Beyond evidence-deficit narratives in Indigenous suicide prevention
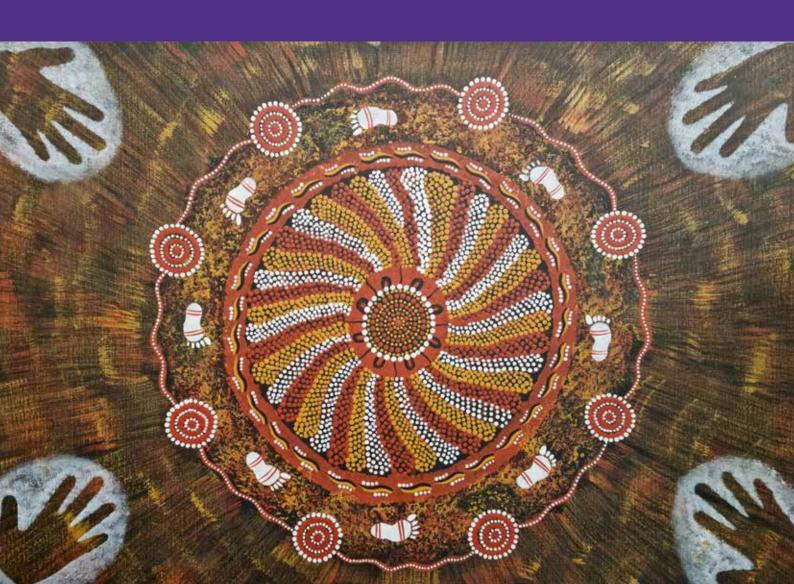
Pat Dudgeon, Abigail Bray, Ian Ring and Rob McPhee

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Contents

About the cover artwork:

Artist: Linda Huddleston

Title: The journey towards healing

At the centre of the artwork is the Clearinghouse. The black half-circles are the people who come to the Clearinghouse for information about mental health and suicide prevention.

The waves of red, yellow and white dots surrounding the inner circle represent strength and healing.

The footprints represent the journey towards healing.

The red and white circles around the edge represent different programs and policies aimed at helping people heal.

The hands represent success and wellbeing.

Summary

Beyond evidence-deficit narratives in Indigenous suicide prevention

What we know

- There are many examples of successful suicide prevention interventions for indigenous people, but many are excluded from evaluation and research literature because of the way 'evidence' is defined.

- Aboriginal and Torres Strait Islander people (Indigenous Australians) view health in the context of a holistic, collective, social and emotional wellbeing (SEWB) model of community healing.

- Most of the evidence for suicide and suicide-related behaviour in the community (suicidal attempts, suicidal ideation and self-harm) is not reported or monitored, so the national and international evidence base for suicide prevention programs and suicide prevention policy is underdeveloped.

What works

- Complex interventions such as suicide prevention initiatives and programs are best evaluated using a realist review approach.

- An experimental reform approach to complex system interventions recognises the importance of learning from failures through a process of continual evaluation and builds a practice-based evidence base.

- Embedding evaluation into the policy cycle ensures that the implementation of evidence-based policy is effective and useful for Indigenous Australians.

- A narrative synthesis, as recommended by the Cochrane Review Guidelines, can help inform the implementation of complex interventions.

What doesn't work

- Evidence hierarchies that prioritise systematic reviews of randomised control trials (RCT) are limited in scope and so are not suited to evaluating the evidence from complex interventions such as suicide prevention programs and strategies.

- Similarly, complex intervention policy should not be based predominantly on evidence from RCT.

- Evaluations of Indigenous suicide prevention programs that are not placed in the context of an Indigenous model of community healing, knowledge systems, evaluation measures and tools produce an evidence base that has limited use for Indigenous communities.

- Unrealistic policy and program goals that underestimate the complexity of the problem not only risk failing but also deliver a weak evidence base that puts future funding and support for interventions at risk.

- Evidence-based programs and policies should not be implemented without continual evaluation of the implementation process and the evidence base used to inform the policy.

What we don't know

- A comprehensive Indigenous-defined evidence base for suicide prevention and SEWB (healing and wellbeing) is lacking.

- Indigenous-specific and culturally appropriate evidence of healing has yet to be fully developed, measured or integrated into Indigenous suicide prevention evaluations. Evidence of healing within the domains of SEWB, for example, has yet be developed.

1

Introduction

1   Introduction

There have been consistent calls in recent years for evaluation frameworks of suicide interventions that reflect the knowledge systems and community needs of Aboriginal and Torres Strait Islander people (hereafter Indigenous Australians; Cargo et al. 2019; Finlay et al. 2021; Productivity Commission 2020; Walter et al. 2020). These calls are aligned with the right to Indigenous self-determination that is enshrined in the United Nations *Declaration of the Rights of Indigenous Peoples* (UN 2017):

> Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions (Article 23).

> Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicine, knowledge of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. (supra note 80, at article 31).

While an evidence base for specific interventions exists (Doupnik et al. 2020; Mann et al. 2021; Zalsman et al. 2016), there are few evaluation frameworks (Platt et al. 2019).

The absence of health equity evidence in systematic reviews has been recognised for some time (Petticrew et al. 2004). Indeed, it has been estimated that only 20% of MEDLINE systematic reviews address health equity questions (Welch et al. 2012). The issue is likely to be compounded in relation to the complex health equity issues facing Indigenous populations because most of the evidence guiding suicide prevention policy and programs comes from systematic reviews.

Understanding the complex relationship between evidence, effectiveness and policy (and the resulting funding) is a challenge for evaluating suicide interventions and for public health interventions more broadly. Suicide prevention interventions often combine multiple public health interventions with clinical interventions. Overall, 'evaluating complex interventions with multiple components makes it hard to determine the effective elements' (Mann et al. 2021:10).

There are a number of issues associated with the implementation and evaluation of suicide prevention strategies. Foremost among them is the difficulty in ensuring timely, accurate identification and recording of suicides (Australian Government Senate Community Affairs Reference Committee 2010). Factors affecting the process include the difficulty determining intent, the duration of the coronial process, differing coronial legislation and practice, and inconsistency in police data collections. Family pressure to avoid recording death by suicide can also arise from perceived stigma and also insurance and financial issues (Australian Government Senate Community Affairs Reference Committee 2010).

Other issues include:

- difficulties in ascertaining whether changes in suicide rates are part of a temporal fluctuation in 'normal' periods or the result of a prevention strategy
- difficulties with the accurate measurement of levels before (the 'baseline'), during and after implementation of the strategy
- how implementation is defined, including stages of implementation and the implementation of second generation strategies
- systemic gaps between the strategic suicide prevention plan and the actual implementation of the strategy
- failure to identify and analyse the impact of confounders and covariates, for example, economic recession or political disruption
- use of traditional evaluation approaches, which are 'likely to limit opportunities for learning about the intricate pathways between the program (as a whole and through its component parts) and intended outcome' (Platt et al. 2019:79).

This paper explores the issues of evidence, evidence hierarchies and evidence-deficit narratives in Indigenous suicide prevention. It examines:

- the need to expand the definition of 'evidence' beyond randomised control trials (RCT) and systematic reviews so that Indigenous-developed programs will be clinically useful, culturally specific, and supported by funding agencies (Sahota & Kastelic 2012)
- evidence-based practice and the evaluative bias that may be introduced by RCT
- the value of practice-based evidence, realist reviews and Indigenous-led innovations in suicide prevention
- the role of self-determination across the entire process of program design, implementation and evaluation, including culturally sanctioned understandings of what counts as useful evidence of healing for communities
- the importance of embedding evaluation in all policies directed at Indigenous suicide prevention
- the need to continually evaluate the implementation of those policies through a capacity-building participatory process
- the importance of building evidence through a combination of culturally appropriate processes and evaluation of impacts and outcomes.

