

*We are not the problem,  
we are part of the solution:*  
Indigenous Lived Experience Project Report

Professor Pat Dudgeon, Leilani Darwin, Tanja Hirvonen, Maddie Boe, Rebecca Johnson,  
Rowena Cox, Lionel Gregory, Raeylene McKenna, Vicki McKenna, Donna Smith, Julie Turner,  
Steffanie Von Helle and Lilya Garrett

*we're always left high,  
and just floating around  
like little lost leaves*

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we are part of the solution:*  
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The Centre of Best Practice in  
Aboriginal and Torres Strait  
Islander Suicide Prevention



**Black Dog  
Institute**

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AUSTRALIA**

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Indigenous Health

Aboriginal and Torres Strait Islander readers are advised that this publication may contain information on deceased persons.

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# Executive Summary

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In the past fifty years, Indigenous<sup>1</sup> suicide has emerged as an area of increasing concern across Australia, with Indigenous Australians being more than twice as likely to die by suicide than non-Indigenous Australians (ABS, 2018). There is also increasing attention towards understanding the perspectives and experiences of people who survive a suicide attempt and people who have been bereaved by suicide. These experiences are commonly referred to as lived experience. Lived experience organisation Roses in the Ocean define lived experience as *having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has been suicidal or been bereaved by suicide* (Roses in the Ocean, 2018).

In June 2018, the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATISIP) facilitated a workshop to investigate Aboriginal and Torres Strait Islander lived experiences of suicide. The aims of the workshop were to ensure the meaningful inclusion of Aboriginal and Torres Strait Islander peoples in an overall Lived Experience Project (the Project). Information was sought about possible differences regarding the lived experience of Aboriginal and Torres Strait Islander peoples to that of the non-Indigenous population. Another aim was to examine the need for a specific Aboriginal and Torres Strait Islander lived experience definition and network.

The workshop sought to involve Aboriginal and Torres Strait Islander peoples from across Australia, however, most workshop participants were from Western Australia, Queensland, or the Northern Territory. The workshop was co-hosted by the Black Dog Institute and was held in Perth, Western Australia. Ten participants attended from diverse backgrounds, as well as organisational representatives from Roses in the Ocean and Black Dog Institute, three co-facilitators, including an Aboriginal psychologist and staff from the CBPATISIP. All participants and co-facilitators are Indigenous Australians.

The workshop showed that the lived experience of Aboriginal and Torres Strait Islander peoples was different to others. Aboriginal and Torres Strait Islander lived experience is contextualised within a history of colonisation that has resulted in disadvantage, racism, lack of acknowledgement of cultural differences and exclusion.

Specific outcomes from the workshop showed that there was urgent need for the provision of culturally appropriate services and responses to Indigenous suicide prevention. In particular, this involved the prioritisation of Indigenous understandings and practices of wellbeing and healing, particularly in relation to suicide prevention. Further, participants emphasised the importance of local solutions, including capacity building within communities and organisations, being culturally informed and guided by Aboriginal and Torres Strait Islander peoples with lived experience. Alongside increasing the effectiveness and appropriateness of programs and services, prioritisation of local solutions was promoted as a means of increasing self-determination and empowerment for Aboriginal and Torres Strait Islander peoples and communities. Participants agreed that although there are unique and complex differences between the experiences of those from different groups, the significant overarching commonalities of Aboriginal and Torres Strait Islander peoples' lived experiences of suicide emerged as a fundamentally shared cultural experience. These lived experiences of Aboriginal and Torres Strait Islander peoples were different to that of mainstream lived experience.

The following themes emerged from the workshop:

- The Need for an Indigenous Lived Experience Definition and Network
- The Need for Self-Determination
- Experiences of Grief and Loss

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<sup>1</sup> The terms 'Aboriginal', 'Aboriginal and Torres Strait Islander' and 'Indigenous' are used interchangeably. It is acknowledged that there are many cultural differences between and within Aboriginal and Torres Strait Islander communities and the use of differing terms does not intend to disregard such differences.

- Experiences of Racism and Trauma
- Lack of Appropriate Services and Responses
- Isolation, Discrimination, and Racism in Mainstream LGBTIQ+ Services: Prioritising Engagement of Indigenous LGBTIQ+SB Peoples and Communities
- Hope for the Future

Participants described grief and loss as not only about the loss of loved ones but also about grief and loss of country and culture. A lack of recognition and appreciation by non-Indigenous organisations of this grief and loss was highlighted as a barrier to effective service provision and a contributing factor to compounding trauma. Increasing non-Indigenous organisations' awareness and education around cultural responsiveness was promoted as a means to reducing such barriers and trauma. The unique experiences of Indigenous LGBTIQ+SB participants around racism and exclusion within mainstream LGBTIQ+ services constituted compounding trauma and undermining of self-determination. The discussions led to recommendations of increased visibility and presence of LGBTIQ+SB Indigenous peoples in all relevant decision-making forums at every level.

This report and associated publications intends to present specific insights from Aboriginal and Torres Strait Islander lived experience. This could lead to positive and culturally responsive change by providing government and organisations with specialised information. Despite the everyday adversity that Aboriginal and Torres Strait Islander communities face, all participants highlighted the strengths and resilience of Aboriginal and Torres Strait Islander peoples and communities. Building upon these strengths is recognised as crucial in working towards a more positive and hope-filled future.

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# Lived Experience Project Background

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In the last fifty years, suicide has emerged as a major cause of premature Indigenous mortality and has major implications for the overall social and emotional wellbeing of communities. In 2017, suicide was the second leading cause of death for Indigenous men, and the seventh leading causing of death for Indigenous women (ABS, 2018). Within Indigenous populations, there are particular groups that are even more vulnerable, including children and young people (National Children’s Commissioner, 2014), members of the LGBQIQ+SB community, and individuals that have been in contact with the justice system. Furthermore, the majority of Indigenous people who die by suicide are men, but there is an ongoing concern for the increasing number of Indigenous women who die by suicide (ABS, 2018).

In 2015, as part of the response to increasing numbers of Aboriginal and Torres Strait Islander peoples dying by suicide, the Australian Government Department of Prime Minister and Cabinet funded the School of Indigenous Studies at the University of Western Australia (UWA) to undertake the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP). The work of ATSISPEP was informed by the first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (NATSISPS) (Department of Health and Ageing [DoHA], 2013) and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017 – 2023* (the MHSEWB Framework) (Commonwealth of Australia [CoA], 2017). The aim of ATSISPEP was to build an evidence base for Indigenous specific and strengths-based suicide prevention programs and policies. ATSISPEP conducted 12 Indigenous roundtables around Australia, undertook a comprehensive literature review on community-led Indigenous suicide prevention, reviewed evaluated programs and services for suicide prevention, and analysed 69 previous consultations on Indigenous suicide prevention. This work culminated into the landmark report *Solutions That Work: What the Evidence and Our People Tell Us (Solutions that Work)* (Dudgeon et al., 2016). The report documented successful and effective approaches to reducing suicide rates amongst Indigenous Australians. The ATSISPEP work is being continued through the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP).

The CBPATSISP was one of several national initiatives established to support and work with Primary Health Networks (PHNs) to address suicide. The CBPATSISP consortium partners include the Healing Foundation, Telethon Kids’ Institute, HealthInfoNet, and the Menzies School of Health Research. The overall objectives of the CBPATSISP are:

- Identifying the need for and facilitating innovative new research (including evaluations of unevaluated activity) to support the further identification of Indigenous best practice;
- Assessing best practice by Primary Health Networks (PHNs) in planning and commissioning Indigenous suicide prevention activities;
- Working to translate best practice for application in Indigenous communities, community organisations, and by PHNs. This includes developing accessible and appropriate guidance and resource materials;
- Developing an Indigenous-specific adaptation of the systems approach (e.g. European Alliance Against Depression model) to suicide prevention, based on identified best practice, and aligned with the current overarching approach; and
- Proactively promoting and disseminating best practice research to ensure accessibility for all stakeholders. Such dissemination includes establishing a research/evaluation directory (clearinghouse). This would include the above being accessible through a website. National conferences also enable effective promotion and dissemination of relevant research and the creation of a responsive education/guidance program tailored to stakeholder needs.

The CBPATSISP also has a partnership with the Black Dog Institute and will undertake a number of activities to support the National Suicide Prevention Trials. These include:

- Ongoing advice and engagement on supporting the national suicide prevention trial sites;
- To develop an overarching Implementation Guide for a systems-based approach for Aboriginal and Torres Strait Islander communities;

- An Indigenous Governance Framework;
- Workshops and a report to develop an Aboriginal and Torres Strait Islander Lived Experience Framework; and
- An Indigenous LGBTIQ+SB<sup>2</sup> Position Paper

## Lived Experience Project

Currently, the CBPATISIP uses the Roses in the Ocean definition of lived experience:

Roses in the Ocean define lived experience as *having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has been suicidal, or been bereaved by suicide* (Roses in the Ocean, 2018).

## The Inclusion of the Perspectives of Lived Experience Experts

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) provided a comprehensive basis for the need for the workshop and overall Project focusing on lived experience perspectives. ATSISPEP findings and recommendations show that mental health and suicide prevention activities need to be owned by Indigenous people, be culturally informed, and be led by the community. Aboriginal and Torres Strait Islander communities must be the drivers of identifying their needs and leading localised solutions. It is therefore critical to involve Indigenous peoples with lived experience of suicide in relevant program development, informing policy agendas and Indigenous governance, to ensure the best outcomes for communities. ATSISPEP outcomes, including both the final report *Solutions that Work: What the Evidence and Our People Tell Us (Solutions That Work)* (Dudgeon et. al., 2016) and the *National Empowerment Project Cultural, Social, and Emotional Wellbeing Program Evaluation 2014 - 2017* (Mia & Oxenham, 2017), led the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATISIP) and the Black Dog Institute to establish the process for Aboriginal and Torres Strait Islander Lived Experience Project (the Project).

