



INDIGENOUS GOVERNANCE FOR SUICIDE PREVENTION IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

A Guide for Primary Health Networks

Professor Pat Dudgeon, Professor Tom Calma,
Professor Jill Milroy, Rob McPhee, Leilani Darwin,
Steffanie Von Helle and Christopher Holland



The Centre of Best Practice in
Aboriginal and Torres Strait
Islander Suicide Prevention



**Black Dog
Institute**

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Artwork: *Shifting Sands*

Artist: Roma Winmar

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Poche Centre for Indigenous Health
School of Indigenous Studies
University of Western Australia
08 6488 3428
35 Stirling Highway, Crawley, Western Australia 6009

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KEY DOCUMENTS

This Guide is a companion to:

- Dudgeon, P., Darwin, L., McPhee, R., Holland, C., Von Helle, S. & Halliday, L. (2018). *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities, A Guide for Primary Health Networks*. Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, Poche Centre for Indigenous Health and Wellbeing, University of Western Australia & Black Dog Institute. Sydney: Black Dog Institute.
- Centre for Evidence and Implementation & Black Dog Institute (2017). *LifeSpan Implementation Framework: Implementing Integrated Suicide Prevention*. Sydney: Black Dog Institute.

This Guide also refers extensively to:

- National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) (2015), *Gayaa Dhuwi (Proud Spirit) Declaration and (2017) Health in Culture: Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide*. Both available from the NATSILMH website: <http://natsilmh.org.au>
- Dudgeon, P., Milroy J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G., & Holland, C. (2016). *Solutions That Work – What the Evidence and Our People Tell Us, The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*. Perth: University of Western Australia. Extracts are also included in this Guide, particularly descriptions of the Indigenous governance of suicide prevention activity in Aboriginal and Torres Strait Islander communities that were evaluated as successful.
- Dudgeon, P., Calma, T., & Holland, C. (2017). Context and Causes of Indigenous Suicide in Australia, Te Mauru – Pimatisiwin, Vol 2, Issue 2. Available online at: <https://journalindigenousewellbeing.com/media/2017/09/82.65.The-context-and-causes-of-the-suicide-of-Indigenous-people-in-Australia.pdf>
- Australian Government (2013). *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. Canberra: Department of Health.
- Australian Government (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023*. Canberra: Department of the Prime Minister and Cabinet.

PREFACE

This is the second Guide intended to support Primary Health Networks (PHNs) working with Aboriginal and Torres Strait Islander communities and organisations to co-design and co-implement integrated approaches to suicide prevention. It follows *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities: A Guide for PHNs* (2018). For reference, the Executive Summary from that publication, containing pointers for action, is included as Appendix 5.4 in this Guide.

Both Guides were undertaken jointly with the Black Dog Institute, funded by the Australian Government Department of Health, and developed in partnership between the LifeSpan Program in the Black Dog Institute and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP), Poche Centre for Indigenous Health at the University of Western Australia. Both are intended as companions to the Centre for Evidence and Implementation and Black Dog Institutes' *2017 LifeSpan Implementation Framework: Implementing Integrated Suicide Prevention*.

Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities focused on PHN engagement and partnership with Aboriginal and Torres Strait Islander communities to ensure community ownership and community-led cultural adaptations of integrated approaches to suicide prevention including specific interventions.

This Guide focuses on the intersecting subject of PHNs working with Aboriginal and Torres Strait Islander communities and organisations under Indigenous governance in suicide prevention. While some overlap with the subjects matters in *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities* is inevitable, this Guide focuses specifically on working in ways that enhance self-determination.

GLOSSARY

ATSISPEP: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project

Cultural safety: An environment which is safe for Indigenous people with shared respect, shared meaning, shared knowledge and experience, and dignity

Indigenous: Used in this Guide predominantly to refer to Aboriginal and Torres Strait Islander people. Where used to refer to Indigenous people of other nations, this is specifically addressed.

Intervention: An action or provision of a service to produce an outcome or modify a situation.

PHN: Primary Health Network

Primordial prevention or interventions: Aim to prevent the risk factors for suicide and include interventions addressing upstream risk factors

Selective interventions: Activities aimed at groups who are identified as being at higher risk of suicide

SEWB: Social and Emotional Wellbeing

Social determinants of health: The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life (WHO)

Universal interventions: Usually refers to a suicide prevention activity aimed at the whole and 'well' population. In this report, 'universal' activity and interventions are defined as Indigenous community-wide activity and preventions (rather than those targeting the whole Indigenous population)

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EXECUTIVE SUMMARY

Indigenous governance in the context of suicide prevention activity is about Indigenous communities' control of the design and implementation of suicide prevention activity taking place within them; or direction and leadership guiding external organisations to the same end.

Suicide is a world-wide population health challenge. This includes among the Australian general population and, in particular, among Aboriginal and Torres Strait Islander peoples. For the latter, the suicide rate is about double that of the non-Indigenous population, and likely to be increasing; among adolescents and young adults, the rate is higher again.

The *2017 Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) makes reducing Aboriginal and Torres Strait Islander suicide rates and improving mental health a national priority (Priority Area 4). The Fifth Plan also marks the adoption of integrated approaches to suicide prevention as the national approach to suicide prevention.

However, while the evidence base for mainstream integrated approaches demonstrates they do reduce general population suicide rates, Aboriginal and Torres Strait Islander suicide is different. In part, it can be understood as a response to challenges affecting individuals (and such should be an important part of an overall approach to reducing Aboriginal and Torres Strait Islander suicide). However, an exclusive focus on individual causes also runs the risk of overlooking underlying influences that operate collectively – at the population and community level. These are the culmination of a history of colonisation, and contemporary systemic social and economic disadvantages stemming from that history.

Preventing Suicide in Aboriginal and Torres Strait Islander Communities is Deeply Connected to the Recovery of Self-governance and Self-determination

Over 2016-17, the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) identified success factors in evaluated Aboriginal and Torres Strait Islander suicide prevention activity. The resulting *Solutions That Work* report is an invaluable resource for all those working in Aboriginal and Torres Strait Islander suicide prevention and is summarised in Appendix 1 of this Guide. Of particular relevance here, the non-negotiable success factor that underpinned successful suicide prevention activity was that the processes associated with design and implementation be empowering to Aboriginal and Torres Strait Islander communities.

There is a logical sequence of considerations and an evidence base that supports the ATSISPEP findings. These considerations connect contemporary Aboriginal and Torres Strait Islander suicide rates to continuing challenges to Indigenous governance that directly relate to colonisation. Therefore, the critical importance of empowering processes around the design and implementation of suicide activity in Aboriginal and Torres Strait Islander communities is paramount. In other words, effective suicide prevention requires design and implementation processes under Indigenous governance.

The sequence of considerations starts with **the connection between culture and community**. A shared culture enables groups to gather, function collectively, strive and thrive. In fact, the health and wellbeing of collectives and their culture are not, in practice, separable. A culture under stress is less likely to be supporting a well-run collective. Similarly, collectively experienced stressors may place stresses on a culture. Culture and community are deeply connected.

The next consideration **connects culture and community with the physical and mental health of Aboriginal and Torres Strait Islander individuals**. In Aboriginal and Torres Strait Islander cultures, health (inclusive of mental health) is understood differently to non-Indigenous concepts of health: that is, as a wider social and emotional wellbeing (SEWB) concept. While the concept varies between groups, in broad terms, the health and wellbeing of the individual and collective is understood as more deeply connected than in western societies.

A further consideration is **the connection between culture, community, and governance**. Governance gives a collective the ways and means to achieve the things that matter to them. Governance concepts, too, are culturally shaped. In Aboriginal and Torres Strait Islander cultures, as in all cultural settings, culture shapes governance and governance shapes culture – in part because governance ultimately includes the governance of culture.

Contemporary forms of Aboriginal and Torres Strait Islander governance have adapted to the legal and other demands of contemporary Australian life, in particular, the requirements of incorporation. However, in Aboriginal and Torres Strait Islander groups and organisations that operate in and with communities, legitimate governance is also aligned with culture, and legitimate governance is what makes the collective, body or organisation strong and effective in that setting.

The next consideration is empowerment - disempowerment and its relationship to governance. To empower is to support the power influence and the authority of a group over decision-making that will affect them: in this case, Aboriginal and Torres Strait Islander communities, their leaders and Elders, their governing bodies and community controlled organisations. To disempower is to do the opposite.

By our sequence of considerations then, culture shapes governance; governance shapes culture; culture and governance shape community; and community (or collective life) affects the health and wellbeing (including the mental health) of Aboriginal and Torres Strait Islander individuals. In fact, all influence each other. What this means is that if governance is diminished or disempowered, culture, community and the wellbeing of individuals will also be affected.

As discussed in the *Solutions That Work* report, preventing suicide in Aboriginal and Torres Strait Islander communities must be understood as deeply connected to the recovery of empowered Indigenous governance and self-determination (a collective human right of Aboriginal and Torres Strait Islander peoples) and not just in relation to suicide prevention activity itself, but in the broader context of all activity that affects a community.

Colonisation and Challenges to Indigenous Governance

The empowerment Aboriginal and Torres Strait Islander communities and governance bodies enjoyed prior to colonisation was challenged in several intersecting stages of colonisation. After the securing of legal equality in the 1960s and the 1967 referendum, such communities might have begun a revitalisation process inclusive of culture and governance, and within a broader, long-term healing and 'recovery-from-colonisation' process. However, and instead, further challenges to Indigenous governance occurred.

In particular, communities in both remote, rural and urban settings continued to be subjected to paternalistic, outside, non-Indigenous sources of governance as a result of continuing cultural racism and non-Indigenous presumptions of superiority regarding the 'right ways' of governance shaped decades of outsider attempts to 'fix' the colonisation-caused challenges in Aboriginal and Torres Strait Islander communities, beginning in the late 1960s. And when these approaches failed, it was interpreted as Aboriginal and Torres Strait community (or otherwise collective) failure rather than the system failure. At worst, such failures resulted in further outside interventions, and so a cycle of ongoing challenges to Indigenous governance continues to this day.

While focused on suicide prevention, this Guide aims to empower communities, and challenge and change processes that undermine Indigenous governance, diminish culture; challenge communities, and affects the mental health and wellbeing of individuals. In particular, this Guide proposes that challenges to Indigenous governance are:

- In themselves an underlying cause of Aboriginal and Torres Strait islander suicide as a population health issue.
- Are as underlying factor contributing to specific causes associated with Aboriginal and Torres Strait Islander suicide, many of which have a collective dimension (contact with the criminal justice system, for example).
- Is otherwise continuing to challenge communities' ability to heal, revitalise, and begin deep-rooted recovery processes from colonisation. This includes in practical ways such as addressing poor quality and overcrowded housing and high levels of unemployment.

What the Evidence Tells Us

As noted in *Solutions That Work*, research among Canadian Indigenous communities clearly associates increasing measures of Indigenous governance of community life and culture, and self-governance institutions in communities with lower suicide rates among their young people.

Reflecting the sequence of considerations presented above, the same research also reported an association between those increased measures of governance and the presence of cultural protective factors against suicide in communities. Implicit in the theory of cultural continuity is the role of Indigenous governance as the source of potential reinvigoration, maintenance and transmission of culture and cultural practice.

Further, in *Solutions That Work*, Indigenous governance helped ensure both community ownership of the challenge of suicide and suicide prevention activity. This also provided a strong and legitimate foundation for the community to ensure cultural and experiential tailoring of mainstream interventions, or of those that were successful in other communities. In turn, this ensured such interventions were effective.

Internationally, the proposition that Indigenous governance leads to better outcomes is also supported by research. Importantly, processes under Indigenous governance supported the better identification of local needs, priorities and – in turn – further appropriate processes to address them.

The Indigenous Governance Framework

This Guide's Indigenous Governance Framework is presented in diagram form below. It highlights areas of suicide prevention activity in which Indigenous governance is particularly important in and success factors in this context.

INDIGENOUS GOVERNANCE FRAMEWORK		
INDIGENOUS GOVERNANCE OF SUICIDE PREVENTION ACTIVITY		
LEVEL	ACTIVITIES	SUCCESS FACTORS
All	All	Utilise existing national guidance and standards Working with Indigenous leaders
Regional	Regional identification of need, planning and implementation	Indigenous Health Councils
Service	Cultural safety and cultural competence in services	Working with Aboriginal Community Controlled Health Services and Community Controlled Organisations
Community	Programs and activities operating in communities Culturally/linguistically adapting mainstream activities and programs Cultural activities and programs/healing	Approaching communities with respect Addressing power imbalances Co-design and co-implementation of suicide prevention activity
FOUNDATION: ORGANISATIONAL CAPACITY TO WORK UNDER INDIGENOUS GOVERNANCE		

1.0 INTRODUCTION: INDIGENOUS GOVERNANCE AND SUICIDE PREVENTION THAT WORKS IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

Suicide is a world-wide population health challenge. This includes in Australia where relatively high rates of suicide in both the general population and among Aboriginal and Torres Strait Islander peoples are a significant concern. For the latter, addressing suicide as a population health challenge is particularly critical because:

The suicide rate is about double that of the non-Indigenous population¹ and likely to be increasing.²

- Over the 5 years from 2012 to 2016, Aboriginal and Torres Strait Islander people in age groups between 15 and 44 years died by suicide at between two and four times the rates of their non-Indigenous peers.³ Their median age at death was 29 years, compared with 45 years in the non-Indigenous population. Aboriginal and Torres Strait Islander children and young people aged 0 – 17 years accounted for more than a quarter of all suicide deaths in this age group. The age-specific death rate for Aboriginal and Torres Strait Islander children and young people was 9.8 deaths per 100,000 persons, compared to 1.9 per 100,000 for non-Indigenous children and young people.⁴
- The impact of suicide in close-knit communities and through Aboriginal and Torres Strait Islander familial and social networks can be particularly devastating and far-reaching. And in negative cycles, one suicide may contribute to others.⁵
- The evidence suggests that many Aboriginal and Torres Strait Islander people who have died by suicide were to some degree identifiable prior to their deaths, particularly by mental health and suicide prevention services.⁶ As such, these suicides are preventable.

As has been observed, ‘Aboriginal suicide is different’⁷. This is because suicide as an Aboriginal and Torres Strait Islander population health issue can be understood as much as the culmination of a history of colonisation, and unresolved deeper ‘structural’ social and economic challenges stemming from colonisation, as it can be understood in terms of challenges affecting individuals.

Reflecting the urgent need to reduce Aboriginal and Torres Strait Islander suicide rates, the 2017 *Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan)* makes reducing Aboriginal and Torres Strait Islander suicide rates and improving mental health a national priority. This is Priority Area 4.

Further, in the Fifth Plan:

- Integrated approaches to suicide prevention (integrated approaches) are established as the foundation national approach to suicide prevention. These involve the simultaneous use of multiple evidence-based suicide prevention interventions, from the universal to indicated-levels, in any given setting. Evidence suggests that the synergistic effect of such produces an outcome that is greater than the sum of their individual parts.⁸ The Fifth Plan lists 11 elements and interventions to support national consistency in integrated approaches.⁹
- Significant oversight responsibility for suicide prevention, including in Aboriginal and Torres Strait Islander communities, is given to Primary Health Networks’ (PHNs)¹⁰. This builds on seven pre-existing, intersecting PHN-priorities that include to improve Aboriginal and Torres Strait Islander health and to improve mental health in the general population.¹¹

The roll out of integrated approaches is beginning with 12 Commonwealth Government-funded PHN trials. Seven of the trial sites include Aboriginal and Torres Strait Islander-specific initiatives and two are solely focused on reducing suicide in Aboriginal and Torres Strait Islander communities. In most of the trial sites, the mainstream LifeSpan integrated approach model (promoted by the Black Dog Institute) and European Alliance Against Depression (EAAD) model, and variations on these, are being trialed.

