



NACCHO
National Aboriginal Community
Controlled Health Organisation



**CULTURE
CARE
CONNECT**

**Operational Guidance
Paper**



Culture Care Connect Program

Community-Controlled Suicide Prevention Networks

Community-Controlled Aftercare Services

Community-Controlled Suicide Prevention Training

Operational Guidance Paper

Table of Contents

Chapter 1: Culture Care Connect Program	4
1.1: Background to the CCC Program.....	4
1.2: Need for an ACCHO-led approach.....	5
Chapter 2: Operationalising the Culture Care Connect Program	7
2.1: Governance	7
2.2: Underlying principles	8
2.3: Integrating the NACCHO Core Services and Outcomes Framework with the program.....	9
2.4: Roles and responsibilities of key partners.....	9
2.5: Using data to plan, monitor, and evaluate	11
2.6: Timeline for implementation	11
Chapter 3: Aspects of a Model of Care	12
3.1: Development of Culture Care Connect Model of Care	12
3.2: Prevention.....	14
3.2.1: Important activities.....	14
3.2.2: Guidance for Program Staff	16
3.3: Screening and Assessment	17
3.3.1: Important activities.....	17
3.3.2: Guidance for Program Staff	18
3.4: Early Support.....	19
3.4.1: Important activities.....	19
3.4.2: Guidance for Program Staff	20
3.5: Response.....	21
3.5.1: Important activities.....	21
3.5.2: Guidance for Program Staff	23
3.6: Supportive care	23
3.6.1: Important activities.....	23
3.6.2: Guidance for Program Staff	24
3.7: Survive and thrive.....	24
3.7.1: Important activities.....	25
3.7.2: Guidance for Program Staff	26
References	27

Acknowledgement of Country

The National Aboriginal Community Controlled Health Organisation (NACCHO) acknowledges Aboriginal and Torres Strait Islander people as the Traditional Owners of the lands where we live, where we work, and across Australia. NACCHO recognises and pays respect to Elders past, present, and emerging across Australia. We thank them for their continuing care and custodianship of land, sea, culture, and community.

Aboriginal and Torres Strait Islander people should be aware that this document privileges the lived experiences of Aboriginal and Torres Strait Islander people and may contain the stories, images, and names of deceased persons.

Acknowledgements

NACCHO sincerely thanks the individuals and organisations who have assisted with the development of this document and work. NACCHO further acknowledges the many Aboriginal Community Controlled Health Organisations (ACCHOs) across Australia, who continue to lead innovative activities to reduce the inequitable burden of suicide and self-harm on Aboriginal and Torres Strait Islander people.

Purpose of this paper

The principal function of the Culture Care Connect: Community-Controlled Suicide Prevention Networks Program (CCC Program), coordinated nationally by the National Aboriginal Community Controlled Health Organisation (NACCHO) is to undertake suicide prevention planning and coordination of:

- existing suicide prevention and social and emotional wellbeing (SEWB) services and funding opportunities within networks regions; and
- deliver culturally safe aftercare services for Aboriginal and Torres Strait Islander individuals following a suicide attempt or suicidal crisis.

This paper discusses the development of a proposed model of care to guide implementation and delivery of local and jurisdictional suicide prevention and aftercare services, as currently funded by the Australian Government Department of Health.

Should program funding and purpose be expanded, this guidance paper will be revised to capture any change in scope of service for example, broader suicide prevention program funding.

Chapter 1: Culture Care Connect Program

1.1: Background to the CCC Program

NACCHO is the national peak body representing 144 Aboriginal Community Controlled Health Organisations (ACCHOs) across Australia. NACCHO supports member services to address local health priorities through the delivery of holistic, comprehensive and culturally safe primary health care services. This includes supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and working to reduce the impact of suicide on Aboriginal and Torres Strait Islander individuals, families and Communities.

On 11 May 2021, the Australian Government announced funding to address the devastating and disproportionate impact of suicide on Aboriginal and Torres Strait Islander Communities, families, and individuals. NACCHO identified an opportunity to integrate three of the proposed Federal budget funding streams and successfully proposed this approach to the Commonwealth Department of Health. The three programs to be delivered by NACCHO in combination are:

- \$23.8 million over four years (2021-22 to 2024-25) for the establishment of up to 31 regional suicide prevention networks and employment of a lead implementation officer for each state and territory to:
 - improve community access to, and coordination of, regional mainstream health, mental health and suicide prevention services;
 - reduce suicide attempts and deaths within the Aboriginal and Torres Strait Islander population;
 - strengthen the role, capability, and capacity of the Aboriginal and Torres Strait Islander health sector in mental health and suicide prevention; and
 - empower Aboriginal and Torres Strait Islander Communities to prevent suicide.
- \$25.3 million over four years (2021-22 to 2024-25) for implementation of culturally sensitive, co-designed aftercare services for Aboriginal and Torres Strait Islander individuals following a suicide attempt or suicidal crisis; and
- \$3.8 million over two years (2021-22 to 2022-23) to support delivery of Aboriginal and Torres Strait Islander Mental Health First Aid Training (ATSIMHFAT), coordinated by NACCHO and Affiliates. This funding aims to improve the awareness, skill set, and capability of the health workforce within Aboriginal and Torres Strait Islander health services, and other whole-of-population health service settings, to appropriately respond to Aboriginal and Torres Strait Islander people's mental health presentations. The funding also aims to build capacity of the workforce in each Affiliate and network to deliver MHFAT in their respective jurisdiction and region.

Three levels of delivery will be adopted to support the success of the programs:

1. National Delivery

- NACCHO will nationally coordinate the three streams of funding under an integrated model of care, in close consultation with the Commonwealth Department of Health.
- NACCHO will develop a national suicide prevention plan, including aftercare.
- NACCHO will coordinate Communities of Practice to facilitate sharing of best-practice and expertise.
- NACCHO will coordinate an evaluation process.

2. Jurisdictional Delivery

- Affiliates will provide coordination of these activities within their jurisdiction.
- Affiliates will develop a jurisdictional suicide prevention plan, support network coordinators within their jurisdiction, and support drafting, development and implementation of regional suicide prevention plans, and aftercare delivery models.
- Affiliates will assist in service mapping, support monitoring, evaluation and reporting.
- Affiliates will train ACCHOs in ATSIMHFAT.

3. Regional Delivery

- At a regional level, network coordinators will bring together all relevant stakeholders to establish CCC Networks
- Network co-ordinators will develop regional suicide prevention plans
- ACCHOs within CCC Networks will be responsible for delivery of locally and culturally competent aftercare services for Aboriginal and Torres Strait Islander individuals following a suicide attempt or suicidal crisis
- CCC Networks will identify two staff members to undertake a ATSIMHFA ‘train the trainer’ course to enable them to deliver ATSIMHFAT to organisations within their region.

While this funding will enable bolstered aftercare services and improved coordination of local and regional suicide prevention activities, there is currently very limited funding for suicide prevention activity and no funding for early support. NACCHO will continue to advocate for ACCHO program activity across the full spectrum of suicide prevention. This will further enable a holistic response to suicide prevention and social and emotional well-being services (of which mental health is a key component) for Aboriginal and Torres Strait Islander people and their Communities. This approach aligns with the *National Agreement on Closing the Gap*, reflects the ACCHO model of care and maximises opportunities for Aboriginal and Torres Strait Islander people to access culturally competent services and supports.

