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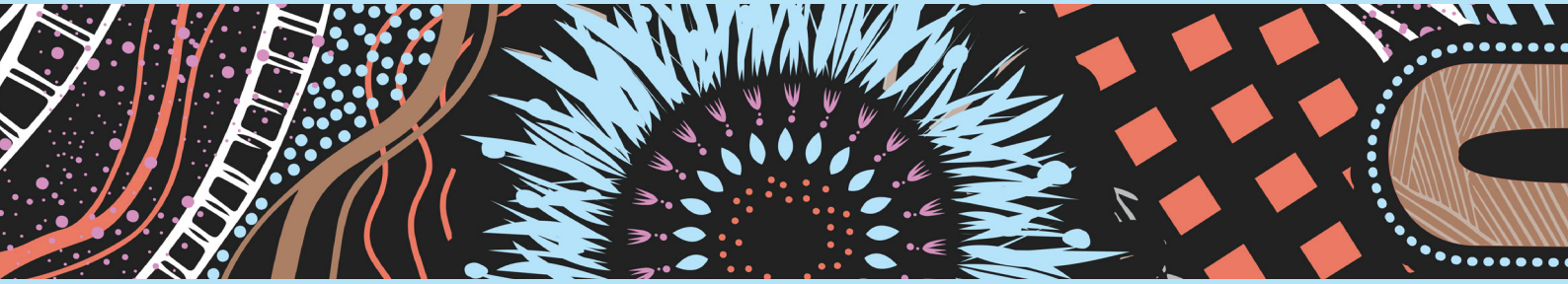

Preventing suicides of First Nations people

Pat Dudgeon, Joan Chan, Georgiana Cheuk, Tjalaminu Mia,
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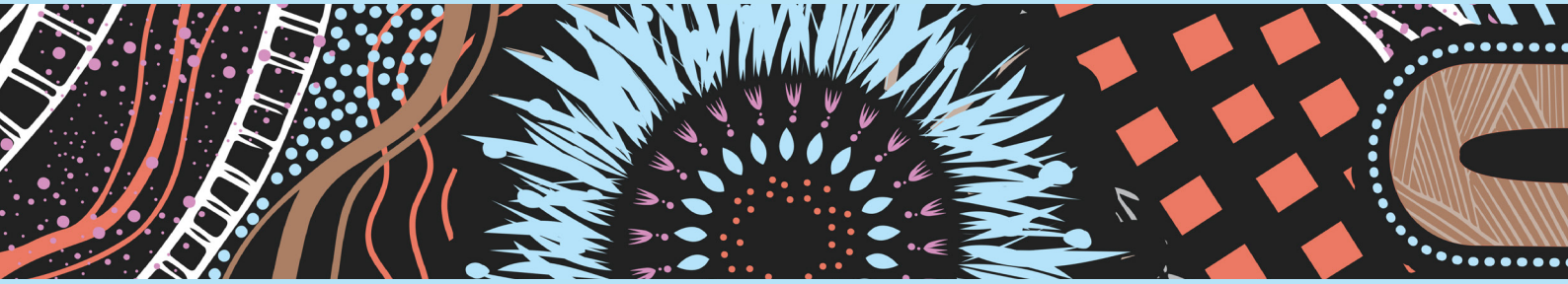

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Contents

Caution: Some people may find the content in this report confronting or distressing.

Please carefully consider your needs when reading the following information about Indigenous mental health and suicide prevention. If you are looking for help or crisis support, please contact:

13YARN (13 92 76), Lifeline (13 11 14) or Beyond Blue (1300 22 4636).

The AIHW acknowledges the Aboriginal and Torres Strait Islander individuals, families and communities that are affected by suicide each year. If you or your community has been affected by suicide and need support, please contact the **Indigenous Suicide Postvention Services on 1800 805 801.**

The AIHW supports the use of the Mindframe guidelines on responsible, accurate and safe suicide and self-harm reporting. Please consider these guidelines when reporting on these topics.

Summary

What we know

- Suicide is preventable. Each life lost to suicide is a tragedy for family, friends and communities.
- Aboriginal and Torres Strait Islander (First Nations) people are a resilient and diverse people, with a strong cultural identity and a deep connection to family and community.
- Suicide was virtually unknown in First Nations people until the second half of last century. It is now a leading cause of death.
- Rates of suicide are rising; the death rate increased by almost a third (31%) between 2018 and 2023 (ABS 2024).
- Social, economic and historic risk factors contribute to suicide – First Nations people experience these factors at higher rates than non-Indigenous Australians. Some factors are unique to First Nations people: loss of culture and identity, intergenerational trauma, racism, discrimination and disempowerment.
- Some groups of First Nations people are at greater risk of suicide; there are higher rates among young people, people who have experienced child sexual abuse and LGBTQIA+ people.

What works

- First Nations healing systems that are strength based and underpinned by the holistic concept of social and emotional wellbeing.
- Restoration of First Nations identity and culture with culturally based programs and initiatives; cultural continuity is a protective factor against suicide – when culture underpins programs it ensures that they are safe and appropriate, and drives greater engagement.
- Partnerships with communities and community organisations to ensure the local relevance of suicide prevention programs, to empower communities and to build capacity. Ideally, First Nations people should own and lead suicide prevention programs and services.
- Recognition that self-determination is important – First Nations people need to design, implement and evaluate programs themselves.
- Community-led responses that are strength based, which will move approaches to suicide prevention away from deficit discourses.
- Culturally safe and appropriate initiatives that draw on the lived experiences, values and knowledges of First Nations communities.
- Acknowledgement that mainstream support systems can be valuable if they are developed to welcome and respect First Nations people and support their culture.

What doesn't work

- Individually focused interventions that implement a purely clinical approach to suicide prevention, which have limited success with First Nations people.
- Lack of consultation with communities, and approaches that are not culturally safe nor locally focused.
- Program evaluations that prioritise Western evidence models – which do not produce a useful evidence base.
- Implementing programs that require whole-of-government action and cross-sectoral collaboration without effective consultation, resourcing and buy-in.

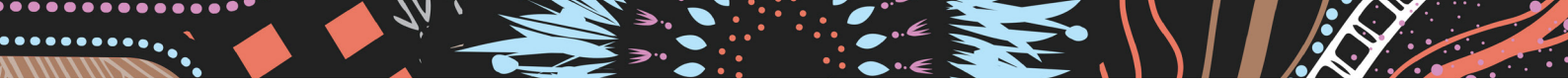
What we don't know

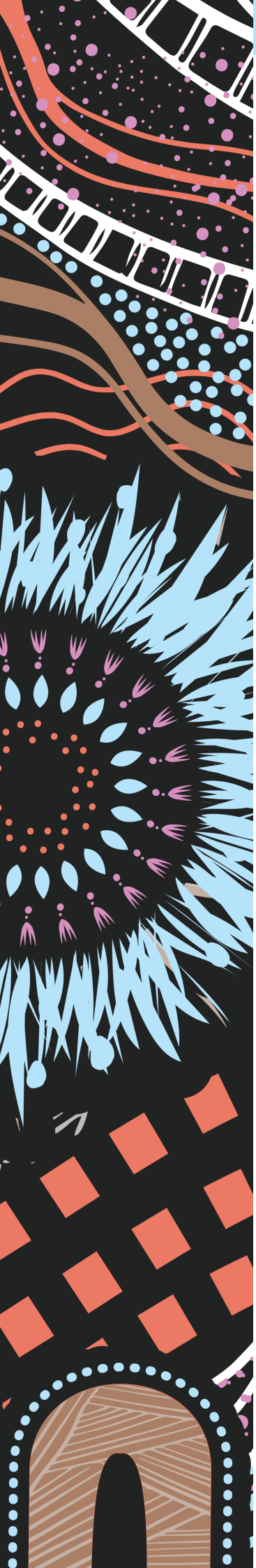
- There are limited details on outcomes for many suicide prevention programs; many programs have not been evaluated, or have measured success in a First Nations context.
- Information on First Nations suicide-related behaviour (self-harming and suicidal ideation) is limited.

Drivers of change

- Suicide prevention programs that are designed, owned and led by First Nations people.
- Implementation of locally focused, strength-based approaches to suicide prevention.
- Capacity-building programs and initiatives that incorporate cultural and lived experience to ensure that First Nations communities can respond effectively to challenges.
- Evaluations that consider and assess what First Nations people value, and then disseminate this information.
- Coordinated efforts across governments to support cross-sectoral and whole-of-government action.
- Featured programs such as 13YARN that:
  - are co-designed by First Nations mental health professionals, with input from people with lived experience
  - are overseen by First Nations management
  - exemplify elements of best practice for suicide prevention initiatives.

The Culture Care Connect program, which is still to be formally evaluated, combines suicide prevention planning and holistic services. It incorporates both national and local First Nations leadership alongside other important principles in its model of care, including place-based, flexible, and strength-based approaches (Ninti One Ltd and First Nations Co 2024).





1

Introduction

1 Introduction

Over the past half century, suicide has emerged as a major cause of premature mortality for Aboriginal and Torres Strait Islander (First Nations) people. Rates of suicide for First Nations people are almost 3 times those for non-Indigenous Australians (ABS 2024). Suicide is the leading cause of death for First Nations people aged 15–44. Between 2019 and 2023, 1 in every 5 Australian children who died by suicide was a First Nations child (ABS 2024) – and the number of suicide deaths is rising across jurisdictions (ABS 2024).

Suicide is preventable. Each life lost to suicide is a tragedy. Its impacts on family, friends and the community are considerable.

Preventing First Nations suicide requires understanding the devastating and lasting impact of colonisation on communities, families and cultures, all of which are fundamental to the social and emotional wellbeing of First Nations people.

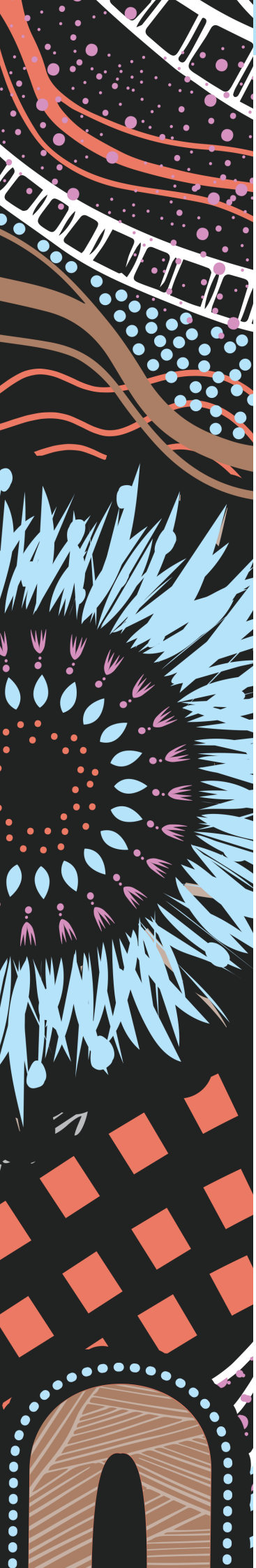
This paper outlines what is known about the causes of suicidal behaviours (suicide, suicide attempt and deliberate self-harm) among First Nations people. It outlines the contemporary policy responses and explores what works to prevent suicide, through examining some contemporary programs and by highlighting essential best practice resources for preventing First Nations suicide.

The latest report card on the National Agreement on Closing the Gap found suicide rates for First Nations people are worsening; the age-standardised rate for mortality due to suicide in 2022 was 29.9 per 100,000 people – above the rate in the previous 2 years and above the baseline rate in 2018 (25.1 per 100,000) (Productivity Commission 2024).

When reporting the latest Closing the Gap outcomes on the 16th anniversary of the Apology to the Stolen Generation in February 2024, the Prime Minister told the Parliament that listening to First Nations communities, groups and individuals was essential:

Canberra must be willing to share power with communities; to offer responsibility and ownership and self-determination; to let local knowledge design programs; to trust locals to deliver them and to listen to locals when they tell us what's working and what isn't (Australian House of Representatives 13 February 2024).

This paper prioritises that knowledge. It explores holistic approaches to suicide prevention and the concept of social and emotional wellbeing as it relates to suicide prevention. It adopts an Indigenous standpoint, prioritising First Nations knowledge in exploring best practice concerning First Nations suicide prevention.



2

Background

2 Background

Suicide was virtually unknown among First Nations people until later in the last century (De Leo et al. 2011; Elliott-Farrelly 2005; Hunter and Milroy 2006). Within a generation, it has become a leading cause of deaths for First Nations people.

In this chapter, we unpack this population health crisis by:

- presenting some historical context for suicide among First Nations people, and information about suicidal behaviour and suicide deaths in the population
- identifying some of the more vulnerable population groups and people
- exploring factors that place First Nations people at greater risk of suicide, and protective factors
- presenting important concepts and a framework that guides suicide prevention activities in Australia, including for First Nations people.

Additional and more detailed information on factors that increase the suicide risk faced by First Nations people is outlined in the following Indigenous Mental Health and Suicide Prevention Clearinghouse publications:

- *Indigenous domestic and family violence, mental health and suicide* (Cripps 2023)
- *Intergenerational trauma and mental health* (Darwin et al. 2023)
- *Racism and Indigenous wellbeing, mental health and suicide* (Truong and Moore 2023)
- *Harmful alcohol and other drug use and its implications for suicide risk and prevention for First Nations people: a companion paper* (Butt et al. 2024).

Legacies of colonisation

Based on their research, Hunter and Milroy (2006) describe suicide among First Nations people as a 'recent phenomenon' (2006:150), flagging a dramatic increase in suicide from the late 1980s when rates were 'at most, extremely low' (2006:143). Further, they describe the rapid social changes that followed the end of Australia's racist legislation as leading to community dysfunction, or 'normative instability', disempowerment and loss of control. Although there was suddenly access to the economy through welfare:

> ... Indigenous Australians remained excluded from the ideals, resources and social advantages of the wider society by continuing denial of access to the means (education, economic, political ...) necessary to realize those ideals (2006:144).

The unresolved legacies of colonisation form the background to today's current rates of First Nations suicide and the associated population health crisis (Dudgeon et al. 2017; Hunter and Milroy 2006). High rates of unemployment, poverty, family dysfunction, incarceration, and alcohol and substance misuse are all outcomes of intergenerational trauma associated with historic and present day experiences of colonisation.

Government legislation following colonisation included race-based policies that saw the forcible removal of children from their families. Much of the First Nations population were forcibly removed from their land to reserves and missions. Under 'Protection' legislation, First Nations people needed permission to leave reserves, to get a job and to marry. The same legislation permitted the exploitation of First Nations people as cheap labour; neither could they sell nor own land.

Colonisation irrevocably damaged family and kinship structures, and culture and land were lost. Despite the end of discriminatory legislation in the 1960s, institutional racism and discrimination have persisted. While past policies that saw the forced removal of children from families have ended, under current child protection laws, First Nations children are being removed from their families at a higher rate than during the period of the Stolen Generations (AIHW and NIAA 2024b).

First Nations adults and children are exposed to stressful life events at much higher rates than non-Indigenous people. Psychological distress can result – a recognised risk factor for suicide (PM&C 2017). A national survey in 2018–19 found that 31% of First Nations adults had high or very high rates of psychological distress – some 4% higher than in 2004–05, when it was last measured (ABS 2019a). The comparable proportion of high/very high levels of psychological distress among non-Indigenous Australians in 2018–19 was 13% (AIHW and NIAA 2024a).

Self-harm behaviours and suicide attempts

It is difficult to know the full extent of non-fatal suicidal and self-harm behaviours among First Nations people, as many people do not seek medical support after self-harming (Martin et al. 2023). Further, while 'some people who self-harm may be suicidal, self-harm is a way of managing painful emotions without being a suicide attempt' (Walker et al. 2022:8). With this caveat in mind, data on hospitalisations provide some insights into non-fatal suicidal behaviour, reflecting those who sustained a serious injury or who were admitted for further mental health treatment.

In 2021–22, the rate of hospitalisations for intentional self-harm for First Nations people (326 hospitalisations per 100,000 population) was over 3 times that for non-Indigenous Australians (96 per 100,000) (AIHW 2023d). The highest rates were for young First Nations people aged 15–19 – 710 hospitalisations per 100,000 (AIHW 2023d). In the 5 years to 2021–22, the rate of hospitalisations for intentional self-harm increased by 60% (from 203 to 326 hospitalisations per 100,000) (AIHW 2023d).

