Report of the Workshop on the Systems Approach to Suicide Prevention

9 December 2016
University of Western Australia, Perth

Workshop Program

8:45 - 9:00	Introduction of all participants and Critical Response Project background
9:00 - 10:00	Presentations on use of the systems approach in Australian suicide prevention trial sites and updates from Partner Organisations
Presenters:	Rachel Green, Black Dog Institute Craig McAllister, WAPHA, Peel Suicide Prevention Trial Site Rob McPhee, Kimberley Aboriginal Medical Services Clive Holt, Bega Garnbirringu Health Services
10:00 - 10:15	Morning Tea
10:15 - 12:15	Discussion
12:15 - 12:45	Lunch
12:45 - 1:30	Discussion
1:30 - 2:00	Wrap up and conclusions

Workshop Participants

Professor Pat Dudgeon, Project Director, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)
Dr Yvonne Luxford, Executive Officer, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)
Karen Phillips – Manager, National StandBy Response Service, United Synergies, Qld
Jennie Grey – Regional Manager South Metro, Anglicare WA, Perth
Rob McPhee – Deputy CEO, Kimberley Aboriginal Medical Services Council (KAMS), WA
Craig McAllister – Project Manager – Mental Health Lead Site, Western Australia Primary Health Alliance (WAPHA), WA
Sharleen Delane – Mental Health Program Lead – Suicide, WAPHA, WA
Nathan Deaves – Manager, Substance Use/Social and Emotional Wellbeing, South Coast Medical Service Aboriginal Corporation, Nowra, NSW
Rachel Green – Director, LifeSpan, Black Dog Institute, NSW
Chris Holland – Indigenous health consultant, NSW
Clive Holt – CEO, Bega Garnbirringu Health Services, Kalgoorlie, WA

Gerry Georgatos – Advocate and Consultant Critical Response Project; Senior Consultant, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)
Adele Cox – Facilitator; Former Senior Consultant, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)

Adele Cox undertook an acknowledgement of country and participants introduced themselves.

It was noted at the start of the day that the process was for open dialogue and discussion about the key issues, and a robust discussion, including questions to generate discussions was sought.

The aim the workshop was to identify which suicide prevention activities could create a culturally appropriate evidence-based systems approach to suicide prevention for Aboriginal and Torres Strait Islander people.

Presentations on the use of the systems approach in Australian suicide prevention trial sites and updates from Partner Organisations

Rachel Green, Black Dog Institute

LifeSpan Integrated Suicide Prevention – the systems approach to suicide prevention – refers to the universal nature of this systems approach.

It is not a comprehensive approach to mental health and social and emotional wellbeing, and the intention is not for it to be seen as replacing those aspects of psychosocial and community approaches that are crucial to mental health. It would be inappropriate for it to be used as a rationale for disinvestment in those services.

The need for the approach is due to the existing fragmented nature of suicide prevention programs across Australia, and the lack of evidence for existing approaches. A real barrier is limited evaluation information for communities to know what to apply and get results. The stigma attached to suicide has also been a reason for the lack of coordination.

There aren't sufficient evaluations showing what is working well or what is doing harm, and it is not easy for people spending limited funding to assess what is evidence based. Australia does not have a good track record of implementing evidence-based practice, including programs that target actual suicide prevention – there is a large gap between what has been implemented and what has been tested.

The system in the approach is about what sits around a program to make sure that the desired change actually happens.

The 9 prevention strategies are:

1. Appropriate and continuing care after leaving Emergency Departments (EDs)
2. High quality treatment (CBT and DBT) including online treatments
3. Gatekeeper training in workplaces and community organisations
4. Community suicide prevention awareness programs
5. Reducing access to lethal means
6. Responsible suicide reporting by media
7. School based peer support and mental health literacy programs

8. Training of GPs
9. Training of front line staff

Under each of the 9 strategies are a comprehensive and complex set of actions that need to happen to make suicide prevention work. Particular issues were addressed under the following strategies:

1. LifeSpan is interested in what pathways exist, and what leads to people seeking assistance/getting help. They are aware that the business rules in EDs aren't being followed so need to understand what is required to get people to do things they need to do.
2. LifeSpan is seeking to identify what sorts of therapies are needed, and what happens when people can't actually access a service. Are people getting access, are online services being used effectively, and what happens when someone does get access and continuity of care?

   There are particular issues around men where this strategy will be key. LifeSpan has a good idea of what this will look like in trial sites – including collaborative care teams and technological interventions in GP practices, such as treatment plans as soon as someone engages with a practice.

   There was a question regarding this being rolled out across all sites including Aboriginal Medical Services (AMSs) – it was noted that Lifespan is aiming to ensure AMSs are a part of this approach, recognising different contexts are needed.

3. LifeSpan wants people to not just have completed Gatekeeper training, but for change to actually occur. They are planning a benchmarking exercise to assess/evaluate what programs are available and if they are effective. This information needs to be used to assist programs to improve.

5. It is possible if all sectors work together, including looking at hotspots and reducing means, that this is one of the most effective strategies if it can be implemented.

