



**Towards a National Aboriginal and Torres Strait
Islander Suicide Prevention Strategy**

Consultation Paper for Community Forums

Consultations on Aboriginal and Torres Strait Islander suicide prevention are conducted by the Menzies School of Health Research and funded by the Australian Government Department of Health and Ageing



National Aboriginal and Torres Strait Islander Suicide Prevention Strategy: Consultation Paper

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What is the aim of the National Consultation?

The consultation to draft a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is being conducted on behalf of the Australian Government Department of Health and Ageing. It will consult members of Indigenous communities across Australia and all those concerned about Indigenous suicide and concerned to improve Indigenous social and emotional wellbeing.

A detailed report documenting the consultation process will be provided to the Department. It will include reviews of evidence, information and resources relevant to Indigenous suicide prevention and an analysis of consultation outcomes to form the basis for recommendations concerning a national framework for suicide prevention for Aboriginal and Torres Strait Islander people.

The key principle of the approach is to ensure that voices from Aboriginal and Torres Strait Islander communities are heard throughout the consultation process and are reflected in the draft strategy. This will be achieved through Community Consultation Forums where priorities and objectives of the Strategy will be discussed.

Representatives of the Federal, State and Territory Governments and key communities and professional groupings participate in a number of high level advisory groups. The consultation works closely with and seeks the advice of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group which includes Indigenous representatives from across Australia. Other peak bodies include the National Aboriginal and Torres Strait Islander Health Equality Council (NATSIHEC) and the Australian Suicide Prevention Advisory Committee (ASPAC). Discussions with these groups will take place over the coming months.

About this document

This consultation paper provides a brief introduction to key issues and possible areas for action as a stimulus to discussion in the community forums. It provides some brief examples of projects or initiatives relevant to each issue, and asks some questions about Indigenous suicide prevention for each issue. These are intended to illustrate some different kinds of actions across Australia. We recognise that a great deal has been done at local as well as state and territory levels and that needs, priorities and achievements at the local level are not always recognised. The commonly cited success stories may not always reflect many other important achievements. We are concerned to ensure that these are reflected in the consultation outcomes.

This paper is intended as a guide and starting point for discussion, and should not limit the range of issues and concerns that may be raised in discussion. It is accompanied by a discussion paper which provides more detail about relevant literature, evidence and sources relating to each of the themes outlined in this document.

The development of this paper was written in consultation with the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group. The members of the group are listed on page 24.

Copies of this document and the discussion paper may be downloaded from the consultation website at: www.indigenoussuicideprevention.org.au.

The Need for a Suicide Prevention Strategy for Aboriginal and Torres Strait Islander People

The human tragedy of suicide touches many families and communities and many people working with them to provide care and support. According to the report, *Overcoming Indigenous Disadvantage: Key Indicators, 2011*, (SCRGSP, 2011), in those jurisdictions in which data on suicide deaths were available, the suicide death rate for Indigenous people including males and females from 2005-2009 was 2.5 times the rate for non-Indigenous people. Suicide accounts for a much higher proportion of all Indigenous deaths than in the Australian population. There is considerable variation in the suicide death rate across the country, ranging from around 10 deaths per 100,000 population in NSW to well over 30 deaths per 100,000 in WA, SA and the NT. Suicide was the leading cause of death from external causes for Indigenous males, with rates ranging from 17 deaths per 100,000 in NSW to over 60 deaths per 100,000 in the NT. Rates for Indigenous females are also much higher than for females in the general population, but much lower than for Indigenous males. Research consistently shows that Indigenous persons commit suicide at much younger ages than members of the general population with the preponderance of suicide deaths before the age of 35 years, and many times more cases among children and youth. Suicide rates for Indigenous populations show variation over time and across regions, with marked clusters in some communities.

Both the magnitude of rates of suicide among Indigenous peoples, and the many differences in their characteristics when compared to suicide in the general population, were noted in the report of Senate Community Affairs Reference Committee, "The Hidden Toll: Suicide in Australia". That report recommended that there be a separate national strategy for the prevention of Aboriginal and Torres Strait Islander people. This consultation aims to identify community views on what such a strategy should contain.

