

THE THIRD CONVERSATION: HAS ANYTHING CHANGED?



THE ABORIGINAL AND
TORRES STRAIT ISLANDER
MENTAL HEALTH AND SUICIDE
PREVENTION ROUNDTABLE

CALL TO ACTION 2014



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THE ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL
HEALTH AND SUICIDE PREVENTION ROUNDTABLE**

**RECORD OF PROCEEDINGS:
COMPANION DOCUMENT TO THE CALL TO ACTION**

**23RD AND 24TH JUNE 2014
PERTH, WESTERN AUSTRALIA**

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– but the evidence is with the
people who have healed and
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ROUNDTABLE ATTENDEE, 2014.

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Listen to local conversations.
Enable these.*

ROUNDTABLE ATTENDEE, 2014.



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*The message for families is;
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THE THIRD CONVERSATION: ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH AND SUICIDE PREVENTION ROUNDTABLE

BACKGROUND

The Roundtable brought together Aboriginal community leaders and experts in Indigenous mental health and suicide prevention along with experts, scholars and policy makers to engage in a third conversation about Aboriginal and Torres Strait Islander mental health and suicide prevention with Emeritus Professor Michael Chandler from the University of British Columbia.

The Roundtable style enabled attendees from diverse backgrounds and areas to come together and share their knowledge and discuss ways forward. Relevant papers and briefs were sent prior to the Roundtable and this formed some of the basis about the discussions. Although specific speakers were nominated to provide brief overviews to topics that were addressed, people came together with the recognition that all attendees have much to offer the discussions. The speakers provided overviews to motivate and focus the process. We were particularly excited that we had a strong representation of Aboriginal individuals and community groups as well as leading community action groups, researchers and policy makers attending. Our conversations finished at the end of the two days with strong priority messages and outcomes detailed in a Call to Action.

ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH

- Aboriginal and Torres Strait Islander suicide occurs at double the rate of other Australians, and there is evidence to suggest that the rate may be higher.
- Suicide is a complex behaviour with many causes. For Aboriginal and Torres Strait Islander peoples there are specific cultural, historical, and political considerations that contribute to the high prevalence, and that require the rethinking of conventional models and assumptions.
- How to prevent suicide is poorly understood for both the general population and Aboriginal and Torres Strait Islander peoples. There is a need for further research in this area. Aboriginal and Torres Strait Islander peoples should lead those parts of this research agenda that touch on suicide in their communities.

It is, however, possible to discuss emerging best practice (or promising practice) in Aboriginal and Torres Strait Islander suicide prevention based on expert opinion and experience. This includes across three levels of intervention:

- ◆ For those at immediate risk of suicide. Culturally safe, non-triggering management of treatment and support to Aboriginal and Torres Strait Islander peoples at risk of suicide is particularly important. Training Aboriginal people to provide such services is one way to achieve this; ensuring non-Indigenous workers are culturally competent is another. Services should be delivered through Aboriginal Community Controlled Health Services and/or Aboriginal and Torres Strait Islander community organisations where possible.
- ◆ For at risk groups, particularly young people and adults. In a preventative approach, the developmental factors that can pre-dispose a person to suicide must be addressed at a relatively early age.
- ◆ For whole communities. There is a high level of need for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs and strategies that build social and emotional wellbeing and resilience and could prove to be effective long term strategies for addressing suicide risk factors. Building on cultural strengths and supporting self-determination is likely to be a core component of any program. Importantly, the content, design and delivery of programs need to have legitimate community support, and be culturally appropriate, locally based and relevant to people's needs. This requires engagement and partnerships with communities.

Aboriginal and Torres Strait Islander mental health and suicide are distinct. Suicide needs to be viewed in the larger context of psychological and social health, and wellbeing. This behaviour or action is only one index of the health and wellbeing of a population. It is not a distinct psychiatric disorder and it results from the interaction of many different personal, historical, and contextual factors.

THE THIRD CONVERSATION

For the last thirty years Professor Chandler's internationally acclaimed research in the social and emotional wellbeing of Canadian First Nation communities has been at the forefront of dialogues about suicide prevention. His research has provided compelling evidence that self-determination protects First Nation communities from the psychologically destructive impacts of oppression. It shows that communities with strong cultural continuity — land rights, gender equality, community-controlled services, self-government and ownership of cultural past — support and heal social and emotional wellbeing. Chandler's findings have clear relevance for those committed to restoring Australian Indigenous social and emotional wellbeing and his research has been taken up at many levels. This is the third conversation that many of us present have had about Aboriginal and Torres Strait Islander mental health and suicide prevention.

Professor Chandler's visits to Australia have served as a catalyst, galvanizing us to come together for public discussion and debate. In 2010, hosted by the Telethon Kids Institute at UWA, he spoke to government officials, academics and interested members of the public about cultural continuity and wellbeing. In 2012, UWA and the National Aboriginal and Torres Strait Islander Foundation brought Professor Chandler to Australia again and he gave a series of public lectures in Perth and Canberra, meeting with ministers to share views on how Indigenous mental health could be restored from the Canadian experience. During that visit he also visited the Kimberley Aboriginal Law and Culture Centre in Fitzroy Crossing speaking with local Elders and community. This Roundtable in 2014 marks the third conversation where we ask ourselves – has anything changed?



WHAT HAS CHANGED IN 2014?

There have been significant changes over the past few years and 2014 has seen an increased national awareness of the severity of Aboriginal suicide.

The first ever-national Aboriginal and Torres Strait Islander Suicide Prevention Strategy has been developed.

Significant community driven campaigns have been established to address Aboriginal and Torres Strait Islander mental health and suicide prevention such as the Dumbartung Community Meeting in 2013; the Elders Report for Aboriginal and Torres Strait Islander Youth Suicide Prevention and Culture is Life Campaign; the Indigenous Times Campaign against suicide.

This Roundtable brought together groups who have been involved in the changes to discuss the issues and to identify pathways forward.

Report Findings Relevant to the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Roundtable

These reports consistently reflect the outcomes of the Roundtable discussions. Together with the Third Conversation, are an affirmation of the research evidence and the knowledge of those who attended. Aboriginal viewpoints and experiences are reflected both in the Roundtable Proceedings and the Reports/Strategy, reinforcing the Call to Action.

The Elders' Report into Preventing Indigenous Self-harm and Youth Suicide was produced between 2012 and 2014 by Indigenous led social justice organisation People Culture Environment in partnership with Our Generation Media. It was developed in response to a massive and unprecedented increase in Indigenous youth self-harm and suicide, that has occurred over the past 20 years across Australia's Top End. The Report is a transcription of interviews held with 31 Elders and community representatives from over 17 communities. Each speaker was asked two primary questions: why is self-harm and suicide happening and what is the solution? In response to the first question there was a high level of agreement between the speakers about the role culture and loss of cultural connection plays in making young people vulnerable to self-harm. In response to the second question there was an equally high level of agreement amongst speakers about the role culture can play in healing and protecting young people. While some details of people's experience differed, the message was unanimous: while most non-

Indigenous involvement with the issues in these communities is well meaning, it is not working; give power back to the Elders of each region to build programs that take Indigenous young people back to country to reconnect with their land and their spirit; and direct funds and programs for ending suicide and self-harm to the Elders and community leaders to lead the healing process. The full report can be found at: <https://bepartofthehealing.org/EldersReport.pdf>

Hear Our Voices is the final report on the community consultations undertaken for the development of an empowerment, healing and leadership program for Aboriginal people living in the Kimberley, Western Australia. Some key findings are listed in Appendix 2, and the full report can be found at:

http://aboriginal.telethonkids.org.au/media/394426/hear_our_voices_final_report.pdf

Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (2nd edition, 2014) is a detailed review of models of practice and strategies aimed at enhancing the effectiveness of a range of professionals who work with Aboriginal and Torres Strait Islander people with a range of social and emotional wellbeing and mental health issues. Building on the first edition produced in 2010, the second edition continues to highlight practices and strategies and create comprehensive understanding of the need for a culturally competent mental health workforce and mental health services well informed to work effectively with Aboriginal and Torres Strait Islander people. Widely disseminated, the text covers: history and contexts; issues and influences; standards, principles and practices; assessment and management; working with children, families and communities; healing models and programs. The full report can be found at:

<http://aboriginal.telethonkids.org.au/media/744561/working-together-aboriginal-and-wellbeing-2014.pdf>



The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released in 2013. The Strategy was informed by extensive community consultation across Australia and by the Aboriginal and Torres Strait Islander peoples' holistic view of health that encompasses mental health, physical, cultural and spiritual health. Participants at the community consultations consistently called for community-focused, holistic and integrated approaches to suicide prevention with an emphasis on investment in "upstream" prevention efforts to build community, family and individual resilience and on restoring social and emotional wellbeing. Six goals underpin the objective of reducing the cause, prevalence and impact of suicide on individuals, their families and communities. These are translated into six action areas: 1] *building strengths and capacity in Aboriginal and Torres Strait Islander communities*; 2] *building strengths and resilience in individuals and families*; 3] *targeted suicide prevention services*; 4] *coordinating approaches to prevention*; 5] *building the evidence base and disseminating information*; and, 6] *standards and quality in suicide prevention*. The full strategy document is available at:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/305B8A5E056763D6CA257B-F0001A8DD3/\\$File/Indigenous%20Strategy.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/305B8A5E056763D6CA257B-F0001A8DD3/$File/Indigenous%20Strategy.pdf)

SUMMARY OF PROCEEDINGS

There are many parts to talking about suicide in Aboriginal and Torres Strait Islander communities.
ROUNDTABLE ATTENDEE, 2014.

CULTURE AND COMMUNITY

Culture

Culture is a big word with many small packages. Acceptance of culture is central to addressing the issue of suicide. ROUNDTABLE ATTENDEE, 2014.

- **Centrality:** The foundation of culture strengthens resilience (when applied to) culturally meaningful healing programs.
- ◆ **Promoting the role of community and keeping culture alive**
 - ❖ Working from within (community driven/led)
 - ❖ Capacity building in communities – share the load
 - ❖ Community led healing initiatives, as identified in the Elders Report
- ◆ **Cultural identity**
 - ❖ Through being on country, to take away the emptiness of being
 - ❖ We are all created from the dust of the earth and that is the way to healing
- ◆ **Role of culture**
 - ❖ Telling stories in our own way and own meaning, true culture
- ◆ **Disruption to culture**
 - ❖ Government policies took the culture away
 - ❖ Wider appreciation of Aboriginal culture and spirituality is needed in the broader Australian community
 - ❖ Colonisation has changed the name, changed the identity, changed the diet, changed the language and validated the theft of land. All this stops people connecting and now Native Title asks people to prove their identity
- **Definition:** culture as rights, as identity; acknowledging diversity and common factors, and recognising that not everyone lives on country.
- ◆ **Knowledge**
 - ❖ There are self-actualised ways of working, and many people in communities know the answers, starting with community led healing and supporting family members

Family

Suicide is not statistics, they are family members. The message for families is: they are not in their journey alone. ROUNDTABLE ATTENDEE, 2014.

- **Community Knowledge**
 - ◆ **Family**
 - ❖ Family members may have lost young men and women, but the family is the tribe (strength and large extended group) and they can come together
 - ❖ Work within communities to bridge the gap between young people and elders
 - ◆ **Community**
 - ❖ Support communities to identify issues and create solutions
 - ❖ Conversations are occurring in all places, listen to local conversations
 - ❖ Community members/communities have knowledge but are not being given the resources to implement what is required

Young People

Young people are the leaders of today, not tomorrow, and need their voices heard. ROUNDTABLE ATTENDEE, 2014.

- **Youth Forum:** Their voices, their ideas. A complementary Youth Report is needed to sit alongside the Elders Report.
- **Identity**
 - ◆ **Articulation**
 - ❖ The world is different for youth today
 - ❖ To move into the future requires young people to come along
 - ❖ Encourage young people into community leadership/professions
 - ❖ Young people are not the problem but are part of the solution
 - ◆ **Adaptation**
 - ❖ Young people are accustomed to mainstream education/living, but negotiation of two ways of living can happen but needs support

GOVERNMENT AND UNIVERSITIES

Education

The first time she learnt about Aboriginal history was in university and this helped her to feel a connection to her own cultural meaning. ROUNDTABLE ATTENDEE, 2014.

- **Schools And University**
 - ◆ **Young people**
 - ❖ Too much non-Aboriginal education, not enough cultural education
 - ❖ Young people need more opportunities to learn to help find connections
 - ❖ Teach political awareness as part of young people's identity to be strong, resilient and understand what is happening to them

Research

Coexistence of grassroots and research academics. ROUNDTABLE ATTENDEE, 2014.

- **Aboriginal Led:** The Healing Foundation could lead a research agenda.
 - ◆ To identify missing gaps that impact on social and emotional wellbeing of young people, their families and communities
 - ◆ To enhance and build on current initiatives and best practice
 - ◆ Engage in an advisory and advocacy role
- **Partnerships:**
 - ◆ **Evidence**
 - ❖ Cultural continuity measures are needed to establish relevant community values
 - ❖ Critical analysis of the numbers
 - ❖ Community based organisations cannot effectively communicate with governments (requires evidence gathering, outcomes and process which explain these). Community organisations already doing this often have a close association with academia

Government

The government says there is no evidence – but the evidence is with the people who have healed and can claim this for themselves. ROUNDTABLE ATTENDEE, 2014.

