Discussion Paper on Renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

Statistical snapshot from ABS Causes of Death (2019)¹

- Suicide is the fifth leading cause of death among Aboriginal and Torres Strait Islander (Indigenous) peoples. There were 169 Indigenous suicide deaths in 2018. Of these, about a quarter were female deaths.
- The median age of 2019 Indigenous suicide deaths was 31.8 years for males and 26.0 years for females. Compared to the non-Indigenous population, there are much higher death rates among younger Indigenous people (15 to 44 years of age) with lower rates among those 55 years of age and over.
- Suicide as a challenge varies across the Indigenous population. In particular, Western Australia has consistently recorded the highest and most growing death rate (34.4 in 2009-2013 and 37.9 in 2014-2018), with the lowest rates recorded in New South Wales. The Northern Territory in contrast has recorded a decrease in death rates across these periods.
- Suicide was the leading cause of death for both Indigenous and non-Indigenous children (under 18 years of age), but Indigenous children account for about a quarter of all child suicide deaths.

Overview

Gayaa Dhuwi (Proud Spirit) Australia (GDPSA) have identified seven steps in the process of renewing the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS):

Step 1: Establishing Indigenous control, governance and coordination of national and jurisdictional level suicide prevention activity relevant to Indigenous communities.

Step 2: Establishing Indigenous control and governance at the regional level.

Step 3: Establishing Indigenous control and governance at the community level

Step 4: Identifying program elements to be considered for integrated approaches to Indigenous suicide prevention at the community level.

Step 5: Identifying vulnerable groups within the Indigenous population challenged by suicide for selective prevention activity within an integrated approach.

Step 6: Developing and implementing Integrated service models for mental health and those at risk of suicide / after a suicide attempt/ postvention within an overall integrated approach.

Step 7: Ensuring the cultural safety of mainstream services.

Each step is now considered below. GDPSA invite you to provide comments at each, including in response to the questions we ask.
Step 1: Establishing Indigenous control, governance and coordination of national and jurisdictional level suicide prevention activity relevant to Indigenous communities.

NATSISPS Outcome 4.1 calls for:
- multi-sectoral coordination of suicide prevention to be established and sustained across levels and sectors of government;
- horizontal and vertical alignment of suicide prevention activity at Commonwealth... levels; and
- alignment between key policy frameworks relating to alcohol, mental health, Closing the Gap, Indigenous early childhood and... education.

National oversight and coordination of Indigenous suicide prevention efforts was necessary in 2013 – at the time of the NATSISPS publication - and remains important now. Further, as the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) acknowledges, national oversight and coordination is essential to most effectively ‘utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours’.2

Such an oversight and coordination mechanism or mechanisms should be under Indigenous governance as made explicit in the:
- Principles underpinning the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project’s (ATSISPEP) Solutions That Work report3;
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017-234;
- Gayaa Dhuwi (Proud Spirit) Declaration5; and
- Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention’s (CBPATSISP) Indigenous Governance Framework.6

Further, the 2020 Closing the Gap Agreement includes a target to achieve ‘significant and sustained reductions in Aboriginal and Torres Strait Islander suicide towards zero’ over the life of the agreement7. The achievement of a national suicide prevention target requires national coordination of activity towards a shared goal.

Such a mechanism could be placed within The National Suicide Prevention Leadership & Support Program, a group of bodies funded by the Australian Government to guide a national approach to suicide prevention.8

Question: If there is a national mechanism for the implementation of the renewed NATSISPS, which organisations should be a part of it? Consider:
- National Aboriginal Community Controlled Health Organisation (NACCHO);
- CBPATSISP within the National Suicide Prevention Leadership & Support Program. Its focus is on research and identifying best practice – effectively continuing the work of ATSISPEP;
- Gayaa Dhuwi (Proud Spirit) Australia; and
- Other organisations or groups.

(a) Alignment of State and Territory level activity to ensure national consistency in Indigenous suicide prevention

The NATSISPS was developed by the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group – a group of Indigenous suicide prevention experts and leaders - for the Australian Government. It was intended to guide a national response, but the States and Territories were not...
parties to it. Indeed, since 2013 many of the States and the Northern Territory have developed their own general population suicide prevention strategies but that include responses to suicide in Indigenous communities.

Against this background, the Fifth Plan commits all Australian governments to a national, integrated or systems-based approach to suicide prevention with 11 program elements which are discussed below in this paper. Further, for Indigenous suicide prevention:

**The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)** evaluated the effectiveness of existing suicide prevention services and programs with a final report, *Solutions that work: What the evidence and our people tell us*, presented to the Commonwealth Government in late 2016. This work will inform approaches adopted in the Fifth Plan. The National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2017–2023 is also a guiding document in the implementation of the Fifth Plan.

Because it aims for a national approach to suicide prevention, the Fifth Plan states that:

*many activities, plans and strategies that governments, peak bodies, commissioning agencies and service providers currently have under way align with the [11 program elements of integrated or systems approaches to suicide prevention]... Therefore, the critical step that needs to be taken is to bring into alignment all of these individual actions into a consolidated national suicide prevention implementation strategy with a national, cross-jurisdictional body responsible for governance and oversight.*

The Indigenous oversight and coordination mechanism discussed here, within The National Suicide Prevention Leadership & Support Program, could provide the governance and oversight required in relation to a national approach to Indigenous suicide prevention as set out in a renewed NATSISPS: an approach that ensures community control and is inclusive of responses to particular community needs.

