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09 May 2016 **Deadline for Submissions: 13/05/2016**

Revised KALACC Submission to the Education and Health Standing Committee Inquiry in to Aboriginal Suicide In Western Australia

Dear Alison

On 20 March 2016 KALACC lodged via email a submission with the Education and Health Standing Committee. This was acknowledged by the Committee on 23 March.

That submission was in the form of email correspondence and it was not formatted so as to respond directly to the terms of reference for the Inquiry.

We take the opportunity today to submit to you a revised ***KALACC Submission to the Education and Health Standing Committee Inquiry in to Aboriginal Suicide In Western Australia***. This present document:

- Takes the form of a PDF document, not an email;
- Is structured so as to directly respond to the Inquiry Terms of Reference;
- Also provides KALACC with an opportunity to provide to the Committee the Notes arising from KALACC's 31 March 2016 meeting with the Director General Health, Mental Health Commissioner, CEO WA Country Health; Director General Department of Aboriginal Affairs and Deputy Director General WA Department of Culture and the Arts.

The notes from that 31 March meeting are attached as an appendix to this present document.

On 01 February 2016 the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project [ATSISPEP] publicly released its ***Kimberley Roundtable Report***, based on a Kimberley Suicide Prevention Forum held on Thursday 27th August 2015. This report is available online at http://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2862603/Kimberley-Roundtable-Report-Final-March.pdf A key recommendation in that report is as follows:

> Aboriginal and Torres Strait Islander participants strongly supported existing programs that work such as on-country programs, mentoring and youth leadership, [saying they] should be adequately invested in and "rolled-out wherever possible". Participants expressed the need for Governments to invest in Aboriginal-led social and emotional wellbeing approaches in programs. [page 21]

The State Government's main interagency forum in the Kimberley Region is the District Leadership Group [DLG]. The DLG is chaired by Tracey Gillett, Director, Regional Services Reform Unit, Department of Regional Development. Ms Gillett wrote to KALACC as follows on 19 March 2016:

> Thank you for your recent emails, which were tabled at the DLG on 10/3/16. Members were appreciative of your contact and comments in relation to these long standing and critical issues. We will be focusing on the ***ATSISPEP Kimberley Suicide Prevention Roundtable Report*** recommendations to provide focus to our future work.

However, the reality of this matter is that Government has tremendous difficulty fitting community – based and culturally – based concepts of Aboriginal wellbeing in to its policy and funding frameworks. At the Kimberley Regional Level, the Remote Services Reform Unit and the District Leadership Group are exploring opportunities in terms of the Kimberley Regional Aboriginal Mental Health Planning Forum. And at State level, KALACC met on 31 March with the Mental Health Commissioner and he repeatedly referred to the ***2020 Suicide Prevention Strategy***.

But the realities here are that the things that are most central to the ***ATSISPEP Kimberley Suicide Prevention Roundtable Report*** were not central to the authors of the ***2020 Suicide Prevention Strategy***. So, when the Education and Health Standing Committee poses the question regarding 'The gaps in strategies and services available to reduce Aboriginal youth suicide in remote areas' there first and foremost needs to be a recognition that current State Government processes, policies and strategies are not predicated upon the centrality of culturally based social and emotional wellbeing programs. Governments invariably look to their own mechanisms, rather than looking to the community for solutions. What is the State Government agency responsible for Aboriginal social and emotional wellbeing? The clear answer is that there is no such agency. And, because there is no such agency, Government continually gets it wrong and continually fails to invest in the most important things to reduce Aboriginal suicide.

Professor Michael J Chandler provides us with these key messages:

- Cultural Wounds Require Cultural Healing
- Still more counsellors? [If we think that counsellors are the solution, when will we have enough counsellors? When every Aboriginal youth has his or her own personal counsellor?]

- If you cannot picture yourself in the past then you cannot picture yourself in the future. And, if you cannot picture yourself in the past then you are highly elevated risk of suicidal ideation.

The most significant action which the State Government needs to take is to respond to the recommendations from the ***ATSISPEP Kimberley Suicide Prevention Roundtable Report*** published in early February 2016. Culturally based programs are central to that report and supporting these kinds of programs is the single biggest gap in the strategies and services available to reduce Aboriginal youth suicide in remote areas.

KALACC notes the 05 May ABC online news article ***WACOSS calls for WA budget boost*** http://www.abc.net.au/news/2016-05-05/wa-labor-proposes-community-services-collaborative-funding-trial/7387522. In particular we note the following:

> Meanwhile with the state budget to be handed down next week, WACOSS said it wanted the Government to deliver more funding into preventative programs to help ease the pressure on acute and crisis services.
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> "We already have a lot of knowledge about this stuff, there's already a lot of evidence out there. We need to be investing in the services that intervene early," Ms Cattalini said. ….
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> Ms Cattalini said it was clear services struggled to turnaround the impacts of long-term disadvantage.
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> Ms Cattalini said there should be more investment in prevention and support.
>
> "The longer governments ignore the need to invest in the prevention and primary services, the longer they are going to be stuck with no choice but to fund an expensive tertiary system," she warned.
>
> "You can't not do that. You have to tackle crisis."

The comments from WACOSS may have been made in the context of service provision to the social services sector but the same comments are equally true of the social and emotional wellbeing context. There are truly massive investments in to an expensive tertiary system and very minimal investments in to Aboriginal – owned and controlled social and emotional programs which serve to build resilience and to grow protective factors in the individual and in the community as a whole.

Key Points

- **The Community, Not the Individual** - Aboriginal suicide is NOT an individual phenomenon, it is a collective and community phenomenon [19 suicides in 3 months in the Kimberley in 2016; 325 episodes of officially – reported acts of self- harm in the first four months of 2013 – Kim Hames, Hansard, 13 November 2013]. We must focus on the community and NOT on the individual.
- **Suicide Prevention is NOT Mental Health** - Aboriginal suicide, is for the most part, NOT related to schizophrenia or bipolar condition or any form of "severe and persistent mental illness". Suicide Prevention Australia repeatedly emphasises that suicide prevention is NOT the same thing as the delivery of Mental Health services. [Suicide Prevention Australia December 2015, January 2016].
- **Governments Focus on the Individual** - Governments perceive of Aboriginal suicide as being an individual phenomenon ie they pathologise the phenomenon as 'sick individuals.'
- **Governments Focus on Clinical Interventions** - Government investments in response to Aboriginal suicide are heavily weighted towards clinical interventions which are predicated on an individualised conception of the phenomenon. [correspondence from Mental Health Commission, herein].
- ***Suicide Prevention 2020: Together we can save lives*** states as follows on Page 48:
  "The State Government has provided a further $29.1 million over 2014/15 to 2016/17 to consolidate the Statewide Aboriginal Mental Health Service to provide a range of treatment and support services to Aboriginal people with severe and persistent mental illness." This is entirely illustrative of where Government resource allocations currently sit.
- **Current Patterns of Government Resource Allocation** - The total State Government investment in to the Statewide Aboriginal Mental Health Service is a sum of $51.57 million. KALACC doesn't criticise this program. It probably delivers much needed services. But it has very little to do with suicide prevention. Why did Minister Morton repeatedly write to us about this program when we asked her about suicide prevention programs?
- **The Suicide Rate in the Kimberley has doubled in five years** - The 2016 ***ATSISPEP Kimberley Roundtable Report*** shows a doubling of the rate of suicide in the Kimberley over a five year period.
- **Serial Government Failures to Respond to Many Reports** - There have been very many reports with very many recommendations over many years and governments singularly and collectively have failed to act on those recommendations. [detailed herein]
- **ATSISPEP Kimberley Roundtable Report Recommendation** - Through the 2016 ATSISPEP ***Kimberley Roundtable Report*** the Aboriginal people of the Kimberley have called for:

"existing programs that work such as on-country programs, mentoring and youth leadership, [to] be adequately invested in and "rolled-out wherever possible".

- **10 Years of KALACC Advocacy for On Country Mentoring Programs** - KALACC has called for the same thing for 10 years ie 10 years of advocacy for investments in to culturally based resilience programs. Many community – based reports published over the last 10 years have also called for investments in to culturally based resilience programs. [detailed herein]
- **We Can't Undo Social Trauma Overnight But We Can Build Protective Factors** - We cannot overnight 'solve' or 'fix' alcoholism, child abuse, unemployment, lateral violence, or post – colonial trauma including the impacts on the stolen generation. But we can invest significantly in to protective factors which enable people to best respond to these challenges.
- **08 May 2001 Aboriginal Suicide Prevention Steering Committee Recommendations to Aboriginal Affairs Minister Alan Carpenter** - The State Government was provided with an outline of an Aboriginal Suicide Prevention Strategy on 08 May 2001. But most of the recommendations in that Briefing Paper weren't acted on and to this day the State has not developed an Aboriginal Suicide Prevention Strategy, relying instead on generic, whole of community approaches such as ***Suicide Prevention 2020.***
- **Government Responses to Alistair Hope's Three Coronial Inquest Reports** - KALACC wrote to WA Coroner Alistair Hope in February 2007. The Coroner then handed down two major coronial Inquest reports in 2008 and a third one in 2010. The Government did respond comprehensively to the ***Oombulgurri Inquest Report*** but not to the ***Balgo Inquest Report*** and its responses to the first of the three inquests [***Kimberley Inquest Findings Report***] have focused largely on one of the Coroner's Recommendations ie # 24 – relating to clinical mental Health.

Recommendations from KALACC

1. That the State Government of Western Australia implement in full the recommendations from the February 2016 ***ATSISPEP Kimberley Suicide Prevention Roundtable Report-*** with a particular emphasis on the following:

   "existing programs that work such as on-country programs, mentoring and youth leadership, [to] be adequately invested in and "rolled-out wherever possible".

2. That the State Government of Western Australia accept the findings and recommendations from two earlier Inquiries from the WA Parliament Standing Committee on Health and Education and from the ***Balgo Inquest Report*** brought down by Coroner Alistair Hope, and provide funding to the Yiriman Project.

3. That the State Government of Western Australia revisit the ***Working Together Report*** published by the Aboriginal Suicide Prevention Steering Committee on 08 May 2001, and that the Government develop a specific Aboriginal suicide – prevention strategy to sit alongside the more generic, whole of community ***Suicide Prevention 2020.***

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Term of Reference # 1 The status of previous inquiry recommendations related to Aboriginal youth suicide in remote areas.

On 8 May 2001 the ***Working Together Report*** produced by the Aboriginal Suicide Prevention Steering Committee was presented to the Hon. Alan Carpenter, MLA Minister for Aboriginal Affairs [This report is attached as an appendix to this present document]. The ***Working Together Report*** was a briefing paper prepared for the Minister and consisted of:

> *'Recommendations for across-government and inter-sectoral universal prevention initiatives to promote well-being and resilience and to reduce self-harm and suicide among Aboriginal youth.'*

Tragically, and prophetically, the introduction to the document states as follows:

> On the basis of current trends, the rate of suicide among Aboriginal people can be expected to increase further unless there is concerted community and Government action at all levels to address both the immediate and the underlying causes.

Yet, to this day, some 15 years later:

- most of the recommendations from that ***Working Together Report*** have not been implemented
- The State Government still does not have a specific Aboriginal suicide prevention strategy.

As such, it is little wonder that the rate of Indigenous suicide in Western Australia has skyrocketed in the 15 years since 08 May 2001.

In February 2007 Wes Morris and Joe Brown of KALACC wrote to the WA Coroner, Alistair Hope, calling on him to undertake a major Coronial Inquiry in to the rate of suicide in the Kimberley. Many of the recommendations from Coroner Hope's 2008 ***Coronial Inquest Report*** have yet to be acted on.

On 01 February 2016 the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project [ATSISPEP] publicly released its ***Kimberley Roundtable Report***, based on a Kimberley Suicide Prevention Forum held on Thursday 27th August 2015. This report is available online at http://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0009/2862603/Kimberley-Roundtable-Report-Final-March.pdf A key recommendation in that report is as follows:

> Aboriginal and Torres Strait Islander participants strongly supported existing programs that work such as on-country programs, mentoring and youth leadership, [saying they] should be adequately invested in and "rolled-out wherever possible". Participants expressed the need for Governments to invest in Aboriginal-led social and emotional wellbeing approaches in programs. [page 21]

Outlined within the pages of this current submission is a 10 - year history of KALACC's advocacy to the State Government. For nearly 10 years KALACC has said essentially the same as what the 2016 ***ATSISPEP Kimberley Roundtable Report*** has said and for 10 years Governments [State and Commonwealth] have assiduously and consistently ignored our representations.

As a nation we entrust the Productivity Commission to measure for us what works and what doesn't work and part of that task is the development of the Overcoming Indigenous Disadvantage Reports and the COAG Indigenous Expenditure Reports. The ***2014 Overcoming Indigenous Disadvantage Report*** cites KALACC's Yiriman Project not once but three times as an exemplar of national best practice in Things that Work in regards to programs for working with Indigenous youths in remote areas.

KALACC notes the following comments from the long – standing Chairman of the Productivity Commission, Mr Gary Banks:

> Yiriman has struggled to attract sustained financial support. Government funding agencies in particular seemingly find it difficult to fit the Project's culturally-based model into any of their boxes.
>
> Meanwhile substantial funds are directed to mainstream mental health services which arguably are not addressing the deeper needs of the young.
>
> Really the only challenge these organisations should present for public policy is how to harness and propagate them. [page 9, ***Reconciliation News***, December 2012]
> https://www.reconciliation.org.au/wp-content/uploads/2013/12/2012-December-Reconciliation-News.pdf

In relation to Inquiry Term of Reference #1, it is very far from the first time that the State Government has been told of the importance of the contribution which culture and culturally based programs make towards Aboriginal social and emotional wellbeing. And it certainly won't be the last time.

Professor Michael J Chandler shows us that we cannot continue to conceive of Aboriginal suicide as being an 'individual' phenomenon. For as long as we continue to believe this, we will continue to think that an appropriate response is 'still more counsellors' and individualised, Western, European, clinical, medical interventions. If such approaches were ever going to work, then they would have worked by now. But what Chandler shows us is that the failure for these approaches to work in Western Australia is the same as their failure to work – anywhere in the world - as an effective and appropriate response to Indigenous suicide.

There are now a great many reports in Australia which say the same thing as what Chandler says, and we note that his message is echoed in the views of organisations such as the Lowitja Institute, the Healing Foundation, Reconciliation Australia, the Productivity Commission, and the Human Rights and Equal Opportunities Commission.

Despite the great many reports indicating what an appropriate response to Indigenous suicide looks like, the State Government is yet to respond with anything resembling an appropriate manner. If the State Government continues along this path, then, KALACC can do nothing other than to repeat the 08 May 2001 words of the Aboriginal Suicide Prevention Steering Committee:

> On the basis of current trends, the rate of suicide among Aboriginal people can be expected to increase further unless there is concerted community and Government action at all levels to address both the immediate and the underlying causes.

Amongst the reports which KALACC is aware of, we note as follows:

- ***Working Together, Recommendations for across-government and inter-sectoral universal prevention initiatives to promote well-being and resilience and to reduce self-harm and suicide among Aboriginal youth,*** A briefing paper prepared by the Aboriginal Suicide Prevention Steering Committee, 8 May 2001;
- Three major Kimberley ***Coronial Inquest Reports*** prepared by WA Coroner, Alistair Hope [2007 – 2010];
- Kimberley ***Hear Our Voices Report***, March 2012;
- ***The Mental Health and Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples, Families and Communities*** ; Supplementary Paper to ***A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention***, March 2013;
- The ***Elders Report***, April 2014;
- The ***2014 Closing the Gap Progress and Priorities Report***, February 2014;
- ***National Coalition for Suicide Prevention Response to World Health Organisation World Suicide Report: An Assessment of Australia's Progress in Suicide Prevention***, September 2014;
- ***The Third Conversation: Has Anything Changed? The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Roundtable Report***, September 2014;
- ***Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people***, Issues paper no. 12 produced for the Closing the Gap Clearinghouse [Pat Dudgeon, Roz Walker, Clair Scrine, Carrington Shepherd, Tom Calma and Ian Ring] November 2014
- Professor Michael Chandler's 30 – plus year research history in to the pattern of Indigenous suicide in Canada;

- Murdoch University Three Year ***External Review and Evaluation of the Yiriman Project***, December 2013;
- National Mental Health Commission, ***National Review of Mental Health Programmes and Services***, December 2014, released publicly in April 2015;
- February 2016 ***ATSISPEP Kimberley Roundtable Report,*** being the report of the ATSISPEP Kimberley Roundtable held in Broome in August 2015.

