Australian Government

Department of Health and Ageing

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

May 2013

FOREWORD

Suicide is a complex and multidimensional issue that impacts on individuals and families and has ongoing implications for the communities in which they live. This is even more so for Aboriginal and Torres Strait Islander peoples who are experiencing suicide within their communities at approximately twice the rate of the rest of the population.

This is why the Australian Government has made a commitment to tackling suicide within Aboriginal and Torres Strait Islander communities through increased investment for suicide prevention activity that is specific to Aboriginal and Torres Strait Islander peoples and their communities.

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy has a holistic and early intervention focus that works to build strong communities through more community-focused and integrated approaches to suicide prevention and commits the Government to genuinely engaging with Aboriginal and Torres Strait Islander peoples to develop local, culturally appropriate strategies to identify and respond to those most at risk within our communities.

It gives us great pleasure to release, on behalf of the Australian Government, the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The Strategy demonstrates the Government's commitment to working with other portfolios and across all levels of government to reduce the longer term incidence of suicidal and self-harming behaviour amongst Aboriginal and Torres Strait Islander peoples. This includes addressing other social determinants that contribute to social disadvantage for Aboriginal and Torres Strait Islander peoples such as unemployment, education, housing and community safety and focusing on building strong, resilient families, young people and communities.

We would also like to acknowledge the many Aboriginal and Torres Strait Islander people, state and territory governments, local government and non-government organisations who helped shape the Strategy through participation in the community forums held across the country. We would also particularly thank the members of Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group who contributed their time and expertise in guiding the development of the Strategy.

The Hon Mark Butler MP   The Hon Warren Snowdon MP

Minister for Mental Health and Ageing   Minister for Indigenous Health

Contents

List of tables and figures

Executive Summary

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

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

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

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

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

Six goals underpin this objective:

1. Reduce the incidence and impact of suicide and suicidal behaviour in the Aboriginal and Torres Strait Islander population and in specific communities affected by suicide.

2. Ensure that Aboriginal and Torres Strait Islander communities and populations are supported within available resources to respond to high levels of suicide and/or self-harming behaviour with effective prevention strategies.

3. Implement effective activities that reduce the presence and impact of risk factors that contribute to suicide outcomes in the short, medium and long term and across the lifespan.

4. Build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels.

5. Build the evidence base to support effective action and to evaluate the outcomes of suicide prevention activity at local, regional and national levels.

6. Make high quality resources, information and methods to support suicide prevention for Aboriginal and Torres Strait Islander peoples available across all contexts and circumstances.

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

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

The action areas are as follows:

Action area 1: *Building strengths and capacity in Aboriginal and Torres Strait Islander communities.* This action area focuses on strategies to address two key areas: the encouragement of leadership, action and responsibility for suicide prevention on the part of communities; and the development, implementation and improvement of preventive services and interventions for communities and their members. The actions reflect the importance of organisations understanding communities, respecting local cultures, strengths and histories and recognising differences in social relationships and possibilities for action in rural, urban and remote settings.

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

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

Action area 3: *Targeted suicide prevention services.*

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

Action area 4: *Coordinating approaches to prevention.*

This action area relates to the importance of coordinated action of Commonwealth and state or territory governments, coordination between different departments—health, schools, justice, child

and family services, child protection and housing—and coordination with the community sector to ensure that there is capacity within local Aboriginal and Torres Strait Islander organisations to provide preventive services. This will help to reduce duplication and overlap of services and to improve infrastructure and resources.

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

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

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

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

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

In order to achieve its objectives and goals, the implementation of the Strategy will involve, in different ways, all sectors and levels of government, the non-government and community sectors, research and training institutions and, most importantly, the communities themselves.

It will also be essential that the implementation of the Strategy links to a number of other complementary policy frameworks to ensure synergies between these:

- The Fourth National Mental Health Plan;[1]

- The 'Closing the Gap' commitments and National Indigenous Reform agreements;

- The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013[2] and National Aboriginal and Torres Strait Islander Health Plan[3] (in development);

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[1] Fourth National Mental Health Plan – An agenda for collaborative action in mental health 2009-2014
[2] Commonwealth of Australia National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013

- The National Aboriginal and Torres Strait Islander People's Drug Strategy (in development);[4]

- The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing 2004-2009 (currently under review);[5]

- The Roadmap for National Mental Health Reform 2012-2022[6]; and

- State and territory government suicide prevention strategies.

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[3] National Aboriginal and Torres Strait Islander Health Plan (in development)

[4] Commonwealth of Australia National Aboriginal and Torres Strait Islander Peoples Drug Strategy (currently in development)

[5] National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Wellbeing 2004-2009 (currently under review)

[6] The Roadmap for National Mental Health Reform 2012-22

1 Context

The June 2010 report of the Inquiry into Suicide in Australia by the Senate Community Affairs References Committee *The Hidden Toll: Suicide in Australia* noted the high rates of suicide among Aboriginal and Torres Strait Islander peoples, differences in the pattern of suicidal behaviour and its disproportionate impact on families and communities. Recommendation 27 of the report recommended that:

> *"…the Commonwealth government develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy…"* (SCARC, 2011).

The report also recommended that this strategy should:

- develop the capacity of communities and community organisations to provide local leadership and resources to enable Aboriginal and Torres Strait Islander peoples to take on the challenge of preventing suicide;
- provide postvention support to families and communities bereaved through suicide;
- be based on evidence and should provide professional support for effective practice; and
- be supported by the resources of all levels of government and across the whole of government.

In its response to the report the Australian Government acknowledged the unacceptably high rates of suicide amongst Aboriginal and Torres Strait Islander populations and supported the recommendation by announcing in September 2011, the establishment of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group (the Advisory Group) to guide the development of the Strategy (list of members at Appendix 1). The Advisory Group's role was also to provide critical advice to Government on the investment of funding to be provided through the Taking Action to Tackle Suicide package for suicide prevention activity specific to the needs of Aboriginal and Torres Strait Islander peoples. An important piece of work that was completed by the Advisory Group during its tenure is the development of key principles to guide government investment in suicide prevention for Aboriginal and Torres Strait Islander communities. These principles underpin this Strategy and are listed on page 25.

Development

Following an open tender process, the Menzies School of Health Research was engaged in May 2012 to develop the Strategy in consultation with Aboriginal and Torres Strait Islander peoples and stakeholders across Australia, seeking public input into the development of the Strategy and assisted by the National Aboriginal Community Controlled Health Organisation.

Extensive consultation undertaken in the development of the Strategy included community forums and a national workshop. A summary of the community forums and the outcomes of the national workshop can be accessed on the website at: http://www.indigenoussuicideprevention.org.au/.

Aboriginal and Torres Strait Islander suicide: Origins, trends and incidence

While suicide is believed to have been a rare occurrence among the Aboriginal and Torres Strait Islander people of Australia in pre-colonial times, it has become increasingly prevalent over recent decades, accelerating after the 1980s, albeit with variations in rates and in geographical distribution from year to year (ABS, 2012).

For example, the Royal Commission into Aboriginal Deaths in custody (RCIADIC, 1991) drew attention to the links between substance misuse and mental health disorders in the years and months before most of the deaths that it investigated. It also highlighted the disproportionate number of these deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children. The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged by the Commission as contributing to the heightened risk of mental health problems, substance misuse and suicide. (Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice; 2010).
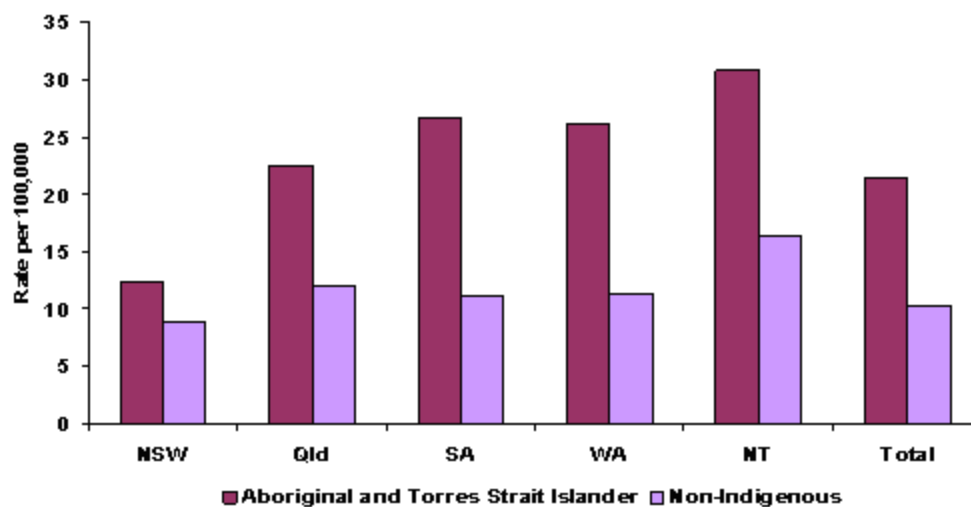
The mobility of Aboriginal and Torres Strait Islander peoples between remote communities and regional centres, particularly in the more remote areas is another anomaly of Aboriginal and Torres Strait Islander suicide that needs to be recognised. This means that these locations need to be considered as part of a larger system when considering the occurrence of suicide and its impact on communities.

The age distribution of the Aboriginal and Torres Strait Islander population is much lower than that of the non-Indigenous population because of higher child-to-adult ratios and shorter than average life expectancy. This has important implications for understanding the psychological impact of suicide on families and the available community response capacity in terms of supports and services for treatment and prevention. It is also relevant to another distinct feature of Aboriginal and Torres Strait Islander suicide: the phenomenon of 'suicide clustering', where an unusual number of suicides and episodes of suicidal behaviour occur in close proximity to one another within a particular community or region (Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice; 2010).

It should also be noted that there have been significant peaks and clusters of suicides in some regions in the context of a generally wide distribution across most states and territories, particularly those with significant remote populations. There are significant fluctuations in rates from year to year in some states (De Leo et al, 2011).

Reducing suicide and suicidal behaviour among Aboriginal and Torres Strait Islander peoples is now a public health priority for all Australian governments (SCRGSP, 2009; 2011). The most recent Australian Bureau of Statistics (ABS) data on suicide in Australia reported that an average of 100 people of Aboriginal or Torres Strait Islander origin ended their lives through suicide each year over the 10 year period from 2001-2010 (ABS, 2012). In 2010, suicide accounted for 4.2% of registered deaths of Aboriginal and Torres Strait Islander peoples (NSW, Qld, WA, SA and NT combined). After adjusting for the different age profiles of the two populations, the suicide rate or Aboriginal and Torres Strait Islander peoples was 2.6 times the rate for non-Indigenous Australians.

