental health, mental health services, suicide crisis response services, universal, selective, indicated and postvention suicide prevention services • regional suicide prevention and other relevant efforts undertaken under the auspices of the PHN with ACCHS and health and mental health services/ local government, state and territory and national efforts • efficiencies identified from partnerships at regional levels 	1.5 (ii – vi) 3.4 (i, ii) 4.1 (i) 4.2 (i, iv) 4.4
	(xii) Capacity to monitor, internally evaluate and continually improve the response with inclusion of the evaluation component of plans developed under indicator 2(iv) and the outcome assessments in Part 5 of this Framework <ul style="list-style-type: none"> • ongoing evaluation of activity/service/materials with community/consumer involvement • continuous quality improvement practices in indicated services 	4.2 (i) 6.3 6.4

APPENDIX 3: OVERVIEW OF THE RESEARCH AND EVIDENCE

Part 1: Indigenous specific

1. Literature Review

- *Risk factors*

The literature focused on identified individual risk factors for Indigenous suicide which include exposure to trauma and depression, alcohol and drug problems, suicide clustering, along with additional challenges experienced by youth and males. Some of these risk factors are discussed in the Text Box below (see also, the Introduction).

TEXT BOX A3:1 Factors associated with Indigenous suicide identified in the Literature Review

As covered in the ATSIPEP Literature Review, a 2012 study of 271 WA Indigenous community residents found that almost all (97.3%) participants had been exposed to traumatic events. The same group of participants also had a lifetime prevalence of 55.2% for PTSD, 20% for depression, and 73.8% of participants met diagnostic criteria for alcohol abuse or dependence.¹⁴²

Trauma

Trauma is also associated with suicide. A 2006 study associated trauma and suicidal ideation in a sample of almost 750 West Kimberley Indigenous adolescents and young people, and found that in comparison to the non-Indigenous sample, Indigenous adolescents reported significantly increased exposure to direct trauma (trauma occurring to self) and secondary trauma (witnessing trauma occurring to others). Indigenous adolescents were four times more likely than non-Indigenous adolescents to have a family member die by suicide (29% Indigenous compared to 8% non-Indigenous). Multiple regression analysis revealed suicidal ideation and previous suicide attempts were significantly linked to exposure to direct trauma and PTSD.¹⁴³

For Indigenous people, research by Atkinson covered in the ATSIPEP Literature Review contends trauma can be passed through generations, whereby abuse incurred during childhood increases the likelihood of perpetuating abuse and destructive behaviours as an adult. In particular, the practice of forcible removal of mixed race Indigenous children from their families and communities in order to assimilate them into non-Indigenous society is associated with intergenerational trauma and mental health problems in the contemporary Indigenous population.¹⁴⁴ The 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) found that just under half of respondents reported that they and/or a relative had been removed from their natural family. Such were more likely to have high levels of psychological distress (35%) than those never affected by family removals (26%).¹⁴⁵

Other mental health problems

Other mental health problems are also associated with suicidal behaviour among Indigenous people. Researchers estimate that people with major depression are at a 20 times increased risk of suicide.¹⁴⁶ In the AATSIHS, 12% of respondents reported feeling depressed or having depression as a long-term condition compared 9.6% in the general population.¹⁴⁷ Over 2008–13, depression was the most frequently reported mental health related problem managed by GPs among Indigenous clients, followed by anxiety, and then use of tobacco, alcohol and other drugs.¹⁴⁸

- Researchers estimate that men with alcohol dependence and those who drink at levels of risk are at six times increased risk of suicide, with an increased risk for women.¹⁴⁹ Among Indigenous Australians, Chikritzhs et al. found suicide to be the most common cause of alcohol-related deaths among Indigenous males and the fourth most common cause among females.¹⁵⁰ In the AATSIHS, 16% of men and 12% of women reported problems related to alcohol¹⁵¹ – 13.9% of Indigenous men were drinking more than five standard drinks per day,¹⁵² and from these 8.1% were drinking more than seven standard drinks per day.¹⁵³ Indigenous people were admitted to hospital for acute intoxication at around 12.1 times the rate for the non-Indigenous population, with the highest rates of Indigenous people being from remote and very remote areas.¹⁵⁴ As covered in the ATSIPEP Literature Review, Hunter et al. suggest alcohol abuse is a symptom of wider Aboriginal and Torres Strait Islander disadvantage which the authors describe as a 'lifestyle of risk'.¹⁵⁵

- *Responses that have been the subject of studies*

However, while programmatic responses have been implemented across Australia only a relatively small subset have been evaluated, and few studies based on these evaluations have occurred.

While the Literature Review recognised a need for further research into current and past programs for success factors to be conclusive, it identified the following points as important approaches in preventing suicide in Indigenous communities:

- alcohol supply reduction strategies
- gatekeeper training programs modified to target Indigenous populations
- upstream community programs to address negative social determinants, to increase resilience and protective factors surrounding suicide, and to improve social and emotional wellbeing.

Much of the literature was concerned with scope and understanding the size, causes and determinants of Indigenous suicide. The literature indicated that the history of colonisation and associated disempowerment experienced by Indigenous people – not only in Australia, but also in New Zealand, Canada and the United States – is linked to current social and economic disadvantage among many in these populations, and to associated higher rates of suicidal behaviours.

As such, an address to suicidal behaviours among Indigenous people in postcolonial settings can be usefully framed in terms of ‘decolonisation’. That is, healing the worst impacts of colonisation and restoring and empowering communities to exercise self-determination in relation to the challenges they face.

The broadest responses to suicide prevention among Indigenous communities will require working with a different set of contributing factors than those that might be evident in non-Indigenous settings. It is accepted that ‘Indigenous suicide is different’.

Therefore, in contrast to non-Indigenous settings where the focus may be on particular families and individuals, Indigenous suicide prevention must take the broadest approach to include whole communities, at the same time as recognising differences between Indigenous communities. To accommodate this approach, ‘universal’ responses to Indigenous suicide prevention are defined in this Report as community-wide, not whole of population. The first level of response in healing communities is to tailor approaches so that a community’s particular history, cultures and challenges are included and that the community’s unique strengths are built upon.

The literature then identified upstream, community-led and tailored primary prevention programs. The programs, which aim to build on strengths, incorporate healing elements and are informed by culture and Indigenous concepts of social and emotional wellbeing, were the foundation response to Indigenous suicide prevention. This was the platform not only for empowerment (as important as that is) but also for communities themselves to begin to address their social and economic disadvantage and associated self-destructive behaviours (including, but not limited to suicidal behaviours).

The overarching finding of the Literature Review was the need for additional research. In particular, evidence was lacking to support the effectiveness of screening tools, online technology and crisis support and indicated interventions, including postvention, for preventing suicide in Indigenous populations.

Because of the need for future research in Indigenous suicide prevention, the Literature Review identified the following principles for this activity.

- Evaluation activity and resources must be incorporated into program development and implementation. Program evaluation must be seen as a key part of implementation, rather than a separate phase of policy development.
- There were limits on what could be expected from research in community contexts, particularly upstream community work described above. This is because identifying the cause and effect relationship between upstream approaches and reduced suicidal behaviours in communities presented significant challenges to researchers. There were also ethical challenges, in particular, randomised control trial (RCT) methodologies which, while acknowledged as providing the most robust evidence for or against suicide prevention activity, might be inappropriate. However, all Indigenous individuals, families and communities are entitled to benefit equally from suicide prevention research activity.

Research methodologies that could be useful to Indigenous people could include participatory action research whereby not only are communities empowered to lead the research and implement their own responses, but there are direct benefits from the research as a positive feedback cycle is created with learnings adopted and incorporated as soon as they become evident. More widely, research outcomes can then be disseminated from that basis.

Finally, the Literature Review did not identify any extant evaluation frameworks specifically for Indigenous suicide prevention programs, although it acknowledges the LIFE Framework as a valuable starting point.

2. Roundtable Consultations

Key themes which emerged from the Roundtable Consultations include:

- Self-determination and Local Leadership
- Social Determinants of Health
- Trauma
- Incarceration and Justice Issues
- Culture and Identity.

DIAGRAM A3:1 Locations of regional Roundtable Consultations



• **Mildura Roundtable**

Indigenous Australians reside everywhere from small, remote and discrete communities to capital cities. Each kind of location will bring its own challenges and suicide risks. Mildura was chosen as an example of a larger Australian town with a significant Indigenous population among whom high rates of suicide are recorded. In such a setting, with Indigenous and non-Indigenous living at close quarters, racism and social exclusion is a common experience. Here, the Indigenous population tended to live in relatively defined 'ghettos' where intergenerational poverty is perpetuated and access to government services, quality education and employment is low. Surrounded by often relatively affluent non-Indigenous areas, anger at their situation often leads Indigenous young people to alcohol and drug use, violence and other crime, and contact with the criminal justice system. Suicide can also result.

Participants highlighted that responses to suicide should be community-generated and owned, and that a 'one size fits all' approach that may work well in a discrete community would likely be ineffective. In Mildura, trauma and intergenerational trauma resulting from the colonisation process were seen as overarching, community-wide issues that government services were not effectively addressing.

Further, a range of needs from better housing to culturally appropriate diversion programs (from the criminal justice system) and alcohol and other drug reduction programs were identified. Overall, quality, engaging, culturally appropriate education that prepared young people for employment was identified as key to improving the wellbeing of Indigenous young people. In turn, families were recognised as being key to ensuring education was accessed and attended, but support from culturally sensitive government agencies would be needed to assist families in many cases.

- **Youth Roundtable**

The Roundtable focus was on the developmental factors that are associated with Indigenous youth suicide including better access to and support with education, reducing the rates of juvenile incarceration, and addressing trauma in young people. Participants highlighted the need for Indigenous young people to be empowered to work in suicide prevention activity among their peers, and that the role of Indigenous youth peers was seen as a critical success factor in some existing activity.

Participants identified the current impacts of colonisation – intergenerational poverty, racism and social exclusion and the lack of educational and employment opportunities – as critical to understanding the high rates of suicide among young people. Further, the high rates of juvenile detention and imprisonment, the inequalities in health status, and the high incidence of substance misuse were all different facets of this one problem.

Participants cited culturally appropriate, community-led solutions to the problems in Indigenous communities that impact on young people as critical to addressing these issues. Another strong theme was the involvement of Indigenous young in all decision-making forums associated with these activities. It was suggested that governments should include, and partner with, Indigenous youth leaders on regional and national forums when developing and implementing youth-specific strategies and priorities.

- **LGBTQI Roundtable**

The Roundtable considered structural factors to be addressed by suicide prevention activity aimed at this population group if it were to be effective. This involved identifying Indigenous LGBTQI suicides in data so that the problem could be quantified, and dedicated resources based on a needs assessment provided. Specific research into suicide prevention for this group was also a priority.