8. Key issue is how do you make the pathways to services as easy as possible?

9. Is information being used appropriately for the purpose of training staff on the frontline?

It was noted that with the suicide prevention trial sites funding flowing through the Primary Health Networks (PHNs) to communities, that it will be need to be determined by communities what strategies they want to use. However, it is expected that the approach will be a condensed version of the systems approach. There was a discussion about the Centre of Research Excellence in Suicide Prevention (CRESP) and Black Dog Institute paper on the effectiveness and reduction of suicide with different approaches.

Core features of LifeSpan

- Locally shaped and delivered
- Collaboration between government, non-government, health, business, education, research and community agencies and organisations
- Defined geographic region

- Sustainability and long-term commitment.
- Can be used to target approaches to particular areas, for example schools

The approach is being rolled out through four trial sites in NSW, however there is an interest from the Black Dog Institute in the Commonwealth suicide prevention sites in order to have joint approaches with all services and sectors, including state services and local services.

LifeSpan responding to ATSISPEP

The presentation looked at the 9 strategies from the approach and how these might translate to the success factors for suicide prevention in community-led Indigenous suicide prevention programs.

There was a discussion about what sort of model is needed in Aboriginal and Torres Strait Islander communities – LifeSpan + ATSISPEP, or a merged, redesigned model, and how is this to be locally determined.

For more information on specific issues and sections, see the full presentation at Attachment 1.

Craig McAllister, WAPHA, Peel Suicide Prevention Trial Site

This was presented by Sharleen Delane.

Approach being applied

WAPHA will be trialling an Integrated Primary Care Model using an evidence based systemic approach to suicide prevention from the European Alliance Against Depression. It was noted that the catchment area is still to be defined by the community.

This is based on a systems approach to suicide prevention. It is a community based, four level intervention that includes:

- education of primary care physicians,
- a professional public relations campaign,
- training for community facilitators, and
- interventions with affected persons and high-risk groups.

A key issue to note is that if the four areas are not addressed and integrated, that suicide rates are unlikely to reduce. It is about giving communities the capacity to facilitate ongoing approaches, particularly so it is sustainable beyond the funding.

WAPHA is aware that most people contemplating suicide aren't accessing services, including GPs, so there is a need to destigmatise mental health services to increase access. Central to all of the approaches is the person not the services, and ensuring that the process is community driven.

Stakeholders

The central question is how stakeholders are identified. It was noted that WAPHA has a working group, which includes a range of people across the community, with the idea being that it is inclusive and if people need or want to be there, they are.

Amongst they high-risk groups, one if the most significant is young Aboriginal men.

It was noted that the ATSISPEP project is guiding WAPHA's approach, and what the community are telling them they need – such as online services. This is a small part of the overall approach.

Participatory design workshop

A participatory design workshop was conducted, with the main elements being:

1. Discovery – exploring participant practices, goals, values and needs within their group and region
2. Evaluation – participants explore and evaluate current online resources (including apps and e-tools) focusing on their strengths and weaknesses.
3. Prototyping – brainstorming with participants as they suggest ideas, sketch concepts, and envision future use and developments. Participants evaluate the new design and approve the final version.

They are adopting a whole-of-person approach and not wanting young people to have to go to several people to get help, and a key factor in this will be working through GPs. It was noted that in some regions there are no physical services, so phone services will be providing some access and service.

They are also working closely with the WA Mental Health Commission, and looking to co-commission services with them.

For more information on specific issues and sections, see the full presentation at Attachment 2.

There was a question about state education and how to disaggregate the people and groups who are suiciding. It was noted many weren't known to the system, including not being engaged actively with schools. There was also a question about juvenile detention and how that will be involved. WAPHA noted that they will be a part of the community response and that discussions are underway regarding working with young people exiting youth detention. It was reiterated that they are very much being guided by the community and who they want to be involved.

It was noted by WAPHA that what is being trialed is the approach itself and the evaluation of this. A key part will be looking at high-risk groups and the sub-cultures in these groups. It was acknowledged that the challenge is the young people who aren't engaged or known to any system.

The most important aspect of the model is the community themselves driving the process, however what it looks like and how it does that is decided by the community not the model. It was noted that the model will look different each location due to this community direction.

Rob McPhee, Kimberley Aboriginal Medical Services (KAMS)

KAMS is the peak organisation for the Kimberley region and has been in existence for 30 years. KAMS was established to provide a mechanism for AMSs in the region to come together and work regionally.

KAMS provides a Social and Emotional Well Being Training Unit across the region which is focused on suicide prevention and, more broadly, resilience and leadership. They also auspice Headspace in the region. A key factor for them is that 93% of the region is considered to be very remote, with the remainder (the big towns) being remote.

In terms of suicide prevention work, this is an area where KAMS has been involved for a numbers of years. When the Kimberley Suicide Prevention Trial Site was announced, they met with the community to determine what they wanted to tell government they needed. They held a recent workshop, which examined what suicide looks like in the region and what the community would like the trial site to examine. A key factor for them is that they also have high cases of self-harm in the region and 90% of the cases are by Aboriginal people, with around 42% of these cases being under the age of 45 years.