The adoption of integrated approaches reflects international thinking about preventing suicide. As observed by the World Health Organization:

*Suicide is a serious public health problem; however, suicides are preventable with timely, evidence-based and often low-cost interventions. For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed.*¹²

The ATSIPEP *Solutions That Work* report success factors are summarised in Appendix 1. See *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities* for further information on the trial sites, and the LifeSpan model.

While the evidence base for mainstream integrated approaches demonstrates they do reduce suicide rates, in Aboriginal and Torres Strait Islander communities, the application of mainstream integrated approaches is problematic. This is due to lack of testing in Aboriginal and Torres Strait Islander community contexts such that particular interventions within any mainstream integrated model might not be suitable or else need cultural and/or experiential adaptation to 'fit' with a community.¹³

Perhaps most importantly, and as identified by the *Solutions That Work* report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP), integrated approaches will likely need fundamental re-thinking if the impacts and legacies of colonisation that culminate in suicide are to be addressed in Aboriginal and Torres Strait Islander communities.¹⁴

The critical factor that *Solutions That Work* identified as a non-negotiable 'success factor' that underpinned the successful suicide prevention programs that ATSISPEP evaluated was that the processes associated with design and implementation were empowering to Aboriginal and Torres Strait Islander communities.¹⁵

To empower is to support the power influence and the authority of a group over decision-making that will affect them (in this case, Aboriginal and Torres Strait Islander communities, their leaders and Elders, their governing bodies and community controlled organisations. To disempower is to do the opposite). To disempower then 'to deprive of power, authority, or influence'¹⁶.

This Guide adopts the broad Australian Indigenous Governance Institute definition of Indigenous governance as being about:

*How people choose to collectively organise themselves to manage their own affairs, share power and responsibilities, decide for themselves what kind of society they want for their future, and implement those decisions...Governance gives a nation, group, community or organisation the ways and means to achieve the things that matter to them.*¹⁷

To do that, they need to have processes, structures, traditions and rules in place so they can:

- Determine who is a member of their group
- Decide who has power, and over what
- Ensure that power is exercised properly
- Make and enforce their decisions
- Hold their decision-makers accountable
- Negotiate with others regarding their rights and interests
- Establish the most effective and legitimate arrangements for getting those things done¹⁸

Solutions That Work framed Indigenous governance in the context of a community's design and implementation of suicide prevention activity occurring within it, or a community's direction and leadership in genuine partnership with external organisations to the same end.

The logic and evidence base for Indigenous governance as non-negotiable in suicide prevention activity is discussed in Part 2.0 of this Guide. In summary, this is because:

- Challenges to Indigenous governance themselves are a deeper 'structural' issue that is contributing to suicide in Aboriginal and Torres Strait Islander communities. As such, supporting Indigenous governance both within and outside the context of suicide prevention is a critical way of contributing to lower rates of suicide. In particular, it must be recognised as inherently self-contradictory with the broader aim of suicide prevention to work in any way that challenges Indigenous governance in an Aboriginal and Torres Strait Islander community when designing and implementing suicide prevention activity, as indeed in all other areas of life.
- When communities are in control of process, better outcomes could be expected. And not only because tailored and culturally adapted mainstream interventions 'owned' a community are likely to be significantly more impactful. But more importantly, and as discussed in *Solutions That Work*, broader design processes under Indigenous governance will identify and address other deeper, structural problems that could also be contributing to suicide, or could protect against it: for example, social determinants associated with suicide, or supporting cultural practices and cultural re-vitalisation to build protective factors against suicide.

Because of these potential points of difference, the Fifth Plan requires PHNs to be guided by the *Solutions That Work* report when working with Aboriginal and Torres Strait Islander communities to prevent suicide and it is a major point of reference for this Guide.

Part 3.0 of this Guide presents a framework for working with Indigenous governance – including at the national, regional, community and organisational levels.

2.0 IMPORTANT CONSIDERATIONS AND THE EVIDENCE BASE FOR INDIGENOUS GOVERNANCE IN ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION

There are a number of considerations and an evidence base that support the proposition that Indigenous governance is non-negotiable in designing and implementing suicide prevention activity in Aboriginal and Torres Strait Islander communities. This illustrates the connection between contemporary Aboriginal and Torres Strait Islander suicide rates and the unresolved legacies of colonisation. It starts with culture.

2.1 Culture and Community

Considerations need to start with the connection between culture and community. Culture has been defined as ‘a whole system of knowledge, beliefs, ideas, values, powers, laws, rules and meanings that are shared by the members of a society or collective, and together form the foundation for the way they live’¹⁹. A shared culture enables groups to gather, function collectively, strive and thrive. A shared culture includes agreement on a group’s governance, inclusive of the governance of the culture itself, and concepts of wellbeing, health and cultural healing practices. Culture and community are therefore not in practice separable, and one will affect the other. Both these intersecting concepts are discussed further below.

2.2 Community and Social and Emotional Wellbeing

Health is understood in Aboriginal and Torres Strait Islander cultures differently to non-Indigenous concepts of health: that is, as social and emotional wellbeing (SEWB). As noted in the Fifth National Mental Health and Suicide Prevention Plan:

*Aboriginal and Torres Strait Islander peoples embrace a holistic concept of health, which inextricably links mental and physical health within a broader concept of social and emotional wellbeing. A whole-of-life view, social and emotional wellbeing recognises the interconnectedness of physical wellbeing with spiritual and cultural factors, especially a fundamental connection to the land, community and traditions, as vital to maintaining a person’s wellbeing.*²⁰

For further information on social and emotional wellbeing, see the *National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2017–2023*.

While the SEWB concept varies between Aboriginal and Torres Strait Islander groups, shared features include that culture is central to SEWB, and that SEWB is holistic in conception. Indeed, SEWB can be thought of as an intersecting set of cultural determinants that can include not only cultural practices and identity, but also connect the health of individuals to the health of their families (including culturally determined concepts of extended family), kin and communities.²¹

Critically, the SEWB concept affirms a strong association between collective and individual wellbeing such that the wellbeing of an Aboriginal and Torres Strait Islander community may have significant impacts on the health and wellbeing on the individual members and families of that community²² – more than is generally acknowledged in western societies.

2.3 Indigenous Governance and Community Wellbeing

Governance, as discussed in the Introduction, cannot occur independently of cultural context and the relationship of culture and governance is always interrelated. Culture shapes governance and governance shapes culture, just as culture and community are deeply inter-related.

In mainstream corporations today, as well as meeting business aims and processes, governance requires that a Board’s actions both reflect and uphold the cultural values of the society it operates in, and that Boards also shape the culture of the corporation according to these. For example, workplace cultures are expected to be free of bullying and harassment and Boards are required to enforce this. Internal policies and the threat of legal and social sanctions for breaches of such cultural norms help ensure conformity.

Governance in mainstream Australian political and corporate life could be described as ‘western governance’ even though its pervasive nature means most citizens are unaware of the specifically western cultural influences. However, critical thinking about governance must start with an understanding that culture and governance are not separable in practice.

Indigenous governance is different from mainstream governance because Aboriginal and Torres Strait Islander cultural contexts and norms are different, as are the community-level settings in which they operate. In Aboriginal and Torres Strait Islander community organisations and governance bodies, the alignment of governance with culture is what makes those organisations and bodies legitimate, strong and effective. Shared characteristics of Indigenous governance have been identified as:

- Respecting law/lore and the authority of Elders, ‘cultural bosses’.
- A high value placed on family connections and support; kin relationships, mutual responsibility and sharing of resources.
- Attachment to ‘country’ and ensuring the role of traditional owners in decision-making about their lands.²³
- Decision-making by consensus where possible.
- Some areas of governance split into men’s and women’s ‘business’.
- Women in leadership roles.
- The wellbeing of the collective prioritised over personal ambition.
- Development seen as an interrelated social, economic and cultural goal, rather than a thing of value in itself, or to be driven solely by a profit motive.
- Accountability being downwards to the community or membership and that focuses on collective goals.²⁴

2.4 Indigenous Governance, Communities and Colonisation

The historical context of this Guide is that:

- During colonisation, the empowerment Aboriginal and Torres Strait Islander communities and governance mechanisms enjoyed prior to colonisation was challenged through dispossession and marginalisation. This included the attempted destruction of communities and their governance and legally enforceable segregation of community members into reserves and missions under non-Indigenous governance.²⁵
- During the 1960s, following the struggles to achieve legal equality and the 1967 referendum, Aboriginal and Torres Strait Islander communities might have begun a re-vitalisation process inclusive of culture and governance and within a broader, long-term healing and recovery process.²⁶ However, Indigenous governance faced further challenges. These included:
 - The challenge of significant social, cultural, economic and political disadvantage of life on the reserves and missions continuing; as well as for those in urban centres, or who moved to urban centres. This was compounded by destructive behaviours provoked by these desperate conditions.²⁷
 - Continuing cultural racism: that is, non-Indigenous presumptions of superiority, regarding the ‘right ways’ of governance about Indigenous matters.²⁸ These often uninspected attitudes on the part of Indigenous people manifested as paternalistic and ‘top down’ approaches in efforts to address ‘Indigenous disadvantage’ from the 1970s onwards and continue to the present day. But, the history of top down approaches in Indigenous Affairs suggests they are broadly ineffective, inefficient and unsustainable to the degree they exclude Indigenous governance in design and implementation processes.²⁹ Moreover, when top down approaches fail, it is often seen as Aboriginal and Torres Strait islander community failure rather than systems failing³⁰. ‘Top down’ or otherwise imposed approaches deprive a community both of the ownership of problems and solutions. At worst, they can do harm by being culturally or linguistically inappropriate, and not addressing the lived experience of community members.³¹

Indeed, the first significant reports of Aboriginal and Torres Strait islander suicide as a population health issue occur in the 1960s at a time not only when challenges to Indigenous governance from colonisation continued, but new challenges presented.³²

Placed in this context, high Aboriginal and Torres Strait Islander suicide rates can be understood as a manifestation of the delayed need for communities’ ‘recovery’ from the broader colonisation process.³³ As such, and discussed in the *Solutions That Work*, preventing suicide in Aboriginal and Torres Strait Islander communities can be understood as deeply connected to the recovery of self-governance and self-determination and to addressing community challenges, securing access to services, and economic, cultural and language revitalisation as required.³⁴

Other legacies of colonisation that also contribute to Aboriginal and Torres Strait islander suicide rates are discussed in Text Box 1 on the following page.

A good source of information and an Aboriginal and Torres Strait Islander perspective on the community challenges associated with suicide can be found in *The Elders Report into Preventing Indigenous Self-harm and Youth Suicide*.

TEXT BOX 1: Other Legacies of Colonisation and Their Relationship to Suicide

Today, many of the specific challenges associated with the suicide of Aboriginal and Torres Strait Islander individuals also originate in the historical and present-day collective experience of Aboriginal and Torres Strait Islander peoples including racism, poverty, poorer housing, and lower lack of access to health services.

Overall impacts include significantly higher exposure at a population level (when compared to the non-indigenous population) to stressful and traumatising incidents resulting in significantly elevated levels of high and very high psychological distress and trauma. Further, mental health difficulties, including depression and challenges associated with alcohol and drug use, are reported at significantly higher rates.

In response to these SEWB-challenges, cultural healing practices including their contemporary forms and community based programs are critically important:

- At the indicated level, (aimed at individuals who are identified as being challenged by suicide) such might involve work to heal people in several areas of their life in order to restore the wellbeing of the whole Aboriginal and Torres Strait Islander person. This can include addressing range of challenges such as grief and loss, contact with the criminal justice system, alcohol and drug use, mental health difficulties, trauma and domestic violence (and, etc.). Responses too can include building on protective factors against suicide such as employment, connection to family, culture country and community. (See the *ATSISPEP Solutions That Work* report for further information or the Summary Table at Appendix 5.1.)
- At the universal (here defined as community-wide) and selective levels (here defined as particular groups within the broader Aboriginal and Torres Strait Islander population) strengthening SEWB and healing practices are also an important to help build protective factors to prevent suicide.

For further discussion and references see Appendix 5.3.

2.5 Indigenous Governance and Lower Suicide Rates

International research associates increasing measures of Indigenous governance in Indigenous communities with lower suicide rates among their young people. See Text Box 2 below.

TEXT BOX 2: International Research

Chandler and Lalonde's studies among almost 200 British Columbian (Canadian) First Nations' communities focused on community-level protective factors against suicide. Indicators of Indigenous governance and self-determination included:

- A measure of self-government
- Litigation for Aboriginal title to traditional lands
- A measure of local control over health, education, policing and child welfare services
- Community facilities for the preservation of culture
- Elected band councils composed of more than 50 percent women.³⁵

The studies found that communities where all of these protective factor indicators were present had no cases of suicide. Conversely, where communities had none of these protective markers, youth suicide rates were many times the national average.³⁶

As noted in *Solutions That Work*, the following thematic elements of importance to Indigenous suicide prevention work can be drawn from the Chandler and Lalonde studies:

- Community empowerment: Supporting communities' agency to make real choices and change their experience for the better. This could be through education and awareness raising, supporting the emergence of leadership and decision-making structures, the devolution of decision-making power to such structures, and the presence of services and support organisations to assist in achieving goals and/or the provision of resources.³⁷

- Cultural maintenance and renewal under Indigenous governance.³⁸ It is proposed that Indigenous young people who have a sense of their past and their cultures will not only draw resilience-building pride and identity from them, but also an awareness that strengthens their sense of connectedness with family and community.³⁹ Further, by extension, younger people will also conceive of themselves as ‘having a future’ as bearers of that culture.⁴⁰ Implicit in the theory of cultural continuity is the role of Indigenous governance as the source of potential reinvigoration, maintenance and transmission of culture and cultural practice.
- Primordial prevention, that is, upstream interventions had an important place in Indigenous suicide prevention.⁴¹

The work of Chandler and Lalonde has already influenced suicide prevention activity in Aboriginal and Torres Strait Islander communities. In particular, in the ongoing National Empowerment Project (NEP) that aims to empower communities through education in identifying and addressing challenges (including those associated with suicide) and supporting community capacity for self-governance and organisation to address those challenges. Echoing Chandler and Lalonde’s work, the NEP also places a strong emphasis on leveraging cultural strengths and supporting a community’s cultural renewal on its own terms.⁴²

Ensuring a community initiates and/or drives the processes associated with a systems approach to suicide prevention is critically important. In particular, empowerment cannot be ‘forced’ onto a community, by definition, but will only occur as communities create their own momentum, gain their own skills, and advocate for their own changes. Empowerment also means that Indigenous communities set their own time frames compatible with their own cultural protocols for decision making about co-design, and co-implementation of, systems approaches to suicide prevention.