In terms of the unique challenges facing Indigenous LGBTQI, the importance of a healthy and combined cultural and sexual identity, without one excluding the other, was seen as critical. This was often a challenge. On one hand, homophobia and transphobia-based rejection by some Indigenous families and communities was traumatising. On the other, the negative impact of compounding discrimination (homophobia, transphobia and racism) from some among the non-Indigenous population, including racism from the LGBTQI community, took its toll. With so many variables, placing Indigenous LGBTQI at the centre of responses was highlighted as a critical principle to guiding activity in this area.

The Roundtable recommended that an ATSISEPP Fact Sheet be developed specifically to address issues for LGBTQI Indigenous people. A workshop was held at the inaugural Aboriginal and Torres Strait Islander Suicide Prevention Conference on May 4, 2016 in Alice Springs.

- **Justice Roundtable**

The Roundtable participants reported historical factors as significant and ranked ‘theft of identity and spirit’ as primary contributing factors in high incarceration rates. Trauma and intergenerational trauma stemming from colonisation were underlying issues compounded by poverty and poor housing. Participants were not only concerned that the development of a strong cultural identity was difficult for young Aboriginal and Torres Strait Islander people, but also their effective exclusion from educational and employment opportunities was also difficult. In effect, they were excluded from two worlds.

At the Roundtable, empowered communities and families were identified as key to restoring the wellbeing of Indigenous young people. Healing approaches that built on cultural strengths and otherwise aimed to reclaim and restore the practice of culture were also considered important. But equally, culturally appropriate government services should play a role in improving housing and the living conditions of young people. In the context of this Roundtable, access to quality legal services was important in reducing contact with the criminal justice system and the associated suicide risk.

- **Darwin Roundtable**

High rates of Indigenous suicide are reported across the Northern Territory. Intergenerational poverty and social exclusion were identified by the participants as predominant underlying factors that lead to self-destructive behaviour including (but not limited to) self-harm and suicide. Homelessness and crowded housing were described as significant issues. (It is estimated that about 12% of the Northern Territory’s Indigenous population is homeless to some degree). Participants also noted the high unemployment rate among Indigenous people in remote communities and towns (where the existing workforce is likely to be predominantly non-Indigenous), and the lack of opportunities in such places as a contributing factor to high suicide rates.

The Roundtable emphasised the importance of strengthening culture and identity in improving mental health and reducing suicide. Participants felt strongly that culture went to the heart of identity and was critical to self-worth, self-esteem and social and emotional wellbeing.

Participants described the value of cultural practices and knowledge systems and how they remain a part of Indigenous life, particularly in remote communities of the Northern Territory. These were strengths that could be built upon in suicide prevention.

Another theme was the need to address childhood trauma stemming from family dysfunction, violence, sexual abuse, substance misuse and the high incarceration rates among youth and adults. Participants felt strongly that in order to overcome challenges with trauma, a strong identity underpinned by culture was a critical foundation and one that required Indigenous perspectives and terms of reference to be at the fore.

In common with other Roundtables, the Darwin Roundtable highlighted local, Indigenous led solutions as key to preventing suicide. Participants described the need for an Indigenous suicide prevention workforce that should consist predominantly of local community members. They described the need for community leaders to be encouraged to support, lead and empower their communities in suicide prevention activity.

- **Critical Response Roundtable, Perth**

The Roundtable was a response not only to the Indigenous suicide rate in Western Australia being the highest in the nation, but also to suicide clusters (or spates of 'copycat' suicides) in WA communities. In this context, the Roundtable considered whether a highly mobile team able to identify and rapidly respond to suicide crisis situations in Indigenous communities was an important complementary response to existing services and programs.

After surveying existing responses to suicide, participants identified the following as undermining the effectiveness of existing responses to suicide:

- lack of coordination between responses at the Commonwealth, state and regional levels including service duplication
- lack of sustainable, 'staged' responses, with too many services in the immediate aftermath of a suicide, but too few over the medium and longer term
- lack of resourcing during 'peak suicide times' including weekends, after normal working hours, and at Christmas and New Year
- lack of access to services during wet season for some areas
- service insecurity caused by a lack of ongoing funding.

The need for community support and coordination with community services was also important if a 'critical response' service was to work. However, while there was agreement that local community members should be involved, trained and employed to address suicide and trauma, caution needed to be exercised to prevent such 'burning out', and the possibility that community members may need support themselves if those who completed suicide were kin or family members.

The following was agreed as important parts of a critical response:

- protocols to ensure a consistent approach to critical response that were sustained over time
- regional coordinators of suicide critical responses and workers
- identifying and working through the primary resource person in a community and providing support to them in this role
- a dedicated, resourced and appropriately trained pool of local trusted support workers to attend immediately following an incident. Among these there should be an equal distribution of men and women, and of Indigenous and non-Indigenous people. Caring and supporting these workers is essential.
- effective assessment tools to identify need and level of service provision – to calculate specific type of response required and length
- provision of 'wrap around' services over time and appropriate ongoing case management including development of multi-agency, coordinated response packages with appropriate information sharing between agencies.

It should be noted that attendees expressed their concern that the suicide crisis was just the 'tip of the iceberg' comprising the compounding impacts of negative social determinants, trauma and long-term psychological distress and psychiatric disorders among WA's Indigenous people. There was an equal need to respond at this level to Indigenous suicide.

Recommendations from the meeting:

1. It is recommended that the development of a critical response model takes place with each of the relevant stakeholders, including Commonwealth and state governments. This should address the various needs and suggestions identified in the Critical Response Meeting on 17 July 2015.
2. There should be ongoing discussions and planning between the ATSISEEP Team and Minister Scullion's office so that a more concise draft plan – with the inclusion of short-, medium- and long-term strategies – is identified and put into place.
3. The idea of establishing a Critical Response Model should be considered as an immediate short-term strategy. This work needs to be undertaken in partnership with the WA Mental Health Commission, and should work alongside existing plans such as the WA Suicide Prevention Strategy.

The above led to the establishment of the ATSISEEP Critical Response Project in December 2015 which will operate on a trial basis in WA until December 2016.

- **Kimberley Roundtable**

As in other Roundtables, participants highlighted negative social determinants and entrenched, intergenerational poverty as the fundamental issues that led to self-destructive behaviours including self-harming and suicide. Crowded housing, poor health, avoidable deaths among family and friends, a high unemployment rate and lack of opportunities were aspects to be addressed in any comprehensive effort to solve Indigenous suicide in the Kimberley. Yet the currently available social and emotional wellbeing approaches, programs and services (which also include family wellbeing programs) were, according to most participants, ineffective or insufficiently funded to be effective.

There was consensus that empowerment-based approaches that restored community leadership, agency, hope and regaining a sense of control were critical. These were based on education to support understanding of the causes of problems, and how individuals, families and communities can respond to them. So understood, empowerment not only had practical implications in that it promised to generate community-tailored responses, but also that – in itself – empowerment was important to counter the pervasive disempowerment of individuals, families and communities that flowed from colonisation, and that underpin present day intergenerational poverty and disadvantage. In that sense, empowerment was decolonising.

Empowerment would be truly effective when governments supported community leadership and adequately funded community generated and based solutions. This included a mental health workforce predominately comprised of local Indigenous people to help address unemployment. When this occurs, a sense of control over life will grow and create positive cycles in the place of negative ones. Empowerment based approaches will also strengthen a community's capacity for self-determination and for hope as well as build connectedness with other community members.

In the shorter term, participants expressed concern at the capacity of the mental health system and primary mental health care providers to deal with the number of Indigenous clients with mental health problems and the issues that caused or exacerbated them. Also these services were not always culturally appropriate. Participants expressed their concern at an increasing disconnection between service providers and communities. Other identified gaps included a lack of after-hours services when people in crisis need them most, especially those considered at high risk of attempting suicide.

Participants from stakeholder organisations expressed frustration at government funding criteria, which did not always align with community needs and priorities. They described that they were increasingly underfunded, overstretched and restricted in what they can provide and do. They expressed their frustration that they could not provide the levels of case management that they would like.

- **Suicide and Suicide Attempts Data and Statistics Roundtable**

The Roundtable considered three challenges in Indigenous suicide and attempted suicide data collection.

The first challenge was the variable quality of Indigenous identification in data records that results in the under-reporting of Indigenous suicides. While the National Coronial Information System is a robust entity, it is only as good as the data it receives. A number of possibilities for improving identification were discussed, most focusing on improving identification by linking data sets. The Registry of Births, Deaths and Marriages, for example, could supply Indigenous identification made at birth for death certificates or in hospital records. These could also be linked to hospital data. It was acknowledged there would clearly be confidentiality and ethical issues for data to be linked in this way. Other discussions focused on the capacity of police forces and even funeral directors to play a role in the identification of the Indigeneity of the deceased by sensitive enquiry among community, family and kin.

The second challenge was the need for real time data to support the identification of suicidal behaviour trends as they emerge, and for rapid responses to these trends. Delays in reporting suicide and attempted suicides at the moment mean that such might not be known for a considerable time after the fact. Potentially pioneering approaches were being considered in Queensland whereby potential suicides are flagged and reported daily by the coroner prior to making a formal finding. The Western Australian Coronial Suicide Information System (WACSIS) project is another example of work in this direction.

Finally, the third challenge was the apparent reluctance of coronial systems to identify the death of a child as a suicide. Of this, Victoria is emblematic – where there are no findings of suicide of children under 13 recorded. This is apparently on the basis that children under 13 are unlikely to comprehend what suicide means, and therefore cannot be said to hold the requisite intent when otherwise performing self-harming acts. In response, discussion considered Canadian research that showed that 80% of eight year olds understand the concept of death, and 100% of children at age ten understand the concept of death and suicide. While a very sensitive issue, not having accurate data could make a pressing Indigenous community concern invisible. The existing evidence suggests Indigenous children are completing and attempting suicide at significantly higher rates than their non-Indigenous peers.

- **Cairns Roundtable**

A general theme from the participants in the Cairns Roundtable was that socioeconomic disadvantage and various social and emotional wellbeing issues have led to the high rates of suicide. However, there was greater focus by these participants on the issue of Native Title and its significant negative effect. Participants believed that Native Title has impacted on communities causing fractured relationships along with an entrenched and deepening economic disadvantage for the majority of the region. However, the strongest message from participants was that solutions must be led by the communities and the workforces implementing solutions must be comprised of local Aboriginal and Torres Strait Islander people. Participants were adamant that such inclusion was paramount to effective outcome.

Participants from Cairns held similar opinions to those from the Kimberley and Darwin Roundtables with the view that as long as economic inequalities and social determinants remain effectively unaddressed, the impacts of various trauma and the self-destructive behaviours that culminate in the high self-harm and suicides rates will continue and worsen. Participants felt that social determinants are significantly fundamental to wellbeing. Each Roundtable had called for the implementation of Aboriginal and Torres Strait Islander led services and programs and for workforces to be predominately comprised of local Aboriginal and Torres Strait Islanders. However, the Cairns participants emphasised this even more so.

Participants felt strongly that transgenerational trauma is compounded by contemporary high unemployment rates and low education levels. Participants expressed the view that trauma recovery is inhibited by entrenched socioeconomic disadvantage and, by translation, racism.