A strengths-based approach to resolving the gap between Indigenous suicide prevention evidence and practice policy would also recognise the innovations that already exist in the field. This approach would affirm an Indigenous evidence base for suicide prevention and challenge the evidence-deficit narrative surrounding suicide prevention.

2

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Background

2   Background

Suicide interventions are complex interventions due to the sensitive nature of suicide and suicide-related behaviour. Decades of research have not yet been able to accurately predict who will die from suicide, when or where.

The evidence hierarchy used to assess Indigenous suicide prevention programs often risks downgrading innovations in practice because they do not conform to particular dominant hierarchical evidence pyramids, which are governed by the importance of RCTs. As Malezer (2013:69) argues:

> Conventional evaluation methodologies…fail to comprehensively understand the full range of factors that contribute to the successful delivery of services to Aboriginal and Torres Strait Islander clients. Consequently, there is a failure to understand how programs for Aboriginal and Torres Strait Islander communities can be delivered and evaluated in a framework of self-determination.

This paper examines 2 broad paradigms of evidence that drive programs, policy and prevention strategies:

1. evidence-based practice—based on clinical models evidence gathered through RCT

2. practice-based evidence—based on continuous refinement in response to outcomes.

Evidence-based practice

Evidence-based practice has been a dominant model since the 1980s. It was founded on a biomedical model of evidence gathered in clinical RCT to avoid harmful and wasteful practices in health interventions. In advocating for RCT, Cochrane (1972) was calling for the evaluation of health care strategies to streamline the provision of accurate and reliable health care.

A lay definition of evidence-based practice is an approach to prevention, including treatment, which is supported by scientific evidence usually gained from clinical trials. An example of evidence-based practice is the wearing of surgical masks and protective clothing by nurses in hospital settings in order to prevent the spread of infectious illnesses. Vaccinations for infectious diseases are also an example of how evidence-based practice is based on evidence-based medicine. Much of evidence-based medicine is based on clinical trials.

Evidence from RCT was and is central to evidence-based practice. RCT is a comparison between 2 groups—one is the subject of the intervention (for example, a drug, or a diet)—and the other group (known as the control group) receives no intervention (or a placebo). Members of the groups are selected at random to avoid bias. The differences between the 2 groups is then measured. If the RCT is 'blinded'—if neither group knows what it is they are being subjected to—then the evidence is understood as stronger because it is less influenced by non-controllable (biased) reactions to the experiment.

Evidence from RCT is often used to inform the practice base for various kinds of medical treatments and even public health interventions. In relation to suicide prevention, the findings from RCT have supported the use of drugs such as ketamine, which has been found to reduce suicidal ideation in the short term (Grunebaum et al. 2018).

The strengths and limitations of RCTs are widely recognised (Olofsgård 2014). Limitations involve external validity (generalisability) and the narrowness of selection, leading to a lack of applicability to real world situations. In the 'real world', interventions are not delivered in a controlled setting but in a complex, fluid social system with unpredictable variables (for example, fluctuating social determinants) that influence the effects of the intervention (Baker et al. 2009).

Indigenous suicide prevention interventions that do not conform to the rules of RCT are often not accounted for in the larger picture of evidence-based suicide prevention. For example, the White Mountain Apache Tribe Suicide Surveillance and Prevention System resulted in a 38.3% reduction in suicide and a 23% decrease in youth suicide, along with a significant reduction in suicide attempts. Despite being a successful indigenous-led suicide prevention innovation, it does not register as evidence of prevention within an evidence hierarchy dominated by systematic reviews of RCTs (Cwik et al. 2016).

For non-Indigenous and Indigenous populations alike, the fluctuating impact of social and cultural determinants cannot be predicted or accurately measured (Green 2006, 2008). These issues are compounded when a complex intervention is addressing 'wicked problems' such as Indigenous suicide and the clustering of social determinants influencing suicide.

The result is that the public health implications of Indigenous systems may not be considered. A reliance on RCT can marginalise the centrality of culture in strengths-based approaches that are connected to Indigenous knowledge systems, the role of Elders, and the protective force of life-affirming cultural values. It can marginalise Indigenous ways of being, knowing and doing in relation to the prevention of the suicide of their people.

Further, as Kirmayer noted, the 'production of evidence does not occur on a level playing field' (2012:254). Funding for evaluations is generally limited, so innovations in suicide prevention may be unreported and ultimately lost (Allen 2019).

Practice-based evidence

Practice-based evidence has developed as a response to the issues associated with RCT. It comes from a process of systematic, continual refinement of the evidence base for a program or complex intervention through rigorous gathering and continual testing of evidence. Knowledge is acquired in real-time and inductively, rather than years later when the findings of retrospective studies are adopted into evidence-based interventions.

This approach is realistic and improves the quality of the evidence base. It recognises the complexity of the system—the community, its environment, and the social and cultural determinants that impact the community. It is also linked to the principles of the primary health care movement, which recognises the agency of participants in any public health intervention as co-creators of change and sources of knowledge or 'evidence' about what works, for whom and when. It allows the intervention to become embedded in the community organically and have the potential to achieve holistic and long-term positive change. In this way, it supports the goals of improving public health and reducing wasteful expenditure and harmful or ineffective interventions.

Another way of defining practice-based research is as a 'systematic inquiry into the systems, methods, policies, and programmatic applications of public health practice' (Potter et al. 2006:3).

In other words, it is research into the whole system of practices involved in public health, including the relationship between practices and the policies, research and evidence supporting those policies and their implementation. Practice-based research also has affinities with 'participatory action research' and 'actor network theory' in that the subjects of the intervention, and indeed the intervention itself, are recognised as complex system change-agents. In this context, such approaches might examine the way that a public health intervention changes the whole ecology of a complex system—including government policy, schools, other social services and the culture of the society.

An example of a successful practice-based program to reduce anxiety and depression is the Improving Access to Psychological Therapies (IAPT) in the United Kingdom. Currently, IAPT is the world's largest publicly funded and implemented evidence-based psychological intervention (Wakefield et al. 2021).

> IAPT services have three distinctive features: a stepped care model of service provision, the implementation of evidence-based and highly standardised and protocol-driven treatments, and also the systematic use of *routine outcome monitoring* (Wakefield et al. 2021:2, emphasis added).

It is this last feature, the routine monitoring of patients, that has enabled IAPT to expand and refine the success of its practice through the use of evidence about how treatment is experienced. This program demonstrates the importance of practice-based evidence to the success of a large-scale mental health intervention.
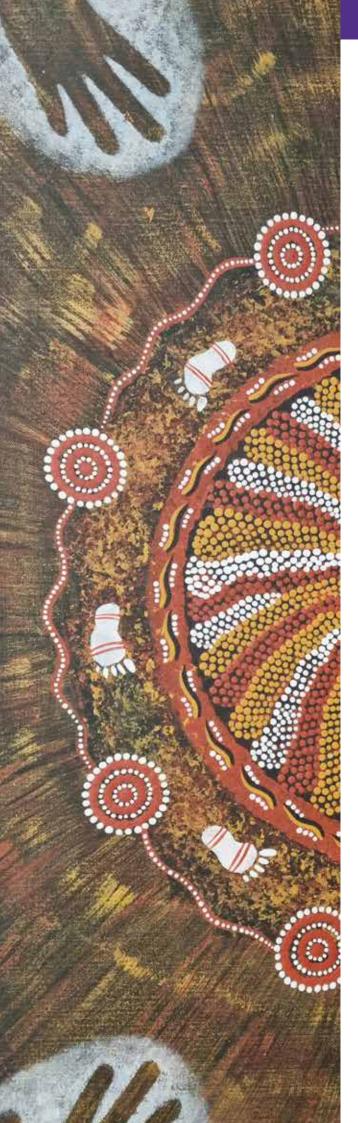
Researchers are calling for more practice-based evidence for Indigenous suicide prevention (Redvers et al. 2015; Sahota & Kastelic 2012). As IAPT demonstrates, the systematic use of routine outcome monitoring can build effective health interventions. It will also address a persistent narrative that Indigenous suicide prevention interventions lack sufficient evidence of effectiveness.