Alongside the publication of all of those reports, ever since KALACC wrote to WA Coroner Alistair Hope on February 2007, KALACC has endeavoured to engage productively with the State Government over these matters. A summary of our engagement with Government is as follows:

A timeline of KALACC's Endeavours to Discuss The Yiriman Project With the State Government looks as follows:

- May 2008 The Hon Shelley Archer MLC, Delivered an Adjournment Speech in Parliament in regards to Yiriman
- 15 May 2008 Parliamentary Standing Committee on Health and Education tabled a report in Parliament ie ***Ways Forward Beyond the Blame Game: Some Successful Initiatives in Remote Indigenous Communities in WA***. The Report recommended that the State Government fund and support the Yiriman Project
- 29 July 2009 Meeting With the then Minister for Mental Health, Dr Jacobs, in Fitzroy Crossing After the election of the Barnett Liberal Government, KALACC met with the then Minister for Mental Health, Dr Jacobs. Our requests and our propositions are essentially the same today as they were seven years ago
- November 2010 KALACC presented to the Commonwealth and the State Governments the ***Yiriman Business Plan***. [We need to emphasise that at no time was that Business Plan predicated upon the State Government paying the full costs of that Business Plan. Nothing could be further from the truth. But we did seek some level of State Government support and indeed the Deputy Premier seemed initially very supportive of the idea – see immediately below]
- 24 November 2010 Deputy Premier, Kim Hames, letter to KALACC - In November 2010 the Deputy Premier, Kim Hames, wrote to KALACC in the following terms, in response to having received a copy of the Yiriman Business Plan: "I retain the view expressed in the report released in 2008 by the Parliamentary Standing Committee on Health and Education [Recommendation 13] stating that the Yiriman Project should be supported by Government and I will urge my fellow Ministers to consider your request favourably from within their portfolios."

- 17 March 2011 Parliamentary Standing Committee on Health and Education tabled a report in Parliament ie ***Alcohol Restrictions in the Kimberley: A Window of Opportunity for Improved Health, Education and Housing.*** This Report recommended funding for the Yiriman Project
- 13 July 2011 Letter from Minister for Mental Health [Helen Morton] - wrote to KALACC to advise that KALACC's requests for support for youth programs would be considered through the Remote Service Delivery processes
- 27 October 2011 ***Coronial Inquest Report*** from Coroner Alistair Hope, inquiring in to 5 deaths in the community of Balgo. Coroner Hope recommended that the State Government fund the Yiriman Project
- 2011 – 2013 Remote Service Delivery Processes. Page 34 of the ***Fitzroy Crossing Local Implementation Plan*** reads as follows: "Safe Communities. PRIORITY: Ongoing funding for Yiriman Juvenile Diversion Program.Undertake consultation with possible funding sources to provide for the delivery of the Yiriman Pathway for Young people at Risk Program. (FITSC1.01) DIA Jul-2012" No outcomes arose from those processes.
- 27 August 2012 Teleconference involving Wes Morris of KALACC, Ian Thomas of DAA and Jill Mills of FaHCSIA. Meeting agreed to bilateral investment inputs in to Yiriman. These investments never occurred
- 18 December 2013 the Hon Peter Collier, Minister for Indigenous Affairs, wrote to KALACC advising of the AACC Sub Committee processes
- 03 April 2014 Minister Collier wrote to KALACC, referencing the work of the Aboriginal Affairs Coordinating Committee on Aboriginal Health and Aboriginal Mental Health
- 17 October 2014 Minister Collier again wrote to KALACC, again referencing the work of the Aboriginal Affairs Coordinating Committee on Aboriginal Health and Aboriginal Mental Health
- 19 May 2015 KALACC presented to the AACC Sub Committee on Aboriginal Health and Mental Health, co – Chaired by the DG Health and by the Mental Health Commissioner. There were no outcomes arising from this presentation
- 31 March 2015 KALACC met with the DG Health, CEO WA Country Health, Mental Health Commissioner, DG DAA, and Deputy DG DCA. There are not outcomes thus far from this meeting.

Alongside the many reports and alongside the timeline of KALACC's endeavours to engage with the State Government, KALACC has written on numerous occasions to the WA Parliament Education and Health Standing Committee on the following dates:

- 10 November 2014 – Calling on the Committee to expand its terms of reference Regarding Youth Needs in Western Australia
- 10 November 2014 - Effective Strategies in Aboriginal mental health and wellbeing – Sharing a new report from the Telethon Kids Institute
- 12 November 2014 - KALACC Re - Yiriman Youth Project - Parliamentary Adjournment Speech May 2008 and a recent [2014] meeting with the Mental Health Commission
- 27 January 2015 - Follow up to KALACC meeting with MHC 23 January 2015 Re Yiriman and the AACC Sub Committee - Meeting Notes and Outcome
- 11 February 2015 - KALACC - Sharing With You the Closing the Gap Progress and Priorities Report 2015 - Culture and Wellbeing
- 12 May 2015 - KALACC Submission in regards to The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 - Meeting next week with AACC Sub Committee
- 25 December 2015 - KALACC Response to 1. Children's Commission Report on Mental Health and 2. AACC Sub Committee on Aboriginal Health and Mental Health

In the face of all of these reports and all of these recommendations, KALACC asks:

- Why has KALACC never received any substantive Government response to the 2010 ***Yiriman Business Plan***?
- Why has KALACC never received any substantive Government response to the 2010 Murdoch University ***Review and Evaluation of the Yiriman Project***? Why did the Government provide KALACC with $150, 000 of funding to engage the services of Murdoch University if the Government never intended reading or responding to the outcome of that evaluation process?
- Why was the Parliamentary Standing Committee Recommendation of May 2008, that the Government fund the Yiriman Project, not responded to and implemented?
- Why was the Parliamentary Standing Committee Recommendation of March 2011, that the Government fund the Yiriman Project, not responded to and implemented?
- Why across all of 2014 and 2015 did the Parliamentary Standing Committee on Health and Education not respond tangibly or take any substantive action in response to KALACC's many and repeated calls for the Committee to carefully examine the issue of Aboriginal suicide in the Kimberley?

Should the Parliamentary Standing Committee on Health and Education in 2016 recommend funding for the Yiriman Project, it will be the third time that this committee has brought down a report with such a recommendation in it [in addition to the Coroner's Balgo Inquest recommendation]. And what guarantee is there that the Government will respond to a third such recommendation from this committee?

Term of Reference # 2 The allocation of resources to current Aboriginal youth suicide prevention strategies and services in remote areas, and the effectiveness of these strategies and services.

A significant portion of KALACC's response to the previous Term of Reference is also of direct relevance to this second Term of Reference. We note in particular that should the Parliamentary Standing Committee on Health and Education in 2016 recommend funding for the Yiriman Project, it will be the third time that this committee has brought down a report with such a recommendation in it.

DAA has released a 'YOUTH EXPENDITURE REVIEW FACT SHEET'
http://www.drd.wa.gov.au/Publications/Documents/Regional_Services_Reform-youth_expenditure_fact_sheet.pdf
This Fact Sheet states as follows:

- State Government investment of around $ 115 million annually into these programs
- less than 15% of these could demonstrate effectiveness.

KALACC also notes that Corrective Services Minister Joe Francis wrote to KALACC on 18 March 2015 in regards to the $42 million investment in to Remote Justice Services in the Kimberley. The Government has undertaken a review of this program but it refuses to publicly release the report of that review. But what we do know from Minister Francis' letter of 18 March 2015 is that the investment of $42 million has coincided with an INCREASE of 10% in Juvenile offending. One might have hoped that an investment of $42 million would have led to a decrease in juvenile offending rates.

Across the State of Western Australia, led by the Department of Premier and Cabinet working in conjunction with the Youth Affairs Council of WA, the Government is rolling out a new system which according to the Fact Sheet will:

- Provide Larger grants
- More focused number of programs
- Longer funding arrangements

In the Kimberley region, similar processes are being pursued, but they are being led by the Regional Services Reform Unit and not by DPC and YACWA. Both processes, however, are still at time of writing in formative early stages of development and the change processes are described by those directly involved in them as being quite complex.

KALACC notes with considerable interest the following points:

- State Government currently invests around $ 115 million annually into these Aboriginal youth at risk programs
- less than 15% of these could demonstrate effectiveness – this doesn't mean that 85% are ineffective but it does mean that 85% can't demonstrate effectiveness
- the Yiriman Project was awarded first place in Category B of the Indigenous Governance Awards in 2012
- Reconciliation Australia cites Yiriman as being an exemplar of national best practice in its online Indigenous Governance Toolkit http://toolkit.aigi.com.au/case-studies/the-yiriman-project
- The ***2014 Overcoming Indigenous Disadvantage Report*** cites KALACC's Yiriman Project not once but three times as an exemplar of national best practice in Things that Work in regards to programs for working with Indigenous youths in remote areas
- KALACC notes the following comments from the long – standing Chairman of the Productivity Commission, Mr Gary Banks:

  > Yiriman has struggled to attract sustained financial support. Government funding agencies in particular seemingly find it difficult to fit the Project's culturally-based model into any of their boxes. Meanwhile substantial funds are directed to mainstream mental health services which arguably are not addressing the deeper needs of the young. Really the only challenge these organisations should present for public policy is how to harness and propagate them. [page 9, Reconciliation News, December 2012] https://www.reconciliation.org.au/wp-content/uploads/2013/12/2012-December-Reconciliation-News.pdf

- the state government provided $150, 000 to KALACC for us to engage Murdoch University to undertake a three - year evaluation of the Yiriman Project
- the Mental Health Commission has never responded to the ***Yiriman Evaluation Report*** but has in April 2016 committed to reading it and to providing a response to KALACC
- the Murdoch University ***Yiriman Evaluation Report*** concludes with these words:

  > The author is presently involved in reviewing six community-based projects across Western Australia. In his view the Yiriman Project represents one of the country's most impressive stories of local people's attempts to deal with the central and pressing public policy challenge of securing the future for Indigenous young people living in remote communities.

KALACC has very good reason to have faith in the views of Murdoch University, Reconciliation Australia and the nation's measurer, the Productivity Commission. The state currently invests $115 million annually in to youth at risk programs, suicide rates have doubled in five years and the state has evidentiary confidence in 15 % of its investments. It is long overdue for the state to provide investment in to a program like Yiriman which the Education and Health Standing Committee has twice earlier recommended be funded.

When the Education and Health Standing Committee brings down its report and delivers its recommendations to Government, the Government will inevitably respond by referring to the fact that it is already undertaking a major review and restructure of its $115 million annual investment in to youth at risk programs.

KALACC would like to have faith that these new processes will lead to better outcomes and we would like to think that after 10 years of calling on the State Government to invest in the Yiriman Project, that the State Government would finally take the action which needs to be taken. However, at time of writing, May 2016, we have no solid grounds for holding significant optimism in regards to this.

What we do know is that the Youth Affairs Council of Western Australia, together with the Department of Premier and Cabinet, are not playing a significant lead role in relation to the youth reforms in the Kimberley, but are instead leaving leadership of and carriage of those processes up to the Regional Services Reform Unit [RSRU] within the Department of Regional Development. KALACC has frequent and ongoing dialogue with senior officers of the RSRU but to date we have not seen evidence that the RSRU has as its starting point the empowerment of Aboriginal organisations to deliver services to Aboriginal communities.

Rather, the RSRU seems to have a focus on joined up and collaborative government processes. KALACC is aware that the Alliance of Western Australian Land Councils has very recently written to Minister Mitchel and to the Premier, stating the view that effective reform must involve Aboriginal people making decisions about their own future. The Land Councils are calling on the RSRU to rethink the way that it operates and to stop putting government at the centre of the equation and starting putting community at the centre.

KALACC has for 10 years put forward this same view through the Tripartite Forum, through COAG RSD, through 3 Regional Partnership Agreements, through the AACC Sub Committee, and now through the Regional Services Reform Unit. Through all of these processes, we are yet to see a genuine State Government commitment to empowering Aboriginal people to make decisions about their own future.

Yiriman is not a magic bullet and it is simply one element of what an appropriate, overarching Youth strategy for the Kimberley would look like. But no one from any agency in the State Government is beating a path to our door to discuss Yiriman with us, despite the State investing $150, 000 in to a ***Murdoch University Yiriman Project Evaluation Report*** which concluded that:

> The Yiriman Project represents one of the country's most impressive stories of local people's attempts to deal with the central and pressing public policy challenge of securing the future for Indigenous young people living in remote communities.

Term of Reference # 3 The gaps in strategies and services available to reduce Aboriginal youth suicide in remote areas and ways to address these gaps, including broader mental health strategies and services.

KALACC notes the 05 May 2016 ABC online news article ***WACOSS calls for WA budget boost*** http://www.abc.net.au/news/2016-05-05/wa-labor-proposes-community-services-collaborative-funding-trial/7387522. In particular we note the following:

> Meanwhile with the state budget to be handed down next week, WACOSS said it wanted the Government to deliver more funding into preventative programs to help ease the pressure on acute and crisis services.
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> "You can't not do that. You have to tackle crisis."

The comments from WACOSS may have been made in the context of service provision by the social services sector but the same comments are equally true of the social and emotional wellbeing context. There are truly massive investments in to an expensive tertiary system and very minimal investments in to Aboriginal – owned and controlled social and emotional programs which serve to build resilience and to grow protective factors in the individual and in the community as a whole.

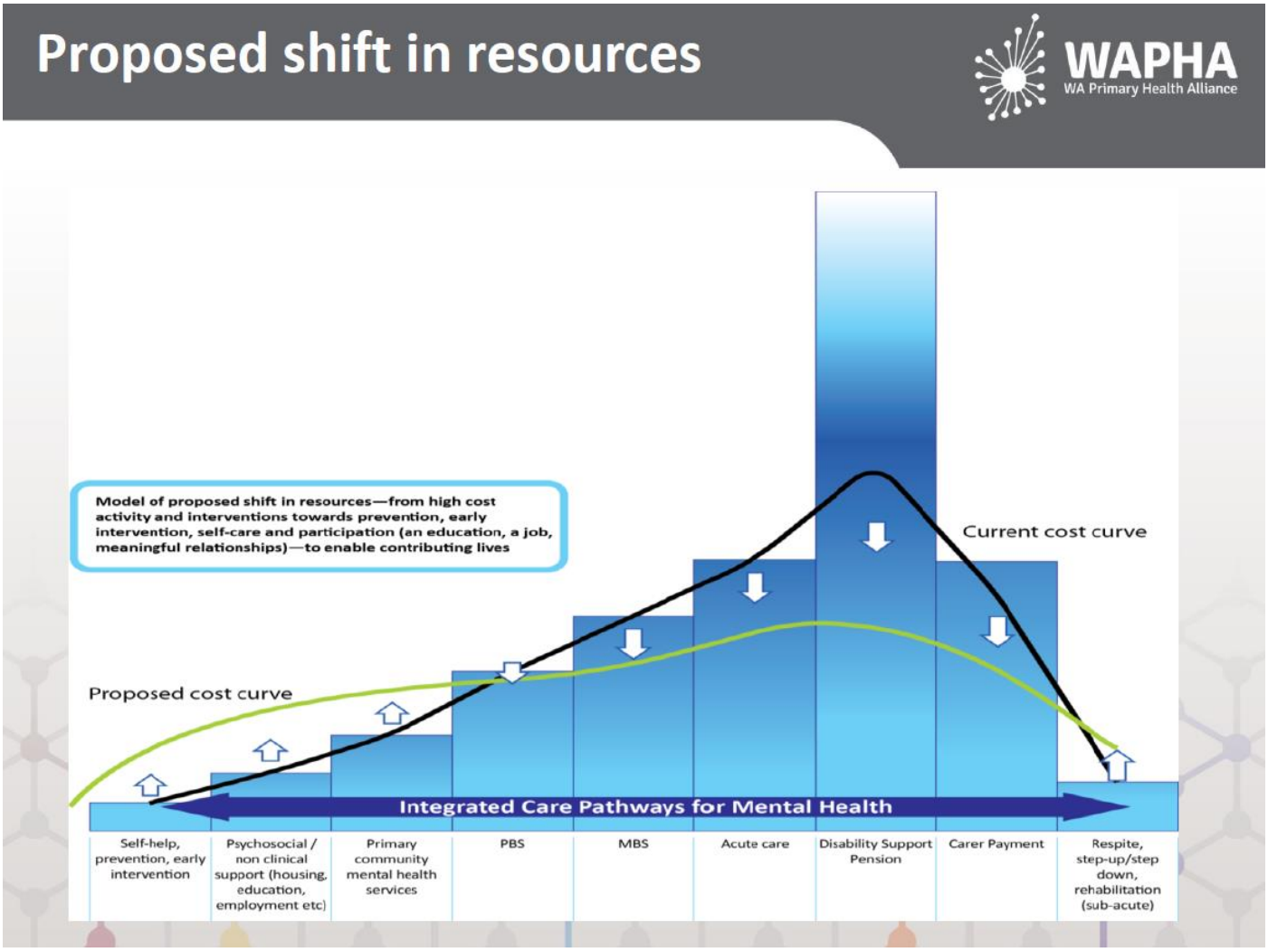
The Kimberley Development Commission's ***Kimberley Blueprint*** tells us that the level of social need in the Kimberley is so great that the state Government never has, does not now and never will be able to meet that level of social need and demand for services. And in this context, the ***Kimberley Blueprint*** calls for a shift away from downstream services and for a greater level of investment in to upstream, preventative programs. http://kdc.wa.gov.au/kimberley-regional-investment-blueprint/

One notes that downstream programs tend to be government owned and delivered whereas upstream programs tend to be community owned and delivered. So, were such a shift in resourcing to occur, it would almost inevitably be associated with a shift away from government programs towards community programs.