A Framework for Suicide Prevention for Aboriginal and Torres Strait Islander People

Australia's National Suicide Prevention Strategy is based on the Commonwealth, State and Territory *Living is For Everyone (LiFE) 2007 Framework*. It consists of two main elements: *Living is For Everyone: A Framework for Prevention of Suicide in Australia* which outlines the vision, purpose and action areas for a national suicide prevention strategy, and *Living is For Everyone: Research and Evidence in Suicide Prevention*, which provides an overview of recent theories and research evidence on suicide and suicide prevention. These two elements are primarily aimed at policy makers, service providers, community organisations, professionals and researchers. *Living is For Everyone: Practical Resources for Suicide Prevention*, is a third element, consisting of information and resource materials for use by communities, carers, employers, friends and families of those affected by suicide.

A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy will help to set priorities at the national level for the planning and coordination of activities and allocation of resources aimed at preventing Indigenous suicide in Australia. It will link with the existing National Suicide Prevention Strategy for all Australians, and with suicide prevention strategies of state and territory governments. It will be compatible with other related Australian Government initiatives, including

the development of a National Aboriginal and Torres Strait Islander Health Plan and the review of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework.

Key Issues and Action Areas

The National *LiFE Framework* for suicide prevention identifies six action areas in the National Suicide Prevention Strategy. A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy will similarly identify a number of key action areas whilst explicitly allowing for state, regional and local variations.

The six action areas of the *LiFE (2007) Framework* have been taken as a starting point for the consultations. They have been adapted to focus on issues of specific concern and questions for Aboriginal and Torres Strait Islander People. In particular, the consultations will explore the role of culture and community in contributing to social and emotional wellbeing and reducing sources of risk, particularly for young people. The consultations will provide an opportunity to take account of the way culture shapes how people respond to and view mental health, mental distress and suicidal behaviour, and how it can affect the ability of community members to access appropriate care through both mainstream and Indigenous-led services.

For each issue, this paper provides a brief outline of objectives, along with working examples of attempts to realise these objectives in Australia or overseas. Questions to stimulate discussion about what options might be available to improve work in this area in your context, region or community are asked. For further information about the sources referred to in this paper see the accompanying *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy: Discussion Paper* and other links on the consultation website.

References

SCRGSP (Steering Committee for the Review of Government Service Provision) 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra

The Senate Community Affairs References Committee, 2010, *The Hidden Toll: Suicide in Australia*, the Commonwealth of Australia, Canberra.

The Commonwealth of Australia, 2008, *Living Is For Everyone (LiFE) Framework (2007)*

Issues and Questions for Your Forum

Issue 1: Improving what we know about suicide and its prevention among Aboriginal and Torres Strait Islander people.

Suicide causes great distress to those directly affected by it, family members and members of communities or workplaces and schools, and by many of those working to prevent it, through their work with those at high risk of suicide or work with communities and families experiencing suicide of their members. In the context of powerful emotions and experiences of distress, it is important that there is sound evidence to inform policy and ensure that careful decisions can be made about the most appropriate and effective services, interventions and support.

Recent studies and reports have identified gaps in the evidence base in the following areas:

1. Problems and limitations of the data available on Indigenous suicides
2. A lack of epidemiological evidence concerning distribution of suicides and suicide risk factors
3. A lack of evidence concerning patterns of service use and gaps in services and patterns of social and educational participation and how these relate to suicide risk and opportunities for prevention through services
4. A lack of reliable evidence concerning the effectiveness of approaches to suicide prevention for Aboriginal and Torres Strait Islander people, their families and communities
5. A need for collaborative partnerships between communities, and the community sector in health and mental health care and researchers to develop relevant evidence and evaluate outcomes of prevention

Some examples of what is being done or might be done

Building research infrastructure and improving data:

- Efforts to improve identification of Indigenous status in health and hospital systems, medical records of death and coronial reports (Victoria)
- Establishment of Coroner's database on suicide (Western Australia), a suicide register (Queensland) and commitment to establish a Coroner's suicide register (Northern Territory), to monitor trends, causes and contributing factors
- Establishment of hospital databases for intentional self harm and follow-up systems at hospitals (Western Australia)

International examples

- The New Zealand Health Research Council has a funding program dedicated to research in Maori mental health including suicide and suicide prevention
- Multi-level Intervention Suicide Prevention (MISP) trial, New Zealand is a randomised controlled trial to compare practice as usual to the delivery of multiple-level suicide prevention initiatives that are intensive and synchronised within a local system

- Te Ira Tangata (NZ Ministry of Health, 2010). The New Zealand Ministry of Health is funding the design, implementation and evaluation of two randomised controlled trials, one of them, specifically for Maori who have made a suicide attempt, to inform improvement in longer-term care. *Te Ira Tangata* compares treatment as usual with a package of promising evidence-based interventions informed by Maori knowledge and cultural processes

Key questions

- *Where are the most important needs for evidence to support suicide prevention for Aboriginal and Torres Strait Islander people?*
- *How can high quality information on suicide and suicide risk factors be conveyed to communities, organisations and professional groups concerned with suicide prevention?*
- *What kinds of research are needed to ensure that early intervention, prevention and support are a) effective in reducing suicide risk and b) appropriate in meeting needs of communities, families and others affected by suicide and suicidal behaviour?*
- *Can networks based on partnerships between the Aboriginal and Torres Strait Islander community sector and researchers promote more relevant research?*
- *What should be the role of a national strategy in funding, facilitating and coordinating improvements in the suicide prevention evidence base for Aboriginal and Torres Strait Islander people?*

Issue 2: Building individual resilience and the capacity for self-help

This issue focuses on strategies for individuals to reduce their vulnerability and to improve their coping and resilience through engagement and provision of services, interventions and supports. In the most widely accepted model, interventions to reduce vulnerability and promote resilience are classified as universal, (provided for everyone), targeted (for those identified as being at risk) or indicated (for those at imminent risk of suicide or self harm).

In addition to targeting varying levels of risk and needs for care, such strategies may take a life-span approach to prevention and aim at both long and short term outcomes. These strategies are based on research that suggests that suicide risks and vulnerabilities arise at a number of points in the life span, from early childhood through adolescence and adulthood. Different kinds of universal, targeted and indicated interventions apply at different points in the life-span.

Universal strategies may include health promotion programs or campaigns that may be delivered to whole schools, communities or through the mass media. They may include specific mental health and wellbeing programs that are delivered through community services. Strategies in communities or regions may include a mix of targeted and universal components, that is, provide services for people at some degree of higher risk, such as life promotion or competence-building interventions for specific communities or age groups (such as males, youth, parents) within a universal approach to promotion of mental health or wellbeing.

Some examples of what has been done or is being done

- MindMatters is a whole-school approach to mental health education for secondary students that provides professional development and resources to teaching staff and aims to provide information, to destigmatise mental illness and promote help-seeking among young people.
- Koori Kids (NSW) provides cultural awareness and whole-of-school mental health promotion programs (based on Mind Matters and Aussie Optimism programs) to improve the emotional and social wellbeing of aboriginal children attending targeted local primary schools. The program also works with parents to support those children who are experiencing mental ill health and behavioural problems.
- The Yiriman Project (WA) runs youth activities with support from senior cultural men and has established links with local agencies such as cultural activities and camps that build strong relationships, self identity and confidence in young people.
- The H.O.P.E. project provides psychological and coordination services to young Aboriginal and Torres Strait Islander students at risk of suicide and self harm in the Mildura area. The project addresses the complex interface between education and anti-social behaviour and provides links to primary care and helps connect participants to positive lifestyle activities in art, culture and sport.

Interventions and Services

- Yorganop (Western Australia), SAFT (Northern Territory): Indigenous organisations providing services for at risk Indigenous families and children in contact with child protection.
- The Let's Start Parent-Child Program (Northern Territory) is a school-based therapeutically oriented early intervention program for Aboriginal parents and children, developed in contexts of high suicide risk and aiming to improve parenting and parent-child relationships.