- **Clinical Factors Roundtable**

The Clinical Factors Roundtable brought together professionals working in the field of mental health to discuss any defining themes that reflected their clinical engagement with Aboriginal and Torres Strait Islander communities and individuals. Interestingly, the issues raised by health professionals reflected the same concerns discussed at the Community Roundtable Consultations.

Education was perceived to be a key solution in the improvement of health, both through the improved dissemination of information promoting healthy behaviours, and as a general comment regarding the social determinants of health. The factual impact of broader health issues upon psychological health was raised, emphasising the interrelationship between physical health and social and emotional wellbeing.

All the participants spoke with considerable concern about the severe and ongoing levels of trauma and stress suffered by Indigenous Australians. As with other Roundtable consultations, the need to increase Indigenous participation in the health and mental health workforce was strongly argued, along with the importance of education. On this theme, the role of cultural healers was discussed and supported.

The damaging effects of alcohol use was acknowledged, as was the need to better assess, monitor and reduce risk so as to reduce the levels of self-harm and suicide.

- **Adelaide Roundtable**

The Adelaide Roundtable did not secure the cross section of representation from the suicide prevention and mental health providers that other ATSIPEP Roundtables secured. However, the participants who did attend did represent suicide prevention networks and the community as consumers of various services. The participants raised similar thematic backgrounds and contexts as in other Roundtables. Participants agreed that socioeconomic disadvantage had led to pronounced acute negative factors and dangerously low levels of social and emotional wellbeing, and that these negative factors and issues had led to high rates of incarceration, self-harming and suicide. There were general themes of incarceration and justice issues discussed. The Adelaide Roundtable participants were the most vocal of all ATSIPEP Roundtable participants in criticising the quality of service providers, describing disconnection between service providers and communities and families.

Participants expressed similar views as participants in the Kimberley, Darwin and Cairns Roundtables stating that incarceration rates continued to increase while the causal factors remain unaddressed. South Australia incarcerates Aboriginal and Torres Strait Islander people at the nation's third highest rate, behind only Western Australia and the Northern Territory.

It was strongly felt that transgenerational trauma was compounded by racism through contemporary views of non-Indigenous South Australians towards Aboriginal and Torres Strait Islander people. Criticism was directed at school curricula for failing to include a comprehensive history of Aboriginal and Torres Strait Islander people and failing to teach colonial invasion, dispossession, segregation, postcolonial and intergenerational poverty. Participants strongly felt that traumas experienced by increasing numbers of Aboriginal and Torres Strait Islander people remained unaddressed.

- **Shoalhaven Roundtable**

The Shoalhaven Roundtable secured a comprehensive representation of the various stakeholders in suicide prevention and mental health. The participants recognised that there was a complex set of factors that contributed to high self-harming and suicide rates. In recent years the Shoalhaven region has reduced suicide rates, however self-harming and attempted suicide rates remain high, with socioeconomic disadvantage, historical determinants and social and emotional wellbeing issues seen as contributing risk factors. The view was expressed that government funding levels were inconsistent and inadequate and therefore contributed to a smaller than desired Aboriginal and Torres Strait Islander workforce.

Strong concerns were expressed at the high levels of serious psychological distresses among people through Shoalhaven communities, with these psychological distresses, particularly among youth, being compounded by substance misuse. Participants emphasised that positive work had been achieved by a community-driven response during the last decade to reduce the suicide toll, however, this is always at risk with Government failing to adequately resource long-term support programs and services. There were concerns that youth are incarcerated in juvenile detention and adults in prisons at increasing rates, and that juvenile detention and incarceration were a damaging experience that compounded existing traumas and, for many, can lead to a degeneration into serious psychological conditions and aggressive complex traumas.

Overall, participants reported that an interconnected community participatory approach that has included mentoring with a focus on healing has contributed positively to reducing suicidal ideation and attempted suicides. Large and smaller service providers developed and piloted leadership, healing and empowering programs that were positively regarded. These included a focus on addressing social inequalities that can lead to a sense of powerlessness, and developing and inspiring a positive concept of self. Participants reported that successful mentoring programs including respect for historical and contemporary identity, the development of communication skills, and defining positive relationships were particularly valuable in restoring family and community relationships.

Transgenerational trauma and collective trauma were seen as significant issues that needed addressing. As with other ATSIPEP Roundtables, trauma was a major theme and social, emotional, mental, cultural and spiritual wellbeing were pivotal to renewal.

3. Previous consultations on Indigenous suicide prevention, including for the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

In addition to the Roundtable Consultations, ATSIPEP conducted a thematic analysis of previous consultations on Indigenous suicide prevention. In all, the contributions of 1,823 largely Indigenous participants from 69 sites across Australia over 2009–15 are included in the analysis. The National Empowerment Project consultation initiatives, for example, involved 457 participants across 11 sites respectively. The consultation reports are:

- The Elders Report, 2014
- Hear Our Voices Report, 2012
- Voices of the Peoples Report, 2014
- The Third Conversation Report, 2014
- NATSISPS consultations, 2013
- Blank Page Summit, 2009
- Conversations Matter, 2013

TABLE A3:1 Thematic analysis of previous consultations in Indigenous suicide prevention

Themes	The Elders Report, 2014	Hear Our Voices Report, 2012	Voices of the Peoples Report, 2014	The Third Conversation Report, 2014	NATSISSP consultations, 2013	Blank Page Summit, 2009	Conversations Matter, 2013
Community awareness raising	✓	✓	✓	✓	✓		✓
Community-led initiatives	✓	✓	✓	✓	✓	✓	✓
Connection to country	✓	✓	✓	✓		✓	✓
Cultural components	✓	✓	✓	✓	✓	✓	✓
Employment of community members	✓	✓	✓	✓	✓		✓
Family and kinship networks	✓	✓	✓	✓	✓	✓	✓
Focus on young people	✓	✓	✓	✓	✓	✓	✓
Healing programs or components	✓	✓	✓	✓	✓	✓	✓
Holistic approach	✓	✓	✓	✓	✓	✓	
Hope for the future	✓	✓	✓	✓		✓	
Involvement of Elders	✓	✓		✓	✓		✓
Rights-based approaches	✓	✓	✓	✓			
Strengths-based approaches	✓	✓	✓	✓	✓	✓	✓

These consultations were mapped, and the mapping linked to the various consultation reports as a community resource – see <http://www.Indigenoussuicidepreventionmaps.com.au>.

4. National Aboriginal and Torres Strait Islander Suicide Prevention Conference

Professor Ian Ring from the University of Wollongong identified themes from the Conference through the analysis of keynote addresses, plenary and concurrent sessions, and recommendations and comments as recorded by participants in notes and evaluation forms. Participants were encouraged to record recommendations and comments on paper covering the walls of the main conference hall.

A summary of these identified themes showed a significant concern for, and an interest in, culturally informed approaches to suicide prevention and culture acting as a protective factor against self-destructive and suicidal behaviours. The key themes are reflected in the Conference Recommendations at the conclusion of the Inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference Report which can be www.atsispep.sis.uwa.edu.au.

Themed topics:

- Language and culture teaching in schools, especially in remote areas, to provide protective factors against suicidal and self-destructive behaviours to children and young people
- Aboriginal Community Controlled Health Services and Indigenous control of Indigenous-specific Services in general. Priorities include the transfer of government Indigenous-specific services to Indigenous community control, especially health services, and the building of community capacity where required to take on the responsibility and accountability associated with controlling services
- Primary Health Network guidelines – these should designate Aboriginal Community Controlled Services as preferred providers of health services and the preferred location of suicide prevention services for Indigenous communities
- Expanding the National Empowerment Project to a nationwide program as a primary community empowerment based approach to addressing the upstream factors that can lead to suicidal and self-destructive behaviours
- National dissemination of the evidence-base for successful suicide prevention programs
- Critical response teams in all areas
- Child sexual abuse as a risk factor for suicidal and self-destructive behaviours
- LGBTIQ Indigenous people as a priority at-risk group within the Indigenous population
- Alcohol and other drug use (including 'ice') and the association with suicidal behaviours
- Justice reinvestment principles as a way of securing needs-based funding for mental health programs, alcohol and other drug programs, suicide prevention programs and youth programs (as below)
- Youth programs to engage young people and divert them from a range of self-destructive behaviours including suicidal behaviours

- Racism and its association with self-destructive behaviours including suicidal behaviours
- An annual or regularly scheduled national conference on Indigenous suicide prevention as a means of maintaining focus on the issue, dissemination of knowledge
- The need to develop a *National Aboriginal and Torres Strait Island Suicide Prevention Strategy* implementation plan (including an address to the thematic elements listed above, and others). The plan should clearly define actions for Indigenous communities to undertake, and the role of government including funding.

5. ATAPS Operational Guidelines – Indigenous-specific clinical services

The 2012 *Operational Guidelines for the Access to Allied Psychological Services, Aboriginal and Torres Strait Islander Peoples Suicide Prevention Services* were developed by the Aboriginal and Torres Strait Islander Mental Health Advisory Group, a group of mainly Indigenous mental health and suicide prevention experts in partnership with the (then) Commonwealth Department of Health and Ageing. Themes are:

- Time protocols
- Cultural competence of staff working with Indigenous people at risk of suicide/mandatory training requirements
- Operating within a cultural framework
- Partnerships with Aboriginal Community Controlled Health Services
- Recognising diversity in Indigenous client groups.

Part 2: General population sources

1. Synthesis of general population sources of evidence of suicide prevention that may hold some relevance to Indigenous communities

The ATISPEP team proceeded with particular caution in identifying themes from the general population suicide prevention space. The team only proceeded only when it was clear that there would be no harm to Indigenous communities or where there was no evidence to suggest an approach would not work.

Quality Indicators for Indigenous Suicide Prevention Activity are outlined in Appendix 2 of this Report. As part of the Community Tool, these Quality Indicators were tested in Indigenous community settings where there has been involvement with suicide prevention activity programs. This testing provided a further risk management strategy.