Figure 1: Age-standardised rates of suicide by jurisdiction and Indigenous status, NSW, QLD, SA, WA and NT, 2001-2010[7]

Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 *Suicides Australia, 2010*

The 2012 ABS data for the period 2001-2010 show the overall (all ages) rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females. However, there was also significant variation in the age-standardised rates of Aboriginal and Torres Strait Islander and non-Indigenous suicide between the five jurisdictions having reliable Aboriginal and Torres Strait Islander mortality data. Due to small numbers it is difficult to detect significant variation by geography. Figure 1 shows that the Northern Territory appears to have the highest Aboriginal and Torres Strait Islander suicide rate of all jurisdictions, followed by South Australia, Western Australia and Queensland, all with substantially higher rates than New South Wales. [8]

Aboriginal and Torres Strait Island peoples also take their own lives at younger ages than non-Indigenous Australians, with the majority of suicide deaths occurring before the age of 35 years. Figure 2 shows that in the period 2001-2010, the greatest difference in rates of suicide between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians was in the 20-24 years age group for females and the 25-29 years age group for males.

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[7] Age-standardised rates take into account differences in the size and structure of the population and are therefore more reliable for comparison purposes.
[8] NOTE: Due to small numbers recorded in VIC and Tasmania, data for these states are not shown to protect privacy.

Figure 2: Age-specific suicide rates by Indigenous status and sex, NSW, QLD, SA, WA and NT, 2001-2010

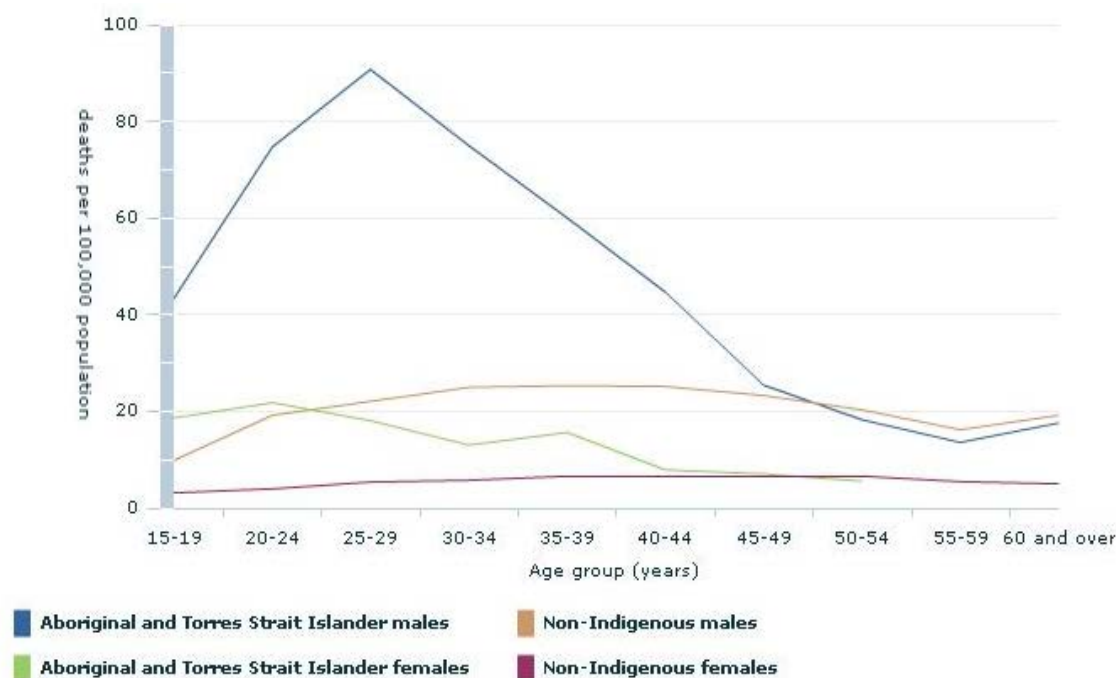Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 *Suicides Australia, 2010*

The highest age-specific rate of Aboriginal and Torres Strait Islander suicide was among males between 25 and 29 years of age (90.8 deaths per 100,000 population), four times the rate for non-Indigenous males. For Aboriginal and Torres Strait Islander females, the highest rate of suicide 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. For the non-Indigenous population, the highest rate of suicide occurred among males between 35 and 39 years of age (25.4 deaths per 100,000) and for non-Indigenous females (6.6 deaths per 100,000) at consistent rates across the age groups between 35 and 54 years of age.

The prevalence of self-harm presents a different picture, with rates of hospitalisation for intentional self-harm many times higher than the rate of completed suicide for both Aboriginal and Torres Strait Islander and non-Indigenous persons, with females hospitalised at higher rates than males (Figure 3). In 2008-09, the rate of hospitalisation for non-fatal intentional self-harm was higher for Aboriginal and Torres Strait Islander peoples (3.5 per 1000) compared to non-Indigenous people (1.4 per 1000) (SCRGSP, 2011: 7.68). For this same period, a higher rate of hospitalisation for non-fatal, intentional self-harm was recorded for Aboriginal and Torres Strait Islander females (3.9 per 1000) compared to Aboriginal and Torres Strait Islander males (3.0 per 1000), with both rates higher than hospitalisation rates for non-Indigenous males and females. Hospitalisation for self-harm was also higher in remote areas (4.1 per 1000) compared to major cities (3.5 per 1000) (SCRGSP, 2011: 7.68). A recent survey found that the estimated proportion of the population that would self-injure at some point in their lifetime for Aboriginal and Torres Strait Islander peoples was 17.2%, which was 2.2 times that reported by non-Indigenous participants (OR 2.2, 95% CI 1.5-3.3) (Martin et al, 2010: 15). Because of limitations in sampling (random telephone survey), this study almost certainly

significantly understates differences in lifetime prevalence of self-injury between Aboriginal and Torres Strait Islander and non-Indigenous persons.

Figure 3: Age-standardised non-fatal hospitalisations for intentional self-harm, NSW, VIC, QLD, WA, SA and public hospitals in the NT.
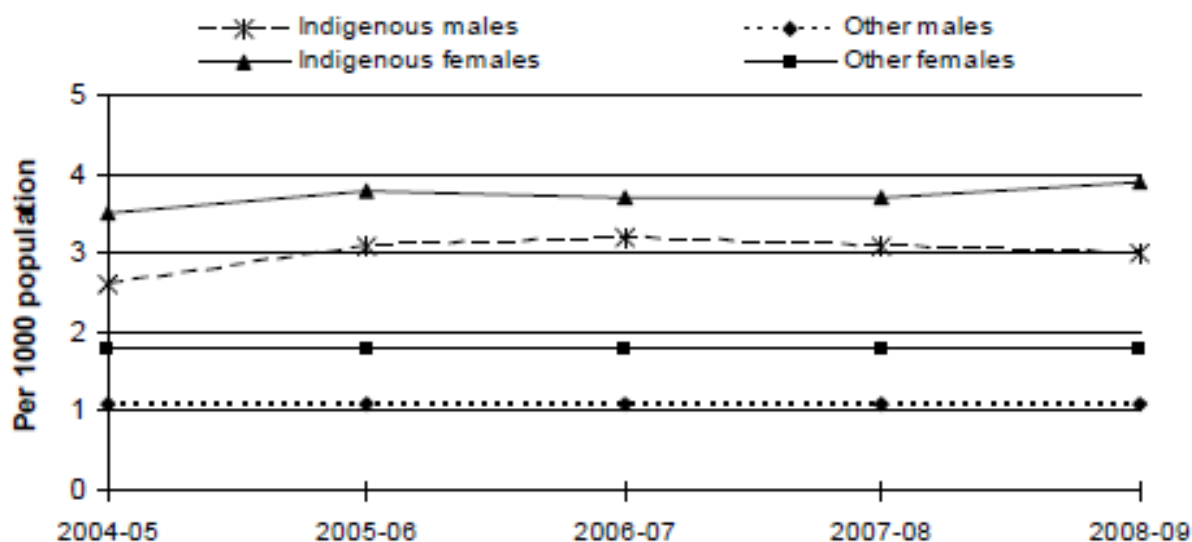
Source: SCRGSP, 2011: 7.68

Social and Emotional Wellbeing

Suicide is a multidimensional issue, which has a devastating impact on individuals and families and ongoing implications for the communities in which they live. High rates of suicide among Aboriginal and Torres Strait Islander peoples are commonly attributed to a complex set of factors which not only includes disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic determinations that impact on Aboriginal social and emotional wellbeing and mental health. The Social Health Reference Group for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group (2004) responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009* draws an important distinction between the concepts of 'social and emotional wellbeing' used in Aboriginal and Torres Strait Islander settings and the term 'mental health' used in non-Indigenous settings.

Aboriginal and Torres Strait Islander peoples view health in a holistic context that encompasses mental health, physical, cultural and spiritual health. Land is central to wellbeing and when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health persists. Additionally there is no single Aboriginal and Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. These differences should be acknowledged and universal prevention strategies, which promote strong, resilient communities focusing on restoring social and emotional wellbeing should be implemented through the development of locally developed strategies in a way that is supported.

In this context the Social Health Reference Group concluded that:

The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment.

The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.
(Social Health Reference Group, 2004, page 9)

Figure 4: Policy context of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
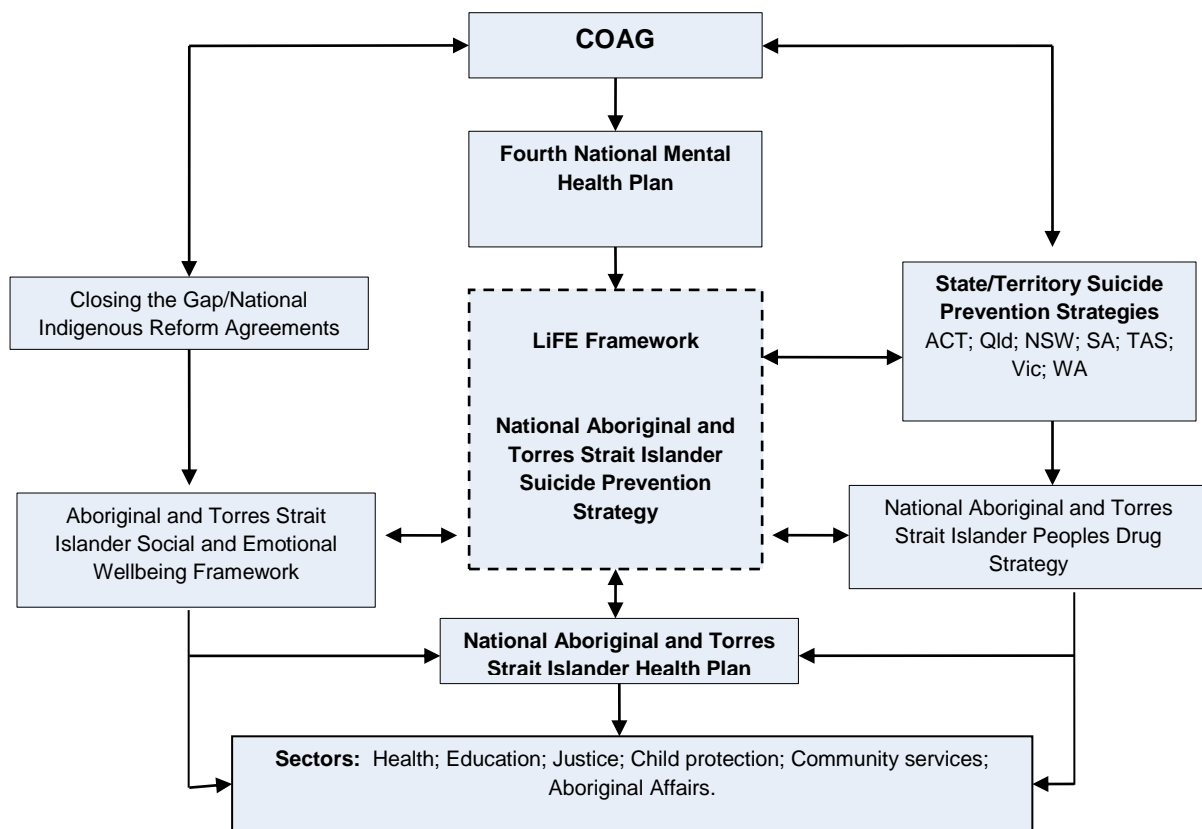
Suicide prevention: Changing the discourse

