



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

# **Discussion Paper**

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National Aboriginal and Torres Strait Islander Suicide Prevention Strategy: Draft  
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## Introduction

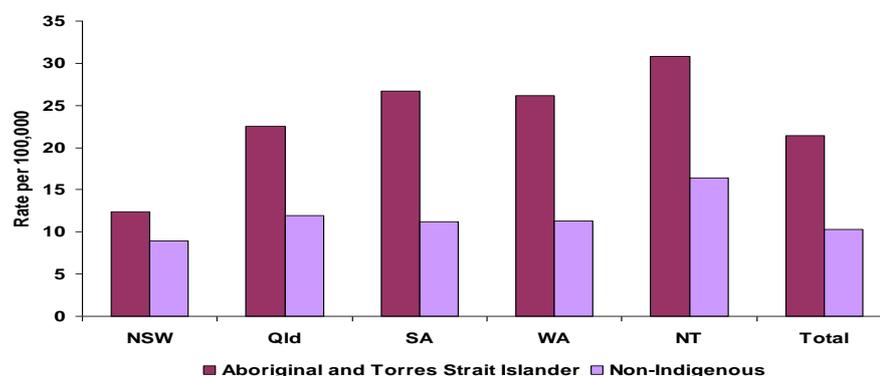
This discussion paper presents information about a number of areas of policy, evidence and practices relevant to suicide prevention for Aboriginal and Torres Strait Islander Communities. It is intended as a preliminary resource to inform discussion at the community forums that will be held in capital cities and regional centres across Australia as part of a national consultation process. It is not a definitive review of sources, and should be read in conjunction with other material, including documents of the National Suicide Prevention Strategy and State and Territory strategies referred to in this document.

It begins with an overview of the evidence demonstrating why a national approach to Indigenous suicide is needed (Section 1). This is followed by a brief discussion of the policy context in which this national approach is to be developed (Section 2). Section 3 organises some of the research relevant to Indigenous suicide prevention by key thematic areas identified within the LiFE (2007) Framework. Section 4 concludes with an outline of principles relevant to the development and implementation of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

## 1. Aboriginal and Torres Strait Islander Suicide in Australia: Why We Need a National Approach

1.1 The most recently available Australian Bureau of Statistics 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 2001-2010 (ABS, 2012). In 2010, suicide accounted for 4.2% of all registered deaths of Aboriginal and Torres Strait Islander people, compared with just 1.6% for all Australians. In other words, suicide was 2.6 times more frequently the cause of death for Aboriginal and Torres Strait Islander people than it was for all Australians.

**Figure 1: Age standardised rates of suicide by jurisdiction and Indigenous status, NSW, Qld, SA, WA & NT, 2001-2010<sup>1</sup>**



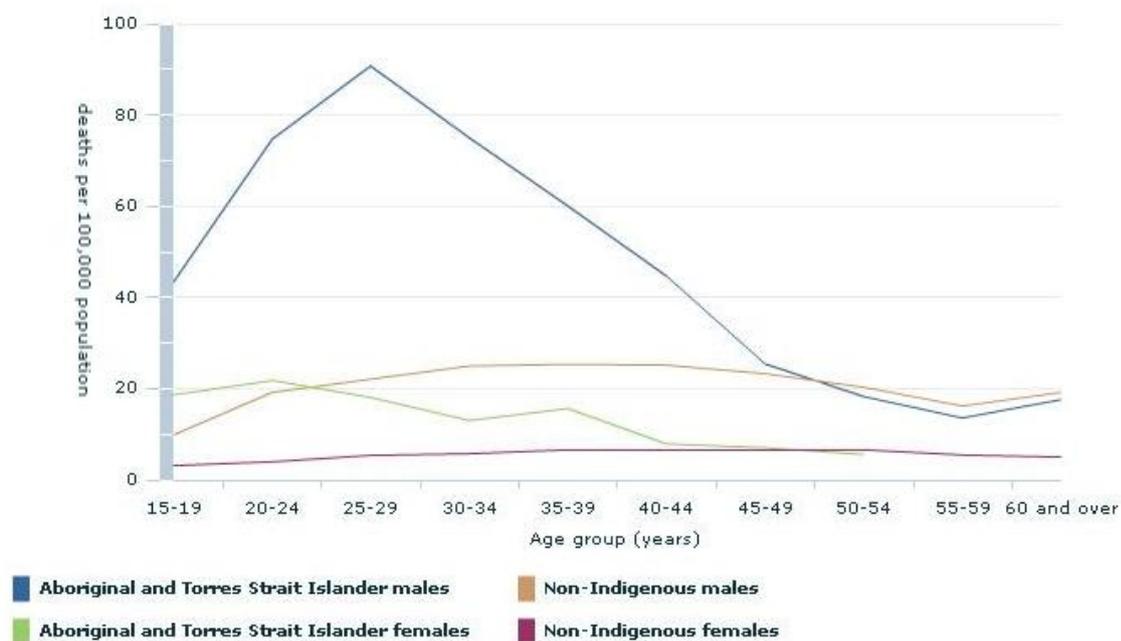
Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 *Suicides Australia, 2010*

<sup>1</sup> Age-standardised rates take into account differences in the size and structure of the population and are therefore more reliable for comparison purposes.

1.2 Figure 1 above shows the variation in the age standardised rates of Aboriginal and Torres Strait Islander and non-Indigenous suicide over the 2001–2010 period for these five jurisdictions. Not only are there significant differences between jurisdictions, as shown by this graph, but there are also important geographical variations in the distribution of deaths within jurisdictions – for example, rates of suicide are generally higher in remote areas.

1.3 Indigenous rates of suicide are consistently higher than suicide in the general population. In addition to the difference in rates of suicide, there are other important differences between Indigenous and non-Indigenous suicide. For example, Indigenous persons commit suicide at much younger ages than members of the general population with the preponderance of suicide deaths occurring before the age of 35 years. Over the years 2001-2010 the greatest difference in rates of suicide between Aboriginal and Torres Strait Islander people and non-Indigenous people was in the 15-19 years age group for both males and females. For Aboriginal and Torres Strait Islander females aged 15–19 years, the suicide rates were 5.9 times higher than those for non-Indigenous females in this age group, while for males the corresponding rate ratio was 4.4 times higher. In older age groups the rate ratios for suicide deaths of Aboriginal and Torres Strait Islander and non-Indigenous peoples are lower, with similar rates of mortality observed from the age of 45 and above (ABS, 2012).