Further detail on roles and responsibilities of key partners are stepped out at section 2.4

1.2: Need for an ACCHO-led approach

The ACCHO sector is a critically important part of the Australian health system and is best placed to deliver programs and services to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project and the Productivity Commission have both identified the need to empower Aboriginal and Torres Strait Islander Communities to prevent suicide as a priority reform for government.(2)

Aboriginal and Torres Strait Islander leadership and control are the core foundation for primary health care service design, integrated client and family-centred care, and community empowerment that will achieve better health and wellbeing for our Communities.

The integration of suicide prevention coordination and delivery of aftercare services, underpinned by this same leadership and control, will enable an Aboriginal and Torres Strait Islander-led and coordinated approach to reduce the prevalence of self-harm, suicidal ideation, and suicide, in a way that meets the needs and priorities of our Communities.

Integrating funding for suicide prevention networks, aftercare services and ATSIMHFAT has several benefits, as follows:

- national co-ordination, reducing reporting and maximising service delivery;
- efficiencies of scale for procurement and program management and delivery;

- equitable distribution;
- decreased duplication;
- holistic responses to suicide prevention that are tailored to local need and priority;
- more comprehensive and patient-centred clinical care for those at risk;
- strengthened social and emotional wellbeing (SEWB) services;
- increased access to culturally competent services and supports for Aboriginal and Torres Strait Islander people; and
- alignment with ACCHO models of care and the *National Agreement on Closing the Gap*.

The ACCHO model of care takes a holistic view of the individual across their lifespan, which reflects the Aboriginal and Torres Strait Islander view of health and SEWB. Integrating aftercare services and suicide prevention coordination reflects this holistic and patient-centred approach. Suicide attempts and suicidal ideation are the strongest predictors of suicide death,⁽⁴⁾ and aftercare is therefore an essential part of suicide prevention care for those most at risk. Integrating networks and aftercare services also leverages existing SEWB and clinical services in the ACCHO and ACCO sector. ACCHOs and ACCOs are trusted access points for clients, families and Communities to have culturally safe conversations about suicide prevention, and to work together to identify appropriate, holistic responses through SEWB, clinical, and mental health teams.

National Agreement on Closing the Gap

The *National Agreement on Closing the Gap*, finalised in July 2020 between the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian Governments, seeks to overcome entrenched inequality so that Aboriginal and Torres Strait Islander people experience life outcomes equal to all Australians.

The four Priority Reforms in the Agreement are: shared decision-making; building the Community-controlled sector; improving mainstream institutions; and Aboriginal and Torres Strait Islander-led data.

There are 17 socioeconomic and health outcomes in the Agreement, all of which are relevant to social and emotional wellbeing and suicide prevention, including Target 1 to close the life expectancy gap by 2031 and Target 14 to achieve a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero. This program of work will support efforts to achieve Targets 1 and 14 and will be designed to align with the four Priority Reforms of the Agreement.

Chapter 2: Operationalising the Culture Care Connect Program

CCC networks will bring together suicide prevention planning and coordination across the region, including identifying gaps in prevention approaches and where possible identifying and utilising existing or future funding streams to address these gaps.

In addition, the program will enable enhanced delivery of aftercare services in ACCHOs participating in a network. Embedding suicide prevention planning and aftercare services within each network, delivered by ACCHOs in partnership with existing regional mental health services, will provide a strong and clear pathway between Community-controlled services and mainstream, acute care settings for individuals at risk of or recovering from a suicide attempt, their families, and communities.

CCC networks and their network co-ordinator, supported by the jurisdictional co-ordination officer in the state and territory Affiliates, will develop and coordinate suicide prevention activities at the local level which are reflected in their regional suicide plan. CCC networks will be Aboriginal and Torres Strait Islander-led, and bring together local services, including for example, PHNs, Local Health Networks (LHNs), GP representatives, police, family support services, social services, education systems, sporting clubs, and government agencies, to ensure connectedness between systems and supports, and decrease duplication. Combining the design and delivery of the aftercare services into the CCC networks gives additional purpose to these networks to plan, and monitor, suicide prevention activities and provide seamless links to aftercare.

Integration of ATSIMHFAT further improves the holistic nature of the program by incorporating workforce and training at a jurisdictional and local level using a train the trainer model. Trainers based in the Affiliates would deliver the ATSIMHFAT course to staff in the ACCHOs/ACCOs and networks, as well as other health settings such as medical practices, mental health services, PHNs and GP clinics. ACCHOs will also be offered opportunities to undertake training to deliver IMHFAT at a local level. This will build Aboriginal and Torres Strait Community-controlled workforce capacity and contribute to improved awareness among mainstream health sector about culturally competent responses to clients requiring support.

2.1: Governance

The program will reflect the deep understanding and expertise that ACCHOs have in promoting and supporting the health and wellbeing of Communities. The program will be supported by two key governance committees:

1. Government and Sector Advisory Committee to ensure national integration and coordination with mainstream services. Membership will include key stakeholders such as State and Territory Governments, Gayaa Dhuwi (Proud Spirit) Australia, headspace, Lifeline, and NACCHO Affiliates.
2. Aboriginal and Torres Strait Islander Advisory Group – will provide advice to NACCHO on the implementation of the program, including informing development of a model of care, referral pathways, linking services, identifying and addressing service gaps, workforce and training requirements, and evaluation and monitoring of the program.

Figure 1 demonstrates the overarching program governance.