International examples

- The Zuni Life Skills Development (ZLSD) initiative (USA).
- The Incredible Years (NZ) is an evidence-based behavioural parenting program adapted for Maori children and parents and the mainstay of early intervention and prevention for Maori and non-Maori families in New Zealand.
- The Western Athabaskan community-based suicide prevention strategy (USA) consisted of integrated multiple evidence-based interventions aiming at long and short term prevention.

Key questions

- *Are Indigenous issues and needs appropriately and adequately met by universal mental health promotion programs through the mass media?*
- *Do existing resources to de-stigmatise mental illness, to educate about mental health, wellbeing and suicide and to encourage help-seeking adequately engage and/or address the needs of Indigenous people? If not, what is needed?*
- *What initiatives to build resilience for Indigenous people are available in your area?*
 - *For example: Life skills; parenting and family support; others?*
- *What is needed to promote help-seeking and use of services and for whom?*
 - *For example: adolescents; males; families, parents and children?*
- *Considering resilience-promoting initiatives and programs in your areas, are they:*
 - *Evaluated and/or based on evidence?*
 - *Specifically adapted for Indigenous clients and adequately supported by culturally appropriate strategies, materials and resources?*
- *In your view, what resilience-building strategies are most needed in your area and how can they be supported and sustained?*
- *How could a national strategy support improvements in prevention aiming to improve resilience and reduce vulnerability?*

Issue 3: Improving community strength, resilience and capacity in suicide prevention

Communities can be defined as groupings or networks of people defined by common social characteristics such as cultural values and beliefs and activities, shared histories or common interests and/or, simply by geographical residence in a town, neighbourhood or “community”.

Communities across Australia are very diverse, both in terms of location – urban, rural or remote environments –social homogeneity and culture. For Aboriginal and Torres Strait Islander people, *Community* is closely related to ideas of *Culture* and *Identity*. Community is also a basis for recognition of leadership and authority.

Communities are important contexts for suicide prevention. They shape and define key resources and supports available to individuals and which may be critical for their sense of wellbeing and identity. Some communities are disadvantaged in terms of income and access to resources; there may be social problems including violence, alcohol and substance misuse. Many discrete communities have been affected by rapid rises in the numbers of suicides in suicide ‘clusters’.

Community level strategies may contain a number of key elements: improvement of community awareness through campaigns, life promotion, and positive community action to promote social emotional wellbeing; providing training for “gatekeepers” and “natural helpers”; building services and more effectively coordinating them; and identifying and supporting those most at risk (youth, men, families). In communities suffering suicide at epidemic levels, there may be a need to combine emergency responses, postvention responses and both short and long term prevention and early intervention approaches to contain the epidemic.

Some examples of what has been done or is being done

- Pathways to Resilience: Rural and Remote Indigenous Communities Suicide Prevention Initiative (Queensland Government, 2010).
- Community life consultation paper (Commonwealth of Australia, 2005). This resource was developed for consultation, and provides guidance on the formation of community action plans to raise awareness and build capacity to prevent suicide.
- Suicide Story (NT) was developed within the Life Promotion Program of the Mental Health Association of Central Australia. The program trains Indigenous community members in the delivery of the ‘Suicide Story’, an Indigenous focused DVD/program aimed at reducing the incidence of suicide/suicide attempts in remote communities.
- The Building Bridges (QLD) project aims to: support leadership and collaboration among local men in suicide prevention; harness the capacity of the Family Well Being program to develop life promotion skills in the broader community; obtain a better understanding of the meaningfulness and dimensions of suicide and self-harming behaviours and foster participation and communication of messages of purpose and identity to young people.

International examples

- The Wind River Behavioural Health Program (USA) was a community based response developed to address suicide epidemics involving both crisis intervention and emergency responses; community action, and long and short term prevention involving communities, individuals and families.
- Northwest Territories Suicide Prevention Training (NTSPT; Canada). A program to make training in suicide prevention accessible to communities and to create suicide prevention expertise among community members.