- **Implementation:** The strategies/frameworks exist (Aboriginal and Torres Strait Islander Suicide Prevention Strategy; Social and Emotional Wellbeing Framework and Aboriginal and Torres Strait Islander Health Plan) need to be implemented:
 - ❖ National Cultural Healing Plan – where is it?
 - ❖ Develop an operational plan for the Suicide Prevention Strategy and Social and Emotional Wellbeing Framework

- ❖ Flexibility is required and acceptance of Aboriginal ways of working
- ❖ Aboriginal people need to write the policy, implementation plans and milestones
- **Strategies:** Local communities understand the way, and need to be supported by government to:
 - ◆ Define reportable criteria for how organisations/government agencies work with Aboriginal people
 - ◆ Create mechanisms for meaningful consultations to take place for community members and organisations to direct and influence funding allocations
 - ◆ Evaluation built in (and funded) with measures relevant to (and set by) communities and government (in consultation/partnership)
- **Cultural Recognition:** Government has intervened in the capacity to practice culture and a wider appreciation is required of culture and spirituality.
 - ◆ **Cultural Competence**
 - ❖ Cultural competence would improve the capacity of non-Aboriginal people to discharge their roles more effectively when working with Aboriginal people
 - ❖ Require level of cultural competence for non-Aboriginal people involved in policy development, programming, funding
 - ◆ **Institutional Racism**
 - ❖ Requires system approaches to eliminate
- **Funding Models:** Funding allocation needs trust (by government) that community is able to provide the best interventions. Too many funding models – these need to be more relevant to fit communities and the actions they want to take.
 - ◆ **Consultation**
 - ❖ Needs to be meaningful and translated through an Aboriginal lens
 - ◆ **Equity In Application Processes**
 - ❖ Partnerships – large organisations need to engage in proper partnerships with small organisations and communities
 - ◆ **Criteria**
 - ❖ Build in an Integrity Statement (requiring demonstrated expertise in working with Aboriginal communities)
 - ❖ Place based framework to bring all the statistics together at the community level
 - ◆ **Terms Of Funding**
 - ❖ There should be 'forever funding' (minimum 20 years) renewed and renegotiated on ongoing basis to give program sustainability

THE ABORIGINAL AND TORRES STRAIT ISLANDER ROUNDTABLE ON MENTAL HEALTH AND SUICIDE PREVENTION CALL TO ACTION

In June 2014, over 50 Aboriginal and Torres Strait Islander and non-indigenous leaders, experts and stakeholders met in Perth to discuss suicide prevention among Aboriginal and Torres Strait Islander peoples and to identify the actions needed to turn the high rates of suicide around.

This resulting *Call to Action* affirms culture as central to improving social and emotional wellbeing, mental health and reducing suicide. It affirms that action to reduce suicide should be informed by culturally informed research knowledge and evidence, and supports Whole of Community and Whole of Government approaches.

CULTURE AND COMMUNITY: are of central importance to the health and wellbeing of Aboriginal and Torres Strait Islander peoples and strengthen individual and community resilience against psychological distress and suicide. Any program addressing mental health issues and suicide needs to be culturally based and community driven.

ACTION 1: PRIORITISE ABORIGINAL AND TORRES STRAIT ISLANDER WAYS OF WORKING

Aboriginal and Torres Strait Islander cultural ways of working and community-led healing programs to prevent suicide are prioritised. Culture is central to any program aimed at supporting individual and community social and emotional wellbeing. This should be stipulated in funding models for services and programs.

OUR YOUNG PEOPLE: sometimes need support to negotiate 'two ways' of living. They also should be supported to contribute to the suicide prevention conversation and assisted on their pathways to community leadership.

ACTION 2: ESTABLISH AN ABORIGINAL AND TORRES STRAIT ISLANDER YOUTH FORUM

Aboriginal and Torres Strait Islander voices and cultural values should support relevant healing initiatives for suicide prevention. Young people's views on suicide prevention need to be heard. A 'youth report' is urgently needed to complement the recently published Culture is Life Campaign's *Elders' Report into Preventing Indigenous Self-harm and Suicide*.

RESEARCH AND EVIDENCE: is crucial to understanding and preventing suicide and self-harm. Formal partnerships are needed between community based organisations, data custodians and researchers to develop a culturally informed evidence-base to support effective action. This will require the development of measures and indicators of cultural continuity, the establishment of new, robust data collections, and the optimal use of existing datasets (including the use of linked administrative data) at aggregate and unit-record levels.

ACTION 3: STRENGTHEN THE EVIDENCE BASE FOR ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION

A taskforce is established to map all services and programs that aim to reduce Aboriginal and Torres Strait Islander suicide. A further task is to review existing community consultation outcomes, research evidence, systemic approaches and community-led strategies for suicide prevention.

GOVERNMENT STRATEGIES: the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, the *Social and Emotional Wellbeing Framework* and the *National Aboriginal and Torres Strait Islander Health Plan* all require plans of action for implementation that are developed in partnership with Aboriginal and Torres Strait Islander communities and stakeholders to ensure the cultural integrity of the resulting services and programs.

ACTION 4: DEVELOP AN ABORIGINAL AND TORRES STRAIT ISLANDER CULTURAL FRAMEWORK FOR SUICIDE PREVENTION SERVICES AND PROGRAMS

A cultural framework should guide Whole of Government responses (services and programs) to suicide. This would prioritise cultural competence, cultural safety and cultural consultation. It would also enable the monitoring of the success of such responses by measures of the above.

ACTION 1:
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ABORIGINAL AND
TORRES STRAIT
ISLANDER WAYS
OF WORKING

ACTION 2:
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TORRES STRAIT
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CALL TO ACTION

ACTION 3:
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ACTION 4:
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ABORIGINAL AND
TORRES STRAIT ISLANDER
CULTURAL FRAMEWORK
FOR SUICIDE PREVENTION
SERVICES AND
PROGRAMS



THE ROUNDTABLE

*What follows is a precise of the conversation as manually recorded across the two days.
Please see Appendix 4 for the full Roundtable Program.*

DAY ONE

The convener, Professor Pat Dudgeon, and the Roundtable facilitator, Greg Phillips welcomed the fifty plus delegates. They raised a number of issues for consideration during the opening discussions.

Consideration: What are the practical actions to address issues affecting the mental health of Aboriginal and Torres Strait Islander peoples? People come together from personal experience of suicide. There are self-actualised ways of working, and many people in communities know the answers, starting with community led healing and supporting family members.

The following questions were asked:

Why are the suicides continuing?

Why are the services rendered to support individuals, families and communities failing to reduce the suicide crisis in far too many of the nation's regions?

Does racism and institutional racism contribute to self-harm and suicide?

Acknowledging mental health issues: What are the culturally appropriate tools required to measure the full range of mental health issues – psychosocial, psychological and psychiatric in reference to the suicide crises among Aboriginal and Torres Strait Islander peoples?

Promoting conversation in communities: How do we refine the ways forward in how to work with communities in promoting conversation - on the range of issues – from causal to various culminations?

Being on country: What are benefits of Being on Country?

Connecting with the spirit: How can we make possible Being on Country experiences and how can we extend and nurture their benefits?

Young people understanding who they are: How do we better understand what is important about Aboriginal and Torres Strait Islander cultural identities?

SCENE SETTING - WHERE WE ARE NOW?

An overview of the data, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS), the Social and Emotional Wellbeing Framework and the dedicated Aboriginal and Torres Strait Islander suicide prevention programs and services and mainstream suicide prevention services and programs and services.

Two introductory speakers, Adele Cox and Gerry Georgatos provided a broad positioning of the conversation, and were followed by the keynote speaker, Emeritus Professor, Michael Chandler.

Adele Cox spoke on behalf of herself and Dr Tom Calma.

Aboriginal and Torres Strait Islander males between 20 years to 40 years of age have very high rates of suicide in comparison to the national rates.

Ms Cox said that the most vulnerable age range for Aboriginal and Torres Strait Islander women is the same as the male age range although females are less than seven per cent of the overall suicides.

She highlighted that Aboriginal and Torres Strait Islander suicide has different causal factors to suicide in general when compared to the rest of the national population. Governments and organisations within the suicide prevention sector must highlight the need to underwrite the maintaining of links to culture and where necessary for the reclamation of culture. This understanding must inform suicide prevention programs and policies and is also important to engaging community and goes to the heart of concepts of Aboriginal and Torres Strait Islander being.

She referred to the National Empowerment Project that has been rolled out nationally across 11 locations. Ms Cox said that culture is consistently identified as being at the centre of empowerment. Currently there is too much focus on bio-medical models and that instead a more pronounced shift is required to socio-cultural models, which encompass various social determinants within health, and acknowledges ongoing trauma and high levels of distress that are evident in communities.

Ms Cox emphasised that suicide prevention care requires a Whole of Government response, and how this might look needs to be a substantive outcome of the Roundtable.

Gerry Georgatos then addressed the meeting.

Mr Georgatos said that he and Professor Dudgeon had met with Minister Scullion and that the Minister expressed his support for the Roundtable and was interested in the outcome.

At-risk communities will optimally benefit by having well-resourced community-led programs – led by local leaders and experts, with local knowledge at the fore and who are supported in this context wherever possible by a network of Government and non-Government organisations. The full range of issues that may culminate in suicide need to be addressed however it is imperative that the psychosocial context should be highlighted as it goes to causality.

His research has reported suicides among Aboriginal and Torres Strait Islander peoples at higher rates than that reported by the Australian Bureau of Statistics (ABS) – which reports 1 death in 24 by an Aboriginal and Torres Strait Islander as a suicide. He said that from 2001 to 2010, the ABS reported 996 suicides of Aboriginal and Torres Strait Islanders – an average of 100 per year. Mr Georgatos reported that in the three year period since he has collated data – he estimates that there have been almost 400 reported deaths by suicide of Aboriginal and Torres Strait Islanders – an increase to about 130 suicides per year. He said that suicide is under reported and that he believes that instead of 1 in 24 of all Aboriginal and Torres Strait Islander deaths by suicide that the suicide rate is instead somewhere within 1 in 16 to 1 in 12. This under reporting of suicides flows on to an under reporting of self-harm.

It is important to disaggregate the demographical data and to identify the high-risk regions and consequently understand the reasons why and therefore the ways forward.

There is a cultural shift occurring that is responding to the increasing awareness of the suicide crises. He said it is imperative that communities are resourced and supported to function with suicide prevention care 24/7 – and that high at-risk communities must be guaranteed capacity for prevention, intervention and postvention.

Georgatos estimated 400 suicides in our communities in the last three years (see) <http://nacchocommunique.com/2014/01/29/naccho-aboriginal-health-estimated-400-suicides-in-our-communities-in-last-three-years/>

A Canadian Experience – What are the key findings?

Emeritus Professor Michael Chandler was the keynote speaker of the Roundtable, having travelled from Canada. It was his third journey to Australia to discuss suicide. Professor Chandler is renowned as an expert in understanding Indigenous suicide in Canadian First Nations peoples.

Indigenous people in Canada are very different from each other (and from the broader Canadian society) and the question is asked: can ideas from the work that has been done in Canada be imported into the Australian context? There are commonalities. While he would be speaking about *numbers* of suicides this does not take away from the heartbreak that accompanies suicide. However, understanding the causes of the epidemic can help to identify what can be done.

Professor Chandler reinforced the concept that Indigenous suicide differs fundamentally from non-Indigenous suicide. He stated that colonisation has had deleterious impacts upon identity – to the point that for many there has been an erasure of identity.

Professor Chandler described many similarities between the high rates of Indigenous suicide in Canada and Aboriginal and Torres Strait Islander suicide in Australia. He said that it is imperative to pursue an understanding of the causes of the disproportionately high rates of Indigenous/Aboriginal/First Nations peoples.

Professor Chandler described research he had examined in Indigenous communities in Canada with high rates of suicide as well as communities that had low rates or negligible rates of suicide. He said the comparative studies assist in understanding and unravelling the factors contributing to identity formation, how identity formation unfolds and in discovering what negatively contributes or disturbs identity to the point that behaviourally the self is guided to a culmination such as suicide.

In the study of Indigenous suicides there is often too much data and too little conceptual understanding of the problems. The role of self and cultural continuity has special meaning in Indigenous contexts. This includes the issue of identity formation and how this unfolds, for young people personal identity formation is a process of growing but this is attached to cultural continuity.

Professor Chandler said that the role of the self is imperative to cultural continuity. The disruption and departure from fluent cultural continuity has

contributed to the disproportionate Indigenous suicide rates – not just in Canada and Australia but globally.

“Suicide is a penalty paid for failing to achieve personal and cultural identity and the continuity these represent in maintaining self-determination,” said Professor Chandler.

Epidemiology of the Canadian experience in British Columbia shows that Indigenous people are 3-4% of population but account for 9% of suicides. Nearly one quarter of all youth suicides are Aboriginal young people. Over one half of all suicides are Aboriginal people. These rates do not apply to any ‘living group’ but are generalised across the Indigenous population and this dehumanises the toll of suicide.