**National-level Activities Requiring Coordination in Integrated or System Approaches to Indigenous Suicide Prevention**

The 2013 NATSISPS also refers to multiple national-level Indigenous suicide prevention agencies and activities that might require oversight and coordination. These, and initiatives established or proposed since 2013, include:

**A National Suicide and Self-harm Surveillance System**

NATSISPS Outcome 1.4 calls for: high levels of suicide and self-harm in communities to be identified and monitored to facilitate a planned response; with standardised methods for assessment and recording of suicidal behaviour and self-harm... reviewed for adoption by primary health care and specialist mental health services.

Further, ATSISPEP clarified that this should be a ‘real time’ surveillance system in order to support timely responses. In the Fifth Plan, a suicide surveillance system is one of 11 program elements within an overall integrated approach to suicide prevention. In the 2019-20 budget, $15m/3yrs (2019–20 to 2021–22) was allocated to the development of a suicide surveillance system by the Australian Institute of Health and Welfare, the National Mental Health Commission and the
Commonwealth Department of Health. This should include monitoring suicide in Indigenous communities.

**A National Indigenous-specific Phone Helpline.**

NATSISPS Outcome 2.4 calls to: review and remodel Kids Helpline and Lifeline counselling services to provide appropriate services for Indigenous peoples in each state and territory.

While not specifying helplines, ATSISPEP identified ‘access to counsellors and mental health support’ with ‘24-hour availability’ as a key success factor in Indigenous suicide prevention activity. The Australian Indigenous Psychologists Association have developed a proposal for a ‘Call-a-Cuz’ helpline.

In recent years, Indigenous specific jurisdictional and other helplines have opened, and the Covid-19 outbreak has increased Australian Government attention on the general population need for digital/online and helpline mental health supports. However, there is still a need for a national, 24/7 Indigenous-specific helpline.

**National Indigenous-specific Tele-mental health Services**

NATSISPS Outcome 2.5.ii calls for: the identification of strategies to expand Indigenous access to family and individual counselling through universal primary health care.

A national stream of health service-based tele-mental health services has been effectively trialled during the Covid-19 outbreak. Tele-mental health - including potentially national hubs servicing remote and urban areas - provides a promising avenue for expanding Indigenous access to family and individual counselling including to contribute to suicide prevention efforts. While this should not be viewed as a replacement, it might be useful as complementary, or additional to, services in communities.

**National Indigenous Suicide Prevention Research Agenda**

NATSISPS Action Area 5 (and Outcomes 2.5.iii and 6.3) are dedicated to an expanded research and existing activity evaluation agenda.

Outcome 1.2 of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017-23 (Social and Emotional Wellbeing and Mental Health Framework) calls for ‘a strong evidence base, including a social and emotional wellbeing and mental health research agenda, under Indigenous leadership.’

ATSISPEP has been a noteworthy example of this within the suicide prevention space. But while there are some Indigenous-led research projects underway, a new pool of research funds could be created to help communities lead suicide prevention research as well as for additional national projects.

**National Service and Workforce Standards in Indigenous Suicide Prevention**

NATSISPS Action Area 6 focuses on this area

This part refers to the need to revise the National standards for mental health services 2010; and National practice standards for the mental health workforce 2013. In particular, consideration
might be given to minimum standards in workforce clinical and cultural competence and service
cultural safety, and whether these need updating - including with reference to the Access to Allied
Psychological Services (ATAPS) Operational Guidelines for Indigenous Suicide Prevention Services\(^{23}\).

The generation of nationally consistent suicide prevention support resources is also needed.

In the NATSISPS:

- **Outcome 1.1** calls for the development of information and resource guides for coordinating
  community action to prevent suicide’; and ‘the review and dissemination of information on best
  practice models for community suicide prevention.
- **Outcome 1.2** is that materials and resources are available that are appropriate for the needs of
  Indigenous peoples in diverse community settings’ - with specific action to: (i) Identify resource
  gaps and needs (ii) Review and extend Indigenous language training programs for mental health
  and social and emotional wellbeing and (iii) produce resource materials in diverse formats for
  use by Indigenous peoples in different community contexts, including those with Indigenous
  languages.
- **Outcome 4.3.iii.** is to develop data, information and resources to support regional level planning
  and coordination of strategies’ as discussed below.

ATSIPEP and now CBPATSISP have already begun the development of such resources, including
identifying protocols and mental health and other assessments for use in services\(^{24}\). In particular,
CBPATSISP is currently developing a *Manual of Resources in Aboriginal and Torres Strait Islander
Suicide Prevention*. This will comprise navigable collections of existing and newly developed
information resources, for communities and individuals, services and clinicians, and funding
organisations. It is being developed under the guidance of Indigenous community members, with
additional engagement of priority groups including LGBTIQ+SB communities and children and young
people, and also draws on expertise from Indigenous and non-Indigenous support and service
organisations\(^{25}\).