In 2022, the Staying Deadly Survey explored mental health challenges facing urban First Nations adults residing in south-east Queensland. One in 5 survey participants (21%) had attempted suicide and 1 in 2 (55%) had experienced suicidal thoughts at some time in their life (QUIMHS Research Team 2023). The cross-sectional design of this survey and the specific geographic sample preclude broader findings concerning mental ill-health in the wider First Nations population.

Suicide deaths

In 2023, suicide was the fifth leading cause of death for First Nations people – the second leading cause of death for males and the eighth for females. Suicide accounts for 5.1% of deaths among First Nations people, and for 1.7% among non-Indigenous Australians (ABS 2024).

Readers should note the advice on the quality and consistency of suicide deaths data for First Nations people outlined in Box 2.1.

Box 2.1: Measurement and reporting of suicide deaths in Australia

The Australian Bureau of Statistics (ABS) records deaths due to suicide as 'deaths due to intentional self-harm (suicide)' (ABS 2023). Factors such as unreliable recording of Indigenous status and difficulty in determining suicidal intent affect the production of accurate and timely data (AIHW 2022).

Lags of up to 18 months in the data may occur due to the need for complex coronial investigations (AIHW 2022). These delays can hinder a jurisdiction's intervention responses to prevent suicides, and efforts to ensure that bereaved families and communities receive the support they need. Most Australian states have set up suicide registers, which record a suspected suicide when it is referred to the coroner, allowing for almost real time data on suicide deaths.

For deaths registered in 2023, the ABS considers that 6 jurisdictions have adequate levels of Indigenous identification in their mortality data – New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory. The ABS only recently added Victoria to this list, following improvements to the derivation of Indigenous status for deaths registered in 2023. The ABS recommends that year-to-year changes in deaths data should be treated with caution due to annual fluctuations in jurisdictions with small numbers of deaths.

The national and jurisdictional analysis included below focuses on the 5 jurisdictions with sufficient quality of Indigenous identification over a longer period of time – New South Wales, Queensland, Western Australia, South Australia and the Northern Territory – and deaths are aggregated to examine trends in the periods 2014–2018 and 2019–2023.

As already noted, suicide rates have risen among First Nations people. Between 1998 and 2023, the age-standardised death rate increased by a third (31%) (ABS 2024). In 2013, the age-standardised rate of suicide was 22.5 per 100,000 population; in 2023, it was 30.2 per 100,000 (ABS 2023, 2024; AIHW 2023e).

Suicide rates vary by age. Between 2019 and 2023, suicide rates were highest among First Nations people aged 25–34 (48.5 per 100,000 population) and 35–44 (48.3 per 100,000), followed by those aged 15–24 (36.5 per 100,000) (ABS 2024). Suicide was the leading cause of death for First Nations children aged 5–17 over the same period (ABS 2024) – with almost a quarter due to suicide; more than half of these deaths (56%) were the death of girls (ABS 2024).

There are geographic differences in First Nations suicide death rates across the states and territories. All 5 jurisdictions with data of sufficient quality for reporting over time saw age-standardised death rates for First Nations people due to suicide rise between the periods 2014–2018 and 2019–2023, except for Western Australia (35.3 per 100,000 population and 35.2 per 100,000, respectively). South Australia recorded the greatest increase in rates between these 2 periods, rising from 18.6 per 100,000 to 30.7 per 100,000. The other 3 jurisdictions recorded the following rates between these 2 periods:

- New South Wales: 15.0 per 100,000 and 21.7 per 100,000, respectively
- Queensland: 21.9 per 100,000 and 26.1 per 100,000, respectively
- Northern Territory: 26.6 per 100,000 and 33.4 per 100,000, respectively (ABS 2024).

Vulnerable groups

While the broad statistics presented above portray an alarming picture of suicide among First Nations people, they obscure the greater risks faced by some groups within the community. Predominant among the information on vulnerable groups that follows is the deep, pervasive and persistent effect of trauma associated with colonisation.

Young First Nations people

Between 2018 and 2022, suicide rates among First Nations people aged 0–24 were more than 3 times those of non-Indigenous Australians of the same age (16.0 suicide deaths per 100,000 population, compared with 5.2 per 100,000) (AIHW 2023b). A systematic review of suicide, self-harm and suicide ideation in First Nations young people by Dickson et al. (2019) reported the prevalence of suicidal ideation among these young people as ranging from 9.1% to 46%.

Numerous complex and interrelated factors contribute to suicidal behaviour of young First Nations people:

- Within families, they may experience stress from poverty and economic hardship, overcrowded households, substance misuse of adults around them, violence and relationship conflicts (Walker et al. 2015).
- At school, they may experience stress from poor performance, be disengaged and be subject to bullying (Walker et al. 2015).
- They are often separated from the support of Elders, family or community and 'carry deeper issues of loss of cultural identity and cultural continuity (which would otherwise be a protective factor against suicide)' (Dudgeon et al. 2016:9).
- Their exposure to trauma is also significantly greater; a survey in the Kimberley region found that First Nations adolescents were 4 times more likely to report that a family member had died by suicide than non-Indigenous adolescents (Ralph et al. 2006:129). Bereavement and Sorry Business can also take a heavy toll (Dudgeon et al. 2017).

The impact of intergenerational trauma and opportunities for healing were discussed at a forum of First Nations young people hosted by the Healing Foundation in 2017. These young people identified that factors contributing to suicide included a lack of support options and services, communication barriers arising from feelings of shame, alcohol and substance misuse from young ages, and the need to be carers from an early age (Healing Foundation 2017).

People who have experienced child sexual abuse

Another vulnerable group is those people who were victims of child sexual abuse (Dudgeon et al. 2016). The lifelong impacts of child sexual abuse and the high level of suicidality among victims/survivors were highlighted by the Royal Commission into Institutional Responses to Child Sexual Abuse (RCIRCSA 2017). Victims 'experience deep, complex trauma, which can pervade all aspects of their lives' (RCIRCSA 2017:9). It can have 'ripple effects [that] can be long-lasting, even affecting future generations' (RCIRCSA 2017:12). These lifelong effects include risk-taking behaviours, such as alcohol and substance abuse; parenting difficulties; difficulties with trust and intimacy; and relationship problems that can be passed from generation to generation (Milroy et al. 2018; RCIRSCA 2017).

Numerous studies have warned of the greater suicide risk for child sexual abuse victims (Angelakis et al. 2020; Cutajar et al. 2010; Martin et al. 2004; Plunkett et al. 2001; Ralph et al. 2006). An examination of linked coronial data found that female victims have a 40 times higher risk of suicide, and male victims, a 14 times higher risk (Cutajar et al. 2010:186). Accidental fatal overdoses were also more common in this group of people (Cutajar et al. 2010). Based on their work with sexual abuse victims in the Kimberley region of Western Australia, Raph and colleagues (2006) warned that alongside an increased risk of suicide was an increased risk of self-harm and destructive behaviour, with exposure to trauma giving rise to post-traumatic stress disorder.

First Nations victims of child sexual abuse can endure compounding and complex forms of trauma from their exposure to racism and intergenerational trauma. The lifelong risk of suicide means that early intervention is vital, and ongoing access to services is essential (Dudgeon et al. 2020a). The work of Milroy and colleagues (2018) warned that current approaches to addressing child sexual abuse for First Nations people were not working due to a lack of cultural understanding of the problem and a shortage of culturally based responses. With the assistance of a Knowledge Circle convened by the Healing Foundation, a culturally based framework was developed to create and restore safety and healing for affected First Nations children, families and communities (Milroy et al. 2018).

LGBTQIA+ people

The discrimination and stigma that LGBTQIA+ people face increase their risk of suicide.

The Walkern Katatdjin: Rainbow Knowledge Survey, conducted online in 2022, explored the mental health and wellbeing of more than 600 First Nations LGBTQA+ young people aged 14 to 25. It found that nearly 1 in 2 (45%) young First Nations LGBTQA+ people have attempted suicide at some point in their life (Liddelow-Hunt et al. 2023). Alongside alarming rates of suicide attempts, the survey identified that more than three-quarters (77%) of young First Nations LGBTQA+ people had very high levels of psychological distress (Liddelow-Hunt et al. 2023).

LGBTQIA+ is an acronym of the terms Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual. In the acronym LGBTQIASB+, 'SB' represents 'Sistergirl' and 'Brotherboy', which are terms used by some First Nations people, and refer exclusively to First Nations women and men who are transgender. The '+' symbol is a reminder that there may be other terms that should be covered, including 'non-binary' and 'pansexual'.

The acronyms used in this article may differ and reflect the research cited.

Day and colleagues (2023) flag the compounding risks for First Nations LGBTQIASB+ people, who face discrimination and marginalisation not only as First Nations people, but also as LGBTQIASB+ people; '[They are] at a higher risk of family violence as well as assault and harassment which results in compounded and layered trauma' (Day et al. 2023:vi). Other factors – life traumas, youth, disability and incarceration – can also intersect and add to the risk. Day and colleagues (2023) also note the research limitations of data on First Nations LGBTQIASB+ people and suicides – with most demographic data on First Nations people limited to the binary categories of 'male' and 'female', and information about sexuality and gender diversity rarely recorded at death (Day et al. 2023).

Bonson (2017), one of the contributing authors to Aboriginal and Torres Strait Islander LGBTQIASB+ people and mental health and wellbeing (Day et al. 2023), has reflected on the challenges facing First Nations people who identify as LGBTQIASB+, lamenting a lack of appropriate support services and LGBQTIASB+ voices in suicide prevention (Bonson 2017). Bonson started Black Rainbow in 2013 to fill this gap. It is Australia's first and only national First Nations LGBTQIASB+ suicide prevention charity organisation (Hill et al. 2021). It offers information to support social, cultural and mental health of First Nations LGBTQIASB+ people and advocates for social justice, inclusion and respect. (For more information, see www.facebook.com/BlackRainbowAustralia/).

People in detention

First Nations people are over-represented in the youth and adult justice systems. Nearly 1 in 3 (32%) of the adult prison population are First Nations people (AIHW 2023a). First Nations young people are substantially over-represented in the juvenile justice system; 3 in 5 (63%) of those aged 10–17 in detention are First Nations people (AIHW 2024b).

Incarceration is known to exaggerate risk factors for suicide and is significantly associated with post-traumatic stress disorder (Martin et al. 2023). In the prisoner population, suicide attempts are more common among First Nations adults than among non-Indigenous adults (AIHW 2021a). A study by Shepherd et al. (2018) found that nearly two-thirds (64%) of incarcerated First Nations men had experienced suicidal ideation and over half (55%) had attempted suicide.

There is strong evidence of elevated mental ill-health and suicide risk for the families of prisoners. For example, the study by Dowell and colleagues (2018) of female prisoners in Western Australia – where First Nations females make up 46% of the prison population – drew attention to the vulnerability of children whose mothers have been incarcerated. The study found that children of women prisoners are at increased risk of engaging with the child protection system. These children are, in turn, more likely to experience mental ill-health (AIHW 2021b). Another study by Cumming et al. (2023) found that children exposed to maternal incarceration were at an increased risk of self-harm – 1.75 times greater than the risk for the non-exposed group (95% CI:1.45, 2.09). While the risk for First Nations children was not specifically stipulated, 63% of the study cohort were First Nations women. An elevated risk of suicide was not found in this study; however, the authors flagged limitations, including the small sample size and the follow-up period for the study (Cumming et al. 2023).

Given the over-representation of First Nations people in the criminal justice system, the development of culturally appropriate mental health and social and emotional wellbeing interventions is essential for people in detention and their families.

Previous suicidal behaviour

People who have attempted suicide or have a history of self-harm are at much greater risk of suicide (ABS 2019b; Carroll et al. 2014; De Leo et al. 2011; Dudgeon et al. 2017; Harris and Barraclough 1997). An international meta-analysis in 2014 found the risk of suicide after a previous hospital admission for self-harm was 3.9% (95% CI 3.2, 4.8) (Carroll et al. 2014). An older international study found that the risk for people who have previously attempted suicide was between 20 and 120 times greater than the risk for other population groups (Harris and Barraclough 1997). This risk is further compounded by the recency of the attempt, the frequency of previous attempts, a history of mental health treatment and loneliness or isolation (Harris and Barraclough 1997).

A First Nations person who has attempted suicide is much less likely to access services than a non-Indigenous person (Dudgeon et al. 2017). A 2011 Queensland study found that First Nations people with a history of suicidality are significantly less likely to receive medical treatment after an attempt – '33.6% vs. 49.8% of non-Indigenous cases with a history of suicide attempt(s)' (De Leo et al. 2011:55). The same study also found that '43.3% of Indigenous persons had communicated suicidal intent in their lifetime, with 39.1% communicating intent in the 12 months prior to death' (De Leo et al. 2011:54).

Proactive, urgent follow-up treatment; risk reduction interventions; and culturally safe, continuing care are essential for this group (see Box 2.2).

Box 2.2: Risk assessment

Comprehensive assessments to determine the risk of future self-harm and suicide are recommended for all people presenting to hospital following self-harm and suicidal thoughts. These assessments are used to help to determine care and treatment; they also help to determine the needs and strengths of an individual and can promote hope and improve outcomes (Leckning et al. 2019).

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) emphasised the importance of 'more culturally sensitive and appropriate assessment and testing of Aboriginal people who are experiencing extreme levels of trauma and grief and SEWB [social and emotional wellbeing] issues' (Dudgeon et al. 2016:271). Some mainstream concepts of mental health do not translate into concepts of social and emotional wellbeing. Leckning and colleagues developed *Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts* (2019) in accordance with ATSISPEP principles (Knight et al. 2024). The guidelines support clinicians in making more culturally responsive psychosocial assessments of First Nations people who present to hospital with suicidal thoughts or self-harm.

There are many standardised and validated assessment tools available to assess the risks of people presenting to hospital with self-harm and suicidal thoughts; however, there is contradictory evidence about their effectiveness (Saab et al. 2022). A broad review of the tools used in English-speaking countries with similar health systems (including Australia) concluded that there was insufficient empirical evidence to support the use of these tools as a stand-alone assessment method (Saab et al. 2022). Australian and New Zealand researchers have also warned against relying on risk assessments (Large et al. 2011; Mulder 2011). The meta-analysis to identify risk factors for suicide by Large and colleagues concluded that 'No factor, or combination of factors, was strongly associated with suicide in the year after discharge' (2011:619).

The studies (Leckning et al. 2019; Mulder 2011; Saab et al. 2022) are united in recommending a universal focus on client care and safety, with the guidelines developed by Leckning and colleagues (2019) underscoring the importance of cultural safety, greater engagement and improved communication with First Nations people by clinicians.

Exposure to suicide and suicide clusters

Exposure to suicidal behaviour within a family or by close associates is also a risk factor for suicide and a recognised form of community trauma (Dudgeon et al. 2022). Such exposure plays a role in 'suicide clusters' – suicides or suicide attempts that occur within a small geographic area or community over a period of weeks or months' (Dudgeon et al. 2016; Hanssens 2010; Robinson et al. 2016). Silburn and colleagues (2014) describe suicide clustering as a phenomenon where suicidal behaviour becomes 'socially contagious' or a form of 'copy-cat' behaviour (2014:154). Suicide clusters have been observed as significantly more likely to occur in First Nations communities (Robinson et al. 2016) and among young people (Dudgeon et al. 2016).

Research using suicide data for the 3-year period starting from 2010 found that suicides of First Nations young people aged 24 or under were significantly more likely to occur in a cluster (58%) than those of non-Indigenous young people of the same age (58% and 13%, respectively, $p<0.001$) (Robinson et al. 2016). Equivalent rates for First Nations and non-Indigenous adults aged 25 or over were 11% and 3.4%, respectively ($p<0.001$) (Robinson et al. 2016).

In providing evidence to the Senate Community Affairs Reference Committee for its Inquiry into Suicide in Australia, First Nations psychologist Clinton Schultz identified strong community connections as amplifying the impact of suicide among First Nations people:

> … If there is a suicide in a community, that impacts on everybody in the community, which then has that flow-on effect of constant grief, constant loss, without the services to deal with that, which then can lead to the formation of clusters (SCARC 2010:92).

In their *Hear our voices* report, Dudgeon and colleagues (2012) describe 'ripples of loss, grief and mourning extending throughout the community' as the result of a suicide (Dudgeon et al. 2012:45). The cumulative effect of the cultural obligations associated with funerals and grieving rituals can intensify the bereavement stress, create layers of increased risk and affect the recovery of a community (Dudgeon et al. 2012; Silburn et al. 2014).