There is a gap between the numbers and what they mean. Talking about the aggregated whole rather than focussing on the different groups and their locations takes away vital information. ‘Stirring with a statistical stick’ takes away the possibility of speaking in meaningful ways about the impact and outcome of suicide.

Professor Chandler said that Canada’s Indigenous peoples are a diverse population and considerably different to each other – and that they have different cultural settings. He said that across British Columbia there are more than 200 Indigenous communities – many with different spiritual values and therefore with varying interactions inter-culturally and also in their interface with the “colonising populations.”

He reinforced the argument that statistical data needs to be disaggregated and therefore such disaggregation would produce a different portrayal of communities.

Professor Chandler said that ‘change’ is a constant in Indigenous communities as it is in any community and this needs to be explored. “Part of what it means to be an individual is to have a past and a future. It is the same with culture – sharing a past and a commitment to sharing the future. Continuity is the glue that binds cultures.”

Looking at British Columbia and the 200 bands (communities) and disaggregating these shows where the exaggerated spikes in suicide occur. Not every band has the same rate. Half of the 200+ bands have no suicide deaths recorded. Others are close to zero and others are pitifully high.

How can this issue of numbers be sensibly addressed? For example, looking at data by Tribal Councils where in 1-5 Tribal Councils, there is no suicide. What distinguishes those from the communities where suicide is not occurring?

What doesn't work statistically: rural, remote, urban disaggregation's; children and youth in care; population density; all the usual suspects – as these do not correlate with suicide in different communities. Instead there is a need to narrow the search to that which is reflective of what is going on.

This begs the question: why do people in some communities with no suicide believe that life is worth living?

With sameness and change – change is the only constant. In the face of constant change there must be some way of talking about sameness. Part of what it means to be an individual is to have a past and a future. It is the same with culture – sharing a past and a commitment to sharing the future. Continuity is the glue that binds cultures (looking back, looking forward).

The enterprise of colonisation: robs the past; criminalises the past (removes/delegitimises language and rituals); promotes a paternalistic attitude; and, thus controls the future of the colonised.

There is a need to be backward referring and forward thinking to create a continuity of culture to overcome any disruption or rupture of culture. Life is both behind and in front and owning this view is needed to maintain a sense of self.

The health of the culture and well-being of the individual is tethered to ownership and valuing of the past and tied to control over one's future. This may require rehabilitating or reconstructing the past and identifying how to achieve ownership of the future in the face of government policy, which disenfranchises.

Six of the nine factors identified in Chandler's research in the Canadian context have been as relevant and important in supporting cultural continuity. For example:

1. Cultural reconstruction: inclusive of preservation/rehabilitation/reclamation of language/s (or acknowledging that Indigenous language/s exists) as an important carrier of culture.
2. Self-government – communities reclaiming or being tied to traditional lands, thereby owning its own past.

3. Women in government – women are disempowered by governments (which traditionally have only talked to men) and need to re-establish their positive positions as part of the whole community.
4. Education and health – control over these fundamental issues are central to improving circumstances.
5. Cultural centres.
6. Child protection systems.

As part of establishing the role of the nine factors, research was conducted with more than 200 communities and community members were asked about the extent to which these were present in their community, and this information was then correlated with suicides. The more factors present, the lower the suicide rates. The data has been replicated through 3 waves of data collection. This work was done to push against the myth of the monolithic indigene – the 'one size fits all' approach, which represent fictions.

Half of Indigenous communities have no suicides. Indigenous knowledge in these communities of how to raise children translates and is reflected in lower/no rates of suicide (and evidence supports this). However, Indigenous knowledge may not be equally distributed across all communities.

There are two approaches to government intervention. The first, the top down model, identifies the next strategy and rolls this out across every community. This is a waste of money and does not reflect what is happening on the ground. The second understands the variability of what is happening in individual communities – and disaggregating the numbers to see which communities are doing better than others starts a process of knowing where interventions may be best directed. Professor Chandler said that the approach by Governments of rolling out "a top down model across every community" is "a waste of money and does not reflect what is happening on the ground."

How Cultural Continuity reduces suicide risk in Indigenous communities http://www.ias.uwa.edu.au/lectures/2012_lectures/michael-chandler-lecture

Cultural Continuity as a Hedge Against Suicide in Canada's First Nations <http://www.cryp.wa.gov.au/files/Chandler%20&%20Lalonde%20-1998%20-%20Cultural%20continuity%20as%20a%20hedge%20against%20suicide.pdf>

AFTERNOON SESSION OF DAY ONE

State Strategies and Reports

Three presentations preceded the afternoon group discussions to provide background and position the discussion in the context of what is currently known. The presentations are summarised in Appendix 2.

- Pui San Whittaker : WA Suicide Prevention Strategy
- Kim Lazenby and Sue Robinson : Ombudsman's Youth Suicide Report (2014)
- Roz Walker : Hear Our Voices – Community Research Report

Other strategic responses and suicide prevention:

Small group discussions were held to address the following questions:

- How do we promote self-determination and cultural reclamation as suicide prevention measures?
- Are we able to further develop, evaluate and adapt suicide prevention initiatives for Aboriginal and Torres Strait Islander peoples?

In summary, key points included:

- Cultural reclamation.
- Recognising culture will mean different things to different people.
- Building cultural competence.
- Modifying general suicide prevention programs/ strategies for Aboriginal and Torres Strait Islander peoples.
- Ensure that evaluations of programs and of data are completed “through an Aboriginal lens.”
- Language that can be easily understood by community should supersede academic language.
- The need for halfway houses, transitional accommodation, crisis centres, treatment centres and healing centres.
- Many communities need to be supported with enhanced communication strategies between the youth and Elders.
- Government funding models need to be tailored to meet community needs.
- Assistance and support for families that are struggling.

Points in detail from group feedback:

Defining culture, acknowledging diversity and common factors, and recognising not everyone lives on country.

Funding – evaluate and interpret data through an Aboriginal lens. Look at NAHS, NAEP, Burdekin, RCIADC (plus evidence in Close the Gap paper currently being finalised) – the evidence is there, build it up.

Language – community language (the mother tongue vs introduced language) academic language, all of these impact on Aboriginal and Torres Strait Islander communities.

General comments:

- Lots happening not much difference: no research to policy transfer.
- Voices from community consultations are recorded through consultation but how this translates in policy/practice is not evident. Community has knowledge but this is not being given resources to implement. These issues are (sometimes) controlled by elites – Aboriginal and non-Aboriginal.
- Wider appreciation of Aboriginal culture and spirituality is needed in the broader Australian community.
- Government has intervened in the capacity to practice culture.
- Defining culture within the local context is needed.
- First response (ED) admissions and treatment centres (do not communicate with families, don't discuss; provide interventions but there is a lack of communication between these and families).
- Culture – as rights, as identity.
- Young people are confused (about culture) it is everywhere, but what is it?
- Culture is a big word with many small packages (food, ceremony, language, country, products/ productions).
- Young people may not be raised in community (living in 2 cultures), Aboriginal young people have non- Aboriginal and Aboriginal culture, no balance between, they are walking in two worlds.
- In all places conversations are happening – local conversations, these need to be enabled/ facilitated and listened to.



- Cultural integrity is also about behaviours within communities.
 - ◆ Young people need to know the history behind the impacts/ the outcomes of (colonising) history
 - ◆ A rite of passage (becoming young men and women)
- If young people can see old people infighting this is no good.
 - ◆ Young people are despaired about/ between: religion (earth and land) and (disfranchised by) colonising religion
- Culture – many ways to view (old culture/new, good culture/not good). Helping to assist people to live in two worlds. Helping to raise children; and, support families, lore, and practice. In describing the culture: practice what the young people need to follow. Enable young people to have the conversation – what does culture mean to them – towards developing cultural strengths and identities.
- Community and keeping culture alive – promoting culture. Relationships between youth and elders are disconnected. Work within communities to bridge the gap between young people and elders.
- Funding – pooled funds don't work. Funding allocations need trust (by Government) that community is able to provide best interventions

(e.g. Yirriman project has no resources to translate out to other places or activities because they don't fit the funding framework). Too many funding models – this needs to be more relevant to fit to communities and the actions they want to take. Evaluation processes also need to be relevant to community and government.

Themes from small group discussion were:

Detailed comments are presented in Appendix 1. Following is a summary of the comments made.

1. Culture – promoting the role of community and keeping culture alive.

To strengthen and improve resilience, acknowledge diversity, local context and common factors.

Culture is a big word with many small packages:

- Working from within communities (community driven/led).
- Many ways to describe culture.
- In describing the culture: practice what the young people need to follow.
- Helping to raise children, support families, lore, and practice.
- What is the product of culture (right/wrong, values and respect).

2. Young people

- Enable young people to have the conversation – what does culture mean to them and what's important to their identity.
- Assisting young people to live in two worlds, there is (currently) no balance, they need to know their history, and how policy and law impacts on their everyday lives.
- Are despairing about religion as spirituality (earth and land) and the role of colonising religions.
- Young people are confused – culture is named everywhere, but what is it?
- Relationship between youth and elders has been disrupted.
- Work is needed in communities to bridge the gap between young people and elders.
- Teach political awareness as part of young people's identity to be strong, resilient and understand what is happening to them.

3. Government

Has intervened in the capacity to practice culture and a wider appreciation is required of culture and spirituality.

- Address institutional racism.
 - ◆ Requires systematic approaches to eliminate.
- Consultation needs to be meaningful and needs translation through an Aboriginal lens.
 - ◆ Conversations are occurring in all places, listen to local conversations, enable these
 - ◆ Community members/communities have knowledge but it is not being given resources to implement what is required
- Those involved in policy development, program delivery, etc improve their capacity, for example:
 - ◆ Need to be accredited as knowledgeable about Aboriginal communities, history, worldviews (cultural competence)
- Formal evaluation included as a requirement of all 'healing' programs.
- Cultural continuity measures are needed (viz Chandlers work) to establish relevant community values.
- There are different points of view to consider in establishing responses:
 - ◆ Community
 - ◆ Funders
 - ◆ Aboriginal/non-Aboriginal expertise
- Flexibility is required and acceptance of Aboriginal ways of working.

4. Funding

Needs trust to underpin Aboriginal approaches.

- For communities to provide the best interventions, as defined by community members for their community.
- There are too many funding models, these needs to be more relevant to community fit/need, with appropriate outcomes measures.
- Evaluation of funded programs needs to be relevant to community and government.
- Voices from the communities are controlled; better means of community consultation are required.
- Community to have access to funding decision-making organisations/structures to shape these to community requirements – a shared understanding.

Strategies from the discussion were implicit. These were:

Underpinned by Indigenous knowledges and ways of working, and with Aboriginal people always leading the strategic approaches:

- Strengthening the link between young people and cultural identity.
 - ◆ Based on conversations with young people
 - ◆ Supporting community organisations working with young peopleLocal communities understand the way, and need to be supported by government with the following understandings:
- Define reportable criteria for how organisations/government agencies work with Aboriginal people.
- Require cultural competence for non-Aboriginal people involved in policy development, programming, funding.
- Create mechanisms for meaningful consultations to take place for community members and organisations to direct and influence funding allocations.
- Evaluation built in (and funded) for all strategies with measures relevant to (and set by) communities and government (in consultation/partnership).



THE ROUNDTABLE - DAY TWO

Day Two was an opportunity for delegates to reflect and review on the discussions and preliminary findings of Day One and by the conclusion of Day Two proceed to an endorsement of findings.

PANEL: PERSPECTIVES FROM THE COMMUNITY

There were a series of opening remarks by a panel of speakers, in this order: Scott Herring and Terry Murray, Lorna Hudson, Amanda Sibisado, Darryl Kickett, Josie Farrer, Robert and Selina Eggington and John Watson. Following is a summary of their comments.

Scott Herring and Terry Murray said that the Kimberley region has 46 language groups with strong connections to lore and culture. With a sense of urgency they reflected on the need for youth to safely navigate their identity in a society where two cultures meet, that of mainstream Australia and that of both their local and historical cultures.

The Kimberley is enduring the tragedy of disproportionately high rates of youth suicide and Mr Herring and Mr Murray said this has to do with youth becoming lost between a widening divide between the two cultural settings.

They referred to the Kimberley Aboriginal Land and Culture Centre's Yirriman Project, which mentors youth on Country, and has been doing so for 13 years. The project contributes to a re-engagement with historical and contemporary cultural identity and therefore strengthens psychosocial health, imperative in order for two cultures to safely meet.

Derby Elder Lorna Hudson said that particularly for youth living on Country or remotely, engagement of historical culture needs to be

supported in order to ensure psychosocial health. Where this is denied or reduced youth are becoming lost between competing values from the confrontation of two distinct cultural settings.

Communication between older and younger generations needs to be enhanced and resourced so that historical form and content is carried – cultural continuity. Ms Hudson said that there has to be a balance constructed in cultural and mainstream education.

Amanda Sibisado who works with the Alive and Kicking program in the Kimberley said that there are programs that do work in responding to the needs of youth however these programs need to adequately resourced in order to achieve competent social reach. Ms Sibisado said that the Alive and Kicking program was developed in response to the high rate of suicide. The program has a holistic approach, engaging community through workshops and various training and has an onus on cultural business.