2.6 Indigenous Governance and Better Outcomes in Indigenous Communities

In *Solutions That Work*, Indigenous governance helped ensure both community ownership of the challenge of suicide and suicide prevention activity. This provided a foundation for the community to ensure cultural and experiential tailoring, particularly of mainstream interventions, or those that were successful in other Aboriginal and Torres Strait Islander communities, as a critical Aboriginal and Torres Strait Islander suicide prevention success factors, both requiring Indigenous governance as defined in this Guide.

Further and internationally, the same proposition is supported by research undertaken by the Harvard Project on American Indian Economic Development as described in Text Box 3.

TEXT BOX 3: The Harvard Project on American Indian Economic Development

Extracts from the Harvard Project website⁴³

Through applied research and service, the Harvard Project aims to understand and foster the conditions under which sustained, self-determined social and economic development is achieved among American Indian nations.

At the heart of the Harvard Project is the systematic, comparative study of social and economic development on American Indian reservations to answer what works, where and why? Among the key research findings:

- Sovereignty Matters. When Native nations make their own decisions about what development approaches to take, they consistently out-perform external decision makers on matters as diverse as governmental form, natural resource management, economic development, health care, and social service provision.
- Institutions Matter. For development to take hold, assertions of sovereignty must be backed by capable institutions of governance. Nations do this as they adopt stable decision rules, establish fair and independent mechanisms for dispute resolution, and separate politics from day-to-day business and program management.
- Culture Matters. Successful economies stand on the shoulders of legitimate, culturally grounded institutions of self-government. Indigenous societies are diverse; each nation must equip itself with a governing structure, economic system, policies, and procedures that fit its own contemporary culture.
- Leadership Matters. Nation building requires leaders who introduce new knowledge and experiences, challenge assumptions, and propose change. Such leaders, whether elected, community, or spiritual, convince people that things can be different and inspire them to take action.

While the Harvard Project examined governance in a Native American Indigenous context, the principles are understood to be relevant for application in Aboriginal and Torres Strait Islander communities in Australia, and to developing and implementing systems approaches to suicide in partnership with such communities and their governing bodies.

2.7 Indigenous Governance, the Human Rights Framework and The Fifth National Mental Health and Suicide Prevention Plan

Self-determination is a recognised human right of all peoples, including Indigenous peoples, as set out in the *United Nations Declaration on the Rights of Indigenous Peoples* (Declaration).⁴⁴ For Aboriginal and Torres Strait Islander peoples in Australia, self-determination in a post-colonial context essentially means a right to self-governance and decision-making power in all matters that affect them.⁴⁵ The Declaration is now referenced in a range of Australian Government documents, including the Fifth Plan as an implementation guidance document.⁴⁶ It is discussed in greater detail in *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities: A Guide for Primary Health Networks*.

The *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) approaches Aboriginal and Torres Strait Islander people as both consumers of mental health and suicide prevention services as well as peoples with collective human rights. As consumers, the Fifth Plan provides clear guidance to ensure that:

*Governance and implementation of the Fifth Plan reflect the intent of the National Mental Health Policy regarding consumer and carer participation—that is, ‘Nothing about us, without us’.*⁴⁷

Further, the Fifth Plan defines consumers and carers as

*people with lived experience... who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness...*⁴⁸

For Aboriginal and Torres Strait Islander consumers, lived experience includes of the cultural, historical and social context in which Aboriginal and Torres Strait Islander mental health difficulties and suicide are occurring, in addition to a range of cultural and other barriers for engaging in effective treatment.

The value the Fifth Plan places on lived experience provides a further rationale for ensuring Indigenous governance of suicide prevention activity in communities and the full involvement of Aboriginal and Torres Strait Islander consumers with lived experience of the mental health system and of suicide in suicide prevention design and implementation processes. This should also be considered as a contributor to risk management by helping PHNs avoid common pitfalls that have the potential to result in harm, such as assuming that what works in one Aboriginal and Torres Strait Islander community will work in another, or by imposing integrated approaches, elements or interventions intended for non-Indigenous settings.

Forthcoming: The Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention is developing a framework for PHNs working with Aboriginal and Torres Strait Islander peoples with lived experience of the mental health system and/or suicide ⁴⁹.

3.0 THE INDIGENOUS GOVERNANCE FRAMEWORK

DIAGRAM 1: Indigenous Governance Framework Presented as a Diagram

INDIGENOUS GOVERNANCE OF SUICIDE PREVENTION ACTIVITY		
LEVEL	ACTIVITIES	SUCCESS FACTORS
All	All	Utilise existing national guidance and standards Working with Indigenous leaders
Regional	Regional identification of need, planning and implementation	Indigenous Health Councils
Service	Cultural safety and cultural competence in services	Working with Aboriginal Community Controlled Health Services and Community Controlled Organisations
Community	Programs and activities operating in communities Culturally/linguistically adapting mainstream activities and programs Cultural activities and programs/ healing	Approaching communities with respect Addressing power imbalances Co-design and co-implementation of suicide prevention activity

FOUNDATION: ORGANISATIONAL CAPACITY TO WORK UNDER INDIGENOUS GOVERNANCE

3.1 Foundation: Build Organisational Capacity to Work Under Indigenous Governance

Whole-of-organisation approaches and commitment to working in ways that empower Indigenous governance are required as the foundation for other more specific approaches. Ways forward include⁴⁸:

- Executive level-commitment to supporting and working under Indigenous governance within communities.
- Appointing local Aboriginal and Torres Strait Islander PHN board members who work with Aboriginal and Torres Strait Islander communities within a region to provide overarching leadership to the PHN. In many cases, Aboriginal Community Controlled Health Services' (ACCHSs) CEOs will be ideally placed for such a role.
- Ensuring that PHN Community Advisory Councils (CACs) and Clinical Councils include Aboriginal and Torres Strait Islander members with expertise in the issues impacting Aboriginal and Torres Strait Islander communities within the PHN's region.
- Ensuring that PHN boards, CACs and Clinical Councils have protocols in place to ensure the cultural safety of their Aboriginal and Torres Strait Islander members. Also, ensuring that processes are in place to support them in their roles. Examples might include: adding Aboriginal and Torres Strait Islander issues, including suicide prevention, as standing items on meeting agendas that are distinct from general population concerns; ensuring that a minimum of two Aboriginal and Torres Strait Islander people are present in any fora; and providing financial or transport support to attend meetings, particularly for people from remote areas.
- Ensuring local Aboriginal and Torres Strait Islanders people are employed at all levels of a PHN's organisational structure including by direct recruitment and upskilling of existing Indigenous staff. This can provide leadership from within the organisation and help 'acculturate' the organisation and its non-Indigenous staff to not only working better with Indigenous communities, but under Indigenous governance.
- Require all non-Indigenous staff to undergo local cultural competence training to understand the history, culture and other contexts within which local Indigenous communities operate in the PHN region. Preferably, this training should be commissioned from local ACCHSs or Indigenous providers.

The following Case Study 1 illustrates the value of organisational commitment to Aboriginal and Torres Strait Islander governance through the work of the Western NSW PHN.

CASE STUDY 1: Western NSW PHN and Marrabinya⁵⁰

About one in eight of the Western NSW PHN region's current population are Aboriginal or Torres Strait Islander. Broken Hill's Maari Ma Health Aboriginal Corporation (Maari Ma) and Dubbo's Bila Muuji Aboriginal Health Services Inc. (Bila Muuji) are two of the peak bodies for the ACCHSs that service the region.

The Western Health Alliance Ltd. (WHAL) operates the Western NSW PHN. The WHAL consortium includes Maari Ma and Bila Muuji. The seven member WHAL Board includes representatives from both. The PHN also has formal partnerships with local Aboriginal community bodies such as the Three Rivers Alliance, and the Murdi Pakki Regional Assembly (see Case Study 2).

An Aboriginal Health Council provide the Board Aboriginal-specific health advice and advice on the cultural safety of services, alongside two Clinical Councils and two Community Councils that advise on more mainstream concerns. The Aboriginal Health Council has a dedicated Board member who they liaise with to ensure effective communication from the council to the Board and vice versa. The integration of an Aboriginal Health Council into the PHN council structure is believed to be unique in Australia, and is regarded as one of the drivers of the Western NSW PHN's innovative responses to Aboriginal or Torres Strait Islander health, including Marrabinya, discussed below. In 2016, the Aboriginal Health Council recommended the PHN develop a Cultural Safety Framework to guide the region's health and other relevant service providers, the PHN's commissioning framework, and the PHN itself in building a culturally safe primary healthcare system in Western NSW.

'Marrabinya' is the name chosen for the Western NSW PHN's Integrated Team Care (ITC) chronic disease program. Following a recommendation by its Aboriginal Health Council, the Western NSW PHN Board committed to commissioning its ITC program from among ACCHS in its region using a Single/Most Capable Provider approach, rather than by open public tender. The successful proposal was initiated and developed by Maari Ma and Bila Muuji as a distinct co-design activity. They proposed a unique model of care working equally with GPs and ACCHSs, and with staff being co-located in ACCHS across the Western NSW PHN region. Through sharing facilities and office equipment, this would lead to significant 'overheads' and wages cost reductions. Potential conflicts of interest were managed by the exclusion of Maari Ma and BilaMuuji representatives on the PHN Board from all decision making around the selection of the successful applicant.

The Marrabinya service model is unique. It is a single Aboriginal-controlled brokerage service operating across the vast Western NSW PHN. But it has presence in many areas by staff being co-located in ACCHS and other Aboriginal organisations. Proactively promoting Marrabinya was critical to establishing its presence in the Western NSW health care system. Marrabinya commenced with about 600 patients. Within four months, by March 2017, client numbers had doubled – also suggesting that the cultural governance in place had filled a need for Aboriginal and Torres Strait Islander people to access appropriate services.

MAP 1 : Western NSW PHN and Marrabinya



3.2 Success Factors

3.2.1 Utilise Existing National Guidance and Standards

While section 3.1 above is focused towards PHNs, the actions listed or their equivalent have the added advantage for Local Hospital Networks (LHNs - known as Local Health Districts in NSW; Hospital and Health Services in Queensland, Local Health Networks in South Australia, and Tasmanian Health Organisations in Tasmania) of effectively aligning their governance processes with the National Standards for Mental Health Services. By Criterion 4.2, as considered in the *Implementation Guidelines– Public Mental Health Services and Private Hospitals*, mental health services should have documented evidence to show how the service's relevant committees and working groups consult with and represent Aboriginal and Torres Strait Islander communities.⁴⁹

Further, in the *Implementation Guidelines for Non-government Community Services*, Board membership and staffing are expected to reflect community diversity in order to support the service address attitudinal, physical, and procedural barriers.⁵⁰ This of course includes local Aboriginal and Torres Strait islander people as is particularly relevant to services that a PHN might commission from non-government agencies.

The *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health's* (Cultural Respect Framework) intended audience is mainstream government agencies, services and corporations (such as LHNs and PHNs) involved with health and related service delivery in Aboriginal and Torres Strait Islander communities. The Cultural Respect Framework Vision includes that:

*Cultural differences and strengths are recognised and incorporated into the governance, management and delivery of health services.*⁵¹

The *Cultural Respect Framework* provides a set of cultural respect indicators for PHNs and LHNs when working in partnership with Aboriginal and Torres Strait Islander communities and in ways that ensure Indigenous governance in broad terms. In this Guide, and extrapolating on the Cultural Respect Framework itself, it is further suggested that a culturally respectful partnership is one that supports and works to the leadership and direction of Indigenous governance bodies.

Selected extracts from the *Six Domains of the Cultural Respect Framework* that could function as indicators of what a culturally respectful partnership with Aboriginal and Torres Strait Islander bodies and working to Indigenous governance is are set out in Text Box 4 below.

TEXT BOX 4: The Cultural Respect Framework on Indigenous Governance (selected extracts)

- Aboriginal and Torres Strait Islander leadership and participation in decision-making and governance at all levels of the Australian health care system, both within Aboriginal and Torres Strait Islander-specific and mainstream roles and positions.⁵²
- Cultural safety and responsiveness efforts are directed and guided by Aboriginal and Torres Strait Islander health professionals and/or Aboriginal and Torres Strait Islander people with cultural expertise and/or authority.⁵³
- Cultural knowledge, expertise and skills of Aboriginal and Torres Strait Islander health professionals are reflected in health service models and practice.⁵⁴
- Mechanisms are utilised to facilitate community involvement in developing and implementing cultural safety and responsiveness related activities.⁵⁵
- Governance structures support membership of, and partnerships with, Aboriginal and Torres Strait Islander communities, consumers and carers.⁵⁶
- Governance structures support systematic and ongoing two-way communication with Aboriginal and Torres Strait Islander communities, particularly in relation to policy development, program planning, service delivery, evaluation of services, and quality improvements⁵⁷
- Partnerships established with Aboriginal and Torres Strait Islander Health Organisations (ACCHOs) to collaborate and share best practice in supporting health professionals to provide culturally safe and responsive health services to communities.⁵⁸
- Cross-agency and cross-sector forums and decision-making bodies that include key Aboriginal and Torres Strait Islander organisations, agencies and consumers to share information, make decisions, influence, and develop networks and trust.⁵⁹

It should be noted that at the national level, guidance and directives for working with Aboriginal and Torres Strait Islander communities and organisations and supporting Indigenous governance is likely to evolve over time.

In the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan), implementation oversight is tasked to the COAG Health Council's Mental Health Principal Committee.⁶⁰ This is to be guided by a Mental Health Expert Advisory Group (with two Aboriginal members);⁶¹ and a Suicide Prevention Subcommittee charged with developing a new National Suicide Prevention Implementation Strategy.⁶²

Guiding both the above is an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSISPPRG).⁶³ This has majority of Aboriginal and Torres Strait Islander membership and is chaired by Aboriginal child psychiatrist Professor Helen Milroy.⁶⁴ Its Terms of Reference include providing advice to support the development of a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander people for inclusion in the previously mentioned forthcoming National Suicide Prevention Implementation Strategy.⁶⁵ Further, in relation to service governance, it is tasked to:

*Provide advice on suitable governance for services and the most appropriate distribution of roles and responsibilities, recognising that the right of Aboriginal and Torres Strait Islander communities to self-determination lies at the heart of community control in the provision of health services*⁶⁶

Further focus on this will be provided by the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) who advise the Commonwealth Ministers for Health, Minister for Indigenous Health and Minister for Indigenous Affairs including in relation to PHN mental health and suicide prevention related activity with Aboriginal and Torres Strait Islander communities.

Also relevant to this Guide, Action 12.3 of the Fifth Plan also requires Australian governments to:

*Improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with Aboriginal Community Controlled Health Services and other service providers by: recognising and promoting the importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration.*⁶⁷

The *Gayaa Dhuwi (Proud Spirit) Declaration (Declaration)* of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) calls on Australian governments, mental health services and the mental health professions to commit to supporting a 'best of both worlds' approach to Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention including ensuring access to cultural healing and treatments in addition to mainstream approaches⁶⁸.

The Declaration further calls on Australian governments, services and the mental health professions to commit to supporting Indigenous governance and leadership in mental health and suicide prevention. This includes governance in culturally-informed specialised areas of practice.⁶⁹ For further information on the Declaration see Text Box 5 on the following page.