Culturally safe postvention services – that is, timely actions taken to support those bereaved or affected by a suicide in managing their stress, grief and loss – are essential for First Nations communities after a suicide to reduce the risk of further suicides occurring.

Risks and protective factors

Social, political and historical determinants

While First Nations people share many risk factors for suicide with the non-Indigenous population, a broader set of social, economic and historic determinants affect the social and emotional wellbeing of First Nations people (Department of Health and Ageing 2013). These include low socioeconomic status and poverty, unemployment, financial issues, unstable accommodation and overcrowding, and poor access to services. Trauma and intergenerational trauma associated with colonisation and past and present government policies – including forced child removal of the Stolen Generations; the burden of racism, discrimination and marginalisation; alcohol or substance use; incarceration; exposure to abuse and interpersonal and family conflict – all give rise to psychological distress (Dudgeon et al. 2016).

Taking a social determinants approach to suicide acknowledges the entrenched social disadvantage that stems from the trauma of colonisation. This approach recognises that suicidal behaviours among First Nations people arise from a wider social, political and historical context and are not problems that originate at an individual level (Dudgeon et al. 2020a).

Protective factors

Protective factors against suicide that draw on First Nations knowledge systems can critically address these determinants. Regaining a robust sense of cultural identity is widely recognised as a primary protective factor against suicide, providing a source of resilience in times of adversity (Dudgeon et al. 2020a; Dudgeon et al. 2022; Prince 2018). Factors such as being taught in traditional language and learning about spirituality in childhood provide important foundations for a healthy self-identity. Learning traditional language can assist with understanding social and emotional wellbeing concepts, which cannot always be easily translated into English (Martin et al. 2023).

Cultural continuity is widely recognised as providing a whole-of-community protective force, with substantial evidence for its acting as a safeguard against suicide (Chandler and Lalonde 2008; Dudgeon et al. 2016; Dudgeon et al. 2022; Gibson et al. 2021; Lovett and Brinkley 2021; Salmon et al. 2018). The 2021 study by Gibson and colleagues, for example, examined deaths by suicide of young First Nations people aged 10–19 between 2001 and 2015. The authors measured cultural connection via indicators of cultural social capital (including participation in community activities and contact with family and friends), First Nations language use and reported discrimination. Their research found statistically higher rates of suicide among young First Nations people who lived in communities with high levels of discrimination and low levels of cultural continuity (Gibson et al. 2021).

Contemporary strength-based approaches to First Nations suicide prevention are those that are 'culturally safe, asset-based, engage with community capabilities and capacity building (self-determination) [and] focus on resilience' (Dudgeon et al. 2020b:240). Many communities have approaches and programs that increase social and emotional wellbeing (CBPATSISP n.d.d).

Cultural safety

Cultural safety describes an environment that is physically, spiritually, socially and emotionally safe, where care is responsive and free of racism (Truong and Moore 2023; Williams 1999). It is an environment in which services must recognise and consider the values, beliefs and preferences of their clients (Walker et al. 2014).

Cultural safety must underpin any service for First Nations people; it ensures both the effectiveness of treatment and its accessibility. Services that are community controlled with a First Nations workforce contribute to cultural safety (Truong and Moore 2023). Mainstream support systems can be valuable if they are developed to welcome and respect First Nations people and support their culture. In these services, cultural competency training is needed for non-Indigenous health workers. Such training should be regularly reviewed and actively monitored. Guidelines have been developed for best practice psychosocial assessment of First Nations people presenting to hospital with self-harm and suicidal thoughts (see Box 2.2, Leckning et al. 2019). However, it must be noted that whether care is culturally safe is ultimately defined by the consumer.

Social and emotional wellbeing

For First Nations people, health is a holistic concept, encompassing mental, physical, cultural and spiritual health. Social and emotional wellbeing is the foundation for the health of First Nations people, and refers to the social, emotional and cultural wellbeing of the whole community.

Understanding social and emotional wellbeing is fundamental to understanding the risk and protective factors involved in suicide. Having positive social and emotional wellbeing acts as a source of resilience (Dudgeon et al. 2020a). Lore-informed approaches to social and emotional wellbeing are also important (see Box 2.3).

The social and emotional wellbeing model provides a means of understanding the holistic context of First Nations health and wellbeing (Figure 2.1) (Gee et al. 2014; PM&C 2017). The framework is consistent with First Nations concepts of health and wellbeing, which prioritise wellness, harmony and balance rather than illness and symptom reduction (Gee et al. 2014:64).

Figure 2.1: Social and emotional wellbeing framework

Source: TIMHWB 2024.

Social and emotional wellbeing carries a culturally distinct meaning:

> … it connects the health of an Indigenous individual to the health of their family, kin, community, and their connection to Country, culture, spirituality and ancestry. It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine (Dudgeon et al. 2016:17).

The concept of 'connection' describes how First Nations people experience the 7 interrelated domains of social and emotional wellbeing – body; mind and emotions; family and kinship; community; culture; Country; and spirituality and Ancestors – at different times through their lives (Gee et al. 2014; PM&C 2017). Interrupting these connections is likely to lead to poor social and emotional wellbeing, while restoring and strengthening them is associated with increased social and emotional wellbeing (Gee et al. 2014).

Understanding the historical trauma experienced by First Nations people is essential to understand social and emotional wellbeing. A person's social and emotional wellbeing is influenced by past policies and events. Prominent First Nations researchers, Hunter and Milroy (2006), recognise suicide and suicidal behaviours as reflecting the complex interactions of:

> … historical, political, social, circumstantial, psychological and biological factors that have already disrupted sacred and cultural continuity; disconnecting the individual from the earth, the universe and the spiritual realm – disconnecting the individual from the life affirming stories that are central to cultural resilience and continuity (2006:150).

Box 2.3: The interplay of Lore and wellbeing

Often overlooked in contemporary literature is the importance of Lore to First Nations health and wellbeing. A knowledge of Lore and culture is intrinsic to First Nations people's health and wellbeing; it is central to their ways of knowing, being and doing.

Schultz, a Gamilaraay man, relays an explanation from Elders of what Lore is: 'the essence of what "is" … [with] culture … being how we enact that "what is"' (Redvers et al. 2020:8). Others have emphasised the centrality of Lore, describing it as 'the body of knowledge that defined the culture' (Parker and Milroy 2014:26).

In *The Dreaming path*, Callaghan and Gordon (2022) share their knowledge of the power of Aboriginal culture and spiritual knowledge to achieving wellbeing. They stress the importance of Lore in the healing process: 'From an Aboriginal perspective, healing involves connecting with Country, connecting with spirit, connecting with Lore' (2022:224). And, later, Uncle Paul Gordon expands on this perspective:

> I see many Aboriginal men today who are lost, not knowing what their purpose is in life because the roles and responsibilities of the generations before them have been taken away … Governments think that they know what is best for these men, assuming these men want what others have. But before these men can ever know what they want or where they are going, they really have to connect and know the journey that brought them to where they are today.
>
> Indigenous peoples throughout the world have had their knowledge forcibly removed from them and another set of knowledge and values imposed upon them. By removing the Indigenous story, we have completely disempowered these people. How can a disempowered people move forwards? We must allow these people to reconnect with their stories. Only then will they be healed (Callaghan and Gordon 2022:276–277).

(continued next page)

Box 2.3 (continued): The interplay of Lore and wellbeing

Callaghan's research (2024) also describes how Lore helps people in finding their place in the modern world, describing it as providing contentment and satisfaction, akin to First Nations people's experience of life before colonisation. Similarly, Schultz's in-depth examination of the wellbeing of First Nations health and community service workers from a Lore and cultural perspective emphasises the benefits of learning and practising Lore and culture:

> Experiences of and production of positive Lore facilitate a sense of inner, deep contentment and stronger (positive) holistic wellbeing. Conversely experiences and production of negative Lore promote disturbances in one's holistic wellbeing due to an inability to maintain or experience states of inner spiritual peace or calm (Schultz 2020:Section 10.1).

The ATSISPEP final report, *Solutions that work: what the evidence and our people tell us*, identified success factors for First Nations suicide prevention activities. Fundamental to successful programs are community-led and community-specific programs that heal and strengthen social and emotional wellbeing (Dudgeon et al. 2016).

The inclusion of a new outcome in the National Agreement on Closing the Gap underscores the fundamental link between First Nations people's social and emotional wellbeing and suicide prevention. Among the 19 national socioeconomic targets across areas that have an impact on life outcomes for First Nations people is Outcome 14: 'People enjoy high levels of social and emotional wellbeing'. A 'significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero' has been adopted as the target of this outcome (Coalition of Peaks 2020).

Types of suicide prevention interventions

Suicide prevention activities are often classified into 3 levels of intervention (Department of Health and Ageing 2013; Dudgeon et al. 2016; WHO 2014):

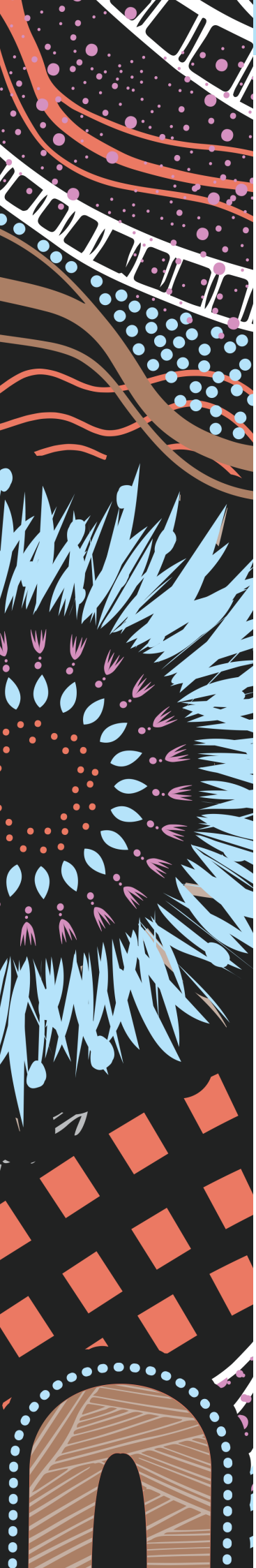
- universal interventions – usually aimed at the whole population, including the 'well' population. Includes addressing risk factors and restricting access to means of suicide
- selective interventions – targeting groups of people at high risk of suicide. Includes postvention services and programs for high-risk groups
- indicated interventions – for those individuals identified as being at-risk of suicide or who have attempted suicide. Includes crisis phone helplines, the treatment and management of suicidal behaviours, and follow-up support after suicide attempts (National Suicide Prevention Project Reference Group 2020).

These levels of intervention support a 'systems-based' approach to suicide prevention, as recommended by the National Suicide Prevention Strategy for Australia's health system: 2020–2023, whereby interventions are integrated, sustained and delivered simultaneously (National Suicide Prevention Project Reference Group 2020). The strategy refers to the ATSISPEP report (Dudgeon et al. 2016) to guide First Nations suicide prevention efforts, which identified success factors in suicide prevention.

The ATSISPEP report uses the term 'universal' to describe community-wide interventions, not the whole First Nations population. Universal interventions are recognised as primordial; they aim to address 'upstream' risk factors for suicide, such as reducing alcohol and drug misuse or family dysfunction. They include the need for community empowerment, the promotion of healing, and the strengthening of resilience in individuals and communities. These interventions may not be immediately recognised as being connected with suicide prevention, but they play an important role in preventing suicide (Dudgeon et al. 2016).

Primary prevention activities are also part of universal interventions. These activities include community-wide approaches to suicide prevention, such as education to support help-seeking behaviour for people in the community (Dudgeon et al. 2016).

An important aspect of indicated interventions is their accessibility, as they are targeted at individuals at risk or who have attempted suicide. Ideally, such supports are available 24 hours a day, and factors such as cultural safety are essential to ensure access by people at risk (Dudgeon et al. 2016).



3

Methods

3 Methods

The researchers for this paper undertook a targeted literature review to identify relevant and informative research on First Nations suicide prevention. Online search engines and scholarly databases – Google, Google Scholar, Medline, Pubmed, the Analysis and Policy Observatory, and the Australian Indigenous Health*InfoNet* – were used to locate pertinent material, including government reports and 'grey' literature. Additionally, the CBPATSISP was searched for relevant programs and research. Snowballing methods (using references from initially identified sources describing relevant programs, policy or research on the topic) were also used.

A number of key search terms were used in the literature search. A combination of the following terms, or parsed variants of these terms, were used:

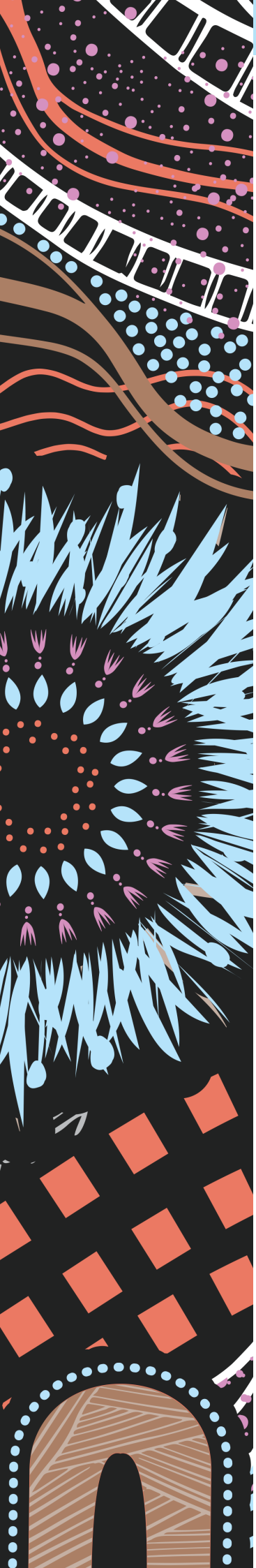
- Indigenous, First Nations, First Australians, Aboriginal and/or Torres Strait Islander
- suicide, suicide prevention, suicidology, self-harm
- social and emotional wellbeing, SEWB, wellbeing, mental health.

The selection of relevant literature was guided by several important principles:

- priority given to First Nations research, perspectives and concerns
- applicability and currency of the information to explain current conceptual thinking in this field of research
- relevance to building understanding of best practice in First Nations suicide prevention.

This paper also sought to locate and feature novel First Nations suicide prevention programs that had not been discussed and analysed in previous publications of the Indigenous Mental Health and Suicide Prevention Clearinghouse. (For more information, https://www.indigenousmhspc.gov.au/publications). Many other suicide prevention programs and initiatives have been well documented in earlier Clearinghouse publications (Darwin et al. 2023; Dudgeon et al. 2021a; Dudgeon et al. 2022) as well as by the CBPATSISP. (For more information, https://cbpatsisp.com.au/).

In adopting an Indigenous standpoint, this paper prioritises First Nations research and voices. Indigenous standpoint theory shifts research from a dominant colonial viewpoint and enables a better understanding of First Nations health outside of Western theoretical frameworks (Cox et al. 2021). Such an approach is particularly useful where there may be competing Western and First Nations knowledge systems (Dudgeon et al. 2020c).



4

Key issues

4 Key issues

Colonisation is a social determinant of suicide, having left a legacy of disadvantage and trauma following assimilative policies for Indigenous populations around the world (Redvers et al. 2015). With elevated patterns of Indigenous suicide – a shared issue among colonised countries – there is value in knowledge sharing among post-colonial countries to strengthen suicide prevention efforts.

In this chapter, we examine dominant contemporary approaches to suicide prevention (including through international literature) to enable a greater understanding of how applicable these suicide prevention interventions would be for First Nations people. We also explore international and national research directions in Indigenous suicide prevention.

Readers should note, in discussing international matters, that this paper uses the term 'Indigenous' to refer to the First Peoples of colonised lands worldwide.

International approaches to suicide prevention

In 2014, the World Health Organization (WHO) released the report *Preventing suicide: a global imperative*, which endeavoured to prioritise the importance of suicide prevention on the global health agenda. It summarises the risk factors for suicide, linking them to a theoretical framework of interventions (similar to that described in Chapter 2), and puts forward an international strategy for suicide prevention (WHO 2014). The WHO report recognises the stresses of 'acculturation and dislocation', discrimination and trauma as suicide risks for Indigenous people and identifies the value of community prevention initiatives and culturally tailored interventions (WHO 2014:36). In recommending a way forward, the report emphasises the important role of communities in suicide prevention.