The Project employed a participatory action research (PAR) approach that was integral to its success. Aboriginal researchers and facilitators led the Project, ensuring shared values and cultural understandings with participants throughout the various stages of the Project. In a PAR process, the connections between the Aboriginal researcher(s) and the Aboriginal community are inseparable (Dudgeon, Scrine, Cox & Walker, 2017). Research is determined in the first place from community needs, the design and outcomes are from Indigenous perspectives and outcomes are validated back to community, who check the accuracy and appropriateness of the Project to ensure its integrity. At every stage, activities are founded on a process of Aboriginal-led partnership and collaboration between researchers and Aboriginal participants. Therefore, research outcomes and recommendations, guided by meaningful and genuine collaboration with Indigenous peoples with lived experience, contribute to closing the gap in existing knowledge regarding culturally appropriate suicide prevention. Whilst this Project encourages the meaningful involvement of lived experience experts<sup>3</sup>, it is crucial that such involvement is responsible. This refers to service providers remaining mindful of their duty of care to ensure that the safety and wellbeing of lived experience experts are not harmed by their participation.

The Project examined the needs for a specific Aboriginal and Torres Strait Islander lived experience definition and network. One of the aims of the Project involves investigating Aboriginal and Torres Strait Islander

2 LGBTIQ+SB stands for Lesbian, Gay, Bisexual, Transgender, Intersex, Queer plus Sistergirl and Brotherboy. The Lived Experience Project has chosen to utilise this acronym in the report to ensure inclusivity and cultural responsiveness, after consultations with Tekwabi Giz. In addition to the mainstream LGBTIQ acronym, the inclusion of +SB represents Sistergirl and Brotherboy identities. Sistergirl and Brotherboy are terms used to describe being trans, in a way that is still inclusive of peoples' Indigenous identity and recognises the additional cultural aspects of gender. These are accepted terms in the Indigenous community, with Sistergirl referring to Aboriginal and Torres Strait Islander transgender women, and Brotherboy referring to Aboriginal and Torres Strait Islander transgender men.

3 Within the context of this Project, the phrase 'lived experience expert' refers to any Indigenous person with lived experience of suicide (survivors and/or bereaved). The Project refers to participants and other peoples with lived experience as 'experts' because Indigenous peoples are the experts about their own lives and culture. Indigenous lived experience experts have firsthand experience about suicide and have unique insights and knowledge.



peoples' lived experience of suicide, in order to ascertain if and how these experiences differ from the lived experience of the mainstream population. The CBPATISIP hosted a workshop on June 29<sup>th</sup>, 2018, that brought together ten lived experience experts and three organisational representatives, to discuss their perspectives on best practice when working with Indigenous peoples in suicide prevention. Organisational representatives shared their knowledge and experiences around suicide prevention and helped to provide participants with a broader context of the mainstream suicide prevention and lived experience sectors. However, the roles of these representatives were more observational in nature to reinforce the prioritisation of Indigenous participants' voices.

The workshop with Indigenous lived experience representatives from across Australia was in conversations with Roses in the Ocean and the Black Dog Institute.

The purpose of the workshop was to recognise what communities need to assist them in reducing the causes, prevalence, and impacts of suicide, and to hear lived experiences about suicide prevention services and programs to help verify understandings of what works and why.

The workshop enabled the Project to:

- Gain increased understandings of the unique expertise of peoples with lived experience of suicide;
- Listen to diverse experiences from lived experience experts and learn about peoples' interactions with current/previous suicide prevention programs and services and other relevant organisations (eg. Coroner's office, police, hospitals) to further identify the elements of these programs and services which constitute best practice;
- Identify programs, or other experiences, that had a positive impact and were perceived by Aboriginal and Torres Strait Islander peoples to be effective; and furthermore, to seek lived experience perspectives about what might be required to encourage and support these programs in their continued implementation; and
- Determine changes required for programs, services, and aligned organisations.

The outcomes of the workshop have reinforced initial findings of the literature review and demonstrate the complex issues unique to Aboriginal and Torres Strait Islander lived experience of suicide, as well as the diverse and unique experiences of vulnerable groups within the Aboriginal and Torres Strait Islander community (for example, people who identify as LGBTIQ+SB).

## **Lived Experience Background**

The aims of this Project were to identify the major issues of concern for Aboriginal and Torres Strait peoples with lived experience, about Indigenous suicide prevention in Australia. Lived experience expertise has emerged as an important inclusion to policy and program delivery in suicide prevention.

Contributions are organised around themes that emerged from different experiences of Aboriginal and Torres Strait Islander suicide, that included the perspectives of survivors, bereaved, and those working in the suicide prevention and/or mental health space. The workshop facilitators worked in partnership with participants, to ensure that they were informed of the Project objectives and to validate their contributions from an Aboriginal and Torres Strait Islander lived experience perspective. This process is vital as it recognises participants as experts in their lived experience and ensures that their voices are heard within the Aboriginal and Torres Strait Islander community, and the broader Australian community. The process is valuable for a number of purposes:

- To ensure that the voices of Aboriginal and Torres Strait Islander peoples with lived experience are valued and present;
- To ensure ownership of the issues;
- To ensure that new insights from Aboriginal and Torres Strait Islander communities on suicide prevention are recognised; and
- To connect the voices of Aboriginal and Torres Strait Islander communities directly to evolving policy on suicide prevention when possible and appropriate.

## Policy Background

The Project is premised upon a number of significant national policies. These are outlined below. The workshop was conducted consistent with the ethical principles of the National Health and Medical Research Council (NHMRC), which is concerned with promoting the health and wellbeing of Indigenous Australians. The NHMRC promotes six core values that guide ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities. These six values are:

- Spirit and Integrity;
- Cultural Continuity;
- Equity;
- Reciprocity;
- Respect; and
- Responsibility.

The values seek to ensure that the research conducted with and for Aboriginal and Torres Strait Islander peoples:

- Respects the shared values of Aboriginal and Torres Strait Islander peoples;
- Remains relevant in terms of needs and aspirations of Aboriginal and Torres Strait Islander peoples;
- Promotes the development of ethical and long-term relationships among researchers, institutions and sponsors; and
- Develops the best practice ethical research standards.  
(NHMRC, 2018)

### **National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (the MHSEWB Framework)**

The principles of the MHSEWB Framework are based on a platform of human rights, recognising the effects of colonisation, racism, stigma, environmental adversity, as well as cultural, intergenerational, and individual trauma (CoA, 2017). The MHSEWB Framework recognises self-determination as essential to the provision of Aboriginal and Torres Strait Islander health services (CoA, 2017). Aboriginal and Torres Strait Islander health is viewed holistically, acknowledging the diversity within and between Aboriginal and Torres Strait Islander identity and culture, with a strong emphasis on family, kinship, community, and connection to land as central components to wellbeing (CoA, 2017).

### **The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS)**

The NATSISPS provides a framework for Indigenous-specific responses to suicide that acknowledge Indigenous differences within experience and culture, to promote respectful responses from the general population (DoHA, 2013). This strategy includes building the capacity of Aboriginal and Torres Strait Islander communities, building strengths and resilience in individuals and families, targeted suicide prevention services, coordination of approaches to prevention, building the evidence-base and disseminating information, and obtaining high standards and quality in suicide prevention (DoHA, 2013).

The NATSISPS (DoHA, 2013) and the MHSEWB Framework (CoA, 2017) are based on collaboration and consultation with representatives from Aboriginal and Torres Strait Islander communities. The values and themes shared by these initiatives that are considered as essential for the implementation of effective programs and services include:

- Acknowledgement of trauma as a significant element of ongoing mental health issues for some individuals, families and communities;
- The need for cultural relevance in the development and implementation of programs;

- Self-determination in the development and delivery of suicide prevention and related mental health programs;
- The need to centralise research and build a strong, coherent knowledge base on Aboriginal and Torres Strait Islander suicide prevention; and
- The necessity of understanding the holistic physical, mental, social and spiritual approach to Aboriginal and Torres Strait Islander suicide prevention within the communities (CoA, 2017; DoHA, 2013).

## Aboriginal and Torres Strait Islander Suicide Statistics

According to the Australian Bureau of Statistics, 165 Aboriginal and Torres Strait Islander people died from suicide in 2017 (ABS, 2018). The standardised death by suicide rate for Aboriginal and Torres Strait Islander peoples was 25.5 deaths per 100,000 persons, a slight increase from 25.1 in 2016 (ABS, 2018).

**Age-specific rates for intentional self-harm, by Indigenous status, 2013-2017 (a)(b)(c)(d)**

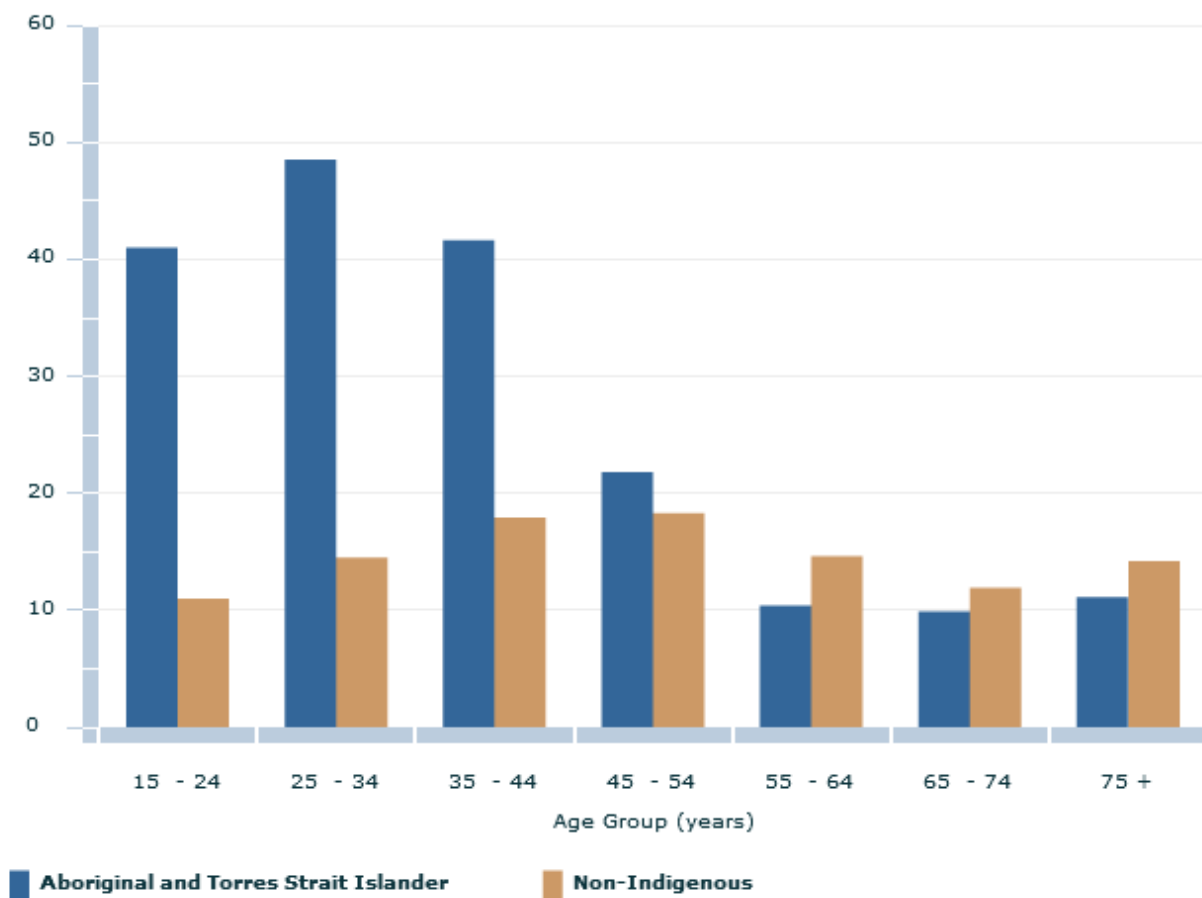


Figure 1: Age-Specific Death Rates for Intentional Self-Harm, by Indigenous Status (ABS, 2018).