TEXT BOX 5: The Gayaa Dhuwi (Proud Spirit) Declaration

As set out in Fifth Plan Appendix A, the five following themes of the *Gayaa Dhuwi (Proud Spirit) Declaration* are central to the development and implementation of actions in the Fifth Plan. They are:

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.
2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.
4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.
5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.⁷⁰

NATSILMH have produced two guides to assist PHNs and LHNs understand their roles in relation to *Gayaa Dhuwi (Proud Spirit) Declaration*, Fifth Plan and other strategic document implementation:

- The first, *Health in Culture: Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* discusses practical steps PHNs, LHNs and other stakeholders can take towards implementation of the *Gayaa Dhuwi (Proud Spirit) Declaration*. See: <http://natsilmh.org.au/sites/default/files/Health%20in%20Culture%20GDD%20Implementation%20Guide.pdf>
- The second, *Health in Culture, Policy Concordance* sets out and cross references directives and strategic directions of about 25 Aboriginal and Torres Strait Islander and mainstream mental health and suicide prevention policy documents including national service standards. See: <http://natsilmh.org.au/sites/default/files/NATSILMH%20Health%20in%20Culture%20Policy%20Concordance%20%282%29.pdf>

In conclusion, Fifth Plan implementation in Aboriginal and Torres Strait Islander communities is intended to be guided by a range of strategic documents⁷¹, in particular the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023*⁷²; and the *2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*⁷³.

Like the Cultural Respect Framework and the *Gayaa Dhuwi (Proud Spirit) Declaration*, these strategic documents emphasise the importance of Indigenous governance across their subject matter areas.

3.2.2 Working Effectively with Indigenous Leaders

Theme 5 of the *Gayaa Dhuwi (Proud Spirit) Declaration*, elaborated upon in NATSILMH's *Health in Culture Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* (see Text Box 5), aims to address the historical and contemporary 'invisibility' of Aboriginal and Torres Strait Islander leadership that is a part of wider social exclusion, discrimination and a failure of governments to recognise Aboriginal and Torres Strait Islander peoples' right to self-determination and Indigenous governance.⁷⁴

The influence of Aboriginal and Torres Strait Islander leaders will usually be exercised through external (to a PHN or LHN) organisations; or from within a PHN or LHN who has employed a suitable Aboriginal and Torres Strait Islander purpose to provide leadership including to the PHN or LHN itself.

Such leaders are likely to be extensively networked including within communities. Beyond communities, such networks are likely to include other Aboriginal and Torres Strait Islander organisations and leaders and Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system and other areas of government activity.

As NATSILMH's *Health in Culture Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* notes, Aboriginal and Torres Strait Islander models of leadership will also have points of difference when compared to non-Indigenous leadership models.

Leadership in this context is not distant, but is hands on, connected to and embedded in Aboriginal and Torres Strait Islander organisations, community life and a network of community-relationships. It is more fluid, less directive and more consensus-oriented. Further, it understands and respects diverse, culturally shaped notions of leadership operating within different communities.⁷⁵

The international *Wharerata Declaration*, upon which the *Gayaa Dhuwi (Proud Spirit) Declaration* is based, asserts that the optimal leadership model in Indigenous mental health will include the best elements of both Indigenous and non-Indigenous leadership models. Nonetheless, this will result in different models of leadership and that PHNs must take action to work effectively with. In particular, the *Wharerata Declaration* considers five qualities of Indigenous leadership. In Table 1 below, these are adapted for use by Aboriginal and Torres Strait Islander peoples.

TABLE 1: Aboriginal and Torres Strait Islander Leadership Qualities⁷⁶

Leadership quality	Description
Informed	<ul style="list-style-type: none"> • Informed by Aboriginal and Torres Strait Islander perspectives, particularly social and emotional wellbeing and holistic concepts of physical and mental health. • Able to work across disciplines – to understand the connections between Aboriginal and Torres Strait Islander mental health problems and social determinants, drugs and alcohol and so on. • Able to work with non-Indigenous and clinical perspectives on mental health. • Using appropriate language styles to communicate effectively to Aboriginal and Torres Strait Islander community members as well as Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians.
Credible	<ul style="list-style-type: none"> • Credible with Aboriginal and Torres Strait Islander community members. • Credible among Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians. • Personally credible: with values such as integrity, capacity to self-reflect, empathy, vision and care for others.
Strategic	<ul style="list-style-type: none"> • Raises awareness. • Future oriented. • Embrace new paradigms. • Able to bring Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians with them. • Promotes consensus.
Connected	<ul style="list-style-type: none"> • Extensively networked, including with other Aboriginal and Torres Strait Islander leaders. • Community connections. • Connected to Aboriginal and Torres Strait Islander and non-Indigenous peers in the mental health system, in the mental health professions, and among mental health policy-makers and politicians.
Sustainable	<ul style="list-style-type: none"> • Practices self-care. • Supportive family, friends, community and work peers • Plans for succession. • Contributes to the betterment of Aboriginal and Torres Strait Islander peoples in many areas of life.

3.2.3 Working at Regional Levels: Indigenous Health Councils

The Fifth Plan requires PHNs and LHNs to partner with a wide range of Aboriginal and Torres Strait Islander communities and organisations to develop an overarching regional ‘integrated’ mental health and suicide prevention plan.⁷⁷ This will include partnering with Aboriginal and Torres Strait Islander communities and community organisations for community-level design and implementation of integrated approaches.

PHNs, LHNs and the Aboriginal and Torres Strait Islander communities they are working with should consider whether such may be best managed through a regional Indigenous Health Council under forms of governance agreed by the communities and organisations involved as members. In particular, an Indigenous Health Council can be useful to help identify regional economies of scale and provide a platform for, and oversight of, the co-design and co-implementation of regional mental health and suicide prevention plans including integrated approaches to suicide prevention that are tailored to individual community needs.

While a regional Indigenous Health Council or councils may not be suitable in all areas, such can provide advantages to communities including a collective voice, and a culturally safe working space for participants. By bringing communities together, it also helps address power imbalances between them as individual entities and PHNs/ LHNs. For PHNs and LHNs, an Indigenous Health Council can also provide a collective point of contact for the development of the regional mental health and suicide prevention plans that incorporate systems approaches.

Case Study 2 demonstrates how an Indigenous regional governance body, such as an Aboriginal Health Council, can operate in an empowered way.

CASE STUDY 2: The Murdi Paaki Regional Assembly: Regional Governance From the Community Up

The Murdi Paaki Regional Assembly is a regional governance body for 16 Indigenous communities across a large region. Each community has established a Community Working Party (CWP). First formed in the 1990s, the work of CWPs was originally focused on improving housing and essential services. Their current governance role, that has expanded as their effectiveness was recognised, embraces health and other areas.

CWPs range in size from 15 to 45 members that usually include community organisations and both male and female Elders. Larger communities tend to elect their CWPs. Smaller communities tend to work to achieve consensus on who should be a CWP member. The cultural legitimacy of the membership is a key success factor to the effectiveness of the CWP's work in their communities. Membership is earned through the demonstration of respect, integrity and accountability. Members also volunteer their time which, while not necessarily ideal, ensures personal commitment to community wellbeing. Each CWP also has a Chair, either an elected or otherwise recognised[1] community leader.

CWPs work directly with the Federal and State Governments in relation to activity that is specific to each community. The CWP Chairs (in some cases, nominated representatives) are also members of the Murdi Paaki Regional Assembly. This is an unincorporated body but works to an agreed 'Charter of Governance'. The regional assembly governs in matters that are regional in nature, or to gain the benefits of economies of scale for communities⁷⁸.

MAP 2: Mardi Paaki Regional Assembly, New South Wales



3.2.4 Working with Community-Controlled Organisations and Health Services

While non-incorporated community governance bodies exist in some communities, many will be incorporated, including, but not exclusively, under the *Commonwealth Corporations (Aboriginal and Torres Strait Islander) Act (2006)*.

As illustrated by Diagram 2 below, extracted from the Australian Indigenous Governance Toolkit, the Act obliges registered organisations' governing bodies to conform to mainstream legal and other requirements while preserving Indigenous governance. Because of this, it is sometimes referred to as 'two-way governance'⁷⁹: offering the advantage of preserving Aboriginal and Torres Strait Islander community and other control within a contemporary corporate governance context. Although two way governance can be a source of tension in governance, optimally incorporation can enable the two forms of governance to co-exist without one overriding the other.⁸⁰

DIAGRAM 2: 'Two Ways Governance'⁸¹



Today over 3000 corporations exist registered under the *Commonwealth Corporations (Aboriginal and Torres Strait Islander) Act (2006)*⁸²; about one for every 250 Aboriginal and Torres Strait Islander people. They are vehicles for the governance of many areas of Aboriginal and Torres Strait Islander community life, including many health and related services. In this context, Aboriginal and Torres Strait Islander corporations can maintain their cultural legitimacy by ensuring:

- If required, the Indigenous governance (by Elders or cultural leader) of cultural programs and activities. The Aboriginal and Torres Strait Islander corporation is providing many communities with an effective vehicle for cultural and language revitalisation efforts, particularly where external sources of funding are involved and must be accounted for. In most cases today, Australian governments will only deal with Aboriginal and Torres Strait Islander communities through their corporations.
- Local Aboriginal and Torres Strait Islander communities and cultures are the starting point in the design, implementation and evaluation of services and programs provided by the corporation, rather than cultural elements being an 'added extra' in an activity run by a mainstream corporation.
- Aboriginal and Torres Strait Islander corporations can also ensure the cultural safety of the corporation and any services or programs it provides by the embedding of an Aboriginal and Torres Strait Islander worldview and culture in what the organisation does and how it operates.

The above are particularly valued in Aboriginal Community Controlled Health Services (ACCHSs). These are defined as a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.⁸³

For ACCHS, the SEWB concept is the foundational concept, and ensuring cultural safety and culturally competent service provision is a far less challenging proposition than in a mainstream organisation. Studies have found that for Aboriginal and Torres Strait Islander people, 'access to service is critical and, where ACCHSs exist, the community prefers to and does use them.'⁸⁴

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) who advise the Commonwealth Ministers for Health, Minister for Indigenous Health and Minister for Indigenous Affairs including in relation to PHN mental health and suicide prevention related activity with Aboriginal and Torres Strait Islander communities promote ACCHSs as the preferred providers of mental health and related services, including suicide prevention services, to Aboriginal and Torres Strait Islander communities as discussed in Text Box 6.

TEXT BOX 6: ACCHSs as Preferred Providers⁸⁵

A fundamental public policy principle is the need to maximise the return on investment of public funds, including in relation to health services. Yet market-based solutions (such as competitive tendering) to maximise the return on investment of public funds only work in a functioning market. In contrast, in many Aboriginal and Torres Strait Islander communities there is evidence of health services market failure.

This is indicated by the existence of a significant health gap between the Aboriginal and Torres Strait Islander and non-Indigenous population⁸⁶ much of which is attributed to lower overall access to primary health care and other service providers across both the mainstream public and private elements of the health care system, including GPs in private practice.⁸⁷ In relation to the private elements, Medicare Benefits Schedule (MBS) data that shows current Aboriginal and Torres Strait Islander population usage of private (MBS-subsidised) health services is not significantly higher than in the non-Indigenous population⁸⁸ despite having about double the health needs of the non-Indigenous population.

Aboriginal Community Controlled Health Services and Australian government-funded health services for Aboriginal and Torres Strait Islander communities that are not community controlled are, in part, a response to market failure in Aboriginal and Torres Strait Islander communities and provide health services that the market alone would not sustain. But even in Aboriginal and Torres Strait Islander communities where competitive tendering processes are possible, competitive tendering will not necessarily maximise the return on investment of public funds. Instead, they will tend to favour organisations that have the best tender application writing skills even though ACCHSs are likely to provide better return on investment:

- The limited evidence available indicates ACCHSs outperform mainstream services in recognising and dealing with chronic disease.⁸⁹
- ACCHSs provide a more accessible service by the being based in Aboriginal and Torres Strait Islander communities, and providing a culturally safe service environment and a culturally competent service experience. In contrast, other services tend to lack these community/ cultural connections that are essential for promoting access to services.

Funds to improve Aboriginal and Torres Strait Islander mental health and wellbeing and reduce suicide rates are limited, and significantly greater investment required to meet need. Adequate funding to support organisations which will struggle to be as accessible as ACCHSs, or produce equivalent outcomes to ACCHSs to Aboriginal and Torres Strait Islander communities (i.e. will not maximise return on investment) is not available.

In these circumstances, the procedure of *preferred provider* should be adopted rather than competitive tendering. By this, ACCHSs should be positioned as preferred providers, and PHN funds for mental health and suicide prevention should be allocated to ACCHSs unless it can be clearly demonstrated that alternative arrangements can produce better results in terms of i) access to services and ii) service outcomes.

Other reasons to support ACCHSs are that they are among governance bodies in Indigenous communities and, by using them, Indigenous governance is supported. Further, they provide employment to community members to support community capacity building and the economy of their communities.

An example of how Indigenous governance involving Elders and cultural leaders occurs in an Aboriginal and Torres Strait Islander corporation is provided by Case Study 3 and 4 below.

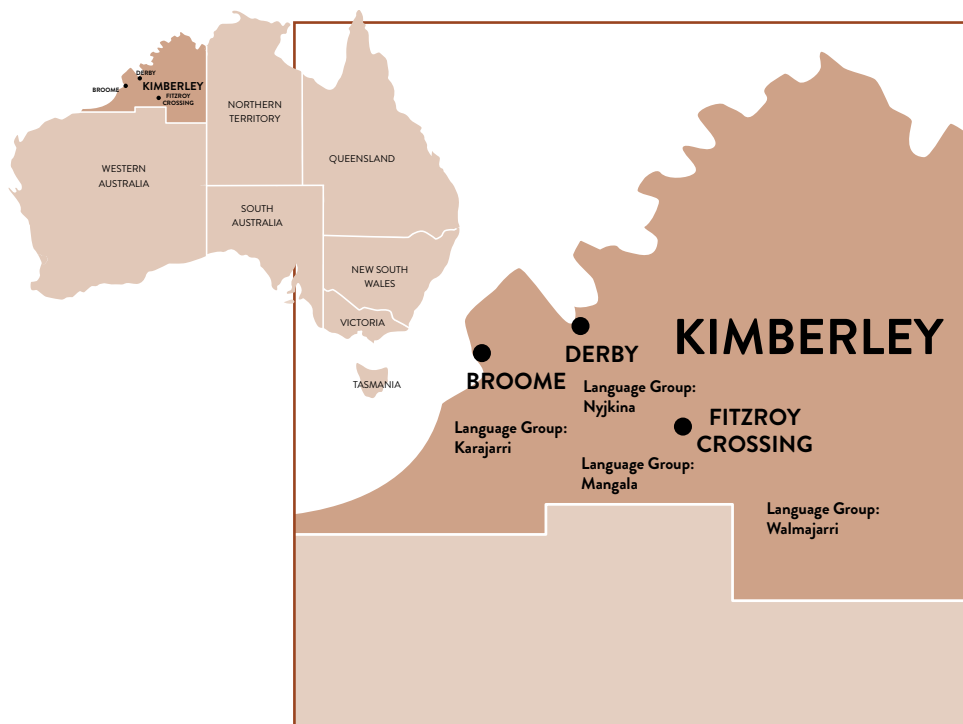
CASE STUDY 3: Kimberley Aboriginal Law and Cultural Centre: Leading Cultural and Language Renewal⁹⁰

The Kimberley Aboriginal Law and Cultural Centre exists to promote Aboriginal culture and languages across a vast region. The Board consists of 12 executive directors elected to hold office for a term of two years. In addition, six honorary life members are appointed as Special Advisors to the Board. They are not elected but are recognised as senior cultural leaders or 'bosses' in the region.