Earlier we have noted that the Department of Corrective Services' $42 million investment in to its government owned and delivered Regional Youth Justice Services program in the Kimberley and the Pilbara regions, coincided with a 10% INCREASE in the juvenile offending rate in the Kimberley. This is somewhat illustrative of the need to shift resources towards a community – based model of service delivery.

In regards to the mental health and the social and emotional wellbeing context, the same point has recently been made by the WA Primary Health Alliance, in its Slideshow document ***Mental Health, Suicide Prevention and Alcohol and Other Drug Information Session February 2016***. Immediately following there is a graph sourced from that WAPHA document and what one can clearly see in that document is a proposed shift away from the current cost curve:

> Model of proposed shift in resources – from high cost activity and interventions towards prevention, early intervention, self – care and participation (an education, a job, meaningful relationships) – to enable contributing lives



[WA Primary Health Alliance, Slideshow document ***Mental Health, Suicide Prevention and Alcohol and Other Drug Information Session February 2016***]

As illustrated above, KALACC – and a wide range of other organisations – have over the last 10 years called for investments in to upstream, culturally based, preventative programs. And as noted above, Mr Gary Banks, long term Chair of the Productivity Commission, states as follows:

> Government funding agencies in particular seemingly find it difficult to fit the Project's culturally-based model into any of their boxes. https://www.reconciliation.org.au/wp-content/uploads/2013/12/2012-December-Reconciliation-News.pdf

This core problem over the last 10 years remains the core problem through to today. As Mr Banks notes, Governments find it terribly difficult to "fit … [the] culturally-based model into any of their boxes."

But there is a recognition by agencies as diverse as the Kimberley Development Commission and the WA Primary Health Alliance, as well as groups like Suicide Prevention Australia, that the single biggest challenge is this challenge of shifting from downstream tertiary and clinical services to upstream, preventative services.

This difficulty is illustrated perfectly by the following email from 13 February 2015 to KALACC from Mr Eric Dillon, Director of Policy, Strategy and Planning of the Mental Health Commission:

> "The Mandate of the Mental Health Commission: The value of early intervention and upstream solutions was acknowledged by the Mental Health Commission. Mr Dillon indicated that there was no new funding currently available to the Mental Health Commission for the sorts of actions raised by Mr Morris and thus if any support for upstream services of this nature was to be provided then it would come at the cost of a reduction in clinical therapeutic and other mental health services which are already in great demand and under pressure."

KALACC is aware of the ***Suicide Prevention 2020 Strategy*** and when we met on 31 March 2016 with the Mental Health Commissioner, the DG Department of Health and with CEO of Country Health, this strategy was repeatedly referenced by Government. And KALACC does acknowledge that this strategy provides a closer degree of policy alignment with the needs and aspirations of Aboriginal communities than earlier Government policies did.

But the essential problem identified by Mr Gary Banks remains. And the essential need identified by the KDC, by WA Primary Health Alliance and by Suicide Prevention Australia, remains. Governments do what Governments always do – they look for a Government agency response.

In this case, the Government looks primarily to the Mental Health Commission. But whilst the Commission has made some small advances in the right direction over the last 12 months, the underlying ethos and the pattern of resource investments have not changed in any significant way since Mr Eric Dillon wrote to KAACC on 13 February 2015 as follows:

> Mr Dillon indicated that there was no new funding currently available to the Mental Health Commission for the sorts of actions raised by Mr Morris and thus if any support for upstream services of this nature was to be provided then it would come at the cost of a reduction in clinical therapeutic and other mental health services which are already in great demand and under pressure.

Government, through the Mental Health Commission always has prioritized clinical therapeutic and other mental health services over upstream, culturally based, preventative programs. And it continues to do so through to today.

The ***2016 ATSISPEP Kimberley Roundtable Report*** shows that the suicide rate in the Kimberley has doubled in a five - year period. On 13 February 2015 Mr Eric Dillon of the Mental Health Commission wrote that "The value of early intervention and upstream solutions was acknowledged by the Mental Health Commission." But in the same email he said that

> if any support for upstream services of this nature was to be provided then it would come at the cost of a reduction in clinical therapeutic and other mental health services which are already in great demand and under pressure

In other words, it has been the government's practice over a very long period of time to invest resources in to clinical therapeutic and other mental health services and to not fund early intervention and upstream solutions. And, as the ***2016 ATSISPEP Kimberley Roundtable Report*** shows the outcome of that strategy has been that the suicide rate in the Kimberley has doubled in a five - year period.

The ***Suicide Prevention 2020: Together we can save lives*** document talks generically about protective factors ie on page 25 we find *Table 2: Building resilience and protective factors across life stages*. None of the information in that table is in any way specific to Aboriginal communities.

On page 29 we find references to the Auditor General's Report and we find comments such as the following:

> Back to country camps were well received by young Aboriginal people

But these are just isolated references and are not structurally developed in any systematic manner.

On page 26 we find the important reference to *Universal, Selected and Indicated interventions*. But, once again, this is generic and not in any way referenced to specific populations such as Aboriginal people.

What the graph from the WA Primary Health Alliance shows is that there needs to be a massive resource re-allocation away from Indicated interventions and towards Universal and Selected Interventions.

And beyond that, as an extension to that general principle, KALACC says that there needs to be an investment in to culturally based, universal, whole of community strategies for Aboriginal people.

Professor Michael J Chandler is a statistician who has spent 30 studying the pattern of Indigenous suicides in Canadian Aboriginal communities. In 2013 he published a paper called ***Cultural Wounds***. This paper can be found on the Australian Parliamentary library website at
http://www.aph.gov.au/DocumentStore.ashx?id=6a2c2d4c-3ac5-4c68-94f3-a8cda44fb8b1&subId=205836
Some of the key points which Chandler says in this paper are as follows:

- This chapter will work to make the case that such applications of so-called individualized "medical models" of suicide prevention are mistaken at every turn, insisting instead that cultural wounds require cultural medicines
- a recent and especially through review of the North American literature carried out by Kirmayer and his colleagues (2009) has come to the harsh conclusion that, not withstanding the untold millions of dollars invested, there is not a single shred of confidence-inspiring evidence that any of these exploratory, publicly funded suicide-prevention projects has actually 'worked' to prevent a single death
- Taken together, the broad implication of both of these position statements is that, when it comes properly catching on, most suicide prevention efforts have been fishing in 'the wrong pond.'
- if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counselors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives.

Chandler says that a rowing boat without a stern is a rowing boat without a bow ie Indigenous youth who cannot picture themselves in the past cannot picture themselves in the future and are thus at hugely elevated risk of suicide. We need to invest in Aboriginal youths' futures, by helping them understand their pasts.

This brings us back to the ***2016 ATSISPEP Kimberley Roundtable Forum Report***. That report delivers this conclusion:

> Aboriginal and Torres Strait Islander participants strongly supported existing programs that work such as on-country programs, mentoring and youth leadership, should be adequately invested in and "rolled-out wherever possible". Participants expressed the need for Governments to invest in Aboriginal-led social and emotional wellbeing approaches in programs.

KALACC notes the following recent comment from suicide prevention researcher Gerry Georgatos:

> Suicide prevention should not be focused alone on reducing risk factors, but just as focused, if not more so, on increasing protective factors.

http://www.sbs.com.au/nitv/the-point-with-stan-grant/article/2016/03/09/gerry-georgatos-national-inquiry-or-royal-commission-indigenous-suicide-long

We are not in any way going to be able to overnight stop child abuse, alcoholism, lack of employment, family and domestic violence. But the solution to this is not white men in white coats with white pills. The solution is to provide young people with the resilience and the skills to be able to deal with the huge challenges which they face.

And as Professor Chandler notes, a rowing boat without a stern is a rowing boat without a bow. In other words, the single best protective factor we can provide to Aboriginal youths is culturally based programs which provide the youths with a clear sense of their past, so that they can develop a clear sense of their future.

Our contact with the Western Australian Government, over a 10 - year period, leads us to conclude that the Government simply doesn't understand this issue and that the Government continues to perceive of Aboriginal suicide as being simply a variation of mainstream, European suicide. Nothing could be further from the truth. KALACC truly looks forward to the day when the Western Australian Government does understand the true nature of Aboriginal suicide. The people of the Kimberley have clearly stated their needs, yet again, through the the ***2016 ATSISPEP Kimberley Roundtable Forum Report***. That report delivers this conclusion:

> Aboriginal and Torres Strait Islander participants strongly supported existing programs that work such as on-country programs, mentoring and youth leadership, should be adequately invested in and "rolled-out wherever possible". Participants expressed the need for Governments to invest in Aboriginal-led social and emotional wellbeing approaches in programs.

It is high time that the WA Government listened and responded appropriately to these clear messages.

Appendix One - Notes from Meeting with DG Health and MH Commissioner, 10 am, 31 March

Attendees:

- DG Health
- Mental Health Commissioner
- CEO WA Country Health
- DG DAA
- Deputy DG DCA
- KALACC – Merle Carter, Wayne Barker, Wes Morris
- Mr Gerry Georgatos – in a private capacity
- Dr Dave Palmer, Murdoch University

Meeting was Chaired by Mr Tim Marney, Mental Health Commissioner.

1. **Meeting Opened** – Tim Marney opened the meeting, welcomed everyone and acknowledged country

2. **Introduction** - Tim Marney provided a brief introduction to the meeting and in the introduction acknowledged that there was a long background and history preceding this meeting. Wes Morris spoke of KALACC writing to the WA Coroner in February 2007, of KALACC's 10 years of advocacy and of the fact that, pending funding outcomes, KALACC was once again in late 2016 likely to provide legal representation to families involved in a major Kimberley Coronial Inquest process.

3. **Agenda Item #1 State Government Response to the *2013 Yiriman Evaluation Report***

- Mr Marney indicated that the State Government had some concerns regarding the findings of the evaluation which included observation that the clear objectives/intentions/outcomes of the Yiriman project were difficult to identify.;
- Wes Morris indicated that the State had contributed $150, 000 of funding to this Evaluation and that there were in fact three reports ie two interim reports and a final report. He indicated that the State Government, through the Deputy Director General of DAA, provided some quite specific feedback on each of the two interim reports and that in each case this feedback was provided to Dr Dave Palmer in order to assist him to write subsequent reports which were more in line with that the State was seeking. It was noted that this Evaluation Report had been raised with the State Government on a number of occasions, and no written feedback on the final report had ever been provided to KALACC;
- Dr Dave Palmer then spoke on his processes and the methodology he employed in developing the three reports. He verbally reiterated his written conclusion that Yiriman was one of the most outstanding programs in the nation for addressing the issues relating to Aboriginal youths living in remote areas.
- Mr Marney indicated that he would ensure that the State Government did provide a written response to the Final Evaluation Report.

4. **Agenda Item # 2 State Government Response to the *2010 Yiriman Business Plan***

- Wes Morris explained that the Commonwealth Health Department had provided funding for the development of the ***Yiriman Business Plan*** and that a condition of this funding was the use of a consultant selected from the Health Department's panel of approved consultants.
- Mr Marney indicated that the State Government was not in any way beholden to processes followed by the Commonwealth Government. He also indicated concerns in regards to the sum of $7.0 million over four years sought in the ***Yiriman Business Plan***;
- Wes Morris noted that KALACC has worked through numerous inter- governmental processes, including the Tripartite Forum, Regional Partnership Agreements and COAG RSD. The Yiriman Business Plan has two components ie consolidation and then expansion. In the context of the COAG RSD KALACC presented to the State Government, through the COAG RSD Processes and through the DAA Kimberley Regional Manager, a request for the sum of circa $494, 000 was discussed with FAHCSIA and DIA on 27 August 2012 – as per attached document.
- Mr Marney spoke of the ***State Suicide Prevention Strategy 2020*** and indicated that that Strategy provided a policy alignment with the long standing requests from KALACC. He indicated that the Mental Health Commission was in the process of appointing Regional Coordinators and and that by September or October 2016 the Regional Coordinators would be in place and that they could then give consideration to resourcing requests.

5. **Agenda Item #3 State Government Response to the KALACC May 2015 Presentation to the AACC Sub Committee on Aboriginal Health and Mental Health**

- Wes Morris spoke of KALACC's engagement with Government ministers, and with every process which the Government told us to engage in ie Tripartite Forum, RPAs, COAG RSD and AACC Sub Committee;
- Mr Marney acknowledged that government had failed to respond and indicated that in future the first point of contact for KALACC in regards to these matters would be himself;
- Mr Weeks thanked Mr Marney for this undertaking and indicated that the arrangement of a single point of contact would be preferable to the previous multi – agency approaches.

6. **Agenda Item # 4 State Government Response to the January 2016 *ATSISPEP Kimberley Roundtable Report*.**

- Mr Gerry Georgatos noted that he was not there in an ATSISPEP capacity but present as a long-time supporter of Yiriman and KALACC. He noted that we all know the 'statistical narrative', the constant narrative of loss. He noted that he had read Dr Palmer's evaluations and had first-hand knowledge of Yiriman's psychosocial benefits. He noted that he had supported Yiriman at the federal level and elsewhere in terms of must-do funding and stated that Yiriman should be rolled further.
- Mr Georgatos noted that he believed it was a good way forward that Tim Marney is the point of contact for Government and Yiriman/KALACC and that he hoped this would expedite additional funding. He noted that the ***Suicide Prevention Strategy 2020*** inherently is fitted to support Yiriman and KALACC because of its onus on "community driven", because of its focus on "cultural healing", because of its culture and capability focus.
- There was no specific statement of a State Government response to that report, but as noted earlier, Mr Marney spoke of the ***State Suicide Prevention Strategy 2020*** and indicated that that Strategy provided a policy alignment with calls for investments in to culturally based social and emotional wellbeing programs.

7. **Broader Discussion Beyond Yiriman.**

- Wayne Barker spoke of KALACC's engagement with the RSRU and of KALACC's work [beyond Yiriman] in providing a beacon of hope in the Kimberley. He invited the State Government to attend the Biridu Community Showcase day and to meet with the KALACC Board of Directors on 27 July – at Biridu Community.

Agreed Outcomes From the Meeting:

- Mr Marney would ensure that the State Government provided written feedback on the Yiriman Evaluation Report;
- Mr Marney indicated that he would be the first point of contact for future engagement with KALACC RE the Yiriman Project;
- Mr Marney indicated that Regional Coordinators would be in place by September or October.
- The State Government would give consideration to KALACC's invitation to join with KALACC at the community of Biridu in the Fitzroy Valley on 27 July 2016.

End of notes.