In 2017, intentional self-harm (suicide) was identified as the leading cause of death for Aboriginal and Torres Strait Islander peoples aged between 15 – 34 years. The age-specific death rate for this group was 47.2 per 100,000 persons with rates of death by suicide over three times that of non-Indigenous Australians (ABS, 2018). This age group accounted for 67.3% of all Indigenous deaths by suicide and reinforces the need for suicide prevention strategies to be relevant for Indigenous young peoples (ABS, 2018). The highest age-specific rate in 2017 was seen in the 25 – 34 year age group, at 52.5 deaths per 100,000 persons (ABS, 2018).

## Aboriginal and Torres Strait Islander Children and Young People

Youth are identified as a high-risk group, with suicide remaining the leading cause of death for Aboriginal and Torres Strait Islander peoples in the age group 5-17 years (ABS, 2018). Indigenous young peoples aged 15 – 17 years accounted for 94.4% of all suicide deaths in young Indigenous peoples (5 – 17 years) (ABS, 2018).

Young Indigenous peoples accounted for more than a quarter (26%) of all youth deaths by suicide in Australia, at 93 of the 358 deaths (ABS, 2018). Death by suicide for Aboriginal and Torres Strait Islander children and young people was 10.1 deaths per 100,000 people, compared to that of non-Indigenous children and young people at 2.0 per 100,000 (ABS, 2018).

Within the ATISPEP *Solutions that Work* report (Dudgeon et al., 2016), there was a strong consensus relating to the need for recognition of the importance of the social determinants of health, regarding health status, mental health and suicide. This view was supported further in the lived experience workshop, where participants advocated for the need for governments to address the social determinants of health as significant influences on Aboriginal and Torres Strait Islander wellbeing. For example, critical disproportions exist on an economic level between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, including housing and homelessness inequalities. The development and implementation of Aboriginal-led, local solutions received significant support, with participants encouraging facilitation through the local Aboriginal workforce.

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# Workshop Methodology

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## Ethics Approval

The Aboriginal and Torres Strait Islander Lived Experience Project was granted approval by the Western Australian Aboriginal Health Ethics Committee (WAAHEC) on May 10<sup>th</sup> 2018. The WAAHEC reference number is 848. Approval has also been granted by the University of Western Australia Human Research Committee (UWA HREC), as determined by approval from WAAHEC. The UWA HREC reference number is RA/4/20/4630.

## Participant Recruitment

A total of ten participants attended the Workshop, all of whom were of Aboriginal and/or Torres Strait Islander descent. Participants ranged in age from 22 – 56 years, with a large proportion of participants in the 40 to 50 year age group. All participants had lived experience of suicide and each brought forward individual, relational and cultural perspectives. The participants came from a range of locations, representing both where they were currently living and working as well as where their country, family and language group is. These locations included urban, regional, and remote areas in Western Australia, the Northern Territory and Queensland. The gender representation was four males and six females, with three participants identifying as part of the LGBTIQ+SB community. Participants were recruited from the researchers' networks, as well as relevant stakeholder organisations including Aboriginal and Torres Strait Islander community groups, such as the Healing Foundation, Telethon Kids Institute (Kulunga), and the Kimberly Aboriginal Medical Service. Potential participants had discussions with an Indigenous psychologist and/or an Indigenous facilitator who also has lived experience, to assess vulnerability. Mainstream suicide prevention organisations that are involved with lived experience experts, such as Roses in the Ocean and Suicide Prevention Australia were also contacted to identify possible participants for the workshop.

## Data Collection

This research employed a participatory action research (PAR) methodology, which is an approach to research that privileges participation and action by the relevant community based on their collective experience and social history (Dudgeon, Scrine, Cox, & Walker, 2017). The PAR approach enables research 'subjects' to become participants in the research process, and consequently, the research becomes more responsive to community needs. Further, this research was conducted by Aboriginal researchers and aligns with the values and ethics set out by the National Health and Medical Research Council (NHMRC, 2018) for ethical conduct in Aboriginal and Torres Strait Islander health research. All research undertaken is strengths-based and Aboriginal and Torres Strait Islander-led and community driven. The workshop involved listening to participants' contributions, interpreting these contributions, and then clarifying with participants that the interpretation was correct.

The workshop commenced with a one-minute period of silence, paying respect to those who have lost their lives to suicide. Aboriginal experts, including psychologists and people with lived experience, facilitated the Workshop, using a program of semi-structured questions about what is needed in appropriate service provision for Aboriginal and Torres Strait Islander suicide prevention and about the role of those with lived experience. Program questions included:

- Is Aboriginal and Torres Strait Islander lived experience of suicide different to mainstream?
  - Do we need a definition of lived experience that is unique to Aboriginal and Torres Strait Islander peoples and communities?
- Have you ever felt that non-Indigenous staff were impeded in their ability to interact with you, due to fear of causing offence and/or harm due to your Aboriginality?
- Do you feel that there is a shortage of Aboriginal and Torres Strait Islander workers/counsellors within the fields of suicide prevention and social and emotional wellbeing/mental health?
- Is there a difference in obligations/responsibilities for community members compared to service providers?

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## Workshop Results

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Participants were invited to be co-authors for both this report and any corresponding journal articles. Rebecca Johnson, Rowena Cox, Lionel Gregory, Raeylene McKenna, Vicki McKenna, Donna Smith and Julie Turner were participants at the workshop and are acknowledged as authors in this report.

The transcript from the workshop discussions was analysed by four co-researchers in the Lived Experience Project. Three of these co-researchers are Indigenous Australians and were facilitators at the workshop and the fourth is a non-Indigenous research officer who also attended the workshop. The researchers independently reviewed the transcript and then collaborated to determine thematic codes. The codes and relevant quotations were organised and analysed thematically. The major themes to emerge are:

- The Need for an Indigenous Lived Experience Definition and Network
- The Need for Self-Determination
- Experiences of Grief and Loss
- Experiences of Racism and Trauma
- Lack of Appropriate Services and Responses
- Isolation, Discrimination, and Racism in Mainstream LGBTIQ+ Services: Prioritising Engagement of Indigenous LGBTIQ+SB Peoples and Communities
- Hope for the Future

These themes are discussed in detail in the next section.

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# Themes

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## 1. The Need for an Indigenous Lived Experience Definition and Network

The Project and the CBPATISIP currently use the Roses in the Ocean definition of lived experience:

Roses in the Ocean define lived experience as *having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has been suicidal, or been bereaved by suicide* (Roses in the Ocean, 2018).

However, this definition is slightly different to Suicide Prevention Australia (SPA):

SPA defines lived experience as *having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way* (Suicide Prevention Australia, 2016, p. 2).

The Roses in the Ocean definition was adopted as a definition for Indigenous lived experience as an interim measure. SPA and Roses in the Ocean are mainstream organisations, who as well as the Black Dog Institute Centre of Research Excellence in Suicide Prevention and Innowell Lived Experience Advisory Board, include Aboriginal and Torres Strait Islander people in their activities and committees. However, the specific cultural considerations relevant to the empowered and genuine inclusion of Aboriginal and Torres Strait Islander lived experience voices need to be reviewed. It is critical for Indigenous peoples to have meaningful involvement within research that affects Indigenous peoples and communities. Further, the inclusion of Indigenous lived experience experts within Indigenous suicide prevention research is crucial, but cultural considerations remain a priority. The historical involvement of Aboriginal and Torres Strait Islander peoples in past research projects and in advisory positions for various programs and services was seen as largely tokenistic by workshop participants. It is difficult for the one person (usually there is only one Aboriginal representative) to represent issues, often in places that are not culturally safe. Despite many participants' previous negative experiences of exclusion, all participants were willing to engage with the workshop.

### 1.1 The Need for Genuine Inclusion

The workshop is innovative in inviting Aboriginal and Torres Strait Islander peoples with lived experience to share their expertise in a culturally safe environment, contributing to research both led and undertaken by Indigenous researchers. Many participants had not considered the details associated with how they identified themselves as having lived experience. This Project and the workshop represent a crucial step towards the meaningful engagement of Aboriginal and Torres Strait Islander peoples who have lived experience within the suicide prevention field. A lack of understanding by service providers around the cultural complexities of engaging an Indigenous person who has lived experience was identified by many participants. This was seen by the majority of participants to be a major barrier to the development and refinement of suicide prevention services and programs. Without an understanding and appreciation of the various relevant safety considerations, both from a cultural and a mental health perspective, service providers are unable to engage and benefit from the expertise of Indigenous peoples with lived experience.

Participants expressed their support around defining lived experience of suicide from an Aboriginal and Torres Strait Islander lens, rather than relying exclusively on the definitions of mainstream organisations. The establishment of a definition for Aboriginal and Torres Strait Islander lived experience, as well as discussions around the formation of a network of Indigenous lived experience experts, was described and supported by participants.