**National Media Suicide Reporting Guidelines for Indigenous Communities**

Everymind, within the National Suicide Prevention Leadership and Support Program, is a national
organisation that promotes responsible media reporting standards around suicide and suicide
deaths\(^{26}\). CBPATSISP continues to work with Everymind to help promote these in Indigenous
contexts, and - where required - media training for Indigenous community leaders to support them
handling media interest in Indigenous suicide deaths\(^{27}\).

**National Postvention/ Crisis Response Services.**

**NATSISPS Outcome 1.6** calls for the development of postvention capacity in mental health services in
addition to services that could respond to natural disasters such as bushfires and floods.

The Fifth Plan lists both postvention and crisis intervention — ensuring that communities have the
capacity to respond to crises with appropriate interventions - as two of 11 program elements for
consideration in all integrated approaches to suicide prevention\(^{28}\).

The National Indigenous Postvention Service currently operates across Australia offering postvention
and crisis support to families and communities in need\(^{29}\).

**National Indigenous-specific Campaigns to Prevent Suicide**
A Fifth Plan program element of integrated approaches to suicide prevention is ‘Awareness—establish public information campaigns to support the understanding that suicides are preventable’\(^3\). National leadership is required in particular to ensure Indigenous-led campaigns are tailored to, and otherwise reach, Indigenous communities.

**A National Indigenous Mental Health and Suicide Prevention Workforce**

NATSISPS Outcome 6.3 is to: work towards a coordinated approach to such workforce development across sectors and levels of government’. This includes that (i) there are comprehensive plans to develop and support the participation of Indigenous peoples in the suicide prevention and wellbeing workforce such as nurses and counsellors (ii) review(ing) pathways to recruitment and training to enhance access to appropriate courses for community members; and (iii) working with Indigenous training organisations, the... VET sector and other organisations to build access to appropriate training options.

There have been many other calls for this critical element of national responses to Indigenous suicide and indeed expanding the Indigenous mental health workforce as follows:

- Outcome 1.1 of the Social and Emotional Wellbeing and Mental Health Framework calls for ‘An effective and empowered mental health and social and emotional wellbeing workforce’.
- Outcome 4.2 of the above calls for that a ‘culturally and clinically appropriate specialist mental health care is available according to need’ with key strategies including ‘ensuring the required mix and level of specialist mental health services and workers, paraprofessionals and professionals required to meet the mental health needs of the Indigenous population, including specialist suicide prevention services for people at risk of suicide’ (our emphasis).
- Theme 4 of the *Gayaa Dhuwi (Proud Spirit) Declaration*\(^3\).
- The ATSIPEP *Solutions That Work* report\(^3\).

**Question:** What do you think about specific national initiatives above that are proposed to be coordinated nationally under Indigenous governance?

What/who is missing?

**c) Coordination of National Indigenous Organisations**

Many Indigenous national organisations work to prevent suicide in some way and need to be accommodated within a national approach. These include:

- CBPATSISP\(^3\);
- NACCHO\(^3\);
- The suicide prevention trial sites in Kimberley\(^3\) and in Darwin\(^3\);
- The Aboriginal and Torres Strait Islander Healing Foundation\(^3\);
- The Secretariat for National Aboriginal Child Care\(^3\);
- The Aboriginal and Torres Strait Islander Lived Experience Centre, Black Dog Institute\(^3\); and
- Gayaa Dhuwi Proud Spirit Australia\(^3\) and the bodies that are its members including the abovementioned CBPATSISP and NACCHO in addition to the National Aboriginal and Torres Strait Islander Leadership in Mental Health\(^3\), the Australian Indigenous Psychologists Association\(^3\), Indigenous Allied Health Australia\(^3\), and the Australian Indigenous Doctors’ Association\(^3\).

Further issues should also be considered within a renewed NATSISPS and that would need coordination at the national level. In particular, an overarching Indigenous-led national strategic
response to heal trauma in Indigenous communities, families and individuals and halt the intergenerational transmission of trauma. This could include (a) trauma-aware and trauma informed mental health and other services; (b) the integration of Indigenous cultural healing and other specialised areas of healing practice into the mental health system as set out in the *Gayaa Dhuwi (Proud Spirit) Declaration*.

**Step 2: Establishing Indigenous Governance at the Regional Level**

In the NATSISPS:
- Outcome 4.2 calls for the development of governance and infrastructure to, and capacity for planning to, support regional and local coordination of suicide prevention.
- Outcome 4.3 calls to investigate the feasibility of approaches to regional coordination of suicide prevention including, but not limited to, roles of key government agencies and partners and (i) identify models for governance to support interagency approaches to coordinated suicide prevention and (ii) to examine models for pooling of funds to support coordinated approaches to prevention.

Since 2015-16 the Primary Health Networks (PHNs) have been charged with developing regional and community mental health and suicide prevention plans with Indigenous communities and have received as follows: in the 2016-17 Budget, $25m/4yrs for Indigenous suicide prevention; a $85m/3yrs for Indigenous mental health in 2016-17; and an additional $89m/3yrs in the 2019-20 Budget.

While the PHNs are required to be guided by the NATSISPS in relation to suicide prevention funding within their regions, the re-establishment of Indigenous governance and/or genuine accountability at that level is a concern. ATSISPEP and CBPATSISP have highlighted the following as critical points of PHN-community engagement 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.
- When a PHN is evaluating a service or program.

