Acknowledgement

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The team also acknowledge the support and input of Mr Rob McPhee, Kimberly Aboriginal Medical Service.

The Aboriginal and Torres Strait Islander Suicide Evaluation Project

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School of Indigenous Studies
University of Western Australia
35 Stirling Highway, Crawley, Western Australia 6009

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

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>ACCHSs</td>
<td>Aboriginal Community Controlled Health Services.</td>
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<tr>
<td>ATSISPEP</td>
<td>Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.</td>
</tr>
<tr>
<td>Cultural Safety</td>
<td>An environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need.1</td>
</tr>
<tr>
<td>Indigenous Community Controlled Organisation or Service</td>
<td>An organisation that is controlled by the community it serves usually through an elected local Chair and Board. This includes Aboriginal Community Controlled Health Services (ACCHSs).</td>
</tr>
<tr>
<td>Community-specific Responses</td>
<td>Responses tailored to the specific challenges a community might face and that build on the community’s specific existing strengths.</td>
</tr>
<tr>
<td>Centre of Best Practice in Indigenous Suicide Prevention</td>
<td>An agency that is intended to operate within the National Suicide Prevention Leadership and Support Program to identify and promote best practice in Indigenous suicide prevention.</td>
</tr>
</tbody>
</table>
| Critical response | The term ‘critical response’ indicates a response to two types of critical incident:  
  - The first is a suicide or a situation where suicide is a high risk. Responses after a death by suicide are referred to as postvention responses (see below). The term ‘critical response’ therefore includes postvention responses; and  
  - The second is traumatic incidents such as murders and multiple casualty events. |
| Suicide Cluster | A concentration of suicide deaths within a defined group of people. |
| National Leadership Role in Suicide Prevention | An agency that is intended to lead the National Suicide Prevention Leadership and Support Program. At the time of writing it is yet to be announced. |
| Indigenous | Used in this Report to refer to Aboriginal and Torres Strait Islander peoples. |
| PHN | Primary Health Network. |
| Postvention | A postvention response occurs after a suicide and is provided to the family, kin and community of the deceased. A postvention response is a form of suicide prevention because after a suicide, the family, kin and community of the deceased might be at elevated risk of suicide. |
| Primary Prevention | Activity to prevent a suicide or a suicide attempt occurring. |
| Primordial Prevention | Activity to prevent suicide by addressing underlying or upstream risk factors: unemployment, poor housing, family functioning and so on. |

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The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Critical Response Project operated across Western Australia from December 2015 to December 2016. It was hosted by the School of Indigenous Studies at the University of Western Australia, and funded by the Australian Government through the Department of the Prime Minister and Cabinet under the Indigenous Advancement Strategy The work of the ATSISPEP Critical Response Project (WA) is the subject matter of this report. The ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities was developed from the work that is presented in this report. It is yet to be considered for implementation.

The National Indigenous Critical Response Service that was announced on 23 January 2017 and is to respond to critical incidents in Indigenous communities is a separate initiative to ATSISPEP and its host.

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Critical Response Project (WA) arose out of ATSISPEP's work to identify success factors in Aboriginal and Torres Strait Islander (hereon Indigenous) suicide prevention.

This work included a roundtable to consider a model for critical responses in Indigenous communities as suicide prevention activity. The term 'critical response' indicates a response to two types of critical incident:

- The first is a suicide or a situation where suicide is a high risk. Responses after a death by suicide are referred to as postvention responses. A postvention response occurs after a suicide and is provided to the family, kin and community of the deceased. A postvention response is a form of suicide prevention because after a suicide, the family, kin and community of the deceased might be at elevated risk of suicide.
- The second is traumatic incidents such as murders and multiple casualty events. Here, too, the family, kin and community of the deceased might be at elevated risk of suicide.

Following the roundtable, the ATSISPEP Critical Response Project (WA) was established. This offered two streams of activity: the Critical Response Stream and the Community Development Stream.

The main elements of the Critical Response Stream were:

- A lead Critical Response Advocate (CRA) and an alternate CRA to ensure a 24 hour, 7 days a week service that operated year-round.
- Notification processes including a dedicated phone line for use by families affected by critical incidents.
- Phone based work by the CRA that involved utilising and coordinating existing community services and agencies to provide the first level of critical response.

In relation to the last point, the CRA would assess a family’s needs; the availability and/or capacity of existing services to meet those needs; and connect the family to services that were appropriate. The CRA might cover costs associated with critical responses (i.e. transport to funerals, catering at funerals, and so on) through the Emergency Relief Fund, or advocate for support on the family’s behalf with a range of services and agencies. For the longer term, the CRA would encourage services and agencies to develop a care plan with the family. The CRA would then remain in contact with the family and monitor the implementation of the care plan over time.

An important additional part of the CRA's work was assessing the needs of communities affected by critical incidents: in particular, whether there was any risk of suicide clusters developing and working with services and agencies to help reduce that risk.

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From mid-December 2015 to December 31, 2016, the Critical Response Stream was notified of 46 families affected by a critical incident; 21 would be provided direct assistance by the CRA and Project Team. The discrepancy between notifications and the provision of assistance is discussed in Chapter 3.

The Critical Response Stream demonstrated:

- The value of building critical responses on existing community based services and agencies rather than duplicating them or adding another ‘layer’ of administration and bureaucracy to the environment in which they operate;
- The need for a coordination role in critical responses; and
- The value of having an independent advocate to navigate complex systems on behalf of people who may not feel they can do this under such grievous and stressful circumstances. An independent advocate could also ask for service responses that individuals may not be aware are potentially available.

THE COMMUNITY DEVELOPMENT STREAM

The Project Team and a Community Development Facilitator (CDF) worked across four WA sites to trial a community development model to support Indigenous communities to respond to critical incidents. The four Project trial sites were the Kimberley region, Geraldton, Narrogin and the Goldfields region, with most work being undertaken in the latter.

Through and with local partner organisations (the preference being for Aboriginal Community Controlled Health Services (ACCHSs)), the Project Team and CDF were required to work in each of the four sites to engage and build relationships with communities, assess their needs, and map and build relationships with relevant community services and agencies to support critical responses.

An important part of the Project’s work in the Goldfields trial site was identifying and supporting both the training of community members in gatekeeper and other skills to support them to identify and respond to suicide and suicide risk and support families after a suicide; and to improve the cultural safety of service environments and cultural competence in service delivery.

The Community Development Stream demonstrated the importance of and need for:

- Proactive critical response planning prior to critical incidents rather than being reactive;
- Empowering local communities to provide local suicide prevention activity and critical responses; and
- Ensuring the cultural safety of service environments and cultural competence in service delivery when delivering critical responses, and working with Indigenous community-controlled organisations and ACCHSs to deliver and support community-specific, controlled and located development activities.

Based on its work, the ATSISPEP Critical Response Project (WA) presents the following Recommended Service Model for Critical Responses in Indigenous Communities.
ATSISPEP RECOMMENDED SERVICE MODEL FOR CRITICAL RESPONSES IN INDIGENOUS COMMUNITIES

### Regional Critical Response Advocates (RCRA)

#### Regional Level Functions:
- **1.** Supports regional and community based primordial and primary suicide prevention activities, and provides or facilitates community member education/training programs.
- **2.** Establishes and maintains a Regional Critical Response Network (RCRN)
  - a) Works with PHNs and ACCHSs to map regional and community relevant services for functions required in crisis response situations.
  - b) Develops and maintains Regional Agency Critical Response Agreements (RACRA) and required partnerships for effective postvention responses.
  - c) Maintains a Regional RCRN Steering Committee.
  - d) Manages the training, as required, of RCRN members.
- **3.** Networks with other RCRAs and RCRN and has entered Shared Regional Critical Response Agreements with them.
  - Networks with other RCRA and RCRNs and enters Shared Regional Critical Response Agreements (SHARCRA) to ensure that any unexpected postvention response needs can be met in a timely manner, including in relation to significant events where local capacity is overwhelmed.

#### Community Level Functions:
- **4.** Prior to incidents
  - a) Monitors communities within their region for suicide, suicide clusters and traumatic incidents, responds appropriately.
  - b) Coordinates the development of community Critical Incident Response Process Agreements (CIRPA).
  - c) Community committee structures.

- **5.** Short term support functions, in the aftermath of incidents
  - a) Protects and supports a community’s control of critical response processes as they happen.
  - b) Coordinates postvention response processes, including by implementing CIRPA; providing timely and practical assistance as required; and using RCR/RCRN from other regions as per SHARCRA.

- **6.** After incidents
  - a) Works with a community and local health services to identify suicide cluster risk and responds appropriately Suicide Risk Assessment(s).
  - b) Ensures required longer-term support. This includes by the development of Post-Critical Response Process Agreements (PIRPA) with families and communities after a suicide or traumatic incident.

#### National Level Support Agencies:
- **National Leadership Role in Suicide Prevention (to be announced)**
  - (Activity 1, National Suicide Prevention Leadership and Support Programme)
  - Hosts a Real-Time Data ‘Red Flag’ Alert System. Drawing on a range of data sources, monitors – nationwide - the need for postvention responses, including in indigenous communities.

- **Centre of Best Practice in Indigenous Suicide Prevention**
  - School of Indigenous Studies, University of Western Australia.
  - Works with the RCRAs to identify best practice and develop national guidelines, standards and protocols in postvention responses to suicide and traumatic incidents in Indigenous communities; and audit training available for Indigenous community members to support suicide prevention, activity, including postventions.

The ATSISPEP Critical Response (WA) Project made three recommendations including in relation to the Recommended Service Model presented above.
RECOMMENDATION 1
That Governments implement the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities. This process should build on Aboriginal Community Controlled Health Services’ (ACCHSs) existing mental health and social and emotional wellbeing services in Indigenous communities where possible.

RECOMMENDATION 2
Relevant bodies should be engaged to support any implementation of the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities. This could include:

a) The National Leadership Role in Suicide Prevention. To host a Real-Time Data ‘Red Flag’ Alert System that monitors the need for postvention responses nationwide, including in Indigenous communities, and alerts Regional Critical Response Advocates and communities as appropriate.

b) Primary Health Networks. To contribute to a directory of services and programs for use in Indigenous-specific critical responses in partnership with Regional Critical Response Advocates and ACCHSs. The directory should identify community controlled, culturally safe and culturally competent services as a priority focus.

c) The National Aboriginal Community Controlled Health Organisation as the peak body of ACCHSs.

d) The Centre of Best Practice in Indigenous Suicide Prevention. To identify best practice and to develop national guidelines, standards and protocols for postvention responses to critical incidents in Indigenous communities.

RECOMMENDATION 3
Indigenous community controlled services are the preferred providers of suicide prevention activities to their communities.

To support this, the Australian Government should ensure that preference is given to Indigenous community controlled services in all relevant service commissioning processes which it funds or influences.

In the event that a service is delivered by a non-Indigenous community-controlled organisation, the Australian Government should ensure the service is delivered in a culturally safe manner by culturally competent staff. This should be measured by using Key Performance Indicators (KPIs) such as:

- Minimum Indigenous employment levels at all levels of the service;
- Minimum cultural competence training levels for non-Indigenous staff that are negotiated with local indigenous communities;
- Requirements that provider governance bodies (such as Boards) include Indigenous community representatives; and
- Indigenous cultural mentors are employed to work with senior management.

KPIs are to be negotiated by Indigenous leaders and the Department of the Prime Minister and Cabinet for adoption across the Australian Government with application in:

- Funding agreements;
- CEO and senior staff employment contracts; and
- Reporting schedules.
CHAPTER 1: BACKGROUND

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) was funded by the Australian Government’s Department of the Prime Minister and Cabinet and operated from the Perth-based School of Indigenous Studies at the University of Western Australia from June 2014 to March 2017.

ATSISPEP identified success factors in Aboriginal and Torres Strait Islander (hereon ‘Indigenous’) suicide prevention. These were published in the November 2016 Solutions That Work: What the Evidence and What Our People Tell Us Report. A success factors summary table can be found in Appendix 1. Included among these, were postvention responses.

Definitions

Postvention responses occur after a suicide and are provided to the family, kin and community of the deceased. They aim to provide counselling or mental health support, and alleviate the practical stresses and financial burden of handling funerals and other challenges at a time of complicated grief reactions.

A postvention response is a form of suicide prevention because after a suicide, the family, kin and community of the deceased might be at elevated risk of suicide. Young people have been known to imitate the suicidal behaviours of their peers. Suicide clusters, a concentration of suicide deaths within a defined group, can occur without a postvention response.

Postvention responses are already delivered in many Indigenous communities by:

- At varying degrees, Aboriginal Community Controlled Health Services (ACCHSs); and
- Mainstream (or general population) postvention services include those provided by United Synergies’ Standby Response Service, the Wesley Mission’s Wesley Suicide Prevention Services, and the ACT’s SupportLink. These deliver postvention responses to a range of clients including Indigenous clients, but not always adapted or tailored to the latter’s needs.

The term ‘critical response’ indicates a response to two types of critical incident:

- The first is a postvention response to a suicide or a situation where suicide is a high risk; and
- The second is traumatic incidents such as murders and multiple casualty events. Here, too, the family, kin and community of the deceased might be at elevated risk of suicide.

The Solutions That Work Report highlights differences between Indigenous and non-Indigenous communities, and between Indigenous communities. These differences must be accounted for in suicide prevention and critical responses programs:

- Indigenous families and communities are often extended, close knit, and include concepts of familial and kin relationship different to non-Indigenous concepts. In this context, the impacts of a critical incident are likely to be different and potentially more widespread compared to those in non-Indigenous communities.
- Each community is different in terms of languages, culture, challenges, dynamics and experience. Critical responses must be tailored to these differences including being culturally safe and appropriate to operate in times of grief and vulnerability.

Related to this, Chandler and Lalonde’s research across Canadian Indigenous communities was considered by ATSISPEP (as discussed in Text Box 1 below).

Thematic elements that are of potential importance to the delivery of critical responses in communities can be drawn from this work. The first is the importance of self-determination and community empowerment, and the second is cultural maintenance and renewal and the association of these with lower suicide rates in Canadian Indigenous communities.

More broadly, the studies indicate that primordial prevention activity that incorporates these two themes has an important place in suicide prevention activity in Australian Indigenous communities.

**TEXT BOX 1: Canadian First Nations Peoples Research About Suicide**

Chandler and Lalonde examined cases of suicide among young First Nations people of British Columbia and the protective effects of ‘cultural continuity’ against suicide. In their first study (1987–92) cultural continuity could be seen as defined according to six indicators of self-determination and cultural maintenance/reclamation:

- Measures of self-government;
- Have litigated for Aboriginal title to traditional lands;
- A measure of local control over health;
- A measure of local control over education;
- A measure of local control over policing services; and
- Community facilities for the preservation of culture.6

Chandler and Lalonde mapped suicides in 197 communities or bands in British Columbia and found that those that had all six markers above had no or little cases of suicide among their younger people. Conversely, in communities where there were none or fewer of these markers, youth suicide rates were many times higher than the national average.7

A second study (1993–2000) identified two other markers and found similar results to those of the first study. The additional markers were:

- A measure of local control over child welfare services; and
- Band councils that included equal numbers of women.8

**THE ATSISPEP CRITICAL RESPONSE ROUNDTABLE**

Over 2015-2016, ATSISPEP hosted 12 roundtables. Six were about suicide prevention challenges in specific areas and six were topical. (See the Solutions That Work Report for further information about these roundtables).

The roundtables included a July 2015 Critical Response Roundtable held in Perth, Western Australia (WA). It was WA-focused because of the high Indigenous suicide rates in the State. The Roundtable was attended by the Minister for Indigenous Affairs and key stakeholders, including representatives of:

- The Standby Response Service;
- Aboriginal Community Controlled Health Services (ACCHSs);
- The Western Australian Mental Health Commission and the mental health services operated by WA Area Health Services; and
- The National Aboriginal and Torres Strait Islander Healing Foundation - among others.

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The Roundtable considered existing critical response/postvention services already provided in Australia and that might be relevant as models for Indigenous-specific responses.

The Roundtable identified Indigenous community-specific and community-controlled postvention responses as a significant gap in existing Indigenous suicide prevention activity, and, more broadly, Indigenous community-specific and community-controlled critical responses to critical incidents.

After surveying existing services, attendees identified the following concerns that would need to be addressed by critical response services working in Indigenous communities:

- Lack of coordination between responses at the Commonwealth, state and regional levels including service duplication;
- Lack of sustainable, ‘staged’ responses, with too many services in the immediate aftermath of a critical incident, but too few over the medium and longer term;
- Lack of resourcing during ‘peak suicide times’ including weekends, after normal working hours, and at Christmas and New Year;
- Lack of access to services during wet season for some areas; and
- Service insecurity caused by a lack of ongoing funding.

The following were also agreed as important parts of Indigenous-specific critical responses:

- Community support;
- Working with existing community services;
- Coordinated critical responses with appropriate information sharing between agencies;
- Protocols to ensure a consistent approach to critical responses that were sustained over time;
- Regional coordinators and workers for critical responses;
- Identifying and working through the primary resource person in a community and providing support to them in this role;
- A dedicated, resourced and appropriately trained pool of locally trusted male and female support workers; and
- Effective assessment tools to identify need, level of need, and length of need of critical response service provision required in any given context.

Attendees also noted that the high rates of suicide in some WA Indigenous communities were the result of compounding impacts of negative social determinants, trauma and long-term psychological distress, and psychiatric disorders. There was, therefore, an equal need to respond at this level with primordial and primary suicide prevention activity.

The Roundtable noted the following tensions in delivering Indigenous community-specific and community-controlled critical responses to critical incidents:

- A minimal range of services in a community might work against meeting a bereaved families or communities’ needs holistically, without some external support. These needs might range from mental health support to financial support to meet the cost of funerals.
- However, the sudden arrival of support services from outside the community might be overwhelming, and a bereaved family and community could lose a sense of control over what was happening.
- Finally, services from outside the community might only be present in the community for a short time, when the support they offered might be important to be delivered over a longer term.

Another important issue was that critical response services in Indigenous communities are forms of suicide prevention activity (as discussed). As such, they could also provide a broader platform for suicide prevention activity including:

- Primordial prevention: empowering communities to address the social determinants of health and associated stressors that can contribute to suicide such as unemployment, lower income and lack of financial security; poorer health outcomes when compared to non-Indigenous people and the greater exposure to grief and loss from premature deaths of family and kin that results; racism: disproportionately high rates of contact with the criminal justice system on a population level; alcohol and drug use; and
- Primary prevention – including training community members to identify peers at risk of suicide and respond effectively.
The Roundtable attendees concluded that over the longer term, an Indigenous community critical response service model should be developed by a partnership that included Indigenous communities, all levels of government involved in suicide prevention and postvention, and relevant service providers. This model should be flexible enough to account for the differences between Indigenous communities and account for both the shorter and longer term needs of clients.