**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

1.4 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). For Aboriginal and Torres Strait Islander females, the highest rate of suicide was amongst 20 to 24 years olds (21.8 deaths per 100,000 population). 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 among females (6.6 deaths per 100,000) across the five year age groups between 35 and 54 years of age.

1.5 The differences in characteristics of Indigenous suicide, and other indicators of Indigenous disadvantage, combined with the distinctive challenges of access to key preventive services clearly underline the need for a specific strategy for suicide prevention for Indigenous people.

## **2. The Policy Context**

2.1 The Commonwealth Government committed to developing an Aboriginal and Torres Strait Islander Suicide Prevention Strategy in its response to the Senate inquiry into suicide *“The Hidden Toll: Suicide in Australia”*. In addition to the establishment of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group, Menzies School of Health Research was commissioned to develop the Strategy including overseeing and organising a consultation process. The Strategy is to be developed with reference to the broader context of policies relating to health and social-emotional wellbeing of Australian people, including policies relating specifically to Indigenous people in state or territory and national levels of government. The following discussion identifies some national policies, drawing on examples from overseas and in Australia.

### **2.1 The National Suicide Prevention Strategy**

2.1.1 Australia’s national suicide prevention strategy was introduced in 1995 and revised in 2000 and 2006. The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is intended to complement the National Suicide Prevention Strategy’s LiFE (2007) Framework, which was adopted by all Australian Health Ministers in September 2011 as the overarching suicide prevention framework in all jurisdictions.

2.1.2 The Commonwealth’s Taking Action to Tackle Suicide budget package committed \$30.2 million to community suicide prevention initiatives. From this, a total of \$6 million has been quarantined for suicide prevention initiatives specifically targeting Aboriginal and Torres Strait Islander peoples and communities.

### **2.2 State and Territory Suicide Prevention Strategies**

2.2.1 All Australian States and Territories have suicide prevention strategies, a number of which are under review. Over the last five years, these strategies have moved into a closer alignment with the National Strategy’s LiFE (2007) Framework. Most of them treat Indigenous people as a high risk group. Victoria has developed a specific Indigenous suicide prevention action plan (Government of Victoria, 2010) while the Western Australian strategy contains specific comprehensive measures for Indigenous suicide prevention (Government of Western Australia, 2008). Other states (SA, NSW and the NT) are taking steps in a similar direction. The development of a national strategy should add weight to these developments at the State and Territory level as well as serving to harness and coordinate action across Commonwealth portfolios.

### **2.3 International Approaches**

2.3.1 Suicide in developed nations occurs at generally comparable rates across national populations. However, in all developed nations with colonial histories like Australia, New Zealand, Canada and the United States of America, suicide occurs among Indigenous peoples at far higher rates than the

general population (Cantor et al., 1996). As a result, in these nations, the suicide of Indigenous peoples has been recognised as a public health concern of significance for national policy (Hunter and Harvey, 2002). However, these nations have implemented national strategies in importantly different ways that may provide instructive comparisons with the Australian context.

2.3.2 For example, Canada's national strategy is dedicated solely to Aboriginal Youth (NAYSPS 2006). It has developed as a formal partnership between Health Canada and Inuit and First Nation organisations and explicitly targets all recognised categories of Aboriginal youth. On the other hand, New Zealand started with separate national strategies for Maori and non-Maori populations, but moved to integrate both within an overarching national suicide prevention strategy in 2006, while retaining responsiveness to specifically Maori concerns. In the USA's National Strategy for Suicide Prevention there is no specific American Indian and Alaska Native (AI/AN) national approach, although the Department of Health has produced a number of resources aimed specifically at supporting AI/AN suicide prevention activities. Fact Sheet 1 provides a more detailed summary of approaches to Indigenous suicide prevention taken by these nations.

2.3.3 Many countries now have comprehensive national approaches to suicide prevention. A recent review of these approaches in 11 countries suggested that on balance, there appears to be evidence for their effectiveness in contributing to reductions in rates of suicide in populations (Martin & Page, 2009). National approaches vary in their emphases, with some focusing on improvements to health services, others on wider social and educational initiatives. According to the authors of the review, the best national strategies have clear frameworks with broad goals that are consistent with research on effective prevention. They take a nation-wide or population approach, including strategies for communication and education of all relevant groups and improvements in a range of services. They take action to reduce access to means and aim to influence identified risk factors such as alcohol and illicit drugs (Martin & Page, 2009: 75-76)

### **3. Issues for Prevention: The National Suicide Prevention Strategy**

3.1 The National Suicide Prevention Strategy's LiFE (2007) Framework identifies six key action areas that are to be used as a guide for developing the National Strategy. This section assembles some of the best research available for each of the action areas as they apply to Indigenous suicide and the Australian policy context. The material in this section is meant to serve as a reference for the issues discussed in the Consultation Paper, which is to inform discussions at community forums as well as written submissions from the public.

#### **3.1 Improving what we know about suicide and its prevention among Aboriginal and Torres Strait Islander people.**

3.1.1 Suicide causes great distress to those directly affected by it, family members and members of communities or workplaces and schools, and to 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. Research is often not considered a priority by many people. However, it is important that there is a sound body of evidence to ensure that appropriate decisions can be made about the most appropriate and effective services, interventions and supports. This includes evidence that

interventions and practices do no harm, as well as evidence that they are effective in reducing rates of suicide and suicidal behaviour.

3.1.2 Suicide prevention also involves investment in strategies, interventions and capacities that are intended to influence suicide outcomes at the population level in the longer term. Building the evidence base for suicide prevention at the population level requires a better understanding of the causes of suicide and its variation across regions (including urban centres) and settings and for different risk groups in the community. This evidence can help to more effectively target responses.

3.1.3 It is also important that there is evidence for the safety, the acceptability and the effectiveness of treatments for those who are unwell, at high or ongoing risk and for those who are affected by suicide deaths and the suicidal behaviour of others. Safe, appropriate and effective ongoing treatment and care, as well as safe and effective crisis responses are very important components of a comprehensive, evidence-based prevention strategy. However, they may not necessarily by themselves reduce the rate of suicide at the population level.