ATSISPEP further recommended 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 fora and by formally requiring effective engagement and partnership with Indigenous communities at key junctures as above.

Finally, the Productivity Commission review of the mental health system that published its interim report on 1 July 2020 had proposed all Australian government funding for mental health should be identified, pooled and distributed through dedicated mental health ‘Regional Commissioning Authorities’ with responsibility for pooled Commonwealth, State and Territory funding.

**Question:** If there is to be Indigenous governance of suicide prevention at the regional level, how could it best be supported?

Which organisations or groups should be involved?

**Step 3: Establishing Indigenous Governance at the Community Level**
In the NATSISPS:

- Outcome 1.1 calls for: communities must have the capacity to initiate, plan, lead and sustain strategies to promote community awareness and to develop and implement community suicide prevention plans.
- Outcome 1.1 includes identifying communities and regions... to workshop models for community action.

NATSISPS principles for implementation include:

- **Community control and empowerment**: projects should be grounded in community, owned by the community, based on community needs and accountable to the community.
- **Holistic**: based on Indigenous definitions of health incorporating spirituality, culture and healing.
- **Sustainable, strength based and capacity building**: projects must be sustainable both in terms of building community capacity and in terms of not being ‘one off’; they must endure until the community is empowered.

To date, the Indigenous-specific Kimberley suicide prevention trial site has been under Indigenous community governance, through the Kimberley Aboriginal Medical Services (an umbrella body for the region’s Aboriginal Community Controlled Health Services)\(^5\(^3\)\).

Even though integrated approaches are to be rolled out nationally, communities should remain in control of how they are implemented in place. This is important because each community, while perhaps sharing some challenges with others, will also be different – with distinct local challenges and cultural practices. Community-specific integrated approaches to suicide prevention must be free to respond flexibly and incorporate community-specific cultural solutions to their particular experiences of disadvantage.

**Question**: How can Indigenous governance of suicide prevention activity be best supported at the community level?

**Step 4: Identifying Program Elements to be Considered for Integrated Approaches to Indigenous Suicide Prevention at the Community Level Including Cultural Considerations**

**(a) Unique Program Elements of Indigenous Integrated Approaches**

**Promoting Social and Emotional Wellbeing**

NATSISPS Action area 2 is: Building strengths and resilience in individuals and families - includes long-term, sustainable prevention strategies that build resilience and promote social and emotional wellbeing that are specifically developed for Indigenous families and children.

The Social and Emotional Wellbeing and Mental Health Framework states that

> Indigenous communities and cultures are strong and support social and emotional wellbeing and mental health. Communities can be sources of support and resilience that promote social and emotional wellbeing when programs and services are culturally informed and provides for cultural practice and transmission. For optimal social and emotional wellbeing in individuals and families, empowering communities to heal and to revitalise culture and cultural practices may be required.\(^5\(^4\)\)

To that end, it recommends (among other activities) at Outcome 2.1:
• Strengthening community cohesion and restore and heal connections to culture and country including through reclamation and revitalisation;
• Engaging Elders and senior community members in leadership roles in a culturally informed way and support communities to support Elder wellbeing; and
• Supporting men’s and women’s groups and gender-specific promotion of leadership, SEWB and healing.

**NATSISPS Outcome 2.1** is to ensure there are culturally appropriate community activities to engage youth, build cultural strengths, leadership, life skills and social competencies.

The relevance of SEWB to youth suicide prevention also stated in Social and Emotional Wellbeing and Mental Health Framework Outcome 2.4 which recommends activity to:

*Support children and young people’s strong connection to culture and sense of belonging in communities, families and friendship networks as a way to support their resilience and to help protect against suicide.*

**Promoting Cultural Strengths**

Since 2013, significant evaluations have confirmed the need for cultural elements in any overall response to suicide, and youth suicide including those discussed in the UWA Transforming Indigenous Mental Health and Welling Project’s discussion paper: *Addressing Inequities in Indigenous Mental Health and Wellbeing through Transformative and Decolonising Research and Practice*.

An example from the above is the National Empowerment Project (NEP) - an Aboriginal led community empowerment project overseen by Professor Pat Dudgeon and that worked with Indigenous communities to develop, deliver and evaluate a program to promote SEWB, address negatively operating social determinants of health and reduce suicide. Using participatory action research, the NEP engaged eight Indigenous communities across Australia in 2012-2013, and a further three sites in 2013-2014, to identify risk and protective factors influencing mental health and social and emotional wellbeing; and develop strategies to respond to these issues through a focus on individuals, families and communities, using a SEWB reference framework. A 2017 evaluation reported that among the successes reported by the program were a strengthened sense of identity, including cultural identity specifically, and a renewed focus in communities of the importance of reconnecting with country and culture. The evaluation noted that ‘the positive benefits of feeling a sense of belonging, and family and community unity were also highlighted by the program’.

ATSISPEP also reported as a success factor in Indigenous suicide prevention ‘connecting to country/culture/Elders’ giving a examples several youth suicide prevention programs with this as their foundation.