The Centre of Best Practice for Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) recommends that integrated suicide prevention in Indigenous communities should be implemented by primary health networks. They should use participatory action research evaluations and processes to build the evidence base for Indigenous suicide prevention (Dudgeon et al. 2018).

Data completeness

An additional complication to do with measuring the effectiveness of suicide interventions concerns the submerged data on suicide-related behaviour (non-fatal self-harm and suicidal ideation). Experts have argued that most suicide-related behaviour is composed of non-hospital-presenting, non-fatal self-harm in the community. An example is adolescent self-cutting. This self-harming behaviour is not always visible to experts or routinely self-reported, which affects systematic monitoring of this behaviour. Without evidence of the precise prevalence of non-hospital-presenting non-fatal self-harm, the effectiveness of interventions into suicide and suicide-related behaviour cannot be usefully measured.

A recognition that coronial data on deaths by suicide is the 'tip of the iceberg' of the larger problem is increasingly important to suicide prevention strategies and interventions. The extent of the hidden problem is significant: a study of self-harm in England estimated that for 'every girl who died by suicide, approximately 1200 presented to hospital following self-harm and 22,000 reported self-harm in the community' (Geulayov et al. 2018:171).

Sophisticated suicide and suicide-related behaviour surveillance systems are needed to capture these data so that interventions can be evaluated more effectively. Indeed, this is a key recommendation made in 2014 by the World Health Organization in Preventing Suicide: A Global Imperative (WHO 2014). Any system of gathering data on Indigenous suicide and suicide-related behaviour would need to be validated by the community and be culturally safe. This is needed to overcome the barriers to disclosure that are all too often the result of an history of being made vulnerable to harmful interventions and research. An option is to embed questions about suicide and suicide-related behaviour in culturally appropriate health surveys (Geulayov et al. 2018).

3

Key issues

3   Key issues

There is a pervasive narrative that Indigenous suicide prevention interventions lack sufficient evidence of effectiveness. A reason for this is the dominance of evidence hierarchies that pivot on RCTs for the evaluation of complex interventions, such as suicide prevention. This has been challenged for decades (Pawson et al. 2005; Schorr & Farrow 2011) with the turn from pure reductionist biomedical models of evidence-based practice to more participatory practice-based evidence (Green 2006, 2008) or evidence gathered by evaluating an intervention while it is being implemented.

There have also been calls to design evaluation strategies that reflect Indigenous knowledge systems, and in particular, an Indigenous definition of what counts as useful evidence for Indigenous communities (Albert et al. 2019; Kirmayer 2012; Redvers et al. 2015; Sahota & Kastelic 2012; Schneider 2014).

Evidence hierarchies and the evidence-deficit narrative

There is a lack of evidence for practices that reduce suicide and suicidal behaviours (Gupta et al. 2020). A systematic review of suicide prevention interventions in Australia, New Zealand, the United States of America and Canada concluded there is an overall lack of evidence on the most effective strategies (Clifford et al. 2013). Gupta et al. (2020:16) advised that 'robust research and evaluation approaches are required to generate the relevant evidence base and inform the development of a nationally recognised promising practice guide'.

The general evidence base for public health interventions involving Indigenous populations in Australia is frequently argued to be lacking (Cargo et al. 2019; Hudson 2016; Paul et al. 2010). Many studies on Indigenous suicide prevention make statements to the effect that there 'is very little evidence on the effectiveness of suicide prevention strategies in Indigenous communities' (CAMH 2020:15). For example, a scoping review of SEWB programs and services targeting young people found a paucity of evidence and research on promising practices. It advised that:

> robust research and evaluation approaches are required to generate the relevant evidence base and inform the development of a nationally recognised promising practice guide (Gupta et al. 2020:16).

Conducting RCT in Indigenous communities is fraught with methodological and ethical issues (Harlow & Clough 2014). In response, some have urged researchers, policymakers and practitioners to collaborate as they focus on the evaluation of suicide prevention (Platt & Niederkrotenthaler 2020).

Ridani and others (2015:40) use the following hierarchy of evidence to assess programs in Australia:

A   The intervention has been shown in a randomised controlled trial to reduce suicidal behaviour.

B   The intervention has been shown in a randomised controlled trial to reduce suicidal thoughts.

C   Pre- and post-study outcomes show a reduction in suicidal behaviour or thoughts.

D   The intervention includes evidence-based strategies to reduce behaviour or thoughts.

E   The intervention has been shown to reduce risk factors such as depression, anxiety, stigma, or to modify help-seeking intentions.

F   The intervention has been tested with the specific population, for example youth.

The assessment by Ridani and others (2015) identified 4 programs that aim to assist Indigenous people. The first 3 are rated E and the last a C:

• Aboriginal and Torres Strait Islander Mental Health First Aid (E)

• Suicide Story (a DVD-assisted program) (E)

• LivingHope Bereavement Support, developed by The Salvation Army (E)

• Standby Response Service, a community-based suicide postvention program (C).

Bainbridge and others (2018) conducted an evidence check of peer-reviewed literature published between January 2013 and September 2018 on improving SEWB for Indigenous Australians. The aim was to discover evidence for the reform of mental health and suicide prevention approaches:

> to identify promising policies, programs and services that can underwrite transformational policy reform as an important contribution to strengthening the social and emotional wellbeing of Indigenous Australians (Bainbridge et al. 2018:5).

The study used the Canadian Hierarchy of Evidence for Promising Practices (Canadian Homelessness Research Network 2013), which defines best practice as the 2 top levels of their pyramid evidence hierarchy:

• Level 1—systematic reviews

• Level 2—RCT and quasi-experimental studies

• Level 3—promising practices, including realist reviews, case studies with evidence of effectiveness (external evaluations with scientific rigour), and case studies with encouraging results (internal or external evaluator that lacks scientific rigour)

• Level 4—emerging practices, which is composed of program descriptions (or reports with limited data or evidence) and opinions (ideas, policies, editorials).

The key findings of this study found that there were no publications:

> that provided best-practice evidence of policies, programs or services that have been effective in improving social and emotional wellbeing for Indigenous people. Twelve peer-reviewed literature sources and two grey literature sources provided evidence of promising practice, and 17 peer-reviewed and six grey literature sources provided evidence of emerging practice. Of the promising practices, 15 peer-reviewed and two grey literature publications described Australian policies, programs or services (Bainbridge et al. 2018:7).

Significantly, Bainbridge and others (2018) identified only 2 publications that also included a SEWB component.

The application of the Canadian Hierarchy of Evidence for Promising Practices and similar evidence hierarchies imposes an *evidence ceiling*. For example, it excludes the work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) and that of Dudgeon and others (2016), despite their importance.

Like a glass ceiling, this evidence ceiling is a barrier to progressing the status of complex interventions such as Indigenous suicide prevention strategies and programs. They are 'stuck' at Level 3 because of their complexity. This could be read as a failure, or a lack of evidence, when it is possible that the evidence hierarchy is not appropriate for complex interventions such as Indigenous suicide prevention.