3.1.4 According to the World Health Organisation (WHO), key characteristics of a comprehensive national suicide prevention strategy include: improving case registration and conducting research; and monitoring and evaluation using specific, measurable, achievable, relevant & time-bound (SMART) indicators (WHO, 2012).

3.1.5 Recent studies (De Leo et al, 2011; Silburn et al, 2010; SCRGSP, 2011) point to numerous gaps in the evidence base. De Leo (2010) notes that while there have been improvements in standardisation of reporting, there remain considerable concerns about accuracy of suicide data. There is a lack of epidemiological evidence concerning the distribution of suicides and suicide risk factors across populations as well as in specific community settings and contexts. There is a corresponding evidence gap on the distribution of key services and use of these services by Indigenous people. These areas of evidence can potentially help with targeting responses according to risk factors that are relevant for service development and for policies at the jurisdictional and regional levels.

3.1.6 Improvements in evidence about the causes of suicide and vulnerability to suicide at a population level require more than continuing improvement in the accuracy of systems of reporting. The supplementation of coronial determinations of suicide and related facts about suicide with a suicidological or epidemiological evidence base that widens the scope of evidence beyond the forensic concern to stipulate causes of death to address interests in prevention of risks and suicide outcomes. In some jurisdictions such as Victoria there is a need to improve identification of Indigenous status in administrative data, including health and hospital systems, medical records of death and coronial reports (Government of Victoria, 2010). Where Indigenous status is accurately identified, the development of confidential data linkage between administrative databases can add to capacity to analyse service use and outcomes across sectors for at Indigenous populations.

3.1.7 There is a need to continue to develop the evidence concerning patterns of service use and gaps in primary healthcare and mental health services for at-risk groups. For example, establishment of deliberate self harm databases and follow-up systems at hospitals (Western Australia), and research into patterns of follow-up care received by those hospitalized for medically serious self

harm could significantly add to an understanding of effectiveness of monitoring and follow-up care for Indigenous persons hospitalised at high risk of further self harm.

3.1.8 In addition to epidemiological evidence concerning risks and outcomes, there is a need for evidence of the effectiveness of prevention activities. Currently, evidence concerning the effectiveness of longer term approaches to suicide prevention for Aboriginal and Torres Strait Islander people, their families and communities is almost entirely lacking. These include interventions that work to reduce risk and improve resilience across the life span.

3.1.9 Examples may include parenting programs for parents of children and youth. They have been found to be effective in reducing conduct disorder and antisocial behaviour which are associated with suicide risk (Burns & Patton, 2000). Parenting and family focused interventions may improve family functioning and wellbeing and reduce the impacts of suicidal behaviour and mental illness within families. These interventions can contribute to a reduction of vulnerability to suicide among adolescents and young adults. Such approaches have been subject to rigorously evaluated implementation trials in other jurisdictions. For example, New Zealand has adopted the “Incredible Years” parenting program as a mainstay of its approach to early intervention, and has invested substantially in specific adaptation and evaluation of its use for Maori parents and children (Fact Sheet 2). By contrast, in Australia, there are very few attempts to employ such approaches with Indigenous children, parents and families and none have been implemented at scale. As a result, evidence for their effectiveness using controlled trials or other rigorous evaluation methods is entirely lacking.

3.1.10 Martin & Page (2009) note that, while there is evidence for the effectiveness of national suicide prevention strategies, there is little understanding of what interventions and actions contribute most to these outcomes, and in what combination. It is, they argue, not reasonable – and probably not feasible – to suggest that all elements of a comprehensive suicide prevention strategy should be subject to rigorous testing before adoption. However, they argue that there needs to be an improved commitment to high quality evaluation for key components of prevention. For example, most initiatives that aim to build community capacity to provide services, to improve recognition of those at risk through provision of gatekeeper training, and to develop life promotion or other activities to engage the community around suicide prevention are largely unevaluated. There is little or no published research evidence about the impact of gatekeeper training on suicide risk factors in Australian Aboriginal communities. With few exceptions, evaluations have stopped at the point of indicating acceptability and uptake of training and have not sought to show other effects (Capp et al 2011; Rodgers, 2010; ACRRMH, 2010). Better research is needed to improve understanding of how such training needs to be implemented if it is to be effective.

3.1.11 A strategy to improve the evidence base for a suicide prevention strategy for Indigenous people, could consider the potential for partnerships between researchers and the primary health care and mental health sectors, including the community controlled sector to evaluate the reach and outcomes of preventive services and to trial the implementation of new initiatives with a view to understanding multiple outcomes of suicide prevention activity. Key questions concern the ability to effectively target and engage those at risk, and the quality and effectiveness of services and care provided to them. These are important questions for applied research that can improve the effectiveness of prevention within current services.

## 3.2 Building individual resilience and the capacity for self-help

3.2.1 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 that may be 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.

3.2.2 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 male and female youth or parents; youth just out of or leaving school, etc.) within a universal approach to promotion of mental health or wellbeing.

3.2.3 It is important to acknowledge that some people suffer from stigma and shame and avoid contact with those who could help to address their difficulties. Efforts to destigmatise mental illness, suicidal thoughts and other difficulties and to promote active help-seeking by individuals can be incorporated in many activities to promote resilience and wellbeing. They also involve strategies to actively engage individuals by relevant services and practitioners through outreach and other targeted activities as well as programs to foster strengths through mentorship and leadership support. Strategies to engage and support at risk individuals need to explicitly acknowledge cultural identity and relationships as a source of strength and resilience.

3.2.4 Targeted interventions may identify adolescents and young adults who are at higher risk of suicide as a result of mental health problems, substance misuse, homelessness or antisocial behaviour. However, they may also include early intervention to reduce vulnerability and promote strengths earlier in the life course, for example through interventions to support parenting, reduce the impacts of neglect, abuse and violence on children, to reduce family suicidal behaviour and to improve family wellbeing. These interventions may need specific adaptation to meet the developmental needs, family circumstances and values of Aboriginal parents and families.