ATSISPEP in particular stressed the need for upstream approaches to Indigenous suicide prevention within a community context. These include:

**Strengthening Families**

**IN the NATSISPS**

• Outcome 2.3 includes: ‘i. Developing culturally appropriate strategies for family engagement in wellbeing programs in multiple settings; ii. Making parenting programs adapted for Indigenous peoples more available in universal and targeted models to strengthen parenting skills and to improve behavioural, developmental and mental health outcomes among children; iii. Develop**
family focused interventions for Indigenous parents and children in partnership with childcare centres and schools; and iv. Disseminate information on models of effective early intervention and prevention for Indigenous families, parents and children.’

- Outcome 2.2. includes ‘developing strategies to promote the strengths of elders, fathers and other men as positive role models able to contribute to the wellbeing of community, families and youth’.

Among the general population, a 2017 report by the NSW Domestic Violence Review Team highlighted the link between domestic violence and suicide. The research used data from police to examine both reported and unreported histories of domestic violence in the lives of those who took their own lives from July to December 2013. Of the 330 suicides in the study, men accounted for 74 per cent and women 26 per cent. Of the women, 39 per cent were known to police in relation to domestic and family violence, either as a victim, a perpetrator, or both. That figure was 38 per cent for men.

While the precise association with family violence is uncertain, the overall number of suicides among Indigenous females nonetheless is an ongoing concern. As noted, about one quarter of Indigenous suicide deaths are female, and rates among Indigenous women are about twice as high as their non-Indigenous counterparts.

Addressing alcohol and drug use

Also reported by ATISPEP, researchers estimate that men with alcohol dependence and who drink at levels of risk are at six times increased risk of suicide, and such drinking levels for women results in even higher risk of suicide. Among Indigenous people in Australian, 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. Related to this, among the success factors in ATISPEP’s Solutions That Work were community responses to problem alcohol and drug use as appropriate and as determined by communities.

Social and Emotional Wellbeing and Mental Health Framework Outcome 2.1. supports communities to restrict alcohol supply and use among their members, while more broadly seeking to empower communities to identify and address alcohol and other challenges.

Contact with the Criminal Justice System

Indigenous peoples today comprised almost three in ten of all Australian prisoners despite comprising about three percent of the population. Almost five per cent of the Indigenous male population was incarcerated at March 2020. Not often considered is the potential association of contact with the criminal justice system and these incarceration rates with Indigenous suicide rates.

In particular, a 2011 Queensland study examined Indigenous and non-Indigenous coroner-declared suicide deaths and reported a criminal history in 32.5 per cent of Indigenous suicide cases: more than twice that recorded in non-Indigenous cases (15.8 per cent). Pending legal issues prior to death were also reported at elevated levels among Indigenous males at 13.7 per cent compared to 8.4 percent for the non-Indigenous. Almost half of the Indigenous male suicide cases were of men less than 24 years of age.

Reducing young people’s contact with the criminal justice system, and supporting the SEWB of Indigenous prisoners, are goals of the Social and Emotional Wellbeing and Mental Health Framework.
(b) Other Programs

Gatekeeper Programs

NATSISPS Outcome 1.3 is that there is access to community-based programs to improve suicide awareness among “gatekeepers” and “natural helpers” in communities affected by self-harm and suicide with action to i. Examine the option of trials for the expansion of culturally adapted gatekeeper programs in remote community and urban settings and ii. Develop, implement and evaluate training for Indigenous natural helpers.

ATSISPEP highlighted the presence of trained gatekeepers training as a success factor in Indigenous community-based suicide prevention, with specifically Indigenous gatekeeper training. And further, the Fifth Plan’s 11 program elements of systems or integrated approaches includes: Training and education—maintain comprehensive training programs for identified gatekeepers.

Means Reduction

NATSISPS Outcome 1.1 - iv.is to develop specific strategies regarding access to methods and means of suicide in the community.

This too is found in Fifth Plan’s 11 program elements of systems or integrated approaches: Means restriction—reduce the availability, accessibility and attractiveness of the means to suicide.

Question: What else is important in suicide prevention?

Step 5: Identifying vulnerable groups within the Indigenous population challenged by suicide for selective prevention activity within an integrated approach

Some groups within the Indigenous population have, or are believed to have, higher rates of suicide than the overall Indigenous rate. This includes those below whom are considered vulnerable to suicide, with specific responses to prevent suicide required.

Children

Particular additional focus should be on preventing the placement of Indigenous children in out of home care (OOHC).

NATSISPS Outcome 6.3 is that there is capacity to identify children with early or emerging risk of conduct, behavioural and developmental problems and options for referral of children and families at moderate and high risk, including families with complex multiple needs, to culturally adapted therapeutic programs. At a service or front-line level, this includes:

- Providing training for child health and early education staff to assist them in effectively identifying and responding to behavioural and early mental health problems at childcare, preschool and school.
- Engaging at-risk parents to provide parenting and family support via access to health, early education and childcare services as well as child protection services.
- Trialing and implementing culturally adapted therapeutic family interventions for Aboriginal and Torres Strait Islander parents and children.
- Developing strategies to identify and reduce risk associated with child protection interventions, including child removal, foster care and kinship care and practices of child placement.
• Improving identification of foetal alcohol syndrome disorder and other developmental impairments in children.