Comments from participants included:

*We have to have a definition for our mob to understand it, there has to be a definition around lived experience and a way that it's connecting for our mob to relate to through communities, the definition of lived experience and then provide education to our communities (Workshop Participant).*

*But then again too, there's a different layer to it as well, I don't feel like the LGBTIQ lived experience is exactly, it has many, many components of who we are as Aboriginal people, but it does have a different element of lived experience as well, that other people don't experience (Workshop Participant).*

*That would probably be something that we would like to see happen too, over the years, is to have people that have lived experience in hospitals or, you know, on call, when we respond (Workshop Participant).*

The workshop supported continuing work towards an Indigenous specific lived experience network.

## 2. The Need for Self-Determination

Participants strongly advocated for the right of Aboriginal and Torres Strait Islander peoples and communities to self-determination and the importance of community capacity building. Participants and organisational representatives expressed the importance of encouraging and empowering Aboriginal and Torres Strait Islander leadership. Leadership is relevant within both organisations and the wider community context, as strong Indigenous leadership links directly to self-determination and also ensures that supervision of health, SEWB, and other community workers is culturally appropriate.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 (the MHSEWB Framework) (CoA, 2017) consists of nine principles that guide the delivery of health, mental health and social services, which consider the cultural, social, spiritual, economic and historical and contemporary contexts of Indigenous communities. One of the MHSEWB Framework principles is explicitly about self-determination:

*Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services. (CoA, 2017, p. 3).*

The theme of self-determination emerged in discussions centred on specific needs for increased access to and availability of community counsellors and culturally appropriate mainstream services. This need was emphasised as particularly crucial during bereavement times within a community, for example following the death of a community member to suicide or any other tragic loss of life.

Participants articulated various approaches to building and empowering self-determination, including:

- Respecting and valuing community knowledge and expertise;
  - Train up people who have already demonstrated their ability to engage fully with communities, avoid prioritising people who have formal qualifications but no demonstrated ability of community engagement.
  - *'... I'm sick of telling people who are sitting on eighty thousand dollars, how to do their job, I'm over it (Workshop Participant).*
- Enabling and encouraging community members to engage with non-Indigenous service providers, rather than only communicating with Indigenous support workers who are often only in the community for a short period of time;
  - *'... I tell them...[Aboriginal community client]... "you need to speak up"... as long as you don't talk, you can stand here and grumble all you like, but if you don't write it down ...nothing will ever get done and you'll still be here grumbling in ten years time...'* (Workshop Participant).
- Upskilling current service providers to ensure cultural competency;
  - A focus on increasing the capacity of community members will then enable communities to be empowered to assist in building the capacity of pre-existing non-Indigenous led services.



- *‘There’s plenty of, if you think about it in terms of self-determination and our mob leading initiatives in our own communities, it’s also up to non-Indigenous organisations to make the commitment and have some Aboriginal and Torres Strait Islander people on the advisories have some Aboriginal and Torres Strait Islander people employed so there are voices in our community, because that’s often how the gaps widen, is to leave our people out of the process’* (Workshop Participant).
- Building the capacity of the whole community, particularly around suicide prevention, to avoid a sense of responsibility falling on a few community members;
  - *‘... it’s not up to just one person, whether they are [a] mental health support person or whatever they might be, because it puts a lot of onus on that person to perform miracles to a degree...’* (Workshop Participant)
  - *‘...whatever information you need to help keep you strong’* (Workshop Participant).
  - *‘... you’re a strong person, but then you feel like when you fall down, it’s like, where’s that help to help you?’* (Workshop Participant)
- Cultural retreats for vulnerable groups (women, youth, people with lived experience);
  - *‘... you might be able to take a group of women out, build their resilience, come back and it impacts, has a ripple effect on the whole community...’* (Workshop Participant)
- Effective engagement of Indigenous leadership;
  - *‘Representation of lived experience network through state and local [government/organisations] of Aboriginal and Torres Strait Islander lived experienced voices – often what happens is non-Indigenous organisations on state and local levels secure funding and then they do it backwards so they come with westernised frameworks, and it just doesn’t work for our mob, so from the get go, a full process would be having Aboriginal and Torres Strait Islander representation in local and state lived experienced bodies.’* (Workshop Participant).

## 2.1 The Need for Natural Helpers

Participants strongly advocated for the inclusion of natural helpers within communities. Natural helpers are Indigenous peoples who already live in the community and are already well known as a reliable support person for anyone to reach out to during a time of crisis. Natural helpers were seen to be older adults who are able to provide a warm, non-judgemental and welcome space for any community member to access, at any time of the day or night, *‘... we’ve already got people out there, in our community that’ll go... so we sat down with [community member], you know [community member X] gets people at [their] place three or four hours a night, because they know they can go to this place, sit down, have a yarn and they can go away feeling good...’* (Workshop Participant).

Participants promoted the benefit of the non-judgmental and safe space for sharing and healing that natural helpers provide – *‘Because people already identify with them and pick them out, you know how you think of people straight up... you know [name] is an old lady and she’s got loads of kids and all the kids go over there, and you know how it is, and that kid knows he can rock up there at two o’clock in the morning and he’s not going to get growled and he knows that that old lady will make him a cup of tea and sit down with him and it’s a sober environment, you know...’* (Workshop Participant). Participants advocated for the establishment of a more recognised role for natural helpers, but acknowledged the difficulties surrounding this, *‘... but the biggest and hardest thing that we had was trying to identify these natural helpers, they’re there and they’re already doing it but to do it in a formal capacity is very hard...’* (Workshop Participant).

Both those who are employed and natural helpers who are in informal and unpaid roles, are under resourced. Participants highlighted the common risk of burnout and vicarious trauma. One participant spoke of their struggle with suicidal thoughts whilst working in the suicide prevention space *‘I felt suicidal, I just called up my partner and said ‘I need to go home’ and I just, that was it, I broke...’* (Workshop Participant). Self-care strategies were discussed, in relation to natural helpers and others working within the suicide prevention and mental health space. Such strategies included turning phones off over the weekend and setting clear boundaries that were identified early on in interactions with community members.

## 2.2 The Need for Self-Care

Acknowledging and defining vicarious trauma involved being aware of the possibility of being triggered by workshop conversations and content. As such self-care and safety measures were discussed and there were supports in place for people to create a safe place. Vicarious trauma is generally described as *'the negative transformation in the helper that results (across time) from empathic engagement with trauma survivors and their traumatic material, combined with a commitment or responsibility to help them'* (Pearlman & Caringi, 2009, pp 202-203). The risk of vicarious trauma increases when one increasingly hears or reads of traumatic stories of people who are seeking help. When a person listens to that story and expresses empathy and supports peoples who are impacted by trauma – this may then impact the person listening to the story. This was considered on the outset of this Project and while self-care was implemented in the workshop, it was an issue for lived experience experts working in services and communities.

One participant spoke of their own experiences of burn out and vicarious trauma, *'One of the reasons I finished up from working there as well because it's just I had enough [...] there was a suicide as well, of a young [person] and that was my last straw, I just, it was too much for me and I said "no, this is enough" because it was affecting my health as well, and after that I just had enough because I wasn't feeling well and too much work and just too much of a workload to carry and then going home to my family and feeling exhausted and stuff like that, so for my best interests I thought to stop... I just needed that break...'* (Workshop Participant). Further, participants acknowledged the risk of perceived responsibility or blame of employed staff and natural helpers if a person saw and spoke with them, and then took their lives, *'... make myself available to listen, attentively, and which I do, I do listen but then they, that person – will make a decision, whether it be right or wrong, and then depending on who it is and then if you were the last person that happened to see them before, someone might blame you as the person that was [the] last [contact]...'* (Workshop Participant).

Recognition by service providers of the complex work undertaken by natural helpers is needed. Particularly as natural helpers are also community members, and are therefore at risk of suffering the same stresses and direct traumas as the community members that they are supporting. Those who work in an employed role within suicide prevention and also as a natural helper spoke of their experiences, *'... we're out there and then we're double dipping and you wonder why you end up burnt out and you're no good to nobody'* (Workshop Participant). Some participants had experienced a devastating lack of support by their workplaces around their role as a natural helper within the community. Even when employed in a formal and recognised suicide prevention role, when they were working outside of business hours (for example supporting a young person in a suicidal crisis at 1am from home), their workplaces failed to recognise this work. Regardless, participants and other natural helpers remained dedicated to their roles, *'... I can tell them, "look, I'm just going to ring triple zero for you" but ... I know that if I walk away, if I do that, there's a greater likelihood that that person will go and take their life, so I'll fucking sit there if it's eight hours that I need to sit...'* (Workshop Participant). One workshop facilitator also discussed this gap in understanding between Indigenous staff and non-Indigenous management in workplaces, *'... there's still a disconnect between us and workplaces in understanding that you need to have a different way of working with your Aboriginal and Torres Strait Islander workforce who are on the ground and doing community responses...'* (Workshop Facilitator).

## 3. Experiences of Grief and Loss

Experiences of grief and loss were expressed by all participants, both in relation to their lived experience of suicide and within other aspects of their lives. The intertwined notions of grief and loss were discussed in various forms and align with the MHSEWB Framework's fourth principle:

*It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects. (CoA, 2017, p. 3).*

The experience of historical and ongoing colonisation contributes to the experiences of grief and loss for all Aboriginal and Torres Strait Islander peoples, in addition to lived experiences of suicide. Whilst participants most often discussed the concept of loss in relation to the loss of life, there was also a strong

emphasis on including the concepts of loss of country and culture, which continue to impact the social and emotional wellbeing of Aboriginal peoples and communities. The prevalence of grief and loss within the daily lives of Aboriginal peoples was discussed and this framed some participants' rationalisation of both the normalisation and high rates of suicide and self-harm, as well as the anger and hurt felt by the bereaved, even before a suicide attempt, '*... especially other family members,[who say] "oh if they want to go out and do that, I'll give them the rope and..." and it's like no, no, no and you got to try and get them into that other space of thinking, because they're so angry and hurt ... and it's like you know "why didn't this person come to us? They could have come to us, we're all here".'* (Workshop Participant).