This evidence ceiling has been used to bolster an Indigenous *evidence-deficit narrative* about Indigenous programs and interventions, which then lose much-needed funding on the grounds that there is not enough evidence that they are working (Kinchin et al. 2017; Rollenston et al. 2020), even though the lack of evidence is common to the field in general.

In order to move beyond this evidence-deficit narrative, it is necessary to create a community validated Indigenous evidence hierarchy of what counts as culturally important evidence of best practice, using Indigenous knowledge systems and methodologies, measurements and evaluation tools.

Realist evaluations and suicide prevention

A realist evaluation looks beyond whether something works to try to understand what works, in which circumstances, and for whom (Pawson et al. 2005). It focuses on 'the particulars of specific measures in specific places for specific stakeholders'.

Realist evaluations are considered to be the most appropriate by the discipline of suicidology and the International Association of Suicide Prevention because suicide prevention strategies are complex systems. They often combine several theories of program logic with many dynamic relationships between parts of the program that respond to fluctuating contexts in different ways (Pawson et al. 2004; Platt et al. 2019).

The Cochrane Review guidelines also advise against conventional evaluation approaches. It notes that a meta-analysis of data from different complex interventions (such as suicide prevention programs) would mean combining data that have been produced using potentially incompatible methodologies and contexts from a wide range of interventions (Ryan & Cochrane Consumer and Consumers and Communication Review Group 2013). Instead, what is advised is a 'narrative synthesis', which is a form of realist review (Pawson et al. 2005).

Narrative synthesis

A narrative synthesis brings together similar elements across multiple studies to tell a 'story' about the combined findings. This is done by discovering a common theme across the studies. While a narrative synthesis can use statistical data, it mostly uses a contextual approach.

A narrative synthesis has 4 major steps in the synthesis of reviews of complex interventions:

1. Identify the theory of how the intervention works, why and for whom. Consider the pathway whereby the intervention is thought to operate: are there outcomes directly influenced by the intervention? Are there intermediate outcomes that should be reconsidered when systematically reviewing the evidence?

2. Develop an initial synthesis of the complex interventions and group them into categories such as intention, population groups and context.

3. Examine the relationship between the data in the interventions.

4. Assess how robust the data relationships are (the synthesis) by examining, for example, the quality of complex interventions and the quality of the methodology of those interventions.

As a form of narrative synthesis, the realist review assesses complex interventions with the purpose of developing evidence-based policy. Realist reviews seek to understand why programs work. It aims to understand what is at play in interventions by analysing the context that enables successful interventions.

What counts as evidence? What counts as healing?

Evidence of the success or failure of a suicide prevention intervention usually rests on 2 statistics:

• changes in rates of death by suicide

• changes in rates of suicide-related behaviour (suicide attempts, self-harm and suicidal ideation, or thinking about and planning suicide).

Evidence of a reduction in either measure that can be clearly attributed to the impact of a prevention intervention is essential to the development of further interventions and the implementation of evidence-based policy. As *Solutions That Work* (Dudgeon et al. 2016) elaborates, Indigenous measures, or evidence, are also important:

> Evaluating outcomes depends on the scale of the activity, and outcome indicators could include measurable reductions in suicide, attempted suicide and suicide ideation across a defined area by comparing 'before and after activity' data. As discussed, because the numbers of people who complete suicide is relatively small, and particularly for activity in a single community, this might not be suitable for evaluating outcomes. In this case, broader outcomes assessment may need to be considered. This could include measurable reductions in risk factors for suicide such as changes in at-risk behaviours including reductions in self-harm, alcohol and drug use. In addition, measurable improvements to the social and emotional wellbeing of the community with a focus on self-governance, cultural activity, physical health, employment, community safety and school attendance might also be relevant (Dudgeon et al. 2016:41).

Such measures—self-governance, cultural activity, physical health, employment, community safety and school attendance—also reflect the 'cultural continuity' theory of Indigenous suicide prevention that was established through the comprehensive research of Chandler and Lalonde (1998). These measures also reflect the articulated needs of communities for self-determination and healing from the trauma of colonisation.

The importance of creating a needs-based evidence base for complex interventions is highlighted in Schorr and Farrow (2011), who argue that in order to improve outcomes, it is necessary to determine through research and theory what the specific needs of a group or a community are. This approach is relevant for Indigenous people:

> Cultures provide their own interpretive frameworks, notions of authority and standards of truth. Listening to the voice of patients therefore means considering other sorts of evidence: not only their own 'subjective' experience but also the specific sources of authority and [their preferred] ways of knowing (Kirmayer 2012:253).

Self-determination over the evaluation of complex interventions, such as community-based suicide prevention, requires the right to determine what counts as *useful evidence* from an Indigenous standpoint. In this context, an Indigenous hierarchy of evidence that values a holistic, collective, SEWB model of community healing is different from a non-Indigenous hierarchy of evidence such as that of the Canadian Homelessness Research Network.

Most of the evidence for suicide and suicide-related behaviour (suicidal attempts, suicidal ideation and self-harm) is not available (AIHW 2020; Pollock et al. 2018). As a result, there are 2 components of preventative healing:

- reducing the known statistical gap between Indigenous and non-Indigenous suicide and suicide-related behaviour

- re-building or re-empowering broader whole-of-community wellbeing so levels of suicidal ideation and self-harm are healed.

Understanding what healing means for Indigenous people allows self-determination through interventions, which can then be guided accordingly (Schneider 2014) (see Box 1). For many Indigenous cultures, healing is a transformative process that strengthens cultural and spiritual knowledge and identity and reconnects people to life-affirming community lore about respect, responsibility and reciprocity (Ward et al. 2021). Many Indigenous knowledge systems about healing are relational—healing is understood as collective and expressed through relationships with others (family, community, culture, kinship networks, the spiritual realm, and Country).

Evidence of healing needs to be culturally specific and embody a holistic collective social and emotional wellbeing process (Grealy et al. 2015). Evidence of wellbeing across the domains of SEWB, for example, would represent culturally different forms of evidence. Similarly, evidence of a healing connection to the wellbeing domain of Country might include practising cultural activities related to ecological sustainability, guarding and healing Country, birthing on Country, or the renewal of land.

Box 1: Healing

Along with the absence of suicide and suicide-related behaviour, healing can be understood as the restoration of whole-of-community wellbeing through harmonious relationships between the 7 domains of SEWB.

- The Indigenous principles of reciprocity, respect, equity, cultural continuity, spirit and integrity, and responsibility govern the harmonious alignment of the SEWB domains of the body; mind and emotions; family and kin; community; culture, Country; and spirituality.

- Self-determination across the social determinants of everyday life and freedom from racism and discrimination is also central to healing. In this respect healing is more than just a whole-of -community process, it is a whole-of-Country journey involving the whole nation.

In 2009, the Aboriginal and Torres Strait Islander Healing Foundation conducted a historically important national consultation with 450 people in a series of 2-day workshops on the theme of healing. They also received 48 written submissions. The final report defined the aims of successful healing programs as strong cultural identity, SEWB and cultural renewal through increased control over their lives by:

> increasing social and cultural identity and self-esteem, cultural knowledge and skills and cultural connectedness. Healing involves a renewal and affirmation of language, dance, story, music, art, identity and land (Grealy et al. 2015:2).

The report from the national consultation resulted in Voices from the campfires (Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009). Grealy and others note that the report established 4 cultural pillars of healing (2015:6, emphasis added):

1. addressing *the causes* of community dysfunction, not its symptoms

2. recognising the fundamental importance of Aboriginal and Torres Strait Islander ownership, definition, design and *evaluation of healing strategies*

3. designing initiatives based on Aboriginal and Torres Strait Islander world-views, not Western understandings

4. strengthening and supporting initiatives that use positive, strengths-based approaches.