Appendix Two - KALACC Briefing Note to the AACC Sub Committee Prior to Meeting on 19 May 2015

ABORIGINAL AFFAIRS COORDINATING COMMITTEE
Health and Mental Health Subcommittee
Agenda Item Request Template

Investing in Things That Work – the Yiriman Project

ISSUE
There are significant shortcomings in the Government's approach to **Indigenous youth at risk programs**. The Government itself readily recognizes these shortcomings:

- DAA has recently released a `Fact Sheet' stating that only 15 % of State Government funded youth at risk programs could 'demonstrate effectiveness';
- Corrective Services Minister Joe Francis wrote to KALACC on 18 March 2015 stating that the $42 million investment in to Remote Justice Services in the Kimberley had coincided with an INCREASE of 10% in Juvenile offending;
- Youth suicide in the Kimberley remains at alarming levels. The Minister for Mental Health recently released a media statement proclaiming that WA had Australia's highest levels of investment in to clinical mental health programs. This was issued a fortnight after the Commonwealth Mental Health Commission called for $1.0 billion to be reallocated away from downstream clinical programs and towards upstream community based preventative programs;
- KALACC has since May 2008 sought State Government support for the Yiriman Project - see attached 'KALACC History of Engagement With the State Government Re the Yiriman Project'.
- On 13 February 2015 Mr Eric Dillon [Director of Policy, Strategy and Planning Mental Health Commission of Western Australia] wrote to KALACC as follows: "The Mandate of the Mental Health Commission: The value of early intervention and upstream solutions was acknowledged by the Mental Health Commission. Mr Dillon indicated that there was no new funding currently available to the Mental Health Commission for the sorts of actions raised by Mr Morris and thus if any support for upstream services of this nature was to be provided then it would come at the cost of a reduction in clinical therapeutic and other mental health services which are already in great demand and under pressure."

The issue is that for a very, very long time, the State of WA has only focused on resourcing downstream services and has failed to invest resources in to upstream programs to support the social and emotional wellbeing of Aboriginal people. Thus there is no policy context and no mechanism for consideration of support for wellbeing programs, even programs with such strong national recognition and widespread plaudits as the Yiriman Project

BACKGROUND
KALACC wrote to WA Coroner Alistair Hope in February 2007 expressing alarm at the high rate of suicide in the Kimberley. Coroner Hope then brought down two Coronial Inquest Reports in 2008 and a third in 2010.
There was an average of 30 Indigenous suicides per year in WA between 2008 and 2014 with every year including 2013 and 2014 being significantly above the 2001-2010 average of 18 deaths per year.

We also note that WA Deputy Premier Kim Hames spoke in Parliament in November 2013 on this issue and said that there had been 325 officially reported cases of attempted suicide or self - harm in the Kimberley in just a four month period. Those figures again from Mr Hames - 325 in four months.

Support for Yiriman has been recommended by two WA Parliamentary Inquiries and by one Report from the WA Coroner. In addition, Yiriman won first place in Category B of the 2012 Indigenous Governance Awards. And the Productivity Commission's ***2014 Overcoming Indigenous Disadvantage Report*** not once but three times cites Yiriman as being national best practice in 'Things That Work' for Indigenous youths living in remote communities – things that really do serve to Close The Gap.
In December 2013 Murdoch University published a three external ***Review and Evaluation of the Yiriman Project***. That evaluation report concludes with these words:
"The author is presently involved in reviewing six community-based projects across Western Australia. In his view the Yiriman Project represents one of the country's most impressive stories of local people's attempts to deal with the central and pressing public policy challenge of securing the future for Indigenous young people living in remote communities."

CURRENT SITUATION
In November 2014 the Kimberley Development Commission released its draft ***Kimberley Blueprint***. That Blueprint calls for investments in to upstream solutions to the massive social needs in the Kimberley region. There were 325 officially reported cases of attempted suicide or self - harm in the Kimberley in just four months. This demonstrates the desperate need to do as the KDC is calling for and switch from downstream programs to upstream programs. These statistics show that a downstream approach would require an army of counsellors – AND STILL WOULDN'T WORK.

In regards to Aboriginal emotional and social wellbeing, Professor Michael J Chandler has spent over 30 years researching and mapping the pattern of Aboriginal suicide in Canada. His conclusion is that Cultural Wounds Require Cultural Healing. In his 2013 paper ***Cultural Wounds***, Chandler writes:
"if suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives."

The National Mental Health Commission Secretariat ***Background Paper*** of 23 October 2014 states:

- **Finding #10:** There is a lack of investment in early intervention programmes. This lack of investment can subsequently generate increased demand for expensive acute mental health services. Page 18 ;
- **Finding #11:** Early intervention and prevention services for children and young people will provide the greatest return on investment relative to other policy interventions. Page 19;
- **Finding #13:** There is no evidence Western focussed stress-vulnerability treatment frameworks are effective in reducing these high suicide rates. Different approaches need to be trialled that promote community, holistic and integrated approaches that acknowledge risk and protective factors for Aboriginal and Torres Strait Islander people. Page 20
- The 'Top Five' issues [from a suicide prevention perspective] are: (2) There needs to be a focus on the socio-cultural issues contributing to suicide: **there is too much attention paid to medical responses. There has been some progress e.g. Yiriman Project**, but more is needed Page 22

Mr Dillon has written confirming that the Government's focus is on clinical services and the Minister has issued a media statement saying WA has Australia's highest investments in to clinical services. But the National Mental Health Commission Report finds that "There needs to be a focus on the socio-cultural issues contributing to suicide: **there is too much attention paid to medical responses. There has been some progress e.g. Yiriman Project**, but more is needed"

RECOMMENDATION

1. That the State of Western Australia follow the recommendation of the November 2014 Kimberley Development Commission ***Kimberley Blueprint*** by investing in upstream solutions to truly massive social issues in the Kimberley;

2. That the State of Western Australia accept the two recommendations from the WA Parliament Standing Committee on Health and Education and the findings of the National Mental Health Commission and invest resources in to the national – award – winning Yiriman Project.

There are a number of major reports and bodies of research which emphasise the important linkages between Aboriginal culturally based programs and social and emotional wellbeing. One of the latest of these is the Productivity Commission's ***2014 Overcoming Indigenous Disadvantage Report***
Other Reports which we refer to include:

- ***Working Together, Recommendations for across-government and inter-sectoral universal prevention initiatives to promote well-being and resilience and to reduce self-harm and suicide among Aboriginal youth,*** A briefing paper prepared by the Aboriginal Suicide Prevention Steering Committee, 8 May 2001;
- Three major Kimberley Coronial Inquest Reports prepared by WA Coroner, Alistair Hope [2007 – 2010];
- Kimberley ***Hear Our Voices Report***, March 2012;
- ***The Mental Health and Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples, Families and Communities*** ; Supplementary Paper to ***A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention***, March 2013;
- The ***Elders Report***, April 2014;
- The ***2014 Closing the Gap Progress and Priorities Report***, February 2014;
- ***National Coalition for Suicide Prevention Response to World Health Organisation World Suicide Report: An Assessment of Australia's Progress in Suicide Prevention***, September 2014;
- ***The Third Conversation: Has Anything Changed? The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Roundtable Report***, September 2014;
- ***Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people***, Issues paper no. 12 produced for the Closing the Gap Clearinghouse [Pat Dudgeon, Roz Walker, Clair Scrine, Carrington Shepherd, Tom Calma and Ian Ring] November 2014

- Professor Michael Chandler's 30 – plus year research history in to the pattern of Indigenous suicide in Canada;
- Murdoch University Three Year ***External Review and Evaluation of the Yiriman Project***, December 2013;
- National Mental Health Commission, ***National Review of Mental Health Programmes and Services***, December 2014, released publicly in April 2015.

Appendix Three - Working Together Report, 08 May 2001

‘WORKING TOGETHER’

Recommendations for across-government and inter-sectoral universal prevention initiatives to promote well-being and resilience and to reduce self-harm and suicide among Aboriginal youth

A briefing paper prepared for the Hon. Alan Carpenter, MLA
Minister for Aboriginal Affairs

by the

Aboriginal Suicide Prevention Steering Committee

8 May 2001

Executive summary

This proposal outlines a policy framework and work-plan to coordinate the development and implementation of universal prevention measures to address the early determinants or 'up-stream' causes of self-harm and suicide among Aboriginal youth in Western Australia.

Current Policy Context:

The problem of fatal and non-fatal suicidal behavior – particularly among younger age groups - is now one of the most pressing social issues affecting Aboriginal communities. Over the past two decades young Aboriginal men have died through suicide at more than double the rate of their non-Aboriginal counterparts (Hillman et al, 2000). There has also been a significant increase in deaths in custody in the latter half of the 1990's (WA Parliamentary Commissioner for Administrative Investigations, December, 2001). Hospital admissions for deliberate self-harm and attempted suicide among WA Aboriginal males and females have also increased substantially over the past decade (Serafino et al, 2000). On the basis of current trends, the rate of suicide among Aboriginal people can be expected to increase further unless there is concerted community and Government action at all levels to address both the immediate and the underlying causes.

State Government Action to date

In response to these trends and representations from Aboriginal community leaders and organizations, the Health minister's advisory committee on youth suicide (YSAC) initiated a process of consultation with Aboriginal community agencies and mainstream service providers in 1996 and 1997. This resulted in the development of a cabinet endorsed strategy for *'Across Government Policy and Programs for Preventing Suicide among Aboriginal Youth in Western Australia'*. The strategy has been built on a partnership model which encompasses Aboriginal and non-Aboriginal perspectives. This has enabled some of the immediate priorities defined by communities to be addressed through a broadly based public health strategy which has endeavoured to coordinate Government and inter-sectoral action to address the complex issues involved. The establishment of the Aboriginal Suicide Prevention Steering Committee (ASPSC) in 1998 has assisted in developing more effective communication between the relevant service providers and key stakeholder groups around the issue of suicide prevention.

The ASPSC has been responsible for coordinating the implementation the recommendations of the cabinet endorsed plan with the active support of the Aboriginal Affairs Coordinating Council (AACC). The prevention measures implemented to date have largely focused on improving service capacity and practice standards in government and community controlled services. They have been focused primarily on meeting the direct treatment and support needs of individuals who are at highest risk of suicide i.e. those attempting suicide or otherwise actively suicidal. Funding in the order of $2.0 million has been allocated for Aboriginal counselling services and 'life promotion workers' in areas of the State with identified high need. These funds have been allocated through the HDWA Office of Aboriginal Health, the HDWA Mental Health Division, AAD and various Commonwealth sources.

Proposed policy framework for universal prevention:

This policy framework seeks to advance the systematic development and implementation of universal prevention measures (population-wide interventions) which address the early 'up-stream' causes of suicide and other adverse youth outcomes. It first aims to build effective

partnerships and the level of collaboration required for joint planning and the development of coordinated administrative and purchasing mechanisms to achieve the shared longer-term objective of improving the health, educational, social and vocational outcomes of Aboriginal young people. It proposes mechanisms to ensure that such partnerships and initiatives are grounded within Aboriginal worldviews of health and well-being and are guided by community determined processes for action within each discreet area or community

Planning process to date

The formulation of this policy framework is the outcome of: a) a service audit of existing preventive strategies and programs within each if the State Government Departments with responsibilities for promoting the wellbeing and developmental health of Aboriginal children and youth; b) a systematic review the available literature on Aboriginal suicide and universal strategies which promote well-being and resilience; and c) extensive consultation with Aboriginal and mainstream service providers and community groups

Proposed strategic objectives

The strategic actions necessary to achieve the long-term objective of reducing self-harm and suicide through the enhancement of well-being and developmental health include:

1. Developing partnerships within and across Aboriginal services, communities and government, which foster effective development and implementation of prevention initiatives;
2. Establishing an agreed framework for joint-planning across Departments and sectors to promote children's developmental health and community well-being;
3. Creating purchasing frameworks which are accountable but flexible in accommodating local need, and that achieve responsive, coordinated service provision at a local level
4. Engaging in a process of community mobilization that actively engages and supports key community leaders and significant stakeholders at the local level
5. Investing in the development of culturally appropriate and evidence-based prevention resources which can be implemented systematically on a population wide basis.
6. Supporting all prevention responses through continuing advancement of knowledge and provision of service infrastructure for implementation and evaluation of state-wide prevention responses;
7. Ensuring ongoing training and development of Aboriginal personnel to ensure sustainability of prevention approaches in the long term.

Proposed work-plan for the next 12 months:

1. The need for effective coordinated action to address this urgent community need will need to be championed at all levels within government and communities. Most particularly, this will require communicating the evidence regarding the efficacy and efficiency of longer-term approaches to early intervention and prevention. Such interventions have considerable potential to reduce a range of adverse youth outcomes of community concern including substance abuse, violence, crime and self-harm and suicide.

2. A comprehensive process of community consultation needs to be conducted over the next 12 months. Such consultation is required first at a regional level with key government and non-government agencies to initiate the development of regional work-plans for effective service coordination to address longer-term prevention objectives as well as joint responses to the immediate service needs of suicidal youth. This stage of work will conclude with the production of a fully costed strategic plan for the Statewide implementation of systematic universal prevention strategies.

3. At the local community level, a community development model of consultation is required to support key community leaders, service providers and other stakeholder to define local priorities and to mobilize community readiness and action to support longer-term strategies of prevention.

Potential funding implications

1. The initial step of promoting more joint planning across government in partnership with Aboriginal community agencies does not have any associated monetary costs.

2. Implementing the regional and community consultation processes throughout the State over the next 12 months is likely to cost in the region of $0.5 - $1.0 million depending on the scope and level of the consultation processes undertaken.

3. The development and evaluation costs to produce culturally appropriate prevention initiatives and trial them a demonstration basis in selected communities will require commitment from a range of state and commonwealth portfolios and is likely to be approximately $5 million over a three year period (2001/2 –2005/6).

4. From 1996/7 the anticipated annual implementation and training costs for a full-scale Statewide delivery of universal prevention strategies and programs could require a commitment of $5-10 million annually. These costs are likely to be met from within the existing budgets of the State Government Departments of Health, Family & Children's Services, Education and Justice and various Commonwealth Department who each have a stake in optimising the developmental outcomes of Aboriginal children and young people.

Concluding comment:

Coordinating efforts across government and between sectors to support Aboriginal families, communities and schools in their shared responsibilities for rearing children is one of the most important and yet difficult tasks facing the Western Australian Government. Current research and good practice knowledge suggest this is likely to be the most effective means to reducing the complex problems of suicide and self-harm among Aboriginal people in Western Australia. It is also a critical part of the ongoing process of reparation for the damage done to Indigenous communities and families by the history of colonisation and the forced removal of children from their parents.

1. The current policy context

1.1 Background

Suicide was almost unknown within Aboriginal societies, prior to colonisation and has only emerged as a problem in the last 20-30 years (Hunter et al., 1999; Tatz, 1999). Over this period the rates of both self harm and completed suicides among Aboriginal people in Australia have increased substantially. The problem of fatal and non-fatal suicidal behavior – particularly among younger age groups -is now one of the most pressing concerns for many Aboriginal communities. The extensive and inclusive nature of kinship relations within and across Indigenous communities has also had the effect of intensifying the exposure of individuals and families to suicide so that Indigenous society as a whole has been disproportionately impacted by these bereavements "*When one person takes their life, the whole community feels it – every suicide is one too many"*(Cox, 2000). Suicides among Aboriginal people occur in the context of ongoing high mortality rates and premature deaths due to unnatural causes (Hunter, 1998).

The most recent official statistics on *completed suicide* in Western Australia show an average rate of suicide of 37 per 100,000 population amongst the state's male Aboriginal population over the period 1986 – 1997. This is almost double the equivalent rate for all males in the state over the same period (Hillman et al, 2000). These data also reveal a sharp increase in Aboriginal rates since 1995 and a continuing trend towards suicides by males at very much earlier ages. Over the same period there has also been a corresponding rise in the rates of hospital admissions *for deliberate self-harm and attempted suicide* among Aboriginal males and females (Serafino et al, 2000). Studies of *self-harming behaviour* in the Kimberley and several communities in Far North Queensland over the past 10 - 15 years have also documented the fact that young Aboriginal people at risk in childhood and adolescence, continue to be at risk into their adult years (Hunter et al., 1999). This is a particularly concerning trend given that the majority of the Aboriginal population in Western Australia consists of young people (i.e. aged 0-25 years) with the largest age group being 0-12 years (Australian Bureau of Statistics, 1999). These findings together suggest that the number of Aboriginal people affected by self-harm and suicide can be expected to increase further unless there is concerted Statewide action to address their immediate and underlying causes.

2. State Government action to date

2.1 *'Across Government Policy and Programs for Preventing Suicide among Aboriginal Youth in Western Australia'*

In response to the above trends and representations from Aboriginal community organizations, the WA ministerial advisory group on youth suicide (YSAC) initiated a process of consultation with a range of Aboriginal communities and agencies and mainstream service providers in 1996 and 1997. This resulted in a set of recommendations for *'Across Government Policy and Programs for Preventing Suicide among Aboriginal Youth in Western Australia'* . This plan was endorsed as State policy by Cabinet in late 1997 and launched by then Minister for Health (the Hon John Day MLA) in February 1998.