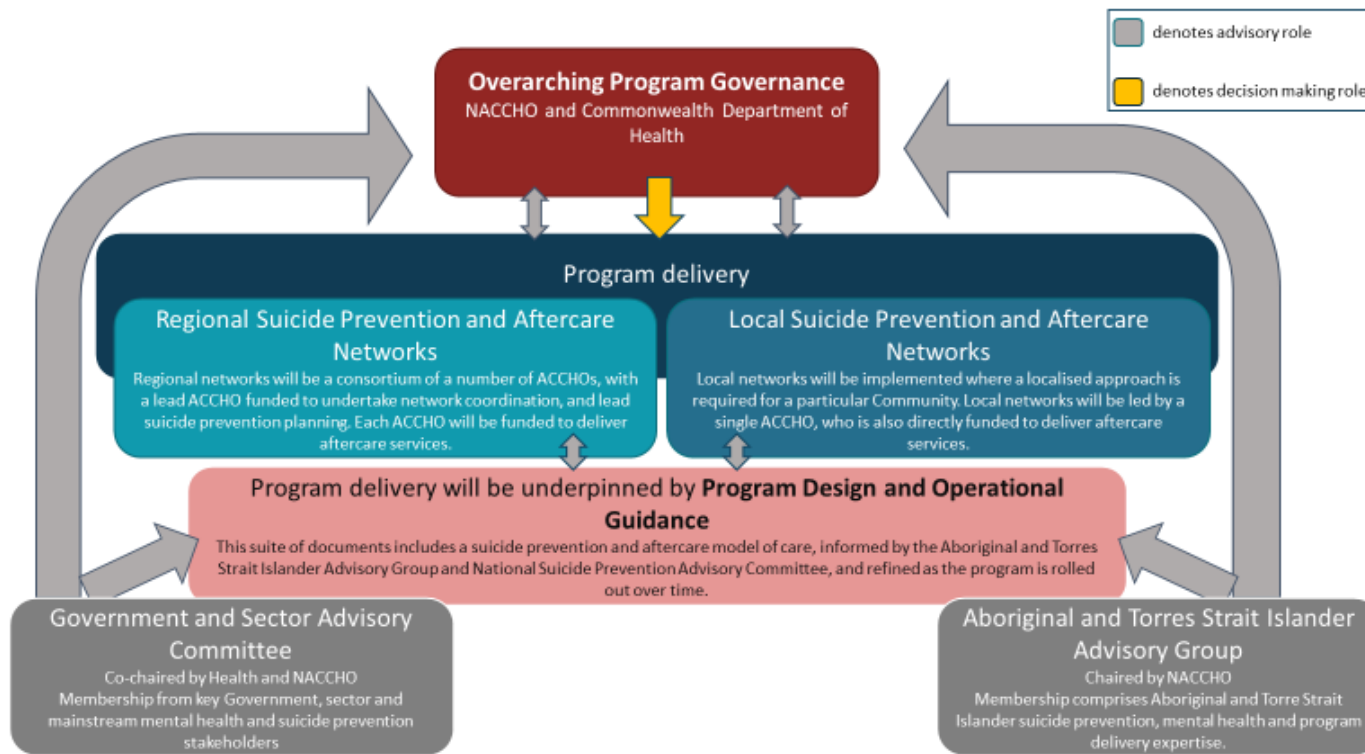


Figure 1: Culture Care Connect Program Governance

Both governance committees will inform final program planning and implementation including the model of care and monitoring and evaluation framework. NACCHO will also work with a broader range of potential stakeholders as is necessary to support the program.

2.2: Underlying principles

Key principles underpinning the program will include:

- **Aboriginal leadership and Community control** – appropriate governance structures to be established, and ensure all actions address Community priorities.
- **Evidence-based** – a broad view of evidence will be taken, recognising the wealth of local and cultural expertise within Communities. Qualitative and quantitative data will inform all aspects of planning and implementation. Data will inform monitoring and where feasible and appropriate may support improvements in local data quality.
- **Culturally safe and appropriate** – all services are developed, delivered and evaluated in a manner that recognises and respects the unique cultural identity of Aboriginal and Torres Strait Islander Communities
- **Place-based** – acknowledging local control and adaptation to local contexts.
- **Rights-based** – equity as a matter of justice.
- **Equity focus** – to address the greatest need and priorities first. For example, subpopulations with the highest need for suicide prevention networks and aftercare services.
- **Holistic, life-course approaches** that address the social and cultural determinants of health and promotes appropriate, sustainable investment in comprehensive Primary Health Care.
- **Strengths-based approaches** – recognising the strength of Aboriginal and Torres Strait Islander individuals and Communities.

- Accountability – ensures accountability and transparency to Aboriginal and Torres Strait Islander individuals and Communities.

2.3: Integrating the NACCHO Core Services and Outcomes Framework with the program

The program is grounded in the four domains of the Core Services and Outcomes Framework (CSOF; detailed below). Program design and implementation will also take into account infrastructure, workforce, and continuous quality improvements (CQI) considerations. The program will integrate with the Core Services and Outcomes Framework more specifically in the following ways:

1. Governance

Community control will inform all aspects of program design, implementation, and evaluation. Two governance bodies will provide oversight and guidance to the program with an Aboriginal and Torres Strait Islander Advisory Group, in particular providing cultural authority and safety to the program.

2. Clinical services

The program will improve access to aftercare services that are supported to be evidence-based, culturally safe, and effective at reducing risk and supporting Aboriginal and Torres Strait Islander people who are at risk of suicide. Aftercare program activities will be based on local priorities and will commit to holistic and comprehensive approaches that extend beyond the limits of biomedical approaches and which value SEWB.

3. Policy direction and partnerships

ACCHOs and/or ACCOs hosting network coordinators will be responsible for strengthening partnerships with other local providers and responding to local gaps and system issues, where possible.

Jurisdictional coordinators in each of the Affiliates will be responsible for development of a jurisdictional suicide prevention plan and provide oversight and coordination. Each Affiliate will provide policy and systems support at a state and territory level, advocate for funding from a wide range of sources to enhance suicide prevention and aftercare services, and further build network capacity.

4. Community health promotion and empowerment

This program is about establishing Community-led suicide prevention networks and aftercare services. Participating ACCHOs/ACCOs and Affiliates will use their deep understanding of the local Community, and social and cultural determinants of health, to inform all aspects of the program.

2.4: Roles and responsibilities of key partners

The program will draw on the expertise and experience of the ACCHO Sector across local, state and territory, and national levels. The table below outlines the key roles and responsibilities of NACCHO, Affiliates, lead and participating ACCHOs and the Department of Health.

Stakeholder	Roles and responsibilities
NACCHO	<ul style="list-style-type: none"> • Develop Aboriginal and Torres Strait Islander suicide prevention policy and operational guidance

	<ul style="list-style-type: none"> • Provide national coordination of the program • Develop and manage service agreements with ACCHOs/ACCOs and Affiliates • Develop a national suicide prevention plan, including aftercare • Coordinate a Community of Practice • Lead consultation on identification of sites • Provide governance oversight • Coordinate monitoring and evaluation • Coordinate rollout of IMHFAT to the ACCHO/ACCO/network workforces
Department of Health	<ul style="list-style-type: none"> • Provision of funding • Governance in partnership with NACCHO • Work with state and territory Governments to facilitate policy and program improvement and enhancement across Australia • Facilitate any required changes to national strategic documents and/or legislation, as required. • Reporting • Evaluate and monitor
State and territory Affiliates	<ul style="list-style-type: none"> • Coordinate and/or deliver ATSIMHFAT • Develop a jurisdictional suicide prevention plan • Jurisdictional oversight and co-ordination of the CCSPNs • Contribute to identification of potential sites • Support network coordinators to draft, develop, and implement regional suicide prevention plans • Undertake service mapping, including advice on existing service to avoid duplication • Monitoring and Report • Collect and report data
State and territory health departments	<ul style="list-style-type: none"> • Address state/territory-relevant system issues • Facilitate any required changes to strategic documents and/or legislation as required.
CCC network – co-ordinating ACCHO/ACCO	<ul style="list-style-type: none"> • Develop and implement a regional suicide prevention plan • Establish regional network • Provide regional oversight and coordination of the network • Service mapping • Monitor and Report • Collect and report data • Develop aftercare service model and deliver aftercare services
ACCHO – participating in the CCC network	<ul style="list-style-type: none"> • Participate in network • Contribute to regional suicide prevention planning • Develop aftercare service model and deliver aftercare services

2.5: Using data to plan, monitor, and evaluate

Wherever possible, the best available data will be used to inform all aspects of planning, implementation and monitoring. This will include available data on suicide-related harm to identify and prioritise locations for program participation, using the available evidence base to inform the model of care, use of local and regional data to map care pathways and access issues as appropriate, and utilising local, state and territory, and national datasets to inform monitoring efforts.

Where possible, this program will empower ACCHOs/ACCOs to collect, monitor and analyse data to best support local program delivery, and quality improvement.