This approach focuses on prevention—on causes rather than symptoms. It provides for self-determination over the healing process including the evaluation of healing strategies, Indigenous world-views (including, for example, SEWB), and the importance of adopting strengths-based approaches.

Self-determination of the evaluation of healing strategies is in alignment with: the United Nations Declaration of the Rights of Indigenous Peoples (UN 2007), the global emergence of the Indigenous Data Sovereignty Movement (Kukutai & Taylor 2016), best practice in Indigenous suicide prevention (Dudgeon et al. 2016; Sahota & Kastelic 2012), and the Productivity Commission's *Indigenous evaluation strategy* (Productivity Commission 2020).

Furthermore, there are complex issues around the cultural property rights of local communities over the process of healing, including their rights over Indigenous data. Indigenous data is defined as:

> information or knowledge, in any format or medium, which is about and may affect Indigenous peoples both collectively and individually [and the right to data comprises the right to] govern the creation, collection, access, analysis, interpretation, management, dissemination and reuse of the data (Aboriginal and Torres Strait Islander Data Sovereignty Collective in Australia 2020:243).

This includes the right to culturally sensitive data about healing. For example, in a review of culturally appropriate evaluations of tribally based suicide prevention programs, Sahota & Kastelic (2012:106) note that:

> Tribes using traditional spiritual/cultural ceremonies to prevent suicide may also be hesitant to evaluate these, since doing so might require documentation and sharing of information about sacred ceremonies.
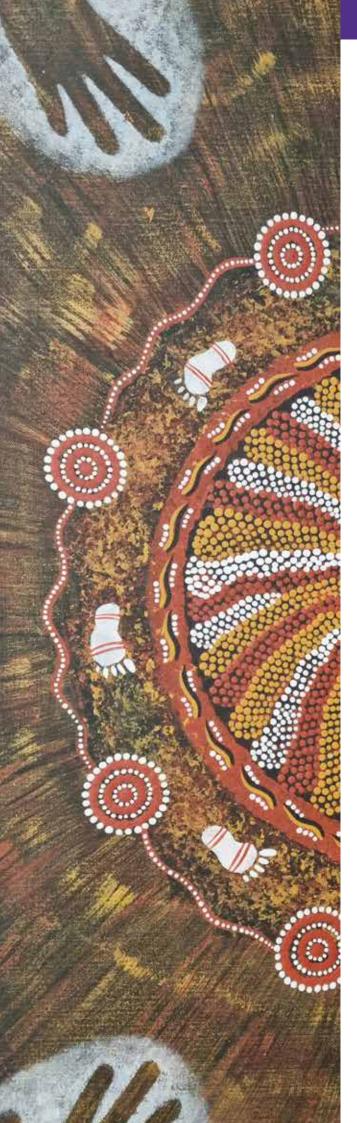
Such ceremonies might be described as 'culture' or 'cultural practices' in order to protect the spiritual and therapeutic knowledge from an evaluation process that might be understood as a form of destructive assimilation.

Finally, Indigenous people have defined healing as telling the truth about the effects of colonisation on their lives, including the history of the Stolen Generations and intergenerational trauma. Healing is understood as a journey that involves processing the past— 'looking back to look forward' (Healing Foundation 2020:18)

The importance of truth telling was also highlighted by the Victorian Aboriginal Community Controlled Health Organisation in the Productivity Commission's (2020) *Indigenous evaluation strategy* background paper in relation to Indigenous people defining what is important to improving their wellbeing and their lives.

The submission to the background paper also identified the importance of improving lives through 'relationships, connection to Country, community and culture (including a sense of belonging), empowerment, and self-determination (the right to make decisions on matters that affect the lives and communities of Aboriginal and Torres Strait Islander people)' (Productivity Commission 2020:60).

The core values or ethical lore of Indigenous people that include 'reciprocity, respect, equity, cultural continuity, spirit and integrity, and responsibility' (NHMRC 2018, cited in the Productivity Commission 2020:61) underpin healing and wellbeing.

4

Policy context

4 Policy context

There are a number of policies and frameworks that protect Indigenous self-determination over research and evaluation, including all Indigenous knowledge systems.

National strategies

Fifth National Mental Health and Suicide Prevention Plan

The *Fifth national mental health and suicide prevention plan* promises that governments will improve data collections and combine evaluation efforts to 'build the evidence base on 'what works' in relation to preventing suicide and suicide attempts' (COAG 2017: Action 4).

Action 13 aims to strengthen the evidence base for better Aboriginal and Torres Strait Islander [mental health] outcomes, specifically:

13.3   ensuring that future Aboriginal and Torres Strait Islander investments are properly *evaluated* to inform what works

13.5   utilising available health services data and enhancing those collections to improve services for Aboriginal and Torres Strait Islander people.

National Suicide Prevention Strategy (2007)

To achieve the National Suicide Prevention Strategy's objective and goals, the Life is For Everyone Framework (the LiFE Framework) sets out 6 action areas that have been adapted by other suicide prevention strategies, including the *National Aboriginal and Torres Strait Islander suicide prevention strategy* (Department of Health and Ageing 2007). The action areas relevant to evidence include:

• improving the evidence base and understanding of suicide prevention through building a high-quality body of research on effective activities and developing thorough evaluation methodologies (Action area 1)

• implementing standards and quality in suicide prevention and drawing on the evidence base to determine effective activities (Action area 6).

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013)

Outcome 2.1 of the *National Aboriginal and Torres Strait Islander suicide prevention strategy* (2013) is to have 'culturally appropriate community activities to engage youth, build cultural strengths, leadership, life skills and social competencies' (Department of Health and Ageing 2013a), specifically to:

• develop criteria for support of cultural programs

• review evidence for effectiveness of culture-based initiatives and evaluate cultural strengths programs.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

Outcome 1.2 of the *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017–2023* seeks a 'strong evidence base, including a social and emotional wellbeing and mental health research agenda, under Aboriginal and Torres Strait Islander leadership' (PM&C 2017).

Key strategies include:

- Key strategy 5—Support practical applied research to progressively enhance service delivery.

- Key strategy 6—Promote *participatory action research* to progressively empower communities and restore and promote SEWB.

National Aboriginal and Torres Strait Islander Health Plan 2013–2023

Evidence-based practice is 1 of the 5 enablers listed in the *National Aboriginal and Torres Strait Islander health plan 2013–2023*. The goal is for health policies and programs to be clearly evidence-based and informed by robust health research and data systems (Department of Health and Ageing 2013b:18–19).

Key strategies to achieve this goal include:

- Promote best practice and innovative approaches guided by research, monitoring and *evaluation* activities.

- Continue to expand *continuous quality improvement* programs in Aboriginal and Torres Strait Islander community controlled health organisations and mainstream health services and support the sharing of lessons for the improvement of patient services and outcomes, and the development of the health workforce.

- Promote the development of research systems and infrastructure that build evidence and support the *translation of evidence into policy and practice*.

- Promote the development of Aboriginal and Torres Strait Islander research leadership and the development of Aboriginal and Torres Strait Islander researchers.

- Build a contemporary evidence base on all aspects of health care including traditional healing and cultural models of care.

- Strengthened evidence base of knowledge across the life course and care continuum, in particular preventative health, including the factors that impact on childhood health and development.

- Quality and completeness of data to support continued policy development and improved service design, planning and evaluation.

Cultural Respect Framework 2016–2026

The *Cultural respect framework for Aboriginal and Torres Strait Islander health 2016–2026* outlines 6 domains that underpin culturally respectful health service delivery. Domain 6 focuses on data, planning, research and evaluation (NATSIHSC 2016:17):

- Requirement for new services, programs and initiatives to include a focus on cultural safety and responsiveness in program *evaluations*
- mechanisms in place for the identification and collection of data and relevant health information related to cultural safety
- dissemination of cultural safety related information/data throughout the organisation to inform planning and development
- organisational assessments and audits are undertaken to identify levels of cultural responsiveness.