2.1.1 General prevention approach adopted

The *'Across Government'* plan firstly acknowledges that preventing suicide and promoting well-being among Aboriginal people is a shared community responsibility necessarily involving all levels of government, Indigenous and community organisations that have responsibilities in relation to children, young people and their families.

Whilst recognizing that each of the relevant Government departments delivering services to Aboriginal families has a responsibility to ensure formal mechanisms are available to manage suicidal behaviour and prevent suicide, the plan recommended that the Health Department (HDWA) should take the lead role in initiating *'Across Government'* action and that this should be supported by the Department of Aboriginal Affairs (DAA) playing a communication and co-ordination role.

The 'Across Government' plan is predicated on a partnership model which encompasses Aboriginal and non-Aboriginal perspectives. This requires the bringing together of:

a) **Effective processes of community consultation** which ensures that preventive and treatment efforts are informed by Aboriginal knowledge of cultural and other local issues of concern. Ongoing consultation with Aboriginal community groups and organisations is seen as essential to ensure appropriate avenues for parents and young people affected by suicide or self-harming behaviour to make their needs known and to facilitate the availability and utilisation of culturally appropriate prevention and treatment services, and;

b) **A public health framework** which can ensure the effective targeting and co-ordination of multi-sectoral action to address the complex range of individual and environmental issues involved. This approach is consistent with current scientific knowledge regarding successful strategies of prevention and the promotion of mental health and resiliency of children and young people. It essentially involves identifying modifiable risk and protective factors associated with suicide and self- harm and targeting the best leverage points to effect population, group and individual level change. This model of prevention has been used with good effect in tackling other complex social and medical problems such as AIDS/HIV in the Aboriginal and non-Aboriginal communities.

2.1.2 Levels of preventive intervention

Consistent with WHO, National and State strategies for suicide prevention, the policy framework recognises that different strategies are required for individuals and groups at differing levels of risk.

a) **For individuals at highest risk** (e.g. youth with active mental health disorders, those who have recently attempted suicide,) ***indicated preventive interventions*** are required to ensure that adequate assessment, treatment, counselling and other supports are available.
b) **For groups at higher than average risk** (e.g. youth with substance use problems or those in prison or police custody, or those in Aboriginal communities with very high local rates of suicide) ***selected preventive interventions*** are needed to ensure that adequately resourced services and programs are available to ensure early identification and appropriate management of those at increased or increasing risk.

c) **For groups at low or average risk** (e.g. the general population of children and young Aboriginal people in families, schools and communities) ***universal preventive interventions*** are required to prevent them from becoming at risk in the first place. This includes community wide programs to strengthen protective factors which promote child health, emotional wellbeing and resilience to stress and adversity.

Table 1. Types of population-based prevention programs

Intervention type	**Target population**	**Example**	**Advantages**	**Disadvantages**
Indicated (i.e. direct treatment)	Directed towards those individuals having disorder or showing the behaviour that is to be prevented	Appropriate treatment of those with established mental health disorders Comprehensive hospital and follow-up care for those admitted following serious suicide attempts	1. Can be very effective in some cases 2. Can prevent recurrence of suicidal behaviour and/or subsequent suicide	1. Expensive 2. Not always available or accessible 3. Does not always work 4. Many who need it refuse to be treated
Targeted	Directed towards specific communities or groups known to be at high risk	Whole community approaches to promote youth well-being in communities with known high risk System wide approaches in prisons to reduce risks of suicide	1. More efficient exclude those not at risk 2. Less resources needed	1. Can be stigmatizing 2. Can miss those at high risk who do not happen to be in the targeted population
Universal	Total population	Support to families communities and schools to optimise children's health, education and social development School & community programs to promote emotional wellbeing and to	Everyone is protected No stigmatization Involvement of children from all income groups increases effectiveness	1. Inclusion of those not at risk increases cost 2. Compliance can sometimes be difficult to obtain

		develop life-skills and competencies		

2.1.3 Implementation of specific recommendations

Significant progress has been made by relevant Departments and community agencies in implementing almost all of the following recommendations specified in the 'Across Government' plan. This was facilitated by suicide prevention being nominated as one of AAD's six priority outcome areas. Through the quarterly meetings of the Aboriginal Advisory Council (AAC) it has been possible to ensure that the CEO's of each of the relevant departments gave high priority to progressing the specific recommendations of the 'Across Government' plan. The following specific recommendations have now been implemented within the time-frame specified by the plan:

1. **Development of formal links and communication processes with key community groups and other relevant bodies.** The establishment of the Aboriginal Suicide Prevention Steering Committee has formalized links between the YSAC, relevant State Government departments, the WA Aboriginal Justice Council, the WA Aboriginal Community Controlled Health Organisations (WAACHO) and relevant Commonwealth agencies such as ATSIC and OATSIHS. This committee meets quarterly and has senior representation from these stakeholder groups and the HDWA Office of Aboriginal Health, the HDWA Mental Health Division, Family and Children's Services and the Department of Aboriginal Affairs. During the latter part of 2000 and early 2001 the activities of the Steering Committee have been supported by a part-time executive officer employed by YSAC with funding from the Department of Aboriginal Affairs.

2. **Developing and implementing practice policies and standards.** The HDWA has required all publicly funded hospital and community mental health services to ensure that practice policies and standards for the management of suicidal patients specifically take into account the cultural liaison requirements and other special needs of Aboriginal clients

3. **Ensuring the availability of appropriate mental services for Aboriginal juveniles with severe mental disorders.** The HDWA has taken steps to ensure that Aboriginal juveniles with severe mental disorders should not be admitted to secure facilities in Adult psychiatric hospitals (e.g. Graylands) when suitable beds and support facilities are available through the Bentley Adolescent Unit.

4. **Developing culturally appropriate policies and student support services within all WA schools.** The EDWA has required all State schools to ensure that existing procedures and services for the early identification and management of students at high risk of self-harm or suicide are adapted to be culturally appropriate to the special needs of Aboriginal students and their families. This also emphasizes the importance of involving schools' Aboriginal & Islander Education Officers (AIEO) where they available. Similar requests have also been made by the YSAC to the WA Catholic Education Office and the WA Association of Independent Schools.

5. **Improving the Ministry of Justice admission risk screening procedures**. Existing risk screening procedures have been adapted to allow more culturally appropriate assessment of the risk status of Aboriginal prisoners and requests made for clinical services provided by the MOJ Special Services Team to include cultural consultation with relevant Aboriginal service agencies.

6. **Updating the WA Police Service Policy Manual**. The WA Police Services Policy Manual has been updated to include a new section on procedures and practice in the

management of deliberate self-harm and suicidal behaviour for both Aboriginal and non-Aboriginal youth

7. **Pre- and in-service training of police officers and police Aboriginal liaison officers. Current training has been expanded to** include awareness and skills training for dealing with suicidal situations and specific issues relevant to the Aboriginal population.

8. **Recruitment, training and employment of Aboriginal mental health workers and counsellors**. The HDWA has increased resources for the recruitment, training and employment of Aboriginal mental health workers and counsellors.

9. **Improving employment opportunities for Aboriginal people who have completed mental health worker and counselling training**. This has been achieved by the appointment of several youth life-promotion officers and other counsellors in areas with particularly high rates of suicide and self-harm

10. **Cultural sensitivity and awareness training**. Steps have been taken in several government departments to ensure that cultural sensitivity and awareness training is more routinely available for non-Aboriginal workers in relevant work settings

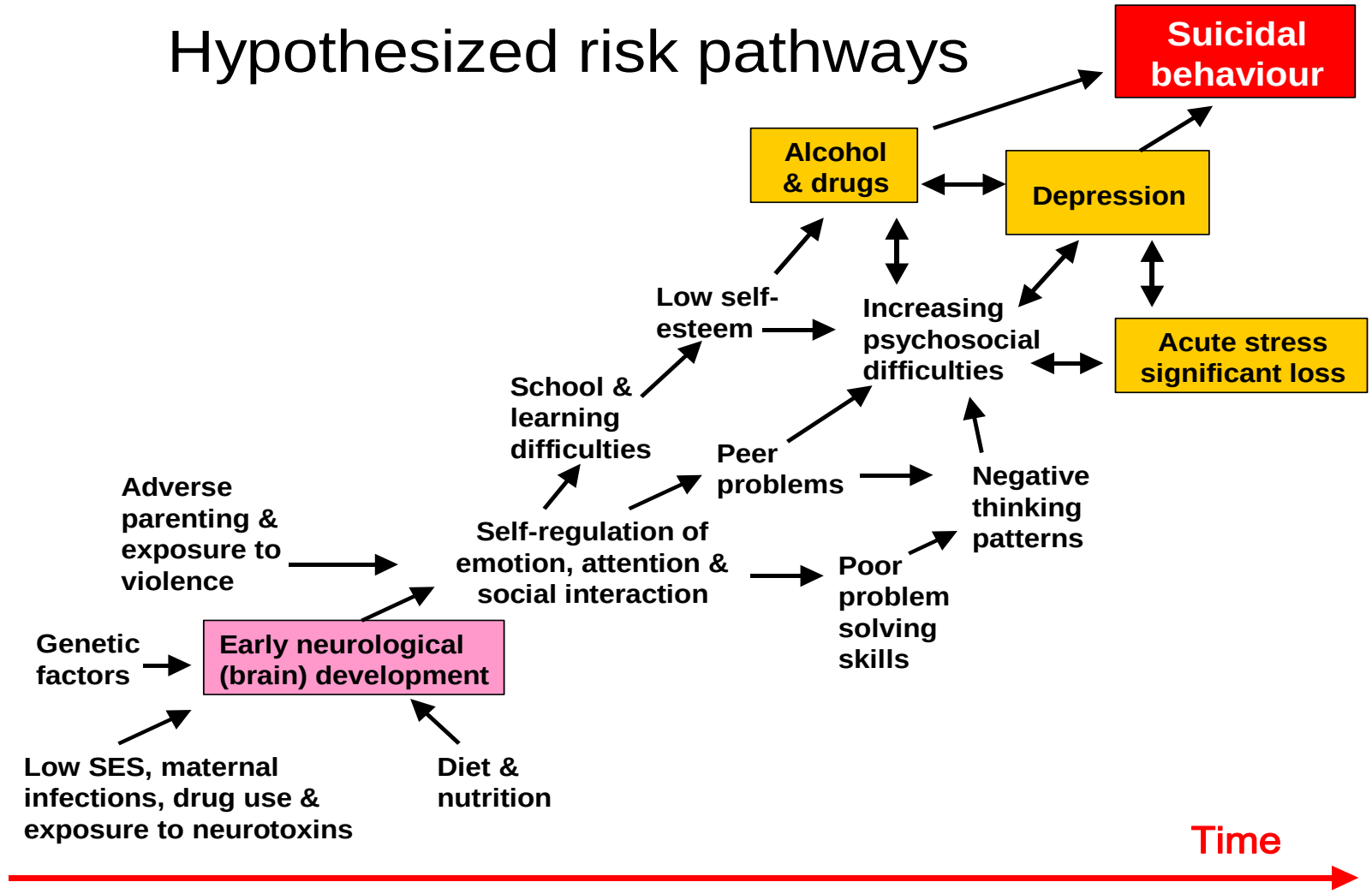
The Aboriginal Suicide Prevention Steering Committee continues to monitor the on-going implementation of these recommendations and reports annually on their status to the AACC.

2.1.5 Longer-term recommendations for universal prevention

The final section of 'Across Government' plan proposes the development of a comprehensive and strategic approach to tackle the 'up-stream' issues underlying the development of suicidal behaviour. It identifies the need for population-wide measures to promote the emotional health and well-being of all Aboriginal children and young people to lessen the likelihood of subsequent suicidal and other youth risk behaviours. The effective implementation of such universal prevention measures requires the targeting of relevant risk factors and interventions strategically targeted at critical points in the causal pathways to self-harm and suicide

Politicians, service planners and implementation staff also need to understand the longer time-frame of such interventions. The experience of successful population wide programs such the US Headstart program has indicated that full benefits of investment in early intervention and prevention may only be realised 10 to 20 years hence. While this far exceeds the period of office of most governments there is now good health economic evidence demonstrating the cost-savings to government for a range of evidence-based early intervention and prevention programs (RAND, 1999). These initial prevention costs should thus be viewed as an investment whose return is likely to far outweigh the subsequent costs to society in having to treat, manage and financially support an increased numbers of youth and young adults with adverse developmental outcomes (Marshall & Watt, 1999).

Figure 1. Hypothesised risk pathways to suicidal behaviour



2.1.6 Current progress towards developing an integrated State plan for universal prevention

The following actions have been taken in furthering the recommendations of the 'Across Government' plan to develop an appropriate framework for integrating universal prevention initiatives to prevent Aboriginal children from becoming at risk for self-harm, suicide and other risk behaviours.

1. Reports have been sought from all relevant Government departments, key Indigenous community agencies and educational institutions with responsibilities for providing population-wide initiatives to promote child health, strengthen family functioning, improve the capacity of schools to meet the needs of Aboriginal students and to build healthier communities.

2. By June 1999 reports were received form 10 such agencies outlining their existing policies and services addressing population based prevention goals and what was being done to ensure that Aboriginal children, young people and their families are included in the provision of these policies and services. These reports were integrated into a summary overview.

3. An initial consultation workshop was convened by AAD in December 1999. This was attended by representatives of key Aboriginal stakeholder groups and agencies. This workshop considered the summary overview of current government initiative and identified areas of unmet need, It also indicated the requirement for a more comprehensive and on-going process of consultations to address the complexity and range of issues identified.

4. In mid 2000 the Department of Aboriginal Affairs made a budget available for YSAC to employ a part-time project officer to review the available literature and to facilitate the process of consultation with stakeholder groups regarding their perceived needs and suggestions for what was needed in terms of universal prevention.

5. The literature review and options for universal prevention initiatives suggested by the community consultations were developed into the '*Working Together'* discussion paper (YSAC, 2000). This was distributed to a wide range of Aboriginal community organizations and service providers to canvass further comments. It was also work shopped in a number of community meetings in late 2000 and early 2001. The feedback from this consultation process has now been incorporated into the proposed framework for *'Across-Government and Intersectoral Universal Prevention Initiatives'.*

3. PROPOSED FRAMEWORK FOR UNIVERSAL PREVENTION

This framework is the outcome of the literature review and the processes of consultation outlined above. This is not another pre-determined 'solution' to be imposed on Aboriginal people and communities, but rather a jointly developed view of possible options and ways forward in more effectively addressing the unacceptably high rates of self-harm and suicide in the State's indigenous population. It incorporates suggestions and directions emerging from the consultation process about what is needed as well as directions from the literature review regarding what is likely to work in achieving meaningful improvements in Aboriginal children's health, education and other developmental outcomes.

3.1 Key issues identified by the preliminary consultation

3.1.1 The need for genuine and effective two-way communication:

The framework takes as its starting point the need for genuine and effective two-way communication the between communities, government and other responsible agencies. This has been the single most frequent suggestion made by Aboriginal people in all of the preliminary consultation meetings. This is essential to clarify the most effective leverage points for intervention and to develop a shared understanding of the issues of most concern and relevance to the later developmental of suicidal behaviour and other adverse outcomes for Aboriginal youth. The need for community consultation to be entered into fully through direct work with communities and mainstream agencies at a community defined pace was also seen to be particularly valuable.

3.1.2 Sufficient program flexibility to accommodate local needs

The framework for coordinated universal prevention needs to be sufficiently flexible to enable locally defined needs and solutions to be supported and integrated within a broader framework of universal prevention. This level of flexibility is also necessary for the local adaptation of programs of prevention shown to be effective in other communities and settings. While such an extensive process of consultation may appear to be excessive in terms of time and resources, it is clear from the community feedback received that efforts to implement universal prevention measures are unlikely to be supported and sustained unless this occurs.

3.1.3 Promoting emotional well-being is a shared community responsibility

Preventing suicide through the promotion of emotional wellbeing necessarily involves all government, Indigenous and community organizations that have responsibilities in relation to Aboriginal children, young people and their families. A genuine and concerted commitment by government to facilitate shared responsibility in this area needs to commence with a recognition of the inefficiency and ineffectiveness of programmes which have been imposed on communities and do not fit a local community frame of reference. Genuine collaboration in planning and decision making will be facilitated by community centered and community driven approaches which are able to mobilize broader community participation.