This emphasis on community contrasts with dominant suicide prevention practices in the Western world. A scan of systematic reviews of suicide prevention approaches undertaken for this paper highlighted cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) as the most well-established suicide prevention interventions (D'Anci et al. 2019; Glenn et al. 2019; Hawton et al. 2016; Mendez-Bustos et al. 2019, Meza and Bath 2021; Ougrin et al. 2015). CBT and DBT are both talking therapies that focus on changing a person's thinking practices. They involve emotional regulation and mindfulness, with DBT, which was created for highly suicidal individuals, emphasising behavioural change (APA 2017; APS 2024). Fundamentally, these approaches conceptualise suicide as a problem originating at an individual level.

Leading researchers into Indigenous suicide prevention question such interventions for Indigenous people. Ansloos (2018), a nêhiyaw (Fisher River Cree Nation) psychologist, contends that approaches to Indigenous suicide prevention require a critical reformulation. He critiques the current dominant biopsychological approach in suicide research, which focuses on the individual self and perceives suicide as the 'logic of a disordered mind', resulting in suicide prevention efforts focused on 'addressing disordered individuals' (2018:17). He contends that the current approaches are 'reductive, stereotyping and ineffective' (2018:18). Ansloos provides a pertinent example:

> … simply having status as an Indigenous person is widely considered a 'social determinant' of suicide, however, there is great variation in suicide rates across Indigenous communities (2018:18).

Ansloos argues that mainstream approaches fail to address key social and structural dimensions of First Nations suicide, recommending that researchers need a more sophisticated understanding of Indigenous culture. He proposes that suicide research needs to respect, value and use Indigenous cultural knowledge and ways of knowing, and move beyond one-size-fits-all approaches to a 'culturally focused approach, grounded in the social and material concerns of communities' (2018:19). He also advocates for using Indigenous research methodologies and a decolonisation approach.

Contextualising suicide

In 2013, the National Action Alliance for Suicide Prevention's (NAASP's) American Indian and Alaska Native Task Force assembled a group of United States suicide research experts to identify priority areas for research. Again, the NAASP group noted that the predominant body of research conceptualised suicide as a problem originating at an individual level rather than a societal one. This tends to ignore 'other social, historical, and cultural realities that affect Indigenous people's health' (Wexler et al. 2015:895). The group flagged Western research approaches as problematic, with their emphasis on observable and reproducible results; it contrasted this with research among Indigenous peoples, which emphasises 'heritage and respect for personal experience' and 'holism' (Wexler et al. 2015:893). The differences in approach were summarised thus:

> The primary contrasts are between knowledge that is general versus particular, reductionist versus holist, and abstracted versus contextualized (2015:893).

Indigenous knowledge systems place importance on contextualising suicide and responding holistically.

Turning again to prevailing suicide prevention interventions, the NAASP group reported that individually focused interventions 'have had limited utility in preventing youth suicide in Indigenous communities' (2015:5). Canadian researchers Sjoblom and colleagues (2022) describe the failure of this approach as being due to 'cultural misalignment with Indigenous paradigms' (2022:1). Other United States researchers have flagged the absence of theoretical frameworks to support cultural adaptations of evidence-based interventions in Indigenous contexts (Gonzales 2017; Wexler et al. 2022). Adaptations face the tension of balancing community needs and values with scientific evidence (Wexler et al. 2022) (see Box 4.1).

Cultural continuity and community-based approaches

Chandler and Dunlop (2018) contend that a common element for Indigenous suicide worldwide is that it is the 'culmination of "cultural wounds" inflicted upon whole communities and whole ways of life' (2018:3). Many Indigenous researchers agree that the solution can be found in community-based initiatives and in empowering communities (Dudgeon et al. 2020b; Sjoblom et al. 2022; Wexler et al. 2015).

The work of Chandler and Lalonde (1998, 2008) in examining youth suicide in Indigenous communities in Canada underscores this point. Their study examined Indigenous youth suicide among the almost 200 Indigenous communities in British Colombia, finding suicide to be concentrated in 10% of those communities. Suicide rates were lower in communities that had secured title to traditional lands, had achieved some measures of self-government, had control of their community services, and had established cultural facilities in the community (Chandler and Lalonde 2008). These factors were described as evidence of cultural continuity. In contrast, suicides were highest in those communities without strong cultural practices and where self-determination was not evident.

The NAASP group describes community-based participatory research and community-driven approaches as an 'ethical imperative' (Wexler et al. 2015:896). Collaborations between Indigenous communities and researchers allow for research to be an 'emancipatory process' and ensure the local relevance of solutions (Wexler et al. 2015:894). Interventions need to build both community and individual wellbeing.

The benefits of strength-based suicide prevention models that emphasise the protective role of culture and cultural processes are well recognised among Indigenous researchers (Barker et al. 2017; Dudgeon et al. 2020b; Sjoblom et al. 2022; Wexler et al. 2015). In these approaches, wellbeing is defined in cultural terms, and suicide prevention interventions draw on local culture and knowledge.

Strength-based approaches in Australia

These international directions parallel the holistic and strengths-based social and emotional wellbeing approaches recommended in the ATSISPEP report (Dudgeon et al. 2016) for First Nations suicide prevention in Australia.

The ATSISPEP report identified 2 thematic elements from Chandler and Lalonde's (1998, 2008) research in Canada:

- 'community empowerment', where communities are strengthened to support their own decision-making and leadership
- 'cultural maintenance and renewal'.

These elements form part of the success factors the ATSISPEP report identifies in suicide prevention interventions (Dudgeon et al. 2016). They are also reflected in the upstream prevention activities outlined in the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (Department of Health and Ageing 2024) (see Chapter 5).

In Australia, activities and interventions for suicide prevention must consider and address the unique context and causes of suicide and suicidal behaviours for First Nations people. Mainstream diagnostic criteria may have less relevance for First Nations people; they themselves conceptualise mental health as following a different aetiology to that of mainstream Australia, and the causal pathways for suicide differ (Vicary and Westerman 2004; Westerman 2020).

Suicide is associated with stressful life events and the psychological distress these events cause. Many of the factors associated with stressful life events for First Nations people stem from their unique history – one of grief, trauma and despair that has come from the disempowerment that began with colonisation. Factors such as racism and discrimination, incarceration, exposure to abuse and violence are some of the stressors that First Nations people commonly face. The determinants of First Nations suicide are complex, often entrenched and ongoing.

The determinants approach to mental health and suicide understands that suicide is a response to the broad social, cultural and political contexts and is aligned with a First Nations standpoint (Dudgeon et al. 2020a).

Indigenous concepts of 'flourishing' or 'living well' are culturally unique around the world (Dudgeon et al. 2020b:238). They are 'founded on a life-affirming and custodial kinship with the earth, and respectful and loving human and more-than-human relationships' (Dudgeon et al. 2020b:28). The social and emotional wellbeing approach to suicide prevention practice that is followed in Australia will restore healthy connections between the 7 domains of First Nations wellbeing –

Country, culture, spirituality and Ancestors, community, family and kinship, mind and emotions, and body (Gee et al. 2014). Many Western therapeutic approaches fail to acknowledge cultural diversity or to accommodate the strengths to be found in social and emotional wellbeing.

The ATSISPEP report acknowledged the challenges in evaluating First Nations suicide programs. It advocates for incorporating evaluation into program development and implementation, recommending participatory action research as a method whereby communities lead research and implement their own responses (Dudgeon et al. 2016:72) (see Box 4.1).

Box 4.1: Establishing the evidence base for preventing Indigenous suicide

Researchers across the colonised countries are united in calling for the decolonisation of suicide prevention, with strength-based, community-driven, culturally grounded approaches that prioritise local Indigenous knowledge. They advocate for strategies that increase community cultural connectedness and reduce institutional and personal discrimination (Ansloos et al. 2022; Gibson et al. 2021; Richardson and Waters 2023; Sjoblom et al. 2022; Walters et al. 2020).

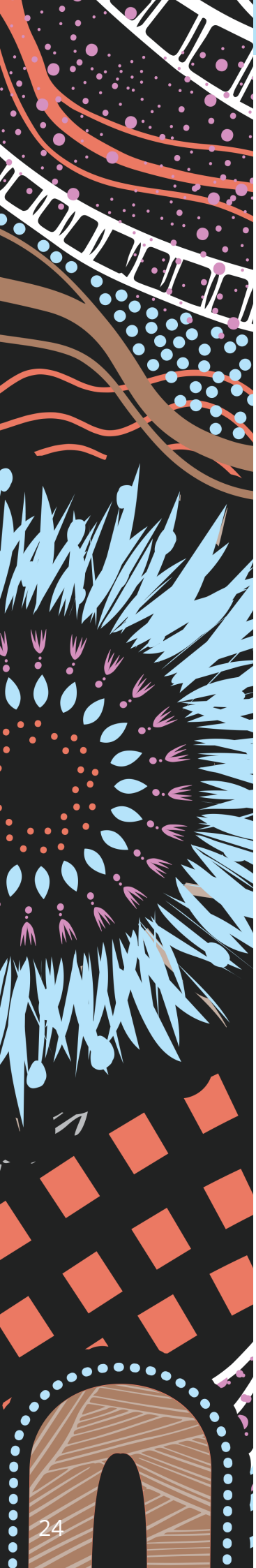
International researchers are also united in their calls for evaluations of Indigenous suicide prevention initiatives, with capacity-building being a fundamental element (Caldwell et al. 2005; Richardson and Waters 2023; Sjoblom et al. 2022; Stoor et al. 2021; Wexler et al. 2015; Young et al. 2015).

Australian researchers have made it clear that, alongside the shift from Western treatment models, a shift is also needed from Western evidence models. 'Indigenous psychology draws on the oldest continuing knowledge systems but remains largely ignored by dominant Western psychological theories and practices' (Dudgeon et al. 2023:259). Evaluations of First Nations suicide prevention programs must be placed in the context of First Nations models of community healing, knowledge systems, evaluation measures and tools if they are to produce a useful evidence base (Dudgeon et al. 2021b).

The Australian researchers contend that Aboriginal Participatory Action Research (APAR) is a critical element to decolonising psychological research, building evidence and, ultimately, to improving the social and emotional wellbeing of First Nations people. APAR involves building evidence through a capacity-building participatory process. Participatory Action Research has its history in decolonising research practices, with APAR re-centring First Nations knowledge systems (Dudgeon et al. 2020c).

Later chapters of this paper highlight the important work of the CBPATSISP in advancing and building on the work of the ATSISPEP report (Box 5.1) and, importantly, in maintaining and developing an evaluation framework for First Nations suicide prevention programs and initiatives (Chapter 7).

From this local and international research, it is clear that suicide prevention responses need to draw on sources of resilience and promote protective factors – at both an individual and a community level. Importantly, community-led responses that are strength based will move approaches to suicide prevention away from deficit discourses.



5

Policy context

5 Policy context

This section briefly outlines current national policies, strategies and frameworks specific to suicide prevention for First Nations people. Further detail is provided at Appendix A.

Policies, strategies and frameworks that relate more generally to First Nations social determinants of health and mental health have been comprehensively covered in other publications and outputs of the Indigenous Mental Health and Suicide Prevention Clearinghouse. (See AIHW 2021a, 2021b; Dudgeon et al. 2021a; Martin et al. 2023; and the Indigenous Mental Health and Suicide Prevention Clearinghouse website – https://www.indigenousmhspc.gov.au/resources/data-resources/policy-context#keynationalpoliciesandstrategies).

The Indigenous Mental Health and Suicide Prevention Clearinghouse article *An overview of Indigenous mental health and suicide prevention in Australia* (Martin et al. 2023) includes a focus on the mental health implications of past policies for First Nations people, which is an important context for understanding the historical trauma experienced by First Nations people.

Mental health and suicide prevention policy

The Australian and state and territory governments share responsibility for mental health and suicide prevention policy. Governments, non-government and private organisations provide funding for mental health and suicide prevention services.

Since 1992, the Australian and state and territory governments have worked together via the National Mental Health Strategy (and Policy) to develop mental health policy, programs and services. Five 5-year National Mental Health Plans were agreed to between 1993 and 2022. These set the overarching direction in mental health and suicide prevention policy. As well, the Council of Australian Governments released the *National Action Plan on Mental Health* in 2006 and, later, a revised *National Mental Health Policy* (AIHW 2024a; Department of Health and Ageing 2009).

Since 2007, First Nations service providers and advisory bodies have been involved in national policy reforms through representative bodies at the national level, such as the National Aboriginal and Torres Strait Islander Healing Foundation in 2013 and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group in 2013 (Zubrick et al. 2014). Consistently, policy documents of the last 15 to 20 years refer to First Nations partnerships and community-led approaches to suicide prevention.

Critiques of the mental health system have noted multiple reforms during this period, describing a fragmented approach to mental health care, shortfalls in service access, with overlapping reporting processes that provide limited detail on health outcomes or quality improvement (Rosenberg et al. 2022; Rosenberg et al. 2023). Other commentators highlight the limitations of suicide prevention strategies, which generally incorporate only a limited focus on social determinants and, while usually signed off by health ministers, face challenges in achieving whole-of-government and cross-sectoral approaches in action on suicide prevention (Pirkis et al. 2023).

Key current national policies and substantial developments in the evidence base for suicide prevention policy are noted below. These cover those for First Nations people as well as major policy initiatives for the general population.

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS) was first released in May 2013 (Department of Health and Ageing 2013). It was developed by First Nations experts and leaders in mental health and suicide prevention in response to a recommendation of the 2010 report of the Inquiry into Suicide in Australia by the Senate Community Affairs References Committee: *The hidden toll: suicide in Australia* (SCARC 2010).

This strategy takes a holistic view of health, outlining the need for community-focused, holistic and integrated approaches to suicide prevention. 'Upstream' risk factors are emphasised, with the strategy highlighting the importance of building capacity, strength and resilience, and coordinating approaches to prevention.

Some changes have occurred since the strategy's release, necessitating its refresh. For example, structural reforms in 2015 saw the replacement of Medicare Locals with Primary Health Networks (PHNs), with PHNs responsible for commissioning primary mental health care and suicide prevention services (GDPSA n.d.a). Suicide prevention activities are expected to be integrated and systems based, and undertaken in partnership with other local organisations, including social and emotional wellbeing services, drug and alcohol services, mental health services and Local Hospital Networks (Department of Health 2019). Importantly, the evidence base on suicide prevention was expanded with the release of the ATSISPEP report in 2016 (see below) (Dudgeon et al. 2016). Gayaa Dhuwi (Proud Spirit) Australia is leading the work to renew the strategy (see also Box 5.3).

The updated NATSISPS (2025 to 2035) builds on the original framework to ensure sustained reduction in suicide and self-harm among First Nations communities through Aboriginal and Torres Strait Islander community leadership and governance. It highlights the importance of Aboriginal and Torres Strait Islander leadership, cultural practices, lived experiences, holistic care, and local solutions to drive meaningful change.

The strategy provides a roadmap for state and territory governments to work in genuine partnership with Aboriginal and Torres Strait Islander peoples, organisations and communities to reduce the rates of suicide and self-harm among First Nations people. It accounts for several changes within the Australian mental health system and aims to incorporate Aboriginal and Torres Strait Islander cultural safety with clinical approaches to achieve the highest attainable standard of mental health and suicide prevention outcomes for First Nations people (Department of Health and Aged Care 2024).

Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project

The ATSISPEP provided key foundational evidence to support the effective implementation of the NATSISPS. With the launch of the NATSISPS, it became more apparent that work was needed to build an evidence base for First Nations suicide prevention programs that addressed the unique causes of suicide among First Nations people. The project was directly tasked by the Minister for Indigenous Affairs in 2015 to determine 'what works' in First Nations suicide prevention services and programs; it was based, in part, on evaluated programs as well as on widespread consultation across the country (GDPSA n.d.a). The resulting final report *Solutions that work – what the evidence and our people*

tell us (Dudgeon et al. 2016) made 17 recommendations to support successful First Nations suicide prevention and self-harm strategies, including several recommendations directly relevant to the role of PHNs.

The influence of this work had been widespread, with its principles and recommendations informing government and non-government policies and programs (Knight et al. 2024). Its importance cannot be overstated, with several key suicide prevention developments arising from the report (see Box 5.1) or drawing on its findings (see Box 5.2).

Box 5.1: Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

Recommendation 14 of the ATSISPEP report was as follows:

> An Indigenous-led national clearinghouse for best practice in Indigenous suicide prevention activity should be established. This should be tasked to maintain the currency of ATSISPEP tools and resources over time (Dudgeon et al. 2016:57).