Self-harm data was being under-reported and they believe they are missing a significant number of cases due to this under-reporting. Overall, data collection has been identified in workshops as a significant issue. They are working to also collect data on levels of drug and alcohol involvement. From next year, KAMS services will use regional coding of suicide attempts and instances of self-harm.

It was noted that Aboriginal suicide is very different, as it is often due to people's immediate reactions to an incident, action or life events. Within this, the social determinants of health have to be addressed and be a core focus. The approaches used will be limited if this isn't addressed. A contributor to risk factors is related to not just suicide but a range of issues, noting that research has shown that around 70% of the people who committed suicide in the region had no previous engagement with the mental health system. Aboriginal people in the region are often dealing with difficult situations, and if anyone is going to address suicide, then they have to address these issues.

KAMS convenes the Kimberley Regional Aboriginal Mental Health Planning Forum that brings together service providers and stakeholders in the region. A challenge for them is to be more strategic and address systemic level issues.

When the community was brought together at the recent workshop, they saw this as an opportunity to take stock and show how the problem looked like in community. It was clear a systems type of approach is what was identified, however, there are cultural limitations with this approach, which needs to be addressed.

The workshop identified that primary health services are very *ad hoc* in the region. For example, police are most often called, a person is then taken to acute services, and then they are released. The follow-up from primary health services is very poor, noting that they are working with the PHN to improve this follow-up. A central factor will be looking for the 'hook' to provide that primary health referral, and also understanding best practice protocols for dealing with self-harm.

24/7 availability of support is a significant issue, as incidents aren't happening within standard hours and within this, young people observing suicides aren't being provided with support. These are the pieces that need to be mapped.

There needs to be a long-term strategy to pull all the pieces together, as there won't be a significant reduction in suicides in the short term. In terms of tracking success, this will change from year to year. Most approaches are very mainstream and need to be made to suit Aboriginal people. However, the systems approach is good for looking at the whole of the system.

There was a question about what in the system approach needs to be 'Aboriginalised' – is it about adapting or having workforce parity. It was noted that it is about both, but intention is to build capacity locally, to build skills in the actual community.

Clive Holt, Bega Garnbirringu Health Services

Bega have been involved in working with the community for some time and suicide is a significant issue in their rural and remote communities. Bega is currently not funded to deliver any suicide prevention related activities, although they have some social support funding and limited capacity to provide within this.

Bega has taken the approach of looking at existing services in their region with the ability to respond to suicide. They believe there should be more activity in the prevention space, and presently they having to rely on bringing people in to address suicide.

The main areas Bega has identified as being critical to any suicide prevention model being effective in Aboriginal communities are:

- Cultural safety and intelligence – this needs to be a complete cycle of care delivered within an organisation. Bega has staff who can pick up early warning signs of a person being at risk of self-harm or suicide, however after they have built trust, they then have to refer to an external agency and lose clients due to this. This ongoing care must be delivered by the AMS, who then has the capacity to deliver the complete cycle of care without having to refer to external agencies.
- Engaging with communities – one of the major issues communities are identifying is that community capacity building is needed, so they can access what is needed in the community and that people feel comfortable accessing the services they need. The emphasis should be on enabling community members to be able to identify those early warning signs and access appropriate support. These people are on the front line and see people showing signs. They have had some staff trained as ASIST trainers to enable them to go into communities and train others. They have made proposals previously to strengthen this aspect of their work, however these haven't been successful.

  The central issue is that they can't take a mainstream program off the shelf and roll this out – it needs to be adapted to each community's circumstances. A key issue going forward is whether we look at adapting existing programs, or develop a specific Aboriginal program in consultation with communities and AMSs.

Discussion points

The Facilitator identified the following topics for discussion:

- Gaps and challenges; and
- What are the opportunities we have to respond better in relation to Aboriginal and Torres Strait Islander suicide prevention?

Gaps and Challenges

When we think about a systems approach there are two ways of working:

1. Clinical
2. Socio-cultural

This comes through very strongly in consultations about what is needed and what will be effective. The central issue is what happens in the crossover or intersection between these two areas and bringing these two separate areas together. The systems approach can work, but how can we develop it to a point where it is appropriately informed by Indigenous community needs?

Discussion

A participant raised the issue of poverty, and that most Aboriginal communities living below the poverty line is a significant factor influencing Aboriginal suicide. It was argued that in the general community this factor is not as influential. Further, the majority of people who suicide in Aboriginal communities have not engaged with the mental health system; and while suicide is a reaction, it is often a tipping point. A key issue is therefore outreach and getting to those people not engaging and not involved, and it may be at the point of self-harm that they need to be engaged. A central group are also Aboriginal people exiting prison and what can be done for them to provide follow-up care and continuity of care.

The question was asked about how we link up the social determinants of health, which are crucial. This is one of the biggest challenges, but it has to be done. This is an opportunity, if we are taking a systems approach, to deal with the social determinants and make it a part of an integrated system.