McAlister et al. (2017) discuss bereavement and the need to better understand its associated experiences for Indigenous peoples:

*The bereavement process for an Aboriginal and Torres Strait Islander person is additionally impacted by cultural factors, in that the loss of someone to suicide may trigger feelings of mistrust of the non-Indigenous community and mainstream health and social services that remain culturally insensitive and immersed in colonial attitudes and practices (p. 52).*

The concept of compounded trauma for Aboriginal peoples during the bereavement process was also articulated by participants, '*You know, we're always left high, and just floating around like little lost leaves because you're trying to understand what's actually happened here. You think that an inquest is going to give us those answers, but it's all foreign for us, you know when you have that first loss within your own family... you're trying to understand that process...'* (Workshop Participant). This particular quote was supported by other participants who felt that the current systems do not support families to better understand the circumstances surrounding the loss of a loved one, particularly through the coronial inquest process. This process was believed by some participants to be worse for extended family members, who were still affected by the loss of a loved one but were not informed of the processes due to the dominance of the western perception of family in regards to sharing inquest information.

Whilst cultural sensitivities following a death are greatly important, many participants shared experiences of their trauma being compounded. This compounding trauma was often the result of services avoiding giving empathetic responses as their lack of knowledge of relevant cultural protocols resulted in fear of saying and doing the *wrong* thing. Participants discussed how non-Indigenous support people seemed to be '*walking on eggshells'* (Workshop Participant) because participants and their families are Aboriginal, rather than approaching them and responding as empathetically as they would if the bereaved were non-Indigenous. Even amongst the many cultural sensitivities following a death, the bereaved families also need to be recognised and support can be provided through simple acts such as being present, bringing food, and being empathetic to their circumstances, '*I don't care if you were a complete stranger but you know what, it gives me comfort that somebody has come and acknowledged my pain and seen my suffering, can be a stranger and say look "you know like, I'm sorry for your loss". I don't care if they're not local, that's meaningful to me...'* (Workshop Participant).

One participant shared a poem that they wrote and performed at a music festival in 2013. This poem titled 'Tears in the Dust' signifies the profound loss felt by Aboriginal and Torres Strait Islander peoples, including loss of children, culture, and country.

*They didn't know, they couldn't tell,  
That, their beautiful lives would turn into a living hell.  
That's when they came, causing havoc and pain  
It would never be the same again.  
Then came the day, when they took them away.  
They cried & cried all night & day  
(Smith, 2016, p. 25).*

The full poem is reproduced in Appendix One.

## 4. Experiences of Racism and Trauma

It is important to consider the historical and contemporary experiences of Aboriginal and Torres Strait Islander peoples, in terms of their cultural, social, spiritual, and economic contexts. This involves recognition of the intergenerational effects of trauma and loss that have been present since the commencement of European invasion, as directly related to current experiences of disruption to culture and wellbeing. The continued presence of racism, stigma, adversity and social disadvantage act as ongoing stressors and negatively affect the mental health and social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander peoples (CoA, 2017). The differences in experiences of Indigenous peoples including significantly higher exposure to trauma and these risks to mental health must be acknowledged. It was found that mental health issues in response to trauma are more prevalent among Indigenous peoples and communities, due to the ongoing effects of colonisation (Dudgeon & Holland, 2018). Impacts continue to be seen within health, education and employment outcomes. Aboriginal and Torres Strait Islander peoples and communities are continuously overrepresented in negative social statistics, including higher rates of suicide. These disadvantages can be attributed to the ongoing effects of colonisation.

Participants identified a significant need to improve the mainstream services' response capacity when interacting with and responding to people who are experiencing trauma, loss and grief. This would involve the development of skills in the areas of suicide prevention, person-centered approaches, conflict mediation and resolution, mental health and first aid, and trauma-informed approaches and care. One participant reflected on the need for culturally appropriate responses following a suicide, expressing their experiences of racism, *'... It's bad enough having to deal with the trauma of what happened, why, and all of those unanswered questions, and then because of the way that we get treated with the racism, the way that the police do their investigations, it just creates more trauma for the families...'* (Workshop Participant).

Participants felt that suicide for Aboriginal and Torres Strait Islander peoples is different from mainstream suicide, due to the variety of unique historical and cultural factors and experiences. Historical and ongoing racism and colonisation experienced by Indigenous peoples and communities have contributed to unique experiences of suicide. Participants discussed relevant factors including forced removal of children from families and culture, social exclusion, disadvantage, lack of self-determination, and long-term overt and covert racism at the individual and structural levels. These experiences are not shared by non-Indigenous people, which demonstrates the differences between experiences of suicide for Indigenous and non-Indigenous Australians.

Participants discussed their interactions with non-Indigenous service providers and many reflected on the lack of empathy and humanity in service providers' responses. There was a common theme around non-Indigenous responders avoiding interactions with Aboriginal peoples for *fear* of being culturally inappropriate. This sense of guilt could be viewed as selfish and prioritises the feelings of the non-Indigenous person above the Indigenous person. Fear of being culturally inappropriate ignores the need and responsibility of non-Indigenous peoples to engage in cultural responsiveness training and build their awareness. One participant shared their experiences of fear prohibiting service providers from engaging the family and community who had suffered great loss of life through a car accident and suicide in a very short space of time. *'[They said]... "well we haven't had an invitation, we haven't been invited to come" and I said "you know what, you don't need an invitation, it's common sense, and you know what, it's a responsibility that you have to this community. All you need and all we want is for your presence, you don't need to say anything, come and pass on your condolences to the family and that's a start... We are human beings for fuck's sake! We are human beings, you know, we're not aliens"'*. (Workshop Participant).

Even though suicide is one of the leading causes of death for Indigenous peoples, self-harm is also significantly prevalent (ABS, 2018). Participants noted that self-harm sometimes included alcohol and drug misuse but emphasised that rather than exclusively blaming substance misuse, service providers must consider and appreciate the various causal factors surrounding this misuse. Trauma, loss and grief are key factors within suicide deaths, including those accompanied by alcohol and substance misuse. Participants advocated for the implementation of early intervention and prevention efforts that are evidence based,

in order to encourage people to make choices that will positively enhance their health and wellbeing. One participant expressed frustration towards the top-down approach of services based on racist assumptions about Aboriginal communities and alcohol misuse, *'All the services decide to come to town and say it's a big grog problem and they just automatically assume it's a grog problem.'* (Workshop Participant).

Participants highlighted their frustrations with how often Westernised practices are held as superior, particularly within a clinical context and little to no respect is given for cultural practices, experiences or skills. The power imbalance and assumed authority of knowledge regarding Western approaches to health can elicit feelings of intimidation for Indigenous peoples. Participants shared that suicide prevention measures often do not account for cultural knowledge and understandings of social and emotional wellbeing as protective factors against suicide and self-harm. One participant expressed their experience of disempowerment associated with the approach of non-Indigenous organisations, *'I still find that, the most important thing when I was working, was lack of respect for, for anyone really, I mean people back in (remote home community) from an agency or organisation, there was a lack of respect you could see ... you could tell by the way you speak to them and the way they kind of speak down to you. For myself, I had that on several occasions and I just thought, I better not get into an argument here with them, you know, I'll just let it go, just didn't take notice of it, but that's one thing I found was the lack of respect...'* (Workshop Participant). The lack of mutual respect was further highlighted in discussions, *'Because it knocks you down even further, it knocks you back, it's like I'm opening up and they don't respect me, what's the point...'*, *'I mean, they expect us all Aboriginal people to respect them so why not [back]...'*, *'[It is a] two way street, yeah...'* (Workshop Participants).

Participants reported that it was a common experience to see Western clinical practices valued and validated while Indigenous practices were viewed as inferior. One participant shared their experiences of mainstream services lacking culturally responsive understandings of Indigenous approaches to healing and counselling, *'And I think that you notice too with a lot mainstream services is, like everyone's saying, sharing around that room that just to go there and to know that the service is there and to just sit down and have a yarn, you know, that's like, to us as Aboriginal people, that's like, yarning is our counselling session but, you know, white people don't see it like that, they think "oh yeah, they're just going over there and talking, like what do they get out of this" you know, it's like "we're paying them to go around and sit and just talk to these blackfella's all the time". But you know, we can see though how it helps but white people can't, they don't notice it, you know, what the real outcomes are of just making that connection.'* (Workshop Participant). Other participants discussed the importance of navigating around the dominant Western clinical model to provide the best culturally responsive practice for people in the communities *'Because where we currently work, it's all non-clinical because most of our community members who are suicidal flatly refuse to go to the hospital. In some cases if they're heavily intoxicated we have no choice, but police is the last [option], because it just agitates them even more, yeah, so we've always worked in non-clinical and the other thing is services have failed them over and over again, you know, [there is usually a wait time of] eight hours from the time of going to outpatients to actually being placed in a ward...'* (Workshop Participant).

## 5. Lack of Appropriate Services and Responses

Participants recognised many gaps in current service design and delivery, especially for peoples with lived experience of suicide (both bereaved and survivors). Participants identified both a general lack of services available (particularly critical responses) and expressed that the services currently provided were often inappropriate and insufficient. Some inadequacies of current services and responses discussed by participants included:

- Limited service availability;
- Lack of cultural responsiveness;
- Dual roles;
- Lack of funding;
- The need for community engagement;
- Lack of self-determination.

These findings, acknowledged by participants, align with areas of focus for best practice identified by the MHSEWB Framework (CoA, 2017) and the ATSIPEP *Solutions That Work* report (Dudgeon et al., 2016). In particular, the areas of the MHSEWB Framework that link to participants' experiences of lack of appropriate services and responses include:

- The right to self-determination which includes community control and empowerment: Projects should be grounded in the community, owned by the community, based on community needs and accountable to the community.
- The need for cultural understanding: Culturally valid understandings must shape the provision of services and must guide the assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.
- Programs and strategies must be sustainable, strengths based and capacity building: Projects must be sustainable both in terms of building community capacity and in terms of not being 'one off'; they must endure until the community is empowered.
- Genuine partnerships: Projects should work in genuine partnerships with local Aboriginal and Torres Strait Islander stakeholders and other providers to support and enhance existing local measures, not duplicate or compete with them. Funding applications need to demonstrate a record of genuine community and stakeholder/provider consultations and a track record of community empowerment.
- Safe cultural delivery: Projects should be delivered in a culturally safe manner.
- Innovation and evaluation, community promotion and education: Projects need to build on existing learning, try new and innovative approaches, share learnings, and improve the evidence base to reduce suicide. Projects should share their learnings, and these should be promoted in other communities. (CoA, 2017).