Participants at community consultations consistently called for community-focused, holistic and integrated approaches to suicide prevention, with intervention strategies that reduce the likelihood of suicide and related problems over the lifespan. This is consistent with evidence emerging from research, which now shows that environmental and biological influences shape brain development in early life and have much greater effects on adult outcomes in physical and mental health and social and emotional wellbeing than was previously understood. Within this overall context account needs to be taken of the risk and protective factors for Aboriginal and Torres Strait Islander peoples which may have different characteristics to that of the rest of the population. For example, the effect and impact of chronic disease and poor physical health, broader social determinants and the relationship this has to social and emotional wellbeing. This knowledge has led to a new emphasis on investment in activities to strengthen the capacity of communities to prevent psychosocial and behavioural problems in childhood and adolescence.

A greater proportion of prevention effort needs to be invested "upstream" in preventive policies and services which build community, family and individual resilience. This can be achieved by a strategic alignment of policies and targeted investment in early prevention in health, family and children's services, education and mental health at key points across the lifespan. Strategies to support

children's social and emotional learning including issues relating to Aboriginal and Torres Strait Islander individual identity, to improve self-regulation and resilience can reduce vulnerability to future outcomes, including antisocial behaviour, mental illness, social withdrawal and suicide, alcohol and drug misuse and crime.

Communities that have been successful in reducing youth problem behaviours have initiated local action to minimise the early development and progression of social and emotional problems. In these communities, families, schools and organisations support each other in placing a high value on the following:

1. Minimising children's exposure to biological and psychological harmful events such as child maltreatment, family violence and substance abuse

2. Teaching, promoting and actively reinforcing pro-social behaviour, including self-regulatory behaviours and the skills needed to become productive adults of the community and society

3. Monitoring and reducing opportunities for problem behaviour to occur

4. Fostering the development of mental flexibility, problem solving and the capacity for emotional self-regulation and self-reflection in children and young people.

Figure 5: Opportunities for prevention: Modifying causal pathways to youth problems and suicide (adapted from Robinson et al, 2012)
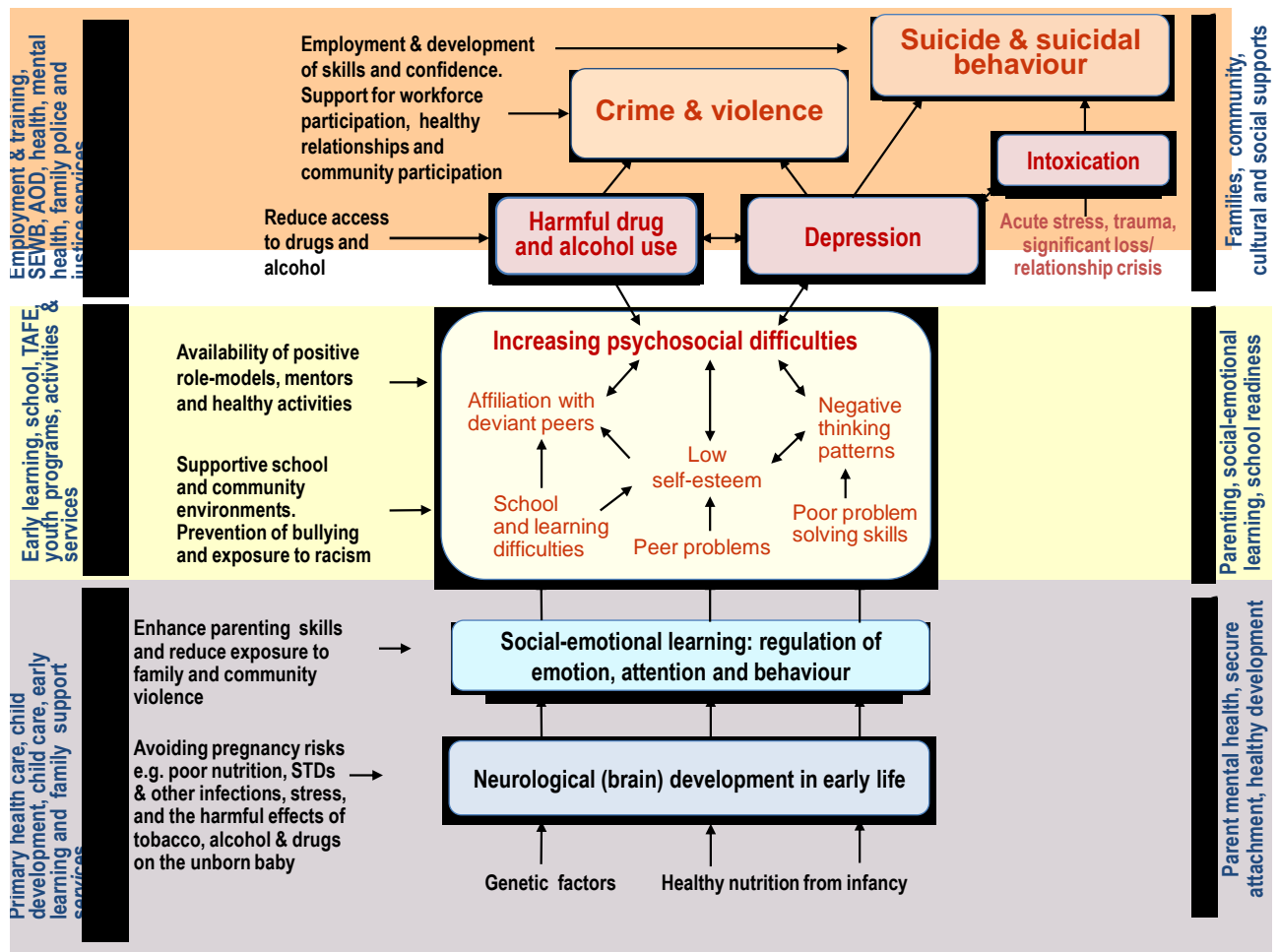
Figure 5 summarises some of the known developmental pathways from conception through to adulthood that research has shown to be associated with an increased likelihood of suicide and other youth problems (O'Connell et al, 2009; Zubrick et al, 2005).

For each developmental period including transition across life stages such as from adolescence to early adulthood, there is a range of known risks that should be a priority focus of those agencies responsible for the services most relevant to that stage of development. At each stage, specific preventive interventions for parents, children, families or youth need to be based on strategies of engagement that acknowledge cultural and individual differences in families and communities.

Working with all communities

Community consultations for the national strategy highlighted the need for a dual focus on:

1. Developing the capacity of Aboriginal and Torres Strait Islander controlled services and communities to lead and sustain strengths-based preventive activities and culturally specific approaches to healing and recovery from trauma; and

2. Building the capacity of mainstream services and agencies to be more inclusive and responsive to the needs and circumstances of Aboriginal and Torres Strait Islander peoples in all cities, towns and communities.

National suicide prevention strategies have generally favoured universal actions that have the broadest possible reach. However, for the Aboriginal and Torres Strait Islander Suicide Prevention Strategy, actions should be implemented in a manner that is proportionate to the level of risk and vulnerability in communities and groups within the wider population. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing 2004-2009 principles state that "….there is no one single Aboriginal or Torres Strait Islander culture or group….." and therefore there are different needs across and within groups. Aboriginal and Torres Strait Islander peoples also live in different settings and it is important that these different needs are addressed through locally developed strategies.

A reflection of the importance of local approaches is contained in the Community LiFE Framework for Effective Community-Based Suicide Prevention – Draft for Consultation (2005) developed as part of the Community LiFE project under the National Suicide Prevention Strategy. These classified mental health interventions range from prevention through treatment to continuing care (See Fig 6 below). This scheme classifies mental health interventions as universal, selective or targeted and indicated.

Figure 6: Spectrum of mental health interventions
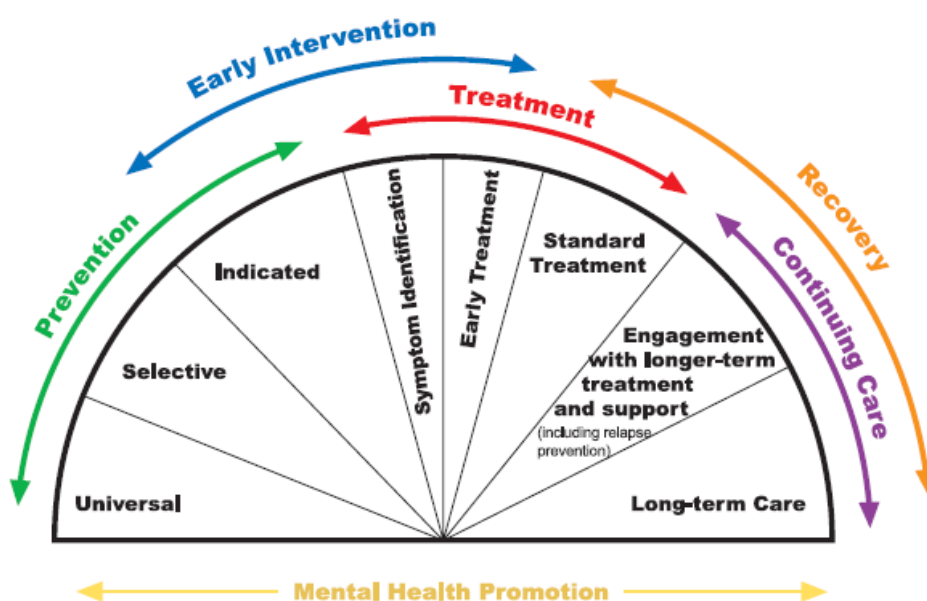
Source: Community LiFE Consultation Draft (2005), p. 16.

For Aboriginal and Torres Strait Islander peoples, the effort to improve the relevance and reach of universal measures and mainstream services as provided by Aboriginal and Torres Strait Islander community-controlled services needs to be balanced by the implementation of targeted strategies for Aboriginal and Torres Strait Islander communities, vulnerable groups and families. The balance will also vary across circumstances in regions of Australia according to availability of appropriate services and resources.