It was identified that the approach has to be placed based. When considering the Kimberley, each of the regions has different approaches, personalities involved, and other differences, so there is a need to engage at a local level. It will need to be determined whether the Kimberley trial should be rolled out on a whole of Kimberley basis, or using with particular towns/regions. It first needs to be established how the systems approach makes a difference and understanding what this looks like. It was noted that it would be difficult to adopt the systems approach with a whole of region trial (although a regional approach can be done with data and referrals), because in terms of addressing local issues, programs have to be designed with local communities.

It was noted that data has been discussed during the workshop and figures stated, which highlights that suicide prevention has focused too much on clinical approaches and not enough on community based services and capacity building. The concentration of efforts and resources is in the clinical sphere rather than the socio-cultural. For many people it is about life circumstances – depression as a consequence of a set of circumstances, which is where the intersection of clinical issues and social determinants can occur.

There was a question about the fact that the systems approach in Europe and Australia does not address social factors. It was questioned whether the issue is if you try to have one approach for all areas, it won't be implementable. A clinical focus underlies the systems approach because a socio-cultural model for all for the population is impossible to achieve, although the psychosocial aspects are acknowledged. It was noted that it has been adapted in Europe to have psychosocial factors such as counselors addressed, however improvement of employment, housing and education is not addressed.

There was a discussion about the inclusion of culture and social and emotional wellbeing in the systems approach through the incorporation of Aboriginal Community Controlled Health Organisations (ACCHOs). If this strategy was developed, acknowledgement would be needed that there must be an equal partnership with Aboriginal community and the other participants – which is an acknowledgement of the current power imbalance. One mechanism to achieve this would be to have hard measures of culturally appropriate service implementation.

The issue was raised about the Federal Government implementing the Aboriginal and Torres Strait Islander Suicide Prevention Strategy, which should guide funding. PHNs must also have a mandatory provision to have Aboriginal and Torres Strait Islander representatives on their Boards, as is recommended in the ATSISPEP report[1].

There is a need to coordinate activities being funded across State and Federal governments if the systems approach is implemented. It was noted that WAPHA are advocating for government to recognise that they can't adopt the same approach in all locations, in particular for Aboriginal and Torres Strait Islander communities, and will use the opportunity to work with communities to do this differently and identify gaps. If this is not done, the process won't be effective.

What have been the challenges for non-Aboriginal and Torres Strait Islander organisations in delivering Aboriginal and Torres Strait Islander specific programs?

The Standby Response Service's whole population program does work well in some Aboriginal communities, however this is not always the case and often depends on who is contracted as the partner organisation. In designing program for Aboriginal communities they need to look at how they can work better, and whether it is better to adapt programs or start again. It was acknowledged a key part of doing this work is developing genuine partnerships led by Aboriginal communities.

There was discussion about the lack of success of attempts to use a whole of population approach in Aboriginal communities. However, if there is a specific approach for Aboriginal communities then a program is better able to adapt to each community.

A participant raised the issue that many agencies do not commission AMSs to run whole of population services because the agencies mistakenly believe that AMSs can only serve the needs of Aboriginal people. Instead such agencies commission mainstream providers, who may have limited cultural competency. It was noted that AMSs can and do provide services to the whole of a population in a region and we should start looking more at AMS' being not

[1] Dudgeon, P., Milroy, J., Calma, T., Luxford, Y., Ring, I., Walker, R., Cox, A., Georgatos, G., Holland, C., 2016, *Solutions that Work: what the evidence and our people tell us : Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*, Crawley, University of Western Australia.

only limited to Aboriginal communities, but all people in their community, and having the capacity to do this. An example is that KAMS provides Headspace and Kimberley Renal Services to the whole Kimberley population.

The issue is that community engagement and consultation takes time. There is a push from the Federal Government for PHNs to get things done to defined, quick timeframes, however if we want something different, then it is important to take the time to do this, for example if want the systems approach. Again, it is important to keep going back to the social determinants of health, getting that area working, and working with all other sectors to get a systems approach together.

The issue was raised that currently when an incident occurs in an Aboriginal community, agencies come in but they don't have an established presence in the community, which results in an *ad hoc* approach without coordination. With Bega, it was noted that they are frequently approached by mainstream agencies wanting a partnership in order to secure Aboriginal and Torres Strait Islander funding, although they haven't spoken or engaged with them before. Therefore, there needs to be genuine partnerships and coordination.

Where you can adapt strategies in the systems approach?

There was a discussion about adapting strategies in the systems approach. With regards to this, there is a need to be specific about what can and can't be adapted, as this will impact effectiveness of the overall approach. Using change theory, the central question is who are you trying to impact – this is where the group might change and the population might change but you'll still be within evidence base of how this works.

For example, a program might plan to ensure there is follow-up after an ED presentation, so as to establish continuity of care in a time of crisis. If the program is in a small region without a hospital and the function of crisis care being done by someone other than the ED, then the program would need that person involved. The key question to keep in mind is whether risk factors are being recognised and pathways properly addressed. Overall an implementable model is needed that looks at who does what in a community, but still has fidelity to the model to achieve outcomes. There is a danger that changes may remove the aspect of the strategy that evidence indicates is effective.