Both the Board and Special Advisors have clearly defined roles. The Special Advisors are at the heart of the organisation's work. The challenge for the Board is to ensure their steering of the organisation and its work while otherwise handling funding, relationships with funders, staff management and legal requirements associated with incorporation.

The organisation reports that having life member Special Advisors helps maintain a sense of stability and continuity despite having biannual directors' elections. Special Advisors are able to pass on their corporate and governance knowledge as well as ensuring that the accepted standards of cultural governance are observed and maintained within the organisation.

MAP 3: Kimberley Aboriginal Law and Cultural Centre, Western Australia



CASE STUDY 4: Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women's Council⁹¹

Aboriginal women of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Lands created NPY Women's Council in 1980 to give a voice as well as create a vehicle to harness the collective agency of the women. A service delivery, advocacy and support organisation, with a significant profile of advancing reform in areas they work, NPY Women's Council is governed and directed by Aboriginal women, leaders and passionate consumer advocates, from across 26 desert communities in the cross-border regions of WA, SA, and the NT.

In 1994 the Council incorporated under the federal Aboriginal Councils and Associations Act 1976 (ACA Act.) The original membership application nominated 25 women from the 'three sides' of the NPY region. In 2007 the Corporations (Aboriginal and Torres Strait Islander) Act 2006 (CATSI Act) replaced the ACA Act.

Today the organisation governs a range of activities and services around child development, youth programs, family violence, disability, traditional healing, and making practical improvements to women's lives including increased income through promoting traditional arts such as weaving. It has a multi-million-dollar budget. The collective agency combined with regular consumer advocacy is a powerful and enviable learning loop for the organisation.

From the membership, 12 directors are elected by secret ballot every two years with equal representation from each of two States and one Territory that comprise the region. Membership of the organisation is open to any Aboriginal woman who is at least sixteen years of age whom the directors consider having sufficient cultural or family ties to the region. An applicant must also be deemed by the directors to be of good character and willing to follow the rules and guiding principles of the organisation.

NPY Women's Council uses a model of working called 'malparara' (meaning 'friendship' or 'companion' or 'partnership'). Developed by senior Aboriginal women, the model invites workers to pair up to share skills, experiences and knowledge so to enhance the effectiveness of the Council's activities and services and ensures that the concerns and problems of local communities are listened to and addressed properly. The pairing up with Senior Aboriginal women and sometimes men with non-Indigenous workers, is an optimal dynamic that does deliver extraordinary experiences. The Council also recognizes the power of pairing people, with diverse skills, backgrounds and experiences, so for example two non-Indigenous workers, as another variation of the model, this pairing can also bring to the fore significant learning and insights within the service and governance model of the Council.

While the non-Indigenous partner when paired with an Aboriginal person will generally bring knowledge of how to navigate services and programs to the partnership, Malparara does not assume that mainstream ways of dealing with issues are the only or the best ways. Further, it is not aimed at 'teaching' the Aboriginal partners the skills of their non-Indigenous partner. Instead, it recognises and values the knowledge, skills and resources of local Aboriginal people as critical inputs to better activities and services, that work in a culturally appropriate and effective way.

CASE STUDY 4 CONTINUED: Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women’s Council⁹²

The work of NPY Women’s Council is an example of how Indigenous culture can go hand in hand with good corporate governance. For example, the organisation’s service development approach includes:

- *Kulilkatinyi* (considering something over a long period of time)
- *Nyakukatinyi* (looking for something as one goes along)
- *Palyalkatinyi* (making something as one goes along)

This process ensures services that are developed and delivered by the organisation are continually reviewed and improved.

The organisation’s constitution includes guiding principles for organisational, member and employee behaviour, these are:

- *Ngapartji ngapartji kulinma munu iwara wananma tjukururungku* – respect each other and follow the law straight
- *Kalypangku* – conciliatory
- *Piluntjungku* – peaceful and calm
- *Kututu mukulyangku* – kind-hearted
- *Tjungungku* – united
- *Kunpungku* – strong. [iii]

All members are invited to attend an AGM in a bush location, to receive reports from Directors and staff and to provide referrals, responses to service delivery and ongoing input on issues that affect them and their families. Members also attend an annual women only law and culture meeting organised at remote locations in the region. These gatherings provide an opportunity for women from the region to come together to celebrate and consolidate their traditional cultural practices and identity.

MAP 4: Area of responsibility Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara Women’s Council



3.2.5 Approaching Communities with Respect⁹³

A PHN should aim to understand a community's history and what might be contributing to suicidal behaviours or challenges related to suicide prior to contact. This should include an understanding any legacies of distrust following previous decades of disempowering experience of interacting with Australian governments and their agencies. This might involve employing community mentors for senior and relevant staff and to guide PHN's first steps towards engagement with communities.

In many cases, a PHN can expect Aboriginal and Torres Strait Islander community leadership, health and other bodies to be incorporated and under community control in community contexts. In this context, building CEO to CEO relationships with ACCHSs and community organisations is a good and respectful basis for establishing partnership relationships with communities. In particular, an ACCHS is likely to be both a leadership role within a community, and/or be able to connect a PHN to a community's governing body, as well as cultural healers used by the community or accepted by the community, and existing cultural and community programs.

ACCHS are also ideally placed for PHNs to partner with to support the co-design and co-implementation of integrated approaches to suicide prevention. These partnerships can then underpin and support the later exploration, installation and implementation stages of integrated suicide prevention activities.

Regardless, the governance bodies of each community should be met on their own cultural terms. It is important not to 'cherry pick' (or selectively nominate) community leaders, but to identify and work with those with genuine governance capacity and community support. Without doing so, a community's culturally legitimate governance is undermined.

3.2.6 Addressing Power Imbalances at the Community Level⁹⁴

In most cases, it will be a PHN or LHN that holds legal/administrative and financial power when working with Aboriginal and Torres Strait Islander communities. Yet, one of the main characteristics of a culturally respectful partnership is that power imbalances have been addressed by power being transferred from one party to another.

Pointers for action include:

- Agreeing to engagement protocols that include recognition of Indigenous community leadership (for example, ACCHSs or recognised governance bodies), and for working with particular Indigenous communities reflecting the diversity among them.
- Commitments from all parties to developing long-term sustainable relationships based on trust.
- Transparency about decision making.
- Contracts or agreements (to provide a sense of greater power in otherwise unequal engagements).
- Strong mutual accountability relationships in agreements and a willingness to share responsibility and accountability for shared objectives.
- Collaboratively developed criteria and indicators for annual self-assessments.
- Agreed conflict resolution processes.⁹⁵
- Practical steps such as providing places and ways for Indigenous community members people to physically come together to support Indigenous community governance activity may be an important part of an engagement agreement.

One of the main characteristics of a culturally respectful partnership is that power imbalances have been addressed by power being transferred from one party to another.

An effective way of working is by encapsulating the above in an engagement agreement. While the overall purpose of the agreement is to transfer design decision-making power and control of implementation processes to Aboriginal and Torres Strait Islander communities, the above list provides a selection of the issues that might be addressed to effect this. Further, engagement agreements and PHN and LHN working in partnership with Aboriginal and Torres Strait Islander communities should be guided by the concept of communities being supported to give their 'free prior and informed consent' to activity that affects them. These are principles that are drawn from the international human rights framework, and are designed to support community self-determination and Indigenous governance in any context. Appendix 5.2 sets out the requirements of obtaining free, prior and informed consent in an Aboriginal and Torres Strait Islander community setting.

3.2.7 Co-Design and Co-Implementation as Empowering Methodologies⁹⁶

The term 'co-design' and related thinking about design processes is being widely adopted in a number of contexts and including the mental health space. Like all services, programs and activities, those focused on mental health and suicide prevention go through an initial phase involving developmental thought processes that can be thought of as a design stage.

Co-design in this context is not a new word for consultation that occurs at the design stage, with the option to accept or ignore the opinions presented. It means involving Aboriginal and Torres Strait Islander consumers and communities in generating ideas, testing them and making decisions about how these ideas could shape responses to suicide.

The critical element is that co-design involves a shift in power, responsibility and control so that Aboriginal and Torres Strait Islander consumers and communities become active partners in designing, shaping and resourcing suicide prevention services, programs and activities rather than being passive recipients. In particular, in an Aboriginal and Torres Strait Islander context, this means ensuring the best possible local community and cultural 'fit' as opposed to a 'one size fits all' approach.

A relatively simple co-design process may mean actively incorporating the voices and experiences of service users in improving outcomes. A more radical version challenges sometimes entrenched power relationships between service providers, clients and consumers and promises to deliver entirely new models of services, programs and activities, including for Aboriginal and Torres Strait Islander suicide prevention.

The following features of co-design processes have been identified:

- Co-design processes are inclusive and draw on many perspectives, people, experts, disciplines and sectors. The idea is to find real, workable solutions to complex issues, so it is important to draw on many perspectives, to challenge entrenched thinking and to draw in other possibilities.
- Co-design is person-centred and aims to understand the experience of a service, program or activity from the consumer's or client's point of view. Co-design asks service providers and service users to 'walk in the shoes of each other' and to use these experiences as the basis of designing changes. This can include using diagrams, telling stories, and so on. Co-design processes thrive when boundaries are flexible and silos are broken down, when real listening and dialogue can occur across what were previously divides.
- Co-design starts with a desired end rather than with what is wrong with the present service. It builds backwards from the outcomes being sought. It stresses positive, open relationships among co-designers and avoids potential conflict by taking focus off the negative.
- Co-design is focused on developing practical, real- world solutions to issues facing individuals, families and communities.
- In co-design processes, service users should also have access to the information, skills, capacities and support to participate effectively in co-designing services. This can include support to attend co-design processes and even training if required.

In co-implementation, prototyping is a method of testing whether ideas work in practice, and then refining ideas until *Solutions that Work* for service users and providers alike are developed. In this way, co-implementation shares some features with Participatory Action Research or 'continuous improvement cycles' in the LifeSpan integrated approach model.

This section concludes with Case Study 5, demonstrating how stakeholders are ensuring Indigenous governance in an Aboriginal and Torres Strait Islander-specific suicide prevention trial currently underway in the Kimberley region.

CASE STUDY 5: Indigenous Governance and the Kimberley Suicide Prevention Trial sites⁹⁷

The remote Kimberley region in the north-west of Western Australia was selected as a national suicide prevention trial site (as discussed in the text) because it is challenged by some of the highest Aboriginal and Torres Strait Islander suicide rates in Australia. The trial itself operates in six towns and across three additional small and spread out remote communities.

For the Country Western Australian Primary Health Networks whose region includes the Kimberley, the focus of work in the first year of operating was to establish Aboriginal-led participatory decision-making fora for the trial. There are now levels of governance and administration across the trial site as set out in the table below. This involve from communities to a national inter agency working party?

Six Town-Based and Three Remote Community, Community-Led Project Groups

This site is operating from existing community organisations. They usually comprise of a core group of highly committed individuals who promote the activities of the trial site within the town or region and work to actively involve other community members in deliberations. The employment of part time Aboriginal community liaison officers in each location has supported efforts to engage the community and support the planning and implementation of a localised approach to suicide prevention. They work closely with the Steering Group's Project Coordinator (on the following page).

Kimberley Suicide Prevention Steering Group

Chaired by the Deputy CEO of Kimberley Aboriginal Medical Services (KAMS) with membership including the CEO of the National Aboriginal Community Controlled Health Organisation, the Poche Centre for Indigenous Health (UWA); the Commonwealth Department of Health; the Western Australian Country Health Service; the Western Australian Primary Health Association (discussed below); and the Kimberley Aboriginal Law and Culture Centre. It met fortnightly initially, but now meets monthly. The Steering Group has Secretariat support and employs a Project Coordinator position through Kimberley Aboriginal Medical Service.

Kimberley Suicide Prevention Working Group

The Working Group, co-chaired by the Commonwealth Minister for Indigenous Health and the Deputy CEO of the KAMS, includes representation from all critical partner agencies within the region and Aboriginal community leaders from the six towns in the trial site. It meets every three months.

Country WA Primary Health Network

Appointment of the Program Manager, Suicide Prevention Trials (Country), to oversee and progress the work of the two trials it is overseeing.

Western Australia is hosting three national suicide prevention trials including in the Perth South PHN region and the mid-west-region of Country WA PHN. Because of this spread of trial sites across Western Australia, the Western Australia Primary Health Alliance (WAPHA), the forum for the State's three PHNs, is also playing a support role in the trials.

Each of these levels of governance preserves Aboriginal leadership in different ways, and works in particular to ensure the place-based, community-led project groups lead the trials in each community or area. As indicated by the chart above, each acts to provide support and a foundation for community-led projects rather than a 'top down' approach.

The foundation for working with the community project groups was a community workshop open to Elders and Aboriginal community people, including those with a lived experience of suicide. These were organised by the Project Coordinator of the Kimberley Aboriginal Suicide Prevention Steering Group and aimed to identify in terms of suicide and self-harm prevention and harm reduction. The community workshops discussed:

- What was already working well
- What was not working well and the gaps
- Suggestions for what needs to happen
- Suggestions and recommendations about people who would be good to involve in public awareness prevention, harm reduction training, promotion etc.;
- A core group of community members and service providers to form town based suicide prevention networks (noting that some already existed) with representation from outlying communities; and
- A process to publicly announce the community's intention to tackle suicide.

At an early stage, WAPHA favored the State-wide adoption of the European Alliance Against Depression (EAAD) four-part integrated approach to suicide prevention and, in the course of the trials, has become the National Chapter of EAAD within Australia. Following this, a Western Australian Alliance Against Depression and Suicide was developed.

However, following feedback from community representatives in the above community workshops, and over its initial meetings, the Kimberley Suicide Prevention Working Group began to move towards the site wide adoption of integrated approaches based on the Aboriginal and Torres Strait Islander Suicide Prevention *Solutions That Work* report success factors. Community feedback suggested that such would be a better and more effective way of trialing suicide prevention initiatives in the trial site communities. Otherwise, synergies between the EAAD model and the ATSIPEP success factors were noted as the basis for continuing to work with WAPHA within an overall State-wide approach.

In the time period of just over two-years into the trial, as might be expected, different communities are working at different paces and with different results depending on the community. However, while implementation of suicide prevention activity is yet to occur in most cases, what is emerging is an empowering process by which communities in the trials are deciding upon, and culturally adapting as required, approaches to suicide prevention. They are also identifying auspicing agencies to administer the trial and hold funds.

The Steering Group has also emerged as the driving force at the regional level. It sees its role not as a decision-making body per se, but as a body whose main role is to ensure that the community project groups are in the driver's seat, and that Indigenous governance at that level is legitimate. The required endorsement of a community's plan by the Steering Group is an endorsement of process, rather than direction. The Working Group, in turn, supports that approach.