Ms Sibisado said the program has been an opportunity for both males and females to

articulate issues, express their feelings and connect remedially with one another. These engagements are an opportunity for identity building, healing and cultural meanings. The engagements are opportunities to give rise to potential community leaders – to increase the pool of leadership and role models.

Kimberley Parliamentarian, Josie Farrer said that multiple trauma accumulates into suicide. However the sense of loss and the associated pains continue on for family. Ms Farrer referred to a visit she made to the Kimberley's Beagle Bay, where in recent years there has been a prevalence of spates of suicide. Ms Farrer took their voices into the State Parliament arguing to her parliamentary colleagues that more must be done now with youth but also with a whole-of-community approach.

Red Dust Healing, Darryl Kickett said pain and hurt continues long after the loss of a loved one. Mr Kickett said that in his long experience in working to help people heal from the sense of loss, and in helping youth strengthen their identities, there has to be an onus of self-responsibility taught.

Mr Kickett said that colonisation has an enduring effect and the reality is that we cannot return to the safety of society that once was. Therefore we need to engage tools from within historical society with which to strengthen identity and empower people. Mr Kickett said that it is important for these tools to be defined and for access to these tools funded.

Mr Kickett said that we may not be able “to decolonise society but we can decolonise the self.”

Dumbartung Aboriginal Corporation CEO, Robert Eggington said that families who endure the loss of a loved one need support in order to engage “fears and uncertainties.” Cultural and historical identities can enrich and empower individuals. This is important to counter the erasure of identity from the impacts of colonisation – dispossession, discontinuity of culture.

Mr Eggington said that more organisations need to work together, reduce any Government imposts, work in ways such as do Dumbartung and the Aboriginal Healing Foundation.

Mr Eggington said that people needed people, and that reductionist programs such as phone line supports will not save lives. In reference to Aboriginal and Torres Strait Islander suicide and self-harm, response services should be exclusively staffed by Aboriginal and Torres Strait Islanders. Cultural methodologies should be avoided and that there should be a reduction of clinical

methodologies. He said that the coalface should be serviced by non-clinical experts.

Mr Eggington said story-tellers, the richest carriers of cultural knowledge and identity, should be encouraged and supported.

Kimberley Aboriginal Land and Culture Centre's **Elder John Watson** said that the impacts on cultural identity by colonisation manifest cultural wounding. Cultural wounds should be responded with cultural medicine underwritten by cultural methodologies. More funding should be allocated to suicide prevention care that in the least should be similar to funding regimes that underwrite clinical methodologies.

On behalf of KALACC's Yirriman Project, Mr Watson proposed a resolution to the Roundtable:

The state of Western Australia should invest in culturally based methodologies to the same extent as they invest in clinical therapeutic programs and that successful programs like the Yirriman Project be funded by the State government.

Following the conclusion of the speakers' presentations, responses were made by the rest of the Roundtable's delegates. Some of these comments and responses included:

Professor Gracelyn Smallwood, recently acclaimed as NAIDOC's National Person of the Year, said that coalface community programs are not securing the funding that they should be and that instead Christian-based organisations are securing the bulk of the funding. She said:

Red Dust, started with men but now works with women as well. Academics and grassroots are coming together. The community is in pain, so much anger, so much suffering. Healing begins with the self.

Professor Smallwood said that programs such as Red Dust Healing should be supported and extended.

Emeritus Professor Michael Chandler said the “self and society” will not be addressed by medical models but by cultural models. The dichotomy between self and society, the medical model is not a good choice; the issue is not medical models but cultural models ‘a broader problem is the culture of the individual’. Forcing ourselves to make choices about which interventions is problematic. In all communities, even in epidemic proportions, suicide is still ‘rare’. If you try and identify the individual [prone to suicide] you will fail. Tools and ideas to build suicide prevention strategies based on the vulnerability of the few will not work. It is not

within capacity to follow a model that attempts to find the individual suffering. Instead aggregate up – find where the problem is, in which community/ies. There are not just two models. We should focus attention on the right level of analysis, using culture or an equivalent term.

The Ombudsman Report (presented the previous day) attempted to draw out what factors indicated the suicide but if this was applied to all young people experiencing those problems, there would be many and no system could manage this. Culture was number four on a list of five according to the ombudsman, but, culture is the only lens through which to conceptualise suicide strategy in Aboriginal communities.

Professor Chandler said that “tools and ideas to build suicide prevention strategies based on the vulnerability of the few will not work” and that instead holistic cultural tools must be engaged.

Professor Chandler said that suicide epidemics could only be reduced by whole of culture perspectives. Each region should develop a healing plan.

Passionate discussion took place and resolutions put forward in regard to supporting funding for community-based programs. This included:

- There should be funding for the Yirriman project - as an example of a long-standing program that has been evaluated, with evidence of an effective and robust cultural methodology, supported by the Elders.
- There should be ongoing support for the role of the Healing Foundation.
- There should be funding for Red Dust Healing including an evaluation to highlight its effectiveness and impact on people’s lives.
- There should be funding for Dumbartung.

Professor Pat Dudgeon said the Roundtable was an opportunity to garner the support and availability of those present in longer term plans to develop healing and suicide prevention care strategies. Specific resolutions for specific community programs were not seen as the role of the Roundtable. Rather, all Aboriginal Torres Strait Islander community based, cultural programs should be supported.

There is no answer to what causes suicide. There are a whole range of issues that contribute to the circumstances, which may lead to suicide. You cannot ‘recognise’ who is suicidal. Instead looking at the issue from the whole of the cultural perspective is the only way to stop this.

The group discussed the resolution put forward, and using terms like ‘to the same extent’ implies there are only two ways, but there are many ways. Community led healing programs, tools are needed. What is missing is a healing plan in all the regions and an aggregation of the resolutions. Commentary included:

- Communities and community-controlled health organisations must be positioned as champions of change.
- A Youth Forum should be realised.
- Western Australia Mental Health Commission’s Tim Marney said that integrating culture and community depended on leadership.
- New South Wales Mental Health Commission’s John Feneley said that Government approaches to mental health and suicide prevention should be guided by community needs. He said that it was imperative to evaluate the relationship processes between Government and communities, and whether they can be meaningfully enhanced.

The remaining commentary of Day Two speakers was both in-depth and diverse, and largely reinforced views and findings of Day One. This is set out in some detail in Appendix 3.

The launch of National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) supported by the Mental Health Commissions of Australia.

NATSILMH’s aim is to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples by advocating and providing advice and leadership in these areas. It also aims to reduce the high rates of suicide among Aboriginal and Torres Strait Islander peoples. NATSILMH is a core group of senior Aboriginal and Torres Strait Islander people working in the areas of social and emotional wellbeing, mental health and suicide prevention. The group is jointly supported by the state and national Mental Health Commissions with many of the group’s representatives involved with the Commissions and other leading Indigenous health organisations. NSW Mental Health Commissioner, John Feneley, officially launched National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), with Western Australian Mental Health Commissioner, Timothy Marney also attending.

See here for more information about the NATSILMH and its members: <http://natsilmh.org.au/>

AFTERNOON SESSION OF DAY TWO

What Are Our Next Steps?

The purpose of this session was to establish the foundations for a call to action to be prepared following the Roundtable Conversation. The task was to create a call to action to identify what is needed in the next 3-5 years. For the breakout session, each group was asked to identify two of the most important things for action. It was understood by the group as that the call to action needed to be underpinned by the notion that:

Strong community includes: spirit, feeling, land, and culture.

It was also acknowledged that existing strategies, such as the National Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework, were in the process of being renewed, but that the nine guiding principles remain relevant. It was also noted that the Aboriginal and Torres Strait Islander Suicide Prevention Strategy requires an implementation plan.

The participants were asked what is it in Australia, what is the spiritual thing, what is it, that is going to make a change? How do we go about strengthening a cultural rebirth?

Some people thought that for community based organisations – applying for funding was an issue. The current perceptions are that partnerships did not exist between communities and those agencies funded to provide services. Instead, relationships need to be established between communities, government and non-government agencies which prioritise the knowledge and solutions identified by communities as relevant to them. This also requires resources for meaningful consultation and genuine capacity building. There is also a need for matching methods of evaluation with culturally relevant criteria within an Aboriginal and Torres Strait Islander social and emotional wellbeing framework to promote community based organisational capacity in all settings.

What keeps us strong?

- Speaking language.
- Being on Country.
- Cultural healing on Country.
- Recognising the bonds of family.
- Strength from the past – education from the Elders about culture.
- Connection to traditional lands and having

- opportunities to be on Country.
- Modern culture causing disrespect among young people towards family and their culture.
- Gaining a sense of strength from supporting your people and Elders.
- Community training in mental health first aid, alternatives to violence, self-care, peer education by women for women in the communities.
- Strong families who understand where pain is coming from (healing process) and have the capacity to protect their children.
- Healing – and having the tools to change ourselves and the way we think and not being fearful.
- Strong Indigenous governance.

What will keep young people strong?

- Learning about history and culture and having more opportunities to do this in supportive ways (not through guilt and shame).
- Educate young people in culture in positive ways and innovative ways.
- Addressing the loss or disconnect from modern culture and lifestyles. By taking young people back to country to learn about ceremony, dancing, adapting back to country in a modern world– reconnecting to not lose that cultural life and connection.
- Having role models in the community to support and mentor young people.
- Having family through skin groups means you are never lost – always have family – this needs to be practiced and strengthened to protect young people.
- Allowing young people to be leaders today – not tomorrow.
- Good representation of age groups in any forums and representative discussions because the generation gaps exist.
- Work with young people to help them adapt to living across two worlds/two cultures.
- Create new initiation ceremonies and rites of passage where these have been lost.
- Aboriginal led healing centres – funded and supported as a necessity for community.
- Helplines.
- Taskforce (to link Aboriginal community to coroner and ministers and vice versa).
- Cultural methodologies underpinning therapeutic treatments and SEWB programs.

CALL TO ACTION BREAKOUT GROUP NOTES

Group 1:

1. Fusion of grass roots and the academic – lets co-exist.
2. Healing villages/centres in both existing and proposed new places that integrate grass roots community based knowledge and programs with the academics.
3. Where policies are borne from this fusion.
4. Where this fusion is underpinned by Indigenous capacity building at all levels with real jobs – invest in Indigenous peoples.
5. Training that leads to elevated real jobs for Aboriginal peoples. Counsellors, mentors, jobs with real titles, real jobs. Aboriginal health workers are totally misunderstood workers in the health services sector.
6. More safe places for kids to go to especially at night.
7. Overcome the differences between needs and what is provided. Again, have Aboriginal health workers at all levels.
8. Year 10/11/12 students to link in with stronger university orientation/outreach and bridging programs or vocational training centres to be set up, eg: Kalgoorlie School of Mines in the Kimberley.
9. Review and prepare an implementation plan for Indigenous housing and infrastructure guides.
10. Plan and implement a quiet house program in the northwest and/or across WA and Australia.
11. Sustainable Indigenous language program in all schools – community specific, community employed, real Aboriginal jobs.

Group 2:

1. Stick together – outcomes from this meeting
2. Acceptance of culture as central (acceptance by government)
3. New models of funding so big non-government bodies don't get it all (give small Indigenous organisations a chance)
4. Change /review what we mean by 'success' – how we measure outcomes/impact – dialogue. Integrity statements.

Group 3 (Healing Foundation Focus):

1. The ATSI HF could take on a research agenda: to identify missing gaps that impacts on social and emotional wellbeing of young people, their families and communities.
2. To enhance and build on current ATSI HF initiative and best practice, within the 12 month funding cycle.
3. To engage in an advisory and advocacy role with the Australian government to lead and facilitate Aboriginal and Torres Strait Islander (Health and SEWB) to add value to the four domains of the Indigenous Advancement Strategy.

Group 4:

Focusing on culture might be too simplistic. Replicating the Chandler research – has distilled the commonalities and differences. Without this approach, it is hard to identify where the issues are. This work has been started through the Healing Foundation (report shows there are geographical regions).

1. Research.
2. Look at communities with no or little suicide rates to see what is working.
3. Community based organisations cannot effectively communicate with governments – (requires evidence gathering – outcomes and process which explains these) community organisations already doing this often have a close association with academia.

To move into the future requires young people to come along. A complementary youth report to sit alongside the Elders report would be very important. The world is different for youth today.

TWO ACTIONS:

1. As a matter of urgency, conduct a Youth Forum – their voices, their ideas – as has occurred with the Elders' Report.
2. Research to be undertaken:
 - Drawing on Chandler's conceptualisations ensuring relevance to the Australian context.
 - Qualitative research (participatory action research) with community based organisations supported to create evidence and is evaluated.

Group 5:

There should be a National Cultural Healing Plan (where is it?) informed by – Elders Report, the Aboriginal and Torres Strait Islander Suicide Prevention Strategy, etc.

Aboriginal and Torres Strait Islander people want a full say in how these funds in the new funding models will be invested (find government words to say same thing).

We want a place (local) based framework to bring all the statistics together at the community level and to develop capacity within these strategies to draw on funds to support places/communities support their vulnerable children (eg: cultural enrichment programs).

People want 'forever funding' (minimum 20 years) that ensures continuity of programs.

There is a need for proper funds to evaluate programs or place based investment strategies.