3.1.4 Interventions targeting current suicidal behaviour vs. universal prevention

A common response from more remote areas of the State was that a stronger focus on universal strategies of prevention is unlikely to be viewed as a priority by many communities where almost all children and young people could be considered to be at increased risk for suicide. Such communities often have limited access to effective treatment and family support resources and may therefore be more likely to see improved availability of intervention services for dealing with acute crises as a higher priority. This view needs to be balanced by the fact that the level of resources required for selected and indicated prevention will inevitable increase unless a greater proportion of resources are invested in universal prevention.
The next phase in developing a more strategic and integrated approach to universal prevention will require a region-by-region, community-by- community, process of community mobilization and consultation. The diversity of the living circumstances and community resources available of the Aboriginal population of Western Australia means that there are no readily generalisable universal strategies of prevention or simple solutions to the immediate

problems of suicidal behaviour. What is likely to emerge from such an individualized area-by-area approach to this issue is: improved local support for prevention initiatives, a better understanding of 'what works' and the identification of common issues and themes which can be used to inform purchasing and service coordination across departments and community agencies at the local, regional and State levels.

A systematic process of regional and community consultations is required to ensure adequate local input regarding what is needed, what can be coordinated better, and what is likely to work in the implementation and support of universal prevention interventions

3.2 Aboriginal worldviews of health, well-being and suicide

It is difficult to define a unitary Aboriginal worldview regarding positive mental health given the diversity of Aboriginal cultures within Australia. These include significant variation in beliefs and conceptions of health and well-being. For some groups and communities, traditional beliefs are more strongly held than mainstream western views, while for others the converse may be true. Despite the varying conceptions of health within different Aboriginal cultures across the State, health from an Aboriginal perspective, is generally an holistic concept, which considers the person within their social, familial and environmental context and which addresses cultural and spiritual, social and economic well-being as well as physical and emotional well-being. Mental health from an Aboriginal perspective has thus been defined as:

"Not just the physical well being of an individual, but ... the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well being of their community. It is a whole of life view and includes the cyclical concept of life-death-life"

(NAACHO, 1997 in Commonwealth DHAC, 1999a)

Aboriginal conceptions of well-being rely on a sense of wholeness and balance in which the individual (and people more generally) are an element of a broader conceptualization of the cosmos, which includes a network of reciprocal relationships between people, land and spirit. Within this world-view, illness is seen to result from a disturbance to the harmony of this broader whole. Suicide, like other indications of unwellness, may in a traditional cultural context be externally attributed as being caused by the intervention of bad, evil or malevolent spirits. This may also necessitate some form of exorcising or ritual intervention such as 'smoking' to restore the harmony of the broader 'whole'.

Given the inter-active nature of the 'whole', greater strength and resilience in one aspect of country, society, community, family or individual is considered to have a flow-on effect for general community well-being, but enough of the 'whole needs to be resilient and strong in order to ensure maintenance and promotion of individual well-being.
Within such cultural contexts it would seem more appropriate adopt Hunter's concept of 'communities at risk' rather than 'individuals at risk' (Hunter, 1999). The implementation of a community development model in such communities would also seem more culturally appropriate than a public health model. Aboriginal concepts of health accord more with the approach of community development which encompasses the broader conception of well-being as it relates to the spiritual, cultural, emotional social and physical well-being of the whole community.

Self-determination and empowerment are the cornerstones of community development approaches. Supporting these processes are likely to be more effective in the longer term, in promoting positive mental health, well-being and resiliency. Promotion of well-being in such a framework thus requires community-centered early intervention across the whole ecological context in which Aboriginal children and young people live and grow. From an Aboriginal perspective, such interventions are necessary to ensure the maintenance of strong and resilient communities, families and children.

It is important that the incorporation of Aboriginal concepts of health and a community empowerment approach are not seen as a token 'catch-cry' or general principle to be acknowledged at the beginning of such a document, but that these are understood and incorporated to guide culturally appropriate implementation of universal prevention initiatives. This will necessitate a genuine commitment to extensive and broad-ranging consultation throughout all stages of the implementation process. While the improved health and well-being of all Aboriginal children, young people and their families are desired outcomes, a great deal of flexibility will be required to facilitate community determined responses to their achievement.

Strategies for universal prevention in rural and remote communities are better developed within the context of a community development model rather than a public health model which is more suited to urban and metropolitan settings. Promotion of well-being in a 'community centered' framework will require early intervention across the whole ecological context in which Aboriginal children and young people live and grow in order to ensure the maintenance of a strong and resilient communities which support families in the task of 'growing up solid kids'.

The existing public health approach of the 'Across Government' plan need to be complemented by a community development approach which is more applicable in remote and other discrete Aboriginal communities

3.3 Proposed Community Development Approach

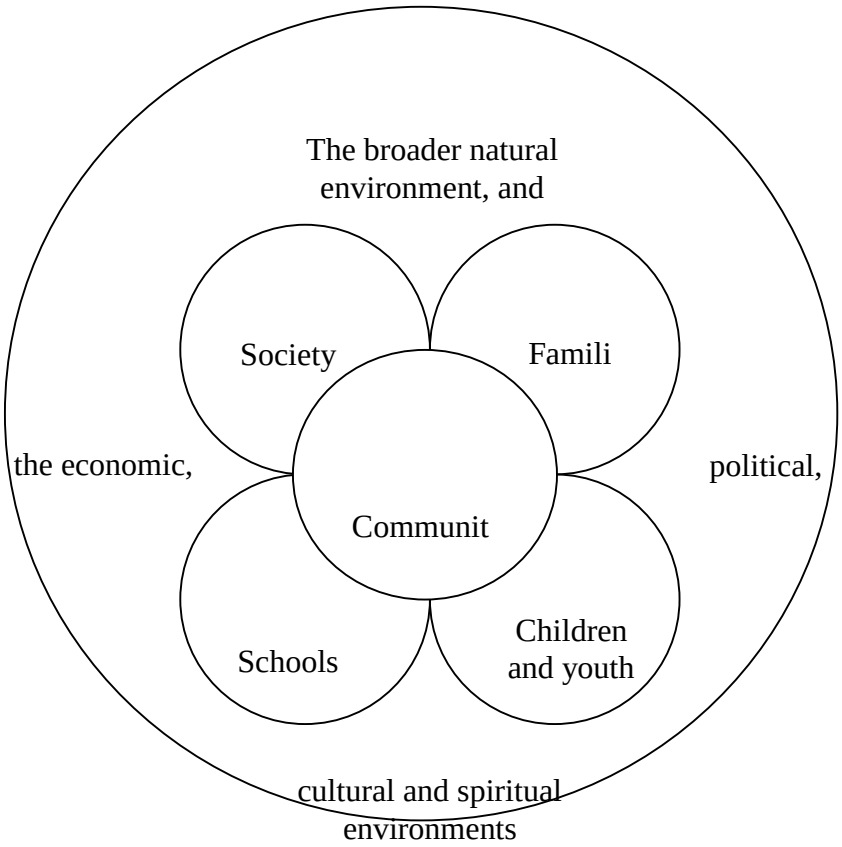
The proposed community development approach incorporates suggestions from Aboriginal communities and service providers consulted in the preliminary consultation process. It includes a consideration of service priorities for children's healthy development and education as well as program based interventions and the infrastructure needed to support their on-going implementation across communities.

The model is 'community centered' in that it based on the needs of discreet Aboriginal communities, specific areas, regions, or discrete Aboriginal communities within an area or region. The central focus of the model is the maintenance of community well-being as a fundamental pre-requisite for family and individual well-being.

'A *sense of community is essential to a sense of self and that this in turn is essential to health'*

(Eckermann, 1992:174).

Figure 2. Community Development Model



Community is the central focus of the model, acknowledging that the well-being and resiliency of community, families, schools and children are interdependent and encompasses spiritual, cultural social, emotional and physical wellbeing at each level. Services or intervention aimed at strengthening resilience and countering risks to well-being, are provided at the level (individual, family, school or community) most appropriate to that particular intervention.

Suicide, like other adverse youth outcomes such as alcohol and drug misuse, delinquency, depression and other mental health disorders, is usually an outcome of earlier childhood difficulties and current adverse environmental circumstances. There is now strong evidence showing that the earlier in a child's life prevention interventions are implemented, the more likely they are to be effective.

Table 2 below outlines the range of interventions and strategies suggested in the preliminary community and agency consultations. These are grouped according their particular focus on communities, families, schools, children and youth, as well as the broader society and the current political processes.

Table 2. Options for universal prevention: Suggestions from the community consultation regarding what should be done in the areas of community, family, school, children and youth, the broader society and political processes.

Community	Family	School	Children & Youth	Broader society	Political processes
1. Indigenous well-being/healing centers/ programs 2. Flexible CDEP that supports families and communities 3. Camps valuing Indigenous culture 4. Effective community justice mechanisms 5. Creative arts programs connecting to spirit and identity 6. Initiatives to address alcohol & drug use & limit access to alcohol and drugs 7. Mentoring and availability of +ve role models 8. Suicide prevention and post-vention training 9. Grief support services	1. Strong women's programs preventing early pregnancy 2. Good pre-natal nutrition and health care 3. Young Mum's programs that include good post-natal care 4. Culturally appropriate parent education through the lifespan for parents of babies, toddlers, children and teenagers 5. Culturally appropriate parenting programs for fathers 6. Family violence prevention programs	1. Community and family focused schools 2. Aboriginal elders / role models in schools 3. Aboriginal studies throughout the school curriculum 4. Anti bullying and ant-racism programs 5. Community use of school facilities (e.g. halls, libraries and sports facilities) 6. Integration of Aboriginal ways of learning 7. Cooperative efforts to increase school attendance 8. Flexible curricula allowing local input	1. Early educational day care and parent support (e.g. Best Start) 2. Supportive, stimulating pre-school environments 3. Life-skills education targeting risk and protective factors 4. Programs to improve literacy and numeracy skills 5. Sexuality and relationship education programs 6. Drug and alcohol education and harm-minimization initiatives 7. Strong men's (health) initiative 8. Availability of sport and other recreation based activities	1. Promotion of positive images of Aboriginality 2. Targeted local health messages 3. Compulsory cross cultural training for workers dealing with Aboriginals 4. Compulsory Aboriginal studies units within all tertiary courses with a human service focus 5. Skilling of service providers in skills of prevention and the promotion of well-being 6. Dialogue with communities to develop a shared understanding of local needs and prevention options 7. Professional and personal support for Aboriginal	1. Purposeful State and Commonwealth agency partnerships 2. Policy, planning and service delivery partnerships extending to the community level 3. Shared knowledge of key causal processes and developmental outcomes of concern 4. Development of shared goals and outcomes 5. Collaborative funding arrangements and accountability 6. Recurrent funding tied to evaluation 7. Program structures that encourage local response to identified

10. Structures for youth input at all levels 11. Safe places for young people			9. Education and training initiatives linked to real job prospects 10. Alternative to custody	workers in communities	outcomes; connect to indigenous values and affirm connection between people place and land 8. Increased resources for primary levels of prevention
Meeting Information Needs: All of the above need to be informed by community knowledge and scientific evidence of: 1) what promotes resilience and well-being; 2) how community well-being protects against suicide; 3) why interventions in the early years of life and at other key transition points are more effective; 4) how programs can be effectively evaluated; 5) what programs and strategies have been implemented successfully in comparable settings; 6) what can be done to facilitate community to community dialogue about prevention and the promotion of well-being.					

(NOTE: The rationale for each these suggested strategies is detailed in Appendix 1.)

The range of possible solutions canvassed highlights the necessity of addressing the multiplicity of factors which may lead to adverse outcomes for Aboriginal children their families and communities.

3.4 Evidence–based programs of prevention

Programs reviewed in the literature which have been shown to be most successful in the long term are those which:

- are implemented from the earliest stages of child development
- extend over a reasonable period of time (e.g. for at least a year)
- address multiple of risk and protective factors
- are targeted to key transition periods at various stages throughout a young person's growing up years (e.g. the transition from home to school, primary to high school and school to work).

The evidence-base for universal strategies of prevention is largely informed by studies across Australia, Europe and North America. Few of the existing evidence-based interventions have been trailed or adapted to the needs of Aboriginal communities. While some of these strategies and programs may be adaptable to the specific needs of Aboriginal families and communities, there remains significant scope for locally initiated action to address specific local requirements. Examples of successful local adaptation of such programs include the 'Bibilung Gnarneep' home visiting program, programs improving the availability of high quality early childhood care and early education such as in the Family & Children's Best Start' program, school based programs to improve school attendance and retention, recreation based programs for youth; and community mobilization programs such as the 'Communities that Care' which facilitates community involvement in providing effective support for families with young children and adolescents in high-risk neighbourhoods and communities.

Reducing the high rate of Aboriginal suicide and self harm across Western Australia is likely to require a mix of programs that builds upon existing evidence based preventive interventions with suitable cultural adaptations and also includes new prevention initiatives. Wherever possible, such responses should be informed by their evaluated effectiveness at the local community level by Aboriginal people with appropriate expertise, within Aboriginal terms of reference.

Resources should be allocated to enable the cultural adaptation and evaluation of existing evidence based programs of prevention successfully implemented in other settings

3.5 Overcoming service coordination failures

Many Aboriginal families facing complex and interrelated difficulties such as poverty, family violence, substance misuse, truancy and involvement with the justice system, also experience the added problem of systems abuse from the number of different agencies, with differing agendas which seek to 'repair or rehabilitate' the family, or who otherwise become involved in their lives in an inappropriate or uncoordinated manner. Positive social and emotional well-being outcomes in communities are interdependent – what happens in the health, welfare sector or education sector for example, impacts upon outcomes in other sectors.

The joint involvement of Aboriginal and non-Aboriginal health, education, welfare and other agencies is critical for effective long-term planning and delivery of universal prevention initiatives. Facilitating the necessary level of collaboration and coordination across Government and in partnership with Aboriginal controlled agencies

will require political resolve and community leadership at all levels. It will also require the development of broader collaborative planning processes which identify mutually agreed outcomes, which enable the possibility of joint funding where appropriate, and the development of partnership agreements which clarify shared and reciprocal responsibilities

Existing failures of service coordination need to be identified and addressed at the State, regional and local community levels. This will require political will and leadership to ensure that administrative reforms to improve service coordination across government departments and between service sectors are implemented.

3.6 Proposed strategies for coordinating preventive interventions

3.6.1 Overcoming existing barriers to effective coordination

Critical to the success of strategically targeted and 'joined-up' efforts to promote children's health, education and the social and emotional well-being of children, young people and their families and communities is the need to overcome existing barriers to effective coordination.

These include:

- Outcomes common to more than one agency are often not jointly considered by the respective agencies.
- Outcome measures are frequently not identified which makes it difficult to determine the extent to which outcomes are being achieved.
- The right mix of outputs needed to achieve the desired outcome is seldom identified.
- Government accountability processes are not responsive to accountability for overlapping outcomes. It is therefore not clear who should be accountable for producing the right outputs in the right quantity with right quality and at the right time.
- Responsibility for funding is not clear. Inter-agency initiatives are very hard to resource as these often rely on contributions from several sources. It is also hard to determine which component of the initiative should be funded by which agency.
- Processes for monitoring and evaluation of effort across agencies are often times not in place.

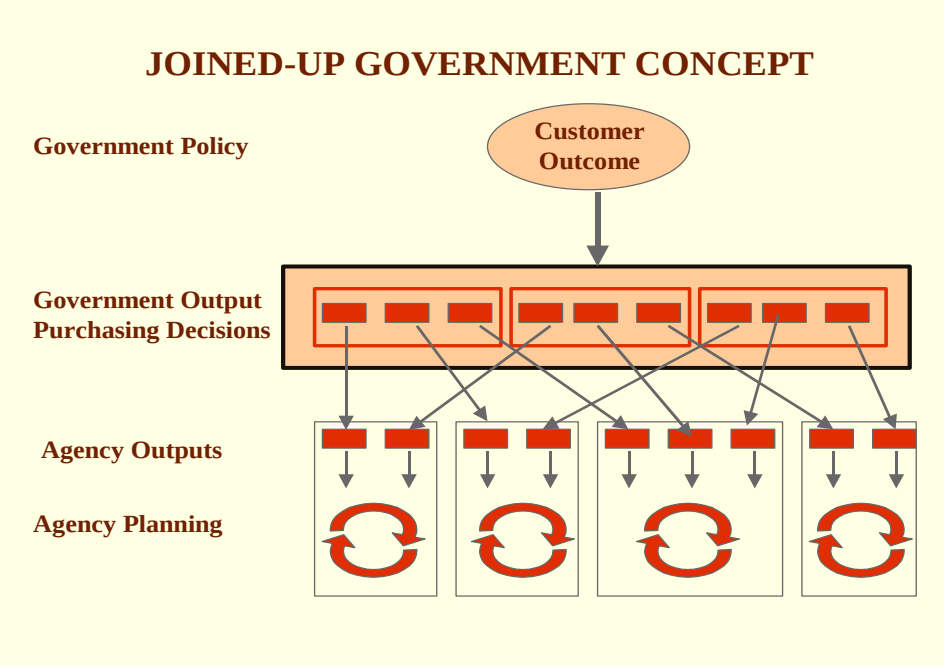
The need for effective coordination and collaboration is much more pronounced in Aboriginal affairs where these barriers are continuously being experienced and improved outcomes have been so much slower to progress.