Indigenous Evaluation Strategy

Within Australia, there is little attention to the evaluation of programs for Indigenous people. Few programs have been rigorously evaluated, and about a third of the evaluations of Indigenous-specific policies and programs reported engaging with Indigenous Australians when making decisions about evaluations (Productivity Commission 2020). Evidence-based practice and policy is not as robust as it should be.

There is a recognised need to improve the entire evaluation process for policies and programs impacting Indigenous people, especially in light of the failure of Closing the Gap to achieve benchmarks in improvements across a range of areas. To this end the Indigenous Advancement Strategy has identified 4 approaches:

1. Centering Indigenous Australian perspectives, priorities, and knowledges in all stages of evaluation
2. 'Lifting the bar' on the quality of evaluations of policies and programs affecting Indigenous Australians
3. Enhancing the use of evaluations to inform policy and program design and implementation, including by supporting a culture of evaluation and building an accessible body of evidence and data on the effectiveness of policies and programs
4. Promoting a whole-of-government approach to priority setting and evaluation of policies and programs affecting Indigenous Australians.

The *Indigenous evaluation strategy* provides a whole-of-government framework for Australian Government agencies to use when selecting, planning, conducting and using evaluations of policies and programs affecting Indigenous Australians.

The Strategy puts Indigenous Australians at its centre. It recognises the need to draw on the perspectives, priorities and knowledges of Indigenous Australians if outcomes are to be improved.

It also emphasises that evaluations must be useful, and to this end should ensure that:

- evaluation is embedded in the policy and program design and delivery cycle and is planned for early.

- evaluations are planned and conducted with the intention that the findings will be available at key decision points and used to inform decision-making by governments and Aboriginal and Torres Strait Islander people and other intended users of evaluation findings.

- evaluation findings and lessons feed into planning cycles, policy formation, program delivery and learning processes for agencies and Aboriginal and Torres Strait Islander people, organisations and communities.

- data is collected and used collected and used for evaluation align with data priorities (Productivity Commission 2020:15).

The Strategy therefore recognises that evaluation is not a stand-alone entity but an integrated component in the *policy planning cycle* and that the findings will be used continuously to improve outcomes to funders, policy makers, service providers and, most importantly, Indigenous Australians.

In relation to suicide prevention policies and programs, increased rates of suicide have been understood as evidence, or proof, that programs and policies are not working effectively. Increased suicide rates have also been linked to a lack of evidence for suicide prevention programs and policies.

A renewed commitment to refining the evaluation process and evidence base for suicide prevention was highlighted by the National Suicide Prevention Adviser (2020:n.p.) to 'ensure Indigenous governance over all aspects of research, evaluation and data collection'.

International and national policies and frameworks support and protect the cultural integrity of Indigenous ways of being, doing and knowing. These are all important to the maintenance of culturally appropriate research. Culturally appropriate research is important because it is able to overcome the numerous barriers that hinder the implementation of public health interventions and suicide prevention strategies and programs. The Indigenous-led reform of the mental health system and the ways in which suicide prevention research is conducted is an important shift that is supported by the overreaching right to self-determination.

State-based strategies

Vic Korin Korin Balit-Djak (2017–2027)

Korin Korin Balit-Djak (2017–2027) is a Victorian based plan to improve Indigenous Australian's health, wellbeing and safety (Department of Health and Human Services 2017). Strategic direction 1.1.1 aims to increase Aboriginal involvement in leadership and strategic government decision-making. Self-determination is a core principle of the plan.

> Self-determination is not simply another program or policy for government to roll out. It implicitly means that Aboriginal people take ownership, carriage and responsibility for designing, delivering and evaluating policy and services on their own terms. (Department of Health and Human Services 2017:20)

The plan emphasises the strong need for 'Aboriginal definitions of success and measurement and evaluation frameworks to be defined and implemented' (Department of Health and Human Services 2017:22). The plan aims to reform systems so they use Indigenous governance over evaluation processes—they should use Indigenous measures of success as the basis of their evaluation.

Priority focus 3.3 'Aboriginal leadership in governance and accountability' further explains the importance of control over evaluation and strategies for implementing self-determination. The following 2 strategic directions offer benefits to how we can develop of Indigenous suicide prevention evaluation strategies:

• 3.3.1 Aboriginal-led governance and evaluation using Aboriginal definitions of success

• 3.3.2 Increase Aboriginal community ownership of data and access to data.

For example, under 3.31 the following aims are pertinent to the evaluation of suicide prevention programs and strategies.

> f. Invest in Aboriginal organisations to develop research and evaluation capacity in health, wellbeing and safety.

> g. Share knowledge of effective and culturally appropriate approaches to manage and respect intellectual property, program delivery and evaluation. (Department of Health and Human Services 2017:22).

Over the next 3 years, the department will:

> Increase the use of Aboriginal research methods, evaluations and evidence to develop, implement and promote services and programs that work both in the department and in the community. (Department of Health and Human Services 2017:29)

The 10-year goals of this particular strategy include the following:

> Evidence-based, Aboriginal-led resilience building, healing and trauma-informed care and recovery approaches are embedded in primary and specialist social and emotional wellbeing and mental health responses. These will contribute to improved social and emotional wellbeing across Aboriginal communities with a reduction in the incidence and impacts of psychosocial distress, mental illness and suicide.

> Aboriginal children and young people have access to culturally appropriate services and reduced levels of psychological distress (Department of Health and Human Services 2017:29).
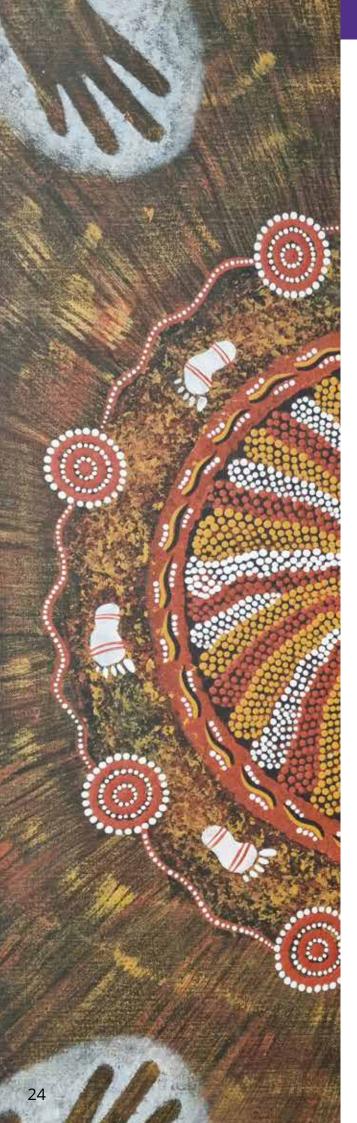
A rigorous evidence base is being developed through self-determination over evaluation design, data collection, measurement, indicators of success and research. This approach strengthens SEWB and works towards eliminating of suicide and suicide-related behaviour. This ambitious Indigenous-led reform is aligned with a human-rights approach.

WA Aboriginal Health and Wellbeing Framework 2015–2030

The WA Aboriginal Health and Wellbeing Framework 2015–2030 recognises the need to improve the evidence base about what works in order to improve health and wellbeing (Government of Western Australia 2015).

Accountability is a guiding principle: it specifically embeds evaluation into the implementation of an activity. This is addressed in 5.6 Priority area: 'Data, evidence and research', which advocates consistent monitoring and data gathering and management. There is a recognition that the under-identification of Aboriginal people is undermining the efficacy of health monitoring systems.