Focusing on OOHC, a key strategy within Social and Emotional Wellbeing and Mental Health Framework Outcome 2.4 is to:

*Develop strategic responses to support the social and emotional wellbeing of children in out-of-home care and establish appropriate connections between child protection services and a range of family and child-support services*.

Children who experience OOHC may also need ongoing mental health support as adults.

Support may also be required to support the SEWB and mental health of children with disabilities and those in carer roles, as indicated in the Social and Emotional Wellbeing and Mental Health Framework.

ATSISPEP highlights the importance of an address to child sexual abuse as upstream suicide prevention activity in some Indigenous communities, stating:

*The lifelong risk of suicide associated with child sexual abuse (40 times higher than the general population for females and 14 times higher for males...) indicates that no single preventative strategy will be sufficient, rather there is a need for ongoing access to services. Early intervention is essential.*

Young People

NATSISPS Outcomes 2.4.i and 2.5 call for adapting training resources and inclusion strategies for Indigenous students and families in mainstream programs such as KidsMatter now the Beyond Blue ‘Be You’ program and MindMatters.

A significant focus of the NATSISPS is on young people given their significant overrepresentation among suicide deaths. This paper has already discussed the NATSISPS emphasis on the importance of school programs, cultural programs and diversion from the criminal justice system as an upstream activity. This section now considers specific suicide-prevention activity among young Indigenous people.

Critical to activity in the Indigenous youth suicide prevention space is Indigenous youth leadership. This was recognised in broad terms in NATSISPS Outcome 2.1(iv), to: promote leadership through youth forums and activities to recognise achievements of young people.

CBPATSISP has also worked to emphasise the importance of youth leadership in youth suicide prevention. In particular, its report: *Empowerment and Accountability in Indigenous Youth Suicide Prevention Workshop Report* details outcomes of a workshop held in April 2019 in response to the Western Australian Coroner’s 2019 Inquest into the suicide deaths of young people in the Kimberley region. A workshop recommendation is that:

*The Council of Australian Governments (COAG) support a dedicated national Plan and strategic response to Indigenous suicide co-designed by Indigenous leadership bodies, people with lived experience, stakeholders and community representatives. A priority within this Plan would be a national response to child and youth suicide developed under Indigenous youth leadership*. 
The release of the workshop report was followed by a 2019-20 Budget announcement of $5m/4yrs for young Indigenous leaders to lead in the development of place-based cultural suicide prevention programs. The National Indigenous Australians Agency is currently implementing the program. Of note also, GDPSA has been funded to develop an Indigenous youth network to support youth leadership across the Indigenous SEWB, mental health and suicide prevention space.

A particular strand of youth suicide prevention activity identified as a success factor by ATSISPEP was youth peer to peer support; something also recommended by the NATSISPS at Outcome 2.1v. In relation to this, ATSISPEP note:

> **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.**

**People who Self-harm**

ATSISPEP reported that hospitalisation rates for intentional self-harm for Indigenous people (suicide attempts and other activity like ‘cutting’ oneself - sometimes understood as ‘cries for help’ but, potentially, paving the way for suicidal behaviours) increased by almost 50 per cent 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 for self-harm compared to 1034 Indigenous males. 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 percent of acts of self-harm resulted in hospitalisation, and that adolescents under-reported or failed to recognise behaviour as self-harm. The study also provided strong evidence for the prevalence of ‘copy-cat’ self-harm.

**Men**

**NATSISPS Outcome 2.2: calls for: Life promotion and resilience-building strategies that are developed for men; and that access to wellbeing services among Indigenous males is improved. This includes by:**

- developing strategies, including information and mental health promotion strategies;
- promoting the use of general health and wellbeing services and specialist services by men;
- identifying and disseminating good practices for men’s self-help group; and
- developing strategies to promote the strengths of elders, fathers and other men as positive role models able to contribute to the wellbeing of community, families and youth.

Efforts to reduce suicide among Indigenous men should continue as a focus of a renewed NATSISPS.

**LGBTIQ+SB**

A group not referred to in the NATSISPS was Indigenous Lesbian, Gay, Bisexual, Transgender, Queer-identifying and Intersex people + and Sistergirls and Brotherboys (LGBTQI+SB) people. While acknowledging that there is little specific data available, that this group are vulnerable was highlighted in the ATSISPEP LGBTQI+SB Roundtable consultation. Since the 2013 NATSISPS
publication, several Indigenous LGBTQ+SB groups have emerged, and Gayaa Dhuwi (Proud Spirit) Australia will also support an LGBTQ+SB community forum within its structure.

**Stolen Generations**

As the 1997 *Bringing them home* report makes clear, being forcibly removed from family as a child can result in a range of mental health challenges associated with the trauma, including grief, depression, self-harm, substance abuse and, for some, suicide.

**Question: Is there any other groups that should be included?**

**Step 6: Developing and Implementing Integrated Service Models for Mental Health and Those at Risk of Suicide / After a Suicide Attempt/ Postvention Within an Overall Integrated Approach**

- NATSISPS Outcome 3.2 calls for the support of integrated services, including targeted and indicated services for families and individuals by (i) developing and disseminating service models for services that combine specific targeted and indicated services in centres providing integrated wellbeing services; and (ii) Strengthening the focus on early intervention and suicide prevention within integrated services.