Other key issues identified were:

- Challenge of how programs are evaluated
- Using hard measures to build into policy streams.
- Involving lived experience in governance

Issues with the nine systems approach strategies applied to a social and emotional wellbeing framework

Key issues:

- How can diversity be incorporated into the systems approach? How do you get this model/strategy to suit each community? For example, can a framework be used where the nine strategies are a part of a framework – this would present greater scope for adaptation rather than using a whole model.
- How do activities align with the nine strategies and actually allow self-determination?

Where LifeSpan can contribute is through designing processes ensuring they can be adapted and actually change behaviours. A holistic view is needed, rather than just stating that Aboriginal communities and approaches need to be considered.

The main points to consider in what makes a successful program based on evidence are:

- Do factors work together to have successful outcomes or do they work on their own?
- What are the criteria we use for the evidence base?
- How do the aspects work in combination or alone?
- How different will situations will be from those in main stream communities?

It was noted that the ATSISPEP Literature Review identified that randomised control trials (RCTs) are not an appropriate mechanism for gathering evidence for Aboriginal and Torres Strait Islander suicide prevention programs.

What are the opportunities we have to respond better in relation to Aboriginal and Torres Strait Islander suicide prevention?

It was stated that successful adaption of the systems approach for Aboriginal and Torres Strait Islander people is not as simple as including ACCHOs in the process. It was agreed that a framework may be more appropriate rather than the current model.

There was a discussion about The Black Dog Institute and ATSISPEP contributing to another workshop early next year (2017), and to developing an appropriate framework for Aboriginal and Torres Strait Islander communities. This was supported by the meeting. This will require collaboration and leadership to action the Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

Overall it was agreed that the systems approach is a valuable model and basis for discussion, but that the effectiveness of the nine strategies in an Aboriginal and Torres Strait Islander context need to be evaluated and aligned to the success factors identified in the ATSISPEP report. There must be Aboriginal leadership and governance, and any adaptation of the model should not substitute for community-led prevention, but instead should enhance this.

The main opportunities identified to use were:

- Sharing of knowledge and experiences;
- Use of the ATSISPEP Evaluation Tools – these are available to assess the effectiveness of programs; and
- The guidance provided by the ATSISPEP report to different bodies.

Other stakeholders to be involves in future workshops include:

- NACCHO;
- AIPA – Australian Indigenous Psychologists Association;
- BeyondBlue; and
- Suicide Prevention Australia.

There was a general discussion about ensuring that the progress of this work has a continued focus on Aboriginal and Torres Strait Islander issues and any involvement by stakeholders is always culturally appropriate and is led by the Aboriginal and Torres Strait Islander organisations involved.

It was agreed that there was a need to be clear about what we are trying to achieve. The reason for this work is because current approaches aren't effective, and we need to merge the clinical and socio-cultural, and apply the systems approach so that it is appropriate for Aboriginal and Torres Strait Islander people. This includes using the tools that are available – such as from ATSISPEP – as an opportunity to evaluate what is happening.

LifeSpan responding to ATSISPEP

There was a discussion about the systems approach aligning with the ATSISPEP success factors and with the nine strategies, and this could include developing new strategies which work for Aboriginal and Torres Strait Islander communities. It was noted that there is a significant amount of funding going into suicide prevention and that this should be used as an opportunity to look at what is working and communicate this between the different programs. The central issue to examine is how the systems approach fits with the social and emotional wellbeing framework.

Agreed issues:

- Need to develop an Aboriginal and Torres Strait Islander model and develop it in true partnership;
- The systems approach is complex to adapt – all the risk factors in the model apply to Aboriginal and Torres Strait Islander communities and this requires more in-depth exploration;
- All factors can be used in Aboriginal and Torres Strait Islander communities but there are other elements that must be considered. All the strategies affect all Aboriginal and Torres Strait Islander communities, however there are layers of complexity around community, poverty and dysfunction – not just getting the system right but improving people's lives;
- All the aspects of the systems approach need to happen, but the other issues also need to be addressed for Aboriginal and Torres Strait Islander communities, such as social determinants of health.

Next steps

Participants agreed that ongoing work would take place about a culturally appropriate systems approach to suicide prevention. This is to be led by ATSISPEP and Black Dog. Other ATSISPEP workshops, including on the factors contributing to suicide, will inform ongoing discussions.

Other issues which need to be addressed include:

- Identification of services and gaps in community development, and how this is communicated;
- The empowerment and resilience building should be part of the approach, and this is one of the missing pieces;
- The systems approach needs to be mapped to the social and emotional wellbeing framework to assess their interrelationships; and
- Mapping and alignment of work across other strategies and approaches needs to occur.
- At informal discussions after the workshop, discussions took place about the stakeholders of systems. There is an implicit assumption that all stakeholders are culturally competent and free from institutionalised and direct racism. There is an assumption that stakeholders have or can have positive relationships with the

Aboriginal community. This might mean that some locations which are unable to operate in a culturally appropriate way will have limited success in implementing a systems approach.