The Roundtable also recommended the development and implementation of an Indigenous-specific critical response service as an immediate short-term strategy. This recommendation was accepted by the Australian Government and implemented as the ATSISPEP Critical Response Project (WA).
CHAPTER 2: THE ATSISPEP CRITICAL RESPONSE PROJECT (WA)

The ATSISPEP Critical Response Project (WA) (hereon ‘Project’) was established to operate across Western Australia from December 2015 to December 2016.

The Senior Management Team that directed the ATSISPEP investigation into Indigenous suicide prevention success factors also directed the Project as a second and distinct phase of ATSISPEP activity.

The Project offered two streams of activity:

• A state-wide Critical Response Stream to assist Indigenous families across WA after a suicide; and
• A Community Development Stream to trial a community development model across four WA sites with the aim of supporting community members and service providers to improve suicide prevention activity and critical responses.

The Project was funded by the Department of the Prime Minister and Cabinet. A contract set out key deliverables and parameters that reflected the ATSISPEP Critical Response Roundtable’s findings and recommendations. This included the development of what is presented in Chapter 5 of this Report as the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities.

The underlying approach of ATSISPEP and the ATSISPEP Critical Response Project (WA) was to work closely with Indigenous communities and Indigenous community stakeholders in empowering ways throughout all Project phases and activities.

ACCHSs are recognised as key Indigenous community representative bodies and because of this they were sought as the local partner organisations for the Community Development Stream, as well as the primary point of contact for the Critical Response Stream when it worked in any given community setting. Other reasons for supporting and partnering with ACCHSs included that they:

• Are among leadership bodies in communities and by using them, community self-governance and self-determination are supported;
• Provide holistic primary healthcare which can link with mental health supports;
• Will be more accessible to community members by providing a localised, inherently culturally safe service environment, and culturally competent service experience;
• Understand the communities they operate in and are familiar to, and trusted by, communities;
• Are best placed to provide a community-specific service response that meets a community’s specific needs; and
• Provide employment to community members to support community capacity building, the economy of the community, and to further embed the service in the community.

In the case of many ACCHSs, additional benefits include that have been demonstrated to provide value for money and improved health outcomes in the communities they serve.9

The ATSISPEP Senior Management Team established a Project Team in the first instance. This included a project director, an executive officer, resource and research staff, administrative staff, and a website administrator.

Further, a lead Critical Response Advocate (CRA) and an alternate CRA for the Critical Response Stream, and a Community Development Facilitator for the Community Development Stream were employed (their roles are discussed in the following two chapters). Hereon a reference to the “Project Team” is a collective reference to these roles (see Appendix 2).

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A Governance Committee with agreed Terms of Reference was also established to provide a forum for WA-based and national stakeholders to meet and coordinate their work in WA as well as steer the Project. This comprised representatives of the:

- ATSISPEP Senior Management Team;
- Commonwealth Department of the Prime Minister and Cabinet;
- Western Australian Mental Health Commission which was responsible for delivering mental health services across WA; and, from June 2016 on, the employment of several Suicide Prevention Coordinators operating across the state, including in the Goldfields, Wheatbelt and South-West regions of WA. These were intended to work with relevant service providers at a regional and local level to support the development and implementation of programs that increase local community and service provider capacity to identify and respond to suicidal ideation and related behaviour in an appropriate manner, reduce stigmatising behaviour towards mental health and support services and community in postvention responses;\(^\text{10}\);
- Commonwealth Department of Health;
- United Synergies, the providers of Standby Response Services (Apart from membership of the Governance Committee, in March 2016, a Letter of Intent to guide how the two projects would work together in regions where the Standby Response Service had presence was completed.)
- Community Development Stream trial site local partner organisations (three ACCHSs and a community controlled organisation - discussed further below);
- Western Australia Police; and
- The Western Australian Primary Health Alliance (WAPHA) - the organisation that oversees the strategic commissioning functions of the three Western Australian Primary Health Networks: Perth North, Perth South and Country WA and that were responsible for implementing the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in WA.

See Appendix 2 for further information on the Governance Committee.

The following chapters set out how the ATSISPEP Critical Response Project (WA) operated over the following year:

- Chapter 3 focuses on the Critical Response Steam.
- Chapter 4 focuses on the Community Development Stream.
- Chapter 5 is the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities that incorporates the Project learnings into a critical response service model for implementation in Indigenous communities.
- Chapter 6 concludes this report with the lessons learned during the Project and Recommendations.

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CHAPTER 3: THE CRITICAL RESPONSE STREAM

The Project Team and Critical Response Advocate (CRA) worked across WA to support Indigenous families after critical incidents.

1. THE MAIN ELEMENTS OF THE CRITICAL RESPONSE STREAM

The CRA function

The CRA function was to navigate services and systems on behalf of Indigenous families and individuals who were not able to do so in the grievous and stressful circumstances following a suicide or critical incident. The CRA was also able to ask for service responses that families and individuals may not be aware were potentially available.

To Provide a 24 Hour, Seven Days Per Week Service to Respond to Critical Incidents

A lead CRA and an alternate CRA (to cover the lead CRA's absence for whatever reason) ensured a 24 hour, seven days per week service that operated year-round was in place.

Notification

An ATSISPEP Critical Response Project (WA) notification protocol was agreed with WA Police but did not gain approval by the WA Coroner's Office Ethics Committee in time for it to operate during the Project. The Project Team therefore relied upon other sources of notification:

- By families (and those connected to families) affected by critical incidents contacting the CRA by a dedicated phone line (0455 252 678) that was available 24 hour, seven days per week across WA;
- By monitoring social media, news reports, and so on; and
- Through establishing a Project - Western Australian Mental Health Commission (MHC) two-way information exchange protocol. This involved the MHC informing the Project Team about the suspected suicides of WA Indigenous school age people in particular, and any other suspected suicides of Indigenous people what were reported to them. In turn, the Project Team would notify the MHC if it was contacted for help or notified of any suspected suicides.

If the Project Team or CRA was contacted by people or organisations connected to an immediate family in need but not the family itself, the CRA's first step was to attempt to contact the family.

Assessment of Need and Service Capacity to Respond

Once a family was in contact with the CRA, the next step was to assess a family's needs, and the availability and/or capacity of existing services to meet those needs. This might involve assessing:

- What services, if any, were already being provided to the family;
- What services were otherwise available; and
- Those services’ suitability for supporting the family (including considering the family’s cultural safety).

Assistance

A key principle underpinning the Critical Response Stream was the utilisation of existing services and agencies as the first level of response. As such, the work of the Project Team and the CRA was expected to be mostly phone-based: working with and through ACCHSs or with existing postvention responses such as the Standby Response Service.

Examples of the types of services that might contribute to a critical response include (but are not limited to): health and mental health services (including ACCHSs and headspace), alcohol and drug services, Centrelink and welfare services, housing services, women's support services and emergency housing providers, family services and legal services.

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11 The MHC, in turn, was notified about these by the WA Department of Education School Psychology Services (SPS) who already coordinated postvention responses among WA school age younger people led by regional Local Lead School Psychology Coordinators. The SPS were in turn notified by the Police Coronial Investigation Unit.
Assistance provided to families might include:

- Connecting the family to the above services and agencies;
- Advocacy on the family’s behalf with a range of services and agencies;
- Utilising the Governance Committee’s members’ services and networks;
- With other services and agencies, helping coordinate care planning and support over the longer term;
- Monitoring the implementation of the care plan with follow up regular telephone calls to the family and service providers as required; and
- Assessing broader community needs, particularly the risk of suicide clusters and how to reduce that risk.

The CRA was prohibited from counselling bereaved families given a lack of qualifications in this field, and on the expectation that counsellors or mental health services would be available to take on that role in any given context.

The CRA position description is set out in Appendix 3.

Because of the expectation that critical responses would be mostly managed by phone, conditions had to be met before the CRA (or Project Team member) was to visit a community and work with a family and service providers directly. Circumstances where a visit might be necessary included where:

- Families were in a remote area and there were no, or minimal, local services;
- Conflict existed between services or within the community and a visit was required to help resolve the conflict or otherwise;
- Affected families requested a visit; or
- A Governance Committee member requested a visit.

**Emergency Relief Fund**

During critical responses, the Project Team and CRA were asked by families, Governance Committee members and services and agencies to cover response-associated costs in a timely way. Such costs included those of hiring buses to transport mourners to funerals, of food, tea and coffee for mourners, of memorial books, and other unexpected costs.

An ATSISPEP Critical Response Project (WA) credit card linked to an emergency relief fund (ERF) was established to cover these costs, and an ERF protocol was put in place as a risk management tool.

**Reporting**

The ATSISPEP Critical Response Project (WA) was required to develop and use a *pro forma* Critical Response Record (CRR) to:

- Facilitate the gathering of data that the Department of the Prime Minister and Cabinet required the Project to report on;
- Be user friendly - including for use by the CRA while on the phone or during a community visit; and
- Prompt the CRA to gather, at phone notification stage and then onwards, potentially useful information for an effective critical response (for example, the history of suicide in the family, the family's contact with mental health services, and so on).

The CRR was developed with the Western Australian Mental Health Commission, the Standby Response Service and SupportLink, and was endorsed by the Governance Committee.
2. CRITICAL RESPONSES IN PRACTICE

From mid-December 2015 to December 31, 2016, the Project Team were notified of 46 families affected by a critical incident. Of the 46 cases:

- 39 involved suspected suicides;
- Two involved suicide attempts;
- One involved two sisters threatening suicide;
- One involved an alleged case of manslaughter by motor vehicle;
- One involved a death after the deceased was refused admission to a hospital;
- One involved an alleged murder; and
- One involved a death by drowning.

Of the 46 families, 21 would be provided direct assistance by the CRA and Project Team. Selected snapshots of this assistance are provided in Table 1.

Although attempts were made to reach all 46 families for whom a notification was received, in some cases this was not possible. Instead, for:

- 14 families, there was only a notification of an incident without further contact occurring despite efforts on the part of the CRA and Project Team to reach them;
- Ten families, conversations took place between the CRA and extended family members, but not the most directly affected immediate family members; and
- One family, assistance was given to extended family members.

Over the life of the ATSISPEP Critical Response Project (WA), the Project Team and CRA:

- Took part in 354 phone calls and 45 tele-meetings with family members; and in 497 phone calls and 72 tele-meetings with services;
- Visited Kalgoorlie, Leonora, Perth, Kununurra, Wyndham, Carnarvon and Groote Eylandt; and made eight visits to the Goldfields site to visit families and service providers (as discussed in the next chapter);
- Personally met with 92 families and extended family members, community groups and leaders, and services while on the above visits; and
- Dispersed $13,058 in emergency relief funds to 15 families in addition to securing financial support from benefactors and other agencies for families in need.
The following charts summarise key data about the work of the Critical Response Stream.

**AGE DISTRIBUTION OF CRITICAL INCIDENT CASUALTIES**

- 0-10 yrs
- 11-20 yrs
- 21-30 yrs
- 31-40 yrs
- Over 60 yrs
- Unknown

**NATURE OF CRITICAL INCIDENT**

- Suspected Suicide
- Attempted Suicide
- Threatened Suicide
- Alleged Manslaughter or murder
- Other

**ASSISTANCE TO FAMILIES**

- Notified but not assisted
- Assisted extended family/kin
- Families Assisted

**GENDER DISTRIBUTION OF CRITICAL INCIDENTS**

- Female
- Male
- Unknown
Table 1 below provides snapshots of the work of the Project Team and CRA in selected cases.

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>How the Project Team and CRA Responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>A man in his twenties who died by suspected suicide</td>
<td>• reconnected the family with the services available from a local ACCHSs.</td>
</tr>
<tr>
<td>A teenage girl who died by suspected suicide</td>
<td>• connected the family to their local ACCHS and headspace; and • attempted to find the family permanent housing through direct advocacy to the WA Department of Housing.</td>
</tr>
<tr>
<td>A woman in her thirties who died by suspected suicide</td>
<td>• connected the family to their local ACCHS; and • provided food and essentials with privately raised funds.</td>
</tr>
<tr>
<td>A woman in her twenties who died by suspected suicide</td>
<td>• worked with other agencies to support the deceased’s childrens’ relocation to a place where they had the support of extended family; • lobbied to assist the family to secure WA Department of Housing accommodation; • secured emergency accommodation; • worked with other agencies to connect the family to their local ACCHS, WAPHA, headspace and the regional school psychologist; and • provided vouchers for food and essentials.</td>
</tr>
<tr>
<td>A woman in her forties who died by suspected suicide</td>
<td>• relocated the family, in part to protect them from reported threats to the family’s safety.</td>
</tr>
<tr>
<td>A woman of unknown age who died by suspected suicide</td>
<td>• connected her husband and two daughters to appropriate services; and • provided vouchers for other food and essentials.</td>
</tr>
<tr>
<td>A man in his twenties who died by suspected suicide</td>
<td>• connected the mother to services; • provided funds to repair her car so she could spend some time on country; and • provided vouchers for food and essentials.</td>
</tr>
<tr>
<td>A man in his twenties who died by suspected suicide</td>
<td>• advocated to the Department of Housing to prioritise the mother's application for housing for herself and her other children; and • provide vouchers for food and essentials.</td>
</tr>
<tr>
<td>Two teenage sisters who threatened suicide</td>
<td>• supported efforts to secure short term emergency accommodation; • connected the sisters to counsellors; • helped develop an action plan for the sisters’ wellbeing with other agencies; and • provided vouchers for other food and essentials.</td>
</tr>
<tr>
<td>Critical Incident</td>
<td>How the Project Team and CRA Responded</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------</td>
</tr>
</tbody>
</table>
| A man in his thirties who died by suspected suicide | • negotiated with the funeral director, and raised funds privately to assist with funeral costs;  
• connected the family to the Department of Child Protection who provided materials needed for school for the deceased’s children; and  
• provided vouchers for food and essentials. |
| A woman in her thirties who died by suspected suicide | • connected family to a local ACCHS; and  
• facilitated financial assistance from a third party to repatriate the deceased’s body. |
| A man in his twenties who died by suspected suicide | • connected the family to a local ACCHS;  
• provided financial assistance for funeral catering;  
• provided vouchers for other food and essentials; and  
• provided financial assistance for travel expenses for the funeral. |
| A man in his twenties who died by suspected suicide | • connected the family to the agencies to assist;  
• with funeral costs; connected the family to a local ACCHSs for additional assistance; and  
• provided financial assistance for food and essentials, travel expenses for the funeral and the printing of a memorial book. |
| A teenage girl who died by suspected suicide | • worked closely with local PM&C staff to connect the family to local services;  
• provided vouchers for food and essentials; and  
• provided travel vouchers to enable the mother to visit and comfort her remaining family from another location. |
| A young girl who died by suspected suicide | • assisted extended family members and younger relatives at school in Perth. |
CHAPTER 4: THE COMMUNITY DEVELOPMENT STREAM

The Project Team and the Community Development Facilitator worked across four sites, with a primary focus on the Goldfields region, to trial a community development model to support Indigenous communities in the sites to prevent suicide and respond to critical incidents.

1. SELECTING THE TRIAL SITES

The four Community Development Stream trial sites are set out in Table 2 below.

<table>
<thead>
<tr>
<th>Location</th>
<th>Partner organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberley region</td>
<td>Kimberley Aboriginal Medical Services [<a href="http://www.kams.org.au">www.kams.org.au</a>]</td>
</tr>
<tr>
<td>Goldfields region</td>
<td>Bega Garnbirringu Health Service [<a href="http://www.bega.org.au">www.bega.org.au</a>]</td>
</tr>
<tr>
<td>Geraldton</td>
<td>Geraldton Regional Aboriginal Medical Service [<a href="http://www.grams.asn.au">www.grams.asn.au</a>]</td>
</tr>
<tr>
<td>Narrogin</td>
<td>Kaata-Koorliny Employment and Enterprise Development Aboriginal Corporation (no website)</td>
</tr>
</tbody>
</table>

The sites were chosen because in each:
- High suicide rates were reported;
- Potential local partner organisations could be identified; and
- It was assessed that each could benefit from the Community Development Stream.

2. THE MAIN ELEMENTS OF THE COMMUNITY DEVELOPMENT STREAM

Local Partner Organisations and Partnership Agreements

Once the trial sites were identified, the Project Team's initial engagement was with the local partner organisation. As noted, ACCHSs were the preferred local partner organisations for Community Development Stream work and this helped determine the suitability of three of the sites. The exception was Narrogin where, even though no ACCHSs operate in this community, because of the high suicide rate, the Western Australian Mental Health Commission requested the Project work with the Kaata-Koorliny Employment and Enterprise Development Aboriginal Corporation as the local partner organisation.

A partnership agreement was developed with each local partner organisation setting out expectations regarding process and outcomes and identifying a site designated liaison officer who would liaise with the Project Team and the Community Development Facilitator (CDF).

Building Relationships/ Assessing Need

Through the local partner organisations, the Project Team and CDF were required to work in each of the four sites to:
- Engage and build relationships with communities;
- Engage and build relationships with relevant services; and
- Assess communities’ and services’ needs regarding suicide prevention and critical response training (in the Goldfields trial site only).

Mapping

The Project Team were to work through local partner organisations to map services and identify service gaps relevant to critical responses across a site. For information on the services mapped in each site see Appendices 7 (Goldfields), 8 (Kimberley), 9 (Geraldton), and 10 (Narrogin). Relevant government and other initiatives at each site were also mapped and can be found in these same appendices.

As a part of mapping, information about a service or programs’ degree of community control (usually assessed by reference to the ratio of local Indigenous/ Indigenous to non-Indigenous Board members) and their employment of local Indigenous people was gathered.
As relevant service providers in communities were identified, they were informed of the Project and the Community Development Stream and invited to participate in the site trial. In some cases, they were given specific focuses within the trial site (for example, focusing on suicide prevention among younger people).

**Training**
A focus of the Community Development Stream in the Goldfields trial site (but not the other sites) was on training to build both the capacity of communities and services to prevent suicide and respond to critical incidents. That is by:

- Improving services by facilitating training in providing a culturally safe service and cultural competence in service delivery; and
- Training community members in ‘gatekeeper’ and other skills to support them to identify and respond to suicide and suicide risk and support families after a suicide.

In relation to the latter point, optimally, this would contribute to the employment of community members in much-needed community based and located mental health services. Further details on this are in the following section.

### 3. THE PROJECT IN THE GOLDFIELDS REGION

The focus of Community Development Stream activity was in the Goldfields site and on the towns of Kalgoorlie (population: 33,310; 6.27 per cent Indigenous\(^\text{12}\)) and Leonora, about 240 kilometres north of Kalgoorlie (population: 2,630; 18.6 per cent Indigenous\(^\text{13}\)). The work of the Project Team there included that of the Critical Response Advocate (CRA) and the CDF and highlights the complementary nature of the Critical Response Stream and Community Development Stream in practice.

**Critical Responses**

Three suspected suicides occurred in the Goldfields region in November/December 2015 (prior to the Community Development Stream’s work commencing in any of the sites).

The Western Australian Mental Health Commission initially brought this information to the Project Team’s attention and asked that the CRA travel to the Goldfields to help coordinate a service response to the bereaved families. Both the CRA and the alternate CRA travelled to the site on December 20, 2015. The CRA returned to the site in the first week of January.