- Action 3 calls for Targeted services to be provided to individuals and families at a higher level of risk including those with mental illness, particularly those with a prior history of attempted self-harm; people in, or discharged from, custody; those with histories of alcohol and drug abuse or of domestic violence; and some people with histories of neglect and abuse.

Such integration is particularly important in post suicide attempt care including active services outreach and social and emotional wellbeing support after a suicide attempt, including after discharge from hospital or mental health facility. As the Fifth Plan notes:

*Suicide prevention efforts need to consider how services respond to people who have attempted suicide or are at risk of suicide. By providing intensive follow-up care during the days and weeks after a suicide attempt, or following discharge from inpatient psychiatric care, it is possible to reduce the risk of future suicide attempts*.87

Accessible treatment and post attempt care is one of the 11 program elements of integrated or systems approaches to suicide prevention in the Fifth Plan.88 Such calls are also broadly consistent with the calls in the NATSISPS (as above) and the Social and Emotional Wellbeing and Mental Health Framework for integrated mental health, social and emotional wellbeing, alcohol and other drug and suicide prevention services in Indigenous primary health care settings and other services settings.

Promoting the use of mental health services (albeit through the lens of stigma reduction in the mainstream) is one of the 11 program elements of integrated approaches to suicide prevention in the Fifth Plan.89 In relation to this, providing place based mental health services that are culturally appropriate and otherwise aligned with the SEWB concept is critical in Indigenous community contexts if mental health service use.

Along these lines, the Social and Emotional Wellbeing and Mental Health Framework calls for the establishment of social and emotional wellbeing teams in Indigenous primary health care services (including ACCHSs) linked to Indigenous specialist mental health services. Such teams could include SEWB workers, mental health workers, psychologists, Aboriginal and Torres Strait Islander mental health workers and occupational therapists depending on the need of any given population group.
Teams should also have the capacity to work with, and make appropriate referrals for children with symptoms of distress and trauma as illustrated below:

Diagram: Potential Reach of a Social and Emotional Wellbeing Team

In terms of clinical supports available to these teams, a range of culturally appropriate assessment tools should be available, and -as noted - the CBPSTSISP has provided best practice guidance regarding these. Such should provide a foundation for culturally and otherwise sensitive enquiry for suicide ideation by mental health professionals provided by or through social and emotional wellbeing teams and the services they are connected to, with ongoing clinical support, particularly after a suicide attempt.

Gayaa Dhuwi (Proud Spirit) Declaration Theme 1, Article 2 is that: Across their lifespan, Indigenous people with wellbeing or mental health problems must have access to cultural healers and healing methods. This touchstone of a ‘best of both worlds’ to Indigenous mental health care is promoted by GDPSA and reflects the fact that cultural healers already play an important role in maintaining and healing SEWB in many communities, and that an Indigenous person may want to use a cultural healer when within the context of mental health service delivery and should be so supported. Indeed, recognition of, and rights to, such are already included, respectively, in South Australia’s Mental Health Act 2009 (S.7) and Western Australia’s Mental Health Act 2014 (Ss: 50; 81; 189).

Partnerships with Aboriginal Community Controlled Health Services

The NATSISPS calls for partnerships: ‘projects should work in genuine partnerships with local Indigenous stakeholders and other providers to support and enhance existing local measures, not duplicate or compete with them’. Further:

- Outcome 3.2.v calls to investigate innovative models for partnerships between specialist mental health and wellbeing services (e.g. headspace) and Aboriginal and Torres Strait Islander wellbeing services and community organisations.
- Outcome 3.4, calls for links and partnerships between mainstream specialist mental health and wellbeing services and Indigenous wellbeing services and community organisations; and
• Outcome 4.4. calls to ‘build the capacity Indigenous organisations to sustain partnerships with governments and other organisations. And further, (i) Identify opportunities for complementary service provision arrangements and referral linkages between mainstream services and Indigenous community services to coordinate the provision of targeted preventive services.

While significant mental health service gaps are reported by these services, many of the approximately 150 ACCHSs spread across Australia already ensure their communities’ access to psychologists, psychiatrists and other mental health practitioners in place. Such is particularly important if place-based after attempt care is to be feasible in Indigenous communities. Partnerships otherwise provide a way of bringing additional expertise and clinical care to ACCHSs delivery sites and otherwise.

Perhaps the most compelling ACCHSs partnership model to be implemented to date, however, is within the Statewide Specialist Aboriginal Mental Health Service (SSAMHS) of WA aimed at Indigenous people with severe and persistent mental illness. The key objectives of SSAMHS are improving access to culturally appropriate mental health services for Aboriginal people and their families; building the capacity of the Aboriginal mental health workforce; developing and maintaining interagency partnerships aimed at the development of a more holistic approach to Aboriginal mental health; as well as improving the cultural understanding and functioning of mainstream mental health service providers.