A community development approach

Communities can include significant diversity. For Aboriginal and Torres Strait Islander peoples, *community* is closely related to the idea of *culture*. There are many shared elements of culture, just as there is also cultural and sometimes linguistic diversity between communities and within communities identifying as Aboriginal and Torres Strait Islander. Confidence in recognition based on cultural identity is a source of strength. Cultural change and discontinuity are also important influences. For example, many people may feel cut off or disconnected from their cultural heritage or community. Many young people may be in conflict with parents and elders and see theirs as the culture of a "new generation". Culture may mean something different as resource or source of identity for youth in a large city compared with young people in a remote community.

These differences may have different implications for the needs of youth for support and for engagement by services or recognition by elders. Global influences on culture, including new electronic technologies and images are part of the experience and styles of communication of young people. They may shape particular areas of vulnerability, while also representing important opportunities for engagement of the young. The place of sports, the arts, including music, painting and dance in resilience promotion and in encouragement of healthy cultural affirmation of identity are relevant here. These initiatives may occur in conjunction with active development of resilience-building interventions and services to promote mental health and social-emotional wellbeing.

The idea of community is also associated with recognition of leadership and authority based on authentic relationships. Leadership is in part about representation in governance and organisation, and Aboriginal leadership is important in developing partnerships in prevention. However, leadership is also about mobilising participation, engagement, action and ideas within communities, and may come from outside of organisations that are often seen as representing the community.

A further potentially powerful perspective within communities is provided by those families and individuals who have been affected by suicide either directly or indirectly. There are many instances of action networks that have been important catalysts for change to services and policies or who have worked effectively as partners of community services and non-government organisations to strengthen prevention, postvention and life promotion responses. Community and partnership should not be seen solely from the perspective of governments or services. These are some of the reasons why it is important to define what "community" means for the purpose of developing prevention strategies.

The Community Life Framework – Draft for Consultation (2005) sets out a number of principles for planning and decision making at the community level to adopt programs and initiatives that achieve the intended outcomes of reductions in suicide and self-harm in communities in which these occur at high rates. Some of these are:

- **A focus on risk and protective factors**
Prevention should focus on the risk and protective factors faced by the target group and community.

- **Comprehensive, multi-level programs**
Prevention should be undertaken across a range of settings – individual, family, school and community, with multiple components delivered within multiple settings.

- **Effective, evidence-based interventions**
An effective intervention achieves its intended effect in the 'real world' (Hawe et al. 1997). Effective interventions are based on available research evidence about their efficacy.

- **Intensive, long-term and developmentally appropriate activities**
Evidence suggests that 'one-stop' prevention efforts are not very effective and that the most successful activities are intensive, developmentally appropriate and maintained over time.

- **Community-focused and relevant programming**
Prevention programming should address the specific nature of the problem in the local community or population group. It should be relevant to the community.

- **Culturally appropriate activities**
Prevention should be culturally appropriate – consistent with the cultural identity, communication styles, protocols and social networks of clients and stakeholders (Thomas 2002).

- **Early intervention**
The higher the level of risk in the population group, the more intensive the prevention effort must be and the earlier it should begin. Transition points – preschool, middle school, entering high school, leaving high school and entering the workforce – are times when major setbacks can occur, and that represent natural opportunities for providing supportive interventions.

- **Multi-dimensional capacity-building efforts**
Interventions need to be multi-dimensional, with capacity-building efforts to support them.

This framework illustrates that action needs to be taken at a number of levels, beginning with mobilisation of community understandings of suicide and the options for action, along with planning and development of a community action plan for adoption of strategies that have been shown to be effective and that represent "good practice" (see Figure 7). Finally, there needs to be capacity building, action to develop infrastructure and resources.

Figure 7: Developing a community plan for suicide prevention

Develop a shared understanding of suicide and prevention

Part One

Establish community infrastructure to support suicide prevention

Part Two
- knowing your community
- building community capacity
- achieving community readiness

If already have established community infrastructure

Develop a community-based suicide prevention plan

Part Three
- identify key priority areas
- identify target population
- select appropriate strategies
- develop an evaluation strategy
- develop a package or relevant programs
- develop a timeline

Good-practice strategies

Part Four
- framework for choosing good-practice strategies

Source: Community LiFE Framework for Effective Community-Based Suicide Prevention (2005)

Responding to high levels of suicide in communities

Many Aboriginal and Torres Strait Islander communities across Australia face high levels of suicide and self-harm, some of which occur in marked clusters. In such circumstances, steps need to be taken to mobilise community and organisations to respond to the immediate risk through training and support for community providers, peers and other natural helpers (family members, elders, traditional healers); through the provision of effective and sensitive postvention and bereavement support for people in peer and family networks; through coordinated action to work with and to follow up with individuals in high risk settings; and to build the capacity of community-based services to maintain targeted preventive activity. There is limited evidence for the effectiveness of postvention responses for the reduction of suicide (Szumilas and Kutcher, 2011). Suicide awareness and postvention training, if well integrated into community services and adapted for the needs of

communities and families, are important forms of treatment and follow-up care. However, it is likely that on their own they are not sufficient to prevent suicide at either community or population levels.
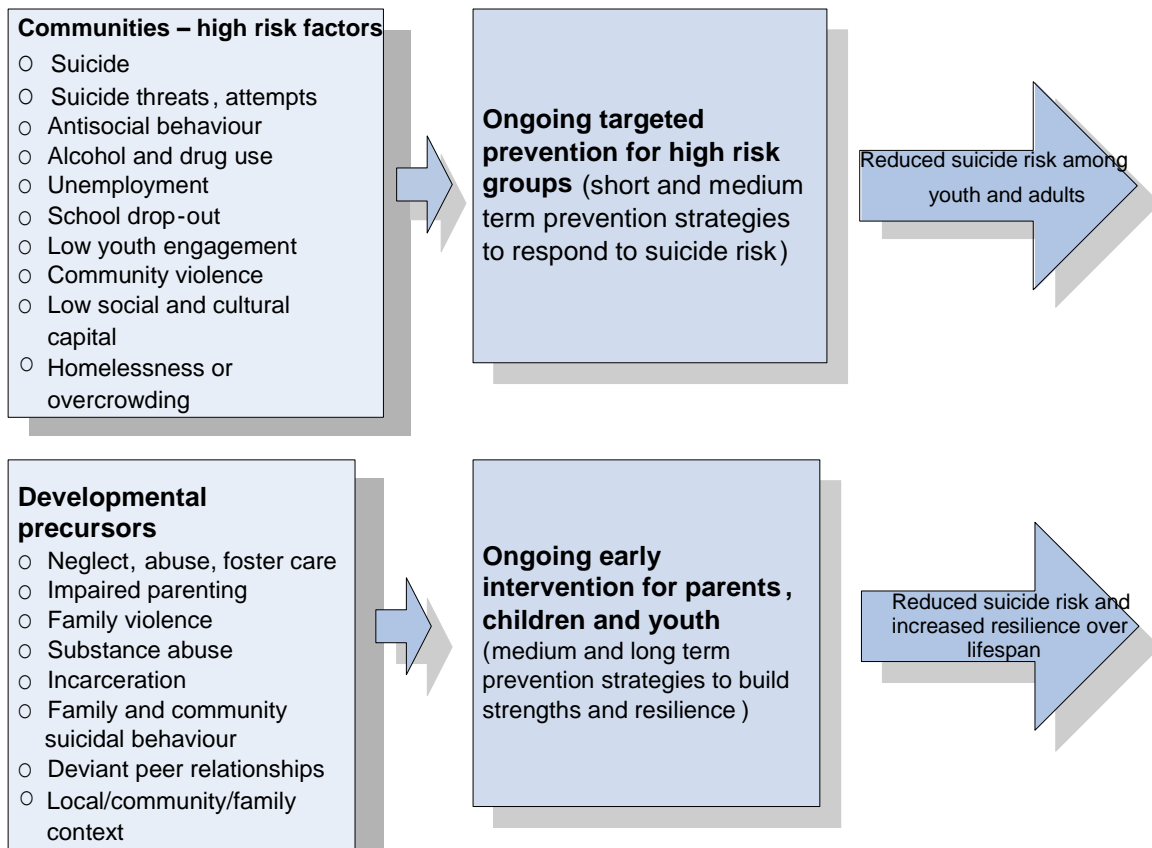
There is growing evidence that, in order to reduce rates of suicidal behaviour and suicide over the longer term, measures should also be put in place to address the developmental precursors of suicide and suicidal behaviour. These measures should be targeted to reduce the impact of adversities over the lifespan and to support healthy social and emotional development from early childhood through to young adulthood. It is especially important that there is intervention to support children and young people growing up in adverse family environments, to reduce early emotional and behavioural problems.

Preventive responses should include parenting programs and therapeutic interventions for high risk families and children, and a mix of therapeutic, supportive and competency-building or "life skills" interventions for youth in schools or in post-secondary training, as well as for those who are unemployed or entering the workforce. In many contexts, young people leaving school struggle to undertake further training or to stay in work and are in need of counselling and support.

For young people and adults who have been arrested, incarcerated or placed under residential supervision, including mandated residential treatments for drugs and alcohol, the transition back to their communities is often poorly supported. Given that substance misuse, mental health issues and problem behaviours leading to arrest or incarceration commonly co-exist, it is increasingly important that prevention policies focus on their common precursors in human development. There needs to be a shift towards collaborative, cross-sectoral approaches to treatment and prevention to treat both current risk and its developmental precursors.

Figure 8 suggests that in community settings with high multiple risks, action to respond to the vulnerabilities of high risk groups, such as adolescents and adult males and their families, should be accompanied by long-term prevention strategies targeting the developmental precursors of these sources of difficulty.

Figure 8: Long-term and short-term prevention and early intervention activities in high risk communities

Communities – high risk factors
- Suicide
- Suicide threats, attempts
- Antisocial behaviour
- Alcohol and drug use
- Unemployment
- School drop-out
- Low youth engagement
- Community violence
- Low social and cultural capital
- Homelessness or overcrowding

Ongoing targeted prevention for high risk groups (short and medium term prevention strategies to respond to suicide risk)

Reduced suicide risk among youth and adults

Developmental precursors
- Neglect, abuse, foster care
- Impaired parenting
- Family violence
- Substance abuse
- Incarceration
- Family and community suicidal behaviour
- Deviant peer relationships
- Local/community/family context

Ongoing early intervention for parents, children and youth (medium and long term prevention strategies to build strengths and resilience)

Reduced suicide risk and increased resilience over lifespan

2 Principles

The LiFE Framework sets out a number of key overall principles for the National Suicide Prevention Strategy. These cover a range of important considerations, including statements about ethical practice; safety, quality and cultural sensitivity in activities; services and interventions within the strategy; about the shared responsibilities of government, service providers and communities for taking action; and about the target groups for different elements of the Strategy. They include the principle that the components of the Strategy should be evidence-based and sustainable, and should be responsive to the many factors that influence suicide risk such as the social, environmental, cultural and economic factors that contribute to quality of life and life opportunities and their variation across different cultures, interest groups, individuals, families and communities.