The Project Team and CRA returned to the Goldfields in mid-January 2016 to meet in various forums with representatives from: community volunteer services and community members, the Western Australian Primary Health Alliance (WAPHA), the Bega Garnbirringu Health Service (‘Bega’ an ACCHS and the site’s local partner organisation), the WA Country Health Service, the Aboriginal Legal Service, the local police, and the Mayor and various councillors of Kalgoorlie-Boulder Shire.

The meetings highlighted the willingness of service providers to work together to provide effective critical responses and also the significant overlap between what they offered, at least in some areas. From these meetings and the work of WAPHA, the Goldfields Suicide Prevention Group formed to support suicide prevention and critical response service providers to work more collaboratively.

Over the course of the life of the ATSISPEP Critical Response Project (WA), the CRA visited the Goldfields to assist families on six occasions.

The overall impact of this initial critical response work was to cement key Project – community relationships that supported not only greater notifications of suicides in the region to the Critical Response Stream, but that paved the way for the work of the Community Development Stream in the site.

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Community Development Stream

The Project Team and CDF visited the Goldfields site five times over the life of the Project. During these visits and from Perth they:

- Supported collaborative work between the Goldfields Regional Office of the Department of the Prime Minister and Cabinet, the WA Department of Aboriginal Affairs, the WA Country Health Service and the Western Australian Primary Health Alliance to prevent suicide with local Indigenous communities; and
- Successfully mediated a better relationship between two key service providers where a relationship break down had occurred.

In mid-February 2016, Leonora experienced a suspected suicide – one of several within a three-month period. Community leaders and residents began to organise and identify the suicide prevention and critical response needs of Leonora as:

- Action to address ongoing social problems that could contribute to suicide including alcohol restrictions;\(^{14}\)
- Collaborative arrangements between communities, services and agencies with the latter two located in the community, including by the significantly increased employment of local Indigenous people; and
- Culturally safe services with culturally competent staff, including by the significantly increased employment of local Indigenous people and cultural mentors.

On this foundation of community driven action (that occurred concurrently with the Project’s work), the Hope Council community action group was established to support Leonora community members hire a bus to attend the ATSISPEP National Aboriginal and Torres Strait Islander Suicide Prevention Conference in Alice Springs in May 2016.

The Hope Council included representatives from Leonora’s four main families, local Elders, a school principal, a Director of Nursing from the Western Australian Country Health Service, a local police superintendent, and the Deputy President of Leonora Shire Council.

Further details of this unique community initiative that was filmed and called the *Bus of Hope* can be found in Text Box 2.

The ideas presented and exchanged at the Conference provided significant further impetus to the Hope Council to prevent further suicide in Leonora, and for local community members to become better educated and employed in this field.

In the months following, the Hope Council was renamed as the *Northern Goldfields Caring Connected Community* and developed the *Community Wellbeing Network Action Plan* (included in Appendix 8) which includes the *Grow Local Training Program*.

Northern Goldfields Caring Connected Community began meeting monthly to implement their plan. To that end, by the end of the ATSISPEP Critical Response Project (WA), it had:

- Begun negotiations with the WA Department of Housing to address overcrowded housing;
- Created the ‘Northern Goldfields Wellbeing Facebook Page’ to publicise the visits of service providers and the *Community Wellbeing Network Action Plan*;
- Advocated for local mental health services and counsellors to be based in Leonora;
- Promoted the *Grow Local Training Program* (discussed further below);
- Began negotiations on restricting access to alcohol in the region;
- Supported collaborations between the community, service providers and government agencies;
- Promoted younger people’s engagement of services;
- Supported mental health conversations among community members; and
- Promoted the presence of Aboriginal Health Workers and mental health nurses in the community.

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\(^{14}\) Kado Muir, Unpublished letter to Senior Project Officer, Goldfields Esperance Development Corporation, February 16, 2016.
TEXT BOX 2: Bus of Hope

Mr Richard Evans is a Leonora community leader who was affected by suicide and interacted with the Critical Response Advocate on their initial visits to the Goldfields. When ATSISPEP hosted the May 2016 National Aboriginal and Torres Strait Islander Suicide Prevention Conference in Alice Springs, WAPHA offered Mr Evans a small bursary to attend. Mr Evans then approached WAPHA to assist him to take a group of 25 Leonora young people to attend the conference by bus. Through this process the Hope Council was formed. Eventually, $40,000 was raised from various service providers and local government to sponsor the trip and the young peoples’ attendance.

The Anglicare Regional Manager, Ashley Gibb, donated his time to travel from Leonora to Alice Springs with the delegates, as did Tom Hearm from Bush TV, who videoed footage for the documentary, Bus of Hope, using his own funds. WAPHA funded the development of the documentary, subsequently screened in Perth and Leonora. Bus of Hope can be viewed on the ATSISPEP website www.atsispep.sis.uwa.edu.au

There were positive outcomes from sharing the experience. Those who attended included members from three of the four main Leonora families, which also helped with the healing and strengthening of some inter-family relationships.

In some cases, young people have undertaken the training discussed in the text below and helped support the implementation of the Community Wellbeing Network Action Plan. While other attendees still engage in risk behaviours, their openness and positive views to further mental health conversations including in relation to alcohol and drug use based on their experience, has been reported.

Training

As noted, in the Goldfields (but not the other sites) the Community Development Stream was to facilitate training to build both community and service capabilities to work more effectively in suicide prevention and critical responses. In practice, this included:

- **Helping implement the Grow Local Training Program.** The Western Australian Primary Health Alliance (WAPHA) and the Northern Goldfields Caring Connected Community community action group worked with the Australian Medical Association to deliver training in modules from the CHC43515 Certificate IV in Mental Health Peer Work Consumer Stream; and CHC43315 Certificate IV in Mental Health. This was initially funded by WAPHA and supported Leonora residents’ goal of training in ways that contributed to employment in mental health services as these modules could be used towards qualifications for such. By August 2016, 40 community members had passed
- **the initial ‘Recognising and Responding to Crisis Situations’ module.** The ATSISPEP Critical Response Project (WA) has supported the ongoing development and provision of these modules.
- **Applied Suicide Intervention Skills Training (ASIST) Training of ‘Gatekeepers’ in Communities.** ASIST aims to educate people to recognise when somebody is at risk of suicide, and how to ensure they are effectively helped. Bega, the local partner organisation-ACCHS, identified the need to increase the number of their staff who can provide ASIST training to community members by completing an ASIST train the trainers course. The Project has supported this training of Bega staff as ASIST Trainers and their provision of ASIST training to community groups.
- **Cultural Competence Training for Service Providers.** The Project sought the advice of the community to identify a local Indigenous provider to provide Goldfields-specific cultural competence training to service providers. This will be taking place in the coming months after the Project has completed.

As a part of this work, the Project Team and CDF mapped relevant training options for community members as set out in Appendix 9.

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4. THE COMMUNITY DEVELOPMENT STREAM IN THE KIMBERLEY REGION, GERALDTON AND NARROGIN

The Kimberley

The Kimberley Aboriginal Medical Services (KAMS), a member based, regional Aboriginal Community Controlled Health Service (ACCHS) that supports and represents the interests of the seven independent Kimberley ACCHSs, agreed to become the Project local partner organisation.

Efforts to prevent suicide in Kimberley Indigenous communities had been underway for some time prior to the ATSISPEP Critical Response Project (WA). The Standby Response Service was reported to be operating effectively and in a culturally appropriate manner with Kimberley Indigenous communities with community control supported by having KAMS on the Standby Response Service governing committee.

Service mapping was progressed. Given the potential for overlap between the work of Critical Response Stream and the Standby Response Service in the Kimberley region, the previously discussed formal Letter of Intent was agreed between United Synergies and the Project.

In August 2016, the Australian Government announced that the Kimberley would be one of two suicide prevention trial sites specifically focused on Indigenous suicide prevention under a renewed national approach to suicide prevention. The trial will be funded by the Commonwealth Department of Health and administered by the Western Australian Primary Health Alliance (WAPHA). In addition to the work of the Standby Response Service, this superseded the need for the Project’s Community Development Stream in the site.

Geraldton

Between July and October 2016, the CDF visited Geraldton five times and established relationships with the:

- Geraldton Regional Aboriginal Medical Service (GRAMS) - the ACCHS/local partner organisation;
- Regional staff of the WA Department of Aboriginal Affairs;
- Regional office of the Department of the Prime Minister and Cabinet; and
- Midwest Aboriginal Organisations Alliance.

Prior to the ATSISPEP Critical Response Project (WA), GRAMS had worked to establish both Indigenous and non-Indigenous forums to facilitate better service delivery to Indigenous communities within the region. As a part of this, WAPHA funded GRAMS to operate an extended hours health clinic (6.00 – 9.00pm Monday to Friday; Saturday from 10.00am-2.00pm) with a mental health nurse.

Otherwise, initial mapping established that whilst there are suicide prevention services and programs in Geraldton they were not well publicised or connected to other services such as the local police. (See Appendices 7-10 for the mapping of services in Geraldton, the Goldfields, the Kimberley and Narrogin)

In 2016, the Australian Government Department of Health established a Wesley Mission Life Force suicide prevention program in Geraldton. This superseded the need for the Project’s Community Development Stream in the site.

Narrogin

In 2008, the Narrogin community was devastated by eight suicides and four attempts. Eight years later, many of the same challenges that affected the community at that time were still evident.

As noted, the ATSISPEP Critical Response Project (WA) partnered with the Kaata-Koorliny Employment and Enterprise Development Aboriginal Corporation (Kaata) at the site. In July 2016, Kaata and the CDF committed to establish an Indigenous Reference Group under Kaata to assist in the development of networks with other service providers including for suicide prevention.

The CDF also met with community members and hosted a suicide prevention workshop with Kaata and other local agencies to begin the mapping of services, exchange information about the services available, and take steps towards a collaborative approach.

Kaata chose not to proceed as a Project local partner organisation because they were funded by the WA Mental Health Commission to offer a similar program to the Community Development Stream.

While the provision of new suicide prevention responses in the above Project trial sites was welcome, these developments also point to the need for overarching coordination in relation to suicide prevention and critical responses at the governmental level.
5. RESOURCES

The Community Development Stream was required to maintain a suicide prevention and critical response resources page within the ATSISPEP website. (See: http://www.atsispep.sis.uwa.edu.au/resources). Here, access to uploaded documents (rather than links) was to provide immediate support and advice to family members and community people affected by critical incidents including those in the four Community Development Stream trial sites.

Identifying resources involved:

- Seeking expert advice on where to find materials;
- Conducting a broad scan of available materials;
- Ensuring every item included on the resource page was reviewed and approved for use in Indigenous contexts by two Indigenous psychologists; and
- Seeking permission from the relevant publishers to include the material on the ATSISPEP website.

The list of resources selected through this process can be found in Appendix 10.

A need for video resources was also identified, including to ensure people with less literacy could access key suicide prevention and critical response messaging. To meet this need:

- A video with key messages was commissioned by the Project using a balance of male and female Australian Indigenous Psychologists’ Association spokespeople;
- Videos of talks and proceedings in the ATSISPEP May 2016 Aboriginal and Torres Strait Islander Suicide Prevention Conference were reviewed and added if appropriate; and
- The Bus to Hope video discussed in Text Box 3 was uploaded to the website.

Media Management

Over the life of the ATSISPEP Critical Response Project (WA) in some of the communities in which it is operated, community members were approached by the media to comment on suicides or incidents, or to be part of a larger Indigenous suicide prevention stories. Community members were often unsure of how to manage media in this context.

Comprehensive media management materials had previously been produced by ATSISPEP to support those being interviewed at the May 2016 ATSISPEP Aboriginal and Torres Strait Islander Suicide Prevention Conference in Alice Springs. These materials were updated and added to the resources webpage.

Further, media advice was provided so that individuals and communities can use media to promote their own messages and in an empowered way.
CHAPTER 5: THE ATSISPEP RECOMMENDED SERVICE MODEL FOR CRITICAL RESPONSES IN INDIGENOUS COMMUNITIES

Regional Critical Response Advocates (RCRA)

Regional Level Functions:

7. Supports regional and community based primordial and primary suicide prevention activities, and provides or facilitates community member education/training programs.

8. Establishes and maintains a Regional Critical Response Network (RCRN)
   a) Works with PHNs and ACCHSs to map regional and community relevant services for functions required in crisis response situations.
   b) Develops and maintains Regional Agency Critical Response Agreements (RACRA) and required partnerships for effective postvention responses.
   c) Maintains a Regional RCRN Steering Committee.
   d) Manages the training, as required, of RCRN members.

9. Networks with other RCRAs and RCRN and has entered Shared Regional Critical Response Agreements with them.

   Networks with other RCRAs and RCRNs and enters Shared Regional Critical Response Agreements (SHARCRA) to ensure that any unexpected postvention response needs can be met in a timely manner, including in relation to significant events where local capacity is overwhelmed.

Community Level Functions:

10. Prior to incidents
   a) Monitors communities within their region for suicide, suicide clusters and traumatic incidents, responds appropriately.
   b) Coordinates the development of community Critical Incident Response Process Agreements (CIRPA). Community committee structures.

11. Short term support functions, in the aftermath of incidents
   a) Protects and supports a community’s control of critical response processes as they happen.
   b) Coordinates postvention response processes, including by implementing CIRPA; providing timely and practical assistance as required; and using RCR/RCRN from other regions as per SHARCRA.
   c) Monitors their RCRN’s psychological support needs as well as their own.

12. After incidents
   a) Works with a community and local health services to identify suicide cluster risk and responds appropriately Suicide Risk Assessment(s).
   b) Ensures required longer-term support. This includes by the development of Post-Critical Response Process Agreements (PIRPA) with families and communities after a suicide or traumatic incident.

National Level Support Agencies:

National Leadership Role in Suicide Prevention
(Activity 1, National Suicide Prevention Leadership and Support Programme)
Hosts a Real-Time Data ‘Red Flag’ Alert System. Drawing on a range of data sources, monitors – nationwide - the need for postvention responses, including in indigenous communities.

Centre of Best Practice in Indigenous Suicide Prevention
School of Indigenous Studies, University of Western Australia.

Works with the RCRAs to identify best practice and develop national guidelines, standards and protocols in postvention responses to suicide and traumatic incidents in Indigenous communities; and audit training available for Indigenous community members to support suicide prevention, activity, including postventions.
1. BACKGROUND

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) was funded by the Australian Government Department of the Prime Minister and Cabinet and operated from the Perth-based School of Indigenous Studies at the University of Western Australia from June 2014 to March 2017.

ATSISPEP identified success factors in Aboriginal and Torres Strait Islander (hereon ‘Indigenous’) suicide prevention. These were published in the November 2016 Solutions That Work: What the Evidence and What Our People Tell Us Report (see www.atsispep.sis.uwa.edu.au).

Over 2015-2016, ATSISPEP hosted 12 roundtables. Six were about suicide prevention challenges in specific areas and six were topical. (See the Solutions That Work Report for further information about these.)

The roundtables included a July 2015 Critical Response Roundtable held in Perth, Western Australia (WA). It was WA-focused because of the high Indigenous suicide rates in the State. The Roundtable was attended by the Minister for Indigenous Affairs and key stakeholders including representatives of:

- The Standby Response Service;
- Aboriginal Community Controlled Health Services (ACCHSs);
- The Western Australian Mental Health Commission and the mental health services operated by WA Area Health Services; and
- The National Aboriginal and Torres Strait Islander Healing Foundation - among others.

The Roundtable considered existing critical response/postvention services already provided in Australia and that might be relevant as models for Indigenous-specific responses.

The Roundtable identified Indigenous community-specific and community-controlled postvention responses as a significant gap in existing Indigenous suicide prevention activity, and, more broadly, Indigenous community-specific and community-controlled critical responses to critical incidents.

After surveying existing services, attendees identified the following concerns that would need to be addressed by critical response services working in Indigenous communities:

- Lack of coordination between responses at the Commonwealth, state and regional levels including service duplication;
- Lack of sustainable, ‘staged’ responses, with too many services in the immediate aftermath of a critical incident, but too few over the medium and longer term;
- Lack of resourcing during ‘peak suicide times’ including weekends, after normal working hours, and at Christmas and New Year;
- Lack of access to services during wet season for some areas; and
- Service insecurity caused by a lack of ongoing funding.

The following were also agreed as important parts of Indigenous-specific critical responses

- Community support;
- Working with existing community services;
- Coordinated critical responses with appropriate information sharing between agencies;
- Protocols to ensure a consistent approach to critical responses that were sustained over time;
- Regional coordinators and workers for critical responses;
- Identifying and working through the primary resource person in a community and providing support to them in this role;
- A dedicated, resourced and appropriately trained pool of locally trusted male and female support workers; and
- Effective assessment tools to identify need, level of need, and length of need of critical response service provision required in any given context.

Attendees also noted that the high rates of suicide in some WA Indigenous communities were the result of compounding impacts of negative social determinants, trauma and long-term psychological distress, and psychiatric disorders. There was, therefore, an equal need to respond at this level with primordial and primary suicide prevention activity.
The Roundtable noted the following tensions in delivering Indigenous community-specific and community-controlled critical responses to critical incidents:

- A minimal range of services in a community might work against meeting a bereaved families or communities’ needs holistically, without some external support. These needs might range from mental health support to financial support to meet the cost of funerals.
- However, the sudden arrival of support services from outside the community might be overwhelming, and a bereaved family and community could lose a sense of control over what was happening.
- Finally, services from outside the community might only be present in the community for a short time, when the support they offered might be important to be delivered over a longer term.

Another important issue was that critical response services in Indigenous communities are forms of suicide prevention activity (as discussed). As such, they could also provide a broader platform for suicide prevention activity including:

- Primordial prevention: empowering communities to address the social determinants of health and associated stressors that can contribute to suicide such as unemployment, lower income and lack of financial security; poorer health outcomes when compared to non-Indigenous people and the greater exposure to grief and loss from premature deaths of family and kin that results; racism; disproportionately high rates of contact with the criminal justice system on a population level; alcohol and drug use; and
- Primary prevention – including training community members to identify peers at risk of suicide and respond effectively.

The Roundtable attendees concluded that over the longer term, an Indigenous community critical response service model should be developed by a partnership that included Indigenous communities, all levels of government involved in suicide prevention and postvention, and relevant service providers. This model should be flexible enough to account for the differences between Indigenous communities and account for both the shorter and longer term needs of clients.

The Roundtable also recommended the development and implementation of an Indigenous-specific critical response service as an immediate short-term strategy. To this end, the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities was developed.

2. MAIN FEATURES OF THE MODEL

1. Regional Critical Response Advocates (RCRAs)

The primary element of the service model presented here are the Regional Critical Response Advocates (RCRA).

RCRA-regions will correspond to PHN boundaries but are determined on a needs basis and not arbitrary, administratively determined limits. In urban areas, for example, an RCRA may be able to work effectively across several PHNs. In contrast in larger PHNs, several RCRAs may be required within a PHN - particularly to work effectively in areas of elevated suicide risk such as the Kimberley, WA.