The CBPATSISP was established in 2017 and has continued to build on the foundation of the ATSISPEP report by influencing 'Indigenous suicide prevention policy, practice and research and [...] through advocacy' (Knight et al. 2024:11). The centre is funded through the Australian Government's National Suicide Prevention Leadership and Support Program. It provides accessible resources to support programs that promote social and emotional wellbeing and reduce high-risk behaviours and suicide.

The CBPATSISP maintains a clearing house of best practice programs and research in suicide prevention programs. It also maintains the Manual of Resources for Aboriginal & Torres Strait Islander Suicide Prevention; this manual contains tools and practical resources that communities, health practitioners and funding organisations can use to improve social and emotional wellbeing and prevent suicide (see https://manualofresources.com.au/). In establishing best practice and evidence-based suicide prevention, the CBPATSISP evaluates programs holistically. The critical importance of community-led cultural responses is central, as are the rights of First Nations people to self-determination (Knight et al. 2024).

See also Chapter 7 for information on the CBPATSISP's best practice evaluation criteria.

The ATSISPEP study was also tasked to examine the feasibility of critical response 'intervention teams', and it developed a model for suicide postvention services in First Nations communities. The work of Thirrili, which has since been contracted to provide Indigenous suicide postvention services, is discussed in Chapter 6.

Box 5.2: National Suicide Prevention Trials

The Australian Government announced the National Suicide Prevention Trials in 2016. Between 2016 and 2021, PHNs in 12 trial sites implemented local systems-based approaches to prevent suicide behaviour. All 7 sites with First Nations populations drew on the ATSISPEP report's findings and principles, which were recognised as the best evidence of what works in First Nations populations (Currier et al. 2020). Two of the sites were exclusively focused on suicide prevention for First Nations people. The Darwin site, for example, drew on the ATSISPEP framework as a resource to guide the development of their own local framework: Strengthening our Spirits (Currier et al. 2020).

The final evaluation report commended the ATSISPEP approach as being central to multi-component, multi-level suicide prevention initiatives. It drew on the ATSISPEP's principles, recommending that

> … suicide prevention strategies must originate from Aboriginal and Torres Strait Islander-specific evidence and knowledge and genuine Aboriginal and Torres Strait Islander governance is fundamental (Currier et al. 2020:98; Knight et al. 2024:19).

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

This framework describes the interactive relationship between social and emotional wellbeing, mental health, and suicide, highlighting the importance of service integration. The framework was originally developed for the period 2004 to 2009 and was renewed in 2017 (PM&C 2017). It is designed to guide the provision of social and emotional wellbeing health services that would be culturally appropriate for First Nations people and is applicable to mainstream services and First Nations-specific services. It was prepared to support the implementation of the Fifth Plan (see below) and the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Department of Health 2013, since superseded by the 2021–2031 Health Plan (see below).

As part of the actions supporting Outcome 14 of the National Agreement for Closing the Gap (see below), a policy partnership between governments and Gayaa Dhuwi (Proud Spirit) Australia will oversee a refresh of this framework and an implementation plan (GDPSA 6 June 2023).

Fifth National Mental Health and Suicide Prevention Plan

This plan, commonly referred to as the Fifth Plan, was endorsed in 2017; it outlines the current national approach for government efforts across 8 priority areas (COAG Health Council 2017). These areas cover integrated approaches to suicide prevention and include a specific fourth priority area: 'Improving Aboriginal and Torres Strait Islander mental health and suicide prevention'.

The plan sets out governments' commitment to integrated, systems-based approaches to suicide prevention. It specifies strategies to address social and emotional wellbeing, mental illness, and suicide for First Nations people. It references the ATSISPEP report (Dudgeon et al. 2016) as informing the approaches it has adopted. It also endorses the importance of First Nations leadership by committing to implement the Gayaa Dhuwi (Proud Spirit) Declaration (see Box 5.3).

Box 5.3: Gayaa Dhuwi (Proud Spirit) Declaration

In 2010, a group of senior Indigenous mental health leaders from New Zealand, Samoa, United States, Canada and Australia developed the Wharerata Declaration (Sones et al. 2010). It provided a framework for improving Indigenous mental health, highlighting common mental health challenges for Indigenous peoples and setting out the importance of Indigenous leadership to address these. Subsequently, key government mental health agencies in Australia endorsed the declaration.

The National Aboriginal and Torres Strait Islander Leadership in Mental Health group formed as a result of this declaration. The group launched a companion declaration in 2015 for First Nations people in Australia; known as the Gayaa Dhuwi (Proud Spirit) Declaration, it covers 5 themes:

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

Gayaa Dhuwi (Proud Spirit) Australia was established in 2020 as the national peak body for First Nations social and emotional wellbeing, mental health and suicide prevention.

National Aboriginal and Torres Strait Islander Health Plan 2021–2031

Released in 2021, this plan was a collaboration between state, territory and Australian governments and First Nations health leaders. The plan prioritises a holistic model of care. It endorses the Gayaa Dhuwi (Proud Spirit) Declaration, draws on the ATSISPEP success factors and is guided by the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing.

Priority 10 of the plan covers mental health and suicide prevention, referring to a holistic approach and integrated suicide prevention – whereby multiple prevention elements occur at the same time. These include wellbeing promotion to prevent mental health conditions, early intervention, continuity of care, and the extension of support to people bereaved by suicide. Four objectives are listed in support of this priority, including strengthening the role of the Aboriginal Community Controlled Health Service (ACCHS) to deliver and coordinate suicide prevention services and ensuring First Nations people with lived experience are central to the development and delivery of mental health and suicide prevention services (Department of Health 2021).

National Suicide Prevention Strategy for Australia's Health System: 2020–2023

This strategy was an action of the Fifth Plan (see above), committing all governments to a target of zero suicides. It reaffirms the need for collaborative, whole-of-government approaches to suicide prevention. It also stipulates the need to partner with First Nations Elders and communities to 'strengthen the connection with culture, Country and self-determination' (National Suicide Prevention Project Reference Group 2020:3). The strategy recommends systems-based approaches for First Nations people and refers to the ATSISPEP report (Dudgeon et al. 2016) for an articulation of the necessary interventions, cultural considerations and success factors.

National Agreement on Closing the Gap

This agreement commits Australia to ambitious reforms and targets to improve life outcomes for First Nations people. It commits governments and First Nations people to work together to overcome the inequality experienced by First Nations people. All parties to the agreement are committed to action, with Implementation Plans setting out the policies, programs and actions that achieve the outcomes.

A new National Agreement on Closing the Gap (Coalition of Peaks 2020) was agreed in 2020, developed in partnership by Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks). Outcome 14 of the agreement states: 'Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing'. The key measure to achieving this goal is directly related to suicide prevention: Target 14 – 'Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero'.

Reporting on the progress of Target 14 includes reporting on contextual indicators, such as experiences of racism and barriers to health services. Several drivers (factors that may affect progress) were under development at the time of writing, including non-fatal hospitalisations for intentional self-harm (PC 2024).

Australian Government investments in suicide prevention initiatives include funding for the Culture Care Connect Program being implemented by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the establishment of 13YARN, a 24/7 crisis line (see Chapter 6) (NIAA n.d.).

National Mental Health and Suicide Prevention Plan

This plan – Prevention, Compassion, Care: National Mental Health and Suicide Prevention Plan – was released in 2021 at the time of the COVID-19 pandemic and following the 2019–20 summer bushfires. Described as a reform agenda for mental health and suicide prevention, it highlighted 2021–22 budget investments over 4 years in mental health and suicide prevention (Australian Government 2021).

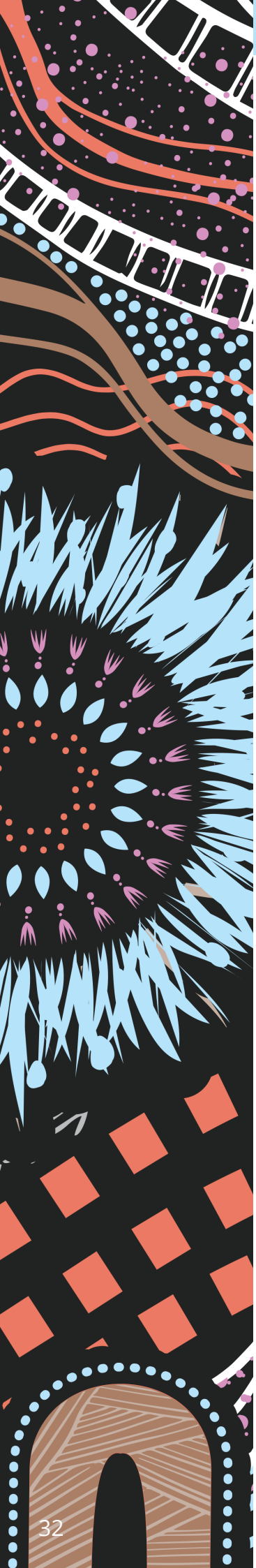
The plan noted some Australian Government investments in First Nations suicide prevention, including the National Indigenous Postvention Service (see Chapter 6, Thirrili – Indigenous Suicide Postvention Services) and referred to the renewal of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (described earlier).

National Mental Health and Suicide Prevention Agreement

This agreement came into effect in March 2022, supported by bilateral agreements signed by the Australian Government and all state and territory governments. The focus of these bilateral agreements is on providing community-based services, along with more locally based commitments that address service gaps (Australian Government 2022).

The National Mental Health and Suicide Prevention Agreement reaffirms the Closing the Gap targets, and specifically refers to:

- Target 14 – 'Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero'
- partnership arrangements between governments and First Nations people, which ensure shared decision-making and building a strong and sustainable community-controlled sector
- the need to align any activities with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing.



6

Programs and initiatives

6 Programs and initiatives

This chapter briefly explores 5 suicide prevention programs, which cover the 3 levels of suicide prevention intervention: universal, selective and indicated. All of the programs examined are for First Nations people. More information on these programs is provided at Appendix B.

These programs are included not only because they are good examples of the 3 levels of suicide prevention intervention programs but also because they have not previously been reviewed in other Indigenous Mental Health and Suicide Prevention Clearinghouse publications. There are many other valuable programs that seek to prevent suicide among First Nations people that have been well documented in other Indigenous Mental Health and Suicide Prevention Clearinghouse publications (Dudgeon et al 2021a; Dudgeon et al. 2022; Darwin et al. 2023) and by the CBPATSISP (www.cbpatsisp.com.au).

Culture Care Connect

The Culture Care Connect (CCC) program combines community-driven approaches to suicide prevention planning and holistic after-care services with cultural sensitivity and community empowerment (NACCHO n.d.). The NACCHO – the national leadership body for First Nations health in Australia – coordinates the program, and it is funded for the period 2021–22 to 2024–25 by the Department of Health and Aged Care.

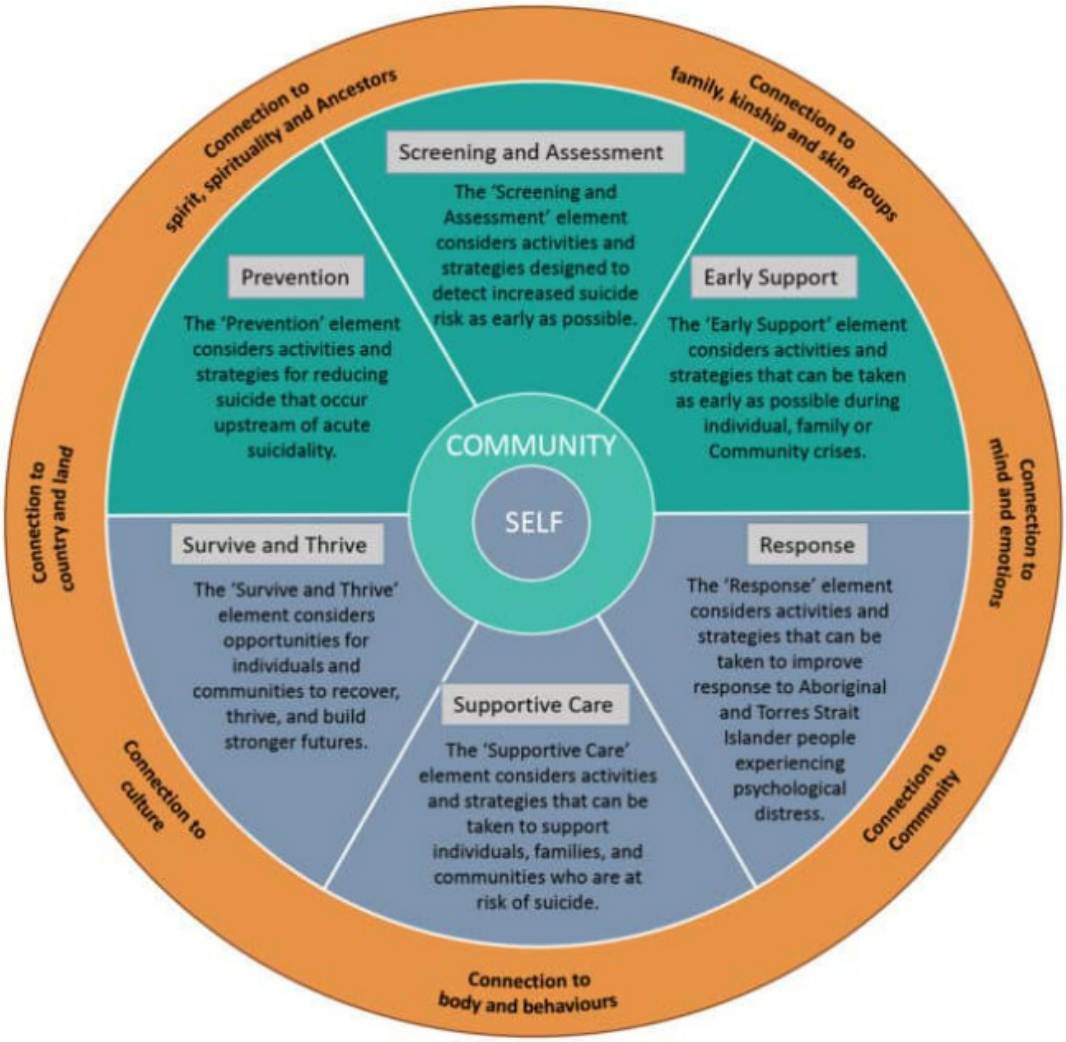
The program has established 36 community-controlled suicide prevention networks (CCSPNs) (including state/territory-based networks) and 38 after-care services across the country (Stephenson 27 June 2024). The program is founded on community involvement; consultation and co-design have seen the establishment and delivery of community-controlled after-care services in CCSPN regions. These work in collaboration with existing community-controlled and non-Indigenous services.

The program is also supporting locally coordinated and delivered community-controlled suicide prevention training, including mental health first aid training.

Inspired by the social and emotional wellbeing model (developed by Gee et al. 2014, see Figure 2.1), the NACCHO has developed a CCC model of care that embeds social and emotional wellbeing, and which operates as a blueprint for local and jurisdictional suicide prevention planning, coordination and delivery of services (see Figure 6.1) (NACCHO n.d). Principles underpinning the model include its:

- being place-based and flexible
- having Aboriginal and Torres Strait Islander leadership and community control
- being holistic, and adopting life-course and strength-based approaches (Ninti One Ltd and First Nations Co 2024).

Figure 6.1: NACCHO CCC program model of care



Source: NACCHO n.d.

Evaluations and reviews

Still in its infancy at the time of writing, the CCC program has not yet been formally reviewed. An independent evaluation of the program is underway and due to be completed in 2025.

The NACCHO describes community involvement as central to the success of the program. As Kellie Stephenson (Acting Director of Mental Health at the NACCHO) explains, services are:

> … delivered for community, with community, by community … each CCC service is place-based and responsive to the priorities and needs identified by [the] community. The program centres on self-determination and community-led action while ensuring national consistency (Stephenson 27 June 2024).

The NACCHO also reports that the program sites have seen an increase in facilitation of local suicide prevention networks, with strengthening and engagement from mainstream services in suicide prevention activities. A strength of the program is its incorporation of continuous quality improvement processes, ensuring 'lessons learnt are incorporated as the program develops' (Stephenson 27 June 2024).

The CCC program is seen as an exemplar of a working partnership between government and the community-controlled sector. It was assessed by the Australian Government as part of the 2023 Commonwealth Partnership Stocktake – under Priority Reform One of the National Agreement on Closing the Gap. It was found to have met 13 of the National Agreement's 15 strong partnership elements (with one of those 15 not applicable to the program) (NIAA 2023). These elements include First Nations participation in decision-making, support for self-determination, and respect for lived experience.