The meeting concluded with an intention to reconvene early in the new year with the additional stakeholders as detailed above.

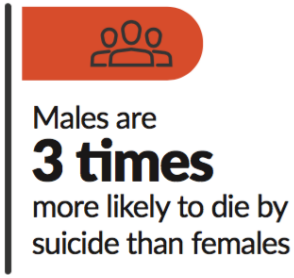
LifeSpan
Integrated suicide prevention

LifeSpan
Integrated
Suicide
Prevention

Black Dog
Institute

Need for an integrated approach

- Current suicide prevention activity is fragmented.
- Limited evaluation of Australian developed programs.
- Lack of benchmarking
- Tendency for ad hoc commissioning of programs not necessarily supported by evidence.
- Good programs/training does not necessarily equal behaviour change.



LifeSpan Integrated Suicide Prevention | Black Dog Institute

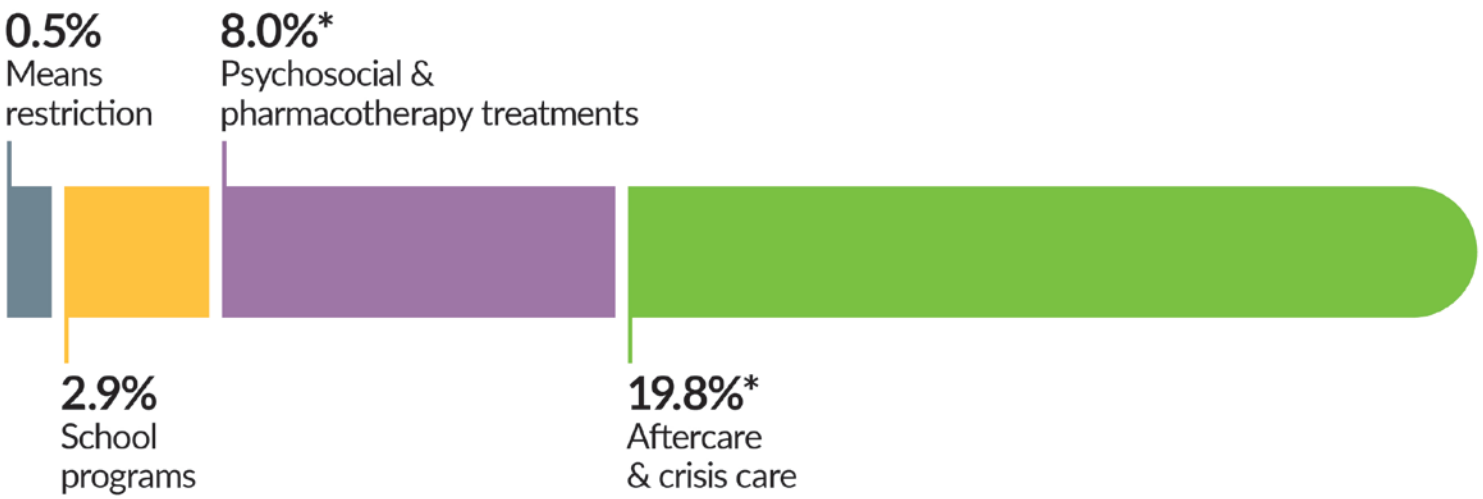
Opportunity for change

Strong evidence that multiple evidence-based strategies, simultaneously will have a greater impact on reducing suicide deaths and attempts.