Group 6:

Educational institutions must engage effectively (build relationships) with the Aboriginal nations they serve and to facilitate the engagements between the nations. This enables communities to develop their culture. Other items included:

- Develop an operational plan for the Aboriginal Suicide Prevention Strategy, include mental health in the Implementation plan of the ATSI Health plan.
- Replicate Chandler's research in Australia,
- Have a centralised community and government list of suicide prevention activities, establish healing centres in every community – run by the community.
- As part of National Health Plan, schools to be funded to provide culturally relevant training and services for young people in partnership with their communities.

Call to Action summarised as:

1. Fusion/co-existence of grassroots and research academics.
2. Healing villages/centres creating spaces for Elders and young people (the research/community based can inform each other) – the evidence is available.
3. We need to stick together, come together in collaborative voice.
4. Acceptance of culture as central to addressing the issue of suicide (governments, policy makers and others need to accept that culture

is central) and needs to be embedded in all approaches.

5. New models of funding to support community based (who need access to funding to continue). Building in an Integrity Statement (requires demonstrated expertise).
6. A dialogue of what is being talked about, what is evaluation for, what is being measured – better measures of success, can't just be numbers through the door.
7. Focus on youth:
 - Healing Foundation to take on the research agenda and identify the missing gaps.
 - Enhance and build on HF initiatives (within a 12 month cycle) what can be translated.
 - Relationships with, engage in advisory and advocacy role to work with the 4 domains of Indigenous Advancement Strategy.
 - Youth must be involved – a process to have their voices heard.
 - ♦ Research to support/attest and build evidence in the same way in which Chandler's work has informed this area within the Canadian context, particularly, the importance of cultural continuity
8. Connect with new strategy and the newly identified Commonwealth five categories, with intervention required (regional partnership agreements). We want a full say. Recommend place based framework. Develop capacity to participate including enough time. Responding to hot spots of vulnerability. Forever funding (20 years) to plan and evolve. Proper funds to evaluate findings (and improve and draw upon community knowledge).
9. A National Cultural Healing plan – that acknowledges what has gone before.
10. Bureaucratic perspective: government has:
 - An Aboriginal and Torres Strait Islander Suicide Prevention Strategy: governance requires an operational plan.
 - The Aboriginal and Torres Strait Islander Health Plan – needs a mental health focus.
 - Chandler's Research (as above).
 - Education – institutions must engage with Aboriginal and Torres Strait Islander communities. Establish healing centres in every community, by the community (formally evaluated using culturally relevant approaches, participants are best placed to say what has worked for them).

PARTICIPANTS OF THE ROUNDTABLE



Associate Professor Dawn Bessarab

Associate Professor Dawn Bessarab is of Bardi and Yindjibarndi descent. She lived and worked in remote, regional and urban settings before settling in Perth. She has extensive experience in Aboriginal child protection, family violence, drug and alcohol misuse, justice and health, and leads the Aboriginal Health Education and Research Unit at the Curtin University Health Innovation Research Institute. Associate Professor Bessarab is a Chief Investigator on the Centre for Research Excellence in Aboriginal Health and Wellbeing in collaboration with the Telethon Kids Institute.



Tom Brideson

Tom Brideson is an Aboriginal man who has been actively involved in Aboriginal mental health since 1993 and has published a number of journal articles on issues facing the Aboriginal mental health workforce. He chairs the Aboriginal Advisory Committee of the NSW Centre for Rural and Remote Mental Health and is currently the Chair of the Management Committee of The Mental Health Services Conference (The MHS). Tom has had a number of appointments to state and national Mental Health and Suicide Prevention Committee's. In 2012, he was appointed to the Board of Indigenous Allied Health Australia and in 2013 he was appointed to the Community Advisory Council of the NSW Mental Health Commission.



Dameyon Bonson

Dameyon Bonson is a First Nation Australian of both Indigenous and Caucasian heritage. Dameyon is a Social Warrior (Social Work) with an interest in decolonising the academy. He is a contributing author at The Good Men Project, Aboriginal Service Officer (men's health) at WA County Health Service, Male Health Reference Group Member at Aboriginal & Torres Strait Islander Advisory Committee of the Australasian Men Health Forum. Previously he has been a Board Member at Men's Outreach Service, SEWB WSU Officer and Projects Coordinator at Kimberly Aboriginal Medical Services Council Inc.



Robert Brooks

Dr Brooks has an extensive applied and academic history in mental health and wellbeing. The interaction of applied and theoretical work has provided a unique perspective on many aspects of research and evaluation work conducted. As Deputy Director of the Global Mental Health: Trauma & Recovery certificate program I work with International workers in refugee and development. I teach on the short and long term outcomes and interventions for traumatised

communities in the internationally recognised program from Harvard University. Robert works with diverse populations including Aboriginal and Torres Strait Islander peoples, peoples of Timor Leste and Cambodia. Areas of clinical work have included male prisoners, child protection field work, training and research. Robert has an extensive track record of practice research and teaching in trauma, mental health and suicide.



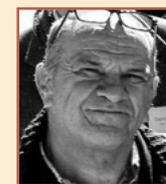
Emeritus Professor Michael Chandler

Dr Chandler is an Emeritus Professor in the Department of Psychology at the University British Columbia. Dr. Chandler's ongoing program of research involves an exploration of the role culture plays in constructing the course of identity development, shaping young people's emerging sense of ownership of their personal and cultural past, and their commitment to their own and their community's future wellbeing. Professor Chandler's program of research dealing with identity development and suicide in Aboriginal and non-Aboriginal youth was singled out for publication as an invited Monograph of the Society for Research in Child Development.



Maxine Chi

Maxine Chi is a Bard Aboriginal woman who also has Japanese, Chinese and white Australian ancestry. She has a long history of working in government and organisations such as the Kimberley Land Council and the Aboriginal Legal Service. She was born in Broome WA and maintains her connections with the Kimberley. She has worked with the Department of Housing as a Principal Policy Officer for the last 6 years.



Professor Len Collard

Len is an Australian Research Council, Chief Investigator with the School of Indigenous Studies at the University of Western Australia. Len has a background in literature and communications and his research interests are in the area of Aboriginal Studies, including Nyungar interpretive histories and Nyungar theoretical and practical research models. Len has conducted research funded by the Australian Research Council, the National Trust of Western Australia, the Western Australian Catholic Schools and the Swan River Trust and many other organisations. Len's research has allowed the broadening of the understanding of the many unique characteristics of Australia's Aboriginal people and has contributed enormously to improving the appreciation of Aboriginal culture and heritage of the Southwest of Australia. Len's groundbreaking theoretical work has put Nyungar cultural research on the local, national and international stages. Finally Len is a Whadjuk Nyungar and who is a Traditional Owner of the Perth Metropolitan area and surrounding lands, rivers, swamps, ocean and it's culture.



Adele Cox

Adele Cox is a Bunuba and Gija woman from the Kimberley region of Western Australia. She has spent the majority of her early working life in the Kimberley region in media and in

suicide prevention and since 2001 has been in Perth. She has worked at the Telethon Kids Institute as a Senior Researcher Officer on numerous projects including Indigenous Suicide Prevention and Maternal and Child Health Research. She is a current member of the WA Ministerial Council for Suicide Prevention, and the newly established National Aboriginal and Torres Strait Islander Leadership in Mental Health group.



Kevin Cox

Kevin Cox has had extensive experience in health service program delivery, most recently as Director of Aboriginal Health with the WA Department of Health and Director of Aboriginal Health at St

John of God Health Care. Prior to this he was CEO of Broome Regional Aboriginal Medical Service and has had a long career with both the Broome and Kimberley Aboriginal Medical Services. He has undertaken tertiary studies in business, education and accounting, and has had a range of board appointments, primarily community based. More recently Kevin has been on the board of the Edmond Rice Institute for Social Justice.



Damien Curtis

Damien Curtis is a filmmaker with Our Generation. He has a MA (Hons) in World Religion from Edinburgh University with a focus on Indigenous religions, and a Masters in Environment

and Development from Cambridge University. For the past 12 years he has worked on the interface between environmental conservation and indigenous rights, with organisations such as UNESCO and The Gaia Foundation. Now resident in Australia, he is deeply committed to inspiring social change with respect to Indigenous rights and environmental protection. He recently created and now directs, the Stand for Freedom campaign, supporting Aboriginal people's challenge to the Stronger Futures legislation (Intervention 2).



Professor Neil Drew

Professor Neil Drew was Deputy Head of the University of Notre Dame Broome Campus from 2009-2013. He trained in social and community psychology and has over 30 years'

experience working with a diverse range of communities and groups. He has worked with Aboriginal and Torres Strait Islander communities since beginning his career as a volunteer at the Aboriginal and Torres Strait Islander Medical Service in far North Queensland in 1980. At UNDA Professor Drew is the program head and cofounder of the Aboriginal Youth and Community Wellbeing Program in the East Kimberley, established in 2006.



Professor Pat Dudgeon

Professor Dudgeon is from the Bardi people of the Kimberley. She is a research fellow and psychologist known for her leadership in Indigenous higher education and mental health.

Currently she is a Research Fellow at the School of Indigenous Studies, University of Western Australia. Her roles include Commissioner, National Mental Health Commission; co chair with Dr Tom Calma, of the national Aboriginal Torres Strait Islander Mental Health and Suicide Prevention Advisory Group; and chair of the Aboriginal and Torres Strait Islander Leadership Group from State and National Mental Health Commissions Australia.



Francine Eades

Francine Eades is an experienced Aboriginal Registered Nurse currently employed as the Aboriginal Health Advisor at the Sydney Children's Hospitals Network, working across the

Network at the Children's Hospital in Randwick and the Children's Hospital at Westmead. She has previously been a research associate with the Kulunga Research Development Unit at the Telethon Kids Institute and worked on the landmark research study - WA Aboriginal Child Health Survey. She is a Senior Project Officer at Derbarl Yerrigan Health Service in Perth, Western Australia.



Robert Eggington

Robert Eggington is a Nyoongah man from Perth and executive officer at Dumbartung Aboriginal Corporation. He has worked in the Noonhghah community for 32 years.

Prior to working at Dumbartung, Robert worked as the coordinator of Diurupin Livings Arts Centre in Fremantle, Western Australia. As part of Robert's role at Dumbartung he has published an extensive amount of literature including audio-visual texts on cultural matters, and spoken and addressed many national and international forums and lectures, including the Brazil international childcare forum, and the Murdoch University racism in a global perspective forum.



Selina Eggington

Selina Eggington is a Nyoongah woman from the Wheatbelt town of Narrogin in Western Australia. Selina has worked at the Dumbartung Aboriginal Corporation for the past seven years

as the co-ordinator of the Kootamiara ("healthy") Oub ("strong") Women's Healing Program. Selina has worked with many community women, empowering them to make positive choices in their lives. Selina also assists in delivering lectures to the various groups that visit Dumbartung.



Josie Farrer MLA

Elected to State Parliament in March 2013, Josie is the first local female Kimberley Aboriginal MP to represent the region. Her maiden speech was exceptionally powerful as she spoke

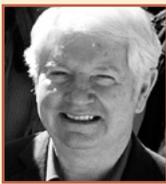
about the high rates of suicide, economic development, housing and job creation in the Kimberley. Josie resides in Halls Creek with her husband Mario Jazyk where they raised their 13 children. They now have 52 grandchildren and 17 great grandchildren. Josie has been an active member of numerous regional boards including, director of the Kimberley Land Council, Kimberley Language Resource Centre and Kimberley Aboriginal Law and Culture Centre, Deputy Chair of the Kimberley Development Commission, Chairperson of the Regional Road Group, Halls Creek Shire Councillor and Halls Creek Shire President.



John Feneley

Mr Feneley was appointed as the inaugural Commissioner of the NSW Mental Health Commission on 1 August 2012. He brings to the position extensive experience within the mental

health sector as Deputy President of the Mental Health Review Tribunal (2007 to 2012) and prior to that through mental health policy and law reform work as Assistant Director General NSW Department of Attorney General and Justice. He has served on the board of the Schizophrenia Fellowship and government boards and committees such as the Youth Justice Advisory Committee, the Child Death Review Team and the Legal Profession Admission Board. Mr Feneley is also a former Deputy Commissioner of the Independent Commission Against Corruption.



Peter Fitzpatrick AM JP FSAE GAICD

Peter Fitzpatrick is a natural leader and an outstanding communicator who motivates and encourages people to reach their full potential. He achieved

personal success as executive director of the Law Society of Western Australia for over a decade and now as Chief Executive Officer of the Motor Trade Association of Western Australia. In 1990, he was the inaugural chair and driving force behind the establishment of Youth Focus, a not-for-profit organisation that offers a lifeline to young people who show early signs of suicide, depression and self-harm. In 2004, he became Chair of the Celebrate WA Council, which manages an annual statewide program of community initiatives.



Gerry Georgatos

Gerry Georgatos is a life-long human rights and social justice campaigner, and multi-award winning investigative journalist. In 2011, he left a management background and the tertiary sector

and found himself called upon to contribute as a journalist and researcher predominantly for the National Indigenous Times and the National Indigenous Radio Service. He is working on a documentary and completing a book on the crises and prevention care. In 2008, he was recognised by the WA Government Department of Communities – Outstanding Individual Contribution – for his work in the tertiary sector; his work with the homeless and for his work alongside First Peoples communities. He is a regular traveller to remote communities Australia-wide.