There are known gaps in the available data regarding suicide-related harm for Aboriginal and Torres Strait Islander people. This includes timely access to data on suicide deaths, data on suicide related harms including self-harm and suicide attempts and comprehensive SEWB data. Where possible and appropriate, the program will seek to address some of these challenges in data capture, analysis, and reporting.

2.6: Timeline for implementation

This discussion paper will inform planning discussions with the Advisory Committees. The program roll out has the following key deliverables and dates:

- February 2022 – Establishment of Aboriginal and Torres Strait Islander Expert Advisory Group
- July 2022 – Establishment of government/sector advisory committee
- 30 June 2022 – Establishment of Tranche 1 CCSPNs.
- 30 June 2023 – Establishment of Tranche 2 CCSPNs.
- 30 June 2024 – Establishment of Tranche 3 CCSPNs.
- 30 June 2025 – Establishment of Tranche 4 CCSPNs.

Chapter 3: Aspects of a Model of Care

3.1: Development of Culture Care Connect Model of Care

As part of this program, NACCHO will develop a clear operational guide including a suicide prevention and aftercare model of care for participating ACCHOs. To assist with developing this model of care, NACCHO has identified three key frameworks that are useful for conceptualising the delivery of suicide prevention and aftercare activity in an ACCHO setting:

- Social and emotional wellbeing model from an Aboriginal and Torres Strait Islander perspective developed by Gee, Dudgeon, Schultz, Hart, and Kelly, 2013.(5)
- The NACCHO NCD Model, adapted from the WHO Cancer Framework¹ which incorporates prevention of disease through to supportive care and surviving and thriving (internal documentation).
- NACCHO Core Services and Outcomes Framework: The model of Aboriginal and Torres Strait Islander Community-Controlled Comprehensive Primary Health Care (not yet published).

Collectively, these three models: outline the core components of SEWB for Aboriginal and Torres Strait Islander people; group service activity to support SEWB and reduce the burden of suicide into various stages of the patient journey; and contextualise this activity within the ACCHO setting. NACCHO has combined these key approaches into a model (Figure 2) for use in program design and delivery. Enablers of the model include: data and indicators; workforce training; and career pathways. The Aboriginal and Torres Strait Islander Advisory Committee was consulted in the development of this model.

¹WHO Guide to Cancer: Early Diagnosis (p. 11)
<https://apps.who.int/iris/bitstream/handle/10665/254500/9789241511940-eng.pdf?sequence=1&isAllowed=y>

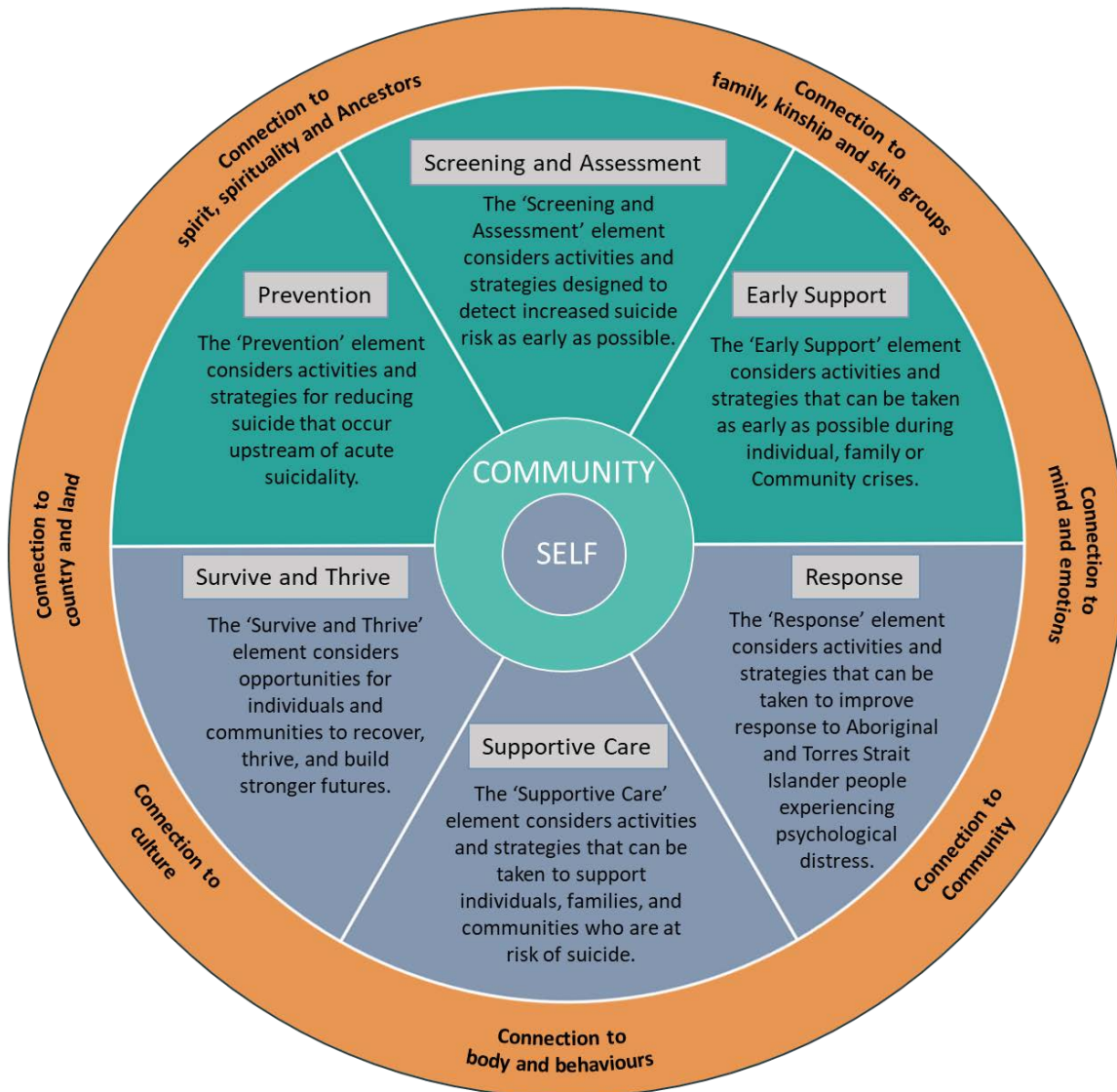


Figure 2: Culture Care Connect Model of Care (network co-ordinators). Enablers of the model include: data and indicators; workforce training; and career pathways.

In the model, there are six elements of the patient journey that are described in further detail in sections 3.2 to 3.7. Case studies and definitions are provided where appropriate.

While some effort has been made to clearly define each aspect and potential activities, NACCHO notes that there is considerable overlap between activities in each element of the patient journey. There are consistent enablers across each element that are vital for supporting activities. The use of local and regional data and indicators will enable ACCHOs/ACCOs to plan, monitor and evaluate activities. Building and supporting a strong workforce that is skilled, confident, resilient and culturally competent will also be essential to delivering an effective program. In addition, the model by its very nature is a key enabler to the provision of culturally safe and comprehensive care for people at risk of suicide.

3.2: Prevention

The ‘Prevention’ element of the model considers activities and strategies for reducing suicide that occur upstream of acute suicidality.