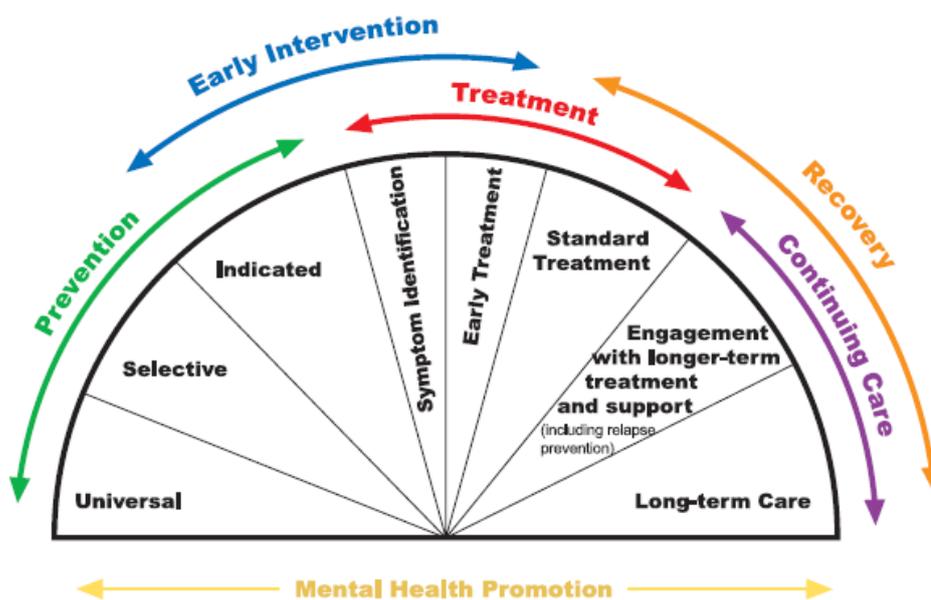
3.2.5 The Community LiFE Framework for Effective Community-Based Suicide Prevention (2005) was developed as part of the Community LiFE project under the National Suicide Prevention Strategy. The Community LiFE Framework classifies mental health interventions ranging from prevention through treatment to continuing care (See Fig 3 below). This scheme classifies mental health interventions as universal, selective or targeted and indicated.

3.2.6 The scheme clarifies the requirements for different types of intervention. To be effective, they need to appropriately engage the target group and the intervention needs to be able to modify the specific sources of risk for each group before acute problems arise. This is particularly important when gauging the need for the mix of services needed in any community or regional context, and indeed for considering the best opportunities for delivering universal interventions and engaging populations at risk. For example, school-based prevention may include both universal strategies to

destigmatise mental illness and to encourage help-seeking, as well as targeted strategies to identify and engage at-risk adolescents.

3.2.7 These different levels of prevention, treatment and care may each require specific skills. This may set some limits to the degree to which they can be integrated within the one service or agency. However, there is little doubt that for effective treatment and follow-up and to improve the effectiveness of preventive intervention for those at risk, coordination and integration between levels of care are needed.

**Figure 3: Spectrum of mental health interventions**



Source: Community LiFE Framework for Effective Community-Based Suicide Prevention (2005), p. 16.

### 3.2.1 Long and short term prevention

3.2.1.1 A lifespan approach to prevention extends the frame of reference to target determinants or risks earlier in time with respect to the emergence of specific risks for suicide. These may include sources of vulnerability already established in early child development and therefore many years before the emergence of any acute problems or risks. Parenting interventions to improve family functioning and quality of care for young children may improve resilience and reduce the adverse effects of life in chaotic or stressed families, mitigate or correct effects of neglect and experiences of foster-care. They have been shown to reduce the incidence of and long term adverse outcomes associated with conduct disorder and antisocial behaviour. These interventions act over the longer term and their effectiveness may be judged in terms of a number of aspects of social and emotional wellbeing, including, but not limited to suicide. They may also improve young children’s readiness for school through improvements to self-regulation and social-emotional learning and lead to improved social and educational participation and reductions in antisocial behaviour and crime, as well as reducing suicide risk. There is robust evidence for the effectiveness of these interventions as both universal and targeted intervention strategies. However, there are very few examples of evaluated programs for Aboriginal and Torres Strait Islander families.

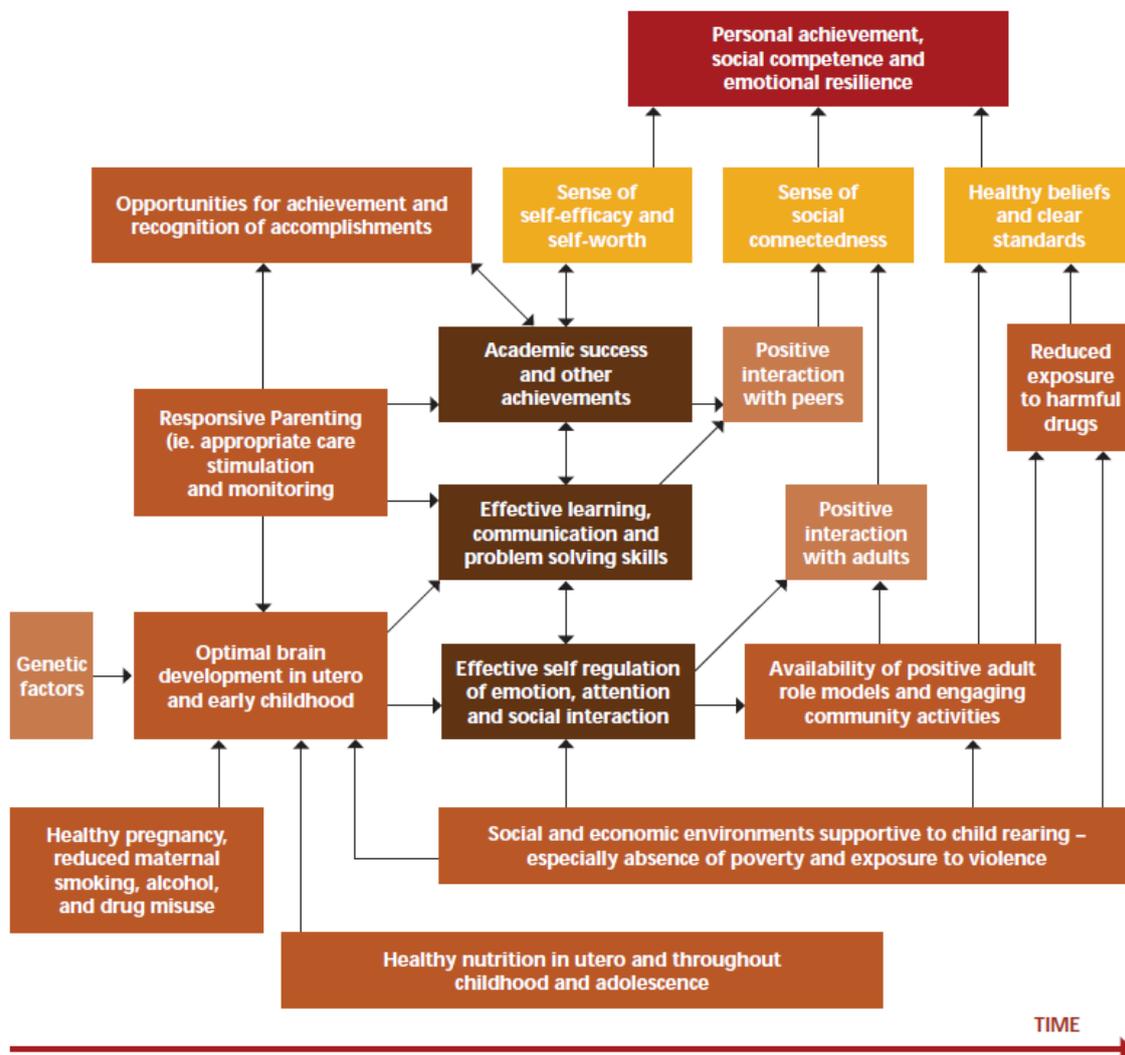
3.2.1.2 Parenting or family focused interventions may also be relevant for at risk youth as well as for families with young children. Suicide risk in adolescents is often affected by family difficulties, parental breakup or separation and poor or hostile communication between parents and young people. Studies of effective prevention among adolescents at risk of dropping out of school suggest that it may be important to engage their families – in addition to providing school-based counselling or other individual-focused interventions (Toumbouru & Gregg, 2002).