- *Suicide prevention strategy themes identified at state and territory level:*
 - Western Australian Suicide Prevention Strategy 2009–13
 - NT Suicide Prevention Strategic Action Plan 2014–18
 - NSW Suicide Prevention Strategy 2010–15
 - SA Suicide Prevention Strategy 2012–16
 - Tasmania’s Suicide Prevention Strategy 2010–14

TABLE A3:2 Themes in State and Territory suicide prevention strategies and Australian Government reports and inquiries on suicide prevention

Themes	Western Australia 2009 –13	Northern Territory 2014–18	New South Wales 2010–15	South Australia 2012–16	Tasmania 2010–14
Community leadership	✓	✓	✓	✓	✓
Crisis response	✓	✓	✓	✓	✓
Cross-agency collaboration	✓	✓	✓	✓	✓
Cultural competence of staff	✓	✓	✓	✓	✓
Data collection	✓	✓	✓	✓	✓
Dissemination of learnings	✓	✓	✓	✓	✓
Evaluation indicators	✓	✓	✓	✓	✓
Focus on young people	✓	✓	✓	✓	✓
Further research in suicide prevention	✓	✓	✓	✓	✓
Healing elements		✓			
Indigenous-specific responses	✓	✓	✓	✓	✓
Partnership with communities	✓	✓	✓	✓	✓
Postvention programs and support	✓	✓	✓	✓	✓
Referral pathways	✓	✓	✓	✓	✓
Strengths-based approaches	✓	✓	✓	✓	✓
Primary prevention/upstream approaches	✓	✓	✓	✓	✓

TABLE A3:3 Themes identified in Australian Government reports and inquiries on suicide prevention

Themes	Working Together Report, 2001	Gone Too Soon: Committee Report, 2012	The Hidden Toll Report, 2010	WA Ombudsman Report on Youth Suicide, 2014	Auditor General's Report WA, 2014
Crisis response	✓	✓	✓		✓
Cross-agency collaboration	✓	✓	✓	✓	✓
Cultural competency of staff	✓	✓	✓	✓	✓
Data collection		✓	✓		✓
Dissemination of learnings	✓	✓	✓		
Evaluation indicators	✓	✓	✓	✓	✓
Further research in suicide prevention	✓	✓	✓	✓	
Indigenous-specific responses	✓	✓	✓		✓
Postvention programs and support	✓	✓	✓		
Primary prevention/upstream approaches	✓	✓	✓	✓	✓
Partnerships with communities	✓	✓	✓	✓	✓

2. The 'systems approach' to suicide prevention

While not yet tested in Indigenous communities, the systems approach involves nine evidence-based suicide prevention activities taking place simultaneously in any given setting, with the understanding that they will have a cumulative effect in reducing suicide. There has been success in using this approach in Europe, where services and government have worked together in an integrated fashion with a localised focus.

At the time of writing, the systems approach underpins the development of Primary Health Network (PHN) guidelines for the planning and commissioning of suicide prevention activity across Australia within their regions. This includes suicide prevention activities for Indigenous communities as the PHNs will utilise funds pledged for the implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy to that end. The ATSIPEP team recognises that this engagement of the PHNs in the systems approach, and the Australian Government commitment to review national suicide prevention policy in its 2015 response to the National Mental Health Commission's report of its National Review of Mental Health Services and Programs, demonstrates a need for Indigenous suicide prevention activity to accommodate the systems approach. For this reason, the systems approach is used as a source of indicators for the evaluation framework, and ATSIPEP proposals align with the approach's nine evidence-based general population activities on the understanding that these might need adapting to account for Indigenous cultural and experiential differences.

The systems approach involves nine key strategies which range from individual through to community responses.

1. Appropriate and continuing care once people leave Emergency Departments (ED), and for those at risk in the community at any one time that includes:
 - 24/7 call out emergency teams experienced in adult/child/adolescent suicide prevention
 - crisis call lines and chat services for emergency callers
 - assertive outreach for those in the ED and discharged including those hard to engage with
 - e-health services of web programs through the Internet.
2. High quality treatment, such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT) for those with mental health problems (including online treatments).
3. Training of GPs in detecting depression and dealing with suicide risk.
4. Suicide prevention training of frontline staff every three years, including police, ambulance staff, and other first responders.
5. Gatekeeper training for persons who are likely to come into contact with at-risk individuals (teachers, youth workers, friends and family, clergy, counsellors).
6. School-based peer support and mental health literacy programs.
7. Community suicide prevention programs and awareness programs about suicide.
8. Responsible suicide reporting by the media.
9. Reducing access to lethal means of suicide.

APPENDIX 4: A DESCRIPTION OF THE METHODOLOGY USED AND FINDINGS AND SUCCESS FACTORS IN THE META-EVALUATION OF COMMUNITY-LED INDIGENOUS SUICIDE PREVENTION PROGRAM EVALUATIONS

The meta-evaluation of community-led Indigenous suicide prevention programs was undertaken alongside the Literature Review (discussed in the previous section of this report) to support the broader development of an evidence-base for Indigenous suicide prevention. The full title of the meta-evaluation is Suicide Prevention in Aboriginal and Torres Strait Islander Communities: Learnings from a Meta-evaluation of Community-led Aboriginal and Torres Strait Islander Suicide Prevention Programs, and in this Report is referred to as 'the meta-evaluation'.

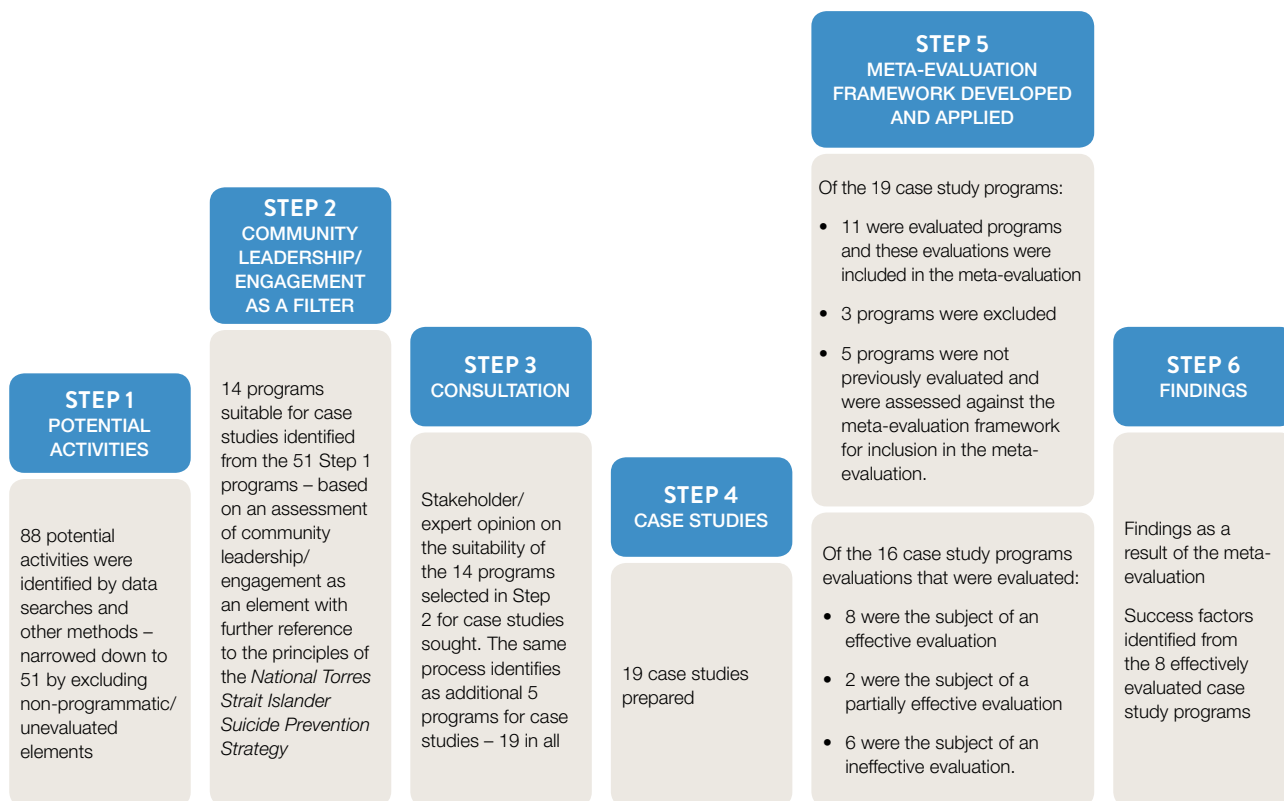
The meta-evaluation contributed to the above objectives by:

- undertaking a meta-evaluation of 16 Indigenous suicide prevention program evaluations, making findings and identifying success factors
- providing cases studies of 19 promising practice programs with strong community leadership or engagement
- providing an overview of 37 evaluated promising programs that were not within the ATSIPEP Terms of Reference.

The methodology to create the meta-evaluation comprised six steps:

1. The identification of 88 potentially 'in scope' Indigenous suicide prevention activities. Of these, 51 were selected as appropriate for further analysis. This was based on programs being programmatic and/or previously evaluated in some way.
2. The categorising of the 51 programs identified in Step 1 as 'promising' or 'other' according to the criteria of community leadership (by effective engagement or direct leadership). This was based on evidence, to a significant degree, in the development and implementation stages. In this Step, 14 programs were identified as 'promising'.
3. Consulting stakeholders and experts on the 14 programs identified at Step 2 as to the appropriateness of their identification as 'promising', and seeking advice as to whether there were additional community-led programs that should be part of the program evaluation review. This resulted in the addition of 5 programs to the 14 already identified (19 in all).
4. Preparation of case studies of the 19 selected programs (and preparing summary overviews of the 37 of the 51 programs that were categorised as 'other' at Step 2).
5. Undertaking the meta-evaluation, as follows:
 - Developing and applying a meta-evaluation analysis framework. Three criteria for an effective evaluation were used:
 1. whether community leadership and engagement had been effectively evaluated
 2. whether quality evaluation indicators were evident in the evaluation
 3. whether the evaluation included an impact assessment. In summary, did the evaluation seek to demonstrate that the program worked?
 - Applying the above to the 11 of the 19 selected programs identified as promising and that had been previously evaluated.
 - Conducting an assessment of 5 of the 19 programs that were identified as promising but had not previously been evaluated.
 - (Note that 3 of the selected promising programs were not included in the above because they were non-programmatic, for example, being focused on training workers).
6. Making findings and identifying success factors based on the meta-evaluation.

Diagram A4:1: Schematic representation of the methodology used to create the meta-evaluation



The meta-evaluation revealed that:

- eight of the promising programs were identified as having been the subject of an effective evaluation using the meta-evaluation framework
- two of the promising programs were identified as having been subject to a partially effective evaluation – that is, that some elements of the program were subject to effective evaluation but others were not
- six of the promising programs were identified as having been subject to an ineffective evaluation.

Findings of the meta-evaluation

1. Evaluation should be built into suicide prevention program design. Communities, and service providers exploring new models of suicide prevention activity with communities, should routinely access evaluation expertise before commencing the implementation of a new initiative – otherwise they run the risk of being unable to demonstrate the ongoing value and scalability of their initiative.
2. Promising programs with strong community engagement and/or leadership are not evenly geographically distributed. The applicability of promising community-led or -shaped models for suicide prevention needs examination in a broader range of jurisdictions; there are large populations of Aboriginal and Torres Strait Islander people that seem less likely to be able to access promising programs in New South Wales, Victoria, South Australia and Tasmania.
3. Partnerships between Indigenous communities/providers and general population providers to develop new, or adapt existing, suicide prevention programs for use in Indigenous communities should be encouraged. Governments should explore mechanisms for encouraging such partnerships.
4. Community leadership and engagement in Indigenous suicide prevention activity (universal and selective in the context of Indigenous communities) should be maintained, but strengthened in indicated and postvention services. Leadership groups in Aboriginal and Torres Strait Islander suicide prevention should assess whether there is a way to increase the breadth of new program development by program type beyond the current focus on prevention programs.
5. The systems approach to suicide prevention should be assessed for its suitability in diverse Indigenous community settings, and otherwise adapted under community leadership/with community engagement to account for Indigenous cultural and experiential differences in those settings.