The coincidence of RCRA-regions and PHN boundaries is to facilitate the funding of the RCRA and their teams with suicide prevention funds being dispersed through the PHN network. However, this model also acknowledges the possibility of additional cross-government/cross portfolio funding opportunities being used to support its implementation. For this reason, and where practical, RCRA regions should also be aligned with the 12 Regional Networks of the Department of the Prime Minister and Cabinet to take advantage of potential opportunities from the Indigenous Affairs portfolio.

The role of RCRA in any region:

- Will be based in and managed from ACCHSs or suitable Indigenous-community controlled organisations within an RCRA-region, and not PHNs. (In regions without ACCHSs or suitable Indigenous-community controlled organisations, where an RCRA is based will be developed on a case-by-case basis);
- Will preferably be a suitably qualified and senior member of an ACCHS’s staff or SEWB team recruited for this purpose;
- Will involve, in addition to critical response (including postvention) activity, supporting primordial and primary suicide prevention and mental health and social and emotional wellbeing promoting activity within communities; and
- Will be accountable to the ACCHSs or suitable Indigenous-community controlled organisation.

Core funds for the employment of the RCRAs and the implementation of the model at the regional level should be provided by the Australian Government Department of Health directly to ACCHSs, or suitable Indigenous-community controlled organisations within an RCRA-region, and not PHNs, and through long-term funding agreements.
The role of the RCRA will also require significant mobility, and require their ability to source emergency relief funds (ERF) to respond quickly to critical incidents. Optimally, an RCRA will be able to leverage their networks among service providers and stakeholders to provide ERF in any context. However, the RCRA will also have an ERF to access in cases where this is not possible, subject to use protocols.

RCRA accountability will be ensured by an RCRA Code of Conduct and RCRA performance indicators. These could be developed as a priority function of the Centre of Best Practice in Indigenous Suicide Prevention. ACCHSs or employer organisations will also consult with Community Committee Structures (see below) in their assessment of RCRA performance.

An RCRA might also hold other positions within an ACCHS or employer organisation. It is expected that in the initial phases of their work, an RCRA will probably work full-time establishing key elements of the model, moving over time to being more focused on maintaining the model and responding to suicide or traumatic incidents as required.

However, the requirement that an RCRA be available 24 hour, 7 days per week (see below) requires ACCHSs/ employer organisations to support the RCRA role as the priority function of the person employed as such as a non-negotiable component, over-riding all other potentially conflicting functions within the organisation when required.

Qualifications and career development path guidelines for RCRA could be developed as a priority function of the Centre of Best Practice in Indigenous Suicide Prevention.

Criteria might include:

- Being a relatively senior and respected Indigenous person living in the region and known to/ with knowledge of the communities within the region;
- Training in mental health-related skills – for example, in being trauma-informed; in counselling, in Mental Health First Aid, and in self-care;
- Financial management skills;
- Being able to drive a motor vehicle;
- Being able to operate within a cultural framework; and
- Being available 24 hours, 7 days per week including weekends and after normal working hours, Christmas and New Year (with arrangements in place to cover their absence for any reason).

Where required, training in completing records should be provided to RCRAs to ensure that accurate and useful records are kept and data collated.

2. RCRAs and Regional Critical Response Networks

A primary function of the RCRA is to work with existing responses to enhance overall ‘system’ capacity to respond to suicides and incidents in Indigenous communities, from the regional level. This involves the RCRA bringing together and maintaining a Regional Critical Response Network (RCRN).

In general, an RCRN will consist of core functions such as mental health and health workers, welfare support workers and so on; and more ad hoc functions or members who may be called upon only on occasion.

The core elements of a team and RCRN performance indicators need to be agreed upon as a priority function. An RCRA will be accountable for the effective operating of the RCRNs they bring together and maintain.

Developing an RCRN involves identifying, building relationships with, and integrating, the work of existing responses available in any given community or regional setting and avoiding duplication of responses. To that end, an RCRA may work with:

- Aboriginal Community Controlled Health Services (ACCHSs);
- Existing general population postvention responses: Standby Response Service, the Wesley Mission’s Wesley Suicide Prevention Services, the ACT’s SupportLink and so on; and
- In Western Australia, the Suicide Prevention Coordinators with their general population networks and coordinators; and with similar positions in other jurisdictions as appropriate.

The main principle underlying an RCRN is that is in already in place, prior to a critical incident. The process of developing an RCRN therefore involves the RCRA proactively:

i) Working with their local PHN(s) and ACCHSs to map existing regional and community-level responses. This is to be able to develop effective Regional Agency Critical Response Agreements (below) to establish RCRNs, as well as to leverage additional support for communities as required. This work should also support the development and maintenance of a directory of local and relevant services to be provided in a booklet form for use in communities.
ii) Developing and maintaining Regional Agency Critical Response Agreements (RACRA). A RACRA should include all those who will provide the core functions of the RCRN and who otherwise might be involved in critical incidents – police, ambulance workers, health services and ACCHSs, welfare agencies, mental health services, charities, and so on. The agreements would define the core roles/ protocols in relation to critical responses, potential ad hoc roles, and otherwise recognise the leadership role of the RACRA in relation to responding to suicide and critical incidents in Indigenous communities; and the need for RCRN members to cooperate in community settings through the RCRA. General principles guiding this function of the RACRA include:

- Optimally, that all core RCRN team roles are dedicated Indigenous positions, although the value of having non-Indigenous people involved in some contexts is acknowledged;
- Ensuring adequate remuneration, or covering of reasonably incurred expenses, for all involved in an RCRN and in critical responses. The latter in particular includes those not otherwise employed formally such as Elders and other community members but who play a critical role in postvention responses; and
- Achieving gender balance - there should be, when possible, an equal distribution of men and women across the RCRN. Age groups, cultural groups and so on should also be adequately represented where possible.

A model RACRA should be developed as a priority. The agreement of RACRA does not preclude the RCRA entering parallel MoUs or other agreements as required with other critical services such as police, counselling providers, local general population health services.

iii) Founding a Regional Steering Committee. The RACRA should underpin the forming of a Regional Steering Committee that meets at regular intervals (as required) and is made up of community members, the RCRA or RCRN members, and others as optimal – such as previously bereaved family members.

iv) Managing RCRN’s training needs. A key RCRA function to be included in RACRA is ensuring appropriate training and the capacity of RCRN core, but also as required ad hoc team members. This might include skill(s) development for Elders and leaders in the community as part of a community’s longer-term support needs (see below).

3. RCRA Networks with Other RCRAs and RCRN -- Shared Regional Postvention Response Agreements

Acknowledging the possibility of an RCRN being overwhelmed in a crisis of magnitude; that specific RCRN members may become ‘burnt out’ in critical responses; or that specific skills not within a regional RCRN, but available in other RCRN, may be needed in any given situation, an RCRA should network with other RCRA and RCRN Teams and have entered Shared Regional Critical Response Agreements (SHARCRA) to ensure that any unexpected postvention response needs arising in communities within their region can be met in a timely manner.

Model SHARCRA for use by RCRAs should be developed as a priority.

4. Community Level Functions of the RCRA

a) Prior to Incidents

- Monitors Communities Within Their Region for Suicide, Suicide Clusters and Traumatic Incidents

This includes by building key relationships with police and first responders, health services, hospitals and so on and making agreements within the RACRA to ensure that the RCRA has a ‘real-time’ picture of suspected suicide and traumatic incidents occurring within their region appropriate to their role.

The National Leadership Role in Suicide Prevention’s Real-Time Data ‘Red Flag’ Alert System might also issue alerts for the information of RCRAs.

- Coordinates the Development and Maintenance of Community Critical Incident Response Process Agreements (CIRPA).

If a community is ready, a RCRA should work in partnership with its Elders and members, and in a culturally respectful manner, to agree CIRPA that connects to work of the RCRN and RACRA. CIRPA are agreed in advance by communities either working informally (i.e. through yarning groups) or through community based committees that may emerge over time (and may be the foundation for Community Committee Structures).
A CIRPA will:

- Contain an agreed definition of what constitutes a critical incident, or how one will be identified;
- Define the role for the RCRA in a critical response, and the respective roles and responsibilities of local community organisations (ACCHSs), Elders, age and other peer mentors, women and men’s groups, emergency services, NGOs – whatever is appropriate;
- Set out protocols for ‘outsiders’ working with the community and families during a crisis response; and
- Be reviewed at regular intervals.

CIRPAs will usually contain common elements but should be tailored to the individual circumstances of a community.

b) Short Term Support Functions in the Aftermath of Incidents

- Protects and Supports a Community’s Control of Critical Response Processes as They Happen.

This can include:

- Assessing family and community readiness to engage with postvention supports and services;
- Negotiating required financial assistance with relevant agencies and, at last resort, utilising an emergency relief fund to provide support;
- At a community’s request, effectively managing the implementation of its CIRPA;
- Managing the community’s relationship with RCRN and ‘outside’ support agencies including by acting as an interface between families and outside services; and requiring the observance of CIRPA-agreed protocols for outside engagement with a family or community;
- Monitoring the potential ‘burn out’ and psychological support needs of RCRN and community members involved in crisis response; and
- Observing CIRPA agreed protocols when calling in outside help for them, or replacement workers.

This function includes working with communities who may not have a CIRPA and yet require assistance that is negotiated with community members in the short-term aftermath of a critical incident. In such a situation, key principles including ensuring community control and working within a cultural framework must be observed.

- Coordinates Postvention Response Processes Including by Implementing CIRPA; Providing Timely and Practical Assistance as Required, and Otherwise Being Responsive to Needs.

Whether a CIRPA exists or not, assistance should be responsive to the situation – it might include ‘grief and loss packs’ and other practical supports and connecting community members to mental health or other support services, healing programs/ cultural healers and cultural supports on an as needed basis. It could involve liaising with employers if a person needs time off work because of a critical incident.

The RCRA can draw on additional support through their networking and through SHARCRA.

- Monitors their RPRN’s Psychological Support Needs as Well as Their Own. Able to respond appropriately and access supports as required, even replace RCRN through SHARCRA.

c) After Incidents

- Following a Suspected Suicide or Traumatic Incident, Works With a Community and its Health Services to Identify Suicide Contagion Risk and Responds Appropriately.

Within this model, a priority function of the Centre of Best Practice in Indigenous Suicide Prevention could be to develop a flexible Suicide Risk Assessment tool for, and to train RCRAs to use them in, communities and that can help gauge the risk of suicide clusters. If a risk is identified, the RCRA should ensure appropriate arrangements are in place. For example, a roster system for 24-hour watches for people at risk of suicide, involvement of mental health services and so on.

- Ensures Required Longer-Term Support. This Includes by the Development of Post-Critical Response Process Agreements (PIRPA) With Families and Communities After a Suspected Suicide or Traumatic Incident.
A PIRPA is like a CIRPA - although PIRPA are agreed in a timely manner after a critical incident to account for its precise nature and impact and the long-term support needs flowing from it. A PIRPA will:

- Contain a description of the incident and its impact;
- Define the role for the RCRA in a longer-term support role, and the respective roles and responsibilities of local community organisations, Elders, age and other peer mentors, women and men’s groups, emergency services, local and state government departments, and NGOs – whatever is appropriate;
- Set out protocols for ‘outsiders’ working with the community and families after a traumatic incident; and
- Be reviewed at regular intervals.

As before, the RCRA can draw on additional support that may be required through SHARCRA.

5. **RCRA Work with National Level Support Agencies**

The RCRA will:

- Work with the National Leadership Role in Suicide Prevention to:
  - Provide information and data to, and otherwise utilise the proposed Real-time Data ‘Red Flag’ Alert System (Red Flag System). This is intended to nationally monitor all suicide – both Indigenous and non-Indigenous, down to the community level, and to alert the RCRAs to Indigenous suicide and potential suicide clusters. The data gathering function could be coordinated by this body utilising a range of sources including coronial and police reports, PHNs, ACCHSs/AMSs and the 12 Regional Networks of the Department of the Prime Minister and Cabinet;
  - Host an annual conference of Indigenous postvention stakeholders to support an integrated response to Indigenous suicide and critical incidents at the state and territory, regional, and community level.

- Work with the Centre of Best Practice in Indigenous Suicide Prevention
  - to identify best practice and develop national standards and protocols in postvention responses to suicide and traumatic incidents in Indigenous communities. This could include, but is not limited to helping identify:

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<th>Agreements</th>
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<td>Performance indicators for key milestones in model-establishment</td>
<td>Performance indicators</td>
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CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

The following elements of the ATSISPEP Critical Response Project (WA) are considered to have been successful and as such, are contained in the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities presented in the previous chapter.

In summary, the important outcomes are as follows. The Critical Response Stream demonstrated the:

- Value of complementing existing service providers in critical responses rather than duplicating them or adding another ‘layer’ of administration and bureaucracy to the environment in which they operate;
- Need for a coordination role in critical responses. The Project Team and CRA often faced the same challenges as that faced by bereaved Indigenous families: siloed and fragmented services and programs resulting in a lack of coordination and communication including across levels of government;
- The value of having an independent advocate to navigate complex systems on behalf of people who may not feel they can do this under such grievous and stressful circumstances. An independent advocate could also ask for service responses that individuals may not be aware are potentially available; and
- Need for long-term support to be provided to bereaved families, and the need for a coordination role to, in part, ensure this happens.

The Community Development Stream demonstrated the:

- Importance of proactive critical response planning prior to critical incidents rather than being reactive. Preparatory work also included local partnership agreements, service mapping, relationship building and so on;
- Need to train and employ community members in suicide prevention and critical responses. This also potentially provides a foundation for their training for, and employment in, much needed community-located mental health services;
- Value of working with Indigenous community-controlled organisations as local community partners;
- Need for improved levels of cultural safety amongst mainstream service provider responses including by the employment of community members; and
- Need for primordial prevention activity to take place as part of a range of suicide prevention activities in Indigenous communities.

There were also challenges in delivering the Critical Response Stream that are reflected in differences between the way the ATSISPEP Critical Response Project (WA) operated and the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities.

The primary difference is the absence of an operation centre, away from communities, such as that in the Perth-based Critical Response Stream. As discussed, this was initially located in Perth as the work of the CRA was intended to be phone-based. However, as discussed in Chapter 3, being distanced from the communities they were intended to work in, the Project Team and Critical Response Advocate (CRA) encountered significant challenges in reaching the Critical Response Stream’s primary target audience, which are the immediate families of deceased persons. This was particularly the case when the Project was not contacted directly by them.

The reasons why a significant number of families where contact was attempted did not return calls or otherwise utilise the CRA role it are unknown. However, the Project has assessed that reasons might include contact messages from the CRP not being passed on to the immediate family, that the immediate family were too overwhelmed by loss and grief to respond, that the immediate family were already receiving sufficient support (confirmed later in one case), or that the family preferred not to involve the CRP for their own reasons. The latter might include a lack of understanding about the Critical Response Stream, an absence of prior connection to it, and perhaps a perception that it might not be culturally appropriate as a result.

Connected to this, the Project assesses that the Critical Response Stream’s lack of local presence resulted in considerable delays between a critical incident and the Project receiving notification and responding. The operation involved considerable distances across an area about the same size as Western Europe. See Map 1 for a pictorial overview.
Across such distances, community based pre-existing networks and long term relationships of trust proved to be the best lines of communication.

In contrast, the Goldfields site, where project workers from both Project streams made multiple site visits and in doing so built relationships of trust from the start, showed the difference between how a community based and located critical response service would operate compared to a phone based or otherwise centralised service. In this site, relationships of trust assisted not only with improved notifications of critical incidents, but also with the Project Team and CRA’s ability to improve service coordination and the support provided to bereaved families.

However, this was one site, and it is the Project’s further assessment that the more ‘localised’ quality of the Project in the Goldfields could not be repeated by a centralised operation centre across the many hundreds of Indigenous communities across Australia. More localised responses are required.

The ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities (in Chapter 5) locates critical responses at the regional level where the reach into communities is far more direct and strong relationships can be built effectively and maintained.

At the regional level, it is intended that Regional Critical Response Advocates (RCRA) work from ACCHSs to coordinate existing services in critical responses.

Adopting some of the functions of the Project’s Community Development Stream, the RCRAs can facilitate the development of proactive Critical Incident Response Process Agreements with communities prior to critical incidents, and that are complemented by Post-critical Incident Response Process Agreements to ensure support for bereaved families is sustained over the longer term.

The RCRAs can also facilitate and maintain Regional Postvention Response Networks governed by Regional Agency Response Agreements.

This leads to the first of three recommendations made in this report.

**RECOMMENDATION 1**

That Governments implement the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities. This process should build on Aboriginal Community Controlled Health Services’ (ACCHSs) existing mental health and social and emotional wellbeing services in Indigenous communities where possible.
The key elements of the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities that involve central agencies are:

- A national Real-Time Data ‘Red Flag’ Alert System. While the Project has stated above that one advantage of a community-located critical response model is that notifications of critical incidents would be enhanced, nonetheless the Project believes a national Real-Time Data ‘Red Flag’ Alert System is still required to ensure timely and complete coverage of suicides and attempted suicides as possible, and to ensure the national picture is effectively monitored.

- Work that could be done by the Centre of Best Practice in Indigenous Suicide Prevention. That is, to identify best practice and develop national guidelines, standards and protocols in postvention responses to suicide in Indigenous communities as well as map training options for community members to support critical responses.

It is essential that the National Aboriginal Community Controlled Health Organisation, as the peak body for the ACCHSs, is a lead partner in the implementation of the ATSISPEP recommended service model to provide support to ACCHSs around the country to host the RCRAs and otherwise as appropriate.

Other Project findings from the delivery of the ATSISPEP Critical Response Project (WA) include:

- Given their contact with families who have experienced critical incidents, provision of counselling by the CRA would have been a valuable addition to their services, in addition to counselling that may be offered by ACCHSs and mental health services. Part of the ATSISPEP recommended service model is that RCRAs are trained in counselling and basic mental health skills.

- Managing the dispersal of emergency relief funds at a distance was challenging. In the ATSISPEP recommended service model, RCRAs maintain a directory of agencies from which to seek emergency relief funding, with the directory also being publicly available. As a last resort, each RCRA should be able to provide limited emergency relief funds governed by regionally negotiated protocols.

- Record keeping was a significant Project challenge. By Project’s end, for twenty-one families assisted by the CRA, six Critical Response Records (CRR) were completed: one in May 2016; three in June; and two in August. These CRR appear to have been completed after CRA support commenced, rather than being completed by the CRA as events unfolded. They sometimes lacked important information as a result. This also resulted in some significant misunderstandings between members of the Project staff.

ATSISPEP immediately notified the Department of the Prime Minister and Cabinet and the ATSISPEP Governance Committee of these issues. Weekly forms were also developed to ensure records were kept and otherwise address some of the challenges associated with record-keeping.

Part of the ATSISPEP recommended service model is that Regional Critical Response Advocates are trained in record keeping skills. The Project notes that maintaining records in the field and across great distances was a challenge shared by other service providers.