### 5.1 Limited Service Availability

The hours that services are open do not meet the demands of peak times in communities. The availability of these services needs to be expanded to respond appropriately when issues are most prominent. Participants stated that most people do not have crises during standard business hours, Monday to Friday, and instead, services must be more flexible in providing after hours services. This flexibility might also include formalising of the roles of natural helpers, who may be able to offer alternative supports throughout the night when other services are unable to open. One participant spoke of how 'shame' might prohibit a person from accessing a service during business hours, *'And a lot of our people won't go during the day, they'll wait until night time so nobody can see them accessing that service, so they'll wait, then when they do rock up it's like "sorry Jack, it's not here"[it is closed] you know...'* (Workshop Participant).

Participants also expressed how more rural communities might experience less availability of services than others, *'...I was working in the SEWB unit at the medical service we used to travel out to these communities and talk to the people, when there was a suicide there and we went to a "deadly thinking" workshop, in [remote community] and one of the ladies said to me that there was a lack of services coming to the community for the people. They come once a month or something like that, they're not really available in*

*the community, there's no one there, there's no counsellors or anything and she said "yeah they come along, and they're here for 5 – 10 minutes" and the whole community is grieving but they don't know that, they only talk to ... whoever they've got on their list, and then they're gone.'* (Workshop Participant). It is important to note that fly-in, fly-out approaches are not the most effective methods of engagement for Aboriginal and Torres Strait Islander peoples. A better method might be to incorporate a more community-based approach that supports the empowerment and self-determination of Aboriginal peoples and communities by building relationships, having longer and informal engagement and training local people to provide basic counselling. The National Empowerment Project is an example of a successful community-based program, which builds on the empowerment and self-determination of participants/graduates ((Mia & Oxenham, 2017).

Further, participants from remote communities spoke of a lack of postvention services, *'... we had three suicides in [remote community] before [public holiday] and I couldn't believe it, there was nothing, they wrote to the [head of state] and asked for a response to come and nothing, we got nothing in [another remote community]'* (Workshop Participant).

## **5.2 Lack of Cultural Responsiveness**

Perhaps the most prominent and one of the most damaging factors discussed by participants was the lack of cultural responsiveness amongst service providers. Participants shared their experiences of culturally inappropriate responses in different contexts, as bereaved family members, as survivors of a suicide attempt, and as staff members. There was agreement that *'very few [services] have cultural safety training'* (Workshop Participant). This was evident in inappropriate responses immediately following the loss of a loved one and in the language used by service providers throughout the resulting journey of grief – *'Yeah, it's true... that we need that cultural safety there, because we've got all these whitefella's coming out to us, like in the [state/territory], when there's a suicide within 24 hours the coroner's office send someone out to support you, and this white woman walks into my yard and she's singing "[name], are you home? Can I help you sweetheart?" (sing-song voice). 'Cause I'm sitting in the front yard crying, "can I help you? Sweetheart? [name]?" (sing-song voice). You, know? Like singing! Like, don't walk in my yard, singing to me, you know, when my [child] just passed away 12, you know, less than 24 hours ago. Don't come in here, singing bloody fucking songs to me, you know? Like you said, insensitive, and I wrote a written formal complaint to the coroner's office, I said "I want a written apology from that woman that came into my yard", I said "I don't want her to step in my yard again", I said "do not send her again" I said "and you, you need to train up your" you know, the coroner's office, I said "you need to train them all up in cultural, um, awareness, you know" I said "don't ever do that, you know, to anyone black or white, you don't walk in their yard signing happy songs like that", you know.'* (Workshop Participant). Culturally inappropriate speech used by service providers was seen to widen the pre-existing gap between themselves and the communities they are aiming to serve. Many felt that the processes following a suicide were not communicated well enough. One participant questioned *'how many of our people understand what happens at an inquest?'* (Workshop Participant).

A lack of cultural responsiveness within services was argued by participants to be part of the reason behind a lack of effectiveness of services. One participant spoke of their grief and the tragic losses in their family that went unattended by services, *'... but not one fucking service came to us. Here I was ringing on the phone and saying "where the hell are you mob?"... we had all these family members in the hospital, I was like "where the fuck are you people?"... we had so many people caught in grief and not one fucking service came to us. I rang around and I said "we need people here, I'm ok, but my family is suffering and so are my [family member's] friends, they're all suffering, so you guys need to get your ass here".* (Workshop Participant). It seemed that the responding organisation felt that that they needed to be invited into the community. However, a courtesy call would have been appreciated and appropriate follow up could have been determined during this.

Even organisations and services who did show interest in cultural safety training were not always equipped or dedicated to be trained in a culturally responsive manner. One participant shared their experience with inappropriate cultural awareness training, *'I had an experience years ago, about the police and we wanted the police to get cultural awareness training in [remote community] and the police said "oh no, we have our training down here, in [capital city] the problem is that never mind if we're Aboriginal, but in*

*every community is different and we argued, we said “no, they should have gotten their cultural awareness training in [remote community]”, not every Aboriginal people, community are the same. You can’t just walk into anyone’s community and say you want to do this or that, you have to get permission and go through stuff with the community...’* (Workshop Participant). This highlights the importance of appropriate delivery of cultural responsiveness training. In order to be culturally responsive itself, the training must be delivered by appropriate peoples/organisations, with emphasis on the need for Aboriginal and Torres Strait Islander peoples leading the engagement. Participants discussed innovative approaches to ensuring cultural responsiveness by non-Indigenous services in their communities. One such approach involved the proposed role of *community navigators* who would be able to guide the service providers in an appropriate manner and ensure that they are engaging effectively with the community. These roles, however, must be recognised and paid, or they perpetuate the exploitation of cultural knowledge and undermine the legitimacy of local knowledge and community engagement, *‘And that’s these people coming in, that’s what pisses me, because you get these people coming in, they don’t do any research on the community that they’re going to, they don’t look around and say “hey, can I get a...” what do we call it ‘... community navigators, can I get you to come in and help me” because it’s not going to go “hey go and see [name] over there, [they’ll] help you with everything” and [name] gets jack shit. We’re going to say “no, we want a community navigator, this person will navigate you around the community, but [they] get paid for that, and [they] will help you’ you know, this kind of stuff, but they never do and then it’s ‘oh, how come it went to shit? Oh, that’s right, we’re not using the right language”...’* (Workshop Participant).

The crucial importance of cultural responsiveness in service design, delivery, and evaluation is well documented, yet it is still not being prioritised and implemented. Participants shared their frustrations with inconsistency in commitment by service providers and highlighted that it must go beyond simply *good intentions*, *‘...it comes back to that respectful, cultural safety, security, understanding and working properly and you know, you can do that until the cows come home but if people aren’t committed to that, they won’t do it, you know, unfortunately...’* (Workshop Participant). The need for services and organisations to engage meaningfully in culturally responsive practices also involves them working together with other mainstream services, *‘And plus, like government agencies as well, like police, the hospital, they need to talk to each other and work together, because there might be a cultural thing [that they need to be mindful of], you know...’* (Workshop Participant).

Participants identified that cultural responsiveness extends beyond a general Indigenous perspective, as this can reinforce an overly simplistic view of diversity and identity. Therefore, cultural responsiveness not only involves being aware and responsive to the needs of Aboriginal and Torres Strait Islander peoples, but also encompassing the diversity of other identities, including Indigenous peoples who identify as LGBTQI+SB, differently abled, or having lived experience. One participant expressed their concern that there are *‘... no organisations, [no] Aboriginal and Torres Strait Islander LGBTQI organisations that offer responses inside localised communities’* (Workshop Participant).

Whilst dominant or mainstream approaches to certain issues may assume one group are more important to engage with, participants noted that these assumptions must be challenged. One participant spoke about how limitations around funding and availability can impact of the overall effectiveness of services, *‘...there’s a lot of services for women out there but there’s not a lot of services for men and one of the other things too is, is that I’m noticing too, is that in particular with family violence and domestic violence, we’ve got all of our perpetrators out there but what services are there to help those perpetrators to get back on track without having to go down that road of, you know, taking their own lives?’* (Workshop Participant). Without appropriate services for people, particularly men who have been violent, participants saw the possibility of a continuing culture of violence and aggression within communities. Whole of community approaches are needed.

The lack of Indigenous leadership within organisations and community workplaces was identified as a barrier to the ability of some participants to work effectively in their various roles. Without culturally appropriate leadership, participants found that they often had to counsel their supposed supervisors, further compounding their own trauma and difficulties, *‘I found it so frustrating like when I was getting professional*



*supervision, I was getting it from a non-Indigenous lady and they'd just freak out when you tell them what's going on in your own life...'* (Workshop Participant).. One participant went on to explain that, *'... I get more frustrated and more angry and trying to put that up to, and we're talking about cultural safety, trying to put that up to management [to get more Indigenous or culturally responsive staff] and they say "no, that's the only person we've got [staff member available]" and it's like "well, hello, [they're] inappropriate" well it's like "sorry [...], that's all you've got to work with" and so you're just left high and dry.'* (Workshop Participant).

### **5.3 Dual Roles**

A lack of recognition and appreciation of the work done by Aboriginal employees, both within and outside of the formal workplace, was a regular experience for participants. Many participants who work(ed) within the social and emotional wellbeing, mental health, and suicide prevention space, expressed frustration over their employer's lack of understanding of the dual roles that Aboriginal employees hold within communities. The experience of having dual roles was expressed by many participants, where they felt that the work they did during regular business hours fulfilled one role, and the responsibilities that they held outside of those hours constituted another important role. However, almost none of the participants had positive experiences of their workplaces appreciating these dual roles, *'...even our workplaces don't recognise that, so like for me for example, doing other work stuff, so like you're saying our work finishes at 4:30 pm, our real work starts then with our families, and because we're, you know, we live in the community, people know where you live so 12 o'clock at night when they want to kill somebody or kill themselves, they're banging on your door and you can't say "go away" and I actually asked, you know, brought it up at a meeting, and said "what about these people, you know, can you recognise the work that we do after hours," Because they're not going to sit with you for an hour, they're going to with you for four or five hours, before you can feel [it is] safe enough to let them go, or they feel safe enough to go home or go somewhere else, you're not going to be with them for an hour and then let them go. A lot of these people don't want to go to the hospital, you know, they just want someone to listen to them, so we don't even get recognised for that...'* (Workshop Participant).