We-Yarn

We-Yarn was the name of suicide prevention gatekeeper training workshops provided in New South Wales between 2016 and 2019. Gatekeeper training teaches people who are generally not clinicians the skills to identify and support people at risk of suicide. The We-Yarn workshops provided culturally safe suicide prevention skills training for First Nations people and for those who work with First Nations people and communities.

We-Yarn evolved from the Good SPACE program (formerly the Farm-Link Project). Facilitators of Good SPACE were asked to deliver an intervention for First Nations people in response to high numbers of suicides in northern New South Wales (Davies et al. 2017). A culturally sensitive Aboriginal Suicide Prevention Skills Workshop was developed by the University of Newcastle's Centre for Rural and Remote Mental Health following considerable consultation with First Nations Elders, community leaders and health workers. Changes were made to the content and mode of delivery of the original workshops, with a First Nations co-facilitator being considered essential (ATSISPEP 2016). The resulting workshops supported First Nations communities in recognising, responding to and preventing suicides. They involved storytelling and discussions of history, and promoted connections to Country. Small groups learnt about specific places and the stories of their ancestors (Kenyon 2019).

Evaluations and reviews

A mixed-methods evaluation of 6 'We Yarn' Aboriginal Suicide Awareness workshops held between December 2016 and June 2017 was undertaken by Davies and colleagues (2017) and Davies and colleagues (2020). These workshops were held in the sites covered by 4 ACCHS organisations which partnered in this research.

With the consent of participants, workshop observers noted anonymised contributions to the workshop. Interviews or focus groups were conducted with consenting participants 3 months after the workshop. Surveys were carried out before and after the workshops to understand whether the workshop had affected

> … a person's knowledge, attitudes and practices regarding support to people experiencing mental distress and its effectiveness in contributing to culturally and locally relevant mental health strategies (Davies et al. 2017:5).

Participants considered that the workshops were culturally appropriate and connected with a holistic model of health. Using skilled facilitators with lived experience was considered to be highly important – their 'shared experience, culture and mutual respect … were vital to opening up the discussion and connecting with workshop participants' (Davies et al. 2017:17).

Significant improvements were self-identified by participants across 4 areas:

- being able to identify signs and symptoms of someone experiencing social and emotional wellbeing problems
- being able to advise someone where to access mental health services and information
- having the ability to understand what places someone at risk of suicide
- having the ability to assist someone at risk of suicide to get the help they need (Davies et al. 2020).

The temporal aspects of these evaluation findings are also worth noting: the observed improvements represent short-term changes to knowledge, with measurement occurring within 3 months of the workshop. Further follow-up would be required to assess long-term change.

There were also shortcomings:

- A stronger focus on clinical training was desired by some participants who were health professionals.
- There was no significant change in participants' perception of their ability to ask someone directly about suicidal thoughts (Davies et al. 2020).

Internationally, the value of gatekeeper training has been questioned, with researchers stating that its effectiveness in reducing suicidal ideation and behaviour is unproven (Mann et al. 2021; Wasserman et al. 2021). The We-Yarn evaluators acknowledged concerns about the suitability of Western gatekeeper training for Indigenous communities; however, cultural tailoring of the training and the use of appropriate training facilitators are considered to contribute to success (Davies et al. 2020; Nasir et al. 2016). The evaluators concluded that community leadership was essential for any ongoing strategies and that such training should form part of a multi-faceted strategy (Davies et al. 2020).

Milpirri Festival and Kurdiji 1.0 app

The Milpirri Festival was established by Warlpiri elder Steven Wantarri (Wanta) Jampijinpa Patrick in response to a suicide in Lajamanu in the Northern Territory in 2005 (Harrison 2022; Tracks Dance 2017). The festival was developed to spread the traditional ideas of 'Kurdiji' – a Warlpiri word meaning 'to shield or protect' – among young people of the community and to foster a sense of belonging (Kurdiji 1.0 n.d.). Warlpiri elder Wanta has described the Milpirri Festival as 'a Warlpiri way to get country to express itself … to make Jukurrpa [the Dreaming] relevant for a 21st century future' (Harrison 2022: para. 3).

The Milpirri Festival has occurred every 2 years since 2005 in Lajamanu in the Northern Territory. It is a partnership between the remote desert community of Lajamanu and Tracks Dance, a contemporary dance company from Darwin. It is a bilingual and bicultural event that brings Warlpiri and non-Warlpiri people together. It is designed to promote a sense of identity and ensure the survival of Warlpiri ways of being and knowing, and to maintain ceremonial cultural practice. Warlpiri elder, Wanta, says the Milpirri Festival is a way to:

> … get both sides [First Nations people and non-Indigenous people] thinking about what country is really trying to remind us about: our home, our country, our identity; about how to learn from Mother Earth and Father Sky (Patrick 2015:122).

The Kurdiji 1.0 app was developed in 2017 by Warlpiri Elders 'to bring Kurdiji into the digital age' (Kurdiji 1.0 n.d.: About, para. 3). It was created in partnership with the Black Dog Institute to support wellbeing and prevent suicide by having strong connections to culture. Funding was provided by grants from Black Dog and a crowdfunding web page.

The app is designed to reach those young people who cannot live on Country, or who feel cut off or isolated, to build resilience and boost self-value in children. It reconnects users with language, skin name, ceremony and law, building resilience by creating a sense of belonging (AAP 6 April 2017; Kurdiji 1.0 n.d.). Warlpiri Elders are changing their laws, by giving access to the Kurdiji ceremony through the app and the Milpirri Festival, in order to save lives (Kurdiji 1.0 n.d.).

Evaluations and reviews

The Milpirri Festival and the Kurdiji 1.0 app have not been formally evaluated. However, a substantial body of research is available that explores the artistic, cultural and societal value of the Milpirri Festival (for example, Biddle and Lea 2018; Biddle and Stefanoff 2015; Dowsett 2021; Dunphy and Ware 2019; Patrick 2015; Pawu-Kurlpurlurnu et al. 2008). In describing the success of this festival, Warlpiri Elder Wanta explained that people enjoyed 'feeling human again and not a shadow, that is, feeling like we have a voice and are not just a background people' (Pawu-Kurlpurlurnu et al. 2008:7).

The Milpirri Festival is recognised for bringing about positive educational, employment, health and wellbeing outcomes (Pawu-Kurlpurlurnu et al. 2008). Tracks Dance reports that it continues to have an enormous effect on the community, with higher engagement levels by children at school where the teaching program incorporates Warlpiri cultural concepts, and greater fitness levels in the adults and children of the community who are active in the program (Tracks Dance 2017). The website describing the Kurdiji 1.0 app development (*c.* 2018–2019) states that there has not been a suicide in Lajamanu since 2005 (Kurdiji 1.0 n.d.).

Dunphy and Ware (2019) examined the Milpirri Festival's focus on dance-making and participation that contributes to quality of life. They highlight the positive effects of the festival on the Lajamanu community and flagged educational, employment, health and wellbeing enhancements.

The widespread use of digital technology by First Nations people and the effectiveness of digital mental health tools for suicide prevention among First Nations people have been discussed elsewhere (AIHW 2023c). Research by Kral (2011) highlights the use of digital media by young First Nations people in remote Australia as a means of communicating cultural activities and concerns of their community. Kral's research includes specific reference to Lajamanu youth and their innovative use of digital media as a new form of cultural production (2011). An examination of mental health apps for First Nations young people noted a preference by users for the use of First Nations Elders as role models, with this being a strength of the Kurdiji 1.0 app (Silva-Myles and Blunden 2020). However, the same researchers stated that only a few service providers in their study were aware of the Kurdiji 1.0 app.

13YARN

Starting formally in March 2022 and funded by the Australian Government, 13YARN is a First Nations-led crisis telephone support line that operates 24 hours a day, 7 days a week. It was developed in collaboration with Gaaya Dhuwi (Proud Spirit) Australia and First Nations mental health professionals (including the NACCHO, Black Dog Institute Aboriginal Lived Experience team and the Centre for

Excellence in Suicide Prevention), along with input from Torres Strait Islander, remote, regional and urban peoples with lived experience. First Nations people run this service and it has a First Nations advisory board.

Some readers may not be familiar with the specific meaning of 'yarn' and the significance of the term in the name of the service:

> Yarning is a cultural process that has been developed and adapted as a clinical, therapeutic, and research tool … Yarning is a unique form of conversation among Aboriginal and Torres Strait Islander peoples, which involves the telling and sharing of stories and information, according to culturally ascribed, cooperative, language protocols. It is a deeply rooted cultural practice and serves as a means of connecting people to each other and to their spirituality. Much more than just conversation, it is a process that establishes relationality and accountability, embedding mutual expected outcomes and responsibilities (Selkirk 2024:31–32).

In phoning 13YARN, community members who seek support are provided with a culturally safe space; they are connected to another First Nations person who understands where they come from and will listen and support them without judgement or shame (13YARN n.d.). First Nations staff of the 13YARN service are trained by Lifeline and are provided with clinical support through Lifeline's infrastructure. The paid crisis support staff are located in New South Wales, Queensland and Western Australia (Lifeline 2023). The service empowers the community by building resilience and providing the opportunity to yarn.

Evaluations and reviews

As noted above, the 13YARN service was developed through a consultation and co-design process and is led and managed by First Nations people – all are features of suicide prevention best practice recognised by the CBPATSISP (CBPATSISP n.d.b). While the 13YARN service has not yet been formally evaluated, funding has been set aside for an evaluation (Lifeline 1 April 2022).

The service is well used; in May 2024, it reached a milestone, having received 50,000 calls (Lifeline 16 May 2024). In 2022–23, the service received 24,296 calls; in the same year, the number of crisis line support staff increased from 24 to more than 50 (Lifeline 2023). Lifeline's 2023 annual report noted that service demand increased by more than 50% in the first 2 years of operation. Marjorie Anderson, the National Program Manager of 13 YARN, observes that many of the peaks in calls to the crisis line coincide with:

> … sorry business, deaths in community and challenging moments in community life. We also support people in distress around the New Year period, Survival Day and through political and news moments such as the Voice referendum in which calls were up by 40% (Lifeline 16 May 2024).

During the debates for the 2023 Voice to Parliament referendum, many First Nations people reported experiencing racism and abuse (Anderson et al. 2023). In a media interview in September 2023, 13YARN manager Anderson reported that the service was fielding a record number of calls; it received more than 170 calls in a single day, more than 5 times the expected volume of calls (Banks 21 Sept 2023).

Thurber and colleagues (2023), in monitoring the wellbeing of First Nations people during the 2023 Voice referendum debates, observed in their report that participants of focus groups reported increased racism; increased mental load and emotional labour; threats to identity; and conflict between First Nations community members and families, as well as with the non-Indigenous community. (Some participants who sought support did not want to further burden friends or family.) The report emphasises the value of 13YARN, with participants discussing the importance of support that provides counselling by mob and by people with lived experience; such counselling was considered to be a 'safe space where deep conversations could be held' (Thurber et al. 2023). Other highlighted benefits of 13YARN were the anonymity and flexibility it provides for those seeking support and that, importantly, it was run by First Nations people.

Thirrili – Indigenous Suicide Postvention Services

Thirrili provides suicide prevention, intervention, postvention and after-care services. Thirrili is a Bunuba word meaning power and strength. Previously, Thirrili provided the National Indigenous Critical Response Service (NICRS), which has transitioned to the Indigenous Suicide Postvention Services. Postvention is support provided after the loss of a loved one from suicide; it is a recognised component of suicide prevention (AISRAP and Postvention Australia 2017).

Thirrili supports First Nations people in all states and territories who are dealing with grief and trauma experienced as a result of the suicide of a family member, or the death of a family member because of a fatal traumatic incident. The service operates a 24/7 phone line, which is staffed by First Nations advocates. Once the service is advised of a death, it works with the family, community and local services to ensure that there is coordinated, holistic and culturally responsive care. The service can also advocate on behalf of families to support them in their time of grief.

Thirrili is a not-for-profit organisation, established in 2017. It is an Aboriginal Community Controlled Organisation that contributes to the social, cultural and emotional wellbeing of First Nations people. All Board members are First Nations people. The Australian Government, through the National Indigenous Australians Agency, provides funding to Thirrili to provide suicide postvention services nationally.

Thirrili has a 'Model of Care, Connection and Practice' that supports the importance of cultural identity, collective wisdom, and the healing power of Country for people, families and communities who are on the journey towards recovery and prevention (Thirrili 2023). The holistic care model builds on the strengths and resources of community.

Evaluations and reviews

A summative evaluation of the NICRS delivered by Thirrili was undertaken after its first 3 years of operation (Ridoutt et al. 2020). The evaluation noted that:

- clients valued the support provided
- there was appreciation for the confidentiality provided, given the independence of the service
- clients valued support from a service that was led by a First Nations board, with staff guided by values that aligned with their culture and approach to social and emotional wellbeing
- service providers confirmed the service was filling a service gap (Ridoutt et al. 2020).

The evaluation summarised program activities in the period from the service's establishment in January 2017 to June 2019. During this time, there were 367 incident notifications, with responses to 275 incidents, and assistance provided to 1,001 family members. Of the 'in-scope' incidents, 169 (69%) of the responses involved, at least partially, face-to-face contact. Suicides represented 60% of all NICRS incidents. Interventions provided most commonly were Emergency Relief Fund payments (83%) and referrals (57%). Families (63%) were the most common source of requests for assistance, followed by service providers (39%) (Ridoutt et al. 2020).

At the time of the evaluation – early in the development of the service – its impact on the social and emotional wellbeing of clients could not be determined. The evaluators made recommendations for the development of outcome measures and improved data collection (Ridoutt et al. 2020).

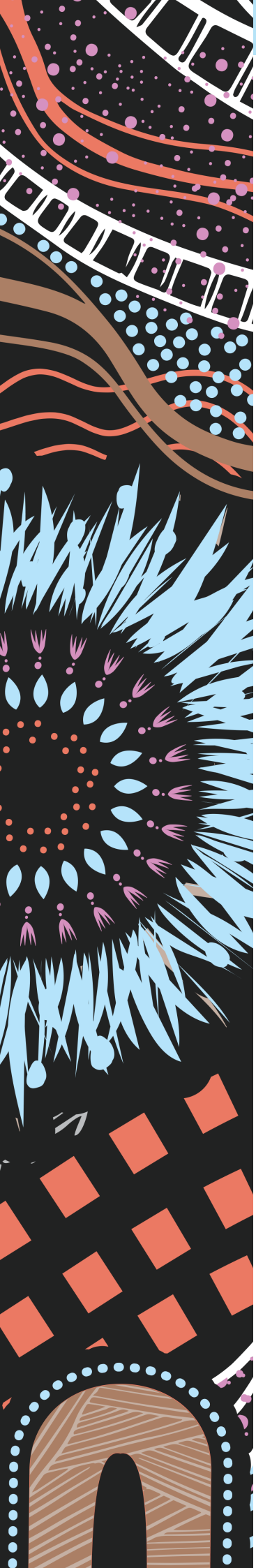
The Thirrili Model of Care, incorporates best practice and review. This

> … involves a continual process of refection, evaluation, and adaptation … [which ensures] that practices and policies evolve in harmony with the lived experiences, values and knowledges of Indigenous communities' (Thirrili 2023: Model of Care diagram).

Thirrili has also developed a strategic plan for 2023–2026, which identifies plans to develop a 'Quality Community Engagement Framework' with annual reviews and feedback from the community (Thirrili n.d.).

The CBPATSISP Clearing House has reviewed Thirrili's Model of Care. It highlighted the flexible approach to delivering care, including the use of advocates who are often familiar with the community. It also recognised Thirrili's support for communities to develop capacity in dealing with trauma (CBPATSISP n.d.e).

A 2024 scoping review undertaken to assess the uptake and influence of the ATSISPEP findings included a literature review and critical appraisal of suicide prevention programs. The appraisal considered a review by Thirrili (Thirrili 2018) along with the services it provides, finding that it had been designed according to ATSISPEP principles, with authorship, leadership and governance provided by First Nations people (Knight et al. 2024).