This section outlines key themes from a rapid review of quantitative and qualitative data about actions that can enhance suicide prevention. The NACCHO Program Policy Landscape and Evidence Paper discusses the literature in detail. Although current program funding does not include direct delivery of ‘Prevention’ activities, the key themes discussed in this section are relevant for network coordinators working with existing activities in their planning and coordination function.

Takeaways from rapid literature review

1. Localised strategies that are culturally responsive are needed.

Local, Community-led prevention strategies create meaningful engagement that effectively and sustainably create greater social and emotional wellbeing (SEWB) within Communities.

2. Suicide is complex, and suicide prevention work must be holistic and comprehensive.

Whole-of-person and family work to prevent suicide should seek to improve SEWB in the context of Community, and integrate with other sectors to improve physical health, target risk factors such as misuse of alcohol and other drugs and where possible, respond to the social determinants of health.

3. The successes of postvention strategies, mental health first aid training (MHFAT), and gatekeeper training, show that these activities are important aspects of prevention.

These activities should be integrated with key health and social services.

SEWB is a holistic concept that includes mental health and illness but also encompasses the important of connection to land, culture, spirituality and ancestry, and how these affect the wellbeing of the individual and the Community.(5)

Definition

3.2.1: Important activities

Community programs promoting social and emotional wellbeing and de-stigmatising mental health

Community-based programs to promote SEWB and de-stigmatise mental health issues vary in scope and scale. Some programs are broad, beyond single-issue deficit approaches, such as programs that engage through music and the arts. Other programs address risk factors, such as psychoeducation programs focusing on substance misuse. Whatever the focus and approach, successful programs are grounded in Community, culture, connection to land, and are integrated with culturally responsive mental health care. Examples include:

- School based programs aiming to increase health literacy
- Child and youth programs aiming to teach resilience and emotional regulation
- Healthy lifestyle and support programs that promote general and SEWB
- Mums and bubs, Women’s groups and Men’s groups that incorporate education around mental health and SEWB
- Social media and other communication campaigns aimed at reducing stigma associated with mental health and increasing help-seeking behaviour
- Social supports offered by ACCHOs including social work, Centrelink, financial and legal advice

- Programs aimed at reducing risk factors for mental health and psychological distress including drug and alcohol programs.

The Family Wellbeing empowerment program (6)

The adult-focused ‘Family Wellbeing’ empowerment program was adapted for Indigenous youth in one NSW study. The program aims to improve SEWB through social engagement (e.g. employment) and developing individuals’ understanding of emotional, spiritual, mental, and physical needs. The program was adapted for young people by shifting the focus from employment to education.

The program reported significant increases in SEWB and social engagement and noted that successes were due to adapting program content for the young demographic – for example, encouraging participants to listen to and write rap songs.

Mental health first aid training and gatekeeper training

Aboriginal and Torres Strait Islander Mental health first aid training (ATSIMHFAT) prepares individuals to help persons who are experiencing a mental health concern or are experiencing imminent crisis. Effective MHFAT is informed by SEWB.

Definition

Gatekeeper training prepares people who have regular contact with others in Community to recognise and respond to people at potential risk of suicide, or to support those who are bereaved by suicide. Where ATSIMHFAT often focuses on crisis support, gatekeeper training can have a greater focus on detecting early signs, providing psychoeducation, and building resilience.

Definition

ATSIMHFAT and gatekeeper training have been shown to be effective for improving understanding about suicide, reducing stigmatising attitudes, increasing confidence in ability to help people, and increasing intention to help people – even for healthcare workers, ACCHO staff, and other people who already reported high suicide literacy pre-course.

Training should be tailored to accommodate local cultural knowledge, needs and priorities to ensure its effectiveness. Courses with Aboriginal and Torres Strait Islander instructors have been found to have high cultural responsiveness, with Aboriginal and Torres Strait Islander instructors approaching sensitive topics more tactfully and sharing lived experiences that are well received.

ATSIMHFAT and Gatekeeper training should be considered for all ACCHO/ACCO staff (not just clinical staff) as well as other key contacts in the Community including teachers, emergency services personnel and Elders.

‘We-Yarn’ workshop (7)

‘We-Yarn’ is an Aboriginal and Torres Strait Islander suicide prevention workshop that provides culturally appropriate training to identify and respond to a person at risk of suicide. The program reported significant increases in participant knowledge, particularly in understanding the value of cultural strengths in suicide prevention. Importantly, participants reported high engagement when facilitators communicated their lived experiences with suicide and mental health.

Postvention

Postvention refers to interventions and support conducted after a suicide, for the bereaved family, friends, kin, and Community.

Definition

Suicides may have significant flow-on impacts for Aboriginal and Torres Strait Islander Communities, with significant and long-lasting grief and loss experienced by whole Communities, including leading to further suicides. Postvention, which is support for those bereaved in the weeks to months following a suicide death, is therefore an integral aspect of suicide prevention.

Postvention strategies should be guided by Community, who are best placed to identify community-specific needs, depending on what local services are available. For example, bereavement services are lacking in many rural and remote parts of Australia and some (but not all) communities may identify a need for readily-accessible after-hours services. ACCHOs are well-placed to be a point of contact that enables and empowers community access to postvention and/or directly deliver postvention services to Aboriginal and Torres Strait Islander Communities.

Postvention activities are not funded through the CCC program, however network coordinators may wish to explore access to postvention services and build partnerships to improve access or the cultural competency of available services.

Nerida's yarn: Too Many Funerals (8) (Video: <https://www.youtube.com/watch?v=N1fGnzzPWys>)

Nerida is a young Aboriginal girl living with her older sister after her mother's suicide. Nerida's sister says that Nerida has come a long way, gradually opening up to her family. Nerida's sister reflected that, typically, people might attend three funerals a year, but for her Community, funerals come in "threes to fours in a month" due to the frequent occurrence of suicide.

The high numbers of suicides in Nerida's story emphasise how important it is for Aboriginal and Torres Strait Islander Communities to have effective postvention when someone takes their own life. The impact of suicide reaches beyond the immediate family circle especially given highly-connected Aboriginal kin networks.

Nerida's story highlights the importance of talking and remembering. In Nerida's home they keep the funeral pamphlets up on the wall so those that have passed can be greeted daily. This action provides healing, fond memories, and a reminder of "where you come from and who you are".

3.2.2: Guidance for Program Staff

In identifying and coordinating 'prevention' activities, NACCHO suggests the following points to guide your consideration:

1. Mapping and supporting better integration of programs aimed at supporting SEWB and minimising stigma.
2. Ensuring all ACCHO staff, and staff from partnering agencies and key community members have access to MHFAT and gatekeeper training.
3. Building and supporting effective partnerships with services involved in postvention

3.3: Screening and Assessment

The 'Screening' element of the Model considers activities and strategies designed to detect increased suicide risk as early as possible.

This section outlines key themes from a rapid review of quantitative and qualitative data about actions that can enhance screening. The NACCHO Program Policy Landscape and Evidence Paper discusses the literature in detail. Although current program funding does not include direct delivery of 'Screening' activities, the key themes discussed in this section are relevant for network coordinators working with screening activities in their planning and coordination function.