The challenges associated with hosting trials across such a vast region and across nine different communities have also become evident. Lessons learned include:

- The importance of building time into process. Changes will not happen overnight and it is important to factor in community education as a part of the process.
- In the case of a large region like the Kimberley, the impact of distance on process is a issue. In particular, the Steering Group's Project Coordinator spends a considerable amount of time travelling to meet with communities, and community liaison officers. Such travel is not only costly and wearying but consumes a significant amount of the Project Coordinator's time.
- Many communities are 'over-consulted' and cynical of the results of being consulted, having had their opinions ignored and overridden in the past. It might be preferable in this case to 'piggy back' on existing community processes rather than institute a new process for which there is little energy.
- Each community is different. While this is a common observation, the trial has noticed in particular significant differences in capacity to engage with the trials across the various sites. Often, the communities that might need suicide prevention the most are the most challenged to engages processes like the trials by the same factors that might be contributing to suicidal behaviours in the first place.

In moving forward, the Steering Group are hoping to bring the Working Group members more into the direct sphere of the trials. The former recognises that preventing suicide in the Aboriginal communities the trials operate in must include an address to social determinants: housing, employment and so on, if suicide is to be reduced in a sustainable way. The Working Group members with their access to significantly more resources and power within spheres like education and policing can only benefit the trial in that regard.

MAP 5: Kimberley Suicide Prevention Trial Site, Western Australia



3.3 Specific Activities to be Undertaken to Empower Indigenous Governance

3.3.1 Cultural Safety and Competence in Mainstream Services

As noted, the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (Cultural Respect Framework) aims to:

*support the corporate health governance, organisational management and delivery of the Australian health system to further embed safe, accessible and culturally responsive services.*⁹⁸

The *Cultural Respect Framework* is thus also important to PHNs in communities where ACCHSs are not available as a platform for integrated mental health service delivery. In such a situation, the evidence base has long recognised the importance of the cultural safety in mainstream service environments and cultural competence of the staff therein to effective service delivery:

- Culturally safe service environments are welcoming for Aboriginal and Torres Strait Islander people. It is a model of practice which respects and supports patients' identities. Markers of culturally safe environments include local Aboriginal and Torres Strait Islander Elders in advisory and governance roles, local Aboriginal and Torres Strait Islander staff working at all positions of an organisation, and artwork and posters celebrating Indigenous life and culture. Cultural safety is also important for Indigenous health workers to work effectively in mainstream health services - free from discrimination, where their Indigeneity is valued, and that at an individual level they feel secure, safe and respected.⁹⁹
- Cultural competence is the ability to understand, communicate with and effectively interact with people across cultures. It encompasses being aware of one's own world view, developing positive attitudes towards cultural differences and gaining knowledge of different cultural practices and world views. Cultural competency also requires that organisations have a defined set of values and principles, and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally.¹⁰⁰
- Further, for many Aboriginal and Torres Strait Islander people, English may not be spoken at home, or very little. For these people in service or program environments, at a minimum, translators will be required as a part of offering a culturally tailored, consumer-centred program or service.

Indeed, as noted under Priority Area 3 of the Fifth Plan:

*A lack of cultural competency and the attitudes of staff can have a significant impact on the cultural safety of Aboriginal and Torres Strait Islander consumers and co-workers, resulting in lower rates of access to services and fractured care. Cultural competence should be considered a core clinical competence capability, as it can determine the effectiveness of a service for Aboriginal and Torres Strait Islander peoples.*¹⁰¹

Further, (repeating a major message of the *Gayaa Dhuwi (Proud Spirit) Declaration*): Aboriginal and Torres Strait Islander leadership in mental health services is fundamental to building culturally capable models of care.

The overlapping of cultural and clinical competence as workforce and service standards, and the concurrent need for Indigenous governance, occurs in other contexts within the Fifth Plan as set out in Text Box 7.

TEXT BOX 7: The Fifth Plan and Areas of Overlap Between Clinical and Cultural Competence Requiring Indigenous Governance

Under Action 4, the new National Suicide Prevention Implementation Strategy is to have improving cultural safety across all suicide prevention service settings as a priority focus area.¹⁰²

- Action 12 requires health and chronic disease checks of people with mental health difficulties as standard clinical procedure. As Aboriginal and Torres Strait Islander people in the wider population report significantly higher rates of chronic disease than the non-Indigenous, this trend could broadly be expected among Aboriginal and Torres Strait Islander people with mental health difficulties. This additional disease burden only reinforces the need for clinical staff to be able to work in a culturally competent manner with Aboriginal and Torres Strait Islander people.¹⁰³
- Action 12.4 states that all staff delivering mental health services to Aboriginal and Torres Strait Islander peoples will 'be trained in trauma-informed care that incorporates historical, cultural and contemporary experiences of trauma'.¹⁰⁴
- Action 12.1(c) requires the development of 'culturally appropriate clinical tools and resources to facilitate effective assessment and to improve service experiences and outcomes.' It could be assumed that cultural competence will be needed to administer such tests, once developed, within mental health and suicide prevention services.¹⁰⁵
- Action 9, for example, requires Governments to identify pathways for Aboriginal and Torres Strait Islander people to navigate between culturally competent services. It is suggested that identifying and strengthening such pathways will need to be under Aboriginal and Torres Strait Islander control and Indigenous governance to be effective.¹⁰⁶

But as noted in relation to other areas, cultural competence and cultural safety are already required of mental health services (as health services) under the National Safety and Quality Health Service Standards. By these, the governing body of health services must ensure that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people.¹⁰⁷ Further, it must implement and monitor strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people.¹⁰⁸

In closing, when a PHN or LHN is considering reviewing the cultural safety and cultural competence of mainstream services, local Aboriginal and Torres Strait Islander communities and consumers/ people with lived experience must be in the driver's seat. Cultural competence and cultural safety must be recognised as subjective experiences that are, ultimately, 'from the eye' of the Aboriginal and Torres Strait Islander communities and consumers/ people these services work with.

Case Study 6 describes the Looking Forward Project and the process of Indigenous governance improved the responsiveness of mainstream mental health services to the needs of Nyoongar communities.

CASE STUDY 6: Looking Forward Project

The Looking Forward Project (the Project) aimed to improve the responsiveness of mainstream mental health services to the needs of Nyoongar communities in the south-east Perth metropolitan corridor from 2011 to 2015.

Participatory Action Research and Indigenous Research frameworks were utilised in the Project as both approaches are committed to empowering participants to address power imbalances.

The Project commenced in 2011 with 11 community forums during which information and data was obtained and broad themes to improve mental health service delivery identified. The Project's original intention had been to directly connect service providers with the Aboriginal community in the south-east metropolitan region. However, after the forums it was decided not to proceed immediately with this as the communities' frustration at, and distrust of, mainstream mental health providers was significant. Further work was required to establish trusting relationships in the first instance.

Four key attributes were identified by forum participants as essential to establishing trusting relationships with service staff: trustworthiness, inclusivity, reciprocity and adaptability. The next step took place in 2012 with ten small community focus group sessions to develop an appropriate service delivery model that embodied these four attributes. Aboriginal Elders endorsed this model as a starting point for engaging with local services. Service leaders and Elders came together to create a shared space through which they worked together to effect change in the mental health system.

After advice from the Nyoongar community, the Project engaged Nyoongar Elders as cultural consultants to work alongside with mental health and drug and alcohol service providers to assist them to work better with Aboriginal families by investigating factors that enable access to, and responsiveness on the part of, services. Participating services, while committed to engaging and working with the Elders, also indicated that they had no knowledge or experience in doing the 'how' for working with Elders.

Preparations for services and Elders to deepen relationships in meaningful and effective ways was the next step. These activities included trips on Country with Elders, making damper, listening to songs and stories and sharing stories so as to know more about each other. From this working together process, participants identified seven conditions to support effective engagement: being motivated, being committed, being present, being teachable, staying connected, respecting status and continually 'weaving' (developing a greater understanding of worldviews and integrating this new learning into practice) over a period of some two years.

Critical to this working together was the commitment of service partners to engage their leadership directly with Elders, *burdiya to burdiya* (i.e. boss to boss). Regular and in-depth meetings occurred over a period of two years. Service staff were supported to develop a reflective practice in order to integrate their experiential learning with the Elders into their practices. Service leaders were able to integrate their learning into the governance of their organisations, establishing mechanisms to better support cultural security across their services.

Service partners who progressed their policies and practices in a comprehensive way were able to effectively do so where they actively maintained their relationships with Elders and expanded on these relationships to better support Aboriginal staff, as well as non-Aboriginal staff. A committed focus to meaningful preparation for, and consistent and dedicated time to, meetings with Elders was key to service partners' success.

From working together, the Elders and service leaders have co-designed a comprehensive service and systems change intervention called the *Minditj Kaart-Moorditj Kaart* ('from a sick head to a good head') *Framework for Systems Change in Service Delivery* to improve the mental health and drug and alcohol service delivery outcomes for Nyoongar families, and potentially for Aboriginal families across the state.

Acknowledgements

The Looking Forward Aboriginal Mental Health Project (2011 – 2015) was funded by Lotterywest and the WA Mental Health Commission, in partnership with Ruah Community Services, the Centre for Research Excellence in Aboriginal Health and Wellbeing at Telethon Kids Institute, University of Western Australia, and the National Drug Research Institute, Curtin University. The investigators acknowledge that the project was undertaken on Wadjuk Nyoongar boodja and pay their respects to the traditional custodians of this land, in particular the Nyoongar Elders with whom they collaborated.

Project service partners included WA Mental Health Commission, Armadale Mental Health Service, WA Association of Mental Health Services, WA Network of Alcohol and other Drug Agencies, the Drug and Alcohol Withdrawal Network (St John of God Healthcare Subiaco), Palmerston Association, MercyCare, Richmond Wellbeing, Youth Mental Health Services (WA Department of Health), South East Metro Drug Service (Mission Australia), Child and Adolescent Mental Health Service (Armadale), Specialist Aboriginal Mental Health Service, and Ruah Community Services.

Wright, M, O'Connell, M, Jones, T, Walley, R and Roarty, L (2015). Looking Forward Aboriginal Mental Health Project: Final Report. December 2015. Telethon Kids Institute, Subiaco, Western Australia. ISBN 978-0-9775975-7-4.

MAP 6: Perth, Western Australia



3.3.2 Cultural and Community-Based Suicide Prevention Activity

The *ATSIPEP Solutions That Work* report identifies culture and cultural elements as success factors in Aboriginal and Torres Strait Islander suicide prevention including:

- At the universal level (defined by ATSIPEP as the community-wide level) helping to restore community wellbeing through language and cultural revitalisation and a community working to address particular challenges, such as alcohol and drug use, as primordial preventative activity. The National Empowerment Project (NEP) provides a good example of such an approach.¹⁰⁹
- Utilising culture and cultural practices in indicated and selective prevention, including by strengthening a strong sense of Indigenous ‘self-hood’ and cultural pride in young people by connecting them to Elders, culture and country and other protective factors against suicide. A good example from the *Solutions That Work* report is Red Dust Healing, a national cultural healing program working with Aboriginal male offenders and those at risk of offending. It aims to strengthen and restore an Aboriginal men’s cultural sense of identity, responsibilities, relationships and spirituality, as well as their connections to family, kin and community and other protective factors within the social and emotional wellbeing concept. The program offers an innovative approach to assisting men and women to heal and make better choices for themselves and in their relationships. Like other contemporary Aboriginal healing programs, Red Dust Healing explores the role of history and historical trauma and invokes Aboriginal culture and spirituality as core elements of the therapeutic process in an individual’s transformative journey.¹¹⁰

If a PHN is commissioning or funding interventions with cultural content at any level in partnership with an Aboriginal and Torres Strait Islander community, while oversight and risk management considerations require the PHN to ensure that legitimate Indigenous governance is in place, the actual business of governance is not, to use the language of the Fifth Plan, an ‘appropriate role or responsibility’ of the PHN. The role of PHNs in this context is therefore essentially supportive.

In practice, and as noted in *Solutions That Work*, the involvement of Elders cannot be separated from the governance and delivery of cultural elements in suicide prevention activity at any level.¹¹¹ *Solutions That Work* includes case study examples of Elder-driven, on-country healing programs to help young Aboriginal and Torres Strait Islander become stronger and think differently about themselves and their connection with culture and community. These include:

- The Yiriman Project (WA), auspiced by the Kimberley Aboriginal Law and Culture Centre, which aims to build stories in young people and keep them alive and healthy by reacquainting them with country. It hosts ‘back to country trips’ where young people, Elders, community members and stakeholder groups are brought together. Stakeholder groups include land care workers, educationalists, health practitioners, researchers and government officials. The Yiriman model provides young people with opportunities to participate more fully in life through community and other events.¹¹²
- The Warra-Warra Kanyi: Mt Theo Program, again, where Elders play an important outreach and support role, including as cultural advisors, to the Mt Theo Outstation and other Warlpiri communities and in the development of culturally relevant Warlpiri mentoring and counselling resources.¹¹³
- As part of the Mowanjum Connection to Culture program, under the guidance of Elders the Mowanjum Keeping Place and Media Project in Western Australia records stories of people, places, language and perspectives for families and language groups in the region. This activity promotes culture and law through intergenerational teaching and learning for current and future generations. Multimedia and digital archives capture storylines, songs and dance. These learning tools attract young people to the program and help them engage with culture on their own terms. Young people are also encouraged to contribute to the archives.¹¹⁴
- The Junba Project in Western Australia uses ‘Junba’, a form of storytelling through traditional song and dance. The project increases the number and scope of opportunities for young people to engage with Junba by arranging workshops that pair youth with community Elders and multimedia specialists. Junba gatherings on country are arranged in the lead-up to the annual Mowanjum Festival. During this time, Elders, parents and young people practice Junba together. Sessions are recorded for the Mowanjum archive discussed above.¹¹⁵

For PHNs, initial approaches to ensure Indigenous governance of an activity, particularly to Elders, should be made in a culturally respectful manner. For example, it is most likely to be inappropriate to send a junior male staff member, as opposed to a senior female staff member, to engage with senior community women. It may also be necessary to employ translators and otherwise consider how an Aboriginal and Torres Strait Islander person may be using English words in ways that hold different meanings to non-Indigenous usage.

Further support can be provided by:¹¹⁶

- Accessing and/or providing funding or practical support to Elders to attend governance meetings or otherwise take part in suicide prevention activity. This could include providing meeting spaces, transport, allowances and accommodation as required.
- Proactively supporting Elders more broadly. Helping support Elders groups within communities and across regions, including men’s and women’s groups.
- Recognising and remunerating Elders as an essential part of the overall social and emotional wellbeing and mental health areas workforce.
- Supporting the health and wellbeing of Elders through their wider primary health care responsibilities.

3.3.3 Cultural Adaption of Mainstream Suicide Prevention Activity¹¹⁷

Using the *LifeSpan Implementation Framework’s* terminology, the trial sites’ integrated approach plan development stage is referred to as the exploration stage. It involves PHN-Aboriginal and Torres Strait Islander community consideration of the suitability, cultural and otherwise, of ‘usable interventions’ and their possible adaptation to particular community social and cultural contexts. It ends with the adoption of an integrated approach. The risk of not doing so is that a non-adapted element or intervention might cause harm, even one that has proven successful in another Aboriginal and Torres Strait Islander community.

Indigenous governance touches on this exploration/ planning stage in two ways.