Key questions

- *How should culture be taken into account in suicide prevention?*
 - *To maximise the protective benefits of cultural strengths?*
 - *To ensure that services are adapted to culture and community circumstances?*
 - *To strengthen community “ownership” of problems and solutions?*
- *Considering suicide in your area or community, what are the most urgent issues?*
 - *Social problems: drinking & drugs; violence; social isolation?*
 - *Young people’s connection to family, community and culture?*
 - *Lack of mental health & wellbeing services & supports for families?*
 - *Lack of organisational capacity and/or leadership?*
 - *Need for improved postvention and follow-up services*
- *What resources in communities in your area are available to support suicide prevention?*
 - *For example: training; community leadership*
 - *Services and programs for: men; young people; families; schools*
 - *Arts, recreation, sports, participation, employment?*
- *What is needed most?*
- *At a national level, how can effective community prevention be supported?*

Issue 4: Taking a coordinated approach to suicide prevention

Suicide has complex, multiple causes. These include risks in human development over the lifespan; mental illness and disorder and stressors affecting communities and families. Effective responses may involve intervention from many perspectives and involving many agencies. The *LiFE Framework* identifies three outcome areas pertinent to the coordination of prevention:

- Local services linked effectively so that people experience a seamless service
- Program and policy coordination at government, organization and professional levels
- Regionally integrated approaches

For example, adolescents who are at higher risk of suicide may be potentially engaged by mental health services, schools and community services, including sports and recreation; they may be in contact with police, NGOs, substance misuse services or crisis accommodation, if they are homeless or under surveillance relating to antisocial behaviour. Coordination may involve better links between crisis intervention, police and emergency services to ensure follow-up by mental health, welfare or community services after emergency contacts. Many of these services may lack specific protocols or training to respond to Indigenous people or contexts.

Coordination between government, services and agencies may encounter specific barriers. These may include a lack of models for collaborative, interdisciplinary work across sectors of government and between government and the community sector; inability to share confidential information; a lack of policy support across government for collaboration and coordination of services.

Regional coordination of services for Indigenous peoples may take different forms across Australia, including differences in the agreements, partnerships and level of resources required to support it. There may need to be specific strategies for large population catchments in the capital cities; regions with diverse populations across rural towns and mining towns; and for remote Indigenous communities and settlements.

Some examples of what has been done or is being done

- OneLife, (Government of Western Australia, Department of Health). The Western Australian Suicide Prevention Strategy, 2009-2013 emphasises a coordinated approach, with an Agency Coordinator responsible for coordinating links between government, NGOs and the corporate sector, and a Network Coordinator and Community Coordinators responsible for developing community and regional action plans.
- StandBy Suicide Bereavement Support Service – Pilbara and Kimberley Region WA provides an integrated, comprehensive, responsive support system built on existing emergency and community response mechanisms for people at risk of suicide and self harm, their family, friends, associates and those affected by suicide bereavement.

International examples

- The Acoma-Canoncito-Laguna Adolescent Health Program (USA) provides free, multiple integrated health services for adolescents.
- Western Athabaskan community-based suicide prevention strategy (USA) consisted of integrated multiple components: continuous data gathering, screening and clinical interventions; outreach in schools, community services as well as outdoor venues, streets, community functions); social services; school- and community-based programs, life skills; use of volunteers, peers and 'natural helpers' and professionally provided services.

Key questions

- *What is the level of coordination in your area in terms of: continuity and linking of services to improve client experience of care; policy coordination and organizational links; regional coordination?*
- *What initiatives are needed or are under way?*
- *In what ways would better coordination benefit individuals, families and communities in relation to suicide, care and prevention?*
- *How should a national strategy contribute to improved coordination of approaches to suicide prevention for Aboriginal and Torres Strait Islander peoples?*

Issue 5: Providing targeted and indicated suicide prevention activities

This issue area focuses on the provision of targeted services to those at higher risk, including those at very high risk. It considers what specific services are most needed for the higher and highest risk groups. These include people who may be difficult to engage, for reasons of social withdrawal and isolation, geographical mobility or homelessness, or low service use characteristic of age and gender, or because of the complexity and multiplicity of problems experienced by them.