3.6.2 AAD model of 'Joined-up Government'

In attempting to overcome these problems the Aboriginal Affairs Department has recently proposed a model for 'joined-up' government to address each of the six current priority issues in Aboriginal affairs (Acacio, 2000). These priority issues are:

1. Reducing the over-representation of Indigenous people in the criminal justice system
2. Eliminating sub-standard living conditions in Aboriginal communities
3. Preventing suicide and suicidal behaviour among Aboriginal youth
4. Increasing the capacity of Aboriginal individuals, families and communities to engage in commercial enterprise
5. Protect and manage Aboriginal heritage and culture through effective relationships between government agencies
6. Increase ownership and control of land by Aboriginal people

Figure 3.



This diagram illustrates the way in which the 'joined-up' concept, enables the delivery of policy advice that is focused on a desired outcome, and brings together relevant agencies to determine the right mix of outputs to be purchased by government from these agencies. Customer (community) outcomes therefore inform Government output purchasing decisions. The joined-up government concept also provides the framework through which agencies are able to truly incorporate collaborative effort in their agency and inter-agency planning processes.

For example in considering the AAD priority issue 3 (Reducing suicide and self harm among Aboriginal youth) there could be several types of outputs needed:

- The first group of boxes could represent a combination of legislation or regulatory type of outputs that could be purchased from health, education, family and children's services, police, justice and

community controlled agencies to ensure that those individuals at highest risk have access to appropriate treatment and standards of care

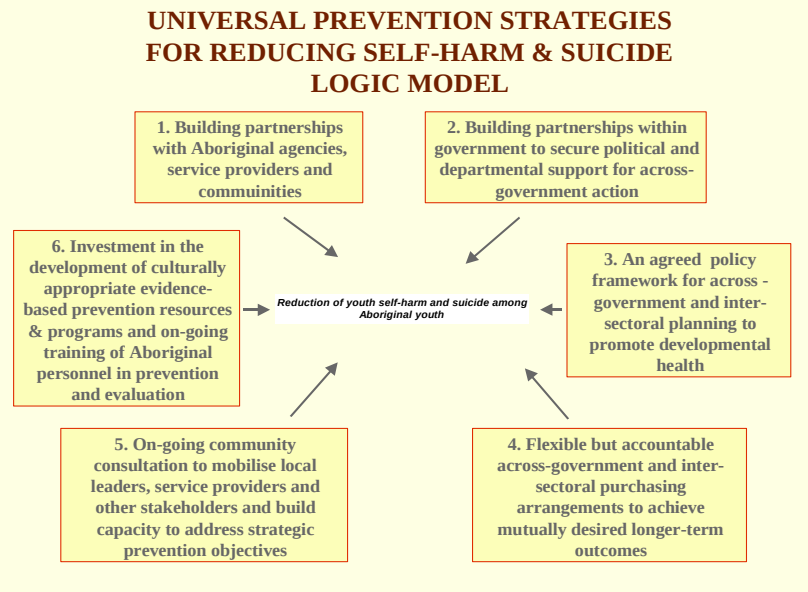
- The second group of boxes could represent the training and workforce infrastructure investments needed to ensure that service outputs (access to treatment and standards of care) can actually be provided and maintained.
- The third group could represent a mixture of service type outputs focusing on universal, selected and indicated preventive interventions to be purchased from health, education and family and children's services, police, justice and community controlled agencies.

What the 'joined-up' concept of Government and community partnership thus delivers is a focusing of the business of government on customer outcomes; it integrates the business of agencies as a whole-of-government effort; it enables better informed budget allocation decisions by providing government advice on the right outputs to purchase, and it enhances the effective and efficient delivery of government services through better coordination and integration, and minimizing duplication.

3.6.3 Program logic for achieving a long-term reduction in Aboriginal youth suicide

Reducing Aboriginal youth suicide requires achieving certain **strategic objectives and results** which are pre-requisites to the ultimate objective. In terms of program logic, these strategic objectives or results operate like levers. The theory is that if the right amount of pressure is applied to these levers, then there is an expectation that a positive impact on rates of youth self-harm and suicide can be achieved.

Figure 4.



a) The first is building partnerships with Aboriginal agencies, service providers and communities to develop a shared understanding of suicide and self-harm and what can be done to address the issue through long-term universal prevention. Through the development of such partnerships strategic objectives can be identifies which are most relevant to perceived community need.
b) The second is building partnerships within government to achieve the necessary level of political and departmental support from various relevant departments and areas of service having responsibilities for children, families and communities or who are impacted upon by the problems of suicide and self-harm and other adverse youth outcomes

c) The third developing a agreed framework for across government and inter-sectoral planning to promote the developmental health of Aboriginal children and youth. This result could be viewed as a policy advice output.

d) The fourth is the development of across government and inter-sectoral purchasing arrangements directed to achieve better statewide, regional and local coordination of basic services to achieve strategic objectives in environmental health, maternal and child health, parenting and quality of child care, early education, schooling, vocational preparation, recreation and involvement in cultural and community life. Such purchasing arrangements need to be sufficiently flexible to address specific local needs but also be clearly accountable.

e) The fifth is initiating community consultation on a region-by-region and community-by-community basis to mobilize key community leaders, service providers and other local stakeholders to assist the effective local coordination of action which addresses specific local needs in prevention.

f) The sixth is investment in the development of culturally appropriate prevention resources and in advancing the knowledge and the service infrastructure needed for implement and evaluate large scale systematic programs of prevention. These could for example include adaptations of evidence-based programs shown to be effective in other settings (e.g. the Triple-P parenting program, school-based life-skills programs to prevent depression and substance abuse, adolescent mentoring and vocational skills training programs). This investment in the infrastructure for prevention also includes provision being made for the on-going training of Aboriginal personnel and capacity building of service providers to ensure that prevention initiatives are bedded down into routine service provision and can be sustainable in the longer-term.

4. Estimated costs of implementation

The first program logic steps build partnerships with Aboriginal agencies, service providers and communities has been underway for the past two years. The only direct cost here has been a one-off seeding grant $45,000 from AAD for the appointment a .6FTE project officer to assist the Aboriginal Suicide Prevention Steering Committee in conducting a literature review, facilitating community consultations and providing administrative support to the Committee. Applications have now been made to the HDWA Mental Health Division and the National Suicide Prevention Strategy funding (DHAC) for this position to be funded at 1.0 FTE in 2001/2002.

a) There are no additional direct costs in implementing the second and third logic steps i.e. to build partnerships within government and to develop an agreed policy framework. Similarly, there are no direct additional costs in the fourth step to develop flexible and accountable across government and inter-sectoral purchasing arrangements.

b) The initial major cost will be to initiate a State-wide process of community consultation over the next 12 months. This will involve facilitating regional consultations e.g. in each of the State's ATSIC regions. It will also involve initiating local community consultation processes following a community development model in remote and other discrete Aboriginal communities with identified high levels of need. This would entail the costs of employing and training of a team of Aboriginal facilitators, professional support, travel and accommodation expenses. Detailed costings can be developed once the scale of consultation process is determined. Depending on the scale and level of consultation undertaken the likely cost in the first year would be somewhere between $0.5 and $1 million.

c) In terms of the sixth strategic objective - investment in development of culturally appropriate evidence-based prevention resources and programs there has already been significant State Government investment in capacity building through specific components of the 'Building Blocks' initiative (the Aboriginal intensive home visiting program, and the 'Strong Women's' program), and the State's Domestic Violence and Substance Prevention Initiatives. The HDWA and the FACS have also recently expressed interest in commissioning the development of Aboriginal specific parenting programs. The initial development costs to implement and evaluate systematic culturally appropriate universal prevention programs targeting infants, children in the pre-school and primary years, and teenagers is likely to be in the region of $5 million over a three year period (2001/2 –2005/6).

While the start-up costs in getting such across-Government and intersectoral programs established may appear high, there are interested government and community stakeholders who would see this as falling within their current purchasing intentions. There is also a growing realization of the potential cost savings of systematic universal prevention. This view is supported by evidence from several randomized control trials of large scale early prevention programs which targeted similar high-risk populations in the USA. These have shown that for each dollar spent in systematic prevention up to seven dollars can be saved in subsequent government costs in health, education, welfare, justice and lost tax revenue (RAND, 1998). The estimated annual cost of an eventual Statewide implementation of a selected set of population based programs targeting children at critical points in their development (from pre-conception to early adulthood) is likely to be somewhere between $5 and $10 million dollars annually. Securing this level of funding will require contributions from State and Commonwealth portfolios of Health, Family & Children's Services, Education Justice and Aboriginal Affairs.

5. Conclusion

Governments cannot afford NOT to address the issue of suicide within Aboriginal communities – the cost of continued alienation and despair of young people is too high. Communities in partnership with government and the broader Australian society need to be supported to provide their young people with positive life outcomes and with the cultural, spiritual, educational and personal lifeskills to manage the challenge of living in rapidly changing times. It is essential that the universal preventive interventions implemented intimately involve and are determined by the Aboriginal community, and that they are supported by a commitment to long term and structural change in government policy, planning and service delivery which supports community determined solutions.

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APPENDIX 1 : Possible Intervention Strategies

This list of possible strategies was derived from the literature review and consultation with Western Australian Aboriginal communities and organizations. It is a sample of community and scientific wisdom about practical steps which could be taken to enhance the strength and resilience of communities and families in their shared task of raising children and young people to take their place in Aboriginal and the general Australian societies. To effectively address the complexity of the issues associated with suicide it is clear that a broad range of initiatives is required to address the specific needs of individual communities and regions of the State. It also requires a comprehensive set of initiatives which are appropriate to the needs of children, young people and their families throughout the developmental life cycle.

Community centered initiatives

Whole of community approaches aim at creating environments that contribute to social and emotional well-being, through fostering of initiatives that build connection and support in and across communities; increase literacy with regard to well-being and mental health; strengthen connection to spirit, culture and identity and reduce stigma and discrimination.

Strategy	Rationale
Indigenous well-being/ healing centres/ programs	As recognised above, indigenous conceptions of mental health and well-being are more holistic and spiritually based than non-indigenous conceptions. Likewise there is evidence that, in the hierarchy of responses to mental health problems for indigenous people, mainstream western responses are often a last rather than a first resort. Culturally derived models are more likely to effectively address indigenous peoples' needs regarding social and emotional well-being, and responses to the stress and trauma of acculturation or alienation from broader Australian society. Within indigenous well-being/ healing models, western responses may be incorporated where and as appropriate.
Flexible CDEP that supports families and communities	While CDEP programs within communities are regarded as having some tangible benefits, they are also seen as a 'dead-end' within communities. Feedback suggests this should be utilised as a development program that operates as a prelude to paid jobs / genuine employment. (i.e – more akin to USA & Canadian Youth Corps models rather than the more welfare based model of CDEP that currently operates). Likewise there should be a capacity to use this program flexibly to open up employment options for young people in particular, within work areas that contribute to community capacity and well-being.
Camps valuing indigenous culture	Understanding of and pride in identity is a significant protective factor for Indigenous Australians. Cultural camps allow opportunities for return to country and imparting of cultural knowledge and stories, which are key factors in promotion of well-being – "Remember where you come from, remember who you are'. Such strategies allow a connection to ancestry, which may allow young people, disillusioned by immediate role models around them who may not embody strong cultural connection, to reach back to those who do.

Effective community justice mechanisms	The values of the community are supported in the way that community justice is administered. The authority of Community justice processes (Councils and Wardens) need to be effectively backed up by community elders and the availability of mainstream services such as the Police and Family & Community Services.
Creative arts programmes connecting to spirit and identity	There are numerous examples of the success of creative arts approaches (e.g., painting, story telling, psychodrama) in working with Aboriginal people. The strength of such approaches is that they are visually and orally based mediums that connect with traditional ways of enlivening and articulating spirit and identity. They constitute encompassing means of self and cultural expression and are an accessible means of expression for Aboriginal people. Programs utilizing such approaches should be regarded as viable therapeutic interventions, rather than being rejected as arts not health based approaches (as has been experienced with a number of funding applications for such programs).
Local initiatives to address alcohol and drug use and limit access to alcohol and drugs	Harmful alcohol and drug misuse is highly correlated with suicide, and shares many of the same risk factors. Evidence suggests that locally initiated strategies delivered through Aboriginal agencies are likely to have greater impact upon reducing harmful drug or alcohol use.
Mentoring and availability of positive role models	A positive relationship with a supportive adult is a strongly protective factor in prevention of suicide across cultures. Aboriginal young people, who experience alienation from immediate family members and perceive a lack of cultural strength or integrity amongst those in their more immediate family groupings, need the support of strong role models and mentors who can connect them to a positive sense of their self, culture and identity. These people need to be immediately available within their communities, rather than sporting heroes etc, who they may have difficulty in perceiving as 'like' them.
Suicide prevention and postvention training	There is a strong need for training in communities to raise awareness regarding early identification and support of those who may be at risk. There is evidence that depression and other states of poor mental health are seen as characterological traits as opposed to transient states of unwellness by many Aboriginal families. Likewise there is a strong element of impulsivity in many Aboriginal suicides, and suicide data strongly supports the role of contagion in completed and attempted suicides among Aboriginal young men. Thus greater literacy within communities regarding identification and response around mental health issues is required.
Grief support services	The 'Bringing Them Home' report documents the profound and reverberating impact past policies of separation from family and dislocation from country have had on Aboriginal nations across Australia. This has left Indigenous Australians with a legacy of grief

	which is inter-generational in its nature, and is further complicated by ongoing high levels of loss within Indigenous societies, often due to direct and indirect consequences of the continuing legacy of Aboriginal oppression and cultural destruction. Services and opportunities supporting resolution of this grief at an individual and communal level are essential to the future well-being of Indigenous Australians.
Structures for youth input at all levels	It is important youth are offered the opportunity for self-advocacy within their own communities, and at a broader state and regional level as part of a genuine effort at empowerment. There is much government rhetoric about youth being the future of Australia. Without genuine commitment to listening and actioning ideas for their wellbeing we risk handing them a future without hope or a sense of self-efficacy. The need for effective youth forums at all levels has been strongly supported by young Aboriginal people across the state.
Safe places for young people	Young people have consistently highlighted the need for safe places to retreat from violence and abuse that surrounds them in some circumstances. The harmful consequences of exposure to abuse and violence are well documented in research. Young people need the option of seeking safety and protection. Such 'safe places' would need to be implemented with sensitivity to broad community and family needs, in order that they support, rather than undermine community and family well-being.

Family initiatives

Strategy	Rationale
Strong Women's programs preventing early pregnancy	Early pregnancy is a recognised factor for possible later adverse outcomes for both young parents and their children. Assisting young women to access personal and cultural strengths and to make informed life choices is likely to assist in prevention of early pregnancies.
Good pre-natal nutrition and health care	Good prenatal care and adequate nutrition for both the mother and the baby dramatically reduce the likelihood of premature and low-birthweight babies, (risk factors for later mental health problems for children). Such prenatal care should include parental access to quality medical care and advice, understanding of and access to good nutrition, health and education for parenthood and maintenance of good social supports.
Young Mum's programmes that include good post-natal care	Support for parents and families early in their children's lives has been demonstrated as effective in preparing parents to cope with difficult times in the care of their children and avoiding some of the long term consequences of child abuse. There is potential to achieve long term mental health benefits from programs that enhance parenting skills and promote secure safe attachment between caregivers and infants. Interventions including a combination of home-visiting and educational childcare programs have evidence of effectiveness.
Culturally appropriate parent education through the lifespan for babies, toddlers, children and teenagers	Parents require practical skills and information about how they can support their children's well-being and sound development. Children's and families' needs change as they develop. Programs to help parents to develop these skills and competencies at significant stages through the lifespan (e.g. early childhood, the middle years, adolescence) can assist to promote strengths within families, and to support their ability to access effective informal and formal supports in times of difficulty or need. The practice of removal of Aboriginal children from their families has had a devastating impact on generations of Aboriginal parents. It is essential that parenting programs acknowledge, reconnect with and are based on the strength of Aboriginal parenting practices, which have been systematically undermined by past policies. It is the strength of parenting and connectedness that have contributed to the resilience existent among Aboriginal people today.
Culturally appropriate parenting programs for fathers	Positive fathering is an important protective factor particularly for boys and young men. This can be promoted through Aboriginal media through practical suggestions and role modeling. Parenting programs for fathers in prison have been shown in overseas studies to improve post-release outcomes for children, families and fathers.