- First, at all stages of the process, community governance bodies including ACCHS where available should be able to give or withhold their 'free, prior and informed consent' before any overall system approach, or particular element or 'usable intervention' is adopted within an integrated approach. This includes being able to make conditions prior to adoption, such as for cultural adaptation, culturally aligned delivery (for example, by men for men, or women to women), delivery in language, particular mechanisms to retain community control, and so on.
- The second context is in what the *LifeSpan Implementation Framework* refers to as 'improvement cycles' applied to LifeSpan usable interventions which is contextualised here within established participatory action research (PAR) and co-implementation methodologies. The important point is to ensure the rapid refinement of interventions' in order to ensure 'fit', including cultural and experiential fit, with the needs of Aboriginal and Torres Strait Islander communities.

Perhaps the main point for PHNs and LHNs, is that PAR based refinements of interventions occurs within a culturally respectful process that acknowledges Aboriginal and Torres Strait Islander governance as a critical element.

Case Study 7 illustrates how mainstream mental health organisations can, under Indigenous governance, adapt their service delivery model to meet the needs of Aboriginal and Torres Strait Islander people.

CASE STUDY 7: headspace Inala Queensland (QLD)¹¹⁸

headspace Inala (QLD) is located in a region with a significantly large and culturally strong Aboriginal and Torres Strait Islander community. There is strong local leadership within the community from the Inala Elders. Historically, there has been a proportionally high rate of Aboriginal and Torres Strait Islander youth suicide. To ensure its accessibility to Aboriginal and Torres Strait Islander young people, headspace Inala was required to adopt a partnership approach with local Aboriginal and Torres Strait Islander communities and develop an Indigenous governance mechanism.

In addition to improving accessibility, this approach demonstrated to local Indigenous communities that the knowledge and wisdom of the community and its Elders was valued. Governance processes were designed to fit with existing community oversight structures. Taking such a governance approach also increased the commitment from the community to the project. Whilst ensuring that the service delivery and subsequent program development included the input and oversight of local Aboriginal and Torres Strait Islander community.

MAP 7: Map Inala Queensland



3.3.4 Integration of Cultural Healing into Responses

At the indicated level, cultural healers can play an important role in maintaining and healing SEWB and Aboriginal and Torres Strait Islander clients may want to choose to use a cultural healer when responding to physical and mental health difficulties, including challenges associated with suicide.

Mental health services in particular will optimally combine traditional and cultural approaches, including that provided by healers, with other clinical practices. In relation to this, Theme 1, Article 2 of the *Gayaa Dhuwi (Proud Spirit) Declaration* states that:

*Across their lifespan, Aboriginal and Torres Strait Islander people with wellbeing or mental health problems must have access to cultural healers and healing methods.*¹¹⁹

The word ‘must’ used here reflects the language of the Western Australian Mental Health Act 2014. S.7 ‘Principles’:

*A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.*¹²⁰

NATSILMH’s *Co-designing Health in Culture - Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* is a good source of guidance as to how a PHN could support access to cultural healers in this context.¹²¹

At the national level also, an approach to ensure the survival of Aboriginal and Torres Strait Islander healing traditions including the protection of Aboriginal and Torres Strait Islander intellectual property in cultural healing practices could be developed under Aboriginal and Torres Strait Islander leadership.

At the regional level, a PHN should work in partnership and to the direction of Aboriginal and Torres Strait Islander communities to ensure access to community-supported cultural healers as a part of PHN/ LHN regional mental health and suicide prevention plans. These should be contacted through Aboriginal Community Controlled Health Services (ACCHSs) or other community organisations.

As previously, if a PHN is commissioning or funding cultural healers in partnership with an Aboriginal and Torres Strait Islander community or ACCHS, while oversight and risk management considerations should ensure that legitimate Indigenous governance is in place, the actual business of governance itself is not an ‘appropriate role or responsibility’ of the PHN. Again, the role of PHNs in this context is essentially to be supportive of healers and cultural governance, rather than to be involved in governance directly. By this, a PHN might consider:

The role of PHNs in this context is essentially to be supportive of healers and cultural governance, rather than to be involved in governance directly.

- Working with local communities and ACCHSs to map the presence of locally recognised cultural healers against need and work to meet gaps as required.
- Recognising and properly remunerating healers as an essential part of the overall social and emotional wellbeing and mental health areas workforce and within the Mental Health and Social and Emotional Wellbeing Teams attached to ACCHS, as listed as a key strategy under outcomes 4.1 and 4.2 of the National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2017–2023 and illustrated in Appendix 3 of that document.¹²²
- Partnering with communities and ACCHS to establish protocols and referral pathways to healers from LHN mental health services, primary health care providers and, particularly, ACCHSs. Accessing and/or providing funding or practical support to healers to attend treatments as required.
- Supporting related capital works. This could be ensuring ‘set apart’ healing spaces are available; even the development of healing centres that service regions or communities.

Finally, a PHN should ensure that cultural healers are appropriately represented in PHN governance structures. This includes, but is not limited to, PHN Community Advisory Committees and PHN Aboriginal and Torres Strait Islander-specific advisory and action groups.

4.0 CONCLUSION

This Guide aims to support Aboriginal and Torres Strait Islander community empowerment after decades of challenge that started with colonisation and continues to this day in top down, paternalistic approaches to community development.

Such approaches challenge Indigenous governance, diminish culture; de-stabilise communities, and affect the mental health and wellbeing of community members. In particular, this Guide proposes that these approaches are both an underlying cause of suicide as an Aboriginal and Torres Strait Islander population health issue and play a role in specific causes of individual suicide deaths.

The Guide aims to counter disempowering approaches and their many impacts by focusing on and supporting Indigenous empowerment and governance as a non-negotiable element of, in particular, suicide prevention activity in Aboriginal and Torres Strait Islander communities. But more broadly, any activity that occurs in Aboriginal and Torres Strait Islander communities.

Empowerment is also key to communities' broader ability to heal, revitalise and begin deep-rooted recovery processes from colonisation. This includes in practical ways such as addressing poor quality and overcrowded housing and high levels of unemployment. Such activity while not usually thought of as 'suicide prevention' can build and strengthen protective factors against suicide.

In the context of suicide prevention activity, the Indigenous Governance Framework presented in this Guide aims to highlight particular areas where Indigenous governance must be exercised and how it can be supported. Practical ideas to support organisations working in this area are also presented in the Framework.

This Guide's foundation approach for organisations working with Aboriginal and Torres Strait Islander communities is developing whole-of-organisation commitment to working under Indigenous governance in designing and implementing suicide prevention activity and in a way that is empowering to Aboriginal and Torres Strait Islander communities.

Pointers to action include:

- Executive level-commitment to supporting and working under Indigenous governance within communities.
- A PHN should make it a priority to understand a local community's history and what might be contributing to suicidal behaviours or challenges related to suicide prior to contact. This might involve employing community mentors for senior and relevant staff and to guide PHN's first steps towards engagement with communities. Through building a relationship with the community, shared objectives can be established.
- Appointing local Aboriginal and Torres Strait Islander PHN board members who work with Aboriginal and Torres Strait Islander communities within a region to provide overarching leadership to the PHN. In many cases, Aboriginal Community Controlled Health Services' (ACCHSs) CEOs will be ideally placed for such a role.
- Ensuring that PHN Community Advisory Councils (CACs) and Clinical Councils include Aboriginal and Torres Strait Islander members with expertise in the issues impacting Aboriginal and Torres Strait Islander communities within the PHN's region and that reach into remote communities, if these are within a PHN's region.
- Ensuring that PHN boards, CACs and Clinical Councils have protocols in place to ensure the cultural safety of their Aboriginal and Torres Strait Islander members and to otherwise support them in their roles. Examples might include: adding Aboriginal and Torres Strait Islander issues, including suicide prevention, as standing items on meeting agendas that are distinct from general population concerns; ensuring that a minimum of two Aboriginal and Torres Strait Islander people are present in any fora; and providing financial or transport support to attend meetings, particularly for people from remote areas.
- Ensuring local Aboriginal and Torres Strait Islanders people are employed at all levels of a PHN's organisational structure including by direct recruitment and upskilling of existing Indigenous staff. This can provide leadership from within the organisation and help 'acculturate' the organisation and its non-Indigenous staff to not only working better with Indigenous communities, but under Indigenous governance.
- Require all non-Indigenous staff to undergo cultural competence training to understand the history, culture and other contexts within which local Indigenous communities operate in the PHN region. Preferably, this training should be commissioned from local ACCHSs or Indigenous providers.

At the regional level, PHNs, Local Health Networks (LHNs) and the Aboriginal and Torres Strait Islander communities they are working with should consider whether their partnership is best managed through a regional Indigenous Health Council under forms of governance agreed by the communities and organisations involved as members. In particular, an Indigenous Health Council can be useful to help identify regional economies of scale and provide a platform for the development and oversight of the co-design and co-implementation of regional mental health and suicide prevention plans including integrated approaches to suicide prevention that are tailored to individual community needs.

While non-incorporated community governance bodies exist in some communities, at the community level PHNs and LHNs are likely to work with Aboriginal and Torres Strait Islander corporations including Aboriginal Community Controlled Health Services operating under Indigenous governance.

In most cases, it will be a PHN or LHN that holds legal/administrative and financial power when working with Aboriginal and Torres Strait Islander communities. Yet, one of the main characteristics of a culturally respectful and community-empowering partnership is that power imbalances have been addressed by power being transferred from the PHN or LHN to the community.

An effective way of addressing such imbalances is by working with communities to strike an engagement agreement. PHN and LHN work in partnership with Aboriginal and Torres Strait Islander communities should be guided by the concept of communities being supported to give their 'free prior and informed consent' to activity that affects them. By this:

- 'Free' means that there is no manipulation or coercion of Indigenous communities or individuals and that the process is self-directed by those affected by it.
- Prior implies that consent is sought sufficiently in advance - accounting for the time taken in Indigenous governance processes.
- 'Informed' means that Indigenous communities or individuals receive satisfactory information on the key points of the project including in language if required.
- 'Consent' means a process in which consent is obtained through legitimate Indigenous governance processes and mechanisms.

The term 'co-design' and related thinking about design processes is being widely adopted in a number of contexts and including the mental health space. Like all services, programs and activities, those focused on mental health and suicide prevention go through an initial phase involving developmental and conceptual processes that can be thought of as a 'design' stage.

Co-design in this context is not a new word for 'consultation' that occurs at the design stage, with the option to accept or ignore the opinions presented. It means involving Aboriginal and Torres Strait Islander consumers and communities in generating ideas, testing them and making decisions about how these ideas could shape responses to suicide.

The critical difference is that co-design, like engagement agreements, involves a shift in power, responsibility and control so that Aboriginal and Torres Strait Islander consumers and communities are empowered as active partners in designing, shaping and resourcing suicide prevention services, programs and activities rather than being passive recipients.

Otherwise, there already exists significant guidance, directives and national standards directly relevant to supporting Indigenous governance in suicide prevention activity. In particular, the National Aboriginal and Torres Strait Islander Leadership in Mental Health's (NATSILMH) have developed a *Health in Culture: Policy Concordance* that groups and cross references policy directives and standards from a wide range of current mainstream and Aboriginal and Torres Strait Islander-specific strategic documents.

5.0 APPENDICES

5.1 Summary of Success Factors Identified by ATSIPEP¹²³

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

5.2 Free, Prior and Informed Consent

The United Nations Permanent Forum on Indigenous Issues has provided guidance as to what free, prior and informed consent means in practice as summarised below.¹²⁴

Who: Indigenous peoples should specify which representative institutions are entitled to express consent on behalf of the affected peoples or communities.

Free: No coercion, intimidation or manipulation.

Prior: Consent has been sought sufficiently in advance of any authorisation or commencement of activities and respects the time requirements of Indigenous consultation/consensus processes.

Informed: Information should be accurate and in a form that is accessible and understandable, including in a language that the Indigenous peoples will fully understand. The format in which information is distributed should take into account the oral traditions of Indigenous peoples and their languages. Information is provided that covers (at least) the following aspects:

- The nature, size, pace, reversibility and scope of any proposed project or activity.
- The reason/s or purpose of the project and/or activity.
- The duration of the above.
- The locality of areas that will be affected.
- A preliminary assessment of the... impact, including potential risks.
- Personnel likely to be involved in the execution of the proposed project (including Indigenous peoples, private sector staff, research institutions, government employees and others).
- Procedures that the project may entail.

Consent:

- As a core principle of free, prior and informed consent, all sides of the consent process must have equal opportunity to debate any proposed agreement/development/project. 'Equal opportunity' should be understood to mean equal access to financial, human and material resources in order for communities to fully and meaningfully debate in Indigenous language/s as appropriate...
- Consultation and participation are crucial components of a consent process. Consultation should be undertaken in good faith. The parties should establish a dialogue that allows them to find appropriate solutions in an atmosphere of mutual respect in good faith, and full and equitable participation. Consultation requires time and an effective system for communicating among interest holders. Indigenous peoples should be able to participate through their own freely chosen representatives and customary or other institutions. The inclusion of a gender perspective and the participation of Indigenous women is essential, as well as the participation of children and youth as appropriate. This process may include the option of withholding consent.

5.3 The Causes and Context Of Aboriginal and Torres Strait Islander Suicide Among Individuals¹²⁵

In practice, many of the challenges discussed below are extensions into the personal realm of the historical and present day collective experience discussed in the text and could as easily be considered as collective experiences of the present-day Aboriginal and Torres Strait Islander population.