- Mapping – overlapping responsibilities. Because the Primary Health Networks are already funded to map mental health and related services in their regions, an efficiency could be gained by allocating the responsibility of mapping relevant Indigenous suicide prevention and postvention services to the PHNs and this is included in the service model presented in this report. However, the PHN must work with local ACCHSs to ensure their mapping is accurate and comprehensive, and that community control and the employment of Indigenous local people in services and programs is a part of the exercise.

From the above, a second recommendation is made.

**RECOMMENDATION 2**

Relevant bodies should be engaged to support any implementation of the ATSISPEP Recommended Service Model for Critical Responses in Indigenous Communities. This could include:

a) The National Leadership Role in Suicide Prevention. To host a Real-Time Data ‘Red Flag’ Alert System that monitors the need for postvention responses nationwide, including in Indigenous communities, and alerts Regional Critical Response Advocates and communities as appropriate.

b) Primary Health Networks. To contribute to a directory of services and programs for use in Indigenous-specific critical responses in partnership with Regional Critical Response Advocates and ACCHSs. The directory should identify community controlled, culturally safe and culturally competent services as a priority focus.

c) The National Aboriginal Community Controlled Health Organisation as the peak body of the ACCHSs.

d) The Centre of Best Practice in Indigenous Suicide Prevention. To identify best practice and to develop national guidelines, standards and protocols for postvention responses to critical incidents in Indigenous communities.
In conclusion, based on its work delivering the Critical Response Project (WA), ATSISPEP was asked by the Department of the Prime Minister and Cabinet to make general recommendations about how the Australian Government could improve service provision in Indigenous communities.

The Australian Government has two main mechanisms for improving service delivery. The first is its direct funding role, when a service provider is contracted to an Australian Government department. The second is its indirect funding role: for example, when a Primary Health Network commissions services using pooled Australian Government funds.

The following recommendation is intended to cover both these situations.

**RECOMMENDATION 3**

Indigenous community controlled services are the preferred providers of suicide prevention activities to their communities.

To support this, the Australian Government should ensure that preference is given to Indigenous community controlled services in all relevant service commissioning processes which it funds or influences.

In the event that a service is delivered by a non-Indigenous community-controlled organisation, the Australian Government should ensure the service is delivered in a culturally safe manner by culturally competent staff. This should be measured by using Key Performance Indicators (KPIs) such as:

- Minimum Indigenous employment level at all levels of the service;
- Minimum cultural competence training levels for non-Indigenous staff that are negotiated with local Indigenous communities;
- Requirements that provider governance bodies (such as Boards) include Indigenous community representatives; and
- Indigenous cultural mentors are employed to work with senior management.

KPIs are to be negotiated by Indigenous leaders and the Department of the Prime Minister and Cabinet for adoption across the Australian Government with application in:

- Funding agreements;
- CEO and senior staff employment contracts; and
- Reporting schedules.
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Success factors for Indigenous suicide prevention, with those identified in the meta-evaluation of evaluated community-led Indigenous suicide prevention programs in blue font.

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<th>Primordial prevention</th>
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<td><em>Community-wide responses</em></td>
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<td><em>Community-wide responses</em></td>
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<td><em>Primary prevention</em></td>
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<td>• Peer-to-peer mentoring, and education and leadership on suicide prevention</td>
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<td>• Programs to engage/divert, including sport</td>
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<td><em>Primary prevention</em></td>
<td>• Connecting to culture/country/Elders</td>
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<td><em>Universal</em></td>
<td>• Community empowerment, development, ownership – community-specific responses</td>
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</tr>
<tr>
<td><em>Universal</em></td>
<td>• Data collections</td>
</tr>
<tr>
<td><em>Universal</em></td>
<td>• Dissemination of learnings</td>
</tr>
</tbody>
</table>
APPENDIX 2 - PROJECT GOVERNANCE

GOVERNANCE
The Governance Committee of the Project comprised experts in the field of critical response and key partners in the Project. Members included representatives from:

- Winthrop Professor Jill Milroy, Professor Tom Calma AO, Professor Pat Dudgeon (Chair), Dr Yvonne Luxford - ATSISPEP Senior Management Team;
- Mr Brendan Gibson, Ms Irene Krauss - Department of Prime Minister and Cabinet;
- Mr Grant Akesson - Western Australia Mental Health Commission;
- Mr John Tunney, Ms Sharon Daniels - Commonwealth Department of Health;
- Mr Christopher John, Ms Karen Phillips - United Synergies;
- Ms Vicki O’Donnell, Mr Rob McPhee – Kimberley Aboriginal Medical Service;
- Mr Clive Holt – Bega Gambirringu Health Service;
- Ms Deborah Woods – Geraldton Regional Aboriginal Medical Service;
- Mr Wayne Coles, Ms Wilhelmina Farmer – Kaata-Koorliny Employment and Enterprise Development Aboriginal Corporation (until August 2016);
- Deputy Commissioner Murray Smalpage, District Police Superintendent Mick Sutherland AM - Western Australia Police;
- Ms Linda Richardson, Ms Sharleen Delaney - WA Primary Health Alliance; and
- Mr Mark Glasson - Anglicare as manager of StandBy Response Service in the Kimberley.

The Committee met monthly and provided a valuable avenue for exchange of information and ideas to improve the Project.

PROJECT TEAM
Some staff of the Project were employees of the University of Western Australia, others were employed as consultants due to the nature of their work. The Project Team included:

**Project Leader and Senior Executive:** Winthrop Professor Jill Milroy, Dean of the School of Indigenous Studies had overarching management of the Project.

**Project Director:** Professor Pat Dudgeon was also the Project Director of the ATSISPEP Project, ensuring synergy, continuity of aims and collaboration.

**Critical Response Advocates:** Mr Gerry Georgatos was the lead Advocate and attended to the majority of cases. Initially Ms Adele Cox filled the role of alternate Critical Response Advocate, subsequently Mr Lionel Quartermaine was available as the alternate.

**Community Development Facilitator:** Mr Lionel Quartermaine

**Resource/ Research Officers:** Ms Amanda Bresnan, Ms Mary Davies and Ms Sue Chiera

**Executive Officer:** Dr Yvonne Luxford

**Administrative Officer:** Ms Jan Burrows and Ms Chrissie Easton

**Website Administration:** Navid Mavaddat
APPENDIX 3 - CRITICAL RESPONSE ADVOCATE POSITION DESCRIPTION

- Provide critical response to people bereaved by suicide or experiencing a similarly significant traumatic event in a timely and culturally sensitive manner;
- Be available 24/7 to respond to incidents from throughout Western Australia;
- Work directly with individuals, families and communities by telephone or other electronic means, or in person when necessary;
- Assess the immediate needs of the individuals, families and communities and facilitate connection to appropriate local service providers;
- Assess the availability and appropriateness of local service providers, particularly in relation to cultural sensitivity;
- Comply with the Commonwealth Privacy Act, 1988 especially in relation to collecting, storing and sharing sensitive information;
- In consultation with appropriate local services such as Aboriginal Community Controlled Health Organisations and Primary Health Networks (PHN), assist in the assessment of community needs and levels of resilience;
- Strengthen family and community trust and relationships with the service system whilst promoting a person centred, holistic approach;
- Monitor ongoing care provision;
- Maintain accurate recording of data;
- Notify the Manager, Suicide Prevention, Western Australian Mental Health Commission of any suspected suicide;
- Undertake regular peer debriefing and psychological mentoring for [CRA] self-care;
- Provide advice regarding appropriate communication of issues and dissemination of information about the Critical Response Service, such as through traditional or social media;
- Monitor use of a dedicated phone line and provide advice on expansion of same;
- In collaboration with relevant stakeholders such as WA Mental Health Commission, PHNs and Standby Response Service, assist in the mapping of availability of services in areas of high risk;
- In collaboration with relevant stakeholders such as WA Mental Health Commission, WA Police, WAPHA, the Coroner and WA Country Health Service, assist in the development of appropriate notification protocols – both as triggers for Critical Response, and mechanisms to access local services even when out of hours;
- Assist in the development of a preferred protocol for provision and linkage of services through a Critical Response program;
- Perform other duties as relevant;
- Participate in training and professional development; and
- Contribute to reporting requirements and further development of the Critical Response Project.
APPENDIX 4 - SUICIDE PREVENTION ACTIVITY PROVIDERS AND OTHER INITIATIVES IDENTIFIED IN THE GOLDFIELDS

For all trial sites information was requested by email with telephone follow up. All information received has been recorded despite not all questions receiving responses.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kalgoorlie-Boulder Mental Health Services</td>
<td>Kalgoorlie Hospital, Kalgoorlie WA 6430</td>
<td>Mental Health Services.</td>
</tr>
<tr>
<td>Goldfields Community Alcohol and Drug Service (GCADS)</td>
<td>Kalgoorlie Office 48 Brookman Street, Kalgoorlie WA 6430 Esperance Office Dempster Street, Esperance WA 6450</td>
<td>Mental Health and Counselling Services. The Goldfields Community Alcohol and Drug Service (GCADS) has offices in Kalgoorlie and Esperance, providing a variety of community services to the Goldfields region. The Kalgoorlie team has extended outreach to Leonora and Laverton.</td>
</tr>
<tr>
<td>Headspace</td>
<td>Level 1, 48 Brookman Street, Kalgoorlie WA 6430</td>
<td>Mental Health Services. Offers early intervention services to young people aged 12 to 25.</td>
</tr>
<tr>
<td>Centrecare</td>
<td>168 Egan Street, Kalgoorlie WA 6430</td>
<td>Mental Health Services. Catholic, not-for-profit organisation delivering professional counselling, support, mediation and training services including weekly and fortnightly services to the communities of Coolgardie, Menzies, Leonora and Laverton and Norseman. Staff provide regular support to the remote Aboriginal communities of Coonana, Tjuntjuntjarra and the Ngaanyatjarra Lands.</td>
</tr>
<tr>
<td>Bega Garnbirr miracle Health Services</td>
<td>16-18 MacDonald Street, Kalgoorlie WA 6430</td>
<td>The service provides a holistic method of service provision, offering clinical services, health promotion and health education.</td>
</tr>
<tr>
<td>360 Health + Community Services</td>
<td>Hannan Street, Kalgoorlie WA 6430</td>
<td>Primary health and community services provider.</td>
</tr>
<tr>
<td>Hope Community Services</td>
<td>48 Brookman Street, Kalgoorlie WA 6430</td>
<td>Mental health; alcohol and drugs. Services include: Counselling; mental health; outreach; parenting; residential; therapeutic community; transition to community; youth services.</td>
</tr>
</tbody>
</table>

FURTHER DETAIL AND OTHER INITIATIVES IN THE GOLDFIELDS

Goldfields Suicide Prevention
Goldfields District Leadership Group Critical Incidents
Kalgoorlie-Boulder Human Services Group
Kalgoorlie-Boulder Aboriginal Community Residents Group
BLAST
Northern Goldfields Caring Connected Community, Community Wellbeing Network
Grow Local
WA Mental Health Commission Regional Suicide Prevention Coordinator
For all trial sites information was requested by email with telephone follow up. All information received has been recorded despite not all questions receiving responses.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mens Outreach Centre - Alive and Kicking Goals program (Indigenous youth suicide prevention)</td>
<td>11 Hamersley, Broome WA 6725</td>
<td>Services include Drop in Service for homeless men; Re-entry service for ex-prisoners; Men and Family Relationships (counselling, referral, advocacy for men). Outreach visits for people in crisis. Alive and Kicking Goals: Suicide Prevention. The project is initiated, managed, and led by Aboriginal people in the Kimberley.</td>
</tr>
</tbody>
</table>
| Kimberley Mental Health and Drug Service (WACHS) | Broome: Cnr Anne & Robinson Streets, Broome WA 6725
Derby Hospital
Fitzroy Crossing: Nindilingarri Cultural
Kununurra Hospital
Halls Creek | Adult & Elderly Mental Health: This community based service is for adults requiring assessment and treatment for mental health conditions. Child & Adolescent Mental Health (CAMHS): This community based service is for children and adolescents (0-18 yrs) and their families. |
| Headspace | Shop A, 38 Frederick Street, Broome WA 6725 | Mental Health Services. Has psychologist and counsellors. Operated by KAMSC. |
| Jungarni Jutyia Indigenous Corporation | 94 Thomas Street, Halls Creek WA 6770 | Crisis response call centre. Alcoholism treatment program. |
| Kimberley Aboriginal Law and Culture - Yiriman Program | Great Northern Highway, Fitzroy Crossing WA 6765 | Yiriman Project is an intergenerational, “on-Country” cultural program, conceived and developed directly by Elders from four Kimberley language groups. |
| StandBy Response Service | 2 Weld Street, Broome WA 6725
2 Banksia Street, Kununurra WA 6743 | Provides crisis response teams on the ground who also work through existing community structures. |
| Kimberley Aboriginal Medical Service (KAMS) | 12 Napier Terrace, Broome WA 6725 | Social and Emotional Wellbeing team; education and training in suicide prevention. KAMSC also provides comprehensive primary health care services in the remote communities of Beagle Bay, Bidyadanga and Kutjungka (Balgo, Mulan and Billiluna communities). |
| Nindillingarri Cultural Health Services | PO Box 59, Fitzroy Crossing WA 6765 | Social and Emotional Wellbeing team; Mental Health Worker; psychologist. Nindillingarri Cultural Health Services (NCHS) is an Aboriginal Community Controlled Health Organisation (ACCHO); partners with Fitzroy Valley Health Service (FVHS). |
| Ord Valley Aboriginal Health Service | 1125 Ironwood Drive, Kununurra WA 6743 | Social and Emotional Wellbeing team; Mental Health Worker; psychologist. |
### Organisation Address Functions

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waringarri Aboriginal Corporation</td>
<td>2229 Speargrass Road, Kununurra WA 6743</td>
<td>Operates the Moongoong Sober Up Shelter. ASIST - suicide prevention training only.</td>
</tr>
<tr>
<td>Wesley Mission</td>
<td>76 Coolibah Drive, Kununurra WA 6743</td>
<td>Suicide prevention community group provides education.</td>
</tr>
<tr>
<td>Wunan Foundation - Kununurra Medical Services</td>
<td>76 Coolibah Drive, Kununurra WA 6743</td>
<td>Focused on empowering the community. Education; employment; accommodation &amp; housing; welfare reform; leadership.</td>
</tr>
<tr>
<td>Yura Yungi Aboriginal Medical</td>
<td>Terone Street, Halls Creek WA 6770</td>
<td>Social and Emotional Wellbeing teams.</td>
</tr>
<tr>
<td>Boab Health Services</td>
<td>20 Hamersley Street, Broome WA 6725</td>
<td>Mental Health Nurses, Psychologists, Clinical Psychologists, Social Workers and Occupational Therapists. Allied Health, Mental Health, and a ‘Closing the Gap’ team. Broome, Kununurra and outreach to communities.</td>
</tr>
<tr>
<td>Nirrumbuk Aboriginal Corporation</td>
<td>34 Blackman Street, Broome WA 6725</td>
<td>15 years working with youth at risk. Employment, training, environmental health, youth services, counselling.</td>
</tr>
<tr>
<td>Ngnowar Aerwah Aboriginal Corporation</td>
<td>471 Great Northern Highway, Wyndham WA 6740</td>
<td>Provides a range of culturally appropriate services for Aboriginal people to address the harmful effects of alcohol and other drug use including: Seven Mile Rehabilitation Centre.</td>
</tr>
<tr>
<td>Australian Red Cross</td>
<td>2/38 Frederick Street, Broome WA 6725</td>
<td>Red Cross is working closely with local Aboriginal services in Broome.</td>
</tr>
<tr>
<td>Aboriginal Family Law Services</td>
<td>Unit 1, 46 Dampier Terrace, Broome WA 6725</td>
<td>Provides legal assistance and advice to victims of family and domestic violence and sexual assault.</td>
</tr>
</tbody>
</table>

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**FURTHER DETAIL AND ADDITIONAL INITIATIVES IN THE KIMBERLEY**

- Kimberley Aboriginal Health Planning Forum (KAHPF)
- Kimberley Regional Aboriginal Mental Health Planning Forum (KRAMHPF)
- StandBy Response Service
- East Kimberley StandBy Response Service
- West Kimberley StandBy Response Service
- Kimberley Aboriginal Law and Culture Centre (KALACC)
- The Yiriman Project
- Alive and Kicking Goals! (AKG)
- WA Mental Health Commission Regional Suicide Prevention Coordinator
- Commonwealth Kimberley Suicide Prevention Trial Site
APPENDIX 6 - SUICIDE PREVENTION ACTIVITY PROVIDERS
AND OTHER INITIATIVES IDENTIFIED IN GERALDTON