7

Overarching strategies, approaches and best practice

7 Overarching strategies, approaches and best practice

This chapter showcases important elements of best practice in First Nations suicide prevention programs. The widely recognised best practice resources to guide suicide prevention programs for First Nations people are:

- the work of the ATSISPEP and its final report – *Solutions that work: what the evidence and our people tell us* (Dudgeon et al. 2016) – which provides essential guidance on First Nations suicide prevention
- the CBPATSISP, established as a recommendation of the ATSISPEP report, which also maintains a clearing house of best practice and the *Manual of Resources for Aboriginal & Torres Strait Islander Suicide Prevention* (see Box 5.1).

We referred to these resources, and to the programs identified in the previous chapter, to distil key principles of effective approaches to First Nations suicide prevention.

Success factors

The ATSISPEP report (Dudgeon et al. 2016) identifies 33 success factors across the 3 levels of intervention (universal, selected and indicated – see Chapter 2 for more information). Common elements are those that are relevant to all 3 intervention levels (see Figure 7.1). This synthesis of the significant and comprehensive work of the ATSISPEP draws together evidence-based success factors for suicide prevention in community and clinical settings.

Of fundamental importance are the rights of First Nations people to govern service design and delivery. Success in suicide prevention requires co-design and implementation under First Nations community leadership. Responses must reflect local needs, meaning that those best placed to design responses are communities who will ensure the incorporation of cultural and lived experience elements necessary for success (Dudgeon et al. 2016). This approach will drive further benefits:

> … the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time (Dudgeon et al. 2016:2).

This message is reinforced with clarity in Culture is Life's research with Elders from around Australia into solutions to address the youth suicide crisis across Australia:

> Aboriginal people need to be involved in solving our own problems. Bringing outsiders into the Kimberley will not create succession, the legacies of change that we need. Outsiders bring in quick fixes, providing there is a level of government funding and resourcing. There are a lot of people running around trying to do good, but it doesn't create inter-generational change. We want to up-skill our own people. (Wayne Bergmann, Culture is Life 2024).

Figure 7.1: ATSISPEP success factors for First Nations suicide prevention

Universal/ Indigenous community-wide In this report 'universal' is used to indicate community-wide responses, not population-wide responses as the term usually indicates	Primordial prevention	• Addressing community challenges, poverty, social determinants of health • Cultural elements – building identity, SEWB, healing • Alcohol/drug user eduction
	Primary prevention	• Gatekeeper training – Indigenous-specific • Awareness-raising programs about suicide risk/use of DVDs } with no assumption of literacy • Reducing access to lethal means of suicide • Training of frontline staff/GPs in detecting depression and suicide risk • E-health services/internet/crisis call lines and chat services • Responsible suicide reporting by the media
Selective – at-risk groups	Schoolage	• School-based peer support and mental health literacy programs • Culture being taught in schools
	Young people	• Peer-to-peer mentoring, and education and leadership on suicide prevention • Programs to engage/divert, including sport • Connecting to culture/Country/Elders • Providing hope for the future, education – preparing for employment
Indicated – at-risk individuals	Clinical elements	• Access to counsellors/mental health support • 24/7 availability • Awareness of critical risk periods and responsiveness at those times • Crisis response teams after a suicide/postvention • Continuing care/assertive outreach post ED after a suicide attempt • Clear referral pathways • Time protocols • High quality and culturally appropriate treatments • Cultural competence of staff/mandatory training requirements
Common elements	Community Leadership/ Cultural framework	• Community empowerment, development, ownership – community-specific responses • Involvement of Elders • Cultural framework
	Provider	• Partnerships with community organisations and ACCHS • Employment of community members/peer workforce • Indicators for evaluation • Cross-agency collaboration • Data collections • Dissemination of learnings

DVD = digital versatile disc; ED = emergency department; GP = general practitioner; SEWB = social and emotional wellbeing.
Source: Dudgeon et al. 2016:16

The ATSISPEP report also acknowledges the importance of tailoring responses to the right age groups. To that end, a project conducted jointly by the CBPATSISP and Culture is Life in 2021 and 2022 aimed to understand young First Nations perspectives on suicide prevention services (Oakley et al. 2023) (Box 7.1). Findings again highlighted connection to culture and cultural safety, along with timely and affordable services.

Box 7.1: Perspectives of young people on effective and accessible services

The *Yarn Up Listen up: community report of Aboriginal and Torres Strait Islander young people's perspectives on suicide prevention* (Oakley et al. 2023) sheds light on the perspectives of young First Nations people on what makes a suicide prevention service effective. The project also sought to understand the lived experience of young people accessing the services. Key findings were summarised as detailed below:

- Connection to culture, Country, family and community are vital in keeping First Nations young people mentally and spiritually strong.
- Cultural safety in services is essential; a perceived lack of trust, understanding and consistent support prevents young people from accessing mainstream mental health services.
- Young people are more willing to access First Nations support services than mainstream services; however, these organisations must acknowledge diversity across communities.
- Access to First Nations mental health services needs to be more affordable, appropriate and able to respond more immediately.
- Health care needs to focus on prevention and early intervention, including promoting positive mental health practices throughout all stages of life (Oakley et al. 2023:9).

Determining best practice

Alongside the success factors, the ATSISPEP report presents an Evaluation Framework for suicide prevention activities. Its purposes are twofold:

- It is a resource for communities; it supports community planning, ownership and delivery of suicide prevention programs.
- It provides a set of principles and standards to review existing programs to determine whether they are effective and culturally appropriate (CBPATSISP n.d.c).

The CBPATSISP has refined the knowledge that the ATSISPEP presented on best practice and evidence-based suicide prevention. The CBPATSISP recommends that programs are evaluated holistically; evaluating programs in First Nations communities via traditional methods (such as randomised control trials) can be fraught with methodological and ethical issues. Establishing 'scientific evidence' may exclude successful interventions. Instead, 'practice-based evidence' is recommended whereby researchers learn from iterations of an intervention and seek to understand why a program works. Realist reviews are undertaken, which recognise the complexity of the system in which an intervention takes place (Dudgeon et al. 2021b).

Evaluation strategies in this context reflect First Nations knowledge systems and emphasise First Nations definitions of what counts as useful evidence for communities. Evaluations should consider and report on what is valued by First Nations people and the outcomes that are sought by the intervention. If those outcomes are not valued, such interventions will not positively influence the lives of First Nations people.

Of fundamental importance in suicide prevention initiatives are measurable improvements to the social and emotional wellbeing of the community and to community resilience. Also central are the principles and right of self-determination (Dudgeon et al. 2021b).

CBPATSISP evaluations are guided by the following criteria:

- Indigenous ownership – evidenced by a First Nations-led steering committee or advisory group
- community leadership – evidenced by formal partnerships or collaborations, often with First Nations community organisations or the local ACCHS
- community consultation and co-design – this will involve a First Nations community reference group with key stakeholders of the target group
- evaluation – continuous quality improvement is assessed by service evaluation through feedback from participants or the community
- cultural responsiveness – whereby non-Indigenous staff undertake cultural responsiveness and safety training
- capacity-building – training and other capacity-building activities are undertaken to support First Nations people leading similar programs (CBPATSISP n.d.a).

Success factors and best practice in featured programs

Among the featured programs in Chapter 6 are many examples of alignment with CBPATSISP best practice principles and the ATSISPEP success factors.

Culture Care Connect program

The CCC program is an example of a program developed within a cultural framework. The CCC model of care guides the implementation and delivery of the program; local programs take a holistic approach, with social and emotional wellbeing embedded in the model of care. The CCC program incorporates both national leadership from NACCHO alongside local leadership, with strong local community involvement in the design of place-based programs, partnerships with the ACCHS and community organisations. There is a strong emphasis on cross-agency collaboration.

The priorities of the community are central to the design of the program. Along with the key principles of the program (itemised in Chapter 6), program requirements include workforce training, evaluation and monitoring.

We-Yarn program

The We-Yarn program provided First Nations-specific gatekeeper training. It was strongly aligned with social and emotional wellbeing elements and incorporated a holistic conceptualisation of health (Davies et al. 2017). The culturally relevant program was adapted from a mainstream program known as Farm-Link in consultation with local community Elders and representatives of Aboriginal medical services. The program featured a culturally safe environment and a focus on capacity-building and empowering participants. The lived experience of facilitators of the workshop also contributed to greater engagement by participants (Davies et al. 2017).

Milpirri Festival and Kurdiji 1.0 app

Indigenous ownership is a key feature of the Milpirri Festival. Both the festival and the Kurdiji 1.0 app have a strong emphasis on promoting and building Warlpiri identity and encouraging a sense of belonging. The key to the prevention of youth anxiety and suicide, say Salmon et al. (2018), are community-based and community-driven programs that restore, promote and maintain health – strongly evident tenets of the Milpirri Festival. Language, which is described as a protective factor against suicide (Chandler and Lalonde 1998; Salmon et al. 2018), is a key feature of the Kurdiji 1.0 app. Wanta, the Warlpiri Elder who established the Milpirri Festival and the app, refers to language as a shield, describing the principles instilled in Kurdiji (that is, the Warlpiri initiation ceremony) as enabling people to:

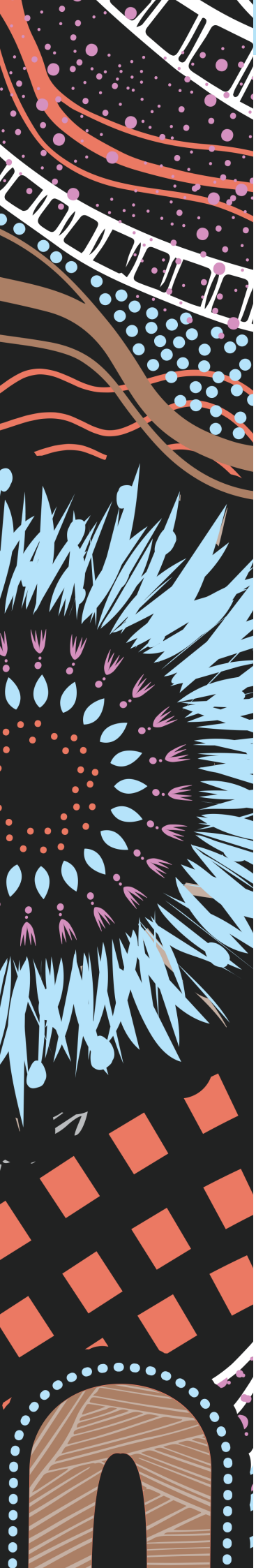
> ...become like a shield for their people and their country ... their strength of character metaphorically covers people and country and protects them from damage, in the same way a shield protects a fighter from attack (Pawu-Kurlpurlurnu et al. 2008:37).

13YARN

The CBPATSISP's overview of 13YARN identifies important elements of its design and management. It is monitored and led by a First Nations advisory board and overseen by a First Nations management team. The service was co-designed by a range of First Nations mental health professionals, with input from people with lived experience in a range of locations throughout Australia (CBPATSISP n.d.b). Cultural safety is central to the service – callers connect with a First Nations person, and the service is available 24/7.

Thirrili

Cultural safety is fundamental to the design of Thirrili's postvention services. The organisation is led by First Nations people and has a solely First Nations workforce. This service also operates 24/7 to provide holistic and culturally responsive care. It operates within a cultural framework, having designed a Model of Care, Connection and Practice that incorporates healing and reconnection, and community-led prevention. The model reinforces the importance of cultural identity, collective wisdom and the healing power of Country (Thirrili 2023). The service works to assist communities in developing greater capacity and aims to support families and communities to thrive and flourish.



8

Conclusions

8 Conclusions

For First Nations people, pride in their identity and culture offers a unique source of strength and builds resilience. It is this strength and resilience, forged through family and community cohesion and a strong connection to culture, that offer protection against stressful life events and the impacts of colonial domination.

The stressful life events endured by First Nations people include racism and discrimination; a history of trauma and dispossession – from land, culture, family and community; unemployment; financial issues; alcohol and substance use; exposure to violence and abuse; and incarceration. All of these events are associated with suicidal behaviours. First Nations people bear a disproportionate burden of social marginalisation, disease and ill-health.

The effects are evident in the higher levels of psychological distress and greater rates of suicidal behaviours among First Nations people – including suicide attempts, deliberate self-harm and suicide. In 2023, suicide was responsible for 5.1% of deaths among First Nations people, compared with 1.7% of deaths among non-Indigenous people (ABS 2024). It is the leading cause of death for First Nations children aged 5–17.

But suicides are preventable. Dudgeon offers 2 clear guides as a solution:

> … mainstream Australia needs to recognize that there are distinct cultural differences between non-Aboriginal and Aboriginal and Torres Strait Islander people, and that these differences must be taken into account in the way help is provided. And secondly, any crisis will not be solved unless partnerships are formed with Aboriginal and Torres Strait Islander people, both in identifying the problem and in delivering the solution (Culture is Life 2024:6).

The ATSISPEP report *Solutions that work* report (Dudgeon et al. 2016) and the CBPATSISP highlight the importance of strength-based and community empowerment-based approaches to First Nations suicide prevention. What works are holistic suicide prevention programs that are developed and controlled by the community (drawing on local culture and knowledge), with strategies that focus on addressing social determinants and strengthening the domains of social and emotional wellbeing.

Cultural connectedness, or cultural continuity, is an essential protective factor of these programs, supporting identity, promoting health and helping individuals and communities to overcome broader disadvantage and trauma. There is a considerable evidence base for the importance of cultural continuity, both in Australia and internationally (Chandler and Lalonde 1998; 2008; Dudgeon et al. 2022; Gibson et al. 2021; Lovett and Brinckley 2021; Salmon et al. 2018; Sjoblom et al. 2022).

Integrated, systems-based approaches to suicide prevention are needed – where various parts of our health and social systems work in synergy. These require cross-agency collaboration and partnerships with community organisations.

To ensure their accessibility, suicide prevention programs must be culturally safe. They must recognise the values, beliefs and preferences of their clients. Fundamentally, inequalities, discrimination and racism at the systemic level – in health, education and justice – need to be addressed if we are to halt the loss of life that continues to devastate First Nations people.

Appendix A: Policies and frameworks

Table A.1: Description of policies and frameworks

Name	Details	Key recommendations	Implementation
National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS) (Department of Health and Aged Care 2024)	First released in May 2013 and updated in December 2024, the strategy was developed by First Nations experts in mental health and service prevention. Its overarching objective is to reduce the cause, prevalence and impact of suicide on individuals, their families and communities.	The strategy specifies 6 goals: 1. Reduce the incidence and impact of suicide and suicidal behaviour in the Aboriginal and Torres Strait Islander population and in specific communities affected by suicide. 2. Ensure that Aboriginal and Torres Strait Islander communities and populations are supported within available resources to respond to high levels of suicide and/or self-harming behaviour with effective prevention strategies. 3. Implement effective activities that reduce the presence and impact of risk factors that contribute to suicide outcomes in the short, medium and long term and across the life span. 4. Build the participation of Aboriginal and Torres Strait Islander peoples in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels. 5. Build the evidence base to support effective action and to evaluate the outcomes of suicide prevention activity at local, regional and national levels. 6. Make high-quality resources, information and methods to support suicide prevention for Aboriginal and Torres Strait Islander peoples available across all contexts and circumstances (Department of Health and Aged Care 2024).	Implementation of the strategy has not occurred. A renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released in 2024, led by Gayaa Dhuwi.

(continued)

Table A.1 (continued): Description of policies and frameworks

Name	Details	Key recommendations	Implementation
Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)	Following the release of the NATSISPS in 2013, it was clear that the evidence base for First Nations suicide prevention programs was lacking. In 2014, the Australian Government commissioned the ATSISPEP to develop the evidence base for 'what works'; the report *Solutions that work – what the evidence and our people tell us* (Dudgeon et al. 2016) was a key result of the project.	Seventeen recommendations were set out (see Dudgeon et al. 2016:56–57): • 7 were general recommendations for First Nations suicide prevention activities, including shoring up evaluation to strengthen the evidence base, justice reinvestment, government support for relevant training and employment • 5 recommendations related to the implementation of the NATSISPS, including that ACCHSs remain preferred facilitators of suicide prevention activities, including through Primary Health Networks (PHNs), and that the ASISPEP assessment tool be used for assessing suicide prevention activity • 5 recommendations concerned disseminating and building on the findings of the ATSISPEP, including the creation of a clearinghouse for best practice in suicide prevention.	Analysis of the influence and implementation of the ATSISPEP was undertaken by Knight et al. (2024), finding the widespread uptake and influence of ATSISPEP across PHNs and First Nations suicide prevention policy and practice.
National Strategic Framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 (PM&C 2017)	This national framework was developed under the auspices of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group. It is intended to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms. It highlights the importance of service integration and describes the relationship between social and emotional wellbeing, mental health and suicide. Some important aspects of the approach prescribed by the report are: • Aboriginal and Torres Strait Islander leadership and partnerships • addressing social determinants of mental health • addressing racism • person-centred care.	The framework sets out action areas and 16 associated outcomes (see PM&C 2017). Nine guiding principles for the framework are specified: 1. health as a holistic concept 2. the right to self-determination 3. the need for cultural understanding 4. the impact of history in trauma and loss 5. recognition of human rights 6. the impact of racism and stigma 7. recognition of the centrality of kinship 8. recognition of individual and community cultural diversity 9. recognition of Aboriginal strengths.	The framework was designed to support the implementation of the Fifth National Mental Health and Suicide Prevention Plan and the National Aboriginal and Torres Strait Islander Health Plan 2013–2023. A refreshed framework is expected in 2024, including the development of an implementation plan and a First Nations-led commissioning framework (CBPATSISP 2024).