Takeaways from rapid review

- 1. Access to mental health care requires a 'no wrong door' approach**
Patients should be easily and routinely linked to appropriate mental health care no matter how or where they come into contact with a health or social service.
- 2. Primary healthcare services can leverage existing assessment tools to routine screening in a safe setting**
Existing psychological assessment tools have been adapted for Aboriginal and Torres Strait Islander people and may be used to more routinely identify and take action on SEWB concerns. However, tools and indicators specifically designed by and for Aboriginal and Torres Strait Islander people are still needed.
- 3. Secondary healthcare services should more closely integrate mental health with other areas of health, including by conducting screening in non-mental health clinical areas**
Many secondary healthcare services maintain a biomedical system that treats mental health as separate from physical health. In reality, settings including emergency departments, child and maternal health, justice health, and many others, are excellent opportunities to screen for and take action on SEWB and mental health concerns.

3.3.1: Important activities

Ensuring a 'no wrong door' approach to accessing mental health care

Screening for suicide risk is important to consider in a wide variety of ACCHO/ACCO programs and services and for a variety of people and presentations. Young people presenting for immunisations or sexual health checks may be in need of SEWB support. Adults attending for substance misuse related care may be struggling with depression or going through a particularly stressful period. It is therefore important that health services take action to routinely screen for SEWB and mental health concerns in a variety of services and programs, and that clinicians are skilled and confident to opportunistically consider screening.

An important activity is for services to have systems in place that allow them to opportunistically identify, and escalate or otherwise act on, SEWB and mental health concerns. This involves ensuring strong links between mental health and primary care and other services such as alcohol and other drug services, child and maternal health, justice health, homelessness and other social services, and secondary and tertiary healthcare services. Culturally responsive approaches to referral are a must.

Trusted professionals can act as effective brokers and enablers for Aboriginal and Torres Strait Islander people to access appropriate mental health care across fragmented services.

ATSIMHFAT training of ACCHO/ACCO staff can assist with ensuring appropriate internal referrals to mental health and SEWB clinicians for early screening and assessment.

Leilani's story: finding a way through suicidal feelings (9)

In early life, Leilani wanted for her family to stay together with her mother, no matter the circumstances at home, such as a lack of food. When Leilani was 10, Leilani found her mother after her mother committed suicide. She then went on to live with her grandmother who soon passed away due to illness. After losing the next most significant person in her life, Leilani felt that she was alone and that no one cared. Leilani was 13 when she first tried to end her life. As an Indigenous child, she knew that others were feeling this way too, so she felt that it was normalised for her.

In her twenties, Leilani sought the support of a women's centre, but they couldn't accommodate her and asked to put her on a waiting list. This experience left her feeling shame and helplessness. However, Leilani also realised that there is incredible courage and strength in being able to share.

Leilani drew on this courage and spoke up, sharing that she had tried to end her life. Her case was escalated and Leilani was connected with counsellors who helped her to re-frame her feelings. Leilani shared a rollercoaster analogy: that if you can stay in the scary part of the ride for longer each time you are there, it eventually becomes normal and feel more manageable. Leilani's advice is to find someone you are comfortable with, even a stranger, and share with them that you are not okay; take the journey to understand your feelings, and finally, know that you are loved.

Making screening in primary and secondary healthcare services routine

Health services should take action to routinise screening for SEWB and mental health concerns. In primary care, this may be through the 715 Health Assessment, routine drug and alcohol program questionnaires or in regular antenatal and postnatal visits. Clinicians can use existing psychological assessment tools that have been adapted for Aboriginal and Torres Strait Islander people and trialled with good validity and acceptability. These include the Kessler K-5 and K-10 and other tools. As mentioned, tools and indicators specifically designed by and for Aboriginal and Torres Strait Islander people are still needed. However, studies have examined narrative-based screening approaches, such as yarning as a methodology, which could be used.

In secondary care, there are also existing tools designed specifically for certain care settings (for example, busy emergency departments) or for specific clientele (for example, new mothers). These tools are under-utilised and ACCHOs/ACCOs, where appropriate, may consider working with secondary services to improve integration of mental health and other services and increase mental health screening in non-mental health clinical areas.

3.3.2: Guidance for Program Staff

In identifying and coordinating 'screening and assessment' activities, NACCHO suggests the following points to guide your consideration:

1. Supporting all ACCHO staff and ACCHO systems to identify and refer people at risk to enable a 'no wrong door' approach.

2. Integrating screening tools into 715 health assessments, drug and alcohol service assessments, postnatal assessments, and other services.
3. Building partnerships with other local and regional providers to increase screening and appropriate referrals including to ACCHOs.

3.4: Early Support

The 'Early Support' element of the model considers activities and strategies that can be taken as early as possible during individual, family or Community crises.

This section outlines key themes from a rapid review of quantitative and qualitative data about actions that can enhance early intervention. The NACCHO Program Policy Landscape and Evidence Paper discusses the literature in detail. Although current program funding does not include direct delivery of all 'early support' activities, the key themes discussed in this section are relevant for network coordinators working with early intervention activities in their planning and coordination function.

Takeaways from rapid review

- 1. Crisis support should be accessible, culturally appropriate, and where possible respond to the social determinants of health that place people at risk of suicide.**
Accessing crisis support services is often difficult, particularly in rural and remote parts of Australia and especially after-hours services. Telehealth-based and other digital solutions could be leveraged to meet immediate service provision gaps, especially during a pandemic.
- 2. Community plays a key role in enabling effective early intervention.**
Early intervention activities are more effective when led by Aboriginal and Torres Strait Islander people, or when access to care is supported by Aboriginal and Torres Strait Islander organisations or liaison officers. Where crises and emergencies exist for whole communities, Community is best-placed to identify local needs and respond to emerging issues.
- 3. Identifying suicide clustering can allow for early intervention.**
Suicide clustering is where suicides occur in a similar timeframe and geographic location. Early postvention and broader support for Communities is essential for reducing subsequent suicides.

3.4.1: Important activities

Crisis support

Effective crisis-oriented services go beyond mental health treatment to addressing upstream social determinants of health that place individuals at risk of suicide in the first place. For example, individuals who are homeless should be supported to find secure, suitable accommodation. Using telehealth for crisis support has been shown to be safe and acceptable to patients and families, particularly if using telehealth reduces the need to travel to urban centres for support.

Not all crisis support services are culturally-safe and more work needs to be done at a systems level to ensure that culturally responsive, trauma-informed services are widely available, particular in rural and remote areas. Although services have a responsibility for cultural safety, Aboriginal and Torres Strait Islander organisations and liaison officers have been shown to be effective for enhancing support for Aboriginal and Torres Strait Islander people in a culturally-appropriate way.

However, barriers limit availability of Aboriginal and Torres Strait Islander workforce in many parts of Australia.

Participating ACCHOs/ACCOs may consider reviewing available local, regional or national crisis support programs, where they are funded to do so, and identifying opportunities to improve access and cultural safety. This may include building partnerships with non-ACCHO providers of crisis support services and/or providing ACCHO support while clients are engaging with a crisis support service.

Community-led early action

Strong relationships within communities have been shown to be a strong protective risk factor against suicide risk. Community-led early intervention programs have been successful in reducing the burden of suicide. For example, resilience programs, such as the Natural Helpers Program in the Kimberley, have received positive feedback and attribute successes to recognising and addressing local needs, including social determinants of health.