LifeSpan Integrated Suicide Prevention | Black Dog Institute

Estimated 30% reduction in attempts

*Priority strategies for reducing suicide attempts



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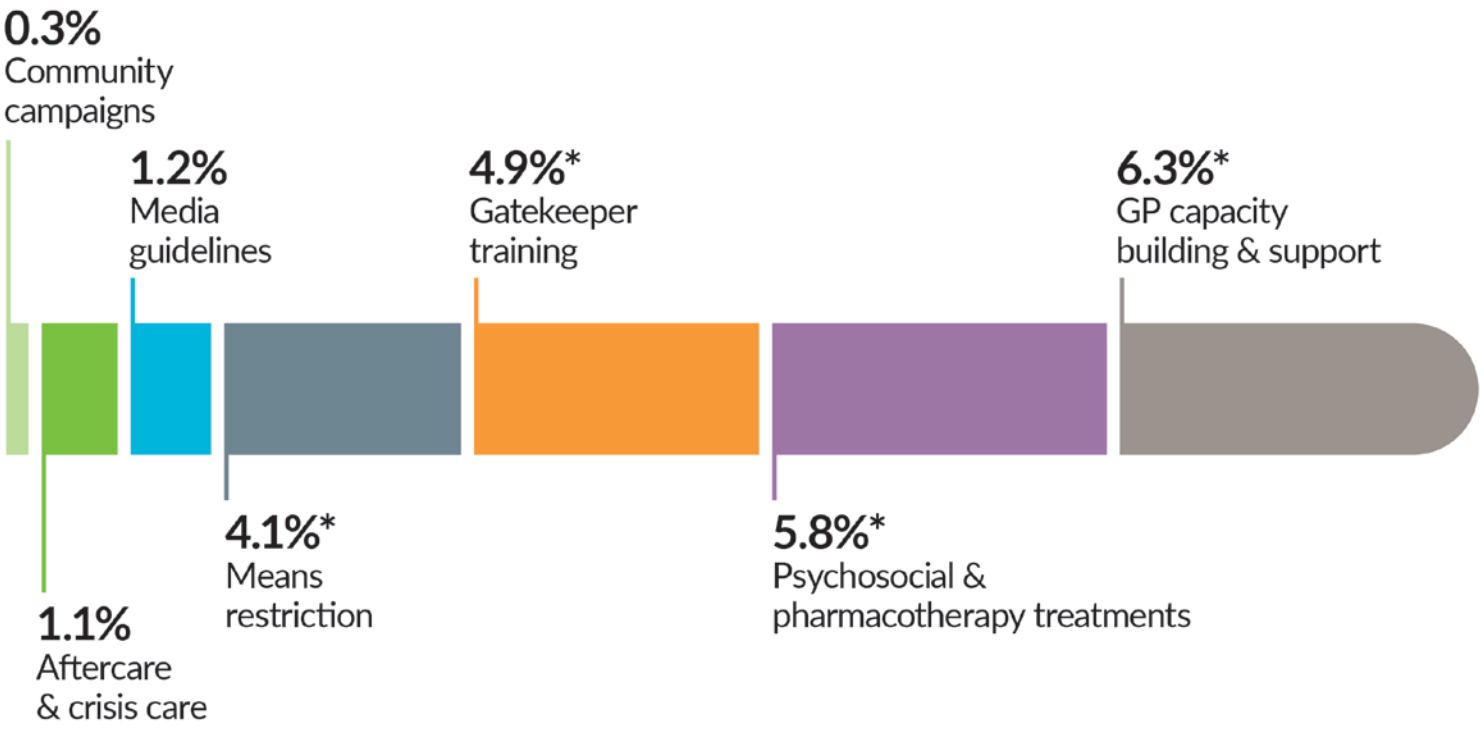
Estimated 20% reduction in suicide deaths

*Priority strategies for reducing suicide attempts



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Core features of LifeSpan

- Locally shaped and delivered
- Collaboration between government, non-government, health, business, education, research and community agencies and organisations
- Defined geographic region
- Sustainability and long-term commitment

LifeSpan Integrated Suicide Prevention | Black Dog Institute

How LifeSpan is implemented

1. Establish multi-agency suicide prevention group representative of local cultures, community, diversity and sector
2. Engage Lived Experience and community members, leaders
3. **Suicide audit to identify hotspots and trends, provide real time data**
4. Review existing services, training to map baseline activity
5. **Develop multi-agency integrated suicide prevention plan, based on evidence and tailoring to local community need and context**
6. Implementation of core interventions relevant for the local region [combination of mainstream and Aboriginal developed programs], with resourcing and support
7. Evaluation

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Why Implementation Science is Critical

"… in some analyses, the quality with which the intervention is implemented has been as strongly related to recidivism effects as the type of program, so much so that ***a well-implemented intervention of an inherently less efficacious type can outperform a more efficacious one that is poorly implemented****. …"*
Lipsey (2009)

LifeSpan Integrated Suicide Prevention

Black Dog Institute

NSW LifeSpan Trial Regions

- Funded through $14.7m grant from the Paul Ramsay Foundation
- Sites selected via Expression of Interest on the basis of readiness and capacity.
- Local health district, PHNs and Community service providers partnering in each region.
- Sites starting sequentially.

Site / (Local Government Area)	Lead agency
Newcastle (Newcastle)	Hunter Alliance
Illawarra Shoalhaven (Wollongong, Shellharbour, Kiama and Shoalhaven)	Coordinare – the South East NSW PHN
Central Coast (Gosford & Wyong)	Central Coast LHD
Murrumbidgee (Bland, Cootamundra, Griffith, Hay, Junee, Leeton, Tumut Shire, Wagga Wagga, Young)	Murrumbidgee PHN

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Implementation Timing

	2016			2017												2018												2019												2020		
	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
Newcastle	Establishment From Oct '16						Implementation Year 1 From Apr '17												Implementation Year 2 From Apr '18																							
Illawarra Shoalhaven					Establishment From Feb '17								Implementation Year 1 From Aug '17												Implementation Year 2 From Aug '18																
Central Coast										Establishment From Jun '17						Implementation Year 1 From Dec '17												Implementation Year 2 From Dec '18													
Murrumbidgee														Establishment From Oct '17					Implementation Year 1 From Apr '18												Implementation Year 2 From Apr '19										