This issue area requires strategies both for the identification of risks and levels of need across populations and communities, as well as development of the capacity to respond effectively. Responses may include a combination of information, targeted training and implementation of effective services and interventions based on the best research and practice evidence.

Examples of high risk groups or situations might include:

- People with histories of previous suicide attempts, self harm
- People related to persons committing suicide who are at elevated risk
- Males, including those suffering significant past or current adversity
- Families with multiple stressors, including suicidal behaviour by parents and siblings, recent history of parental separation and family conflict
- Adolescents and young adults with histories of early or ongoing neglect and abuse
- Emergency situations or call-outs in which self harm is threatened by participants

Culturally appropriate methods of assessment and systems of follow-up support are needed to improve the likelihood of recognition of risk and the adoption of appropriate responses. Specific resources, training and practices to enable Aboriginal wellbeing services and Aboriginal advisors and practitioners to link with key services such as hospital-based acute and emergency care, police and mobile mental health assessment may be helpful.

Some examples of what has been done or is being done

- Koori Mental Health Liaison officers (KMHLOs) in rural Victoria. This element of the *Victorian Aboriginal Suicide Prevention and Response Plan* (Victoria, Department of Health, 2010) aims to improve access to culturally appropriate mental health services for Aboriginal people.
- OzHelp Foundation – Pilbara identify workers who are at risk of suicide or have mental health issues in the building, construction and mining industries in the Pilbara region to facilitate access to support services.
- StandBy Suicide Bereavement Support Service – Pilbara and Kimberley Region WA provides an integrated, comprehensive, responsive support system built on existing emergency and community response mechanisms for people at risk of suicide and self harm, their family, friends, associates and those affected by suicide bereavement.

International examples

- Te Rau Matatini (NZ Ministry of Health, 2010). *Te Rau Matatini* is the Maori Mental Health Workforce Development Centre, which supports workforce development to enhance *whanau ora*, wellbeing and assists policy, training and professional development.

Key questions

- *Overall, what do you see as the key priorities for development of the Aboriginal and Torres Strait Islander workforce in relation to suicide prevention?*
- *How can mainstream services frequently contacted by Aboriginal and Torres Strait Islander people at risk of or affected by suicide be improved?*
- *What priority should a national suicide prevention strategy for Aboriginal and Torres Strait Islander people give to development of targeted and indicated services for high risk groups?*

Issue 6: Implementing standards and quality in suicide prevention

This issue area focuses on the need to develop the infrastructure to support improved prevention responses, if these are to be effective, based on evidence, culturally appropriate and responsive to Indigenous people's needs. This may include a number of elements:

- Development of appropriate evidence-based protocols for mental health care
- Appropriate training for groups of practitioners in different settings
- Development of specific tools and resources that can support quality practice
- Methods of evaluation and quality improvement for monitoring and improving practice

Evidence based practices and standards need to be implemented with consistency and quality across varying local conditions and circumstances. They can guide workforce development and practice improvement in mental health and wellbeing services employing Indigenous people in services from the community level to mainstream preventive services. Evaluation and reporting systems should provide feedback on effective implementation, on the quality of practices and on client responses.

It should be considered how a national approach to suicide prevention for Aboriginal and Torres Strait Islander people might best help to promote the development of standards of reporting, mental health care practice and resources for prevention, along with exchange and sharing of information and dissemination of resources.

Some examples of what has been done or is being done

- *Improving Care for Aboriginal and Torres Strait Islander Patients Program (ICAP)* targets quality of care to Aboriginal mental health patients in hospitals, with KMHLOs identify patients and participate in clinical decision-making (Victoria, Department of Health, 2010).

International Examples:

- Whakawhanaungatanga (NZ Ministry of Health, 2010) Collaboration to implement an evidence-based best practice guidelines, 'The Assessment and Management of People at Risk of Suicide'. *Whakawhanaungatanga* sees clients and providers as kin or *whanau*.