Success factors identified from the eight effectively evaluated programs

Success factors included:

- peer-to-peer mentoring/education and leadership on suicide prevention
- counselling/safe space available for people to discuss their concerns
- community site specific/using community organisations
- support materials, use of DVDs with no assumption of literacy in participants
- connecting with young people through sport
- connecting young people to country, culture and community life
- connecting young people to Elders;
- awareness of critical risk periods
- 24/7 program
- community engagement/empowerment model to address negative social determinants and support social and emotional wellbeing
- gatekeeper training
- postvention.

Case studies of promising programs and overview of 'other' programs

The following 19 promising programs are the subjects of case studies in the meta-evaluation. These case studies are intended as resources for Indigenous communities, and providers wanting to work with communities, who wish to undertake suicide prevention activity.

- Mowanjum Keeping Place and Media Project, Junba Project (WA)
- GREATS Youth Service (NT)
- Alive and Kicking Goals! (WA)
- The Yiriman Project (WA)
- Warra-Warra Kanyi – Mt Theo Program (NT)
- UHELP (QLD)
- Family Wellbeing Project (QLD)
- Wesley Lifeforce suicide prevention (National)
- EK Youth Services Network (WA)
- Aboriginal Mental Health First Aid (National)
- QAIHC Lighting the Dark (QLD)
- National Empowerment Project (National)
- Suicide Story (NT)
- StandBy CPR (National)
- You me Which way (WA)
- The National Aboriginal and Torres Strait Islander Healing Foundation (National)
- The Djirruwang Aboriginal Mental Health Worker Education and Training Program (NSW)
- Red Dust Healing (National)
- Wontulp Bi-Buya Suicide Prevention Training Course (QLD)

APPENDIX 5: OTHER METHODOLOGIES

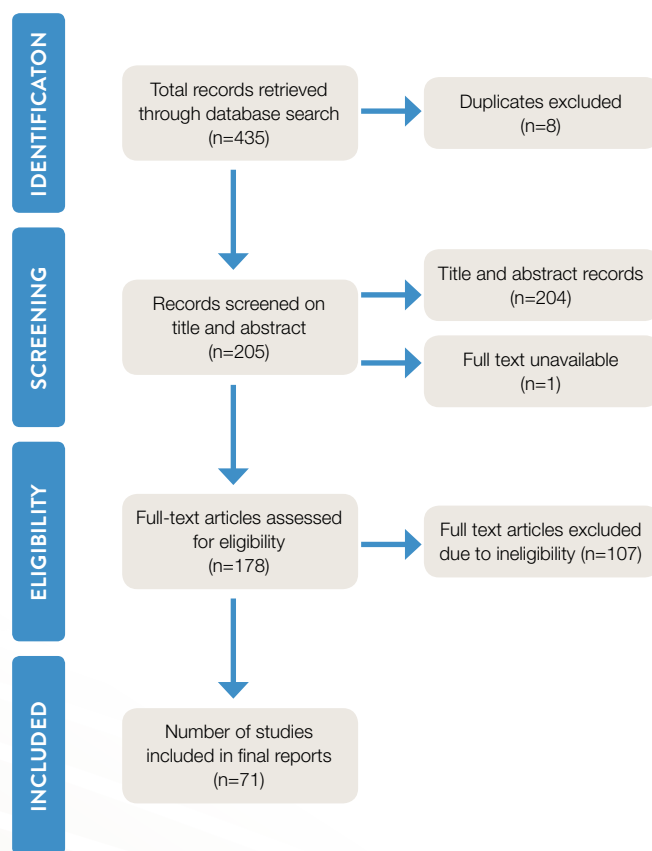
1. Literature Review

Relevant literature was sourced through systematic searches of databases, including MedLine (PubMed), PsychINFO, Cochrane library and Google Scholar, as well as pertinent journals including *Internet Interventions* and the *Journal of Medical Internet Research*.

Searches were conducted against relevant terms and an initial 435 studies were identified by a screen of their titles and abstracts. These were evaluated against inclusion and exclusion criteria. Full text versions of all studies which satisfied this initial screening were then obtained.

In screening the full text papers, the reviewer made the decision on whether the paper should be included or excluded, based on the pre-defined inclusion and exclusion criteria. At the end of this process, 71 studies were identified as illustrated in Diagram 5:1.

DIAGRAM A5:1 A schematic of the process by which literature for review was identified



The Literature Review was undertaken alongside the meta-evaluation of community-led Indigenous suicide prevention programs that is a major project outcome. This Literature Review also underpins the Indigenous Suicide Prevention Evaluation Framework and the Community Development Tool that are primary products of ATSIPEP.

2. Roundtable Consultations

The Project Team held 12 Roundtable Consultations across Australia in 2015–16. The methodology of most Roundtables was to first discuss subjects in full, then breaking into smaller groups to produce lists of concerns.

Mildura

The Project's first Roundtable was focused on the Mildura region, and was held on 12 March 2015 at the offices of the Mallee District Aboriginal Services. It was attended by 17 participants, including 9 males and 8 females between the ages of 30 and 65. A range of occupations and backgrounds were represented including government workers, police, ambulance workers, a psychiatrist, drug and alcohol workers and community controlled health workers. The majority of participants were Indigenous.

Youth

The second Roundtable, held in Canberra on 16 March 2015 and co-hosted by the National Aboriginal and Torres Strait Islander Healing Foundation, invited representatives from across Australia and focused on suicide prevention in the youth sector. The Roundtable was critical to the Project overall because self-harm and suicide rates are highest among Indigenous young people and children, and are increasing at alarming rates. It was attended by 13 participants, aged between 18 to 25 years, consisting of 6 males and 7 females, all who came from diverse professional and community backgrounds.

LGBTQI

People identifying as Lesbian, Gay, Bisexual, Transgender, Queer or Intersex (LGBTQI) are a high risk group for suicide, as are Indigenous people. The third national Roundtable co-hosted by the National Aboriginal and Torres Strait Islander Healing Foundation in Canberra on 18 March 2015 considered the intersection of these two population risk factors within the context of Indigenous suicide prevention. To the best of the Project Team's knowledge, this was the first Indigenous LGBTQI forum on suicide prevention. Ten participants attended, including 7 males and 3 females. They ranged from 25 to 65 years of age.

Justice

The Justice Roundtable, held on 20 March 2015 in Canberra and co-hosted by the National Aboriginal and Torres Strait Islander Healing Foundation, examined the connections between the disproportionate contact of Indigenous people with the criminal justice system, alongside incarceration and suicide rates, and how suicide prevention could work in this context.

Seventeen participants attended including 9 males and 8 females. All were at least 30 years of age, the majority of being 50–60 years of age. The majority of participants were Indigenous. Three self-identified as psychiatrists, two as academics, and others as working in family services, welfare and advocacy. Many also brought backgrounds of their own family experience with social justice and incarcerations and were experts on other related committees and projects.

Darwin

On 13 July 2015, the Darwin Roundtable took place, co-hosted by the Aboriginal Medical Service Alliance of the Northern Territory (AMSANT). In all, 20 participants including community leaders, psychiatrists, psychologists, mental health workers, suicide prevention coordinators, and family service project leaders from across the Northern Territory, took part. Eight were male and twelve were female, ranging between 30 and 70 years of age. The majority were Indigenous.

Critical Response Roundtable, Perth

On 17 July 2015, the Perth Critical Response Roundtable, hosted by the University of Western Australia, took place. Around 25 attendees including Senator the Hon. Nigel Scullion, Federal Minister for Indigenous Affairs, selected stakeholders (particularly from WA Indigenous communities and services) and the ATSIPEP Project Team participated.

Kimberley

On 27 August 2015, a Roundtable was held in Broome, hosted by the Kimberley Aboriginal Medical Services Council and the Kimberley Regional Aboriginal Health Planning Forum. The Kimberley region is believed to have among the highest rates of Indigenous suicide in Australia and suicide prevention in the region is a priority.

In all, 33 participants attended, including 10 males and 23 females aged between 20 and 65 years. Participants included community leaders, community advocates, members of affected families who were also working with service responders, primary and mental health workers, psychiatrists, clinicians, cultural workers, youth workers, family workers, family legal service workers, Standby National Response Service workers, suicide prevention coordinators, trauma counsellors, land council executives, mentor program coordinators, police, social and emotional wellbeing workers, and on-country program coordinators. Around 80% of participants were Indigenous.

Suicide and Suicide Attempts Data and Statistics

On 6 November 2015, a Roundtable on data and statistics was held in Canberra, hosted by the Aboriginal and Torres Strait Islander Healing Foundation. Eleven people attended representing a range of Indigenous and non-Indigenous experts, stakeholders and government representatives. Two members of the ATSIPEP team attended.

Clinical Factors

On 29 January 2016, a Roundtable on clinical factors was held in Darwin. The Roundtable was attended by six mental health clinicians, including a physician, three psychiatrists and two psychologists. Half the attendees were Indigenous. Two members of the ATSIPEP team attended.

Adelaide

On 26 April 2016, a Roundtable Consultation was held in Adelaide. Nine people attended, representing most of the key services. Two members of the ATSIPEP team attended.

Shoalhaven

The final Roundtable Consultation was held on 28 April 2016 in Nowra, NSW within the Shoalhaven region. The Roundtable was co-hosted by South Coast Medical Service Aboriginal Corporation. Twenty-three participants attended, representing local Elders and community members, health and administrative staff, and staff of the Department of Prime Minister and Cabinet. Two members of the ATSIPEP team attended.

For links to the complete Roundtable Reports see: <http://www.atsispep.sis.uwa.edu.au/community-consultations-and-roundtables>.

3. Thematic analysis and mapping of previous Indigenous suicide prevention consultations

While the Literature Review provided some success factors in Indigenous suicide prevention and a core body of indicators, the review also underscored that a comprehensive evidence-base for what works in Indigenous suicide prevention does not yet exist, and the basis for the breadth of indicators to support an effective evaluation framework is only partially present.

4. Mapping exercise

The maps and their features are illustrated in Part 2: Section 4 – Interactive maps on rates of suicide and trends over time.

The maps were developed by the Telethon Kids Institute (TKI) as part of their role in the ATSIPEP Team using data from the National Coronial Information System (NCIS). Some postcodes were aggregated to account for small cell sizes. The data from the NCIS provide the best available picture of suicide in Australian States and Territories, although there are difficulties in establishing conclusively the number of Indigenous suicides. This is because a significant number of suicides are classified as having an 'unknown' Indigenous origin. As a result, while the statistics presented here highlight that Indigenous suicide is a significant public health issue, they are likely to underestimate the true scale of suicide in Indigenous populations.

In general, caution should be exercised when interpreting Indigenous suicide data, particularly trends over time and data for smaller geographic areas.