3.2.1.3 Early intervention and prevention aiming to promote resilience and reduce problems or risks may therefore act both over medium and long terms. Family-focused interventions may be effective both for young children’s development and for young people who are older and potentially at more immediate risk.

3.2.1.4 In addition to improving environments of care and reducing the impact of adversities in early childhood, early intervention can be effectively targeted at key transition points in the life-cycle. These include beginning school and end of school, that is, the transition from school, particularly where this is associated with school failure and unemployment.

3.2.1.5 Evidence shows that, to be effective, resilience-promoting interventions, including parenting programs and interventions to promote children’s social-emotional learning need to have been adapted for and to embrace Aboriginal cultures, parenting styles and values and are supported by appropriate manuals, training and resources.

Figure 4: Developmental pathways to resilience



Source: Victorian Aboriginal Suicide Prevention and Response Team, Victorian Government, 2010 (from Silburn, 2003)

### 3.3 Improving community strength and capacity in suicide prevention

3.3.1 There is a strong focus on community-based approaches, both in the National Suicide Prevention Strategy and in state strategies. For example, the Western Australian One Life Strategy, involves regional coordinators whose role is to lead collaboration between services, practitioners and leaders at the community level. Community is often also referred to in relation to suicide clusters, that is, communities experiencing epidemic levels of suicide, or suicides that cluster in space or time. It is important to consider the nature of the community that is being considered, how it is defined and how it relates to the focus of preventive efforts.

3.3.2 Community can be defined as a grouping or network 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 usually consist of people with a mix of commonalities and differences and are therefore usually not homogeneous. Communities can include significant diversity.

3.3.3 For Aboriginal and Torres Strait Islander people, *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 Indigenous. 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.

3.3.4 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-promoting interventions and services to promote mental health and social-emotional wellbeing.

3.3.5 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.

3.3.6 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 NGOs to strengthen prevention, postvention and life promotion responses. Community and partnership should not be seen solely from the perspective of governments or services.

3.3.7 These are some of the reasons why it is important to define what “community” means for the purpose of developing prevention strategies.

3.3.8 The Community Life Framework (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**

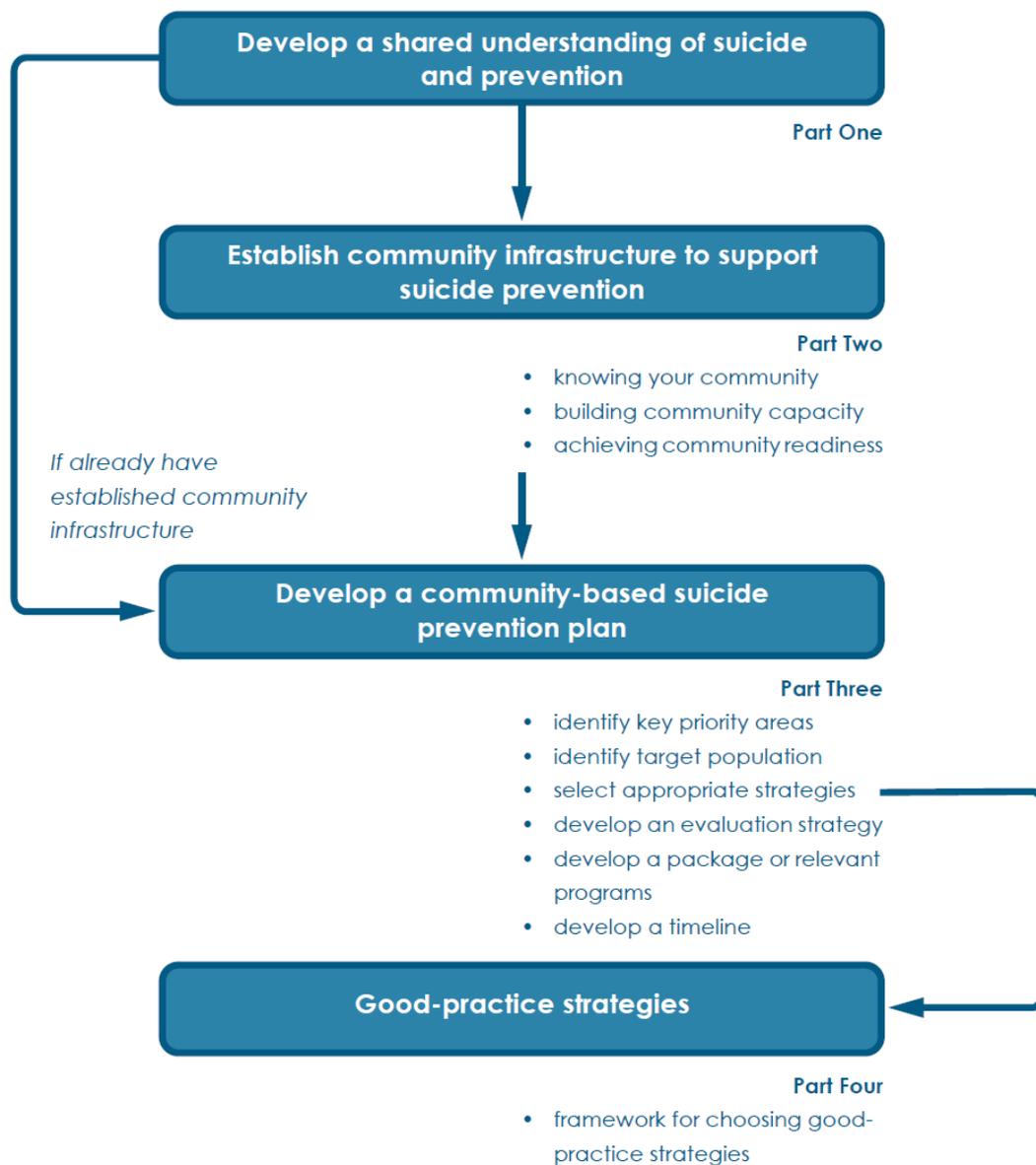
The higher the level of risk in the population group, the more intensive the prevention effort must be and the earlier it should begin. Transition points – preschool, middle school, entering high school, leaving high school and entering the workforce – are times when major setbacks can occur, and that 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.