Family violence prevention programs	The detrimental impact of family violence on children is well documented. Exposure to violence and a stressful environment early in a child's life is a risk for later adverse outcomes. Aboriginal women and children are at higher risk than the general community of being subjected to family violence. Effective programs that intervene systemically offer a greater likelihood of impacting upon this problem.

Initiatives for Young People

Strategy	Rationale
Early educational day care and parent support (eg Best Start)	As articulated above, there is good evidence that strategies fostering attachment of children and their caregivers, and providing a safe, stimulating and engaging learning environment for children in their first years, are effective in promoting health and well-being in children and their families. Such programmes need to support children's acquisition of language skills, and formation of good social relationship skills. Strategies for parents include supporting consistent and fair behaviour management practices and increasing parents' knowledge and skills in issues of health, education and child safety. This needs to be done in a manner that acknowledges the strength of Aboriginal parenting practices and embraces culturally derived models of practice in these areas.
Supportive, stimulating pre-school environments	Such environments support the social and emotional development of children. They provide an opportunity for detection of and appropriate intervention with regard to problems of language development, speech, social and behavioural problems, which are identifiable early in children's lives.
Lifeskills education targeting risk and protective factors	There are now several life-skills training programs which have been shown to be effective in improving the resilience, health, education, social and vocational outcomes for young people in both developed and developing countries (WHO). These skills include communication and social skills; problem solving, planning and decision making skills; managing emotions such as anger or depression, non-violent conflict resolving skills, and skills for developing self-esteem, confidence and self-responsibility.
Programs to improve literacy and numeracy skills	These are a key skill promoting later life opportunities such as management of personal finances and transactions with broader Australian society. A sound level of literacy and numeracy are keystones to later employment options. They are essential skills in promoting a sense of personal empowerment and in reducing alienation. Access to development of literacy and numeracy skills needs to exist in community facilities where those who are alienated from the formal school system, or are beyond compulsory educational age, have the opportunity to access these skills.
Sexuality and relationship education programmes	There is a high rate of teen pregnancy and concerns that many young people in Aboriginal society are beginning relationships without skills to foster healthy relationships or to avoid early pregnancy. Substantial research links teenage pregnancy with being both an outcome of and a continuation of the perpetuation of poverty cycles and negative environmental circumstances.

	Likewise pregnancy intention is correlated with lowered self-esteem and lowered educational aspirations. Thus efforts to skill young people to make safe and self nurturing choices, delivered in the context of broader interventions aimed at supporting families and communities, are a critical factor in supporting positive outcomes for young people and their families.
Drug and alcohol education and harm minimization initiatives	Indigenous approaches to health education and health promotion are recognised to be the most effective way of reaching young people. These need to be communicated through Aboriginal and youth oriented media such as radio, TV, music, drama, posters, sport, art and other community events.
Strong men's well-being initiatives	The suicide rate in young Aboriginal men 15-25 years of age is higher than in any other population group in Australia. Substantial anecdotal evidence relates this to a marginalisation and loss of role within contemporary community life for Aboriginal men, as a result of broader structural and social changes brought about by the continuing impact of colonisation. Many Aboriginal men lack outlets other than drugs and alcohol for their emotions and often feel they have no-one they can talk to without feeling shame. A range of initiatives that strengthen positive roles for men in communities and that support pride and connection in spirit and culture are needed.
Education and training initiatives linked to real job prospects	Employment is seen as central to improvement of well-being among Aboriginal people in the long term. Education is crucial to expand opportunities with regard to access to employment. It is also allows personal control and empowered access to and involvement in aspects of daily living within broader Australian society. Education and training are required in order that Aboriginal people are able to compete equally for jobs in the labour market. Employment of Aboriginal people within organisations should reflect the rate of Aboriginal utilisation of that service. Traineeships within government agencies employing Aboriginal people should be offered to skill local Aboriginal people in service provision within their communities.
Alternatives to custody	The Aboriginal Justice Plan is currently considering a range of alternatives to custody to reduce the unacceptably high rate of incarceration of young Aboriginal people. These include diversionary programs, wider recognition of Aboriginal customary law, community conferencing in which crime victims participate in determining appropriate restitution and punishment.
Sports programs / facilities for kids and families	Physical activity and good physical health have been shown to be a protective factor against depression. Sport is a purposeful activity and is actively embraced by Aboriginal people It is a forum for engagement of young people and has the potential to integrate

	lifeskills learning opportunities within this. Often in more remote communities facilities are inadequate or non-existent, or in rural communities families have difficulty in affording funds for travel and equipment. There needs to be access to sporting opportunities for young people and families at community level.

School Initiatives

Strategy	Rationale
Community and family focused schools.	Adoption of such a focus in schools has been linked with increased family, community and individual well-being. There is more of a partnership in raising children that comes from an environment where parental and family input is encouraged, rather than alienated. Such an approach is particularly critical in working with Aboriginal students and their families, given the historical and continuing alienation of Aboriginal people within mainstream educational institutions. Community involvement must be strongly fostered in order to increase positive academic and social outcomes for Aboriginal children. A school environment where Aboriginal families feel welcomed rather than alienated
Aboriginal elders / role models in schools.	This is an effective way to convey cultural understanding -–both for Aboriginal students of their own culture and for non-Aboriginal students, in order to promote greater awareness and understanding of Australia's original people. The Aboriginal speakers program run in WA schools was seen (in consultation feedback) as a very positive contribution to fostering cultural awareness. There is a need to extend this and to integrate it with Aboriginal studies streams within school curriculums (see below).
Aboriginal studies throughout the school curriculum.	Racism and a lack of understanding and acceptance from broader Australian society is seen as a significant risk factor with regard to the rate of suicide within Indigenous communities in Australia. While there is a developing understanding of the history of colonisation and subsequent government policies within the general community, many misconceptions still exist. Implementation of Aboriginal studies throughout the school curriculum (primary and secondary) in a manner acknowledging it as vital and alive (as opposed to a pre-historic artifact) provides a significant counter to such misconceptions and would increase understanding acceptance and valuing of Aboriginal and Torres Strait Islander cultures within the broader community.
Anti-bullying and anti-racism	Substantial research exists internationally regarding the negative impact of bullying and racism on children's well-being. A whole-of school approach to these issues, whereby altering the school

	organisation and system, in addition to approaches within the classroom, have led to a reduction in bullying and racism and improved academic outcomes for all students.
Community use of school facilities.	Schools constitute valuable potential resources within communities – having a range of facilities appropriate for recreation, community education etc. After hours access to such facilities would be part of fostering a community accessible school. A number of initiatives involving school-based family support programs in early school years, have demonstrated success in building effective parent-school partnerships.
Integration of Aboriginal ways of learning	Aboriginal students have recognised differences in learning styles, when compared to western children's learning styles. Further accommodation of this into teaching systems through education of trainee teachers and teaching staff, and practice changes within schools is likely to enhance academic outcomes for Aboriginal children.
Cooperative efforts to include high levels of attendance at school	The school in partnership with the local community should develop strategies to increase and maintain attendance of children within schools, particularly in the critical early years, where early intervention may support more effective learning and achievement in the later years. This will require comprehensive and coherent approaches, rather than piecemeal efforts.
Flexible curricula allowing local input.	It is important local communities are actively recruited and encouraged to participate in schools around the aims of education and the nature of learning in schools – with the possibility of input into curricula to ensure relevance of learning to the local community / region.

Initiatives Targeting Broader Society

Strategy	**Rationale**
Promotion of positive images of Aboriginality.	The media has significant influence on public opinion and attitudes. As such it may be used to promote understanding and acceptance of diversity and positive messages to reduce discrimination. An exercise on behalf of the Equal Opportunities Commission by the Shorter Advertising Group provides evidence of the success of such media campaigns. Prejudice and racism are strongly linked to alienation of Aboriginal youth – a source of significant risk in suicidal behaviour for Aboriginal youth.
Targeted local health messages	Health messages regarding a range of well-being issues (e.g. the association between suicide and a range of factors such as harmful

	drug use, offending, learning and education and employment, sexual abuse etc) need to be made available in youth friendly means, and also in manners accessible and appropriate to particular communities. These need to challenge community perceptions around acceptance of underage drinking, binge drinking, drug use, risk taking behaviours of young people etc. Evidence suggests that media campaigns, when conducted in conjunction with appropriate community activities, can improve mental health literacy (CDHAC, 2000). See Spark, R (1988), as an example of successful community devised health messages.
Compulsory cross-cultural training for staff of agencies with an Aboriginal client base.	It is recognised that a lack of sensitivity to Aboriginal culture, values and knowledge constitutes a significant barrier for Aboriginal people in accessing services. Racist or discriminatory attitudes and inappropriate interactions with Aboriginal people have been recognised both as a correlate of alienation and suicide in Aboriginal communities; and as a barrier too effective access to protective measures against suicide. The 1998 *'Across Government Plan'* recognised the need for non-indigenous staff who routinely work with young people, to be given training to increase their cultural sensitivity for working with Aboriginal youth. Training needs to extend beyond this. This also impacts on ensuring appropriate design and delivery of services, and realistic demands of Aboriginal staff within organisations. Thus training in cultural sensitivity is required for ALL staff across sectors that work with Aboriginal people or communities (e.g. state government agencies, local government, other agencies and services), in order to promote understanding, acceptance and valuing of Aboriginal and Torres Strait Islander peoples. Aboriginal people consulted were very clear such training should not be restricted to those at a service delivery level but should be compulsory throughout all levels of organisations to assist the cultural responsiveness of organisations to Aboriginal clients and colleagues.
Compulsory Aboriginal studies units within all tertiary courses with a human service focus.	A lack of empathy or understanding is experienced by Aboriginal people from the broader society in a number of ways on a frequent and ongoing basis. Implementing a compulsory Indigenous studies stream within university courses that train professionals likely to work with Aboriginal people or communities, means people are prepared and have a greater level of awareness prior to working in professional contexts with Aboriginal people. Such tertiary courses as teaching, nursing, psychology, social work, medicine and dentistry should be included in this. An experiential component allowing an insight into the vibrancy of Aboriginal culture is strongly recommended as a component of such studies.
Skilling of service providers in skills of prevention and	The successful implementation of an effective strategy of universal prevention will require investment in appropriate training of service professionals to develop an understanding of the merits and

promotion of well-being.	approaches required for implementation of such strategies and to ensure an appropriate level of skills for this.
Dialogue with communities to develop shared understandings of local needs and prevention options	It is important community members are supported to understand prevention response models and rationales and to ensure preventive and treatment approaches are amalgamated with Indigenous understandings so that idiosyncratic models of intervention, relevant at the local level, are derived.
Personal and professional support for Aboriginal workers in communities.	Historically programs have been purchased by government for communities with a very lean allocation of funds, focussed on service provision. This has resulted in piecemeal services, inadequately resourced to provide a service able to genuinely meet identified outcomes. Effective program outcomes will require adequate funding and structural changes that ensure adequate skilling of Aboriginal service providers, and regular support and supervision to prevent burn out. Local Aboriginal staff are exposed to a level of trauma and grief which is part of their lived reality not just in the work setting but in their community as well. While they are often best positioned to work most effectively with members of their local community, the personal impact of a lack of relief from the level of grief and trauma present in communities must be acknowledged in service planning for effective outcomes.

Initiatives Targeting the Political Processes

Strategy	Rationale
Purposeful state and Commonwealth agency partnerships.	A range of factors impact upon mental well-being across many domains of everyday living. Promotion of well-being and universal prevention approaches requires cooperation, commitment and partnerships that reach across the spectrum of government services and across the community. It is important government agencies develop coherent, focussed working strategies that recognise that their distinct services often contribute to the same outcomes for families and communities.
Policy, planning and service delivery partnerships extending to community level.	The nature of mental health promotion and prevention approaches requires people working together within and across all sectors of the community. It is essential that structures exist at all levels of departments and agencies to allow effective collaboration amongst stakeholders at each level. Time for such activities must be delegated as part of core job responsibilities and endorsement for such collaboration needs to be actively promoted from the highest level of departmental and agency structures. Likewise mechanisms for feedback between levels within and across agencies and departments must be articulated and functional.
Share knowledge of key causal processes and developmental outcomes of concern	To effectively enact effective prevention strategies, it is important that agencies and communities are literate in this approach and share the same understandings (i.e. speak the same language) with regard to causal factors relating to and outcomes sought as a consequence of interventions/ policies/ programs.
Develop shared goals and outcomes	Goals and outcomes sought from such collaboration must be clearly articulated and shared, to ensure coherent and purposeful action toward outcomes of promoting social and emotional well-being and reducing risk in communities.
Collaborative funding and accountability.	It is necessary that such across government initiatives have across government funding strategies, where funding is pooled, rather than requiring accountability to a number of different departments with a variety of different reporting mechanisms.
Recurrent funding tied to evaluation	Such prevention approaches require a commitment to long term strategies, and hence long term funding. Outcomes aimed at reducing the prevalence of risk are not immediate but are the result of sustained effort. It is essential adoption of a prevention approach is seen as a long term commitment. Evidence suggests universal prevention responses are the best known way of reducing risk within communities and strengthening factors that support well-being. Recurrent funding will be required to ensure the sustainability of effective initiatives. Evidence that programmes are

	working in a manner likely to achieve the required outcome should be demonstrated before further funding of an initiative.
Develop program structures that: *encourage local response to identified outcomes; *connect to indigenous values and affirm connection to people, place and land	It is essential that program and funding structures and approaches promote rather than constrain local solutions that are holistic and culturally valid. This requires flexible policy, planning and funding structures that identify clear outcomes required but are not deterministic regarding the way in which such outcomes are achieved.
Increase resources for primary levels of prevention.	Currently funding across government is heavily weighted toward tertiary (clinical and treatment) responses. While the continuation of treatment services is necessary, responses limited to this level will not ever meet the need for service and will not serve to reduce the prevalence of suicide or compromised mental health within the population. A re-orientation of government to resource primary prevention is essential for community, family and individual well-being.

Meeting Information Needs

All of the above strategies need to be informed by community knowledge and scientific evidence regarding resilience and well-being in Aboriginal community contexts. There is a need to:

Strategy	Rationale
Find out more about what promotes resilience and well-being.	A considerable amount is known about risk and protective factors that impact upon suicidal behaviours. Research is now also at a point where there is a strong evidence base on the value of early intervention to prevent the onset of problem trajectories leading to adverse outcomes such as offending, harmful drug use or suicide. Knowledge regarding effective intervention in Aboriginal communities is not as developed. A continuing effort is needed to understand with more specificity how best to ensure effective intervention in indigenous communities.
Promote understanding of how community well-being protects against suicide.	See below
Promote understanding of why interventions in the early years of life and at other key transition points are effective the importance in promoting individual and community well-being.	Wide spread dissemination of information relating to these approaches is required in order to improve mental health literacy amongst service planners, providers and communities. Ongoing supportive education and training is needed to keep policy-makers and practitioners current with research and motivated regarding such an approach.

Ensure thorough evaluation of programs in communities.	All intervention relating to such an approach requires evaluation at a community level, within ethical guidelines appropriate to the community in which the evaluation takes place. While there is a growing body of evidence regarding effective prevention approaches, such evidence is not situated within Aboriginal community contexts. It is important all approaches are developed from an Aboriginal perspective, utilising prevention science where valid. All efforts should be evaluated for their effectiveness in order that Aboriginal and Torres Strait Islander communities acquire a culturally relevant evidence base for interventions.
Create / find/ adapt evidence based community education and prevention programmes	It is important Aboriginal people are supported to develop culturally relevant interventions to promote well-being and protect against suicide and poor mental health. These culturally relevant interventions may be devised from scratch or adapted from other evidence based preventions, which have proven efficacy for other populations.
Ensure mechanisms for community to community dialogue about prevention and promotion of well-being	Part of facilitating culturally relevant responses, requires the opportunity to network with other like communities experiencing similar issues, in order that a body of knowledge may be shared regarding possible strategies and approaches to life enhancing initiatives.