For all trial sites information was requested by email with telephone follow up. All information received has been recorded despite not all questions receiving responses.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Address</th>
<th>Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>WACHS Midwest Mental Health Services (CWMHS)</td>
<td></td>
<td>Provide acute mental health services throughout the Midwest region including suicide prevention.</td>
</tr>
<tr>
<td>Midwest Yellow Ribbon</td>
<td></td>
<td>Provides education to community on suicide prevention.</td>
</tr>
<tr>
<td>Geraldton Resource Centre</td>
<td>114 Sanford Street, Geraldton WA</td>
<td>A non-profit organisation providing services to people experiencing disadvantage in the Mid West and Gascoyne regions of WA.</td>
</tr>
<tr>
<td>Fusion Australia</td>
<td>68 Boundary Road, St James, Perth WA</td>
<td>Focused around providing accommodation and housing services for people in need, socially at risk, mental health issues.</td>
</tr>
<tr>
<td>Headspace Geraldton</td>
<td>193 Marine Terrace, Geraldton WA</td>
<td>Headspace Geraldton is operated by Youth Focus for young people aged between 12 and 25 years.</td>
</tr>
<tr>
<td>Geraldton Sobering Up Centre</td>
<td>3110 Larkin Street, Geraldton WA</td>
<td>Offers shower, pyjamas and bed. Basic medical care and referrals where appropriate. In partnership with Hope Community Centre and Geraldton Yamatji Patrol Aboriginal Corporation.</td>
</tr>
<tr>
<td>Geraldton Yamatji Patrol</td>
<td>7 Larkin Street, Geraldton WA</td>
<td>The Yamatji Patrol promotes mutual understanding and respect between Aboriginal and non-Aboriginal people, and members of the police force.</td>
</tr>
<tr>
<td>Hope Community Services Geraldton</td>
<td>11 Bayly Street, Geraldton WA</td>
<td>Provides support to people affected by alcohol, drugs and socioeconomic disadvantage.</td>
</tr>
<tr>
<td>Geraldton Regional Aboriginal Medical Service</td>
<td>Rifle Range Road, Geraldton WA Outreach at Mt Magneta</td>
<td>Community controlled Aboriginal organisation, offering an affordable and culturally appropriate health services to the Mid West and Murchison communities.</td>
</tr>
<tr>
<td>Bundiyarra Aboriginal Community Aboriginal Corporation</td>
<td>Cnr Eastward &amp; Blencowe Roads, Geraldton WA</td>
<td>A resource centre offering programs and resources to help improve Social, Cultural, Economic and Community Engagement for Aboriginal people in the Midwest, Murchison and Gascoyne regions.</td>
</tr>
<tr>
<td>Chrysalis Support Services and Women's Refuge</td>
<td>114 Sanford Street, Geraldton WA</td>
<td>Counsel in Relationship and family violence; Sexual assault; Child sexual assault; Domestic violence advocacy. Community education. Operate Women's Refuge.</td>
</tr>
<tr>
<td>360 Health and Community</td>
<td>5 Chapman Road, Geraldton WA</td>
<td>Primary health care organisation to coordinate primary health care delivery and tackle local health care needs and service gaps.</td>
</tr>
<tr>
<td>Organisation</td>
<td>Address</td>
<td>Functions</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Centacare and Family Relationships Centre</td>
<td>3 Maitland Street, Geraldton WA</td>
<td>Grief and general counselling. Advocacy, Welfare services, family support, education programs, emergency relief/money.</td>
</tr>
<tr>
<td>Aboriginal Legal Service</td>
<td>73 Forrest Street, Geraldton WA</td>
<td>Legal representation and support services for Aboriginal and Torres Strait Islander peoples in Western Australia.</td>
</tr>
<tr>
<td>Department of Aboriginal Affairs</td>
<td>45 Cathedral Avenue, Geraldton WA</td>
<td>Responsible for advising Government on the adequacy, implementation and coordination of services to Aboriginal people in Western Australia.</td>
</tr>
<tr>
<td>Community Drug Service Team</td>
<td>Community Health Centre, 51-58 Shenton Street, Geraldton WA</td>
<td>Support &amp; counselling for alcohol and drug abuse. Life skills programs. Information &amp; education.</td>
</tr>
<tr>
<td>Department of Child Protection</td>
<td>45 Cathedral Avenue, Geraldton WA</td>
<td>Works with families, foster carers, agencies &amp; community to ensure safety of children.</td>
</tr>
<tr>
<td>Department of Housing</td>
<td>201 Marine Terrace, Geraldton WA</td>
<td>Aboriginal Housing Coordinator. Public &amp; community affordable housing. Home loans, rental &amp; bond loan assistance.</td>
</tr>
<tr>
<td>Short Term Accommodation for Youth (STAY)</td>
<td>24 Quarry Street, Geraldton WA</td>
<td>Crisis service for young people aged between 15 and 25.</td>
</tr>
<tr>
<td>Geraldton Regional Hospital Aboriginal Liaison Officers (ALOs)</td>
<td>Shenton Street, Geraldton WA</td>
<td>Liaison officers help Aboriginal patients at the regional hospital; provide transport for clients.</td>
</tr>
<tr>
<td>Bundiyarra- Irra Wangga Language Centre</td>
<td>Cnr Eastward &amp; Blencowe Roads, Geraldton WA</td>
<td>Preservation &amp; revitalisation of language, history &amp; culture. Language resources.</td>
</tr>
<tr>
<td>Skill Hire</td>
<td>14 Anzac Terrace, Geraldton WA</td>
<td>Employs Aboriginal workers and places some through the WA Department of Employment through the Work for the Dole Jobactive program. Partners with Bundiyarra Aboriginal Community Aboriginal Corporation (BACAC).</td>
</tr>
<tr>
<td>Yamatji Marlipa Aboriginal Corporation (YMAC)</td>
<td>171 Marine Terrace, Geraldton WA</td>
<td>Native title representative body for the Yamatji and Pilbara regions of WA.</td>
</tr>
<tr>
<td>Meenangu Wajarri Aboriginal Corporation</td>
<td>122 Chapman Road, Geraldton WA</td>
<td>The Meenangu Wajarri Aboriginal Corporation and its sister organisation, Winja Wajarri Barna Ltd, were created as a result of the Murchison Radio-astronomy observatory Indigenous Land Use Agreement.</td>
</tr>
<tr>
<td>Midwest Employment &amp; Economic Development Aboriginal Corporation (MEEDAC)</td>
<td>25 Jose Street, Mullewa WA</td>
<td>MEEDAC is a Community Development Program provider (CDP) on behalf of the Australian Government.</td>
</tr>
</tbody>
</table>
Organisation | Address | Functions
--- | --- | ---
**Midwest Aboriginal Organisations Alliance (MAOA)** | Cnr Eastward & Blencowe Roads, Geraldton WA | The Midwest Aboriginal Organisation Alliance (MAOA) is a participatory action research group working towards greater community engagement in Indigenous issues.

**FURTHER DETAIL AND OTHER INITIATIVES IN GERALDTON**

- Wesley Mission – LifeForce Suicide Prevention Program
- Wesley Mission – Wesley LifeForce Geraldton Suicide Prevention Action Group
- Mid-West Gascoyne Human Services Regional Managers Group
- Mid-West Aboriginal Organisations Alliance
- Mid-West Critical Incident Response
- WA Country Health Service (WACHS)
- The Yamatji (Midwest) Regional Aboriginal Health Planning Forum
- Bundiyarra Aboriginal Community Aboriginal Corporation (BACAC)
- WA Mental Health Commission Regional Suicide Prevention Coordinator

**WIDER REGIONAL INITIATIVES**

- Wesley Mission – LifeForce Suicide Prevention Program Carnarvon
- Meekatharra/Mt Magnet Aboriginal Community Reference Groups
- Reconciliation Action Plans
For all trial sites information was requested by email with telephone follow up. All information received has been recorded despite not all questions receiving responses.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Location</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baptistcare</strong></td>
<td>Narrogin WA 6312</td>
<td>Primary Mental Health Peer Support.</td>
</tr>
<tr>
<td><strong>CANWA</strong></td>
<td>7 Wald Street, Narrogin WA 6312</td>
<td>Aboriginal and Torres Strait Islander Social and Emotional Wellbeing programs.</td>
</tr>
<tr>
<td><strong>Central Agcare Family Counselling</strong></td>
<td>Bruce Rock Medical Centre, Bruce Rock WA 6418</td>
<td>Mental Health Services – Brookton, Bruce Rock, Corrigin, Hyden, Kondinin, Kulin, Narembeen, Pingelly, Quairading, Wickepin</td>
</tr>
<tr>
<td><strong>Kaata Koorliny Aboriginal Corporation - Personal Helpers and Mentor Service</strong></td>
<td>112 Federal Street Narrogin - Service provided in Narrogin with outreach to Katanning, WA 6312</td>
<td>Mental Health Services. Participates in joint group projects with Avivo and Wheatbelt Aboriginal Health Service.</td>
</tr>
<tr>
<td><strong>Regional Men’s Health Initiative</strong></td>
<td>75 York Road, Northam WA 6401</td>
<td>Men’s Primary Mental Health &amp; Wellbeing.</td>
</tr>
<tr>
<td><strong>Share &amp; Care Community Services Group Inc</strong></td>
<td>88 Wellington Street, Northam WA 6401</td>
<td>Family &amp; carer support Suicide bereavement support service. Mental Health Program.</td>
</tr>
<tr>
<td><strong>Southern Agcare Family Counselling</strong></td>
<td>Community Resource Centre, Gnowangerup WA 6335</td>
<td>Mental Health Services.</td>
</tr>
<tr>
<td><strong>WGPN - Rural Community Support Service</strong></td>
<td>Federal Street, Narrogin WA 6312</td>
<td>Primary Mental Health service.</td>
</tr>
<tr>
<td><strong>Wheatbelt GP Network - ATAPS/MHSSRA</strong></td>
<td>Holtfreter Avenue, Northam WA 6401</td>
<td>Community Health Services. Wheatbelt Psychological and Counselling Services.</td>
</tr>
<tr>
<td><strong>Wheatbelt Aboriginal Health Service: Managed through WACHS</strong></td>
<td>Hospital Grounds Williams Road, Narrogin WA 6312</td>
<td>Community Health Services.</td>
</tr>
<tr>
<td><strong>Wheatbelt AgCare Community Support Services Inc</strong></td>
<td>PO Box 101 Nungarin WA 6490</td>
<td>Community Health Services - Kellerberrin, Koorda, Mount Marshall, Mukinbudin, Merredin, Nungarin, Tammin, Trayning, Westonia, Wyalkatchem, Yilgarn.</td>
</tr>
</tbody>
</table>

**FURTHER DETAIL AND OTHER INITIATIVES IN NARROGIN**

Mental Health First Aid Training

Kellerberrin Noongar Centre

WA Mental Health Commission Regional Suicide Prevention Coordinator
APPENDIX 8 - COMMUNITY EMPOWERMENT AND TRAINING

THE LEONORA STORY
Prepared in collaboration with staff of WAPHA, especially Tralee Cable, Regional Coordinator/Network Support Officer, Northern Goldfields Region

Late in 2015 three suicides occurred involving families from Leonora, including two teenagers. The younger brother of one of the teenagers attempted (and was hospitalised) in January, and a young mother suicided in early February. The Critical Response Project assisted in each of these cases, and developed a close relationship with many community members.

This led to one of the community Elders, Richard Evans, being offered a bursary to attend the inaugural National Aboriginal and Torres Strait Islander Suicide Prevention Conference in Alice Springs on May 5-6.

The Bus to Hope
Richard Evans approached Tralee Cable of Western Australian Primary Health Alliance (WAPHA) to assist him to find a way to take a group of youth from Leonora to the ATSISPEP conference, using the $3,000 bursary he had been granted by one of the conference sponsors, WAPHA.

To ensure even coverage of all groups within the community, the Community Action Group (at that stage called the Hope Council) was created. The Action Group was made up of representatives from Leonora’s four main families, and a number of other leaders from within the community including Aboriginal Elders, a school principal, a staff member from WACHS, a Director of Nursing, a police superintendent, and the Deputy President of Leonora Shire Council.

This group recommended a complement of 25 people, including Richard and Sandra Evans, who would benefit from attending the conference.

A proposal document was created, and $40,000 was raised from various sources including:

- ATSISPEP;
- WAPHA;
- WAPHA;
- Shire of Leonora;
- Hope Community Services;
- Red Cross;
- Minara Foundation;
- Anglicare;
- WACHS Mental Health Team;
- Independence Group; and
- 360 Health.

The Leonora Shire agreed to auspice the donations, donated the bus for the use of the participants, and covered the small budget shortfall arising from flooded roads and additional accommodation requirements.

The Anglicare Regional Manager, Ashley Gibb, donated his time to travel from Leonora to Alice Springs with the delegates, as did Tom Hearn from Bush TV, who shot footage for the documentary, Bus to Hope, using his own funds. WAPHA funded the development of the documentary, subsequently screened in Perth and Leonora. Bus to Hope can be viewed on the ATSISPEP website www.atsispep.sis.uwa.edu.au.

The journey was advertised locally, mostly by word of mouth.

Some of the initial 25 delegates did not experience the journey. Many young people in town were unwilling to go without alcohol for the two weeks and chose not to participate for this reason. However, there were members from three of the four main families on the bus, which broke the ongoing silos that were operating in the community.

The journey has had a profound and lasting effect on those youth who did attend. While they have in the most part returned to their previous risky behaviours, each of the delegates is more open to talking about their situations, offering solutions, and realising that they have options to change this lifestyle.
The Action Group continued to meet on at least a monthly basis. The attached Northern Goldfields Wellbeing Plan was created and is used as the Term of Reference for the group, and each matter identified in the plan is addressed at each meeting.

Outcomes to date

- Negotiations with St Barbara Ltd regarding disposal of aerosol cans out of town;
- Discussion with Department of Housing about overcrowding issues, and suggestion that they refer to the Development Commission report as an indicator of housing needs in the community rather than waitlists which the Department acknowledge is a flawed system;
- Created the Northern Goldfields Wellbeing Facebook page to share itineraries of visiting service providers and encourage the identified factors in the Wellbeing Plan;
- Advocated and lobbied for local Mental Health counsellors;
- Supported the Grow Local strategy by advertising and promotion; and
- Workshopped Leadership and modelling behaviours to the rest of the community.

The Group is currently working in collaboration with Laverton Residents Group on an application for a liquor accord in the region.

Grow Local

Whilst attending the National Aboriginal and Torres Strait Islander Suicide Prevention Conference, the group were impressed with initiatives being undertaken in communities across Australia, and wished to bring training into the Leonora community so as to increase resilience and improve the opportunities for local people to work in the field of mental health. The Northern Goldfields Wellbeing Plan articulates some of these intentions in planning that an activity:

- Informs and engages the community and agencies to join together to articulate an integrated community and service approach and explore/develop options for improvement in Community and Aboriginal Mental health and wellbeing remote service delivery in the Northern Goldfields;
- Encourages broader collaboration at an early stage to build a shared vision with the community and agencies for improving the mental health in Leonora initially, then to the greater Northern Goldfields;
- Builds on an opportunity for community engagement with other communities and strategy sharing in approaching the challenge of remote mental health support;
- Explores options for youth engagement in creating purpose and meaning to assist them and their communities to become self-supporting, resilient, promote healing and solutions focussed;
- Begins community capacity and workforce development by engaging currently disconnected community members with the mental health conversation and solutions and encourages their diverse individual voices to be heard in the greater discussion and service design/responsiveness;
- Career focussed training of potential AHW and MH Nurses in the community; and
- Mindfulness and Resilience training in schools and wider community (perhaps yoga/meditation classes).

The Action Group sought assistance from WAPHA to deliver the initial training, but has maintained Indigenous governance and control of the process. Training participants were selected by the Action Group, with most of the members of the CAG choosing to join the training program themselves. A number of young people were invited to participate alongside local word-of-mouth advertising. The program is very much driven by the Action Group who identify the modules to be completed and the timing for delivery. This community driven approach has resulted in the building of a relationship of trust between the trainers and the community.

Some participants from the first program were particularly energised by the training. One young woman had been a carer for an older family member and her siblings for most of her life, and had therefore missed a lot of school. Through the training she came to understand that the experience she had gained in caring for these people was actually an asset. This small change in thinking resulted in a significant change in her attitude.

The community considered there was a need to have Aboriginal people develop skills which could enable them to be employed as mental health workers. Whilst their first interest was to gain skills which would help them and their communities address issues, they were also interested in employment opportunities in the future. It is very difficult to get qualified mental health staff in the Goldfields region and training local people was considered by them to be the best way to gain and retain a workforce.
In considering the local training needs, the Action Group was concerned that most training was provided as a single event, for example Aboriginal Mental Health First Aid, which did not articulate into a certificate qualification which could lead to employment. The Australian Medical Association (AMA) has worked with WAPHA and the Action Group to develop modules of training building towards the Certificate IV in Mental Health and the Certificate IV in Mental Health Peer Work Consumer Stream. The AMA were also interested in working with the community to try to provide Recognition of Prior Learning for some of the elements of the course if community members had competencies gained from participation in other one-off programs, hence enabling people to gain certification more quickly.

ATSISPEP has committed funding to finance the next set of modules of the training program, alongside WAPHA and a local mining organisation.

NORTHERN GOLDFIELDS CARING CONNECTED COMMUNITY
COMMUNITY WELLBEING NETWORK
ACTION PLAN

This document was created by the Community Action Group

Background

Four suicides of younger people from Leonora and surrounds in a four month time period early in 2016 galvanised the community to action to seek options for improving the standard of life and life experience in the town, and the region.

The wider community group grappled to understand why and how young people, some with children of their own, all with loving families, reached a point where suicide seemed to them to be the best solution.

Blame was apportioned, and payback became a contributing factor in causing copycat situations that had a tragic end.

The Commonwealth of Australia responded by creating a team of postvention specialists to assist in such circumstances – ATSISPEP Critical Response Team.

One local community Elder raised a cry for more Boots on the Ground in a campaign aimed at increasing the focus of drive in drive out counselling and mental health services on providing a permanently located, localised solution for local people. This request asked that local people be involved in providing localised cultural awareness training to Agencies to assist them to provide a more meaningful and accessible service, responsive to the particular needs of this community.

Service providers in turn raised the issue of a factionalised community that was reluctant to work in tandem with each other or agencies, and requested that the community engage in cultural awareness training themselves to deal more appropriately with agencies. The responsibility for healing the community was then returned to the leaders before service providers could begin to heal individuals.

The Community Action Group (CAG) or Hope Council, was formed in response to these issues, and consists primarily of four local family Aboriginal group heads, a number of long term residents wanting to be a part of the solution, the school Principal, the OIC of the local Police Station and the DON of the Hospital. The CAG has remained independent of other service providers, with the aim of identifying issues in the community and articulating some solutions or actions that can then be requested from service providers. The CAG:

- Informs and engages the community and agencies to join together to articulate an integrated community and service approach and explore/develop options for improvement in Community and Aboriginal Mental health and wellbeing remote service delivery in the Northern Goldfields;
- Encourages broader collaboration at an early stage to build a shared vision with the community and agencies for improving the mental health in Leonora initially, then to the greater Northern Goldfields;
- Builds on an opportunity for community engagement with other communities and strategy sharing in approaching the challenge of remote mental health support;
- Explores options for youth engagement in creating purpose and meaning to assist them and their communities to become self-supporting, resilient, promote healing and solutions focussed;
- Begins community capacity and workforce development by engaging currently disconnected community members with the mental health conversation and solutions and encourages their diverse individual voices to be heard in the greater discussion and service design/responsiveness;
- Investigates successful aging in remote communities and discuss options for other locations within the Northern Goldfields and
- Takes affirmative action to reduce harmful impacts of substance abuse and antisocial behaviour.
VISION
Caring Connected Community

Mission Statement
To create opportunities for our community; to prevent suicide, connect, care for each other and promote wellbeing and resilience.

Our Values
The Northern Goldfields CAG values people: is a supportive and inclusive network that is friendly and welcoming to all.

We are respectful and ethical in all that we undertake, responsive to the needs of the community and genuine in our endeavours.

THE ACTION PLAN
Our Community Action Group will focus on the following areas:

| Housing                  | • Encourage Home Ownership – assist potential buyers through the IBA process, hold information sessions
|                         | • Advocate tenancy – ask housing and tenancy support to hold information sessions on rights/responsibilities
|                         | • Encourage Alcohol free home agreements – perhaps publish a list of numbers of agreements signed to encourage buy in.
|                         | • Address overcrowding by choice (houselessness vs homelessness)
| Wellbeing               | • Crisis Care for victims of Domestic Violence
|                         | • Healthy food options – quality and quantity of supply (how to incentivise the business owner to provide these)
|                         | • Home beautification programs and incentives (provide native seedlings, mulch, rakes etc prior to Golden Gift each year, investigate Bunnings support in educating people on painting and maintenance etc, hold beautiful home/garden competitions)
|                         | • Hold regular Health forums for the region (quarterly) where communities can discuss needs and gaps – include service providers.
| Mental Health           | • Service provider timetables openly displayed and readily available
|                         | • Mental health referrals chart to be readily available
|                         | • Advocate for locally based Mental Health professional
|                         | • Investigate options for rehabilitation (AOD and VSU) facilities and programs locally based
|                         | • Career focussed training of potential AHW and MH Nurses in the community
|                         | • Mindfulness and Resilience training in schools and wider community (perhaps yoga/meditation classes)
| Education               | • Family based education (childhood nurse, parenting skills)
|                         | • Lifestyle Choices education (AOD, Domestic Violence)
|                         | • Cultural appropriateness for service providers
| Law and Order           | • Address antisocial behaviour as a community
|                         | • Focus on stamping out illegal substance supply
|                         | • VSU, AOD counselling and education
|                         | • Early intervention programs (look into PCYC, Bluelight Disco, further YMCA)
|                         | • Encourage voluntary alcohol restrictions by liquor outlets
GOAL 1
To establish the network’s presence in the community.