In general, the principles of the LiFE Framework also apply to suicide prevention for Aboriginal and Torres Strait Islander peoples. In guiding the investment of funding for suicide prevention activity targeted at Aboriginal and Torres Strait Islander peoples, the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group developed key principles linking with the themes of the LiFE Framework as follows:

Projects need to demonstrate:

- **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 Aboriginal and Torres Strait Islander 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. For example providing Aboriginal and Torres Strait Islander workforces and community members with tools for awareness, early identification and for responding to self-harm issues within the community.
- **Partnerships:** projects should work in genuine partnerships with local Aboriginal and Torres Strait Islander stakeholders and other providers to support and enhance existing local measures, not duplicate or compete with them. Funding applications need to demonstrate a record of genuine community and stakeholder/provider consultations and a track record of community empowerment.
- **Safe cultural delivery:** projects should be delivered in a safe manner.
- **Innovation and evaluation:** projects need to build on learnings, try new and innovative approaches, share learnings, and improve the evidence base.
- **Community Promotion and education:** projects should share learnings and these should be promoted in other communities.

Investment in Aboriginal and Torres Strait Islander suicide prevention should be guided by these key principles as well as the themes of the LiFE Framework.

Overarching principles for a national strategy

The following overarching principles have been developed to guide the implementation of the Strategy. The principles link with the themes of the LiFE Framework as well as the key principles developed by the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group to guide current and future funding for Aboriginal and Torres Strait Islander suicide prevention activity.

The Strategy will:

1. Be based on respect and recognition for Aboriginal and Torres Strait Islander communities, culture and history.

2. Be founded in partnership between communities, organisations and governments and enabled through cross-sectoral approaches to treatment and prevention.

3. Ensure that services maintain high quality standards of safety and security of care for Aboriginal and Torres Strait Islander individuals and families in need of assistance.

4. Be comprehensive, targeted and based on evidence.

5. Not lead to increased risk or vulnerability.

6. Be implemented to high standards of quality in culturally competent engagement and professional practice.

3 Goals

The overarching objectives of the Strategy are to reduce the causes, prevalence and impact of suicide on individuals, their families and communities. These goals will be achieved by action that involves many parties and that is sustained over time.

The goals of the Strategy are to:

1. Reduce the incidence and impact of suicide and suicidal behaviour in the Aboriginal and Torres Strait Islander population and in specific communities affected by suicide.

2. Ensure that Aboriginal and Torres Strait Islander communities and populations are supported within available resources to respond to high levels of suicide and/or self-harming behaviour with effective prevention strategies.

3. Implement effective activities that reduce the presence and impact of risk factors that contribute to suicide outcomes in the short, medium and long term and across the lifespan.

4. Build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels.

5. Build the evidence base to support effective action and to evaluate the outcomes of suicide prevention activity at local, regional and national levels.

6. Make high quality resources, information and methods to support suicide prevention for Aboriginal and Torres Strait Islander peoples available across all contexts and circumstances.

4 Action areas

The action areas of the Strategy set out how the main goals of the Strategy will be achieved in terms of areas of need, intervention and expected outcomes. The order of action areas varies from that of the LiFE Framework to reflect the logic of engagement of Aboriginal and Torres Strait Islander communities and the priority that needs to be given to supporting community leadership and community action in suicide prevention. It does not suggest that one action area is more important than the other; rather, each action area makes an important contribution to the successful implementation of strategies under all other action areas. The approach taken by the Strategy corresponds to that of Marmot's "proportionate universalism": activities are, where possible, implemented for the widest possible benefit for the Aboriginal and Torres Strait Islander population, but with proportionate additional effort for those at greater risk or disadvantage.

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

The Strategy recognises the need to build the capacity of communities to take action in response to suicide. This has two dimensions: one is the encouragement of leadership, action and responsibility for suicide prevention on the part of communities; the other involves the development, implementation and improvement of preventive services and interventions for communities and their members. The focus of the first dimension is engagement of communities to jointly develop the awareness of suicide and the need for action, to assess strategies that are appropriate for the community and to plan for action. It is critical for agencies and organisations to understand communities, to respect local cultures, strengths and histories and to recognise differences in social relationships and possibilities for action in rural, urban and remote settings. The second dimension involves the development of appropriate resources, the implementation of initiatives to enhance community safety, to strengthen preventive mental health and wellbeing services and the implementation of early intervention programs for families and young people.

Outcome 1.1   Communities have the capacity to initiate, plan, lead and sustain strategies to promote community awareness and to develop and implement community suicide prevention plans.

> Issue: Communities differ widely in their composition and their capacity and readiness for action. The concept of community cannot be imposed on people; community action does not guarantee participation of intended groups in prevention and there is a need for locally developed strategies to engage community members in discussion about suicide prevention. External support should aim to assist communities to take charge, plan and act. This can take the form of a facilitated process initiated after expressions of interest.

Outcome 1.2   Materials and resources are available that are appropriate for the needs of Aboriginal and Torres Strait Islander peoples in diverse community settings.

- Issue: There are very wide linguistic, cultural, socio-economic and historical differences between communities and groups. Resources should be developed for specific needs rather than a one-size-fits-all strategy to produce Aboriginal and Torres Strait Islander-specific materials for engagement, training and practice. Substantial local input and capacity is

integral to the generation of high quality, meaningful resources supported by appropriate professional expertise.

Outcome 1.3   There is access to community-based programs to improve suicide awareness among "gatekeepers" and "natural helpers" in communities affected by self-harm and suicide.

- Issue: Gatekeepers are service providers and officials who influence access of clients and community members to care; natural helpers are members of families or communities who are in a position to recognise difficulties in individuals and to assist them to seek help. There is strong demand for improved access to training for gatekeepers and Aboriginal and Torres Strait Islander natural helpers. Training should be adapted for Aboriginal and Torres Strait Islander peoples. There should be evaluation of its effectiveness in suicide prevention, either alone or in combination with other approaches, or as part of a targeted community implementation program. It should be implemented in a planned way that is appropriate for specific settings; for example, in discrete remote communities and more dispersed urban environments, where targeting and implementation of training may require different strategies. There should be strategies to ensure that turnover of personnel does not dissipate the effectiveness of training over time.

Outcome 1.4   High levels of suicide and self-harm in communities are identified and monitored to facilitate a planned response. (see 5.3).

- Issue: There are wide gaps in the capacity of primary health care and mental health services to identify and assess self-harm and maintain appropriate approaches to intervention and follow-up, including follow-up after discharge from hospital treatment. There needs to be improved consistency of assessment and data collection and the ability to compile data on self-harm from multiple sources to help identify potential cumulative risks of suicide.

Outcome 1.5   Communities are assisted to plan and implement a comprehensive response to suicide and self-harm that includes both short–term and long-term early intervention and prevention activity.

- Issue: Suicide signifies multiple sources of difficulty and potential for future or ongoing risk. Community responses should include early intervention and treatments across the lifespan for families, children and youth, delivered in multiple settings, both widely available and appropriately targeted according to risk.

Outcome 1.6   Mental health services and community organisations are able to provide appropriate postvention responses to support individuals and families affected by suicide.

- Issue: Services are not always available or appropriate, and communities and families may resist external intervention or be uncomfortable with "mental health" approaches. Sources of support within the community—church members, elders, family members and Aboriginal and Torres Strait Islander practitioners or traditional healers—may need to be engaged to develop and provide appropriate postvention support in partnership with specialised mental

health services. However, appropriate and confidential external support is often needed by many people.

Outcomes	Strategies
Outcome 1.1 Communities have the capacity to initiate, lead and sustain strategies to promote community awareness and to develop and implement community suicide prevention plans	i. Identify communities and regions (by expression of interest) to workshop models for community action ii. Develop information and resource guides for coordinating community action to prevent suicide iii. Review and disseminate information on best practice models for community suicide prevention iv. Develop specific strategies regarding access to methods and means of suicide in the community
Outcome 1.2 Materials and resources are available that are appropriate for the needs of Aboriginal and Torres Strait Islander peoples in diverse community settings	i. Identify resource gaps and needs ii. Review and extend Aboriginal and Torres Strait Islander language training programs for mental health and social and emotional wellbeing iii. Produce resource materials in diverse formats for use by Aboriginal and Torres Strait Islander peoples in different community contexts, including those with Aboriginal and Torres Strait Islander languages
Outcome 1.3 There is access to community-based programs to improve suicide awareness and prevention skills among "gatekeepers" and "natural helpers" in communities affected by self-harm and suicide	i. Examine the option of trials for the expansion of culturally adapted gatekeeper programs in remote community and urban settings ii. Develop, implement and evaluate training for Aboriginal and Torres Strait Islander natural helpers iii. Provide cultural awareness and suicide prevention training for providers in mainstream services
Outcome 1.4 High levels of suicide and self-harm in communities are identified and monitored to facilitate a planned response	i. Standardised methods for assessment and recording of suicidal behaviour and self-harm are reviewed for adoption by primary health care and specialist mental health services ii. Primary health care and community services implement protocols for mental health assessment and recording data on self-harm
Outcome 1.5 Communities are assisted to plan and implement both short-term and long-term early intervention and prevention activity	i. Identify appropriate early intervention programs that have been adapted for Aboriginal and Torres Strait Islander families ii. Build partnerships with schools, community councils and other agencies to deliver early intervention and prevention programs for parents, children and at-risk youth

Outcomes	Strategies
Outcome 1.6 Mental health services and community organisations are able to provide appropriate postvention responses to support individuals and families affected by suicide	i. Develop protocols for communication between specialist mental health services and Aboriginal and Torres Strait Islander families regarding intervention needs and support following bereavement ii. Build capacity of community members and community-based personnel to lead postvention responses to bereavement iii. Develop innovative strategies for bereavement support including practical assistance with housing, finances, work and children's needs, psychological support and counselling iv. Develop culturally appropriate best practice therapeutic options for responding to traumatic bereavement and complicated grief among Aboriginal and Torres Strait Islander peoples v. Support development of partnerships between communities and NGOs to support emergency response in diverse settings vi. Emergency response should be consistent with best practice (based on systematic review of research on suicide bereavement first responses and emergencies such as Victorian bushfires and Queensland floods)

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

Suicide risk is associated with adversity in early childhood. There should be ongoing work with universal services—child and family services, schools, health services—to help build strengths and competencies and to protect against sources of risk and adversity that make children vulnerable to self-harm in later life. Prevention should work across the lifespan, directly with families or with children in schools to ensure that all Aboriginal and Torres Strait Islander children are supported to develop the social and emotional competencies that are the foundations of resilience throughout life. Some strategies are intended to provide information to all parents, families, and young people to help build skills and awareness, to dispel myths and to promote active use of services and supports. Consistent with the approach to proportionate universalism, those at greater risk are assisted to access specialised services, including targeted therapeutic support for children, adolescents or parents.

Outcome 2.1   There are culturally appropriate community activities to engage youth, build cultural strengths, leadership, life skills and social competencies

- Issue: Young people can be engaged through community cultural activities such as youth forums to promote leadership and recognise achievements that help young people build individual strengths. Culturally adapted mentorship and life skills programs can focus on healthy life choices, being in charge, thinking ahead and setting goals, and responsible approaches to first relationships. Youth need to be engaged in diverse settings including in schools, in the

community, in the workplace and through participation in sports and the arts, including traditional and contemporary media.