3.3.8 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”. Finally, there needs to be capacity building, action to develop infrastructure and resources.

Figure 5: Developing a community plan for suicide prevention



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

### 3.3.1 Mapping prevention strategies at a regional level

3.3.1.1 In planning prevention at the regional level, it may be helpful to think about a framework or matrix for planning for the mix of targeted, selective and indicated services that are needed to address a specific question or to meet the needs of a particular target group, and to identify the resources and the specific mechanisms of coordination needed to support them.

3.3.1.2 The following example sets out an approach to assessment of the mix of services available for youth. A similar approach can be applied to mapping the mix of strategies for early intervention with families, children and youth to reduce vulnerability and improve wellbeing or other target groups.

**Table 1. Constructing a Matrix of Services & Interventions by region and by risk group.**

<b>Matrix of Interventions for Suicide Prevention</b>				
<b>Example: Youth in communities X, Y &amp; Z</b>				
	Clinical/ Biopsychosocial	Psychocultural	Sociocultural & community	Planning & organisation
<b>Universal</b> (The intervention is designed for all people in a defined population)	Depression screening in primary health care practice population care plans	Lifeskills education and engagement at all secondary schools	Talking about suicide; Suicide stories; suicide in the arts & media.	<ul style="list-style-type: none"> <li>• Funding</li> <li>• Risk groups</li> <li>• Access</li> <li>• Integration &amp; Coordination</li> <li>• Community of practice</li> <li>• Evaluation &amp; feedback</li> <li>• Governance, management &amp; leadership.</li> </ul>
<b>Delivery systems &amp; resources</b>	Primary health care, incl. mental health services	Mental health & wellbeing teams; schools; sport & rec. & the arts	Community leaders, family members & practitioners	
<b>Selective</b> (The intervention is designed for particular sub groups at higher risk)	Depression screening and assessment for men in contact with mental health, AOD and DV services.	Identification of youth at risk: counselling on alcohol & drugs, employment, sexual health, healthy choices	Elders & Mentors, visiting youth in detention; life skills for youth out of school & unemployed	
<b>Delivery systems &amp; resources</b>	Primary health care, incl. mental health services; drug, alcohol and rehab services, etc.	AOD Provider; Healthy Life Choices team; SEWB Team.	NGO Mentor program.	
<b>Indicated</b> (The intervention is designed for individuals who are assessed as at very high or imminent risk)	Improve access to CBT (or other indicated therapy) by referral of all those screened and/or presenting at very high risk	Screening and referral for treatment: residential or intensive therapy; mandated treatment.	Night Patrol; Indigenous police; Indigenous mental health workers and consultants in clinical response programs.	
<b>Delivery systems &amp; resources</b>				

Source: Robinson, et al., 2012.

3.3.1.3 It may be important to acknowledge that in some contexts, and in respect of some target groups, for example, youth living rough or street youth, “community” is hard to define. From the standpoint of integration and coordination of services, the critical issue is to define and support a

“community of practice”, or community of interest consisting of agencies, practitioners and others who have a common interest in engagement of and the provision of support for the client group in question and are able to support integrated, coordinated approaches. Such communities of practice are often necessarily multi-disciplinary and need to be sustained by specific mechanisms for referral, coordination and joint management of processes. They present opportunities to support the development of roles for Indigenous practitioners.

### **3.3.2 Suicide clusters**

3.3.2.1 Suicide clusters are suicides occurring in space and time at a higher than expected frequency. They may occur within geographical communities or regions. They may also occur among persons who do not necessarily identify as members of a visible community, but who may participate in other social networks; they may involve people who are not members of a discrete geographical or cultural community but share characteristics (age, gender, Indigenous status, cultural background) that may allow them to be influenced by images or representations of suicide in the mass media. In addition, self harm and suicidal behaviour may occur by people who identify as a member of a cultural group across geographical regions. They may also occur in institutional settings like prisons or schools. Suicide clusters in some contexts have been found to include persons related by family ties and peer group social networks (Hanssens, 2007).

3.3.2.2 Suicide clusters require a number of different kinds of response, including a mix of long and short term preventative interventions, and indicated strategies, including “postvention” services for those most likely to be affected by the occurrence of suicides in a community or social network.

3.3.2.3 A recent paper on “Developing a plan for preventing and responding to suicide clusters” (Commonwealth of Australia, 2012), outlines these responses in a number of steps. They include identification of risk groups and targets for various forms of prevention activity within a community planning process that may be initiated by government departments or community organisations or other groups of stakeholders.