The following activities are suggested to address priority area 5.6 in regards to data, evidence and evaluation:

- Involve Aboriginal people and communities in the research agenda.
- Conduct research that is ethical, culturally relevant and of practical value to Aboriginal people and their service providers.
- Focus on identifying 'positive models' or examples of success.
- Build the capacity of the Aboriginal workforce to undertake research and evaluation of Aboriginal health policies and programs.
- Ensure Aboriginal people are not left behind in health research and application.
- Conduct priority-driven research, delivered in partnership with Aboriginal communities, Aboriginal community controlled health services and WA Health.
- Ensure data is available for program evaluation, at the time programs are planned and implemented.
- Review existing data sources collected across the WA health system that can improve understanding of Aboriginal health utilisation and profiles.
- Build the evidence base on health inequality, the social determinants of health and what works to improve them.
- Identify strategies to address the under-identification of Aboriginal people (Government of Western Australia 2015:21).

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Overarching approaches and best practice

5   Overarching approaches and best practice

There are some significant Indigenous-led and implemented prevention strategies that enable us to look beyond the evidence-deficit narrative in Indigenous suicide prevention. These include:

- the work of the AIHW Closing the Gap Clearinghouse
- the Aboriginal and Torres Strait Islander suicide prevention evaluation framework.

Closing the Gap Clearinghouse 2009–2014

The Closing the Gap Clearinghouse identified what does and does not work in programs and interventions with Indigenous communities. Kalisch & Al-Yaman (2013) found that:

- building blocks for successful programs and interventions include:
  - adequate resourcing and planned and comprehensive interventions
  - community involvement and engagement
  - respect for Indigenous languages and cultures
  - commitment to doing projects with, not for, Indigenous people
  - development of social capital
  - a recognition of underlying social determinants of health and welfare status
  - a recognition that issues are often complex and contextual.
- the following approaches don't work:
  - 'one size fits all' approaches
  - lack of collaboration and poor access to services
  - interventions without local Indigenous community control and culturally appropriate adaptation
  - short-term, one-off funding, piecemeal interventions, provision of services in isolation and failure to develop Indigenous capacity to provide services.

These principled building blocks have been identified by Indigenous communities across several frameworks (Dudgeon et al. 2016) and are readily applicable to Indigenous suicide prevention interventions.

The evaluation hierarchy used to assess program evidence is often not appropriate to Indigenous interventions (Kalisch & Al-Yaman 2013; Pawson et al. 2014). The Australian Institute of Health and Welfare has advised using a 'realist synthesis' because:

> high-quality evaluations can still come from observational studies, case studies, field visits, experts and lay knowledge and reports on interventions (Kalisch & Al-Yaman 2013:140).

There have been some important advances in the field of Indigenous evaluation in recent years. For example, Finlay and others (2021) have produced a conceptual map of culturally safe evaluation and highlighted the importance of aligning evaluations with community needs so that research is of clear benefit to communities.

Aboriginal and Torres Strait Islander suicide prevention evaluation framework

Significant and innovative work has also been conducted by ATSISPEP (2017). During 2014–2016, ATSISPEP identified key factors that are common to successful whole-of-community, on-the-ground, whole-of-government approaches to suicide prevention (Dudgeon et al. 2016).

Embedded in this work is a recognition that Indigenous suicide prevention involves engagement with complex systems, of families, communities, of the social and cultural determinants of those systems, and with the model of SEWB which can also be understood to be a complex system.

The CBPATSISP has refined this knowledge base in Indigenous suicide prevention. It is a repository for programs, services, guidelines, research and resources—including for evaluation—that are considered to be best practice in suicide prevention for Indigenous Australians (CBPATSISP 2020). The CBPATSISP evaluation tools are aligned with the central guiding principle of the new *Indigenous evaluation strategy* (Productivity Commission 2020) which is an expression of the international right of Indigenous peoples to be self-governing, including the ownership of their knowledge systems.

The following is an introduction to *An evaluation framework for Indigenous suicide prevention activities* from CBPATSISP (2018:n.p.):

> The CBPATSISP evaluation framework is based on and compliments the ATSISPEP Evaluation Framework, which was developed over 6 years of community consultations, roundtables, systematic literature reviews and a meta-evaluation of programs. Both frameworks are guided by expert Indigenous groups, such as the National Aboriginal and Torres Strait Islander Mental Health Indigenous Leadership. They privilege Indigenous ways of doing, knowing and being in program design, methods and delivery.

> These frameworks are supported by a substantial national and international evidence base about best-practice evaluation and suicide prevention and by Indigenous understandings of the social, cultural and historical determinants of SEWB and mental health. The CBPATSISP evaluation framework provides tools for evaluating key outcomes from programs that are community-based, focus on universal prevention, and include indicated and targeted group prevention.

The following essential criteria are identified by the CBPATSISP framework and are based on evidence of what works in suicide prevention and SEWB programs and services:

- assist in Indigenous capacity-building
- prioritise Indigenous knowledge and experience
- respect cultural values
- recognise Indigenous rights and self-determination
- facilitate cultural strengthening
- facilitate and promote Indigenous leadership and governance
- foster genuine partnerships and community engagement
- promote healing.

This conceptual framework is intended as both a process guide and a 'cultural audit' for applying Indigenous evaluation principles and indicators to specific populations, issues, and community and organisational contexts (CBPATSISP 2018). It is recognised as useful for the evaluation of effective and culturally appropriate suicide prevention and interventions.

This work extends the work of the ATSISPEP and comes from the principles in:

- the *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional well being 2017–2023* (PM&C 2017)

- the Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and Communities: Guidelines for Researchers and Stakeholders (NHMRC Ethical Guidelines) (NHMRC 2018).

The CBPATSISP's evaluation framework is designed to evaluate suicide prevention activities that are already underway, and to provide guidance around evaluation while in the planning stages. It can be used by governments, communities and funders such as Primary Health Networks. The literature has shown the best-practice programs and services should be concerned with self-determination and community governance, reconnection and community life, and restoration and community resilience. Best-practice programs and services should meet the indicators shown in Box 2.
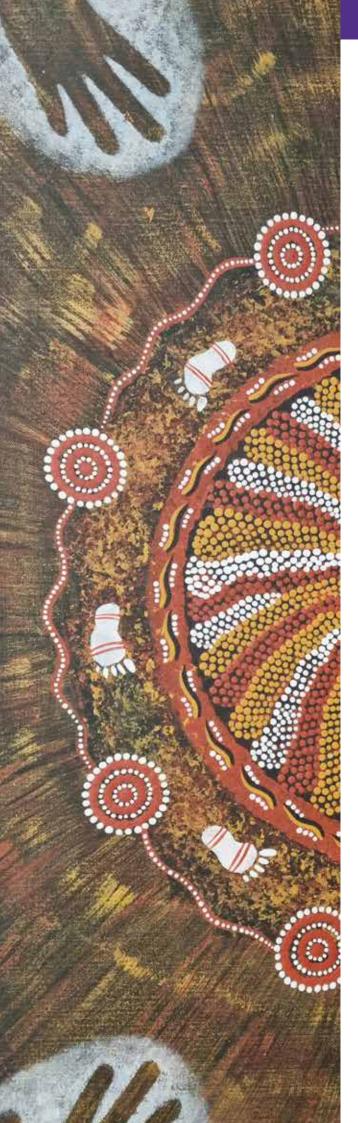
Currently, these evaluation guides are the most advanced in the area of Indigenous suicide prevention in Australia. They contain important strategies for designing, implementing and evaluating interventions that are guided by what is useful for communities. Threaded throughout this evaluation strategy is the guiding and non-negotiable principle and right of self-determination.