SSAMHS is delivered by the WA Department of Health Mental Health Services in both metropolitan and country areas except for the Kimberley Region, where services are delivered by the Kimberley Aboriginal Medical Services Council (which oversees a number of ACCHSs services in the region) in partnership with the Kimberley WA Country Health Service. Such partnerships between the mainstream mental health system and Indigenous specific health services, with staff potentially co-located in place-based service services, offers a model for further investigation. The SSAMHS services have been evaluated but the outcomes apparently not made public.

Likewise, the National Strategic Framework at Outcome 1.3: proposes the formalisation of effective ACCHSs partnerships to achieve the best possible social and emotional wellbeing, mental health and related outcomes for Indigenous people in all regions in order to ensure culturally and clinically appropriate specialist mental health care is available according to need.

Particular ACCHSs partnerships could also include with:

• **Headspace**

NATSISPS Outcome 3.2.v envisaged headspace as an ACCHSs partner in the delivery of mental health services to young people in communities.

Some headspaces in the Kimberley region and others are already working from ACCHS. This suggestion is repeated at NATSISPS Outcome 2.5.iii: to ‘Build partnerships to enable Indigenous clinical services and workforce to be supported by the resources of headspace and other non-Indigenous...services’.

• **Residential Mental Health/Custodial Settings –**

NATSISPS Outcome 3.5 calls for partnership programs to build links between residential/custodial settings and community support (such as transition from prison to community or from alcohol...
rehabilitation to community reintegration) including to provide specific suicide prevention and assessment training for staff in high risk settings who work with Indigenous clients.

- **Postvention Services**

See the abovementioned National Indigenous Postvention Service.

**Question:** How can ACCHSs and other relevant services work together better? Who else needs to be considered?

**Step 7: Ensuring the Cultural Safety of Mainstream Services**

NATSISPS Outcome 1.3 iii recommends: ‘Provide cultural awareness and suicide prevention training for providers in mainstream services’; and Outcome 3.3 iii: ‘Expand availability of appropriate cultural awareness training for mainstream services.

Outcome 3.3 – recommends ‘Targeted and indicated services, including emergency services, are culturally appropriate. They are delivered by Indigenous personnel and include Indigenous-specific protocols and training for targeted and indicated services.

Ensuring the cultural safety of mainstream services has been a constant call from within the Indigenous suicide prevention and mental health space since at least the 1995 *Ways Forward Report*.

Further, and in relation to this, the *Gayaa Dhuwi (Proud Spirit) Declaration* supports shifting this paradigm by ensuring Indigenous presence and leadership in place across all parts of the mainstream Australian mental health system as the best guarantee of cultural safety. As such:

- Identified leadership positions should be established across relevant parts of the mental health system to help ensure it is culturally safe for us at times we are vulnerable and able to deliver a best of both worlds approach. The Declaration states that these leaders should be supported and valued to be visible and influential within the system

- While a culturally competent non-Indigenous mental health workforce is important, more important is the training and employment of an Indigenous mental health workforce for working in the mainstream system in addition to ACCHSs and place-based services. The Declaration suggests a national process inclusive of Indigenous stakeholders, professional colleges, universities and Australian governments to train and employ psychiatrists, psychologists and other practitioners, including emerging workforces, to at least Indigenous population parity-level, but also factoring in greater need as required, and within an agreed time frame to achieve this.

**Questions:**

How can we make mainstream services more culturally safe?

How can we rapidly increase Indigenous employment across mainstream mental health and suicide prevention services?


[4] Australian Government (undated). *The National Suicide Prevention Leadership & Support Program Information for Primary Health Networks*. Published online:


37 See: https://healingsfoundation.org.au/
38 See: https://www.snaicc.org.au/
40 See: https://www.gayaadhwari.org.au/
41 See: https://natslmh.org.au/
44 See: www.aid.org.au
45 See fn.5.
50 See fn.47.
51 As above.
54 See fn.4, p.20.
55 As above.
56 As above, p.23.
60 There were 169 Indigenous suicide deaths in 2018. Of these, about a quarter were female deaths. See fn.1.
63 See fn.3, p.19.
64 At March 2020, the rate was about 29 per cent of all prisoners — 12,902 Indigenous prisoners in a total prison population of 44,159. Australian Bureau of Statistics (ABS) (2020). 4512.0 - Corrective Services, Australia, March Quarter 2020. Published online: https://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0 [Verified 4 September 2020].
65 As above. Impression rate for Indigenous males in March 2020 was 4,682 persons per 100,000 of the Indigenous male population.
67 As above.
68 As above.
69 See fn.4, p.23 (Outcome 2.4)
70 As above, p.25 (Outcome 3.2)
71 See fn.3, p.20.
72 See fn.2. (Element 5)
73 See fn.2. (Element 2)
74 See fn.4, p.23.
75 As above.
76 See fn.3, p.9.
77 Co-hosted with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.
81 See fn.3, p.21.
83 As above
86 National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (1997). Bringing them home: report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families. Sydney: Human Rights and Equal Opportunity Commission
87 See fn.2, p.23.
88 As above
As above

90 See fn.4, p. 39 (Appendix 3).

91 See fn.24


93 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council Aboriginal Corporation (2013). Traditional Healers of Central Australia. Broome, Western Australia : Magabala Books Aboriginal Corporation


96 At p.24.


100 See: http://kams.org.au/kamsc-services/headscape-broome/