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Table A.1 (continued): Description of policies and frameworks

Name	Details	Key recommendations	Implementation
Fifth National Mental Health and Suicide Prevention Plan 2017–2022 (COAG Health Council 2017)	The Council of Australian Governments (COAG) Health Council agreed on the First National Mental Health Plan in 1993. Subsequent iterations have been released, with the most recent, at the time of this report, being the Fifth National Mental Health and Suicide Prevention Plan 2017–2022. Each plan sets out actions to achieve the vision of National Mental Health Policy, which specifies mental health reform and service delivery objectives across governments. Priorities include reducing system fragmentation and prioritising investment in prevention and early intervention.	The Fifth Plan has 8 priority areas to achieve system reform, with the 4th area being 'improving Aboriginal and Torres Strait Islander mental health and suicide prevention'. Other priorities include important service activities, such as Priority Area 3 – 'Coordinating treatment and supports for people with severe and complex mental illness' – which identifies the importance of cultural safety and cultural competence. The Fifth Plan also committed to establishing First Nations governance (the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee) to report to the Principal Committee on planning priorities and investment. Additionally, the Plan included a commitment to implement the Gayaa Dhuwi (Proud Spirit) Declaration (GDPSA n.d.b). The Fifth Plan includes strategies to address social and emotional wellbeing, mental illness and suicide for First Nations people, with the ATSISPEP report (Dudgeon et al. 2016) informing approaches to suicide prevention.	The Fifth Plan included an Implementation Plan that set out responsibilities for agreed actions. The Mental Health Commission has published annual progress reports of the Fifth Plan through to *Progress Report 4* (NMHC 2023). Of the actions associated with Priority Area 4, all were marked as completed or ongoing by the National Mental Health Commission in 2023 (NMHC 2023). Nationally agreed indicators to track the progress of the plan were also developed. Reporting against the indicators occurred annually (NMHC 2023). The final progress report acknowledges that performance against many indicators is stagnant or deteriorating. It draws attention to the increasing suicide rate for First Nations people. With the dissolution of COAG, an evaluation of the Fifth Plan did not occur.

(continued)

Table A.1 (continued): Description of policies and frameworks

Name	Details	Key recommendations	Implementation
National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (Department of Health 2021)	This plan was developed in partnership with First Nations health leaders and experts. It is the main policy document to guide action to improve health and wellbeing for First Nations people, and aligns with the National Agreement on Closing the Gap. It prioritises a holistic model of care and endorsed the Gayaa Dhuwi (Proud Spirit) Declaration (GDPSA n.d.b). It also drew on the ATSISPEP success factors (Dudgeon et al. 2016) and the National Strategic Framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Wellbeing.	The plan focuses on 4 Priority Reforms, which emphasise the commitment to the National Agreement on Closing the Gap. These reform areas are Enablers of change, Focusing on prevention, Improving the health system, and Culturally informed evidence base. Priority 10, under the reform area 'Improving the health system', relates to mental health and suicide prevention with 4 stated objectives: • 10.1 Implement key reforms to Aboriginal and Torres Strait Islander mental health and suicide prevention policy • 10.2 Strengthen the role of ACCHSs to deliver and coordinate culturally safe and responsive mental health and suicide prevention services • 10.3 Embed integrated models of suicide prevention and mental health for continuity of care • 10.4 Ensure Aboriginal and Torres Strait Islander people with lived experience are at the centre.	The plan proposes embedding First Nations leadership, with mechanisms for implementation, governance and accountability to be established in partnership with First Nations health experts. The plan also proposes that First Nations experts co-design culturally safe and responsive accountability mechanisms. A mid-cycle review of the plan is proposed to occur in 2026 to evaluate progress and respond to emerging trends and changing priorities. The plan also states that an end-of-cycle review will also occur in 2031.
National Suicide Prevention Strategy for Australia's Health System: 2020–2023 (National Suicide Prevention Project Reference Group 2020)	This strategy was an action of the Fifth Plan. It commits all governments to working collaboratively on a journey towards zero suicides in Australia.	The strategy set out 24 areas of focus across 4 'priority domains' and 3 'priority foundations'. These areas of focus were considered to have the highest priority by governments and the suicide prevention sector. 'Community-driven Aboriginal and Torres Strait Islander suicide prevention' was one of the 4 domains. The areas of focus within this domain were: • support a new national Aboriginal and Torres Strait Islander suicide prevention strategy and implementation plan • support culturally safe post-suicide attempt after-care models • support clinically and culturally appropriate risk assessment tools and resources to support the assessment of risk of suicide in Aboriginal and Torres Strait Islander people.	The Strategy was implemented through national, regional and local suicide prevention frameworks and priorities. It noted that different priorities, approaches, systems and community needs would affect the pace and sequence of implementation.

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Table A.1 (continued): Description of policies and frameworks

Name	Details	Key recommendations	Implementation
National Agreement on Closing the Gap (Coalition of Peaks 2020)	This agreement was developed in partnership between Australian governments and First Nations peak organisations (represented by the Coalition of Peaks). The agreement set out new Closing the Gap Priority Reforms and ambitious targets that are intended to change the way governments work to improve life outcomes experienced by First Nations people.	Four Priority Reforms are specified, with their own targets and indicators. These are: • Formal partnerships and shared decision-making • Building the community-controlled sector • Transforming government organisations • Shared access to data and information at a regional level. There are 19 national socioeconomic targets across 17 socioeconomic outcome areas. Given their intended impact on First Nations life outcomes and wellbeing, all are important for social and emotional wellbeing. Target 14 is the most pertinent to this paper, being: 'Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero'. It is supported by Outcome 14 – 'Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing'.	The agreement provides for shared accountability and the ability to demonstrate progress more than before. The Australian Government, state and territory governments, local government and the Coalition of Peaks are jointly accountable for the outcomes and targets under the National Agreement. The Joint Council on Closing the Gap has an ongoing role in monitoring progress by all parties in delivering on the commitments in the agreement. Implementation Plans were developed by all parties to the agreement and annual reporting on progress is required. These plans include information on funding and time frames for actions.
National Mental Health and Suicide Prevention Plan (Australian Government 2021)	This plan outlined activities arising from the 2021–22 Federal Budget, with $2.3 billion allocated to the plan. At the time, the plan described this as 'the single largest Commonwealth investment in mental health and suicide prevention in Australia's history' (Australian Government 2021:2).	The plan included 5 pillars to the Australian Government's investments: • Prevention and early intervention • Suicide prevention • Treatment • Supporting the vulnerable • Workforce and governance. A specific investment related to suicide prevention was funding of the National Indigenous Postvention Service.	Released to coincide with the 2021–22 Federal Budget, the plan set out government investments in mental health and suicide prevention. It specified that the next step towards long-term system reform would be the National Mental Health and Suicide Prevention Agreement.

(continued)

Table A.1 (continued): Description of policies and frameworks

Name	Details	Key recommendations	Implementation
National Mental Health and Suicide Prevention Agreement (Australian Government 2022)	This agreement between the Australian Government and state and territory governments came into effect in March 2022. It sets out plans for a comprehensive, coordinated and consumer-focused mental health and suicide prevention system. Priority areas include regional planning and commissioning, priority populations, stigma reduction, safety and quality, gaps in the system of care, suicide prevention and response, psychosocial supports outside the National Disability Insurance Scheme, consistency in assessment and referral, workforce, and data and evaluation (AIHW 2024a). Bilateral agreements with each of the states and territories support the agreement and focus on local priorities including community-based services. The agreement includes enhanced commitments to culturally responsive services for First Nations communities.	The agreement reaffirms: • the Closing the Gap targets, and specifically refers to Target 14 – 'Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero' • partnership arrangements between governments and First Nations people, which ensure shared decision-making and building a strong and sustainable community-controlled sector. Also specified is the need to align any activities with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing – both of which are being renewed in 2024.	The National Mental Health Commission has been tasked with undertaking annual progress reports on the implementation of activities, outputs and outcomes of the agreement. The Commission has reported that it is resetting its framework guiding monitoring and reporting with the release of a National Report Card 2023 (NMHC 2024). This included an initial set of core indicators based on reliable data collected nationally. Disaggregations by Indigenous status were not included in the report.

Appendix B: Programs

Table B.1: Description of programs, associated evaluations, and their outcomes

Program	Program details		Evaluation	Evaluation details		Findings
Culture Care Connect Coordinated by NACCHO, the program is establishing community-controlled suicide prevention networks and after-care services across the country.	Location(s)	National	Not yet evaluated	Location(s)	n.a.	An evaluation is underway and expected to be completed in 2025.
	Participants	First Nations people		Participants	n.a.	
	Duration	2021–22 to 2024–25		Duration	n.a.	
	First Nations specific	Yes		First Nations specific	n.a.	
	Focus	Integrated suicide prevention planning		Focus	n.a.	

(continued)

Table B (continued): Description of programs, associated evaluations, and their outcomes

Program	Program details		Evaluation	Evaluation details		Findings
We-Yarn Suicide prevention gatekeeper training workshops for First Nations people and people who work with First Nations people and communities.	Location(s)	Rural New South Wales	Davies et al. (2017); Davies et al. (2020) Mixed methods evaluation involved observations of 6 workshops between December 2016 and June 2017; pre- and post-workshop surveys; and interviews with consenting participants 3 months after the workshop.	Location(s)	Workshops at Tamworth, Tingha, Tenterfield, Walhallow and Orange	Findings reported by Davies et al. (2020) included: • participants reported the workshops were culturally appropriate, connected with a holistic model of health • We-Yarn workshops were considered useful, with expectations mostly met • there were significant improvements to participants' self-reported knowledge and capacity to support someone struggling with social and emotional wellbeing problems • there were mixed reports on the impact on community level changes; evaluators noted that the program was not integrated with other strategies or existing services • professional interviewees considered information on suicide risk and response was already known through previous education, and that the training did not meet clinical or therapeutic intervention skill needs.
	Participants	Adults		Participants	106 workshop attendees, 91 pre-workshop surveys and 81 post-workshop surveys	
	Duration	One day workshops, delivered 2016 –2019		Duration	During workshops and 3 months afterwards.	
	First Nations specific	No		First Nations specific	No	
	Focus	Suicide prevention gatekeeper training		Focus	Participant expectations; engagement/ participation in workshops; self-reported knowledge and ability after workshops; assessment of effectiveness	

(continued)

Table B (continued): Description of programs, associated evaluations, and their outcomes

Program	Program details		Evaluation	Evaluation details		Findings
Milpirri Festival and Kurdiji 1.0 app The Milpirri Festival has occurred every 2 years since 2005 in Lajamanu, Northern Territory. It is a ceremonial festival largely based around dance that reflects the history of Warlpiri culture. The festival is a collaboration between the Warlpiri community of Lajamanu and Tracks Dance company. The Kurdiji app (for Android phones) was developed in 2017 by Warlpiri Elders to support wellbeing and build connection to culture.	Location(s)	Lajamanu, Northern Territory	No formal evaluations from a psychological perspective have occurred; however, anthropological and artistic reviews of the festival are available.	Location(s)	Lajamanu, Northern Territory	Numerous artistic and cultural reviews of the festival are available and cited in Chapter 6 and below. For example, the Milpirri Festival is: • recognised for positive educational, employment, health and wellbeing outcomes (Pawu-Kurlpurlurnu et al. 2008) • described as a 'revitalisation movement' responsible for reviving ceremonial life and encouraging school attendance (Wild et al. 2024:325) • a means of reactivating Warlpiri knowledge, language and heritage (Patrick and Biddle 2018) • responsible for encouraging engagement of 'Country, people and place in the very place from which it derives and to which it remains beholden', and changing societal perceptions of remote parts of Australia from being places of disadvantage where people are unable to lead productive lives (Newth et al. 2015:133).
	Participants	Open to all. The performance is by over 150 community members including Elders, adults and young people.		Participants	n.a.	
	Duration	Festival occurs for one night every 2 years		Duration	n.a.	
	First Nations specific	No		First Nations specific	n.a.	
	Focus	The festival has a focus on health, wellbeing, learning, cultural identity and cultural enactments (Tracks Dance 2017).		Focus	Cited reviews largely focus on cultural, artistic and educational merits of Milpirri.	

(continued)

Table B (continued): Description of programs, associated evaluations, and their outcomes

Program	Program details		Evaluation	Evaluation details		Findings
13YARN A First Nations-led crisis support telephone line operating 24/7 for First Nations people.	Location(s)	National	Not yet formally evaluated. Money has been set aside for the evaluation of 13YARN (Lifeline 1 April 2022).	Location(s)	n.a.	The CBPATSISP has assessed 13YARN and identified important service features including: • it had First Nations ownership, with a First Nations Board and management team • it was co-designed with First Nations mental health professionals • it is available 24/7 • it provides a culturally safe space, where callers are connected with another First Nations person who listens without judgement or shame (CBPATSISP n.d.b).
	Participants	Open to all First Nations people		Participants	n.a.	
	Duration	Commenced March 2022		Duration	n.a.	
	First Nations specific	Yes		First Nations specific	n.a.	
	Focus	Suicide prevention and crisis support		Focus	n.a.	

(continued)

Table B (continued): Description of programs, associated evaluations, and their outcomes

Program	Program details		Evaluation	Evaluation details		Findings
Thirrili Thirrili supports communities, families and individuals after a suicide or other traumatic incident(s) by providing national Indigenous Suicide Postvention Services (formerly the National Indigenous Critical Response Service).	Location(s)	National	Ridoutt et al. (2020) Summative evaluation of the first 3 years of the NICRS.	Location(s)	Western Australia, South Australia, Queensland and Northern Territory	The evaluation of Thirrili's initial operations confirmed the importance of postvention services and client appreciation of the service, particularly for the emotional, financial and advocacy support provided. Recommendations to improve the service, included: • location of staff in known 'hotspot' areas • stronger governance • greater consistency and clarify in core guiding documents and in applying organisational policies • professional and emotional support and clinical supervision to frontline workers • improved data collection, including the collection of outcomes data. The CBPATSISP assessment of Thirrili commends the Model of Care which provides for culturally safe and respectful care. They note the support for development of capacity in communities dealing with trauma (CBPATSISP n.d.e).
	Participants	Open to all First Nations people		Participants	125 case studies; 18 client interviews; 14 staff and management representatives interviews; 31 stakeholders interviews	
	Duration	Operating 24/7 since 2017		Duration	First 3 years of operation from 2017–2020	
	First Nations specific	Yes		First Nations specific	Yes	
	Focus	Postvention support		Focus	Summative evaluation	

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AIHW	Australian Institute of Health and Welfare
APAR	Aboriginal Participatory Action Research
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CBPATSISP	Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
CBT	cognitive behavioural therapy
CCC	Culture Care Connect
COAG	Council of Australian Governments
CCSPN	community-controlled suicide prevention networks
DBT	dialectical behaviour therapy
LGBTQIA+	lesbian, gay, bisexual, transgender, queer, intersex, asexual, with the + denoting possible other gender such as non-binary and pansexual
NAASP	National Action Alliance for Suicide Prevention
NACCHO	National Aboriginal Community Controlled Health Organisation
n.a.	not applicable
NATSISPS	National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
NICRS	National Indigenous Critical Response Service
PHN	Primary Health Network
SEWB	social and emotional wellbeing
WHO	World Health Organization

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This paper examines suicide among First Nations people and the importance of culturally grounded, community-led prevention. It highlights the need for strengths-based, locally relevant approaches that restore culture, empower communities, and centre First Nations leadership. It also examines gaps in evidence and key drivers long-term change.

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Stronger evidence,
better decisions,
improved health and welfare