The evaluation of the process, impact and outcome are all important to the refinement of the evidence base and the development of best practice policy and programs. As well as measuring changes in at-risk behaviour, the CBPATSISP's evaluation framework has suggested that gathering evidence on changes to:

> improvements to the social and emotional wellbeing of the community with a focus on self-governance, cultural activity, physical health, employment, community safety and school attendance might also be relevant (CBPATSISP 2018:n.p.).

Box 2: Indicators of best practice programs and services

1. The program or service uses the guiding principles by:
    –   having a cultural and community focus
    –   strengthening Indigenous governance
    –   demonstrating cultural respect.
2. NHMRC Ethical Guidelines were considered in developing the program or service.
3. Community/cultural governance are in place for the program or service.
4. Aboriginal and Torres Strait Islander people were involved in the development of the program or service or steps were taken to include them later.
5. The organisation of the program or service is involved with local Indigenous community groups as shown by:
    –   the process being community-led and directed
    –   formal partnerships
    –   other types of collaboration.
6. An Indigenous Australian community reference group or similar was established for the program or service. The group included key stakeholders or members of the target group (for example, youth, Elders, consumers, carers, LGBTIQ) and meetings were held regularly.
7. The program or service considers the social and historical context of where people are living.
8. The program is specific to local groups by considering, for example gender, the delivery location.
9. The program has relationships with similar programs, services and other stakeholders and integrates with them.
10. The program or service is working with the local Aboriginal Community Controlled Health Service.
11. There is evidence of community capacity-building having taken place.
12. Ongoing activity is in place to ensure a continuous development and quality improvement process—the program is being refined.
13. There is follow-up for participants after completion of the program or service.
14. Community feedback processes are built into in the program or service.
15. Aboriginal and Torres Strait Islander staff and other workers are involved in program or service development and implementation.
16. All non-Aboriginal staff and workers involved had completed cultural competence and safety training.
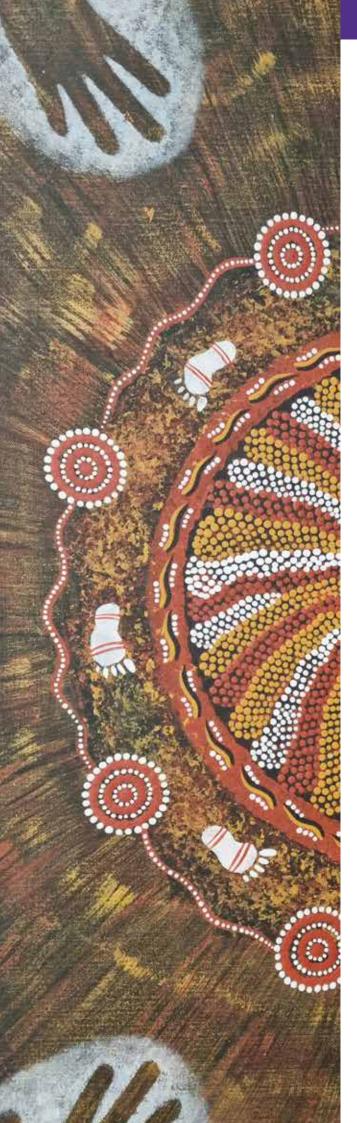
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Gaps and limitations

6 Gaps and limitations

The following currently affects the evidence base for suicide prevention initiatives:

- An 'iceberg model' of Indigenous suicide recognises that most of the evidence on suicide-related behaviour (suicidal ideation, self-harm) is not known and so therefore the effectiveness of intervention programs cannot be realistically assessed.

- Indigenous-led initiatives can contribute to the collection of data that may not be captured in mainstream services and measures. For example, there is evidence that the Celebrating Life surveillance system used by the Apache people is able to capture data on suicide and suicide-related behaviour that was not captured by other more mainstream measures (Cwik et al. 2014).

- What counts as evidence of healing from an Indigenous standpoint is not yet fully determined and would contribute to the development of a scalable healing strategy.

- An Indigenous hierarchy of evidence for suicide prevention programs needs to be developed.

- Data silos affect analysis of the complexity of the evidence base supporting strengths-based Indigenous suicide prevention interventions.

- There is limited research into why Indigenous suicide prevention interventions do not work. There is a need for more research into systemic barriers to implementation and culturally safe process evaluation. There is also a need for continual evaluation of the implementation of programs and policies.

7

Conclusions

7 Conclusions

There have been substantial innovations in the field of Indigenous suicide prevention, both nationally and internationally. These achievements have not always been recognised, in part because of the evidence-deficit narrative about Indigenous suicide prevention interventions and the associated evidence ceiling. The effect of this limitation may be the loss of valuable knowledge from Indigenous advances in suicide prevention and funding for promising community-based programs.

Practice-based evidence offers a promising path for suicide prevention interventions. This approach benefits from the routine systematic gathering of evidence of the effectiveness of an intervention that is then used to refine the intervention. It is highly effective in creating successful large-scale mental health interventions. However, the benefits—reductions in suicide—are not permanent, so programs that support and maintain protection against suicide should be ongoing.

The most appropriate way of evaluating a complex intervention is a narrative synthesis or a realist review (Pawson et al. 2005). The realist review has been specifically designed to assess complex interventions with the purpose of developing evidence-based policy (Jagosh et al. 2011; Pawson 2006).

Realist reviews are considered to be the most appropriate way of analysing the evidence in complex interventions as they:

- support development of an understanding what 'works for whom, in what circumstances, in what respects and how' (Pawson et al. 2005)

- seek to uncover the hidden or underlying mechanism (the theory or logic) at play in successful interventions by analysing the context that enables successful interventions

- focus 'on understanding why programs work by identifying underlying theoretical mechanism while exploring the causes and failures of a particular programs' (O'Campo et al. 2009:967).

When based on Indigenous suicide prevention knowledge about the theoretical mechanism of prevention (for example, cultural continuity), such an approach has great promise in producing evidence-based policies. This is particularly true when those policies are implemented alongside culturally appropriate routine systematic evaluation of their effectiveness. Combining process evaluation with outcome evaluation (Gupta et al. 2020) also strengthens program effectiveness, the evidence, and potential policies based around this knowledge.

Building evaluation into policy design and implementation can mitigate against larger failures and provide a practice-based evidence that enables the continual refinement of both policy and the evidence-base for policy (James 2013). The Productivity Commission has emphasised the central importance of embedding evaluation into the policy planning cycle to ensure the findings are used to improve outcomes for Indigenous Australians. Even so, the cost of evaluation is a clear barrier to effective evaluation: the budget for many programs does not include a rigorous evaluation (Kalisch & Al-Yaman 2013).

Reforming the system would entail addressing the importance of funding sustainable ongoing evaluation based on Indigenous ways of knowing, being and doing, on Indigenous knowledge of what works and what does not, and recognising the principle of the right to self-determination across suicide prevention.

Acknowledgments

Abbreviations

AIHW	Australian Institute of Health and Welfare
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CBPATSISP	Centre of Best Practice in Aboriginal & Torres Strait Islander Suicide Prevention
IAPT	Improving Access to Psychological Therapies
NHMRC	National Health and Medical Research Council
RCT	Randomised control trials
SEWB	Social and economic wellbeing
WHO	World Health Organization

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Complex interventions such as suicide prevention initiatives are best evaluated using a realist review and narrative synthesis approach. Such an approach looks beyond whether something works to try to understand what works, in which circumstances, and for whom. This publication looks at the nature of evidence and the value of evidence-based practice and practice-based evidence in the evaluation of Indigenous suicide prevention programs.

Stronger evidence,
better decisions,
improved health and welfare