Outcome 2.2   Life promotion and resilience-building strategies are developed; access to wellbeing services among Aboriginal and Torres Strait Islander males is improved

- Issue: Aboriginal and Torres Strait Islander men from 20-34 years old have been identified as being at highest risk of suicide. They access wellbeing and counselling services or seek health for psychological distress infrequently. Traditionally recognised men's roles have been subjected to heavy pressure from association with violence, child abuse, alcohol misuse and incarceration. Many men's programs are not sustained and lack structure or access to professional advice.

Outcome 2.3   Long-term, sustainable prevention strategies that build resilience and promote social and emotional wellbeing are specifically developed for Aboriginal and Torres Strait Islander families and children

- Issue: Parenting has been identified as a critical focus for early intervention and prevention. There are very few, if any, evidence-based parenting programs specifically developed for Aboriginal and Torres Strait Islander families and children that are demonstrably effective. General parenting and family wellbeing programs need to be made widely available, along with targeted interventions for high risk vulnerable families, parents and children.

Outcome 2.4   Services for the general population are adapted to improve access and use by Aboriginal and Torres Strait Islander peoples and are appropriately linked with culturally competent services

- Issue: Existing large scale whole-of-school programs to promote social and emotional wellbeing do not have Aboriginal and Torres Strait Islander-specific inclusion or engagement strategies or resources and national telephone counselling programs only reach a very small component of the Aboriginal and Torres Strait Islander population. The preventive role of primary health care can be enhanced for Aboriginal and Torres Strait Islander peoples.

Outcome 2.5   There is capacity in Aboriginal and Torres Strait Islander organisations to provide counselling and therapeutic support, including services for families who have experienced suicide or traumatic bereavement

- Issue: There is a need to increase access to Aboriginal and Torres Strait Islander psychological services, both within primary health care and in dedicated Aboriginal and Torres Strait Islander counselling services. Intervention studies that specifically adapt and trial the effectiveness of therapeutic interventions for Aboriginal and Torres Strait Islander peoples are required, and mental health programs in the general population should be encouraged to contribute to the capacity of Aboriginal and Torres Strait Islander wellbeing services.

Outcomes	Strategies
Outcome 2.1 There are culturally appropriate community activities to engage youth, build cultural strengths, leadership, life skills and social competencies	i. Develop criteria for support of cultural programs ii. Review evidence for effectiveness of culture-based initiatives and evaluate cultural strengths programs iii. Develop school and community-based life skills programs for adolescents iv. Promote leadership through youth forums and activities to recognise achievements of young people v. Develop models of training and skills development for peers as natural helpers
Outcome 2.2 Life promotion and resilience-building strategies are developed; access to wellbeing services among Aboriginal and Torres Strait Islander males is improved	i. Develop strategies, including information and mental health promotion strategies, to promote use of general health and wellbeing services and specialist services by men ii. Identify and disseminate good practices for men's self-help groups iii. Develop 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
Outcome 2.3 Long-term, sustainable prevention strategies that build resilience and promote social and emotional wellbeing are specifically developed for Aboriginal and Torres Strait Islander families and children	i. Develop culturally appropriate strategies for family engagement in wellbeing programs in multiple settings ii. Make parenting programs adapted for Aboriginal and Torres Strait Islander peoples more available in universal and targeted modes to strengthen parenting skills and to improve behavioural, developmental and mental health outcomes among children iii. Develop family focused interventions for Aboriginal and Torres Strait Islander parents and children in partnership with childcare centres and schools iv. Disseminate information on models of effective early intervention and prevention for Aboriginal and Torres Strait Islander families, parents and children v. Identify school-based strategies to counter bullying, racial discrimination and lateral violence

Outcomes	Strategies
Outcome 2.4 Services for the general population are adapted to improve access and use by Aboriginal and Torres Strait Islander peoples and are appropriately linked with culturally competent services	i. Adapt training resources and inclusion strategies for Aboriginal and Torres Strait Islander students and families in mainstream programs such as KidsMatter and MindMatters ii. Review and remodel Kids Helpline and Lifeline counselling services to provide appropriate services for Aboriginal and Torres Strait Islander peoples in each state and territory iii. Examine strategies to improve the preventive capacity of primary health care, including general practitioner services, routine delivery of mental health assessments, counselling, etc
Outcome 2.5 There is capacity in Aboriginal and Torres Strait Islander organisations to provide counselling and therapeutic support, including services for families who have experienced suicide or traumatic bereavement	i. Identify and evaluate the effectiveness of therapeutic interventions for Aboriginal and Torres Strait Islander peoples ii. Identify strategies to expand access to family and individual counselling through universal primary health care iii. Build partnerships to enable Aboriginal and Torres Strait Islander clinical services and workforce to be supported by the resources of headspace and other non-Indigenous Aboriginal and Torres Strait Islander services.

Action area 3: Targeted suicide prevention services

Targeted services are provided to individuals and families at a higher level of risk. Individuals at higher risk include those with mental illness, particularly those with a prior history of attempted self-harm; people in, or discharged from, custody; those with histories of alcohol and drug abuse or of domestic violence; and some people with histories of neglect and abuse. It is important that the mental health and suicide risk status of individuals are properly assessed in settings such as hospital emergency departments where presentations for mental illness, trauma and substance abuse issues are common. Police responses to antisocial behaviour, alcohol and violence requiring arrest and detention may need to be followed by assessment of risk of self-harm. It is critically important that targeted services are well-coordinated and culturally appropriate and have access to or are followed up by culturally competent community-based preventive services.

Outcome 3.1   There is access to effective targeted and specialist services by all Aboriginal and Torres Strait Islander peoples who are at risk of suicide or self-harm

- Issue: There are significant gaps in access to after-hours and emergency mental health services at hospitals and different factors influencing access to services in urban, rural and remote communities. Assessment and triage teams at hospitals often lack capacity to make mental health assessments, and referrals through networks and crisis assessment teams lack Aboriginal and Torres Strait Islander-specific capacity and the capacity to support follow-up care after discharge.

Outcome 3.2   Integrated services, including targeted and indicated services for families and individuals, are available in Aboriginal and Torres Strait Islander healing centres or other community centres

- Issue: Community health services, community justice centres and counselling services increasingly offer a range of integrated services that may include general health care and/or family support services, combined with more specialised counselling, treatment or rehabilitation services. This approach has potential to improve continuity of care and support for families and individuals.

Outcome 3.3   Targeted and indicated services, including emergency services, are culturally appropriate. They are delivered by Aboriginal and Torres Strait Islander personnel and engage Aboriginal and Torres Strait Islander clients and families

- Issue: Key services lack any specific protocol for identifying Aboriginal and Torres Strait Islander peoples or specifically responding to their needs. Hospitals may lack Aboriginal and Torres Strait Islander liaison or other Aboriginal and Torres Strait Islander wellbeing workers as part of the response and Aboriginal and Torres Strait Islander families may avoid services, abscond from treatment or not make use of follow-up that is available.

Outcome 3.4   There are links and partnerships between mainstream specialist mental health and wellbeing services and Aboriginal and Torres Strait Islander wellbeing services and community organisations

- Issue: Community-controlled services and organisations need to build capacity to provide specialist therapeutic services through innovative partnerships with other specialist services. Some mainstream services do not have specific resources or capacity to work with Aboriginal and Torres Strait Islander clients and could achieve this through partnership with Aboriginal and Torres Strait Islander organisations.

Outcome 3.5   There are integrated and collaborative approaches across sectors responding to Aboriginal and Torres Strait Islander peoples who are at high risk, such as people experiencing mental illness, substance misuse, incarceration, domestic violence, etc.

- Issue: A range of problems, including mental illness and substance misuse, share a range of common risk factors; early prevention approaches that target outcomes across these problems are needed. These may include strengths-based early intervention initiatives and counselling for youth, or community-based programs targeting those with established problems after discharge from treatment, custody or in other identifiable situations of risk.

Outcome 3.6   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.

- Issue: Early behavioural and conduct problems may be a sign of later antisocial tendencies and mental health problems, including vulnerability to suicide and self-harm. Early intervention to address emerging antisocial behaviour and conduct problems has been shown to significantly modify suicide risk factors. There is a need to trial and implement culturally adapted therapeutic early intervention strategies targeting Aboriginal and Torres Strait Islander parents and children with culturally informed assessment and referral options. Developmental impairments caused by foetal alcohol syndrome disorder are associated with suicide risk.

Outcomes	Strategies
Outcome 3.1 There is access to effective targeted and specialist services by all Aboriginal and Torres Strait Islander peoples who are at risk of suicide or self-harm	i. Map service utilisation and barriers for Aboriginal and Torres Strait Islander peoples seeking to access targeted and indicated services in regions and communities ii. Identify barriers to access and utilisation and develop strategies to improve access to referral networks, Aboriginal and Torres Strait Islander-specific information, liaison, flexibility and responsiveness iii. Develop strategies to improve Aboriginal and Torres Strait Islander identification, assessment of suicide risk, psychosocial assessment and culturally informed discharge protocols for hospital emergency departments
Outcome 3.2 Integrated services, including targeted and indicated services for families and individuals, are available in Aboriginal and Torres Strait Islander healing centres or other community centres	i. Develop and disseminate models for services that combine specific targeted and indicated services in centres providing integrated wellbeing services ii. Strengthen the focus on early intervention and suicide prevention within integrated services iii. Build inter-sectoral and professional links to support integrated services iv. Develop and evaluate models for interdisciplinary practice in mental health and early intervention v. Investigate innovative models for partnerships between specialist mental health and wellbeing services (eg headspace) and Aboriginal and Torres Strait Islander wellbeing services and community organisations
Outcome 3.3 Targeted and indicated services, including emergency services, are culturally appropriate. They are delivered by Aboriginal and Torres Strait Islander personnel and engage Aboriginal and Torres Strait Islander clients and families	i. Develop Aboriginal and Torres Strait Islander-specific protocols and training for targeted and indicated services ii. Employ Aboriginal and Torres Strait Islander personnel in outreach, follow-up and engagement roles iii. Expand availability of appropriate cultural awareness training for mainstream services
Outcome 3.4 There are links and partnerships between mainstream specialist mental health and wellbeing services and Aboriginal and Torres Strait Islander wellbeing services and community organisations	i. Identify opportunities for complementary service provision arrangements and referral linkages between mainstream services and Aboriginal and Torres Strait Islander community services to coordinate the provision of targeted preventive services ii. Develop local partnerships between existing services such as headspace centres and Aboriginal and Torres Strait Islander community social and emotional wellbeing services

Outcomes	Strategies
Outcome 3.5 There are integrated and collaborative approaches across sectors responding to Aboriginal and Torres Strait Islander peoples who are at high risk, such as people experiencing mental illness, substance misuse, incarceration, domestic violence etc	i. Develop 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) ii. Provide specific suicide prevention and assessment training for staff in high risk settings who work with Aboriginal and Torres Strait Islander clients iii. Identify alternatives to community reintegration where return to community is not desirable
Outcome 3.6 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.	i. Provide 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 ii. Engage at-risk parents to provide parenting and family support via access to health, early education and childcare services as well as child protection services iii. Trial and implement culturally adapted therapeutic family interventions for Aboriginal and Torres Strait Islander parents and children iv. Develop strategies to identify and reduce risk associated with child protection interventions, including child removal, foster care and kinship care and practices of child placement v. Improve identification of foetal alcohol syndrome disorder and other developmental impairments in children vi. Develop information and resources to assist health and social and emotional wellbeing practitioners to respond to family suicidal behaviour and family mental illness

Action area 4: Coordinating approaches to prevention

A suicide prevention strategy requires coordinated action of Commonwealth and state or territory governments, coordination between different departments—health, schools, justice, child and family services, child protection and housing—and coordination with the community sector to ensure that there is capacity within local Aboriginal and Torres Strait Islander organisations to provide preventive services. Especially where Aboriginal medical services are not available, for example in some rural areas, Medicare Locals and local government councils may be central to support for Aboriginal and Torres Strait Islander community initiatives. Coordination between governments is required to reduce duplication and overlap of services and to improve infrastructure and resources. Coordination at regional or local levels involving partnerships between government (including local government), non-government and community-controlled services can provide consistent care and support to families and individuals who have complex or multiple needs.