3.3.2.4 However, there are some critical questions for developing comprehensive suicide prevention plans for many Aboriginal communities in different contexts. In some community settings apparent clustering is a product of multiple interacting sources of risk, “lifestyles of risk” (Hunter et al, 1999), often involving multiple stressors in families and often involving exposure of individuals from childhood to displays of suicidal behaviour by family and community members. It should be remembered that young children exposed to such stressors and to high levels of suicide behaviour will themselves within ten years already be at rapidly increasing risk of suicidal behaviour. In such contexts, the preventive response should already target preadolescent children and their parents by making available parenting programs and interventions to reduce risk behaviours and support social emotional development in young children. These are powerful but indirect consequences of epidemic suicide that are usually overlooked in postvention responses.

3.3.2.5 In other contexts, including urban settings, Aboriginal youth may be influenced by the symbolic power of self harming behaviours as a form of communication of distress within peer and friendship networks. This may extend beyond peer and friendship groups to wider age and social memberships or persons whose basis for identification is through mass media, including the new social media. They may not live in obvious circumstances of common community stress or exposure

to risk. For prevention targeting these youth, active and coordinated strategies of engagement may need to be developed across a range of school and other community settings. There may need to be planning for communication about suicide, taking action to foster safe communication about suicide in order to promote community ownership and readiness to take positive action. There may also need to be planning for communication about suicide in the mass media and in official reports to reduce the possibility of adverse influences across age or gender based social groups, in addition to impacts on members of identified discrete geographic or cultural communities.

3.3.2.6 Understanding of risk and protective factors therefore needs to be accompanied by thoughtful and proactive strategies for engagement of those at risk. It may be wise to assume that general community capacity building, services designed around “gatekeepers” and postvention targeting those bereaved by suicide will need to be augmented by specific measures to identify, to engage and to respond to young people who are at elevated risk of self harm through some kinds of exposure to suicide among peers, family members and others. Such forms of engagement will involve innovative forms of communication as part of strategies for engagement.

### **3.4 Taking a coordinated approach to suicide prevention**

3.4.1 In the preceding section, the need to plan and coordinate indicated, selective and targeted suicide prevention activities on a regional basis was outlined. Effective responses need coordination at various levels. Suicide has complex causes and effective responses may involve intervention from many perspectives and involving many agencies. The effective coordination and integration of community service responses and capacity building requires explicit strategies to be developed.

3.4.2 The LiFE (2007) Framework identifies three outcome areas pertinent to coordination: local services linked effectively so that people experience a seamless service; program and policy coordination at government, organization and professional levels, and regionally integrated approaches.

3.4.3 In his National Press Club address in August 2012, Professor Allan Fels, Chair of the National Mental Health Commission, discussed the need for a whole of life approach to mental health and suicide prevention. Professor Fels emphasised that, ‘Suicide is complicated and not always directly related to mental illness. Dislocation, drug use, isolation and discrimination all play a role’. The health care system is only part of the answer. Within a holistic approach to recovery issues such as employment, education, physical health and improved social skills also play a role.

3.4.4 For example, adolescents who are at higher risk of suicide may be potentially engaged across health and mental health services, education and community services including sports and recreation; they may also be in contact with police, NGOs, substance abuse services or crisis accommodation services, if they are homeless or under surveillance relating to antisocial behaviour. Coordination of services for youth may be an important means of ensuring that young people do not “fall through the cracks”, that there is potential for diversion from criminal justice into preventive services, and that risks of disengagement and withdrawal (for example from school) can be identified and followed up with appropriate services. Similarly, child protection and family support services, family violence, crisis accommodation and substance misuse services are all potentially relevant to suicide prevention with appropriate training and coordination to improve responsiveness to the needs and vulnerabilities of Indigenous peoples.

3.4.5 Coordination between governments, services and agencies (including NGO and Community Controlled Sectors) is usually necessary for improvements in the integration and coordination of services to occur. Governments, organisations, professional bodies and the research sector should also provide support for coordination at the community or regional level through the development of specific resources, materials and protocols: these need to be developed in partnership with Indigenous communities and organisations to ensure that they are culturally appropriate and relevant for the needs of Indigenous people. Guidelines and protocols for health and mental health and for drug and alcohol treatment services need to be developed on the basis of the best available evidence.

3.4.6 Regional coordination of services for Indigenous peoples may need to take different forms across Australia, with significant differences in the nature of agreements and partnerships and the level of resources that may be required to support it. Indigenous people in the capital cities may need to be accessed by a combination of community health services, mainstream health services including hospitals and GPs as well as local governments and NGOs. Coordination in some regions involves services for diverse populations across rural towns, including mining towns, smaller outlying towns and communities and small discrete Indigenous communities and settlements. In some regions, the challenges of coordination and integration of preventive approaches for Indigenous people may be constrained by lack of Indigenous-specific capacity and resources or visible Indigenous community 'ownership' and control. In some remote regions, there is a strong and visible Indigenous presence in the community and organisations, but a lack of infrastructure, service depth, professional capacity and leadership to support coordinated activity.

3.4.7 Consistent with the aims of the LiFE (2007) Framework, a national strategy to prevent Indigenous suicide and self harm would clarify and support efforts to improve coordination across service sectors and between professional services, including lay community responses, in order to achieve sustainable and comprehensive suicide prevention strategies in regions and communities. It would be clear about responsibility for coordination across government and between levels of government and promote coordinated approaches across community service sectors.

### **3.5 Providing targeted and indicated suicide prevention activities**

3.5.1 Responsibility for supporting the mental health and wellbeing of Australian Indigenous people is shared by a very wide range of services and practitioners working in a multiplicity of roles and in diverse institutional and community settings. The evidence on self harm and clinically significant social and emotional difficulties among Indigenous people is suggestive of poor mental and possibly high rates of undiagnosed mental illness (Zubrick, et al., 2005) Access to a full range services by Indigenous people is therefore a centrally important issue. Access to services is often also related to questions of their cultural appropriateness and their responsiveness to the needs and circumstances of Indigenous people, It may be a reflection of inadequate investment in proactive forms of engagement of individuals families and communities, because of adherence to the assumptions of models developed for the general population. Gaps in data suggest that many Indigenous people – for example, children, youth and males at different ages – make very little use of many important services.