Sandy Gillies

Ms Gillies is a Gungarri woman from southwest Queensland. She is currently the Director, Engagement and Reporting for the Queensland Mental Health Commission and has over 25 years'

experience in senior management roles both within the government and Aboriginal Community Controlled Health care sectors across Queensland. She completed her Graduate Certificate in Health Management in 2009 at Griffith University, Queensland. Ms Gillies has been a strong advocate and leader in the provision of cultural awareness training over many years to both government and non-government organisations.



Professor Jeannie Herbert

Born and raised in the Kimberley region of Western Australia, Professor Jeannie Herbert is currently the Foundation Chair of Indigenous Studies at Charles Stuart University in New South

Wales. Prior to taking up this position at CSU, her long engagement in the sector included positions as Vice-Chancellor of the Bachelor Institute of Indigenous Tertiary Education in the Northern Territory (2006-2009) and Chair of Indigenous Australian Studies at James Cook University in north Queensland (2001-2006).



Scott Herring

Scott has lived and worked in the Kimberley for twenty years. He has worked as the Youth Service Coordinator in Halls Creek for five years, a Remote Teaching Service

teacher for ten years and has been the Yiriman Men's Coordinator since 2011.

Young people are the leaders of today, not tomorrow, and need their voices heard. ROUNDTABLE ATTENDEE, 2014.

**Chris Holland**

Chris Holland worked for three years as a dedicated solicitor on *Trevorrow v South Australia*, the first successful claim for damages by a member of the Stolen Generations. From 2002, under the

direction of the Aboriginal and Torres Strait Islander Social Justice Commissioner, he worked to develop the human rights framework that underpins the Close the Gap Campaign for Aboriginal Health Equality, and managed the Campaign Secretariat from 2006 to 2012 and the Secretariat for the National Health Leadership Forum of the National Congress for Australia's First Peoples in its first year of operation.

**Vickie Hovane**

Ms Hovane is an Aboriginal woman from Broome in the Kimberley region of WA. She holds a First Class Honours Degree in Psychology. Ms Hovane is a Director on the board of the new

National Centre for Excellence in Research for the prevention of violence against women and children. She is currently Co-chair of the Australian Indigenous Psychologists Association and a member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

**Lorna Hudson OAM**

Lorna Hudson is a senior Bardi Elder. She was a key part of *The Elders Report* and has participated in extensive media coverage of the report. Lorna believes that young people need support from

Elders in communities to learn about culture and that people can be empowered by supporting and listening to them. Lorna works in her community to support and teach people cultural ways of living.

**Dr Anton Isaacs**

Dr Anton Isaacs is a researcher in the Department of Rural and Indigenous Health, in the school of Rural Health at Monash University. Dr Isaacs is a public health physician and has worked

in the fields of, HIV and AIDS, reproductive health, occupational health and mental health. Anton's doctoral research focused on help seeking of Aboriginal men with mental health problems and the response of mental health services to their needs. He continues to work in the area of mental health and wellbeing with Aboriginal communities in rural Victoria.

**Darryl Kickett**

Darryl Kickett was an advisor to the Minister for Aboriginal Affairs in Canberra. He has worked in policy positions in the National Aboriginal Conference (NAC), the Royal Commission into Aboriginal

Deaths in Custody and Foster Care Strategy, and led the Kimberley Land Council in Derby, Centre for Aboriginal Studies at Curtin University and the WA Aboriginal Health Council, was the CEO of Aboriginal Medical Services and a Council Member of the WA Ministerial Council for Suicide Prevention. Currently he is a consultant with Anglicare WA, implementing their Reconciliation Action Plan and assisting to roll out the Red Dust Healing Program.

**Kim Lazenby**

Kim commenced her role as an Assistant Ombudsman in June 2008. She has more than 20 years' experience in government roles. Working at the Commonwealth and State levels, in both

line and central agencies, and has a strong background in evaluation.

**Harry Lovelock**

Mr Harry Lovelock is the Executive Manager of Strategic Development and Public Interest at the Australian Psychological Society. For the past 20 years he has been working in state

government and membership based organisations developing high-level policy and managing major initiatives in disability, community health and mental health areas. Prior to working at the APS, he was the Director of Policy for the Royal Australian and New Zealand College of Psychiatrists.

**Tim Marney**

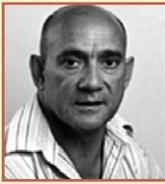
Timothy Marney was appointed as Mental Health Commissioner in February 2014. A graduate of Murdoch University, Tim has 20 years' experience in economics and finance with the State

and Federal Governments. Mr Marney has served on the board of beyondblue, the national depression and anxiety initiative, since 2008, and has been deputy chair of the board since 2010. Mr Marney has been a vocal advocate of mental health issues and has spoken openly of his own experience with depression and anxiety.

**Professor Jill Milroy**

Professor Jill Milroy is a Palyku woman whose country is in the Pilbara region of Western Australia. Jill's current position is the Dean of School of Indigenous Studies. In 2011 was made a member

of 'Order of Australia' in recognition of her services to Indigenous education. Jill has extensive experience with 20 years of working in Indigenous Higher Education, developing Indigenous curricula, working with Aboriginal secondary students and developing and implementing the University's Indigenous and Employment Strategies. She is currently working on a project to design Indigenous curriculum in Engineering.



Michael Mitchell

Michael Mitchell is a Yamatji man (Nyamal/Mulgana) from the Shark Bay /Gascoyne/Pilbara region of Western Australia and has been working in Mental Health for the past 14 years. He has previously worked in the community-controlled sector as a Director of Carnarvon Aboriginal Medical Service and the Manager of the Community Development Employment Program. Michael has completed a Bachelor of Applied Science specialising in Mental Health at Curtin University and is currently the Program Manager of the Specialist Aboriginal Mental Health Service Metropolitan (SAMHSM) North Metropolitan Health Service.



Terry Murray

Walmajarri man Terry Murray lived on Cherrabun Station in a tin shelter. His family had no vehicle so they went hunting on foot. Terry has a strong grounding in bush skills learnt from his parents. Terry is a Heritage Officer for KALACC. He was the Emerging Curator for the Canning Stock Route Project and Curator for Jimmy Pike's Arlines exhibition (Berndt Museum UWA). He regularly works with Yiriman. As Terry has said, "Our Culture is an everyday learning thing. I grew up with this. You have to have a strong mind and strong spirit and soul and always listen to your Elders".



Fiona Nicholls

Fiona Nicholls is the Assistant Secretary at the Mental Health Services Branch, Primary and Mental Health Care Division - Department of Health.



Charles Passi

Charles Passi is the Chair of the Healing Foundation. He is a Daurareb tribesman from the Meriam islands in eastern Torres Strait. Charles lives on Thursday Island where he plays a leading role in the community. He is a member of the Queensland Child Deaths Case Review Committee, an Executive member of Kaziw Asesered Le Inc, a member of Mura Kosker Sorority Inc, Lena Passi Women's Shelter Inc and the Aboriginal and Torres Strait Islander Reference Group for the Queensland Centre for Family and Domestic Violence.



Glenn Pearson

Glenn Pearson, a Noonygar man from Western Australia and father of five, is the Manager of Aboriginal Health Research incorporating the Kulunga Research Network. Glenn is a Chief Investigator in the Institute's Centre of Research Excellence in Aboriginal Health and Wellbeing and is completing a Doctorate at the University of Western Australia. He is also a member of the Health Consumer Council of WA, Curtin University's Human Research Ethics Committee and the Institute's Community and Consumer Participation Advisory Council. His area of research interest includes Aboriginal Health and Emotional Wellbeing, Aboriginal Research Methodologies and Policy and Advocacy.



Jenni Perkins

Jenni Perkins was appointed acting Commissioner for Children and Young People in 2013. Jenni has over 25 years' experience in social policy and community development across the not-for-profit sector and local and state government. With a degree in social work and a Masters in Public Policy, Jenni held senior policy positions with the Disability Services Commission before becoming director general of the Department for Communities in 2010.



Greg Phillips

Gregory Phillips is from the Waanyi and Jaru Aboriginal peoples and comes from Mount Isa in North West Queensland. He completed a Bachelor of Arts in Aboriginal Studies and Government at The University of Queensland in 1994, and has worked in Aboriginal education, youth leadership, land rights, healing and addictions in Alice Springs, Burketown, Brisbane and Cairns. He completed a Masters degree in Medical Science by research at UQ in 2001. His thesis, "Addictions and Healing in Aboriginal Country", passed with no corrections, made the Dean's Excellence list, and was published as a book by Aboriginal Studies Press in 2003.



Dr Tracy Reibel

Tracy Reibel is a Senior Researcher at the Telethon Kids Institute and focusses on research about with maternal and child health and wellbeing. She is one of the chief investigators led by Rhonda Marriott on the "Cultural security of Aboriginal mothers birthing in urban maternity facilities and the cultural competency, workforce and education needs of midwives" project and has completed a number of projects at the Institute related to Aboriginal maternal health. As a mother of two young men, she also has an interest in young people's experiences of health and social support services, and has been involved in several research projects in this area.



Associate Professor Grant Revell

After appointments as a senior land planner/designer in a number of public and private practices throughout Australia and in North America Grant joined The University of Western

Australia's Faculty of Architecture, Landscape and Visual Arts, and School of Indigenous Studies in 1996 and 2013, respectively. Along with his university appointment, Grant practices as a registered landscape architect and planner, and is founding co-principal of Western Australia's Indigenous Design Collaborative (IDC); and the design research consulting group And Landscape Architecture in Fremantle, Western Australia; and in Charlottesville, Virginia, USA. Grant Revell's practice focuses on the research and integrated design of Indigenous healthy-living environments in Western Australia and Virginia, USA.



Professor Ian Ring

Professor Ian Ring is a Professorial Fellow at the Australian Primary Health Care Research Institute at the University of Woollongong. His prior appointment was as Professorial Fellow at Centre

for Health Service Development, also at the University of Woollongong. He has previously been Head of the School of Public Health and Tropical Medicine at James Cook University, Principal Medical Epidemiologist at Queensland Health, and Foundation Director of the Australian Primary Health Care Research Institute at the Australian National University. Professor Ring's interests include public health aspects of cardiovascular disease and Aboriginal and Torres Strait Islander health.



Sue Robinson

Sue commenced her role as Principal Analyst with the Ombudsman Western Australia in September 2012. She has ten years' experience in government roles working in health, auditing and

evaluation. Sue has a strong background in health research and evaluation.



Dr Clair Scrine

Dr Clair Scrine has over 10 years' experience working in government policy and research and more recently as a senior researcher with the Kulunga Research Network and the Centre for

Research Excellence in Aboriginal Health and Wellbeing at the Telethon Kids Institute. Since 2006, Clair has been closely involved with Aboriginal communities in WA and has contributed to a number of peer-reviewed publications and research reports, leading project teams for the St John of God Health Care 'Strong Women, Strong Babies, Strong Culture' program in the Pilbara, and 'Kicked to the Curb': An examination of the critical factors in Aboriginal non-smoking' and 'Examining Aboriginal attitudes to organ donation'.



Laurel Sellers

Laurel Sellers is a descendant of the Minang/Koreng people of the Nyungar Nation. Laurel has a Nyungar mother and Yamiitji father and was born and raised in Waggl Kaip, the country of her

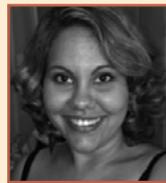
maternal grandmother. Laurel has worked for over twenty years in government, both state and Commonwealth. As a senior manager in Aboriginal Housing for eleven years, Laurel managed housing programs and projects and their delivery to many Aboriginal communities throughout Western Australia. For the past eight years Laurel worked for the Department of Corrective Services where she was responsible for ensuring the delivery of support to Aboriginal people in prisons through the very successful long running Aboriginal Visitors Scheme which came about through the Royal Commission into Aboriginal Deaths in Custody. Laurel is currently the CEO for Yorgum Aboriginal Corporation.



Robyn Shields

Robyn has worked in the mental health sector for many years and is now undertaking specialist training as a psychiatrist. She has concentrated on raising the status of mental illness

in the public consciousness, and developing new models of care for the mentally ill people in the most disadvantaged groups, particularly indigenous people and forensic patients. As a proud Indigenous person, Shields is acutely aware of the need for communities to design and control their own services, "because of distrust and mistrust, a long history with government departments and particularly in mental health," she says. "There's no easy fix but it's essential it never gets put off the agenda." Robyn is a Member, NSW Mental Health Review Tribunal, a Member of Aboriginal Health & Medical Research Ethics Committee and an Order of Australia (AM division) for development of Aboriginal mental health services, 2004.



Amanda Sibosado

Amanda Sibosado is a 27 year old, Bard, Nyigina and Wardandi woman. She lives and works in the Kimberley, having specialised in Aboriginal Sexual Health for the past eight years. She believes

that current sexual health programs only have limited impact due to underlying mental health issues within Aboriginal communities. Due to her interest in this, as well as personal experiences with suicide, Amanda has started volunteering with Alive and Kicking! Goals – a newly formed Women's Reference Group.