Outcome 4.1   Multi-sectoral coordination of suicide prevention is established and sustained across levels and sectors of government in jurisdictions, regions and communities

- Issue: There is a need for alignment and collaboration between national and state/territory suicide prevention strategies with a focus on the coordination of regional suicide prevention strategies. There are opportunities to build the capacity for prevention activity across sectors, such as education, health, child protection and justice at all levels of government. Regional coordination of prevention should have regard for specific regional initiatives, such as the Northern Territory's Stronger Futures program and other national and state or territory programs.

Outcome 4.2   There is development of governance and infrastructure and capacity for planning to support regional and local coordination of suicide prevention

- Issue: Current management systems represent barriers to regional coordination. Data on suicide and self-harm is often not readily available to support regional planning and decision making and linkages between service systems at different levels of government in each jurisdiction mean that states, territories and Commonwealth need to reach agreement on how to achieve regional objectives.

Outcome 4.3   There are agreements to support collaborative approaches to joint case management to ensure continuity of services and supports for higher risk clients

- Issue: Confidentiality of information is perceived to be a barrier to providing continuity of care or care for individuals and families who have complex, multiple needs, or who face transition from one system of care to another. Specific agreements or memoranda of understanding for information sharing, including specific consents by families and individuals to allow for joint case management, should be developed.

Outcome 4.4   Coordinated suicide prevention strategies are supported by improved community sector capacity, based on partnerships between services, agencies and communities

- Issue: There is a need to support the capacity of Aboriginal and Torres Strait Islander organisations to enter into partnerships in suicide prevention. This capacity is not funded, or cannot be sustained, because of the short-term nature of grant funding and the limitation of tender processes.

Outcomes	Strategies
Outcome 4.1 Multi-sectoral coordination of suicide prevention is established and sustained across levels and sectors of government in jurisdictions, regions and communities	i. Identify priority areas for horizontal and vertical alignment of suicide prevention activity at Commonwealth and state levels ii. Develop a joint action plan across levels and sectors of government for the Strategy iii. Develop strategies for alignment between key policy frameworks relating to alcohol, mental health, Closing the Gap, Aboriginal and Torres Strait Islander early childhood and Aboriginal and Torres Strait Islander education
Outcome 4.2 There is development of governance and infrastructure to and capacity for planning to support regional and local coordination of suicide prevention	i. Investigate feasibility of approaches to regional coordination of suicide prevention including, but not limited to, roles of key government agencies and partners ii. Identify models for governance to support interagency approaches to coordinated suicide prevention iii. Develop data, information and resources to support regional level planning and coordination of strategies iv. Examine models for pooling of funds to support coordinated approaches to prevention
Outcome 4.3 There are agreements to support collaborative approaches to joint case management to ensure continuity of services and supports for higher risk clients	i. Pilot and evaluate specific multidisciplinary approaches to service provision for vulnerable individuals and families ii. Investigate feasibility of specific memoranda of understanding to enable joint approaches to case management iii. Clarify agency responsibilities for interagency coordination of care for high risk Aboriginal and Torres Strait Islander clients and families
Outcome 4.4 Coordinated suicide prevention strategies are supported by improved community sector capacity, based on partnerships between services, agencies and communities	i. Build the capacity of Aboriginal and Torres Strait Islander organisations to sustain partnerships with governments and other organisations ii. Establish partnerships between governments and the community sector to develop and train the prevention workforce across health, education and community services iii. Develop options for prevention research partnerships between the community sector, non-government organisations and research and training sectors to build capacity in suicide prevention

Action area 5: Building the evidence base and disseminating information

It is important that activities to prevent suicide are founded on evidence and that services are professionally and ethically sound and do not add to the risk and vulnerability of Aboriginal and Torres Strait Islander clients. Evidence is needed to demonstrate that services are effective in preventing suicide, in reducing risk factors for suicide and minimising its impact on families and communities. Developing a body of research on the effectiveness of preventive interventions developed or adapted for Aboriginal and Torres Strait Islander peoples and their communities is a high priority. In other areas, the evidence base is limited by the lack of data on self-harm in communities and on outcomes or prevention at the community or regional level. The limitations on the collection and publication of population level suicide data is due to the quality of Aboriginal and Torres Strait Islander identification and the small numbers involved making it difficult to detect statistically significant trends and differences by age, sex and region. The Australian Bureau of Statistics is working with the Registries of Births, Deaths and Marriages in each jurisdiction to improve the quality of Aboriginal and Torres Strait Islander mortality data and this work is ongoing.

Further evidence is needed on the causes of suicide and self-harm for specific subgroups and in specific settings. Evidence on effective practice, toolkits and resources needs to be made available to Aboriginal and Torres Strait Islander community organisations, practitioners and government providers to inform the planning and implementation of activities. Opportunities exist for academic research to explore suicide and related issues, its determinants and the effectiveness of programs for prevention and postvention, particularly at the community level.

The Strategy will be an important channel to disseminate information and resources to all groups involved in suicide prevention.

Outcome 5.1   Governments, agencies and services continue to work together to improve completeness and accuracy of data collection, Aboriginal and Torres Strait Islander identification and access to appropriate methods, measures and standards for reporting Aboriginal and Torres Strait Islander suicide and self-harm.

- Issue: Gaps in availability and accuracy of data on Aboriginal and Torres Strait Islander suicide and self-harm remain across Australian jurisdictions

Outcome 5.2   Population-level data and evidence on the distribution of Aboriginal and Torres Strait Islander suicide, self-harm, and risk and protective factors in the Aboriginal and Torres Strait Islander population are available.

- Issue: There is a need for greater research effort to identify determinants of suicide and self-harm in specific subgroups and populations.

Outcome 5.3   There is locally accessible capacity to monitor risk behaviours and indicators of community functioning for individual communities and regions in order to reduce suicidal behaviour and prevent suicide.

- Issue: National population data on risk factors and indicators of community functioning and wellbeing cannot be provided at regional and community levels. An investigation of community characteristics, levels of service use and links to self-harm needs to be undertaken and the capacity of practice systems in health care and other services to capture and report on self-harm needs to be improved. Research into the contribution of community level factors, including cultural change and continuity, community governance and social capital, should be conducted for Australian conditions.

Outcome 5.4   There is an improved evidence base on the effectiveness of suicide prevention activity, including effective services and interventions, community initiatives, mental health awareness promotion and training and capacity development.

- Issue: There is very little research on the effectiveness of suicide prevention based on intervention studies developed with and for Aboriginal and Torres Strait Islander peoples. Research on different interventions and at different intervention points should aim to provide evidence on prevention strategies for specific subgroups such as parents and children, youth and adults.

Outcome 5.5   There is research led by Aboriginal and Torres Strait Islander researchers so that an evidence base built on Aboriginal and Torres Strait Islander knowledge is developed. This could include organisations like the Ninti One network of Indigenous Community Researchers who have knowledge of the contemporary social, cultural and environmental contexts of remote Aboriginal and Torres Strait Islander communities.

- Issue: Leveraging opportunities to build the numbers of Aboriginal and Torres Strait Islander peoples with graduate and postgraduate qualifications to levels comparable with other nations should be a priority across sectors. There is a need to build pathways to suicide prevention research for Aboriginal and Torres Strait Islander students across sectors; areas of Aboriginal and Torres Strait Islander knowledge should also be developed to contribute to evidence across sectors.

Outcome 5.6   Partnerships are established between researchers, Aboriginal and Torres Strait Islander communities and community organisations to evaluate evidence-based practices and provide support for program implementation and quality improvement.

- Issue: Aboriginal community-controlled health organisations and Aboriginal medical services have signalled the need for evaluation research to support policy and practice development and to evaluate outcomes of programs and services. Suicide prevention practices can be developed and incorporated within existing continuous quality improvement systems.

Outcome 5.7   Accessible information on evidence-based approaches, effective interventions, good practice and professionally safe and culturally responsive strategies for use by communities, organisations and services is disseminated and widely available.

- Issue: There is a need for access to information on evidence-based strategies and appropriate, culturally adapted resources and interventions to support planning of responses by communities and organisations. A need to acknowledge successful approaches has been identified. The dissemination and information strategy should include a register of proven and promising interventions, as well as culturally adapted and validated resources and instruments. Proactive, targeted strategies to disseminate information to specific practitioner groups, organisations and to communities are needed. This can include collaboration with Aboriginal and Torres Strait Islander professional associations and information networks.

Outcomes	Strategies
Outcome 5.1 Governments, agencies and services work together to improve completeness and accuracy of data collection, Aboriginal and Torres Strait Islander identification and access to appropriate methods, measures and standards for reporting Aboriginal and Torres Strait Islander suicide and self-harm	i. Governments continue to identify opportunities working with the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data[9] to improve data on deaths and intentional self-harm in each jurisdiction, including data to support coordination and evaluation of suicide prevention at a regional level ii. Work with national data collection agencies and the the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data to improve surveillance data on Aboriginal and Torres Strait Islander suicide and self-harm where possible iii. Continue to Improve standards of Aboriginal and Torres Strait Islander identification within administrative data collection activities across agencies and services .
Outcome 5.2 Population-level data and evidence on the distribution of Aboriginal and Torres Strait Islander suicide, self-harm, and risk and protective factors in the Aboriginal and Torres Strait Islander population are available	i. Develop analyses of suicide and self-harm and key indicators of risk in communities and regions through research activities ii. Explore possibilities of data linkages to compile population-level data on relevant risk factors, characteristics of communities and service usage patterns iii. Examine ways to implement research studies that investigate the determinants of suicide and self-harm in specific subgroups and communities iv. Conduct research into the contribution of community characteristics, culture and governance to prevention

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[9] The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data is an Australian Health Ministers Advisory Council (AHMAC) sub-committee which provides broad strategic advice to AHMAC on ways of improving the quality and availability of data and information on Aboriginal and Torres Strait Islander health and health service delivery. The Advisory Group includes representatives from relevant statistical agencies, jurisdictions, experts and Indigenous membership.