STRATEGIC OBJECTIVE 1
To be widely known and welcoming to all members of the community

<table>
<thead>
<tr>
<th>Action</th>
<th>Activity (How)</th>
<th>Who/What is involved</th>
<th>When</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Branding</strong></td>
<td>Develop a brief for the logo</td>
<td>Network</td>
<td></td>
<td>Logo</td>
</tr>
<tr>
<td></td>
<td>Develop the logo for CAG</td>
<td>Engage a graphic designer</td>
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<tr>
<td><strong>Develop a Marketing and communication plan</strong></td>
<td>Develop a communication plan</td>
<td>Network</td>
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<tr>
<td></td>
<td>Develop Banner, marketing material, Flyer, social media webpage linked to Council webpage</td>
<td></td>
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</tr>
<tr>
<td><strong>Launch the Network</strong></td>
<td>Pre-Launch World Suicide Prevention Day</td>
<td>Network - Council members, Politicians, Key people and groups, service groups and community members</td>
<td>Pre-Launch</td>
<td>Launch</td>
</tr>
<tr>
<td></td>
<td>Handover action plan to key people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Increase Membership</strong></td>
<td>Open meetings</td>
<td>Network Secretary</td>
<td>Ongoing</td>
<td>Membership increase and diversity of mailing list</td>
</tr>
<tr>
<td></td>
<td>Invite widely, social media and paper invites, Council Webpage</td>
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</tr>
<tr>
<td><strong>Corporate Sponsor</strong></td>
<td>Develop a pitch for a corporate sponsor</td>
<td>Network</td>
<td></td>
<td>Corporate sponsor</td>
</tr>
</tbody>
</table>
### GOAL 2
To raise awareness and bring education opportunities to the community.

#### STRATEGIC OBJECTIVE 2
Increase community awareness and responsiveness.

<table>
<thead>
<tr>
<th>Action</th>
<th>Activity (How)</th>
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<th>When</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Break down stigma</strong></td>
<td>Role model the language and attitudes</td>
<td>Network</td>
<td>Ongoing</td>
<td>Monitor and No value statements</td>
</tr>
<tr>
<td></td>
<td>Challenge community attitudes – affirmation statements in public places</td>
<td></td>
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<tr>
<td></td>
<td>Advertising – how to seek help</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Provide education and training</strong></td>
<td>Bring training to the community</td>
<td>Target groups</td>
<td>2 Training/year</td>
<td></td>
</tr>
<tr>
<td><strong>Increase awareness</strong></td>
<td>Provide stories to the media</td>
<td>Network</td>
<td>4 times per year</td>
<td>Media Scrap book Evaluation of events held</td>
</tr>
<tr>
<td></td>
<td>Invite to events, provide pictures</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Run forums, join field days</td>
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</tr>
</tbody>
</table>

### GOAL 3
To develop opportunities for the community to connect.

#### STRATEGIC OBJECTIVE 3
To increase community capacity for wellbeing.

<table>
<thead>
<tr>
<th>Action</th>
<th>Activity (How)</th>
<th>Who/What is involved</th>
<th>When</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Create a facebook page</strong></td>
<td>Disclaimer – develop content</td>
<td></td>
<td></td>
<td>Facebook page Measure the number of likes</td>
</tr>
<tr>
<td></td>
<td>Help line</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>3 administrators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Advertising blocked</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Linking and encouraging people to services and resources to bring about connectedness</strong></td>
<td>Raise the profile of existing services and opportunities to connect</td>
<td>Network</td>
<td></td>
<td>Facebook</td>
</tr>
<tr>
<td></td>
<td>• Gardens</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Nursery</td>
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<tr>
<td></td>
<td>• Men’s sheds</td>
<td></td>
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<tr>
<td></td>
<td>Share with network members and post on social media and council website</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Promote RUOK Day, International Suicide Prevention Day in the community</strong></td>
<td>Promote in accordance with our communication plan</td>
<td>Network</td>
<td></td>
<td>Number of organisations involved each year</td>
</tr>
</tbody>
</table>
### GOAL 3
To develop opportunities for the community to connect.

#### STRATEGIC OBJECTIVE 3
To increase community capacity for wellbeing.

<table>
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<tr>
<th>Action</th>
<th>Activity (How)</th>
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<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link with events occurring in the community</td>
<td>Join with activities such as The Golden Gift</td>
<td>Network</td>
<td>Ongoing</td>
<td>Number of opportunities to fly the banner</td>
</tr>
<tr>
<td>Help to foster community groups</td>
<td>Golf Club, Race Club, Bowls Club, Football and Netball, Art Prize</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### GOAL 4
To support those bereaved by suicide.

#### STRATEGIC OBJECTIVE 4
To bring support and healing.

<table>
<thead>
<tr>
<th>Action</th>
<th>Activity (How)</th>
<th>Who/What is involved</th>
<th>When</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a postvention response plan</td>
<td>Seek assistance from Hope, Headspace, Centercare and WACHS Mental Health Unit to develop a plan</td>
<td>Network, Hope, Headspace School Support, Standby Response</td>
<td></td>
<td>Postvention response plan</td>
</tr>
<tr>
<td>Send forth delegates to ATSISPEP Indigenous Suicide Prevention Conference</td>
<td>Seek financial assistance from key strategic partners, encourage all family groups to support</td>
<td>WAPHA, Shire of Leonora, WACHS, local mining companies, local service providers</td>
<td></td>
<td>Documentary of journey, report to WAPHA, report to WACHS</td>
</tr>
<tr>
<td>Develop Memorial Gardens</td>
<td>Advocate with council for appropriate sites to develop sites for memorial gardens in the community</td>
<td>Network</td>
<td>Ongoing</td>
<td>One garden per year</td>
</tr>
<tr>
<td>Provide an opportunity for those Bereaved to meet</td>
<td>Out of the Shadow’s Walk</td>
<td>Network</td>
<td>Minimum of 1 per year</td>
<td></td>
</tr>
<tr>
<td>Bereaved to meet</td>
<td>Support Silent Ripples to increase groups</td>
<td>Network</td>
<td></td>
<td>Continued with Silent Ripples</td>
</tr>
</tbody>
</table>
#APPENDIX 9 - MAPPING OF COMMUNITY TRAINING OPTIONS

Whilst this list has been extensively researched, it may not be exhaustive and local research should be undertaken when planning a course.

<table>
<thead>
<tr>
<th>Course Title/ Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>#The 14-Hour Aboriginal and Torres Strait Islander Mental Health First Aid Course</td>
</tr>
</tbody>
</table>

**Program Sponsor:** Mental Health First Aid (MHFA) Australia
mhfa@mhfa.com.au
03 9079 0200
Parkville VIC

**Providers:** MHFA does not centrally coordinate courses.
Training arranged by contacting any of the AMHFA Accredited instructors in the relevant area (including WA). See list of instructors at: https://mhfa.com.au/instructors

Teaches members of the public how to help Aboriginal and Torres Strait Islander people experiencing a mental health crisis or developing a mental health problem.

Participants learn about social and emotional wellbeing, the signs and symptoms of mental health problems, where and how to get help and what sort of help has been shown to be effective.

Topics covered include:
- Depression
- Anxiety problems
- Psychosis
- Substance use problems
- Suicidal thoughts and behaviours
- Non-suicidal self-injury
- Panic attacks
- Traumatic events
- Severe psychotic states
- Aggressive behaviours.

None stated. Anyone over 18

Onsite. Workshop format, delivered by Accredited Instructors

6 modules (2.5 hours each)

Usually 2 days; however, delivery flexible.

Costs set by individual trainers and advertised on MHFA website course calendar, see link below.
Programs listed in calendar for WA appear to be free of charge.

**Evaluated:** Program has been well evaluated and reviewed (both internal and external evaluations).

Program developed in 2000 and operates within Mental Health First Aid Australia - a national not-for-profit organisation (based in Melbourne) focused on mental health training and research for communities and the workplace.
All instructors trained by Mental Health First Aid Australia.
Also, offer 5 day Aboriginal MHFA Instructor Training for Indigenous people.
https://mhfa.com.au/courses/instructor/types/5daysa2
<table>
<thead>
<tr>
<th>Course Title/ Provider</th>
<th>Expected Learning Outcomes</th>
<th>Pre-requisites</th>
<th>Suggested Students</th>
<th>Delivery Mode</th>
<th>Duration/ Cost</th>
<th>User Reviews/ Evaluations</th>
<th>Other Information/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suicide Intervention Training</strong></td>
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<tr>
<td>Applied Suicide Intervention Training (ASIST)</td>
<td>• Understand the ways personal and societal attitudes affect views on suicide and interventions. • Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs. • Identify the key elements of an effective suicide safety plan and the actions required to implement it. • Appreciate the value of improving and integrating suicide prevention resources in the community at large. • Recognise other important aspects of suicide prevention including life-promotion and self-care.</td>
<td>None stated</td>
<td>Anyone 16 years and over</td>
<td>Onsite. Workshop delivered by 2 registered trainers using audio visual learning aids; group discussions; skills practice and development.</td>
<td>2 days</td>
<td>Cost varies depending on location of delivery. (Indicative cost is $275 per participant for course Sponsored by Lifeline in Gippsland, Vic)</td>
<td>Evaluated: Supported by numerous evaluations including independent and peer reviewed studies. ASIST proved to reduce suicidality for those at risk based on 2013 study of suicidal callers to crisis lines LivingWorks Australia is a suicide intervention training company that trains community helpers of all kinds to work in this intervention context. It operates as a private social enterprise corporation. ASIST was developed in 1983 and is regularly updated to incorporate advances in this field. Over 80,000 people nationally have taken part in ASIST. Program available Australia wide. Other relevant training offered: • 5 Day Training for Trainers. • suicideTALK - 90-minute session to reduce suicide stigma and raise awareness. • safeTALK – half day workshop to help identify people at risk and how to connect them with life saving resources. • escuicideTALK – online suicide awareness/prevention program. • Suicide to Hope – Recovery to Growth Workshop.</td>
</tr>
<tr>
<td>GateKeeper Suicide Prevention Training</td>
<td>• Understand mental health disorders related to suicidal and self-harming behaviours; and risk and protective elements. • Ability to assess risks, identify warning signs, and put in place intervention and postvention action plans. • Knowledge of the suicide landscape in Australia. • Skills on how to talk to some-one you suspect is suicidal, and how to provide appropriate help depending on their level of risk, and issues to address when dealing with suicide.</td>
<td>None stated</td>
<td>Profession als and Para professiona ls who have regular contact with people at risk of suicide.</td>
<td>Onsite. Workshop delivered by 2 Accredited Trainers.</td>
<td>2 days</td>
<td>Cost varies depending on providers</td>
<td>Reviewed: Numerous Reviews (most recently in 2013-2014) and revision of program during 16 years of delivery Program developed in Western Australia by the then Youth Suicide Advisory Council in 1990. Contact Co-Coordinator to arrange training (see “Course Title/Provider” Column).</td>
</tr>
<tr>
<td>Course Title/ Provider</td>
<td>Expected Learning Outcomes</td>
<td>Pre-requisites</td>
<td>Suggested Students</td>
<td>Delivery Mode</td>
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<td>User Reviews/ Evaluations</td>
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<tr>
<td><strong>Suicide Intervention Training</strong></td>
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<tr>
<td><strong>Aboriginal Suicide Prevention Programs</strong></td>
<td>Knowledge of issues that contribute to suicide risk at community and individual levels, and develop intervention skills to help prevent suicidal behaviours.</td>
<td>None stated. Takes into account varying levels of literacy.</td>
<td>Program targets 3 groups:</td>
<td>Onsite. Delivered in 3 phases – in community</td>
<td>Phase 1: 2 Days for each of the 3 groups (equivalent to 6 days in total)</td>
<td>No formal evaluation located however Website states that: <em>IPS and particularly, Dr Tracy Westerman have received significant recognition in the field generally, but most particularly in the area of suicide prevention</em>.</td>
<td>Private company formed to provide mental health services for Aboriginal people. Commenced in WA but programs also now delivered in other States. THREE STAGE intervention programs already delivered in WA include communities of Derby, Kalgoorlie, Roebourne, Wydham and a one-off forum in Broome. IPS uses a ‘Whole of Community Approach’ and focuses on cementing learnt skills through the delivery of, ideally, all three phases of the community forums. Website states that “this training is the only Indigenous specific indicated intervention program for Aboriginal youth at risk in Australia.” Also, deliver Aboriginal mental health intervention programs. For more information: <a href="https://indigenouspsychservices.com.au">https://indigenouspsychservices.com.au</a></td>
</tr>
<tr>
<td>Indigenous Psychological Services (IPS)</td>
<td>Training delivered via forums with three separate groups.</td>
<td>Content/expected outcomes include:</td>
<td>Service Providers Forums: Indigenous specific suicide intervention package targeting appropriate counselling, assessment and intervention skills. Community Members Forums: Apply learnt skills through role modelling and demonstrations. Identify risk in self and others and develop strategies to address these. Grief and loss; identifying and dealing with trauma; suicide risk assessment and gatekeeper approaches. Understand the extent to which a community person can help someone who is suicidal.</td>
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</tr>
<tr>
<td>East Victoria Park WA</td>
<td></td>
<td></td>
<td>Community members (usually delivered separately to men and women)</td>
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<tr>
<td>(08) 9362 2036</td>
<td></td>
<td></td>
<td>Youth (15-25 years)</td>
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<tr>
<td><a href="mailto:ips@ips.iinet.net.au">ips@ips.iinet.net.au</a></td>
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</table>
### Suicide Intervention Training

<table>
<thead>
<tr>
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<th>Suggested Students</th>
<th>Delivery Mode</th>
<th>Duration/ Cost</th>
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<th>Other Information/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>#The Djirruwang Program&lt;br&gt;Diploma of Health Science (Mental Health).&lt;br&gt;Charles Sturt University (CSU) in Wagga Wagga NSW&lt;br&gt;<a href="http://www.csu.edu.au/courses/mental-health">http://www.csu.edu.au/courses/mental-health</a></td>
<td>Understanding primary healthcare, cultural safety, equity and socio-cultural aspects of care to enhance graduates’ understanding and appreciation of the clients’ and their family’s experience of emotional and social trauma and mental health problems.</td>
<td>None</td>
<td>Restricted entry – designed for Indigenous people to develop high level knowledge and skills in mental health theory and practice.</td>
<td>Mixed Mode of: Distance Education; 3 residential blocks per year (total 21 days); 3-week placement.</td>
<td>Diploma: 1 Year&lt;br&gt;Costs range per subject from $600-$1,000 x 8 subjects.</td>
<td>Evaluated: In 2005&lt;br&gt;The Centre for Rural and Remote Mental Health in conjunction with the NSW Institute of Psychiatry undertook an external evaluation of the program.</td>
<td>Indigenous students can progress to Associate Degree or Degree in Health Science (Mental Health).&lt;br&gt;Course developed in collaboration with Aboriginal community organisations, mental health practitioners to meet needs of Aboriginal and Torres Strait Islander communities. It evolved from a pilot program in 1994 at the Southern Area Health Service, NSW. While not affiliated with a particular accreditation body, all subjects are matched to National Practice Standards for Mental Health Workforce.</td>
</tr>
<tr>
<td><strong>Cert IV Indigenous Mental Health (Suicide Prevention)</strong>&lt;br&gt;Wontulp Bi-Buya College (WBBC)&lt;br&gt;Cairns Qld&lt;br&gt;(07) 4041 4596&lt;br&gt;<a href="http://www.wontulp.qld.edu.au/">http://www.wontulp.qld.edu.au/</a></td>
<td>Professional skills development of Indigenous youth and community leaders in the community services and health industry through empowering and equipping community members to deal with mental health and suicide issues in a culturally sensitive professional manner. Students will develop a community-wide suicide early identification and prevention strategy in consultation with community members, Traditional Owners, Elders and complimentary agencies/ initiatives. Upon completion of both courses graduates will be able to act as role models within their communities and strengthen action, advocacy and apply for employment opportunities.</td>
<td>None. Cert 111 in Addiction Management &amp; Community Development recommended.</td>
<td>General entry program.</td>
<td>Mixed mode including 3 x 2 week residential blocks at campus.</td>
<td>500-550 hours per year. $120 deposit for attending first study block.</td>
<td>Evaluated: 2-year evaluation by James Cook University reported positive findings. Of note former students found to be active in suicide prevention planning and implementation.</td>
<td>Program is part of the Community prevention for high risk groups’ initiative of the Taking Action to Tackle Suicide Package. Currently in pilot phase the course is considered transferrable to other locations and communities.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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</thead>
</table>
| **Culture is Life Campaign**                          | Contact Organisation regarding potential training. Focus is centred on partnering with community to implement projects to support youth suicide prevention. Organisation operates nationwide. “The Culture is Life Campaign aims to give a platform for Aboriginal and Torres Strait Islander Elders and community leaders to influence public awareness, policy-making and service provision around Aboriginal and Torres Strait Islander suicide prevention. It aims to give voice to the Indigenous-held position that culture and connection to country are vital foundations for social and emotional wellbeing in Aboriginal and Torres Strait Islander communities.”  

19 Culture is Life Campaign, Our Work, http://www.cultureislife.org/our-work-2017/# accessed February 20, 2017. | None detailed | None detailed | Contact Organisation for further information. | Contact Organisation for further information. | None located. | Culture is Life was established in 2015 by philanthropist David Prior. It is a not for profit Organisation which supports Aboriginal and Torres Strait Islander led projects by helping to develop networks and focusing on culture to prevent youth suicide. 