School terms NSW	Term 4 10 Oct – 16 Dec			Term 1 Jan 27 – 07 Apr			Term 2 24 Apr – 30 Jun			Term 3 17 Jul – 22 Sep			Term 4 09 Oct – 19 Dec			Term 1 30 Jan – 13 April			Term 2 1 May – 6 Jul			Term 3 24 Jul – 28 Sep			Term 4 15 Oct – 19 Dec			Term 1 30 Jan – 12 Apr			Term 2 30 Apr - 5 Jul			Term 3 23 Jul – 27 Sep			Term 4 14 Oct – 18 Dec			Term 129 Jan – 09 Apr		

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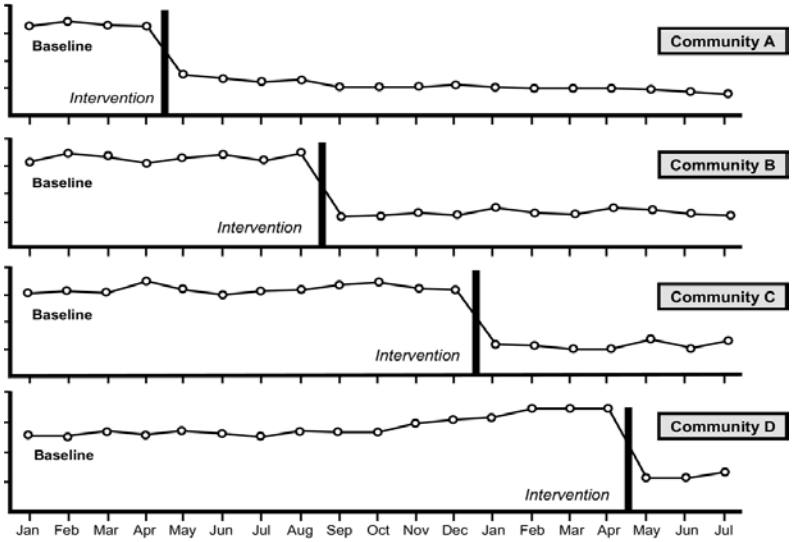
Research and Evaluation design

Measuring:

- Reductions in suicide deaths and attempts
- Impact on suicide literacy
- Implementation effectiveness
- Economic impacts

Timing:

- Sequential roll out from Oct 16, four months between each site.



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LifeSpan: Responding to Aboriginal Torres Strait Islander Suicide Prevention Evaluation Project

ATSISPEP	Key features	Potential link to LifeSpan Strategy
Alive and Kicking Goals (Kimberley, WA)	• Peer • Youth (school and non-school settings) • Help seeking • Context of sport and healthy lifestyles • DVD (no literacy assumed) • Community capacity building with volunteer training	• S6 – Schools programs • Community capacity building • Peer
Warra-Warra Kanyi - Mt Theo Project (NT)	• Youth • Mentoring and peer connection and support • Deeply rooted in cultural practices around responsibility and kin relationships • Supported by community Elders • Addresses broader problems facing Indigenous youth	• S1 Aftercare services • S4/5 gatekeeper and frontline training
Suicide Story (NT)	• Adaptation of ASIST for Indigenous specific gatekeeper training. • Culturally appropriate delivery (inc. DVD) • Community capacity building	• S4/5 Frontline and gatekeeper training
Red Dust Healing (Australia wide)	• Indigenous men and their families • Male offenders and those at risk of offending • Broad scale cultural healing • Community capacity building	• Potentially could be part of S1 aftercare addressing the broader needs of individuals
UHELP (Inala, QLD)	• Youth • Partnership with headspace	• S6 Schools
Gurriny Yealamucka Family Wellbeing (Yarrabah QLD)	• Addresses broader problems facing Indigenous communities • Workshop model • Community capacity building	
Townsville 24 hour mental health service (QLD)	• Works within the mainstream system • Employs ATSI mental health workers • Prioritises culturally appropriate mental health services	• S1 Crisis and Aftercare • S2
Galupa Marngarr Suicide Prevention Group (NT)	• Local suicide prevention group • Collaboration with Wesley LifeForce Suicide prevention networks • Community capacity building	• Localised strategies • Community collaboratives • S4/5

Where to next?

- LifeSpan to **respond to recommendations** from the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, and review mainstream programs for cultural considerations.
- Further work needed to map where the recommended 8 best practice programs for Aboriginal Suicide Prevention sit in relation to LifeSpan and what this looks like.
- Potential options include:
  - **Redesign of LifeSpan model** incorporating ATSISPEP programs, showing the importance of primordial prevention and social and emotional wellbeing?
  - **Reframe the LifeSpan systems model** to demonstrate core theory of change e.g. Strategy 2 is about appropriate therapy and treatment which in Aboriginal communities could mean healing activities, narrative therapies and appropriate use of mainstream treatments & EBP?
  - **Development of complementary Indigenous Systems model** drawing from both LifeSpan and ATSISPEP?
  - **Develop of framework** that enables trial sites to package interventions from LifeSpan/ATSISPEP report together as required?
- Need to ensure models can be locally self-determined based on full range of evidence/program combinations and quality knowledge translation.
- **<u>Possible next steps:</u>**
  - Discussion paper outlining options
  - Further workshop

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Thank you.

For more information, please contact us at**:**
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