Associate Professor Gracelyn Smallwood AO

Gracelyn Smallwood has been a tireless advocate for improved outcomes in Indigenous Health for over forty years. Since qualifying as a registered nurse –

one of the few employment options open to Aboriginal women in Townsville in the early 1970s – Gracelyn has championed the improvement of health, in particular Indigenous Health and HIV- AIDS prevention. Associate Professor Smallwood currently works at the largely Indigenous Cleveland Youth Detention Centre as nurse and mentor, and at Townsville Hospital as a nurse and midwife. She is an Associate Professor and Indigenous Advisor to the Vice-Chancellor at James Cook University.



Dr Werner Stritzke

Dr Werner Stritzke is an Associate Professor of Psychology at the University of Western Australia. He has experience as a clinical psychologist in medical settings and worked in

counselling services in the United States and Europe. For over a decade he was the co-director of the UWA Robin Winkler Clinic and is currently director of the clinical training programs at the School of Psychology. His primary research interests are in the area of addictions and suicide prevention. He has over 15 years' experience in training and supervising mental health professionals in smoking cessation interventions and his books include step-by-step treatment and training manuals published by Cambridge University Press.



Sandi Taylor

Sandi is a proud Kalkadoon, Ngunwun and Jiradali women from north-west Queensland. She has had the privilege and opportunity to work with multiple grassroots community controlled

organisations in the Community Sector, and has worked at various administrative levels with the Commonwealth and Queensland State Government across different regions of the State. Over a thirty-year period, she has amassed a broad array of unique skillsets, knowledge and experience that she has applied creatively to different roles. Her Family (immediate and extended), including warm and loving Community Elders have crafted her spirit as a Social Justice and Political Activist. The values of Access, Equity, Participation and Rights still remain her moral integrity compass.



Professor Komla Tsey

Professor Komla Tsey is a social science researcher with extensive experience in community development, empowerment and related participatory research spanning three decades in

Ghana and Australia. He is based at the Cairns Institute of James Cook University where he is a Tropical Leader. Professor Tsey has a long association with the Institute and its predecessor, the CRC for Aboriginal and Tropical Health (CRCATH) and the CRC for Aboriginal Health (CRCAH), through his involvement as researcher and project leader on a suite of projects broadly termed the Empowerment projects. Professor Komla is currently the Program Leader for Program 2 (Healthy Communities and Settings) of the Lowitja Institute.



Associate Professor Roz Walker

Associate Professor Roz Walker is a Senior Researcher in the Centre for Research Excellence in Aboriginal Health and Wellbeing at the Telethon Kids Institute. She has a PhD in critical

social science, "Transformative Strategies in Indigenous Education: Decolonisation and Positive Social Change", and was a Senior Research Fellow and Deputy Director of the Curtin Indigenous Research Centre at Curtin University for seven years. Associate Professor Walker's principal areas of investigation involve research in Indigenous health and social mental health and wellbeing, and early intervention and prevention initiatives to strengthen Aboriginal capability and capacity building across the life course.



Associate Professor Aileen Walsh

Assistant Professor School of Indigenous Studies - co-ordinating the major in Indigenous History and Heritage. An incomplete phd on colonial linguistics in naming Nyoongars is lurking in the

background as I try to work full time and be a single mum to my youngest two daughters.

Background is Ngalea on my grandmother's Ruby Marwun's side, i.e. Spinifex people. Grandfather was born at Israelite Bay on the south coast. Mum -Violet Newman born on the Nullabor is one of the stolen generations. My father was Australian born Irish. My sister committed suicide in 2002 after some family feuding. She left behind 2 beautiful children. Mental illness has become an everyday part of life as I deal with the tragedy that has been my families experience of prejudice racism, internalised racism and family conflict.

*Culture is a big word with many small packages.
Acceptance of culture is central to addressing
the issue of suicide.* ROUNDTABLE ATTENDEE, 2014.



John Watson

John Watson was born and raised on Mt Anderson Station in the Kimberley region of Western Australia. Chairman of the KLC in the 1980's, he is a Special Advisor for Kimberley Aboriginal Law and Culture Centre and the KLC. He has played a leading role in Aboriginal administration and is widely respected throughout the Kimberley. John is a respected Elder and is one of the founders of the Yiriman Project. Yiriman aims to address issues such as substance abuse, justice, self-harm and suicide by reconnecting young people to their Elders, to Country, to language and to culture.



Pui San Whittaker

Pui San Whittaker is the Acting Manager for Suicide Prevention at the Mental Health Commission. She has over 11 years' experience in public mental health, disability and health services; establishing innovative programs and strategic interagency partnerships. Pui San was awarded a Centenary Medal in 2003 for service as an advocate for migrants with disabilities, women's health care and anti-racism.



Dr Tess Williams

Dr Tess Williams is a Research Development Advisor in The School of Indigenous Studies, a post-doctoral Research Fellow in the English Department, and a published author.



Dr Michael Wright

Dr Michael Wright is a Yuat Nyoongar man from Western Australia. He has extensive experience in the area of Aboriginal health and mental health. He has worked as a social worker in an inner-city hospital and was the manager of the first Aboriginal community-controlled service to provide a psycho-social and emotional in reach service to Aboriginal families living with a serious mental illness in the Perth area. His PhD thesis explored the experiences of caregiving for Aboriginal people living with a serious mental illness. He is a Post-Doctoral Research Fellow at Telethon Institute where he is leading the Looking Forward Aboriginal Mental Health project.



APPENDIX 1: DETAILED RESPONSES DAY ONE

Participants were asked to identify systems issues and a complementary community perspective:

Government	Community/Us/Me
Is government listening (Scullion/Nash)? Suicide is a problem, what do they need to do. Implementation plan for health strategy must include social and emotional wellbeing. Specifics: operational plan or a process that will lead to identifying how to proceed.	Young people are not the problem but are part of the solution.
Aboriginal professionals employed in senior positions across government, all levels of the health system and government.	Community to work with Aboriginal professionals in the system.
Sign off on social and emotional wellbeing is happening. Indigenous specific social and emotional wellbeing officers with strong experience seconded into government to assist with policy/program development. More integrated approach in Canberra and State offices.	Non-government organisations to support experienced staff members to work with government for defined periods of time.
All social and emotional wellbeing officers retained, increased and strengthen community based organisations.	Capacity building in communities – share the load.
Train the workforce – bicultural. Train expertise in the sphere – working with young people (culture competence). Supporting Aboriginal people working in the field. Multi-skilled practitioners, Aboriginal and non-Aboriginal.	Conversation with young people – don't assume that young people want to know about culture, what are their future desires? What are the population trends in Aboriginal communities? What are the policy responses to this?
Diffuse the COAG Close the Gap funding away from non-Aboriginal organisations to Aboriginal community based organisations.	Replication of the work done by successful community groups.
Call to action with an implementation strategy with the relevant dollars to support milestones.	Aboriginal people need to write the policy, implementation plan and milestones.
Remote communities <ul style="list-style-type: none"> • Housing needs to be relevant to family groups • No alternatives in remote areas Mental health issues are dealt with by police rather than through appropriate community based organisations.	
	Critical analysis of the numbers. Engage young people to find out what is, needed to address the rates of suicide, self harm? Lack of elders to supervise, intervene, be there.
No AOD rehab program in Perth for young Aboriginal people. Investment required in the workforce including bringing young people into the workforce.	
Evaluation to build the evidence – needs to be culturally relevant.	How can we ensure that people in the community are adequately resourced?
	Validating culture to Aboriginal young people from the time they start kindergarten.
Mental health now leading burden of disease – but funding cycles don't address this.	Community identify they don't have the capacity to address the burden of grief – feel abandoned by the system.
National rollout of mental health strategy, focussed on youth, managed by the community controlled sector, to build capacity. Women's groups to supplement other work being done with men's groups.	Community led healing initiatives, as identified in the Elders report, men's and women's groups, healing programs.

APPENDIX 1: DETAILED RESPONSES DAY ONE CONTINUED

Summary from the floor:

Mental health in National Implementation Plan.	Needs to start in school – strengthen identity and culture.
Regional remote areas need more resources.	Stay unified.
Review Prof Chandlers work to see how it relates to us.	Community mental health professionals transferred to government.
The strategies/framework Aboriginal and Torres Strait Islander Suicide Prevention Strategy Social and Emotional Wellbeing Framework Health Plan	Capacity building in community: want input to reports/plans/etc but burden on community despite our message to work in partnerships.
Solutions: employ higher level Indigenous people Dedicated social and emotional wellbeing suicide prevention officers already in some states. Integrated areas, ie. Abuse/ social and emotional wellbeing / suicide prevention work with communities and other stakeholders.	Encourage young people into community leadership/ professions.
Ensure non-Aboriginal workforce is culturally competent.	Support communities to identify issues and create solutions.
Ensure continuing funding to community controlled organisations.	Support successful community programs such as Dumbartang, Red Dust Healing, Yirriman, NEP community sites, and the others.
Bring black voices into the commonwealth government – how to stay strong and unified?	Our problems are complex and multi-faceted.
The 500 S&EWB workers are redeployed and kept and more are created.	More healing centres, services, 24 hours.
Policy and providers need specialist cultural competence training, ie: black card system.	Challenge the Coroner's office.
BINGOs need to engage in proper partnerships with communities.	What about Aboriginal Taskforce for Suicide Prevention – one in each state?
What about a young people's roundtable?	
NMH first aid – communities and families involved.	
What culturally appropriate postvention services are there?	

APPENDIX 2: SUMMARY OF PRESENTATIONS DAY ONE

Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people

Kim Lazenby and Sue Robinson, Ombudsman's Office, Western Australia

Background:

- Of the child death notifications received by the office of the Ombudsman, nearly a third related to children aged 13 to 17 years old.
- Of these children, suicide was the most common circumstance of death, accounting for nearly forty per cent of deaths.
- Furthermore, and of serious concern, Aboriginal children were very significantly over-represented in the number of young people who died by suicide.

Methodology:

- The investigation included an extensive literature and practice review, significant consultation with government and non-government agencies and experts and comprehensive collection and analysis of the records and data of the office of the Ombudsman and a range of government and non-government agencies about the interaction of these agencies with the 36 young people who were the subject of the investigation.

Key Findings: age, gender and location

- Of the 36 young people who were the subject of investigation:
 - 22 (61 per cent) were male and 14 (39 per cent) were female
 - 4 young people were aged 14 years; 10 were aged 15 years; 11 were aged 16 years and 11 were aged 17 years at the time of their death
 - 21 young people were residing in a major city, 9 in a regional area and 6 in a remote or very remote area
- Aboriginal Young People:
 - 13 (36 per cent) of the 36 young people were Aboriginal
 - 7 were female and 6 were male
 - Aboriginal young people died by suicide at a slightly younger age than non-Aboriginal young people
- Risk Factors:
 - Mental health problems:
 - ❖ Diagnosed mental illness
 - ❖ Self-harming behaviour
 - Suicidal ideation and behaviour:
 - ❖ Suicidal ideation
 - ❖ Communicated suicidal intent
 - ❖ Previous suicide attempts

- Child maltreatment:
 - ❖ Family and domestic violence
 - ❖ Physical or sexual abuse
 - ❖ Neglect
- Adverse family experiences:
 - ❖ A parent with a mental illness
 - ❖ A parent with problematic alcohol and other drug use
 - ❖ A parent who had been imprisoned
 - ❖ Suicide of a person known to the young person
- Substance use:
 - ❖ Problematic alcohol and other drug use
- Four Risk Groups:
 - The investigation has identified four groupings of young people distinguished from each other by patterns in the factors associated with suicide that each group experienced. The four groups of young people also demonstrated distinct patterns of contact with State government departments and authorities.

A detailed breakdown was provided of the four risk groups, including: risk factors, demographic characteristics, contact with State government departments and authorities.

Key findings of individual agencies were:

- The investigation found that State government departments and authorities have already undertaken a significant amount of work that aims to reduce and prevent suicide by young people in Western Australia, however, there is still more work to be done.
- The Ombudsman has found that this work includes practical opportunities for four individual agencies, namely the Mental Health Commission, Department of Health (Child and Adolescent Mental Health Service), Department for Child Protection and Family Support and Department of Education to enhance their provision of services to young people.
- A number of examples of these practical opportunities are set out in order of the relevant agencies.

Key findings were also provided from the perspectives of the different agencies such as the Mental Health Commission, Child and Adolescent Mental Health Service, Department for Child Protection and Family Support, and Department of Education, both generally and for Aboriginal Young People.

Summary of Recommendations:

- *Arising from the report's findings, the Ombudsman has made 22 recommendations about ways that State government departments and authorities can prevent or reduce suicide by young people.*
- *Three recommendations concern the Western Australian Suicide Prevention Strategy 2009-2013: Everybody's Business.*
- *These three recommendations, directed to the Mental Health Commission, go to the development and inclusion of differentiated strategies for suicide prevention that are relevant to each of the four groups of young people identified in the investigation.*
- *Eighteen recommendations regarding ways that three key government agencies can assist in preventing and reducing suicide by young people as part of their individual service delivery.*
- *These key agencies are:*
 - ◆ *Department of Health*
 - ◆ *Department for Child Protection and Family Support*
 - ◆ *Department of Education*
- *One recommendation that the Mental Health Commission, working together with the Department of Health, the Department for Child Protection and Family Support and the Department of Education, considers the development of a collaborative inter-agency approach, including consideration of a shared screening tool and a joint case management approach for young people with multiple risk factors for suicide.*
- *Each agency has agreed to all 22 recommendations and has, more generally, been highly co-operative and positively engaged with our investigation.*
- *Each of the recommendations will be monitored by our office to ensure their implementation and effectiveness in relation to the observations made in the investigation.*

The Western Australian Suicide Prevention Strategy

Pui San Whittaker on behalf of Danny Ford, Mental Health Commission Western Australia.