The under-identification of Indigenous suicide is of particular concern in Victoria and South Australia. Deaths with 'unknown' Indigenous status accounted for around 30% of suicide in Victoria and over 70% in South Australia from 2001–12. The information provided in the maps for the geographic areas (postcodes) within these states may be too unreliable for general use and should be treated with extreme caution. Data for these two states have been included in an attempt to provide a complete picture of available suicide data across Australia.

In addition, there are challenges in estimating the size and structure of the Indigenous population. Population figures are used to calculate suicide rates and the quality of the population data has direct implications for the validity and reliability of Indigenous suicide rates.

In particular, the rates map was developed using the 2006 Census of Population and Housing because it provides population data at a postcode level and that can be correlated to the NCIS data. However, it has shortcomings with regard to obtaining an accurate count of the Indigenous population, e.g. it typically under-counts the population and there is missing information on Indigenous status. These shortcomings can be significantly amplified in some regions of Australia.

Given the data concerns outlined above, the maps produced should be interpreted with caution. They are designed to highlight the distribution of Indigenous suicide across Australia, the areas with relatively high Indigenous suicide rates, and provide insights into potential hotspots of Indigenous suicide between 2001 and 2012.

5. Discussion papers

ATSIPEP consultants completed two discussion papers: one on institutional racism in the health and mental health system and anti-racist interventions, and the other on real time data collections.

6. National Aboriginal and Torres Strait Islander Suicide Prevention Conference



Participants in the main conference room.

A key ATSIPEP deliverable, and a culminating point of the Project, was a national conference on Indigenous suicide prevention, believed to be the first of its kind in Australia. ATSIPEP brought together experts, stakeholders and members of Indigenous communities for two days at the Alice Springs Convention Centre on 5 and 6 May, 2016.

Intended outcomes were:

- Presentation of, and receipt of feedback on, the products of ATSIPEP, particularly the Evaluation Framework for Indigenous suicide prevention activity and Community Tool presented in sections 8 and 9 of this report respectively
- Recommendations for national action to achieve systemic change
- Forging a national alliance of key stakeholders for Indigenous suicide prevention
- Sharing of knowledge regarding suicide prevention, postvention, community capacity and resilience building
- Engagement and professional development of key stakeholders including Primary Health Networks, Commonwealth and jurisdictional bureaucracies, politicians, health professionals, academics, educators and others.

Governance

ATSIPEP established a committee that met for the first time on 12 January 2016 to oversee the development of the conference program and organisation. The members were:

- Professor Pat Dudgeon (Chair), University of Western Australia
- Dion Tatow, National Aboriginal Community Controlled Health Organisation (NACCHO)
- Mr Brendan Gibson, Department of the Prime Minister and Cabinet
- Mr Richard Weston, National Aboriginal and Torres Strait Islander Healing Foundation
- Ms Sue Murray, Suicide Prevention Australia
- Ms Erin Lew Fatt, Aboriginal Medical Services Alliance of the Northern Territory (AMSANT)
- Mr Dameyon Bonson, Black Rainbow
- Ms Donna Murray, Indigenous Allied Health Australia
- Ms Donna Ah Chee, Central Australian Aboriginal Congress
- Ms Vicki O'Donnell, Kimberley Aboriginal Medical Services Council
- Mr Gerry Georgatos, ATSIPEP
- Ms Adele Cox, ATSIPEP
- Dr Yvonne Luxford, ATSIPEP

Funding

The cost of the conference was covered by sponsorship from the Department of the Prime Minister and Cabinet, the National Aboriginal and Torres Strait Islander Healing Foundation, Western Australian Primary Health Alliance, Black Dog Institute, Healthy Matters, Rotary International, BeyondBlue, Suicide Prevention Australia, OneVision and Conference registrations.

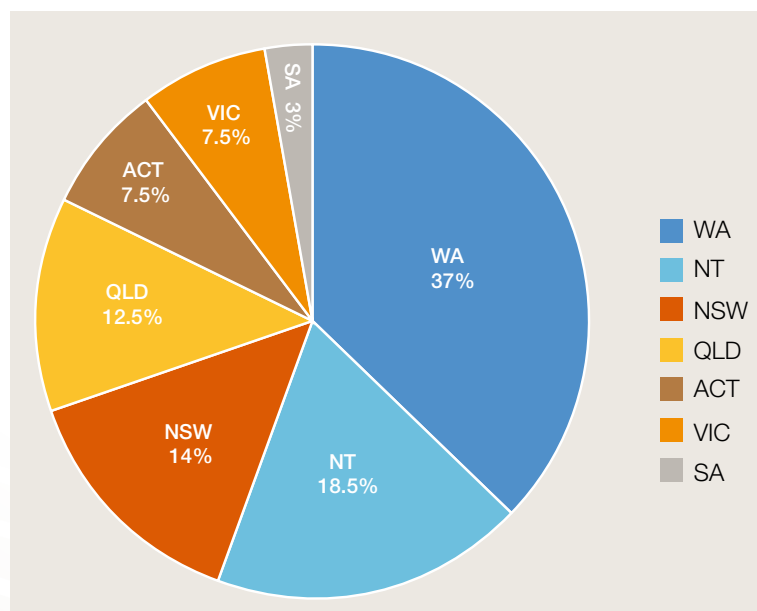
Participants

In total, 362 participants attended the conference including 196 external registrations. In addition, 5 counsellors (to help people who might be re-traumatised or distressed by the subject matter) and 9 speakers were fully supported to attend. In total 14 counsellors attended along with 11 Ngankari and an expert in flower essences available for participants who were distressed through the course of the conference. The National Empowerment Program held a meeting adjacent to the conference which enabled a further 35 participants to attend from the NEP.

Of the 191 attendees who completed evaluation forms, 130 identified as being Indigenous and 175 stated that they worked with Indigenous people.

The following charts show the distribution of participants from states and territories.

CHART A5:1: National Aboriginal and Torres Strait Islander Suicide Prevention Conference, state and territory resident participation



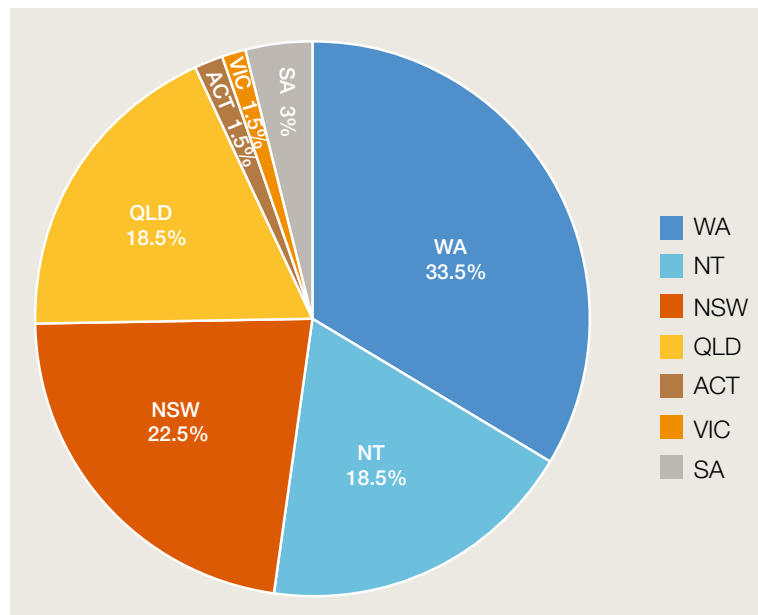
Source: ATSI SPEP

Participants were asked to identify their profession or field of work on the evaluation forms. In descending order, the other most common fields of work were:

- Health/medicine/nursing
- Social work
- Cultural/community development/consultant
- Suicide prevention/ postvention
- Academic/research
- Youth work.

Each full paying attendee paid \$770 (inc. GST) to attend the conference. Some money raised from full fee paying attendees helped to overcome financial barriers for others to attend, with bursaries being offered. Over 100 applications were received by the closing date for applications on 31 March 2016. Of these, 76 bursaries were offered. Chart A5:2 shows the distribution of bursaries allocated across the states and territories.

CHART A5:2: National Aboriginal and Torres Strait Islander Suicide Prevention Conference, state and territory resident bursary allocation (76 recipients)



Source: ATSIPEP

Program and keynote speakers

The themes for the conference were:

- Community-based solutions
- Social Determinants
- Partnership
- Clinical Factors
- Sharing Knowledge.

A call for abstracts and expressions of interest for presentations was made, with the deadline for receipt being 23 March 2016. Abstracts were assessed according to whether the applicant could demonstrate experience working in Indigenous suicide prevention, and/or lived experience delivering programs or services in an Indigenous community. Preference was given to applicants who were Indigenous or teams of Indigenous and non-Indigenous people.

High profile media personalities and champions of Indigenous rights and interests, Mr Stan Grant and Ms Rosalie Kunoth-Monks, were the keynote speakers.

The program is included at the end of this appendix.

Conference evaluation

As part of the conference, a formal participant evaluation form was developed and completed by 191 respondents. Collated, the completed forms revealed that:

- 99.5% of respondents were satisfied or very satisfied with the overall conference experience
- 98.5% agreed or strongly agreed that the conference provided opportunities to build and strengthen relationships and experience national networking opportunities
- 97% were satisfied or very satisfied with the facilities & venue
- 96.5% agreed or strongly agreed that the conference provided a culturally safe environment to learn and be actively involved
- 96.5% were satisfied or very satisfied with the keynote presentations
- 95.5% agreed or strongly agreed that the conference provided a positive experience that valued diversity of cultures and disciplines
- 95% agreed or strongly agreed that the conference developed their professional and personal skills and knowledge

- 95% agreed or strongly agreed that the conference explored innovation in Aboriginal and Torres Strait Islander suicide prevention
- 94.5% were satisfied or very satisfied with the support & organisation of the event
- 94% were satisfied or very satisfied with the concurrent presentations
- 94% were satisfied or very satisfied with the social program (Welcome Event, Dinner)
- 93.5% agreed or strongly agreed that the conference strengthened their understanding of Aboriginal and Torres Strait Islander health and wellbeing
- 93.5% agreed or strongly agreed that the conference was strengths based and action orientated
- 93.5% were satisfied or very satisfied with the panel discussions
- 86.5% were satisfied or very satisfied with the support such as counsellors. (NB 8.5% noted not applicable).

Media

The conference used the services of Croakey to increase its social media reach, assisted by sponsorship from OneVision. Croakey's stories and videos can be found at <http://croakey.org/category/croakey-news-and-projects/croakey-conference-news-service/atsispep/>

Participants also contributed their own blogs such as Joe Williams www.joewilliams.com.au/blog/2016/5/8/atsipep

There was also a strong Twitter presence at the conference. Many used the registered hashtag #ATSISPEP which assisted with analysing impact.

The conference also garnered significant coverage in traditional media, including the onsite recording by Stan Grant for an episode of the current affairs program, *The Point*. There were at least 58 published online and hard-copy articles along with television news stories and radio broadcasts of the conference. The main focus of the news stories were suicide prevention, what works in suicide prevention, what assists healing and wellbeing and improving lives and living conditions.