### **5.4 Lack of Funding**

Participants raised concerns about the negative impacts that unreliable and unstable funding has on the effectiveness of both Indigenous and non-Indigenous services within communities. A lack of funding for targeted activities and short term funding for those that do receive funding does not allow for appropriate evaluation and success of services and programs, *'They've got a commitment and this is bloody a national crisis with, with suicide, that's when you've got to have a bipartisan approach. It doesn't matter if, if, whoever's in power, if this is going to work and this is what we're going to put money to it, put the bloody money to it, let it sit there for ten years, do the bloody evaluations and reviews on it, to make sure it's working properly...'* (Workshop Participant).

### **5.5 The Need for Community Engagement**

Participants spoke of the importance of services establishing genuine and meaningful relationships with communities so that community people are able to trust counsellors and other service providers. Participants highlighted that the ability to engage effectively with communities was crucial to potential success. Participants also highlighted the detrimental impacts of disengagement, *'...there's a divide, natural divide in between the community and the services already, because they don't know how to engage with community and that is one of the biggest concerns that we have, and we've been working on but I think organisations and I think businesses, even private businesses, need to see that as pivotal to working in the [region] amongst Indigenous people'* (Workshop Participant). Inadequate engagement with community might also stem from having inappropriate and inexperienced staff in certain roles, *'Well it's like when you get a [visit] from Family and Children service and the first thing our country men will say is "have you got any kids?", because don't come and tell me about my kids, if you haven't got any kids of your own...'* (Workshop Participant).

Insufficient critical responses within communities was also seen as lack of engagement and not knowing the community's needs and ways. One participant shared their experience of trying to negotiate the gap felt by

community people, by providing critical responses in their remote community, *'...on the ground in [remote community] when there was a suicide, or even a tragic death, a group of us would go out, you know, hey? We'd go out and we'd say ok, what was your first thing, well we make sure that them mob have got phone credit to ring up family, they got toilet paper, the basics - the toilet paper, the power cards, the tea and coffee because you know the [extended] family's going there. But to make sure that they know that they're being supported with that just straight away.'* (Workshop Participant).

## **5.6 Lack of Self-Determination**

One strong topic throughout the workshop was participants advocating for the need of suicide prevention organisations to have Indigenous lived experience experts involved in empowered ways, *'...there's plenty of, if you think about it in terms of self-determination and our mob leading initiatives in our own communities, it's also up to non-Indigenous organisations to make the commitment and have some Aboriginal and Torres Strait Islander people on the advisories and have some Aboriginal and Torres Strait Islander people employed so there are voices in our community, because that's often how the gaps widen, is to leave our people out of the process. So, that's another one then, Aboriginal lived experience advisories as well...'* (Workshop Participant).

## **6. Isolation, Discrimination, and Racism in Mainstream LGBTIQ+ Services: Prioritising Engagement of Indigenous LGBTIQ+SB Peoples and Communities**

One participant who identifies as both Aboriginal and LGBTIQ+SB spoke in detail about the unique and important strengths associated with having appropriate leadership for the Indigenous LGBTIQ+SB community within the social and emotional wellbeing and mental health space. This position was supported by all other participants, including fellow Aboriginal LGBTIQ+SB people, who strongly advocated for appropriate service provision and leadership, demonstrating the clear link between supporting Indigenous self-determination and lived experience and mental health consumer leadership, *'...we want them [psychologists and counsellors] to be Aboriginal and/or Torres Strait Islander, we want them to be LGBTIQ so they understand the issues that we face and the isolation that we face, if we can't have that then we want our own mob with us, our old people, Aboriginal and/or Torres Strait Islander counsellors or psychologists with us. The days are gone where non-Indigenous organisations and people continue to tells us that they know how to fix what is going on in our communities. Our voices matter in this process...'* (Workshop Participant).

Participants took concepts of Indigenous self-determination, lived experience and mental health consumer leadership further, linking these to the importance of meaningful commitment to cultural responsiveness discussed earlier. Participants highlighted the critical importance of Indigenous governance in determining what culturally responsive services look like in their own community. An example of this meaningful interpretation of cultural responsiveness is evident in the following excerpt, *'... the LGBTIQ phone counselling service... what we've done is we've actually brought in our own Aboriginal and Torres Strait Islander mob, Brother-boys and Sister-girls to answer the phones and they're doing their counselling training and stuff, so instead of saying to our mob to ring the phone number and not get to talk to our mob on the phone, I said "if you're serious about it, put our mob in there on the phone" you know, let's start training our mob up so that there is a response, and straight away we've seen an increase in our people accessing [the LGBTIQ phone counselling service] due to linking with Aboriginal and Torres Strait Islander radio stations in rural and remote communities, so that LGBTIQ+SB mob know there is a service with our people answering the phones, which builds the capacity of self-determination of LGBTIQ+SB Indigenous peoples to be the connecting people for our mob.'* (Workshop Participant).

Discussions throughout the workshop highlighted the lack of capacity and understanding by mainstream organisations of the issues impacting LGBTIQ+SB Indigenous peoples. Participants noted that lack of awareness has a compounding traumatic effect by self-determination for LGBTIQ+SB Indigenous peoples working within both the LGBTIQ+SB sector and the mental health sector. Further, participants strongly advocated for the need for increased visibility of LGBTIQ+SB Indigenous peoples as part of the solutions and responses around suicide prevention and increasing cultural, social, and emotional wellbeing. The following quote is from a workshop participant who shared their experiences throughout their own journey of self-

discovery and healing, and how this has impacted their ability to help and guide others ‘... a lot of our LGBTIQ mob leave community to come down to the city and experience their gender identity or sexual orientation. Now, counsellors can’t provide the most accurate help or support to us mob, if you don’t have any knowledge base or experience around LGBTIQ issues. It’s not the same, it is a journey, it’s a journey of exploring, it’s a journey of understanding, it’s a journey of different lines between cultural expectations. You know, I think about my journey and I think about coming out, you know both my parents were born again Christians and that expectation around me of settling down, finding myself a [spouse of the opposite sex] and having children, but also going through the journey of keeping it mentally up here, really messed up so to speak, to say at what point do I let my [parent] down? And at what point do I get help to try and fix it, knowing full well there’s a possibility I could not fix it and I’ve seen that same journey and as our young kids come out of communities and come down and mix in with [Indigenous LGBTIQ organisations and support groups] and they explore gender identity and they struggle with their cultural identity to maintain that balance the impacts that it has on their social and emotional wellbeing, and the rates of suicide that we have. The white services, the government, has a responsibility here, state and federal, they like to invest money in non-Indigenous LGBTIQ organisations and NGO’s that don’t have the solutions, we’re not the problem, we’re a part of the solution and they like to invest money in non-Indigenous LGBTIQ stakeholders to, ah, say “this is what sort of help you can get” but when our babies come out of communities and they come exploring with us older ones that have been around the traps a little bit longer and have got the confidence, when we have to say goodbye to some of our younger jarjum’s [children] that are going through the same experience. Them non-Indigenous LGBTIQ organisations they get all of the bungu [money] for us LGBTIQ mob, blackfella’s they’re not there travelling with us, take them back on country they still, they’re operating their organisations and their businesses, but they’re not there with us, going home on country with them, and like everyone said here, walking in the gate, heart breaking because we know their journey but being respectful to their old people and to their community, walking in that gate, showing our respect and staying there, staying there until we felt comfortable that it was time for us to leave and go back to [capital city]...Non Indigenous LGBTIQ organisations should be more accountable for Cultural Safety and Practices that develop self-determination and leadership of Indigenous LGBTIQ people. Indigenous LGBTIQ people and groups experience inequality and exclusion within both our own communities and the broader non-Indigenous LGBTIQ community, this impacts wellness socially and mentally. The conversations of Lived Experiences of Indigenous LGBTIQ+ should be with us, our stories, our journeys, our survival in two worlds of Cultural Connectedness and Sexuality, integrating our experiences of cultural care pathways” (Workshop Participant).

## 7. Hope for the Future

Indigenous peoples locate physical and mental health within a broader concept called social and emotional wellbeing (SEWB). While the SEWB concept varies between groups, shared features include that it is:

- Inseparable from culture;
- Holistic in conception;
- Comprises an inter-related set of cultural determinants that connect the health and wellbeing of individuals to the health and wellbeing of their families (including extended family), kin, cultures and communities and to the spiritual world and ancestors;
- Affirms a stronger link between collective and individual wellbeing.

In order to restore the wellbeing of the whole Aboriginal and Torres Strait Islander person and community, strengthening SEWB is an important way forward. SEWB acknowledges that connections to land, culture, spirituality, family, and community can impact on their wellbeing and this is influenced by history and contemporary social determinants. The lived experience workshop supported a distinct SEWB approach.

Communities need programs and services that recognise the need to support self-determination and culturally valid understandings of mental health and wellbeing, and address the impacts of trauma, grief, loss, discrimination and human rights issues on the social and emotional wellbeing of Aboriginal peoples and communities. Such programs need to be initiated and controlled by Aboriginal communities and this is essential for providing culturally appropriate and responsive service delivery.

Special strengths and resilience exist in Aboriginal and Torres Strait Islander groups and their cultures. These have contributed to the survival of people through a history of ongoing colonisation. They also help people endure hardships and adversity in the present.

Strengthening culture strengthens resilience, and culturally appropriate universal programs are required. These need to be available across the lifespan, *'I'm looking at prevention, so that's what I think we should be discussing, starting with the babies, with the mother, then we won't have to [experience so many suicides], you know what I mean? This is what I look at, because you're talking about Aboriginal communities, it's about making that community healthy, and supporting a child coming into the world, give them the positives.'* (Workshop Participant).

It is important to target at risk groups, including children and young people, by employing culturally nurturing approaches from an early age, with one participant expressing the importance of childhood support, *'How can we nurture them when they've been brought into the world?'* (Workshop Participant). Peer-support and mental health literacy programs, as well as cultural approaches within education environments should be adopted and implemented by young people. Indigenous young people should be supported through training in suicide prevention, promoting peer-group connections and support, from a culturally-led perspective. This promotes resilience and connection, with one participant stating this need, *'...It's really building cultural resilience first and foremost...'* (Workshop Participant). There needs to be recognition of the great strength and capacity of Aboriginal and Torres Strait Islander peoples and communities within all research, interventions and approaches, to promote personal, relational and communal self-determination and resilience.