Since 2009 the State Government has invested \$21M in the State Suicide Prevention Strategy (Strategy), this includes \$3M in the 2014/15 State Budget to sustain community and youth initiatives.

A key focus of the Strategy was Community Action Plans (CAP) which were divided into two distinct stages: Stage One CAPs (community consultation) and Stage Two CAPs (implementation of suicide prevention initiatives). In the Stage One CAPs, Community Coordinators measured mental health, wellbeing and resilience factors, and considered community-specific suicide risk and protective behaviours. They also assessed the availability and awareness of existing services and resources, gauged levels of help-seeking activities and identified community readiness for suicide prevention initiatives. During the Stage Two CAPs, implemented a range of suicide prevention activities and events, which included awareness raising events, community social events, targeted intervention programs, community support events and suicide prevention training.

Under the Strategy funding for CAPs targeting Aboriginal communities included:

- \$1.36M - Kimberley Stage 1 CAP through Kimberley Aboriginal Medical Services Council (KAMSC) and postvention support through WA Country Health Service and Anglicare
- \$428,148 - Kimberley Empowerment Project through UWA and KAMSC
- \$531,710 - Shire of Derby and Mowanjum through Anglicare
- \$304,650 - Dampier Peninsula through KAMSC
- \$217,880 - Kununurra through Ord Valley Aboriginal Health Service
- \$217,950 - Halls Creek through Yura Yungi Aboriginal Medical Service
- \$131,820 - Great Southern Katanning through Anglicare
- \$778,706 for Wheatbelt through Dallard Pty Ltd and Hyden Community Resource Centre
- \$166,953 - Roebourne/Hedland through Yaadina Family Centre
- \$132,125 - Peel through GP Down South
- \$140,306 - Midwest through Geraldton Aboriginal Medical Service

An evaluation of CAPs by Edith Cowan University is being finalised to identify strengths and areas for improvement. In addition, an overall independent evaluation in 2014 will inform the next multi-year Strategy.

APPENDIX 2: SUMMARY OF PRESENTATIONS DAY ONE CONTINUED

Strategy funding of \$1M in 2014/15 will deliver:

- Community grants of up to \$10,000 to strengthen sustainability of locally owned suicide prevention initiatives.
- Evidence based mental health and suicide prevention training across WA.
- Strategic partnerships with the WA Football Commission and Netball Association of WA to promote suicide prevention awareness.

Strategy funding of \$2 million in 2014/15 will consolidate and increase capacity of the Response to Self-Harm and Suicides in Schools which includes additional specialist staff to support young people at-risk.

As part of the Strategy, 260 agencies across WA have committed to implementing suicide prevention activities. The operational management of the State Strategy will shift from Centrecare to the Mental Health Commission (MHC) in 2014/15 and 2015/16. In addition to the Strategy, the MHC provided \$1.7M in 2013/14 for counselling and early intervention services, crisis lines and postvention support.

Hear Our Voices – Community Research Report

Roz Walker, Centre for Research Excellence in Health and Wellbeing, Telethon Kids Institute

From the key findings of the Report, the following were noted as relevant:

- The underlying principle of all community development and empowerment approaches is that only solutions driven from within a 'risk community' will ultimately be successful in reducing community-based risk conditions. Ensuring that the community drives the process is the most important factor if community outcomes are to be achieved.
- Empowerment and healing strategies that enable people to take greater control over their life and responsibility for their situation; to become strong culturally and spiritually and establish more equitable power relations, are effective ways of addressing suicide risk factors.
- Fostering a secure sense of personal and cultural identity is a powerful protective factor against the threat of self-harm, especially for young Aboriginal people.

- Across the three communities where consultations took place, there was an overwhelming consensus that there is a real need to support individuals to change their lives. People spoke of needing to "build self first" and to "make ourselves strong," to focus on 'rebuilding family' and 'learning to be good parents and role models.'
- Programs need to be culturally-based and incorporate traditional elements into their content and teaching, learning and healing processes. This includes employing local people to work on interventions and training them in community development skills and processes.
- The support and engagement of community members throughout the design, implementation and evaluation of programs and any related materials is another critical factor in the effectiveness of programs.

APPENDIX 3: DETAILED COMMENTS DAY TWO

Other comments were:

What is required is for government to fund and support healing programs?

National priority for public policy (federal and state) developed in response to the issue.

A proposal for public policy in regard to Indigenous youth.

Tough topic, lots of issues, families are blaming each other for what is happening.

We all need to come together to talk in a way that supports us.

The work has been done, it has a national perspective, pay attention to the principles in Healing Our Way, Suicide Prevention Strategy, Elders Report, combine the grass roots with the academic and implement what has been framed, and make sure it is Aboriginal owned, run and employed.

Those non-Indigenous organisation with resources (eg: Beyond Blue – need a Black Beyond Blue) to come to the table to be allies rather than competitors.

There are funding issues – organisations with the capacity (to write the grant proposals) are winning the funding, and Aboriginal organisations require access to the same ‘expertise’ to be able to have a fair chance. Funding models require criteria and measurement of what is Aboriginal led and this needs to fully reflect the values and requirements of Aboriginal communities.

Looking back – what information exists – summarise what has gone before, value add to what has been done, what elements/principles have been identified, the solutions exist over a long time, what can be done to action these, make an operational plan? Strategise to ensure community capacity building and empowerment. Grow the workforce within the mainstream system.

Community models of care – follow what has been successful. These should be strictly community strategies turned into community policy. Value community champions/leaders/innovators. Invest in future leaders. Work with institutions on community terms. Community has the heart and soul.

- Community models of care
- Community policies
- Champions of change

Every community controlled health organisation should be assisted to develop their own healing program for their community. These need to be funded over a long period and evaluated via Aboriginal world views. These then provide evidence.

Large and small organisation have strengths – enable these to come together as consortia (partnerships) to identify who can do what, with larger providing support to smaller.

Consistent state legislation that validates Aboriginal ways of working in relation to mental health. For example, WA has changed legislation to recognise community models of care and healing recognised as being required in health and other services.

The voices of young people are disenfranchised, they are suspicious of older people. A youth focus example – coming together once a month, with the greatest learnings coming from each other with the support of older people behind them (but not leading). Consider a different approach.

A Youth Forum is a matter of priority but with vested people from the Roundtable to hear what they have to say.

Research is required which seriously engages with the concept of cultural continuity and how this does or doesn't occur in different parts of the country. Locally led research of cultural continuity is needed, based on the Australian experience.

Young people become more vulnerable when exposed to suicide. There is no response (from outside) when a suicide happens. A response team is needed to meet with young people immediately after suicide. Young people need debriefing – need to talk to someone. An immediate response is required when this happens. When there are disclosures of suicidal feelings – there are no youth mental health services for young people to turn to. Need to identify members in the communities (and pay these people to be on call). Build on mental health first aid in communities. Small communities don't have the resources/infrastructure. People are too shame to go to hospital or call a help line,

nowhere to go. Health centres (24/7) for young people and families are needed.

Legislation such as in WA with the Mental Health Act – the function is to support culturally sensitive services.

Housing in remote communities of varying sizes (1,000; 300; 40) are not suited to Aboriginal families. Sometime there are no services because communities are too small and the families have to support (without assistance) because there is no one else. There is nowhere to house young people with mental health or other trauma. They need quiet, safe houses.

Tim Marney (WA Mental Health Commission) said that community/culture is crucial in both prevention and postvention services. This is dependent on leadership.

John Feneley (NSW Mental Health Commission) said that a national approach is needed to guide state based mental health commissions. Solutions are known but need to be guided and led by community. Need to evaluate the relationship between government and community, to make sure government is working in ways that are meaningful to communities.

APPENDIX 4: ROUNDTABLE PROGRAM

Time	Day 1 - Monday 23rd June
8.45am	Registration – Tea and Coffee
9.00am	<p>Welcome and Introduction</p> <p>Professor Jill Milroy (Poche Centre for Indigenous Health, UWA) Professor Pat Dudgeon (School of Indigenous Studies, UWA/CREAHW) Glenn Pearson (CREAHW, Telethon Kids Institute) Facilitator : Greg Phillips</p>
9.15am	Welcome to Country – Len Collard
9.20am	<p>SCENE SETTING - WHERE WE ARE NOW?</p> <ul style="list-style-type: none"> ● Dr Tom Calma AO ● Adele Cox ● Gerry Georgatos <p>An overview of the data, the <i>National Aboriginal and Torres Strait Islander Suicide Prevention Strategy</i> (NATSISPS), the <i>Social and Emotional Wellbeing Framework</i> and the dedicated Aboriginal and Torres Strait Islander suicide prevention programs and services and mainstream suicide prevention services and programs and services.</p> <p>Scene setting - Where do we want to go?</p> <p>An outline of goals and process to produce a <i>Call to Action</i>.</p>
10.00am	Morning Tea
10.30am	<p>TOPIC: A CANADIAN EXPERIENCE - WHAT ARE THE KEY FINDINGS?</p> <ul style="list-style-type: none"> ● Emeritus Professor Michael Chandler
11.00am	<p>Roundtable Discussion - Reflecting on the Canadian findings:</p> <ul style="list-style-type: none"> ● How do we promote self-determination and cultural reclamation as suicide prevention measures? ● Are we able to further develop, evaluate and adapt suicide prevention initiatives for Aboriginal and Torres Strait Islander peoples? <p>Towards a <i>Call to Action</i> – what are the priority messages to take from this discussion?</p>
12.00pm	<p>Roundtable Discussion - Reflecting on the variables that prevent suicide:</p> <ul style="list-style-type: none"> ● To what extent has your work in suicide prevention been able to address variables consistent with those in the Canadian research? ● What barriers have been encountered in your work? ● What things need to be included in a <i>Call to Action</i> to overcome these barriers and build on our current strengths? <p>Towards a <i>Call to Action</i> – What are the priority messages to take from this discussion?</p>
1.00pm	Lunch

APPENDIX 4: ROUNDTABLE PROGRAM

Time	Day 1 - Monday 23rd June
2.00pm	<p>STATE STRATEGIES AND REPORTS</p> <ul style="list-style-type: none"> ● Pui San Whittaker : <i>WA Suicide Prevention Strategy</i> ● Kim Lazenby and Sue Robinson : <i>Ombudsman’s Youth Suicide Report (2014)</i> ● Roz Walker : <i>Hear Our Voices – Community Research Report</i>
3.00pm	Afternoon Tea
3.30pm	<p>TOPIC: OTHER STRATEGIC RESPONSES AND SUICIDE PREVENTION:</p> <p>Roundtable Discussion: A system-wide response to suicide.</p> <ul style="list-style-type: none"> ● How do we operationalise the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy? Should this include a dedicated response to suicide clusters? ● How can the Implementation Plan for the <i>National Aboriginal and Torres Strait Islander Health Plan</i> be utilised to support suicide prevention activity and what service models, workforce, funding, information, management and evaluation are required? ● Are any key findings from Canada and overseas being integrated into a system wide response to suicide? <p>Towards a <i>Call to Action</i> – what are the priority messages to take from this discussion?</p>
4.30pm - 5.00pm	<p>Summary and Focus for Day Two - Greg Phillips</p> <p>Towards a <i>Call to Action</i> – the priority messages from today’s discussions.</p>
<p>Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice Book Launch – 2nd Edition</p> <p>5.30pm to 7.30pm – Nedlands Yacht Club</p>	

APPENDIX 4: ROUNDTABLE PROGRAM

Day 2 – Tuesday 24th June	
9.00am	Summary From Day One
9.15am	Panel: Perspectives from the Community Hon. Josie Farrer (MLC) Mr John Watson/Terry Murray- <i>Yiriman Project</i> Robert and Selina Eggington: <i>Dumbartang Aboriginal Corporation</i> Darryl Kickett – <i>Red Dust Healing</i> Peter McConchie/Lorna Hudson - <i>The Elders’ Report</i> Two youth representatives
10.30am	Morning Tea
11.00am	Roundtable Discussion - What Are Our Next Steps? What are the research priorities for Aboriginal and Torres Strait Islander suicide prevention (general, youth and gender specific)? Is there any relevant research on suicide prevention being carried out in Australia? Should the research carried out in Canada be replicated in Australia? Next steps Towards a <i>Call to Action</i> – what are the three priority messages to take from this discussion?
12.00pm	Launch of National Aboriginal and Torres Strait Islander Leadership in Mental Health (Mental Health Commissions of Australia)
	Lunch
1.00pm	Producing a <i>Call to Action</i> <i>Work in small groups</i>
3.30pm - 4.00pm	Close and Future Plans