The Cultural Pathways Program (10)

The Cultural Pathways Program in SA aims to identify Community needs in a holistic way and address social determinants of health. As part of this program, facilitators implemented strengths-based practice to identify social and cultural needs of Community, such as cultural and community connection, food and financial security, housing, mental health, and transport. Facilitators set goals and brokered connections with social and health services to address these needs.

A story from the Tiwi Islands (11, 12)

Having not experienced suicide before 1989, the Tiwi language had no name for it. In 2005, the community saw 60 suicide attempts in a three-week period, due to a combination of many factors. By 2006, the community was experiencing one of the highest rates of suicide in the world.

Conversations within Community and between the four skin groups identified need for immediate aftercare and longer-term suicide prevention. Community worked with health professionals, the Aboriginal and Torres Strait Islander Healing Foundation, police, and support groups, to enhance and establish new programs. Music and sport became essential to the youth engagement strategy.

Several factors helped to successfully reduce the rate of suicide. A key factor was that Elders took the lead and Community took responsibility for dealing with suicide in their own way, based on local knowledge. Community had access to the right resources and did the hard work of supporting families in aftercare and postvention.

3.4.2: Guidance for Program Staff

In identifying and coordinating 'early support' activities, NACCHO suggests the following points to guide your consideration:

1. Facilitating community access to culturally appropriate crisis support services, especially after-hours and for rural and remote areas.
Building pathways for individuals to access early intervention and resilience programs.
2. Linking local health services with available surveillance data, such as around suicide clustering.

3.5: Response

The 'Response' element of the draft model considers activities and strategies that can be taken to improve responses to Aboriginal and Torres Strait Islander people experiencing psychological distress. This includes pharmacotherapy, psychology and counselling services and other health and social supports. Treatment is one part of aftercare.

Aftercare refers to care provided for people after a suicide attempt or suicidal crisis.	Definition
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This section outlines key themes from a rapid review of quantitative and qualitative data about actions that can enhance treatment. The NACCHO Program Policy Landscape and Evidence Paper discusses the literature in detail. Although current program funding does fund the provision of aftercare, it does not fund all 'response' activities. Broader treatment is a key component of an aftercare service. In addition, the key themes discussed in this section are relevant for network coordinators working with mainstream treatment services in their planning and coordination function.

Takeaways from rapid review

1. Holistic, comprehensive, trauma- and violence- informed care is required to improve SEWB

Responses to suicide and suicidal crises should be tailored to the individual and be holistic in nature. Responses may draw from a variety of products and disciplines including pharmacotherapy, psychology, peer support groups, drug and alcohol support, exercise and healing and cultural programs.

2. Effective aftercare occurs rapidly and includes active follow-up of patients by the service.

Aftercare can range from brief interventions through to more comprehensive support care. There is growing evidence that supports more holistic and comprehensive approaches to aftercare.

3. Effective aftercare is comprehensive and extends into communities.

Aftercare fills a key service gap in the days to weeks after hospital discharge. Effective aftercare services are comprehensive in addressing whole persons and have strong Community links.

4. Ensuring continuity of care across siloed care settings is a key opportunity.

People experience high suicide risk when transitioning across different treatment settings. Effective treatment programs are driven by strong local partnerships between different sectors.

3.5.1: Important activities

Aftercare is critical to suicide prevention, because an unsuccessful suicide attempt is the biggest predictor of further suicidal behaviour.

Aftercare

Reviews of different aftercare strategies have found that (what is sometimes called) 'assertive' aftercare tend to be more effective. 'Assertive' aftercare is where a patient's case manager is

responsible for maintaining contact with the patient using multiple methods, rather than relying on the patient or individual to make contact with the service.

Programmatic factors identified as contributing to effective aftercare include the following:

- services are Community-led and sensitive to locally-specific experiences
- rapid follow-up after suicide attempt or suicidal crisis
- supported by systems within health services that reduce 'turning away' of Aboriginal and Torres Strait Islander patients and improve referrals to aftercare
- strong integration of care with emergency departments and inpatient services
- high frequency of follow-up in the first month following a suicide attempt or suicidal crisis
- face-to-face sessions, especially for the first session if telephone follow-up thereafter
- holistic in addressing social issues that individuals face within their own communities, including leveraging multi-agency partnerships to provide supports
- involving support people such as family members, kin, or Elders
- clinicians are supported by systems to take the time necessary to provide effective aftercare
- clinicians are culturally responsive and provided with appropriate training and resources
- aftercare is integrated with primary health care services and patients' other care needs.

Culturally responsive treatments

SEWB and mental health concerns are frequently complex and can involve significant experiences of shame and stigma, rooted in a history of colonisation that is still relevant in the form of trauma, loss, and grief. More work is needed to support organisations to commit to decolonisation processes and improve training around trauma- and violence-informed care.

The model of care which incorporates Aboriginal and Torres Strait Islander concepts of health and wellbeing and often involves a multidisciplinary team is ideally placed to provide holistic SEWB care. Multidisciplinary teams involving Aboriginal and Torres Strait Islander mental health care workers and liaison officers, psychologists, and social workers, have been shown to be acceptable and effective – for example, in improving completion rates of Medicare-funded Mental Health Care Plans (MHCPs).

Conversely, secondary care services may not always provide culturally safe and appropriate care experiences. Inpatient psychiatric care is frequently a negative experience that is compared to prison, and short-stay models of inpatient care have been effective at reducing hospitalisation. Pathways for Aboriginal and Torres Strait Islander people between health services should be more flexible, culturally safe and seamless. This includes timely and appropriate communication between secondary services and ACCHOs/ACCOs including when clients are being admitted and discharged. Participating ACCHOs/ACCOs may be able to leverage existing relationships with secondary services to improve referrals and communication to benefit both clients and clinicians.

Ensuring continuity of care and access to treatments

There is a need for specific, locally-relevant mechanisms for coordinating care across different care settings, which draw on partnerships between different sectors. For example, in the justice setting, ex-prisoners leaving prison often experience 'medical homelessness', going from receiving mental health care while in prison to being on very long, exclusive waiting lists in the community. This manifests as high suicide rates amongst ex-prisoners during the first few months of leaving prison.

Access to treatments can be supported by telehealth-based therapies, which have the most evidence, and digitally-enhanced programs such as self-guided treatments on apps or websites. These treatments have been shown to be acceptable, particularly for youth, effective at improving access in under-served areas, and minimises stigma because resources can be accessed in the privacy of home.

3.5.2: Guidance for Program Staff

In identifying and coordinating 'response' activities, NACCHO suggests the following points to guide your consideration:

1. Supporting local health services to identify how staff can access cultural responsiveness training and re-orient towards holistic and comprehensive approaches to treatment.
2. Facilitating locally-relevant mechanisms to reduce care fragmentation across sectors.

NACCHO suggests the following points to guide your consideration around potential aftercare activities:

1. Establishing clear referral pathways, and staff roles and responsibilities to enable an 'assertive' approach to community-based aftercare.
2. Creating stronger integrations with EDs and inpatient services to improve referral to ACCHO led aftercare services.
3. Involving and empowering families, kin, and Communities in aftercare.

3.6: Supportive care

The 'Supportive Care' element of the draft model considers activities and strategies that can be taken to support individuals, families, and communities who are at risk of suicide. This section includes (but is not solely about) aftercare activities.