3.5.2 The development of specialist Indigenous support services has been recommended in a number of jurisdictions, particularly in capital cities and larger centres where mainstream services predominate. In some rural towns, by comparison with discrete remote Indigenous communities there is frequently a lack of dedicated mental health care for Indigenous people

3.5.3 The provision of targeted services to those at higher risk, including those at very high risk. While it overlaps to some degree with issues identified in Issue Areas 2 and 3, it considers what specific services are most needed for the higher and highest risk groups: these include those groups who may be difficult to engage, for reasons of social withdrawal and isolation, or low service use characteristic of age and gender, or because of the complexity and multiplicity of problems experienced by them. There is a need to implement strategies for the identification of risk and levels of need, in order to develop the capacity to respond effectively.

3.5.4 Examples of high risk groups might include:

- People (especially young people) with histories of previous suicide attempts and threatened self harm, including people with affective disorder
- Persons hospitalised for medically serious self harm
- Families with multiple stressors, such as suicidal behaviour including threats and attempts by parents and siblings, recent history of parental separation and family conflict
- Adolescents and young adults with histories of early neglect and abuse, including parental histories of abuse
- Children and youth in out of home care or residential care
- Males subject to multiple arrests and incarcerations for antisocial behaviour and comorbid substance abuse disorders
- Prison populations.

3.5.5 Many of the risk factors for suicide converge in complex ways and suicide risk is often not identifiable in terms of discrete risk categories. Appropriate training in assessment and systems of follow-up support are needed to improve the likelihood of recognition of risk and the adoption of appropriate responses. However, further research into pathways through care and into patterns of service use following discharge from clinical and emergency services is clearly needed to identify key opportunities for prevention specifically for Indigenous people.

3.5.6 Police and health staff may face emergency situations or call-outs in which self harm is threatened by participants or may be an underlying concern. There may be opportunities to provide training or other support in these categories of incident to increase the likelihood of reporting and action following threatened or attempted self harm. Specific training and mechanisms of coordination (e.g. through Indigenous liaison officers or other personnel) may enable Aboriginal-owned primary health care and wellbeing services to link with key services such as hospital-based acute and emergency care, police and mobile mental health assessment teams. Such measures may help to identify clients and improve the service response and follow-up of individuals in high risk settings and emergency situations. In addition, improved communication between professional services in various settings in which suicide risk is identified needs to be complemented by measures to improve communication with family and community members after discharge or contact is ended.

3.5.7 Strategies to improve access and engagement need to cover the following domains:

- Improvements in primary healthcare
- Mental health and wellbeing services
- Family violence and conflict
- Alcohol and drug misuse
- Policing and custodial settings
- Child protection related family support and therapeutic responses

3.5.8 As outlined in Issue Area 3.5, the mechanisms for coordination and collaboration between a number of these services, and between the longer term preventive early intervention services (such as early childhood parenting programs) and the more acute, selective services (targeted or indicated therapeutic parenting and family support) need to be explicitly developed.

### **3.6 Implementing standards and quality in suicide prevention**

3.6.1 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 should include the development of appropriate evidence-based protocols for mental health care combined with the adoption of methods of evaluation that can contribute to evidence of effectiveness and help build systems of quality improvement for monitoring and improving practice.

3.6.2 Development of the role of research and evaluation relevant to Indigenous suicide prevention must be able to respond to the social and cultural diversity and the geographical dispersion noted as key challenges in this paper. This means that practices and standards need to be responsive to local conditions and needs while at the same time seeking wider use and uptake. Workforce development, training and practice improvement need to be supported as part of coordinated approach to capacity building in mental health and wellbeing services capable of employing Indigenous people in services from the community level to general systems of preventive services. This may involve both the identification of specific professional skills and cultural practices needed in diverse community contexts as well as the adaptation and evaluation of various areas of evidence based intervention practices for Aboriginal and Torres Strait Islander people, such as "gate-keeper training", use of "natural helpers" or approaches to parenting and family support that include prevention of suicide and self harm as primary aims.

3.6.3 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.

- Training and practice development in Indigenous mental health workforce
- Integration of suicide prevention activities in existing protocols and guidelines for primary health and mental health care
- Integrate suicide prevention activities (assessment, counselling & referral) in existing Quality Improvement processes

- Systematically evaluate services, programs and funded projects.

3.6.4 The development and implementation of suicide prevention initiatives are strengthened if evaluation is systematically integrated into activity planning and designed at inception of the activity. Evaluation is necessary to assess whether the activity was implemented as intended, whether the activity benefits or harms people, who it is suited for, what the critical implementation issues are and whether it is suitable for replication use in other communities.

## 4. Some questions for a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

4.1 The issues raised and the evidence discussed in this paper are not exhaustive, but are meant to serve as a stimulus for further discussions about what a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy might address. There are a number of broad questions that may be asked concerning a specific national suicide prevention strategy for Australian Indigenous peoples. The strategy is intended to complement the National Suicide Prevention Strategy's LiFE (2007) Framework. However, there may need to be some differences in emphasis and substance from the LiFE Framework's approach on key issues.

4.2 Some principles to guide the development and implementation of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy might follow those set out in Australia's *National Suicide Prevention Strategy 2009-2010 to 2010-2011 Action Framework*:

- Alignment: policy and program activity is aligned across government portfolios and jurisdictions
- Leverage: the policy leverages off other related social policy and program activity
- Embeddedness: the strategy is most effective when it is embedded in activity at all levels from larger systems to communities.
- Comprehensive: the strategy includes universal, targeted and selective or indicated activities with a balance of national and local level approaches
- Oriented to evidence: the strategy requires improvements in data accuracy and regular evaluation of the effectiveness of programs and initiatives.

4.3 A national suicide prevention strategy for Aboriginal and Torres Strait Islander people should incorporate these broad principles. At the same time, the principles guiding the specific objectives of the national strategy also need to speak to the reality of Indigenous suicide and its impacts. A national strategy has been described as a catalyst for change, not only in systems and practices, but also in public knowledge and discourse about a critically important social issue and the priority it is given in every level of society from everyday community life to policy and governance at the highest levels.

## Links to Other Resources

The following documents can be obtained from the Publications section of the National Consultation website – [www.indigenoussuicideprevention.org.au](http://www.indigenoussuicideprevention.org.au):

Robinson, G., Silburn, S. and Leckning, B. (2012a). *Information Paper: A Selective Review of International Indigenous Suicide Prevention*. Darwin: Centre for Child Development and Education, Menzies School of Health Research.

Robinson, G., Leckning, B. and Silburn, S. (2012b) *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy: Consultation Paper*. Darwin: Centre for Child Development and Education, Menzies School of Health Research.

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