Outcomes	Strategies
Outcome 5.3 There is locally accessible capacity to monitor risk behaviours and indicators of community functioning for individual communities and regions in order to reduce suicidal behaviour and prevent suicide	i. Standardise assessment and recording of suicide risk in health and community services ii. Develop methods for reporting indicators of self-harm at a community level to enable planned responses iii. Develop appropriate strategies for monitoring those at risk, and for referral and follow-up arrangements with appropriate specialist and support services
Outcome 5.4 There is an improved evidence base on the effectiveness of suicide prevention activity, including effective services and interventions, community initiatives, mental health awareness promotion and training and capacity development	i. Identify priorities for intervention studies for the development of universal and targeted early intervention services ii. Evaluate whole-of-community initiatives to identify the best methods of response to suicide clusters iii. Evaluate specific adaptations of gatekeeper training and training for natural helpers iv. Conduct trials to evaluate the effectiveness of multi-component, whole-of-community suicide prevention strategies
Outcome 5.5 There is research led by Aboriginal and Torres Strait Islander researchers. An evidence base built on Aboriginal and Torres Strait Islander knowledge is developed.	i. Identify strategies to support Aboriginal and Torres Strait Islander completions in relevant disciplines at graduate and postgraduate levels of training ii. Improve the participation rates of Aboriginal and Torres Strait Islander peoples as researchers and consultants in intervention trials that develop services for Aboriginal and Torres Strait Islander peoples iii. Conduct studies to show how Aboriginal and Torres Strait Islander knowledge can contribute to social and emotional wellbeing
Outcome 5.6 Partnerships are established between researchers, Aboriginal and Torres Strait Islander communities and community organisations to evaluate evidence-based practices and provide support for program implementation and quality improvement	i. Establish research and implementation partnerships between the community and research sectors to implement and evaluate suicide prevention initiatives ii. Develop research-informed strategies to support quality implementation of preventive activity iii. Develop practice-based evidence to support continuous quality improvement in Aboriginal and Torres Strait Islander wellbeing services iv. Investigate the effectiveness of culturally adapted interventions and instruments specifically for use by Aboriginal and Torres Strait Islander wellbeing workers.

Outcomes	Strategies
Outcome 5.7 Accessible information on evidence-based approaches, effective interventions, good practice and professionally safe and culturally responsive strategies for use by communities, organisations and services is disseminated and widely available	i. Develop an information plan that builds access to information about Aboriginal and Torres Strait Islander suicide prevention ii. Develop specific resources for targeted audiences, Aboriginal and Torres Strait Islander families and communities, practitioners and organisations iii. Explore methods for online access to information about effective practices, resources and instruments, supports for planning and service delivery iv. Strengthen communities of practice in Aboriginal and Torres Strait Islander suicide prevention through targeted provision of information and resources through Aboriginal and Torres Strait Islander professional bodies and information networks

Action area 6: Standards and quality in suicide prevention

The social and cultural diversity and the wide geographical dispersion of Aboriginal and Torres Strait Islander communities across Australia highlights the need for consistent standards of practice for services and interventions and the capacity to assure high quality in programs of activity. There are three major components to the Strategy: 1) Measures to improve Aboriginal and Torres Strait Islander participation in the workforce through access to training and qualifications at all levels; 2) Implementing quality controls to strengthen uptake and embedding of preventive activity in primary health care and other service sectors; and 3) Strengthening the role of evaluation to support quality implementation of programs and to evaluate their outcomes.

Outcome 6.1   There are comprehensive plans to develop participation of Aboriginal and Torres Strait Islander peoples in the suicide prevention and wellbeing workforce.

- Issue: The need for a systematic approach to building the Aboriginal and Torres Strait Islander wellbeing workforce and to improving specific skills in suicide prevention and social and emotional wellbeing was consistently emphasised at the forums. The approach needs to be cross-sectoral with regard to workforces in early childhood, educational services, health care, child protection therapeutic services, police and other sectors. Special provision should be made for Aboriginal and Torres Strait Islander community members unable to access training in universities or colleges in city centres.

Outcome 6.2   Standards are developed for community engagement and cultural awareness in wellbeing services and for early intervention for Aboriginal and Torres Strait Islander peoples, families and communities.

- Issue: Guidelines, resources and information about specific successful models of culturally appropriate engagement are needed. Concerns that a checklist approach to cultural competence may be superficial and counter-productive need to be met by trial and rigorous

evaluation of culturally adapted practice models and training approaches with and for Aboriginal and Torres Strait Islander personnel.

Outcome 6.3   Programs are evaluated and there is quality support for implementation.

- Issue: Provision for evaluation can be significantly improved in funding arrangements under state and Commonwealth contracts. There are currently very few evaluations conducted that contribute to the evidence base in any way. Aboriginal and Torres Strait Islander community services benefit from evaluations of programs that demonstrate their effectiveness and that provide information for practice development, policy and planning.

Outcome 6.4   Suicide prevention principles are embedded in systems of quality improvement for social and emotional wellbeing and mental health care.

- Current guidelines and protocols for mental health care, hospital emergency services and other areas of social and emotional wellbeing practice can be improved in terms of their specificity for suicide prevention and appropriateness for Aboriginal and Torres Strait Islander peoples. There is a need to encourage uptake of current Medicare items where possible for mental health and social and emotional wellbeing assessment in the Indigenous Health Check through training and audit. There is a need to embed suicide prevention practices in existing continuous quality improvement processes.

Outcomes	Strategies
Outcome 6.1 There are comprehensive plans to develop and support the participation of Aboriginal and Torres Strait Islander peoples in the suicide prevention and wellbeing workforce such as nurses and counsellors	i. Work towards a coordinated approach to Aboriginal and Torres Strait Islander workforce development across sectors and levels of government ii. Review pathways to recruitment and training to enhance access to appropriate courses for community members iii. Work with Aboriginal and Torres Strait Islander training organisations, the Aboriginal and Torres Strait Islander VET sector and other organisations to build access to appropriate training options iv. Develop funding options to secure Aboriginal and Torres Strait Islander input into development of training resources
Outcome 6.2 Standards are developed for community engagement and cultural awareness in wellbeing services and for early intervention for Aboriginal and Torres Strait Islander peoples, families and communities	i. Build evidence to support guidelines for community engagement and culturally responsive practice through evaluation of cultural protocols in training and practice ii. Disseminate information on best practice models, including manuals, guidelines and resources for training and service delivery

Outcomes	Strategies
Outcome 6.3 Programs are evaluated and there is quality support for program implementation	i. Ensure that there is provision for evaluation in funded suicide prevention programs ii. Support specific partnerships between research organisations and the Aboriginal and Torres Strait Islander community sector to evaluate program implementation and outcomes iii. Use evaluation to build systems of quality improvement for suicide prevention in health care, child and family services, education and other services.
Outcome 6.4 Suicide prevention principles are embedded in systems of quality improvement for social and emotional wellbeing and mental health care	ii. Where possible encourage through current programs including general practitioners and other clinicians to increase provision of mental health assessments and treatments through training and quality improvement strategies ii. While there are limitations in the Medicare Benefits Schedule data as a measure of provision of services for Aboriginal and Torres Strait Islander clients, examine the possibility of using the Medicare Benefits Schedule to monitor access to general practitioners, psychiatrists and psychologists, and the flow-on effects of these services to Aboriginal and Torres Strait Islander wellbeing services through referral and other links. iii. Work with the Aboriginal and Torres Strait Islander community-controlled healthcare sector to ensure that suicide and self-harm risk assessment are incorporated in continuous quality improvement systems for child, youth and adult mental health services.

5 Implementation

Implementation of the Strategy is everyone's business

Suicide prevention necessarily involves, in different ways, all sectors and levels of government, the non-government and community sectors, communities themselves and research and training institutions. The action areas identify key outcomes of the Strategy. Some actions entail multi-agency collaboration and multiple lines of responsibility, while others are more specialised.

Over a 10 year period, the Strategy will aim to achieve measurable improvements in each of the identified target areas and within this timeframe it is possible and appropriate to set targets in consultation with the Aboriginal and Torres Strait Islander Mental Health Advisory Group which can be related to the National Mental Health Commission's National Report Card and the Roadmap for National Mental Health Reform 2012-2022. Longer-term capacity building (eg data development, building the community sector, building the evidence base, Aboriginal and Torres Strait Islander workforce participation, evaluation of outcomes of specific initiatives and of the overall strategy) will yield reportable outcomes over the 5 and 10 year periods of the Strategy.

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APPENDIX 1

Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group.

Dr Tom Calma AO, Northern Territory (Chair): Dr Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group. Dr Calma is a former Aboriginal and Torres Strait Islander Social Justice Commissioner, and the current National Coordinator for Tackling Indigenous Smoking. Dr Calma was recently appointed as the new chancellor of the University of Canberra.

Ms Adele Cox, Western Australia: Adele Cox is a Bunuba & Kija (Gija) woman from the Kimberley region of Western Australia. Adele is a current member of Australian Suicide Prevention Advisory Council (ASPAC) and past member of National Advisory Council on Mental Health (NACMH).

Prof. Ernest Hunter, Queensland: Ernest Hunter is an Australian medical graduate trained in adult, child, cross cultural psychiatry and public health. He is Regional Psychiatrist with Queensland Health and Adjunct Professor with the University of Queensland based in Cairns.

Mr Tom Brideson, New South Wales: Tom Brideson is a Kamilaroi man. Tom is a Visiting Fellow with NSW Centre for Rural and Remote Mental Health at Newcastle University; past Program Leader for the CRC for Aboriginal Health; consultant on Social and Emotional Wellbeing for Indigenous Health*InfoNet.*

Dr Pat Dudgeon, Western Australia: Pat Dudgeon is from Bardi people of the Kimberley. She is a psychologist and is known for her role in Indigenous higher education. Pat is the current Chair of Australian Indigenous Psychologists Association (AIPA); first convener of the Australian Psychological Society Interest Group, Aboriginal issues and Aboriginal People and Psychology and current Chair of the Aboriginal and Torres Strait Islander Mental Health Advisory Group (ATSIMHAG). Professor Dudgeon was also appointed as a Commissioner to the National Mental Health Commission in 2011.

Mary Victor O'Reeri, Western Australia: WA Local Hero 2011. Mary Victor O'Reeri lives in the Billard and Beagle Bay Aboriginal communities in the remote north-west Kimberley region of Western Australia. Mary convened the inaugural Blank Page Summit in her remote community at Billard in the north west Kimberley in 2009.

Ashley Couzens, South Australia: Ashley is from the Riverlands District of South Australia and has been a senior Aboriginal Health Worker and a community worker for a number of years. He was instrumental in forming the Riverland Aboriginal Men's Support Group, and currently works as a Team Leader for the Life Without Barriers.