The conference sought to ensure a variety of voices and experiences were linked into the media coverage in order to reflect the lived experiences, community-driven programs, what works in suicide prevention and postvention, and also to amplify the needs of communities. In general it sought to educate people to the multifactorial issues that cause self-harming and suicides, but particularly what is needed to respond to these multifactorial issues.

The media coverage fairly reflected the conference and its focus on the ways forward.

Conference Recommendations

Culture

- Aboriginal language, culture and history should be introduced and embedded into the Australian curriculum.
- Traditional knowledge should be acknowledged through cultural maintenance programs and 'learning on country'.

Self-determination

- Government services, especially health services, should be transferred to Aboriginal Community Control. It is noted that a proper process will be required to ensure responsibility for inadequate services isn't transferred to unprepared communities.
- Aboriginal communities should not constantly be used as trial sites.

Services

- Primary Health Network guidelines should designate Aboriginal Community Controlled services as preferred providers.
- Mainstream NGOs should only be used as service providers if there is no suitable Aboriginal Community Controlled Service, and only at request of community.

That any comprehensive approach to Indigenous suicide prevention should include community-specific and community-led 'upstream' programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, such as the National Empowerment Project.

Suicide prevention programs

- All delivery services should be culturally appropriate.
- There is a critical need to have community engagement as a driving force for what people want to have happen in their communities.
- There should be ongoing innovative approaches to suicide prevention programs embracing art/music, multi-media and cultural content.
- National programs need to be adapted to local needs.
- Programs should incorporate the role of Elders.
- Traditional Healers should be recognised and acknowledged as part of the health system under Social and Emotional Healing.
- Training is needed for non-Aboriginal providers to enhance cultural safety.
- There is a need for male and female interpreters.
- People with lived experience should be consulted.
- There should be access to Aboriginal counsellors in all communities.
- Training should be provided for people who want to start healing groups.
- A national 'Healing Day' should be established for families living with the consequences of suicide, chronic illness and/or accidents.
- A greater focus on grief and loss is required with education and training delivered on a community-by-community basis and targeted to different age groups. Regional healing centres should be established.
- There is a need for 24/7 programs.
- There is a need for more programs back on country.
- Crisis response teams are required in all areas. Women's and men's group programs should be run separately.
- There is a need to develop rehabilitation and psychiatric programs, i.e. mental health services.
- Clear mechanisms must be established to ensure accountability of PHNs in their distribution of mental health/suicide prevention funding. They should support the expansion of ACCHO mental health/SEWB.
- Opportunities are needed to develop the Indigenous mental health workforce.
- Memoranda of Understanding should be developed, especially with the police.
- Information about successful suicide prevention programs should be nationally disseminated, along with resources such as the interactive maps which people can access on the ATSIPEP website.
- Resources should be provided to update and modernise Australian Indigenous Healthinonet suicide prevention section.
- Long-term funding is needed for suicide prevention programs.
- A National Peak Black suicide body should be established, with representation from around the nation and it should be funded to research and make policies and be engaged by government.

Child abuse

- Awareness should be raised on the impact and trauma (including historical trauma) of child sexual abuse as a potential contributor to suicide in our communities.

People identifying as LGBTQI:

- are overrepresented in suicides
- should have representation on committees
- should be included in the census or similar survey
- need to be included in the Safer Schools Program
- need to have specific policy gaps identified such as lack of services
- should be included in all suicide prevention plans.

Justice-related programs should be praised, funded and rolled out nationally including:

- justice reinvestment
- support programs inside prison
- post-release mentoring
- restorative justice programs like Koori Court and Working on Sentencing in Adelaide
- additional support to address drug use.

Youth

- State and national youth suicide prevention conferences should be supported.
- Pathways to higher education should be created through improved capacity of youth services.
- Secure safe houses for young children should be available in all locations.
- Local youth detention centres should be established to accommodate youth who are waiting to attend court.

Annual national Indigenous suicide prevention conferences should be held as a means of maintaining focus on the issue and to disseminate knowledge.

A strong contingent from Indigenous communities around Australia should be represented at the World Indigenous Suicide Prevention Conference.

There is a need to develop a funded Implementation Plan for the National Aboriginal and Torres Strait Island Suicide Prevention Plan which clearly defines actions that Aboriginal and Torres Strait Island people can, and will, undertake themselves, and that defines the role of government.

Gayaa Dhuwi (Proud Spirit) Declaration should be prominent in recommendations.

Future Conferences

Maori representatives from the organising committee of the World Indigenous Suicide Prevention Conference attended and presented at the Alice Springs Conference. Participants were encouraged to attend the World Indigenous Suicide Prevention Conference held in New Zealand in June 2016. During this, hosting of the next conference was passed on to the Australian team, and accepted on its behalf by Professor Tom Calma, AO.

Work has commenced to arrange and establish a consortium that will see both a national and an international Indigenous Suicide Prevention Conference, held side by side, in two years' time. This process will utilise the successes and learnings from the Inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference to create even more opportunities and positive outcomes in the future.

The program of speakers for the inaugural Aboriginal and Torres Strait Islander Suicide Prevention Conference follows on the next page.

PROGRAM

WEDNESDAY 4 MAY 2016

12.00pm	Conference Registration open	Foyer
9.00am – 3.00pm	PRE-CONFERENCE WORKSHOP Workshop: LGBTQI meeting	Boardroom
9.00am – 3.00pm	PRE-CONFERENCE MEETING National Empowerment Project meeting	Ellery C
1.00pm – 4.00pm	PRE-CONFERENCE WORKSHOP Art Workshop: Sponsored by IAHA	Ellery A
5.00pm – 7.00pm	<p>Welcome to Country <i>Lhere Artepe Aboriginal Corporation</i></p> <p>Welcome Reception – Alice Springs Convention Centre</p> <p>MC: Professor Tom Calma AO <i>Co-Chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group</i></p> <p>Cultural Activities – local entertainment</p> <p>Facilitator: Adele Cox</p>	

THURSDAY 5 MAY 2016

7.00am – 8.30am	Youth Breakfast	Tali Restaurant, Lasseters Hotel
1.30pm – 2.30pm	Conversations with Commissioner Helen Milroy (<i>invitation only</i>)	Boardroom

PROGRAM continued

THURSDAY 5 MAY 2016

7.30am – 8.30am	REGISTRATION	Foyer
8.30am – 10.00am	<p>Conference Opening Facilitator: Adele Cox</p> <p>Welcome to Country and Smoking Ceremony <i>Lhere Artepe Aboriginal Corporation</i></p> <p>Opening Address <i>Senator the Hon. Nigel Scullion, Minister for Indigenous Affairs</i></p> <p>Welcome to Delegates</p> <p>Professor Tom Calma AO <i>Co-Chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group</i> William Tilmouth <i>Chairperson, Central Australian Aboriginal Congress</i></p> <p>1 minute's silence to acknowledge those who have gone</p>	Conference Room
10.00am – 10.30am	MORNING TEA	Foyer
10.30am – 11.30am	<p>Update from the ATISISPEP Project</p> <p>Professor Tom Calma AO <i>Co-Chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group</i></p> <p>Professor Pat Dudgeon <i>Project Director, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATISISPEP)</i></p> <p>Richard Weston <i>CEO, Healing Foundation</i></p> <p>Rosalie Kunoth-Monks <i>Keynote speaker</i></p>	Conference Room
11.30am – 12.00pm	QUESTIONS	
12.00pm – 1.00pm	LUNCH 'Soul Hunter' film by Yolgnu youth and Elders	

PROGRAM continued

THURSDAY 5 MAY 2016 continued

1.00pm – 3.00pm CONCURRENT SESSIONS					
	COMMUNITY BASED SOLUTIONS	CULTURAL SOLUTIONS	SOCIAL DETERMINANTS	CULTURAL PRACTICES	YARNING CIRCLE
ROOM	Ellery A	Ellery B	Ellery C	Ellery D	Outside
FACILITATORS	Tania Dalton	Rob McPhee	Glenis Grogan	Vicki O'Donnell	Counsellors
1.00pm – 1.25pm		Nothing for us, without us. Themes, Challenges and Solutions Dameyon Bonson and Jay Delaney	Development of a Culturally Appropriate Aboriginal Suicide Prevention Skills Program Fiona Livingstone and Nathaniel Blacklock	Conversations with the Ngangkari Healer Group Uti Kulintjaku <i>Ngangkari Healer Group</i>	Drop in Yarning Place: Stories from the Heart
1.25pm – 1.50pm	Caring for Country, Caring For a Each Other June Mills and Duwan Lee <i>Larrakia Healing Group</i>	Restoring the Circle – CultuRegeneration Nola Turner-Jensen <i>Crackerjack Education</i>	Programs that Work StandBy West Kimberley Micklo McKenzie and Jacob Tyndall		
1.50pm – 2.15pm	Lighting the Dark – Preventing Aboriginal and Torres Strait Islander Suicide Dion Tatow <i>QAIHC</i>	Culturally Safe Practice – Suicide Story Jody Kopp and Natasha Abbott	Domestic Violence, Suicide and Aboriginal and Torres Strait Islander LGBTQI Vanessa Lee		
2.15pm – 2.30pm	Questions, Discussions and Recommendations				
2.30pm – 3.00pm	Feedback from concurrent sessions				Conference Room
3.00pm – 3.30pm	AFTERNOON TEA				
3.30pm – 4.30pm	Panel Discussion: Racism and Suicide Joe Williams Indi Clarke Professor Helen Milroy Tracy Jerri				Conference Room
4.30pm	CLOSE				
6.30pm	Conference Dinner Host – Tom Calma AO/ Ernie Dingo Entertainment: Ted Wilkes, Foxy Empire and Steven Oliver				Lasseters Hotel Amphitheatre

PROGRAM continued

FRIDAY 6 MAY 2016

9.00am	Adele Cox					Conference Room
9.15am – 9.45am	Stan Grant <i>Keynote Speaker</i>					
9.45am – 10.00am	Questions					
10.00am – 10.30am	MORNING TEA					Foyer
10.30am – 11.30am	CONCURRENT SESSIONS					
	DATA AND STATISTICS	PRISON AND ITS IMPACT	STOLEN GENERATIONS	INTERNATIONAL SPEAKERS NZ	YARNING CIRCLE	
ROOM	Ellery A	Ellery B	Ellery C	Ellery D	Outside	
FACILITATORS	Donna Murray	Tom Calma	Benny Hodges	Dion Tatow	Kelleigh Ryan	
10.30am – 10.45am	Kimberley Aboriginal Medical Services Council (KAMSC)	Indigenous Suicide and Incarceration Mervyn Eades	Stolen Generations – Panel Discussion Florence Onus – <i>The Healing Foundation</i>	Te Runanga o Ngati Pikiao Trust Michael Naera and Te Pae Fitzell	Drop in Yarning Place: Stories from the Heart	
10.45am – 11.00am	Vicki O'Donnell and Professor Murray Chapman	#JustJustice Summer May Finlay	Lionel Quartermaine – <i>Chair, National Stolen Generations Alliance</i>	Te Rau Matatini Mapihi Raharuhi		
11.00am – 11.15am	Update on ATSI SIEP project Roz Walker/Glenn Pearson <i>Telethon Kids Institute</i>	Justice Issues Heather Agius <i>Granny Group Member</i>	Ngaree Ah Kit – <i>Darwin Region Indigenous Suicide Prevention Network</i> James Morrison – <i>Consultant</i> Tjalamina Mia – <i>Sister Kate's Home Kids' Aboriginal Corporation</i>			
11.15am – 11.30am	Questions, Discussions and Recommendations					
11.30am – 12.00pm	Feedback from concurrent sessions					Conference Room
12.00pm – 1.00pm	LUNCH					