The Campaign has 3 key streams:  
1. Supporting activation projects, e.g. helping healing centres to become operational.  
2. Partnering with organisations.  
3. Running awareness campaigns. |
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<tbody>
<tr>
<td><strong>Cert II in Indigenous Leadership</strong>&lt;br&gt;Australian Indigenous Leadership Centre Canberra&lt;br&gt;ACT&lt;br&gt;(02) 6251 5770&lt;br&gt;<a href="mailto:enquiries@ailc.org.au">enquiries@ailc.org.au</a>&lt;br&gt;<a href="http://ailc.org.au">http://ailc.org.au</a></td>
<td>• Ability to use general leadership skills to deal with a range of different situations and contexts.&lt;br&gt;• Gain understanding of own personal strengths, capabilities, and leadership to progress personal development and skills.&lt;br&gt;• Apply leadership skills in professional and non-professional settings.&lt;br&gt;• How to work effectively in teams and other partnerships.&lt;br&gt;• Shape leadership attributes and build confidence.</td>
<td>None</td>
<td>Indigenous students over 18</td>
<td>2 weeks face to face on campus. All assessments in class.</td>
<td>Delivered over 10 weeks, with 2 x 5-day intensive training blocks included in this time period. It is a compulsory requirement of the course to attend all blocks. No course cost. ABSTUDY Approved (for travel expenses, etc.)</td>
<td>Testimonials on Webpage&lt;br&gt;Students complete evaluations at the end of their course. Unable to locate any formal evaluation.</td>
<td>Programs Running Since 2002.&lt;br&gt;Courses delivered in Regional Centres. Check with Organisation for current training calendar.&lt;br&gt;AILC runs 6 Certificate II, Indigenous Leadership Courses, per year (about 30 students per intake). Registration online - first in basis.</td>
</tr>
<tr>
<td><strong>Cert IV in Indigenous Leadership</strong>&lt;br&gt;Australian Indigenous Leadership Centre Canberra&lt;br&gt;ACT&lt;br&gt;(02) 6251 5770&lt;br&gt;<a href="mailto:enquiries@ailc.org.au">enquiries@ailc.org.au</a>&lt;br&gt;<a href="http://ailc.org.au">http://ailc.org.au</a></td>
<td>Builds and expands on the expected learning outcomes, outlined above, of the Cert III in Indigenous Leadership.</td>
<td>None. Cert II preferred but not essential.</td>
<td>Indigenous students over 18</td>
<td>3 weeks face to Face on campus. Some assessments and readings out of class.</td>
<td>Delivered over 15 weeks, with 3 x 5-day intensive training blocks. No course cost. ABSTUDY Approved (for travel expenses, etc.)</td>
<td>Testimonials on Webpage&lt;br&gt;Students complete evaluations at the end of their course. Unable to locate any formal evaluation.</td>
<td>AILC runs 4 Certificate IV, Indigenous Leadership Courses per year (about 30 students per intake). Registration online - first in basis.</td>
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<td>Red Dust Healing Program</td>
<td>Program targets four key areas: 1. Healing 2. Pro-social modelling 3. Professional Development 4. Cultural Awareness  With following expected outcomes:  • Understanding the impact of rejection, grief and loss, colonialism and oppression.  • Learning tools to overcome these contributing factors.  • Better understanding of self, allowing participants to address hurt within their lives and improving self-esteem.  • Identifying the link between emotions and behaviours or actions.  • Understanding of identity and learn to self-evaluate matters that impact personal life.  • Development of future role models and fathers.  • How to restore broken relationships and strengthen partnerships.  • How to link in with service providers for ongoing support.  • Leadership – through increasing capacity of Indigenous people to contribute, plan, implement and evaluate a variety of strategies, projects and programs in their community.  • Mentoring and Training skills.  Scope to individualise and personalise program as needed.</td>
<td>None</td>
<td>Takes into account varying levels of literacy.</td>
<td>Onsite by trained facilitators using visual holistic learning modules.</td>
<td>Versions of the program can be delivered in one or three day formats or tailored to need.</td>
<td>Evaluated: Evaluated by Quill 2009; external evaluation by an independent evaluator currently underway. Evaluation is demonstrating that the RDH program is having a positive impact on the lives of participants, who consistently describe the significant positive changes in their social and emotional health, as a result of using the RDH tools. See also powerful video testimonials from partici</td>
<td>RDH is a specific cultural healing program written from an Indigenous perspective. Delivered Australia Wide – to over 5300 people in 300 different communities to date. Has partnered with Organisations such as CARITAS Australia. RDH – uses following self- evaluation/ performance measures:  Feedback forms and interviews from participants. Completed case-plans and links to agencies and support networks. Feedback from local organisations and family members. Participants involved in co-facilitating future training.</td>
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| **Cultural Safety Training** | **Aims:**  
- Improve quality of service delivered by health care staff to Indigenous people.  
- Improve the experience of Indigenous people when accessing health care services. | Unknown | Health Professionals including: GPs, nurses, allied health practitioners, receptionists and administration staff | Onsite | Five modules consisting of:  
- Introduction to Aboriginal and Torres Strait Islander health.  
- Better consultations.  
- Prevention and health checks.  
- Linking with other service providers.  
- Leadership in Aboriginal and Torres Strait Islander health. | Information not located. | None located. | AHCWA has been delivering Cultural Safety Training (CST) since 2005 to various stakeholders within Australia. It is nationally accredited by the Royal Australian College of General Practitioners (RACGP). The training also carries Quality Improvement and Continuing Professional Development (QI & CPD) points on completion of each module. Module 1 is compulsory prior to obtaining any QI & CPD points. After completing Module 1, the participant can then choose one of the remaining modules. Of the 5 modules, the first 2 are the main modules delivered and over the past 12 months CST has been delivered to 279 people. |
| Cultural Awareness | Participants gain an understanding of self, identity and sense of belonging. Program also allows participants to understand impact of colonisation on all countries - including European examples. | None | Non-Indigenous people/service providers. | On site | 1 day (unlimited numbers)  
Contact for quote (varies depending on location, purpose, etc) | See above notes under “Red Dust Healing” Program. Unclear whether Cultural Awareness Program has been evaluated separately. Refer to notes above on the Red Dust Healing Program for additional information. Program delivered nationwide. | |
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| #Culturally speaking - Aboriginal cross-cultural workshops | Develop the ability of participants to engage, communicate and form partnerships with Aboriginal people. Topics covered by the course include:  
- Aboriginal culture in WA  
- cross-cultural communication  
- the impact of attitudes and beliefs on styles of work and communication  
- key issues involved when collaborating with Aboriginal people. | None stated | People who work with Aboriginal clients, co-workers or communities in WA. | Onsite  
Option of 1 Indigenous trainer only, or 2 trainers (1 Indigenous and 1 non-Indigenous). | Tailored packages from 1 hour – 2 days.  
Approximate costs for various options:  
2 days; 2 trainers  
$6,600 + workbooks  
1 day; 2 trainers  
$3,600 + workbooks  
½ day; 2 trainers  
$2,530 + workbooks  
(max 18 participants)  
On-costs for travel, etc. additional to above. | Testimonials and references from user agencies available on request. | Training led by Aboriginal trainer and a non-Aboriginal trainer in partnership. Also work in Nyoongar country, and engage local people in locations outside of Nyoongar Country.  
Training has been delivered to wide range of services including: corrective; WA Health, child and family support; housing; and education.  
Aim is to work with participants to provide them with a greater understanding of cross cultural dynamics and issues, which can be applied to projects, or within the workplace.  
CSD Network currently developing simple videos as additional learning tools. |

CSD Network  
Mt Hawthorn WA  
(08) 9430 5628  
info@csdnetwork.com.au  
http://www.csdnetwork.com.au/content/courses.html
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| #Communicating and Connecting with Aboriginal Clients | Training addresses cultural knowledge and provides skills to work appropriately with Aboriginal individuals, families and organisations in a variety of settings. The focus is on improving the way services are provided to Aboriginal people. The workshop has been developed and is delivered entirely by Aboriginal people. Topics include:  
• service delivery for Aboriginal people  
• practical ways to work with Aboriginal people in the community  
• effective and appropriate communication with Aboriginal people and communities  
• Understanding of Indigenous cultures in Australia, past and present.  
• Other tools and skills to help staff when working with Aboriginal people.21 | None stated | The community services sector and those working with, or wanting to work with Aboriginal clients or communities. | Onsite | 1 day  
Can be tailored to need.  
Approx. $3,200 depending on location.  
(max 20 ppl) | Feedback sheets collected from participants and course evaluated and adjusted if needed, based on this information. | Training can be delivered throughout WA.  
Workshops always include Local Elder along with 2-3 local Aboriginal guest speakers. |

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| Cultural Awareness/Safety Training           | Bundiyarra's training is designed to improve and enhance participants' knowledge about Aboriginal people and develop a respect for cultures. Topics covered include:  
• a comparative history of Australia and how it affects current work practices for Aboriginal people in today's society;  
• how Aboriginal people identify themselves;  
• the languages and culture within the Midwest, Murchison and Gascoyne regions;  
• how to engage and communicate with Aboriginal people;  
• sharing and learning stories of personal and work experiences;  
• local Elders sharing their history and knowledge; and  
• a tour to local significant land and sea sites.  

People who are working with or interested in gaining knowledge about the language and culture of Aboriginal people of the Midwest, Murchison and Gascoyne regions of Western Australia (WA)                                                                                       | None stated.                                                                                                           | Onsite. Delivered with up to 5 local facilitators. | 1 day  
Can be tailored to need.  
Approx. 330.00 pp  
(MAX 20 ppl) | Positive testimonials on Webpage.                                                                                                                                                                                                                                          | Bundiyarra Aboriginal Community Aboriginal Corporation (Bundiyarra) is an umbrella group and resource agency situated in the Midwest of WA. Bundiyarra can tailor programs to an organisation's specific need/sector (e.g. health or education) and present on site (by arrangement). |

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#The Journey Towards Cultural Competence with Aboriginal and Torres Strait Islander Peoples workshop

Australian Indigenous Psychologists Association (AIPA)
(02) 6632 3077
http://www.culturalcompetence.net.au/

Participants will gain cultural competence required to apply the National practice standards for the mental health workforce including:
- Knowledge of Aboriginal and Torres Strait Islander notions of social and emotional wellbeing (SEWB).
- Understand risk and protective issues for Aboriginal and Torres Strait Islander SEWB.
- Apply SEWB framework and allow for social determinants.
- Understand cultural competence in the context of working with Aboriginal and Torres Strait Islander peoples.
- Comprehend the impact of colonisation and effects of social determinants on mental health.  

Non-Indigenous health practitioners including: psychiatrists, psychologists, mental health nurses, social workers and mental health-trained occupational therapists.

Face to face by two AIPA members - Aboriginal and Torres Strait Islander psychologists.

2 days (12-20 participants)

Contact AIPA to request workshop and obtain quote.

http://www.culturalcompetence.net.au/request/dsp-request.cfm?loadref=11

Further information about extensive user evaluations also on Website.

Evaluated: Independent evaluation by Walker 2010, found that the workshop "has been able to successfully integrate cultural competence as a crucial component of effective professional practice."  


In 2012-2015, AIPA was contracted by the Department of Health and Ageing to deliver cultural competence workshops for psychologists, social workers, mental health nurses and OT’s providing mental health services. Over the last six years training has been delivered to over 1100 mental health practitioners.

For those who have completed 2-day workshop, AIPA has developed one-day workshop (Steps on The Journey Towards Cultural Competence) that aims to increase cultural competence of those providing services to children and young people; and those at risk of suicide and self-harm.


24 Ibid.
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<tr>
<td><strong>Introductory Cultural Learning</strong></td>
<td>Aims to ‘Close the Gap’ in health outcomes between Aboriginal and non-Aboriginal Australians by equipping staff to deliver more culturally appropriate health services in more ‘culturally safe’ places for Aboriginal clients.</td>
<td>None stated</td>
<td>Staff of WA Health</td>
<td>Online – e-learning resource.</td>
<td>No Cost</td>
<td>Evaluation of the package was conducted by about 70 staff from around WA Health and was very positive. 86 per cent of participants indicated that it contributed to their knowledge of Aboriginal culture while 89 per cent indicated that it could be applied in their workplace.</td>
<td>Mandatory training component of the induction program for staff at WA Country Health Service and North Metropolitan Health Service.</td>
</tr>
<tr>
<td><strong>Aboriginal Cultural Orientation</strong></td>
<td>This short course focuses on allied health, however much of the content is directed at all health professionals. The five modules are:  - culture, self and diversity  - Aboriginal history  - working with Aboriginal people  - providing clinical services  - improving cultural security.</td>
<td>None stated</td>
<td>Health professionals, health science students and people working in various health care settings.</td>
<td>Online  Five self-directed learning modules. Students are required to log-in with their account details and an enrolment key supplied by the teacher.</td>
<td>2 hours</td>
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A video to introduce resources starts each page. Crisis numbers are included at the side of every page on resources section. Each of the four sections starts with a short video clip, has links and PDFs (where available/permited) for three key resources, plus an “other information section” for other resources related to that category. While some resources have been produced in a particular State/Territory, the information is relevant Australia wide, but contact numbers may be State and Territory specific.

### GETTING IMMEDIATE HELP (FOR YOU OR SOMEONE ELSE)

#### Do you need help right now?

- The best way to get help is to connect with someone face to face - by talking to a person who cares about you. Find someone you know you can trust and talk to them. This could be your cousin, an Aunty, an Uncle, your Granny or a friend.
  - You can go to an Aboriginal Medical Service or health clinic in your community and talk to a doctor or health worker there.
  - If it’s after-hours, you can visit the emergency department of your hospital.
  - Although it may not feel like it now, these feelings will pass and talking to someone else will help you get through them.

You can also call one of the numbers below to speak with someone at any time.

Remember you are not alone, and no matter where you are or who you are, you can get help now.

#### Get Help Now

Dial 000 for life threatening emergencies or go to your hospital's emergency department.

### Crisis Telephone Support

24 hours – 7 days a week:

- **Lifeline** 13 11 14
- **beyondblue Support Service** 1300 22 4636
- **Kids Helpline** 1800 551 800 (for under 25’s)
- **Men’s Line Australia** 1300 78 99 78
- **https://qlife.org.au** 1800 184 5327 (LGBTQI Helpline - 3pm-midnight around Australia)

#### Need Help For Someone Else Now?

If the situation is urgent and you are concerned that someone else is in immediate danger do not leave the person alone, unless you are concerned for your own safety.

Call the person’s doctor, a mental health crisis service listed above or dial 000 and say that the person’s life is at risk.

If the person agrees, you could go together to the local hospital emergency department for assessment.

You can also visit an Aboriginal Medical Service or local health clinic. Click on the State and Territory links below to check if there is one in your area and how to get in touch with them.

| ACT: Winnunga Nimmityjah Aboriginal Health Service | http://www.winnunga.org.au/ |
## GETTING IMMEDIATE HELP (FOR YOU OR SOMEONE ELSE)

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<tr>
<th>Resource</th>
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<tr>
<td><strong>CRP Video</strong> using Indigenous psychologists</td>
<td><a href="http://www.atispep.sis.uwa.edu.au/resources">http://www.atispep.sis.uwa.edu.au/resources</a></td>
</tr>
<tr>
<td><strong>CRP Video</strong> on Community and Social Media by Summer May-Finlay</td>
<td><a href="http://resources.beyondblue.org.au/prism/file?token=BL/0821">http://resources.beyondblue.org.au/prism/file?token=BL/0821</a></td>
</tr>
<tr>
<td><strong>Keeping Strong.</strong> For Aboriginal and Torres Strait Islander people who may be experiencing the signs or symptoms of depression or for those with friends or family members who may have depression. (3 page leaflet).</td>
<td><a href="http://www.atsispep.sis.uwa.edu.au/resources">http://www.atsispep.sis.uwa.edu.au/resources</a></td>
</tr>
<tr>
<td><strong>Aboriginal Suicide Prevention Information</strong> – a toolkit on how to provide help to some-one you think may be suicidal. (4 page booklet)</td>
<td><a href="http://earlytraumagrief.anu.edu.au/files/Lifeline_AborigSuicidePrev_Toolkit.pdf">http://earlytraumagrief.anu.edu.au/files/Lifeline_AborigSuicidePrev_Toolkit.pdf</a></td>
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<tr>
<td><strong>It's OK to Talk About it - DVD on Suicide Prevention.</strong> Produced in ACT by Aboriginal &amp; Torres Strait Islander peoples and developed as an early intervention tool. (Approx 16 mins duration).</td>
<td><a href="https://www.youtube.com/watch?v=8oHlmncQd_A&amp;feature=youtu.be">https://www.youtube.com/watch?v=8oHlmncQd_A&amp;feature=youtu.be</a></td>
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<tr>
<td><strong>Suicide warning signs</strong> (1 page factsheet and podcasts).</td>
<td><a href="https://communitiesmatter.suicidepreventionaustr.org/sites/default/files/67025_MHC_CM_WarningSigns_factsheet_ONLINE.pdf">https://communitiesmatter.suicidepreventionaustr.org/sites/default/files/67025_MHC_CM_WarningSigns_factsheet_ONLINE.pdf</a></td>
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</table>
| **Djambatjthi.** Short video produced NT to assist people in communities and practitioners who provide help to people with mental health problems, including suicidal thoughts. Video produced in two versions; English and local Yolngu Matha language. (16 mins) | Djambatjthi English https://youtu.be/tbyjYQEqqFE  
Djambatjthi Yolngu Matha https://youtu.be/v1-9dBA1oD0 |
<p>| <strong>Suicide prevention – Knowing the Signs.</strong> (6 page fact sheet).       | <a href="http://resources.beyondblue.org.au/prism/file?token=BL/0486">http://resources.beyondblue.org.au/prism/file?token=BL/0486</a>             |
| <strong>#Finding our Way Back.</strong> A resource for Aboriginal and Torres Strait Islander Peoples after a Suicide Attempt. (21 page booklet) | <a href="http://resources.beyondblue.org.au/prism/file?token=BL/1289">http://resources.beyondblue.org.au/prism/file?token=BL/1289</a>             |
| <strong>Wesley LifeForce Steps to Suicide Prevention</strong> (2 page pamphlets and community posters – Aboriginal and Torres Strait Islander Versions). | <a href="https://www.wesleymission.org.au">https://www.wesleymission.org.au</a> |
| A variety of resources including booklets, online information, short videos, etc. for Aboriginal and Torres Strait Islander people. Available on the Beyond Blue website, | <a href="https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people">https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people</a> |
| Mind Australia was established nearly 40 years ago, and is a leading non-government provider of mental health and psychosocial disability support services with over 60 service sites throughout Australia. Services include: helplines and outreach support. | <a href="https://www.mindaustralia.org.au">https://www.mindaustralia.org.au</a> |</p>
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## Helping/Supporting Aboriginal & Torres Strait Islander People

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<tr>
<td>Guidelines For Providing Mental Health First Aid To Aboriginal And Torres Strait Islander People Experiencing Suicidal Thoughts And Behaviour.</td>
<td><a href="https://mhfa.com.au/sites/default/files/AMHFA_Suicide_guidelines_inhouse%20print.pdf">https://mhfa.com.au/sites/default/files/AMHFA_Suicide_guidelines_inhouse%20print.pdf</a></td>
</tr>
<tr>
<td>Cultural Considerations &amp; Communication Techniques When Providing Mental Health First Aid To An Aboriginal Or Torres Strait Islander Person. (4 page booklet)</td>
<td><a href="http://resources.beyondblue.org.au/prism/file?token=BL/0547">http://resources.beyondblue.org.au/prism/file?token=BL/0547</a></td>
</tr>
<tr>
<td>Suicide contagion for Aboriginal and Torres Strait Islander young people. (2 Page Fact Sheet)</td>
<td><a href="https://www.headspace.org.au/assets/School-Support/Suicide-contagion-for-Aboriginal-and-Torres-Strait-Islander-young-people-web.pdf">https://www.headspace.org.au/assets/School-Support/Suicide-contagion-for-Aboriginal-and-Torres-Strait-Islander-young-people-web.pdf</a></td>
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## Information for Practitioners

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