The work and energy invested by regional first responders and suicide prevention workers in Aboriginal communities must be appropriately recognised. Support must be provided through the recognition of the emotionally charged nature of the work, and the need for adequate funding and support of culturally responsive services. One participant discussed their approach to the needs of staff members, and the criticism that follows, *'I'm a regional manager in (the region), mental health, social and emotional wellbeing and I would use my discretion for my team, because this is what we do, use my discretion as the manager to say "ok, you've done this work overnight you can have tomorrow off, rest up and come back" but I'm questioned and finger pointing because you know what [they say], "why are you allowing your workers this day off?" You know, why do we have to justify over and over, because the consequences is greater, either for our community or for the person themselves, their mental health...'* (Workshop Participant).

There were positive experiences of workplace support and acknowledgement of community roles within suicide prevention and medical services, *'While I was working at the medical service, when there was a suicide or attempted suicide they'd usually call us in and we'd go and sit with the family, and assist with the family [with] whatever assistance they needed, and they just said "just write your hours down. However long you were with them" [and claim the hours]'* (Workshop Participant).

Culturally valid understandings should shape and guide the provision of services. In particular, the process of assessment, care and management of Aboriginal and Torres Strait Islander wellbeing and mental health. Recommendations in the *Solutions That Work* report (Dudgeon et al., 2016) demonstrate that mental health and suicide prevention programs must be owned by the community. This means that the needs of Aboriginal and Torres Strait Islander communities should be identified by members and those with lived experience, encouraging self-determination and cultural governance from a place of Indigenous leadership. Indigenous mental health and suicide prevention programs and services must be guided by culturally informed practices, in consideration of Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing. One participant expressed the need for in-depth mental health management plans, specific to individual context, *'...this is how I look at it, I look at it like going to the doctors and they say "you're on the onset of diabetes, I need to put in place a management plan alright, eat healthy, do this, do that" this is what we should be doing, what management plan have we got in place for people and the kids [wellbeing]...'* (Workshop Participant).

With connection to Country, culture, and kinship as protective factors for Aboriginal and Torres Strait Islander health and wellbeing, a strategy might be to have regular retreats that people could attend. One participant

discussed the possibility of culturally based retreats, where individuals learn and grow, which in turn leads to community protection and resilience, *'Lived experience retreats on country, so you say to people, ok, you know "do you do this, do you do that, do you do this in your family or your community, this might be a retreat that you might want to come on". Then you build the capacity of a smaller group of people that connect to larger communities, so it has a ripple effect once they come out of that retreat, inside the retreat you could do things like education, you can be on country, like I know with us, we're looking at the PHN (region), we're going to go on a retreat, and what we're going to do is, one of the days, we're splitting to go men's lake, women's lake on (location), the (local Aboriginal/language group) people, so we're actually specifically going to go on country and a lot of us do have the lived experience, we are LGBTQI people, so we're looking at those models and building the resilience of people inside of those to come back to community and work out what our pathways are...'* (Workshop Participant).

With the involvement of lived experience experts, localised strategies and initiatives should be designed and implemented to work collaboratively with other initiatives. Participants discussed the importance of lived experience campaigns, developed locally, by Indigenous peoples, *'And you know what could be good as well, and I don't know there could be something around this actually, in localised ways, not the same in every community, but a lived experience campaign, that actually speaks to our community, through our AMS's, through our Aboriginal housing, through our grass root community organisations, but developed authentically through localised grass roots people and what they want in those lived experience campaigns, that paint a picture and connect with 'this is what lived experience is', in that campaign, with the same message maybe...'* (Workshop Participant).

Participants found that primary prevention strategies should include multilevel approaches, such as culturally responsive clinical support integrated with Indigenous conceptualisations of wellbeing and healing, and culturally safe phone services provided by appropriate people. Participants discussed the importance of appropriate support workers available for phone counselling services, as a means of providing appropriate services to communities generally, and particularly for youth and LGBTQI+SB specific needs, *'...the LGBTQI+ phone counselling service, is QLife nationally, and then in the states it has all the little centres, so Diverse Voices is for Queensland and stuff, so what we've done is we've actually brought in our own Aboriginal and Torres Strait Islander mob, Brother-boys and Sister-girls to answer the phones and they're doing their counselling training and stuff, so instead of saying to our mob to ring the phone number and not get to talk to our mob on the phone, I said 'if you're serious about it, put our mob in there on the phone' you know, let's start training our mob up so that, you know, there is a response, and straight away we've had a response from Palm Island, the Sister-girls over there just, on the line, on the line...'* (Workshop Participant). The idea of culturally responsive phone services as effective primary prevention was supported by others, *'Yep, I mean, like you say, this Aboriginal call centre, I mean how long has Lifeline been around? That's what we should be calling for, you know saying ok, we've got appropriate services, I mean, you've got a bloody Indigenous taxation mob now, you know you've got this, so we should be having the equivalent, you know, you've got the Indigenous call centre for Centrelink...'* (Workshop Participant).

Approaches to Indigenous suicide prevention must be inclusive of people with lived experience of suicide. Findings from the *Solutions That Work* report recommend that in order to develop and provide suicide prevention programs, the approaches must be community-based and community-led; promoting Indigenous leadership and partnership with Indigenous communities (Dudgeon et. al., 2016). Participants summarised the discussions, *'We've got the definition, provide education, information, management plan, lived experience retreat, build capacity, ongoing support is crucial, lived experience campaign developed by local people, lived experience Aboriginal advisory, groups and boards, natural helpers, vigilant doctors and nurses in ED, that sounds really great but you know...[how does this become a reality?]'* (Workshop Participant). These approaches respect the rights of Indigenous people to be leading and involved in the design and delivery of services to be provided to their community. *'We put up here lived experience campaign developed by local people, so that there's actually a campaign out there so that they, you know, what's actually going on and it's developed by us and it's put out by us...'* (Workshop Participant).

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## Conclusion

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The Lived Experience Project is one of many initiatives undertaken by the CBPATSISP to ensure Aboriginal and Torres Strait Islander leadership in suicide prevention and cultural, social, and emotional wellbeing. The findings of this Project reflected the majority of themes emerging from previous research in the field. However, the outcomes highlighted the unique experiences of Aboriginal and Torres Strait Islander peoples who have lived experience of suicide. The themes from the workshop are powerful and specific to the insight and expertise gained through participants' lived experience. In particular, the theme identifying *The Need for an Indigenous Lived Experience Definition and Network* was discussed by all participants and grew from a genuine need in their own lives and experiences. This theme linked closely to other areas of importance including cultural responsiveness and self-determination.

Whilst coming from diverse professional, geographical, and community backgrounds, participants acknowledged and identified with the impact of a history of colonisation and influence of social determinants on wellbeing for Aboriginal and Torres Strait Islander peoples and communities. The majority of participants advocated strongly for community-based initiatives, guided by lived experience experts as a means of increasing self-determination and empowerment for people and their communities, as well as reducing suicide and increasing cultural, social, and emotional wellbeing. Without appropriate funding and culturally responsive leadership, Aboriginal and Torres Strait Islander peoples, and therefore, their families and communities will continue to be disadvantaged. Funding must be tailored appropriately for each individual program or service, and ensure adequate time for efficient program design, delivery, and evaluation.

Experiences of grief and loss were expressed by all participants, both in relation to their lived experience of suicide and within other aspects of their lives. There was a strong emphasis on including the concepts of loss of country and culture, which continue to impact the social and emotional wellbeing of Aboriginal peoples and communities. The (in)ability of mainstream organisations and support people to comprehend, understand or appreciate the prevalence of grief and loss within the daily lives of Aboriginal peoples was discussed. This was seen as a barrier to the effectiveness of mainstream programs and services as well as a source of compounding trauma for Aboriginal peoples and communities. Mandatory cultural responsiveness training and awareness for mainstream organisations was advocated as a means of reducing the impact of this additional grief and loss felt by participants, their families, and their communities.

These concepts extended further as Aboriginal LGBTIQ+SB participants shared their experiences of racism and exclusion in mainstream LGBTIQ+ organisations. The lack of capacity and understanding by mainstream organisations of the unique experiences of Indigenous LGBTIQ+SB peoples contribute to further compounding trauma and a lack of support for self-determination. Participants highlighted the need for increased visibility and presence of LGBTIQ+SB Indigenous peoples in decision making around suicide prevention and increasing cultural, social and emotional wellbeing.

Aboriginal and Torres Strait Islander understandings and practices of wellbeing and healing must be prioritised. These concepts should be valued by non-Indigenous organisations and support persons, in order for them to be recognised and prioritised to ensure that Indigenous peoples and communities have sufficient access to them. Participants strongly advocated for the need to challenge the assumption that Western approaches are superior to Indigenous methods, and instead prioritise culturally responsive approaches.

Many participants expressed frustrations of providing information that is similar to advice provided over the years with little or no change. Governments have not appropriately responded to previous reports. Participants spoke of feeling ignored and discriminated against by governments and government agencies. Despite this, all participants dedicated their time, energy, and expertise to the Project. It is intended that this report and its associated publications will provide information to enable governments to initiate and support positive and empowering change. Participants all highlighted the strengths of culture and emphasise the resilience of Aboriginal and Torres Strait Islander peoples and communities as the most important issue in suicide prevention.

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# Appendix One: Donna's Poem

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## Tears in the Dust

They all lived happy, healthy and well  
They didn't know, they couldn't tell,  
That, their beautiful lives would turn into a living hell.  
That's when they came, causing havoc and pain  
It would never be the same again.  
Then came the day, when they took them away.  
They cried & cried all night & day  
They went to the coast and down south to stay,  
No-one really knew, they just guessed which way.  
They sang their songs & sang all night long,  
Wondering what happened, what went wrong.  
Worrying for babies, wondering where they could be.  
They could be perished in the bush or lost at sea.  
Some women went mad with all the worry,  
Some tried to hang on to wait for them to come home.  
So many searching from near & afar,  
So many wondering where each other are.  
Then comes the day when some find their way  
Oh what a joyous, happy day.  
Then show them the place, where they cried that day  
The tears in the dust are still there today.

(Smith, 2016, p. 25).