PROGRAM continued

FRIDAY 6 MAY 2016 continued

1.00pm – 3.00pm CONCURRENT SESSIONS					
	EMPOWERMENT	COMMUNITY BASED SOLUTIONS	SHARING KNOWLEDGE	SOCIAL DETERMINANTS	YARNING CIRCLE
ROOM	Ellery A	Ellery B	Ellery C	Ellery D	Outside
FACILITATORS	Tom Brideson	Erin Lew Fatt	Dion Tatow	Dameyon Bonson	
1.00pm – 1.25pm	Kimberley Empowerment Healing & Leadership Program Vicki McKenna and Brendan Cox KAMSC	Yiriman Keeps Country Good so Young People are Healthy Tanya Prizmic, Sylvia Shovellor, Jana Rivers and Dr Dave Palmer	Empowering Aboriginal Men and Women to Break Their Cycles of Abuse and Expressions of Lateral Violence Cheri Yavu-Kama-Harathunian	Warringarri Carol Hapke and Regina Sebastian	Yarning Circle Session Rosalie Green
1.25pm – 1.50pm	Blank Page Summit – Baton of Life Mary O'Reeri	Dadirri and Dialectical Behaviour Therapy (DBT) in Redfern: Deep Listening, Urban Peace Ken Zulumovski	LIGHT Ponds Kanat Wano	Strengthening Cultural Transition and Cultural Identity CASSE Team/Royal Flying Doctor Service	
1.50pm – 2.15pm	First Peoples Disability Network Australia Scott Avery	National Empowerment Project Glenis Grogan <i>Ngoonbi Community Services Indigenous Corporation</i>	Alcohol and Other Drugs Professor Ted Wilkes and Professor Dennis Gray	Hopelessness, Helplessness, Homelessness Cynthia Deeble	
2.15pm – 2.30pm	Questions, Discussions and Recommendations				
2.30pm – 3.00pm	Feedback from concurrent sessions				Conference Room
3.00pm – 3.30pm	AFTERNOON TEA				
3.30pm – 5.00pm	Panel Discussion: Solutions and Future Directions Professor Ted Wilkes Dameyon Bonson Tauto Sansbury Josie Farrer MLA Associate Professor Gracelyn Smallwood Dr Marcus Waters				Conference Room
5.00pm	Ngangkari Healing Session – Men's and Women's healing sessions				Outside
	Drum Atweme/CLOSE				Conference Room
6.00pm	BBQ				Double Tree Hotel
	LGBTQI Talking Together – Shared Yarning Space				Double Tree Hotel

APPENDIX 6: PROJECT GOVERNANCE AND STAFFING

Project Governance

Note: as this report completes Phases 1 and 2 of ATSIPEP (as summarised herein) the below statements are referred to in the past tense. However, many arrangements are still in place in order to progress phase 3 of ATSIPEP: the Critical Response Project.

Formal Project governance arrangements were established at the start of the Project with clear roles and responsibilities outlined for all Project staff.

Professor Pat Dudgeon was the Project Director and was responsible for the day-to-day management of the Project. She was supported in this task by the Project Executive Officer, Dr Yvonne Luxford and prior to that Mr John Shevlin. Duty statements were agreed for all key staff that described the responsibilities and accountabilities of each position.

Consultancy agreements were in place for all non-University of Western Australia (UWA) contractors and the Telethon Kids Institute (TKI), in addition to a formal Collaborative Agreement between UWA and TKI. These agreements clearly described the expected deliverables and timelines for each party. A separate Collaborative Agreement was also finalised with the National Aboriginal and Torres Strait Islander Healing Foundation in March 2015 and detailed the support that the Foundation has committed to the Project.

Key governance elements included the following.

National Advisory Committee (NAC)

The Project enjoyed strong Indigenous leadership on the National Advisory Committee – an important element in Indigenous ownership of the Project's findings and recommendations as well as in facilitating effective engagement with Indigenous communities and organisations across Australia. The Committee also appointed non-Indigenous expert advisors and stakeholders. Overall, the NAC was intended to sow the seed of a national alliance to support Indigenous suicide prevention initiatives.

National Advisory Committee Members:

- Professor Tom Calma AO – Convenor
- Professor Pat Dudgeon – Project Director
- Ms Georgie Harman – Chief Executive Officer, BeyondBlue
- Ms Lisa Briggs – (former) Chief Executive Officer, National Aboriginal Community Controlled Health Organisation
- Ms Pat Turner – Chief Executive Officer, National Aboriginal Community Controlled Health Organisation
- Ms Susan Murray – Chief Executive Officer, Suicide Prevention Australia
- Mr Richard Weston – Chief Executive Officer, The Aboriginal and Torres Strait Islander Healing Foundation
- Ms Donna Murray – Chief Executive Officer, Indigenous Allied Health Australia (representing the Social Determinants of Health Alliance)
- Mr Tony Campbell – Chief Executive Officer, Supportlink National
- Ms Megan Mitchell – National Children's Commissioner, Australian Human Rights Commission
- Professor Helen Christensen – Chief Scientist, Black Dog Institute
- Professor Gary Robinson – Director, Centre for Child Development and Education, Menzies School of Health Research
- Mr Dameyon Bonson – Founder, Black Rainbow Indigenous Lesbian, Gay, Bisexual, Transgender, Queer and Intersex organisation
- Dr Yvonne Luxford – Project Executive Officer (Secretariat)
- Mr John Shevlin – Project Executive Officer (former Secretariat)

The National Advisory Committee met on the following dates:

- 5 February 2015
- 10 April 2015
- 24 August 2015
- 8–9 August 2015
- 8 August 2016

The National Advisory Committee reviewed the Final Project Report prior to submission.

Senior Management Team

A Senior Management Team (SMT) was established to provide strategic guidance and support to the Project Director and to ensure that Project activities were conducted in a manner consistent with the agreed practices and processes of the University of Western Australia and that were likely to enhance the reputation and standing of the University. The SMT comprised:

- Professor Tom Calma AO, also the Project's Expert Adviser
- Winthrop Professor Jill Milroy, Project Sponsor and Dean of the School of Indigenous Studies
- Professor Pat Dudgeon, Project Director

Project Management Team

A Project Management Team (PMT) was established to monitor Project progress and met regularly. The PMT comprised, over time:

- Winthrop Professor Jill Milroy, Project Sponsor and Dean of the School of Indigenous Studies
- Professor Dudgeon, Project Director
- Associate Professor Roz Walker, Telethon Kids Institute, Evaluation and Research Lead
- Ms Adele Cox, Senior Indigenous Community Research Consultant
- Dr Yvonne Luxford, Project Executive Officer

Professor Calma from the SMT held a standing invitation to participate in regular PMT meetings.

Liaison with the Australian Government

Regular monthly meetings were held between the Project Executive Officer and key contacts in the Department of the Prime Minister and Cabinet and the Department of Health, in addition to ad hoc meetings as required.

Ethics Approvals

Obtaining Ethics Approval for the Project was an early focus of activity and one that was critical in ensuring community support and engagement with the Project. It also supported confidence in, and independent assurance of, the appropriateness and integrity of the proposed Project methodology, management and governance arrangements.

The Project sought and obtained Ethics Approval from the UWA Human Research Ethics Committee. The Community Roundtable Consultation held in Mildura on 12 March 2015 and the National Thematic Roundtables held in Canberra from 16–20 March 2015, were conducted in accordance with this approval.

Ethics Approval applications were also submitted to all state relevant bodies to support the National Roundtable consultations as follows:

- SA: Aboriginal Community Council of South Australia
- WA: Kimberley Aboriginal Health Planning Forum
- NT: Northern Territory Department of Health and the Menzies School of Health Research
- NSW: Aboriginal Health and Medical Research Council.

As a Queensland Ethics Approval process does not exist, the consultations planned for Cairns were progressed in accordance with the existing UWA approval with the involvement of the Queensland Aboriginal and Islander Health Council to minimise risk.

Collaboration with the Aboriginal and Torres Strait Islander organisation, The Healing Foundation

The Project was committed to building connections with other like-minded parties and drew on their experience and expertise wherever practical. An example of this cooperative approach is the Collaborative Agreement that was signed between the UWA and The Healing Foundation in support of the Project.

Under this agreement The Healing Foundation was formally recognised as a Project Collaborator and its status as such is acknowledged on the Project website and in formal Project presentations. For its part, The Healing Foundation freely shared its research data with the Project and hosted Roundtable Consultations at its Canberra offices. The Project gratefully acknowledges this support.

Project Staffing

In addition to the SMT and PMT staff described above, project staff over time included the following:

University of Western Australia Project Staff

- Professor Pat Dudgeon – Project Director
- Dr Yvonne Luxford – Project Executive Officer
- Mr John Shevlin – (former) Project Executive Officer
- Ms Adele Cox – Senior Indigenous Community Research Consultant
- Mr Gerry Georgatos – Community Consultant and Media Liaison Officer
- Ms Chrissie Easton – Conference Coordinator
- Ms Jan Burrows – Administration
- Mr Toby Hunter – Conference Administration

Telethon Kids Institute Project Staff

- Associate Professor Roz Walker – Principal Research and Evaluation Consultant
- Professor Sven Silburn – Senior Expert Adviser, Menzies School of Health Research
- Dr Claire Scrine – Senior Researcher, Telethon Kids Institute
- Ms Lana Hill – Research Assistant, Mapping Consultations
- Dr Brad Farrant – Senior Data Analyst
- Dr Carrington Shepherd – Data Analyst
- Dr Stephen Ball – Data Analyst
- Dr Ori Gudes – Spatial Mapping Consultant, Curtin University
- Dr Scott Sims – Adviser, Interactive Mapping

Consultants

- Healthcare Management Australia
- Mr Chris Holland

Administrative Support Staff

- Ms Nerry Nichols – School of Indigenous Studies, School Manager
- Ms Jan Burrows – School of Indigenous Studies, accounts and travel
- Ms Carolyn Mascall – School of Indigenous Studies, administrative support
- Mr Joshua Reynolds – School of Indigenous Studies, website
- Ms Chrissie Easton – Telethon Kids Institute and UWA, websites
- Ms Jacqui Bradley – Telethon Kids Institute, administrative support

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