• **Exposure to Stressful and Traumatizing Incidents.**

In the 2012–13 ABS *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS) 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life event(s) in the previous year. That rate is 1.4 times that reported by the non-Indigenous population. The most frequently reported stressful life events in year prior to the survey were for Aboriginal and Torres Strait Islander respondents: the death of a family member or friend (reported by 37 per cent) followed by serious illness and inability to get a job.¹²⁶

Stressful life events can cause psychological distress and trauma, and, in some cases, can overwhelm a person's resilience and ability to cope, even leading to suicide.¹²⁷

- Researchers have reported that 1.9 – 2.6 overlapping stressful life events are associated with low or moderate psychological distress, with between 3.2 and 3.6 events associated with high or very high psychological distress.¹²⁸ Further, those with high and very high psychological distress measured by the Kessler K-10 scale have been assessed by some researchers as 21 and 77 times more likely, respectively, to be experiencing suicidal ideation.¹²⁹ This is concerning because in the AATSIHS, the resilience and ability to cope of 30 per cent of Aboriginal and Torres Strait Islander respondents over 18 years of age was being challenged with high or very high psychological distress levels in the four weeks before the survey: nearly three times the non-Indigenous rate.¹³⁰
- Trauma is not a mental illness but the result of exposure to traumatic – often violent – stressful life events and can result, as discussed, in intergenerational impacts. Research indicates an association between suicide and an individual's weakened resilience and ability to cope as a result of untreated trauma. Certainly, among soldiers exposed to violence, suicide rates are significantly higher than in other population groups.¹³¹

Sources of trauma and psychological distress that might be contributing to Indigenous suicide deaths or are associated with such include:

- *Adverse childhood experiences.* All forms of child abuse are believed to significantly increase the lifetime risk of suicidal ideation and suicide attempts, in particular child sexual abuse.¹³² Young people leaving care are also reported to be at significantly higher risk of suicide.¹³³ Such highlights the need to support parental and Indigenous family strengths as a part of addressing youth suicide.
- *Racism.* The association between interpersonal and other experiences of racism and psychological distress are well documented.¹³⁴ The AATSIHS, among many other surveys, report racism to be a common experience in many Aboriginal and Torres Strait Islander people's daily lives, and is a factor that can undermine resilience and cause psychological distress. Some researchers believe that regular exposure to racism may result in traumatisation.¹³⁵
- *Lateral violence.* Lateral violence is a challenge associated with oppression. It describes the way members of groups challenged by oppression can treat each other badly including by: gossiping, jealousy, bullying, shaming, ostracism, family feuding, intra-organisation conflict and, ultimately, physical violence. It has been identified as a challenge in some Indigenous communities.¹³⁶
- *Contact with the criminal justice system.* Indigenous people now comprise over one quarter of all Australian prisoners. Incarceration can result from behaviours associated with trauma, as well as potentially exposing people to traumatising incidents. While further research is needed, a 2008 Queensland study reported 12.1 per cent of Aboriginal and Torres Strait Islander male prisoners and 32.3 per cent of female prisoners with Post-Traumatic Stress Disorder.¹³⁷ Studies have also reported stronger associations between criminal history and suicide for Aboriginal and Torres Strait Islander compared to non-Indigenous people. Pending legal issues prior to death by suicide have also been reported at elevated levels among the young Aboriginal and Torres Strait Islander men.¹³⁸
- *Relationship and related challenges.* Studies have strongly associated Indigenous suicide deaths with conflict with a partner or relationship challenges including to separation - but not at elevated levels compared to non-Indigenous suicide deaths. On the other hand, elevated rates of Aboriginal and Torres Strait Islander younger peoples' suicide deaths have been associated with family conflicts and interpersonal conflict of some kind, as well as bereavement.¹³⁹
- *Unemployment/inability to get a job.* Unemployment is associated with both Aboriginal and Torres Strait Islander and non-Indigenous suicide deaths. But because rates of Aboriginal and Torres Strait Islander unemployment are significantly higher than non-Indigenous unemployment, it is not clear whether rates of associated suicide deaths are actually elevated for Aboriginal and Torres Strait Islander people when compared to the non-Indigenous at the population level.¹⁴⁰
- **Mental Health Difficulties/Depression**

In addition to psychological distress and trauma, suicide and depression are significantly associated in studies¹⁴¹ and are likely to be so in Aboriginal and Torres Strait Islander suicide deaths. In the AATSIHS, 12 per cent of Aboriginal and Torres Strait Islander respondents reported feeling depressed or having depression as a long-term condition; compared 9.6 per cent in the total population.¹⁴²

- **Challenges Related to Alcohol and Drug Use**

Challenges related to alcohol and drug use have been associated with Aboriginal and Torres Strait Islander deaths by suicide.¹⁴³ Further, some have proposed that particular causes may be prompting impulsive suicidal reactions in Indigenous people under the influence of alcohol or drugs.¹⁴⁴ Impulsivity and its relationship to suicidal behaviours is, however, a complex issue that cannot be simply attributed to alcohol and drug use; and Indigenous suicide deaths should not be described as impulsive overall. Research suggests that many Indigenous suicide deaths involve premeditation with alcohol used to assist.¹⁴⁵

- **Access to Mental Health, Health and Related Services According to Need**

An important part of Aboriginal and Torres Strait Islander suicide prevention is access to mental health, health and related services. Of particular concern, is that an Indigenous person whose resilience and coping ability is challenged, and who may be in suicidal ideation, is less likely to be able to access the mental health services they need than a non-Indigenous person in the same position.

Access is particularly important to people who have already attempted suicide. People who have already attempted suicide are considered to be at the highest risk of suicide (at up to 40 x increased risk) than any other population group. Further increased risk is related to the recency of a previous attempt, the frequency of previous attempts, and isolation.¹⁴⁶

There is also evidence to support the proposition that greater numbers of Aboriginal and Torres Strait Islander people who later died by suicide were unable to (or otherwise did not) access support and/ or services immediately prior to their deaths when compared to non-Indigenous people in the same position.¹⁴⁷ Lower access and use of mental health services in general is also reported in the AATSIHS. In this, only about one in four (27 per cent) of the Aboriginal and Torres Strait Islander adults with high/ very high levels of psychological distress (as discussed, a known risk factor for suicide) had seen a health professional in response in the previous 4 weeks.¹⁴⁸

- **Suicide clusters**

Suicide clusters need to be mentioned as some researchers have reported that among Aboriginal and Torres Strait Islander suicide cases imitation, normalisation and even glamorisation of suicidal behaviours appears to play an elevated role when compared to non-Indigenous cases. At times, factors that can increase the risk of suicide as an option for Aboriginal and Torres Strait Islander young people are considered to include:

- viewing suicide as a way to end psychological pain;
- the desensitisation of young people towards death and suicide;
- the visibility of suicides occurring in the communities;
- and/or communication about these deaths via media or word of mouth.¹⁴⁹

It should be stressed, however, that imitative suicidal behavior is not unique to Indigenous communities. Internationally, it has been estimated that between one and five per cent of all suicides by young people occur in the context of a cluster.¹⁵⁰ While most commonly documented in Aboriginal and Torres Strait Islander communities in Australia, it is also occurring among the non-Indigenous population.¹⁵¹

The prevalence and reasons for suicide clusters require further research for the phenomena to be properly understood in an Aboriginal and Torres Strait Islander context. At present, the risk of suicide clusters is already being addressed through postvention and responses to suicide or traumatic crisis, and are likely to be an important part of integrated approaches to suicide prevention in Aboriginal and Torres Strait Islander communities.

headspace School Support have also created some useful fact sheets on Aboriginal and Torres Strait Islander suicide, including one on suicide clusters in Aboriginal and Torres Strait Islander communities.¹⁵²

5.4 Executive Summary From Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities: A Guide for PHNs

A summary table of pointers for action with reference to the above.

How to engage	
Organisational readiness to engage	<ul style="list-style-type: none"> • Appoint local Indigenous PHN board members who work with Indigenous communities within the region to provide overarching technical and adaptive leadership. In many cases, Aboriginal Community Controlled Health Services CEOs will be ideally placed for such a role. • Ensure that Community Advisory Councils (CACs) and Clinical Councils include Indigenous members with expertise in the issues impacting communities within the PHN region, and that have the capacity to reach into remote communities if relevant. • Ensure that PHN boards, CACs and Clinical Councils have protocols in place to ensure the cultural safety of their Indigenous members and to otherwise support them. Examples might include: adding Indigenous issues, including suicide prevention, to meeting agendas as standing items that are distinct from general population concerns; ensuring that a minimum of two Indigenous people are present in any fora; and providing financial or transport support to attend meetings, particularly for people from remote areas. • Ensure that CACs develop an overarching Indigenous community engagement strategy that is designed, delivered and evaluated under Indigenous leadership. • Ensure Indigenous people are employed at all levels of a PHN's organisational structure, including by direct recruitment and upskilling of existing Indigenous staff. This can provide technical and adaptive leadership from within the organisation and help acculturate the organisation and its non-Indigenous staff to work better with Indigenous communities. • Employ Indigenous community mentors for senior and relevant staff and to guide organisational engagement with communities. • Require all non-Indigenous staff to undergo cultural capacity building to understand the history, culture and other contexts within which local Indigenous communities operate in the PHN region. Preferably, this training should be commissioned from local ACCHSs or Indigenous providers. • Aim to understand a community's history and what might be contributing to suicidal behaviours or challenges related to suicide prior to contact. Understanding a community's history at least in broad terms might include understanding any legacies of distrust following previous decades of experience of interacting with Australian governments and their agencies, not all of which may have been positive.
Supporting an Indigenous Health Council	<ul style="list-style-type: none"> • Appoint an Indigenous Health Council within the PHN/organisation structure. This could be as a Community Advisory Committee subcommittee or as a standalone body. Such Councils can provide a collective point of contact including for (but not limited to) the development of regional Indigenous mental health and suicide prevention plans that incorporate integrated approaches to suicide prevention. Cross membership between an Indigenous Health Council, a PHN Board and other organisation structures can help ensure the integration of the former into the work of the PHN, and into all levels of a PHN's structure. • Fund and otherwise support member attendance at Indigenous Health Councils. • Appoint members with lived experience of suicide to the Indigenous Health Council and otherwise as appropriate within the organisation.
Approaching communities	<ul style="list-style-type: none"> • Be proactive – reach out to Indigenous communities rather than waiting to be contacted. Early and frequent engagement and time should be allowed for the development of trusting and open relationships at both the interpersonal and organisational level. • As a starting point, build CEO to CEO relationships with local Aboriginal Community Controlled Health Services (ACCHSs) and community organisations as the basis for exploration work. Where they exist, an ACCHS is likely to occupy a leadership role within a community, or be able to connect an organisation to a community's governing body. They are also ideally placed to support the co-design and co-implementation of systems approaches to suicide prevention in partnership with PHNs. These partnerships can then underpin and support the later exploration, installation and implementation stages of integrated suicide prevention activities. • Ascertain whether language barriers may exist and employ translators if necessary.

Engagement agreements

- Agree on engagement protocols that include recognition of Indigenous community leadership (for example, ACCCHSs or recognised governance bodies), and enable work with particular Indigenous communities reflecting the diversity among them.

These could include:

- commitments from all parties to developing long-term sustainable relationships based on trust
- transparency about decision making
- contracts or agreements (to provide a sense of greater power in otherwise unequal engagements)
- strong mutual accountability relationships in agreements and a willingness to share responsibility for shared objectives
- collaboratively-developed criteria and indicators for annual self-assessments
- agreed conflict resolution processes
- practical steps, such as providing places and ways for Indigenous community members people to physically come together to support Indigenous community governance activity, may be an important part of an engagement agreement.

Co-exploration: identifying challenges, gaps and resources

Involving relevant stakeholders

- Stakeholders working in Indigenous suicide prevention must have the capacity to inform and support or contribute to the implementation of an integrated suicide prevention approach in a community setting.

A stakeholder group may include representatives from the following community groups:

- Community governance bodies and recognised local leaders
- Elders and elders' groups
- Men's and women's groups
- Community members with lived experience of suicide, including family, friends and carers
- Aboriginal Community Controlled Health Services
- Existing suicide prevention programs
- Postvention and crisis response services
- Other Aboriginal and Torres Strait Islander community organisations
- Relevant local and regional programs, such as the National Empowerment Project
- Local media
- Aboriginal and Torres Strait Islander health workers

It may also include representatives from the following local or even regional services:

- Mental health services
- Local hospitals
- headspace
- Psychology and psychiatry services
- General practice and allied health services
- Social work, mental health and counselling services
- Link Up workers
- Police and other emergency services
- Child and maternal health services
- Alcohol and other drug rehabilitation services
- Disability, environmental health, education, employment, training, housing, justice, family and community services.

Suicide audit

- Be flexible about what constitutes 'data' that will drive data-driven decision making. In an Indigenous community context, a focus on deaths deemed as suicide by coronial inquest that excludes anecdotal reports and community identification of suicide deaths may be counterproductive. Some commentators believe that suicide is significantly unreported in Indigenous communities. This underscores the need for suicide audits to also occur under community leadership if an accurate foundation picture for suicide prevention activity is to be established.

<p>Service gap analysis</p> <p>ACCHSs</p>	<p>Review whether ACCHS offer, or coordinate, integrated:</p> <ul style="list-style-type: none"> • physical health, social and emotional wellbeing (SEWB) support, primary mental health care, alcohol and drug treatment and suicide prevention services • general-practitioner-provided medical care, including pharmacotherapies of all types • psychological care from a range of mental health professionals, including counsellors • social and cultural support, including long-term, community-based case management when needed.
<p>Service gap analysis</p> <p>Culturally respectful mainstream services</p>	<ul style="list-style-type: none"> • Reviews of mainstream services must be community led. In addition to capacity review (as for ACCHSs above), while cultural competence staff training and so on should be considered, cultural competence and cultural safety must be recognised as subjective experiences that are owned by the Indigenous consumers and communities these services work with.
<p>Service gap analysis</p> <p>General</p>	<p>When reviewing services, ask:</p> <ul style="list-style-type: none"> • Are services trauma informed, as indicated by the Closing the Gap Clearinghouse paper: Trauma-Informed Services and <i>Trauma-Specific Care for Indigenous Australian Children</i>? • Are services' time protocols adequate to meet the needs of people who have attempted suicide or who are at risk of suicide? • Do services offer postvention support?
<p>Workforce review</p>	<p>As with all elements of implementation, a workforce-population ratio appropriate to the community or region in question must be developed with full community participation.</p> <p>When reviewing workforce, ask:</p> <ul style="list-style-type: none"> • Are there enough mental health professionals and related workers to meet the needs of Indigenous communities? If not, why? What is the shortfall? • What is the presence of Indigenous community members in services? If there a sufficient presence? If not, why? What is the shortfall? • Are Elders and peers employed? If not, why?
<p>Community readiness</p>	<ul style="list-style-type: none"> • Community governance bodies should utilise their own methods of decision making when assessing the readiness of the communities they serve. • Particular challenges may need to be addressed before the adoption or within the context of an integrated approach to suicide prevention. • If a community is not ready for a systems approach to be adopted, this may be because it needs support to understand the relevance of the approach, or how it might be of benefit. Community education about SEWB, mental health and suicide prevention may play an important role in this context. • Cultural resources and strengths, such as Elders, men's and women's groups, cultural healers, cultural practices and so on, should be assessed as part of a broader review of suicide prevention resources.

Co-designing and adopting an integrated approach

Questions to ask

The LifeSpan Implementation Framework suggests asking communities the following questions to help guide the co-design and adoption process:

- What is the problem your community aims to solve by implementing an integrated model of suicide prevention?
- What are the outcomes you want to achieve by implementing an integrated model of suicide prevention?
- Is it LifeSpan as a whole that is of interest to you, or only parts of it?
- Which agencies in your community will be implementing an integrated model of suicide prevention?
- How will an integrated model of suicide prevention be funded, both in the short term of two years and beyond?
- What sort of organisational or agency support is required for your site to successfully implement an integrated model of suicide prevention (e.g. support from schools, social service agencies, GP clinics, etc.)?
- What are the potential barriers within your community or participating organisations that may hamper the implementation of an integrated approach to suicide prevention?
- For how long can you commit to implementing an integrated model of suicide prevention?

Co-installation and co-implementation

Installation

- Indigenous community leadership and 'ownership' of multi-agency governance groups and their activities is essential for the successful delivery of systems approaches across regions. Community leadership and direction in multi-agency governance group activity at the community level will, similarly be key to the success of installing and implementing in communities.

Implementation

- When commissioning elements of integrated approaches, a PHN should aim to employ local and community people as much as possible.
- Where service gaps are identified and when commissioning suicide prevention activity, a PHN should aim to build community capacity (including ACCHS and other community-controlled organisational capacity) as much as possible, including as an important part of committing to the empowerment of communities in the context of suicide prevention.
- An effective way of exploring potential untested elements in any integrated approach is by Participatory Action Research (PAR) methodologies.
- PAR-based evaluations and processes should be disseminated to help build an increasing evidence base for Indigenous systems approaches to suicide prevention and suicide prevention in general, and should support the expansion of integrated approaches to suicide prevention in Indigenous communities across Australia.

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