This section outlines key themes from a rapid review of quantitative and qualitative data about actions that can enhance supportive care and aftercare. The NACCHO Program Policy Landscape and Evidence Discussion Paper discusses the literature in detail.

Takeaways from rapid review

- 1. Culturally safe treatment requires a strong Aboriginal and Torres Strait Islander workforce**
A culturally responsive workforce is a key enabler for effective treatment. The Aboriginal and Torres Strait Islander mental health and SEWB workforce has been shown to be more acceptable and effective at achieving outcomes in mental health care for Aboriginal and Torres Strait Islander people.
- 2. A range of supportive care programs, including support groups, are effective**
Programs including community-based SEWB programs such as arts-based therapies, targeted psychotherapy groups, and peer support groups, have helped to de-stigmatise this sensitive issue.

3.6.1: Important activities

Peer and other group support services

Although most emphasis is placed on individualised treatments, there are effective group therapies designed with and for Aboriginal and Torres Strait Islander people. These therapies can vary in scope – for example, programs may be psychotherapies, or may be arts-based therapies such as music or visual arts programs. Some therapies target specific cohorts, such as prisoners, or persons with specific mental health conditions. Youth programs may take a whole-family approach.

Support groups, including men’s and women’s groups, for Aboriginal and Torres Strait Islander people have been shown to improve SEWB. Support groups can de-stigmatise this sensitive issue by embedding messages within a cultural framework and as part of restoring traditional knowledge, engaging peers with lived experience, or by embedding SEWB within other programs. An example of the latter is that SEWB can be discussed in the context of Men’s Health and in the context of deconstructing masculine norms that sometimes place young males at higher risk of suicidal ideation.

Strengthening the Aboriginal and Torres Strait Islander workforce

There is a shortage of mental health/SEWB workforce that is culturally safe for Aboriginal and Torres Strait Islander people in many parts of Australia, particularly in rural and remote areas and after-hours services. There is a need for funding and program design to support more Aboriginal and Torres Strait Islander people to enter and remain in the mental health care workforce and train non-Aboriginal and Torres Strait Islander staff in culturally safe care as part of core business.

The Uti Kulintjaku Project (13)

The ‘Uti Kulintjaku Project’ (meaning ‘to think and understand clearly’) aimed to strengthen shared understanding of mental health between Indigenous people and non-Indigenous healthcare workers, with the long-term aim of increasing help-seeking, strengthening health services’ cultural competency, and increasing Indigenous leadership.

The project involved Aboriginal women and non-Aboriginal workers coming together to create shared understandings of mental health. Deep exchange between the groups allowed Aboriginal women to learn about mental health concepts in a culturally contextualised and culturally appropriate way. This program also increased non-Indigenous mental health workers’ appreciation that mental health for Aboriginal and Torres Strait Islander people cannot be disaggregated from Community and Culture.

3.6.2: Guidance for Program Staff

In identifying and coordinating ‘supportive care’ activities, NACCHO suggests the following points to guide your consideration:

1. Empowering Community-led SEWB programs, including coordination with health services.
2. Facilitating integration between health and other sectors to provide comprehensive care.
3. Linking individuals with culturally competent support groups and targeted therapies.

3.7: Survive and thrive

The ‘Survive and thrive’ element of the draft model considers opportunities for individuals and communities to recover, thrive, and build stronger futures. ‘Recovery’ is not a common word in

mental health, but surviving and thriving is a crucial part of the story of suicide. Aboriginal and Torres Strait Islander peoples are survivors of many adversities and draw on great strengths across Communities.

This section outlines key themes from a rapid review of quantitative and qualitative data about actions that can support surviving and thriving. The NACCHO Program Policy Landscape and Evidence Discussion Paper discusses the literature in detail. Although current program funding does not include direct delivery of all 'survive and thrive' activities, the key themes discussed in this section are relevant for network coordinators working with 'survive and thrive' activities in their planning and coordination function.

Takeaways from rapid review

1. Recovery journeys should be framed in the context of Aboriginal and Torres Strait Islander culture, history, and survival

Many recovery-oriented services are well-perceived by Communities and clients. Services are successful when grounded in Aboriginal and Torres Strait Islander ways of doing health and being healthy and are led by Aboriginal and Torres Strait Islander staff.

2. Recovery-oriented services should be strengths-based

Research has shown that strengths-based recovery services have been successful. Strengths-based approaches include focusing on personal strengths, goals, and aspirations. There is a need to recognise that mental health journeys are often deeply personal and many complex issues may be encountered and services should be comprehensive in addressing locally-relevant social issues.

3. Surviving and thriving is a shared experience

Community-based support groups for men and women have a role in creating safe spaces for empowering participants in their own mental health, building resilience and capacity over time, and strengthening connections within Communities.

3.7.1: Important activities

Grief and loss are experienced collectively. Communities heal just as individuals recover. Surviving and thriving is critically linked with Country and Culture. Given this, surviving and thriving strategies should be closely guided by Community. Aboriginal and Torres Strait Islander Elders and knowledge keepers have not always been involved in program development, research and evaluation, but are critical for program success.

A story of Community empowerment from Yarrabah (11)

Yarrabah is a remote Community in Far North Queensland. The Community has experienced a long history of suicide events that has impacted everyone in the Community, which many people in Community thought was a spiritual attack: a "fight between culture and spirit".

The Community perceive that the turning point was a 400-person Community and multi-sectoral meeting. The meeting identified colonisation and the consequences of "loss of land, loss of culture, confusion, wounding of the spirit, oppression, racism, negative impact of government policies and intergenerational trauma as being responsible for [issues such as] alcohol and drug abuse, violence, and mental illness".

The Yarrabah Community identified and implemented several solutions, including: establishing a

'Crisis Intervention Group'; alcohol restrictions; funding application for Family Life Promotion Program; and, a healthcare feasibility study. The healthcare feasibility study found important underlying needs relating to health and wellbeing in Yarrabah, such as reclaiming spirit, redressing hopelessness, responding to loss around land and culture, and addressing unresolved grief from intergenerational trauma.

This study identified the need for Community-controlled primary health care, and a grant of \$500,000 helped to set up a pathway for programs to address family and child health, alcohol and drug use, and spiritual wellbeing. Simple strategies, such as relabelling support workers from 'Suicide Prevention Officers' to 'Family Life Promotion Officers', were found to be positive and empowering.

Other Aboriginal and Torres Strait Islander-based programs also have had an effect. The Family Wellbeing Empowerment Program is a Community-developed program that provides a qualification in counselling. This program is underpinned by cultural knowledge and experience supported by relevant mainstream material. Over 20 years, this program helped to reduce suicide rates and helped restore cultural identity, spirituality, family values, and men's place in Community. The program also improves relationships within families and supports personal development across a number of areas including leadership, education, and parenting.

The Yarrabah experience highlights that bringing Community together and agreeing on how to move forward together is key to creating change. Importantly, Community-control and a Community-led and Community-driven response is critical.

3.7.2: Guidance for Program Staff

In identifying and coordinating 'survive and thrive' activities, NACCHO suggests the following points to guide your consideration:

1. Empowering Community-led approaches to recovery by elevating Community voices in a multi-sectoral space.
2. Linking individuals to culturally appropriate care including local support groups and strengths-based mental health recovery services.
3. Engaging Elders and other knowledge keepers when recovery and suicide prevention or survive and thrive activities are being developed.

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