Key questions

- *How can the quality and consistency of services relating to mental health, wellbeing and prevention be improved?*
- *How can practices in mental health care and wellbeing services, and in prevention service be made more acceptable and effective for Aboriginal and Torres Strait Islander people?*
- *What role should a national suicide prevention strategy for Aboriginal and Torres Strait Islander people play in regard to the oversight, coordination and development of standards of practice, quality improvement and the role of evidence in suicide prevention?*

Discussion Questions

1. From your perspective, which of the six issues/action areas are the most important? Which are the least important? What is missing?

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2. What is most needed to build the evidence around suicide prevention?
- a. Improved data, epidemiological information and reporting concerning suicide?
 - b. Effective evaluation of government and community-sector programs?
 - c. Research partnerships to improve suicide prevention research?

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3. What actions are needed to build resilience, reduce vulnerability and encourage help-seeking?
- a. What kinds of early intervention/prevention are occurring and/or needed in your area?
 - b. How can the community sector be supported to provide early intervention services?
 - c. What needs to be done for adolescents; men; children & families?
 - d. Evidence-based resilience-building interventions?

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Discussion Questions (continued)

4. How can community capacity for suicide prevention be built and supported?

- a. What kinds of community engagement are needed?
- b. How can community and cultural strengths be built?
- c. What partnerships are needed to help build community capacity to prevent suicide?

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5. How should a national strategy promote coordination of and collaboration between services?

- a. Through development of models for collaborative partnership and governance?
- b. Through specific Indigenous priorities for mainstream services?
- c. A combination of the above?
- d. Include promotion of multi-agency and multi-sector approaches?

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6. What targeted suicide prevention services are most needed?

- a. Specific Indigenous protocols for hospital, emergency and acute services?
- b. Targeted mental health care for at risk groups? Which groups: Youth? Men? Prisons?
- c. Appropriate postvention and follow-up services?

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Discussion Questions (continued)

7. How could a National Strategy help strengthen the protective benefits of culture and community in promoting social and emotional wellbeing and reducing risks for suicide and suicidal behaviour?
- a. Strengthening young people’s resilience and sense of connection with culture and community?
 - b. Developing and supporting culturally informed community action?

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8. Overall, what would you think the most important priorities should be for a *national* suicide prevention strategy for Aboriginal and Torres Strait Islander people? For example:

c. Common standards and approaches

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d. Building the evidence

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e. Supporting applicability to Aboriginal and Torres Strait Islander culture and circumstances

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f. Information & opportunities to learn from others

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g. Promoting training and workforce development

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h. Resources and funding

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i. Filling specific gaps left by state and territory suicide prevention strategies

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j. Other priorities

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How You Can Have Your Say

Participate in a Community Consultation Forum

If you are an Indigenous person or someone who has experience with or responsibility for responding to suicide among Indigenous people, then we encourage you to come along to one of the community consultation forums that will be held across the country over the coming two months.

This paper has been designed specifically to assist participants make a contribution in these forums.

To register for one of the Community Consultation Forums, contact the Project Coordinator (see below) or visit our website to register online: www.indigenoussuicideprevention.org.au

Make a Written Contribution

We are also accepting written submissions to provide the opportunity for considered written responses on key issues. Please make a written submission to ensure specific issues are communicated to the team, if you prefer this method or if you cannot make it to one of the community consultation forums in each state.

Written submissions should address one or more of the Discussion Questions, making use of the online template provided.

For more details on how to make a submission, visit our website:

www.indigenoussuicideprevention.org.au

Note that in making a written contribution, you consent to rights to publication of all or part of your submission by the Australian Government including its appearance on the consultation website.

However, if you wish to make available sensitive information on a confidential basis, please contact us to enable appropriate measures to protect privacy to be undertaken.

Advice on non-standard submissions in multi-media or other formats can also be given.

Contact the Project Coordination Team

If you have any questions or would like to talk to someone directly about the National Consultations please contact the project coordination team..

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- Dr Pat Dudgeon, Western Australia
- Mr Ashley Couzens, South Australia.

