Inquiry into Aboriginal Youth Suicides

beyondblue Submission

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Inquiry into Aboriginal Youth Suicides

beyondblue welcomes the opportunity to make this submission to the Western Australian Legislative Assembly Education and Health Standing Committee Inquiry Into Aboriginal Youth Suicide.

In 2014, 2,864 Australians died by suicide. This equates to around eight deaths by suicide each day. Tragically, the majority of people who suicide are in the prime of their life.

The situation within Aboriginal and Torres Strait Islander communities is of even greater concern. After adjusting for differences in population age structures, available data shows that Aboriginal and Torres Strait Islander people are around twice as likely to die by suicide as other people in Australia.

Young people are particularly at risk. Aboriginal and Torres Strait Islander people aged 14 years and under are 8 times more likely to suicide than non-Aboriginal children. Between 2001-2010, among 15-19 year olds, the rate of suicides among Aboriginal and Torres Strait Islander young women was 5.9 times higher than the rate for non-Indigenous young women, while for Aboriginal and Torres Strait Islander young men the rate was 4.4 times higher in this age group. Overall, suicide is the leading cause of death of Aboriginal and Torres Strait Islander young people aged 15-24 years.

Moreover, suicide rates varying dramatically between different regions and some Aboriginal communities in Western Australia have exceptionally high suicide rates.

Suicide has a devastating impact on individuals, families and communities and *beyondblue* extends its sincere condolences to people affected by suicide in Western Australia.

Over the last two decades a considerable amount of attention has been focused on trying to reduce the suicide rate across the whole Australian population as well as the Aboriginal Torres Strait Islander community more specifically. While there have been successes, the latest Australian Bureau of Statistics Cause of Death data highlight that we have still got a long way to go in driving down rates on a consistent basis.

While some of the causes of suicide and solutions to address them are similar among Aboriginal and Torres Strait Islander young people and non-indigenous people, there are also some major differences. It is therefore not possible to reduce the suicide rate among the Aboriginal and Torres Strait Islander people through mainstream approaches alone. A focus on the impact of colonisation and on the social determinants of health are critical. The importance of connection to land, language, family, community and culture must also be emphasised.

Tackling Aboriginal youth suicide therefore requires a dual track approach that includes a tailored approach which addresses the unique experiences, preferences and needs of Aboriginal and Torres Strait Islander people on a community by community basis, coupled with the successful implementation of known evidence-based suicide prevention activities across the entire population. This is likely to achieve maximum impact.

Aboriginal leadership and involvement is critical for success, as is adequate time and resourcing for initiatives to take shape, achieve impact and become sustainable. Initiatives need to be community led and co-designed, implemented and evaluated by Aboriginal and Torres Strait Islander people and non-indigenous people working together. Governments and bureaucracies need to support Aboriginal and Torres Strait Islander communities to generate solutions while fulfilling their mandate to provide appropriate and effective programs and services.

As with all suicide prevention initiatives, there needs to be an integrated focus on: increasing the protective factors and reducing the risk factors for suicidal behaviour with a particular focus on the social determinants of psychological distress and suicidality; ensuring early intervention through improved access to culturally appropriate services to address underlying mental health conditions and/or substance misuse; and assisting

all young people, particularly those who have attempted suicide, to engage in civic, social and economic life and achieve their full potential.

No one single intervention on its own is likely to be sufficient to prevent all suicides. A combination of approaches is therefore required, coupled with continuing efforts to design, implement and evaluate new strategies. It is essential that initiatives are given time to work. Ongoing monitoring review through consultation with local communities will enable funders and implementers to know whether things are being delivered well and are having an impact.

Recommendations

To reduce the incidence and impact of suicidal behaviours among young people in Western Australia (WA), an integrated multisector approach to promotion, prevention, intervention and postvention is needed that brings Aboriginal and Torres Strait Islander communities, governments and other key stakeholders together in partnership. *beyondblue* proposes the following recommendations.

1. That the WA Government provide support for Aboriginal and Torres Strait Islander young people, communities and organisations to develop localised strategies for their own communities. Responses by the WA Government should be based on the accumulated wisdom of Aboriginal and Torres Strait Islander people**,** particularly those who have been directly affected by the impacts of suicide.

2. That the WA Government base its suicide prevention initiatives on the key principles articulated by Aboriginal and Torres Strait Islander people during recent consultation initiatives such as the Aboriginal and Torres Strait Islander Suicide Prevention and Evaluation Project (ATSISPEP) consultation projects. These principles include:

    - Community ownership and self-determination
    - Clear roles and responsibilities and improved accountability
    - A focus on empowering Aboriginal and Torres Strait Islander people
    - A holistic approach that incorporates physical, mental, social and spiritual wellbeing.
    - A equity-based approach that addresses the social determinants that contribute to suicide
    - Capacity building initiatives and support for the Aboriginal and Torres Strait Islander workforce
    - Improved cultural competency in mainstream services
    - Improved access to and coordination of services

    Mainstream agencies need to work in collaboration with Aboriginal community controlled health organisations and community based service providers, peak bodies, schools, research institutes and respected peoples and Elders rather than trying to assume ownership themselves. They also need to acknowledge and respect the diversity of Aboriginal and Torres Strait Islander people and communities across Australia and recognise the complexities of identity and the fact that some people may identify with a number of communities.

    ATSISPEP is anticipated to provide a report to the Commonwealth Minister for Indigenous Affairs by mid-2016 making recommendations for improvements to existing services and programs, and recommendations about alternative evidenced-based service and program delivery models, where indicated by evaluation. *beyondblue* encourages the WA Government to take the recommendations of this seminal project into consideration when formulating its response to Aboriginal Youth Suicide.

3. That the WA Government complement these tailored initiatives with other ‘generic’ evidence-based suicide prevention strategies. These include**:** interventions to prevent mental health and/or substance

use conditions from developing; reducing access to lethal means; responsible media reporting; community awareness programs; gatekeeper training; school based suicide prevention programs; training of general practitioners and frontline staff; and psychotherapy and follow-up for individuals with a recent suicide attempt.

4. That the WA Government continue to focus on increasing access to early, effective intervention through a stepped-care approach to mental health. Stepped care enables young people to obtain supports and services that meet their needs and their preferences including self-management tools and resources, low and brief-intensity interventions, as well as access to evidence-based psychological therapies provided by primary care and specialist mental health services. Culturally tailored forms of emotional and social wellbeing therapies need to be better researched and made available.

5. That the WA Government encourage its State funded service providers to increase the focus on safety planning and after-care support for young people who have self-harmed or attempted suicide. This requires increases in the availability and use of safety planning tools and improvements in the response to young people presenting to emergency departments following self-harm or a suicide attempt with proactive follow-up to ensure that they do not fall through the gaps. Support for families and support for peers through postvention initiatives are also important. Quick action to prevent suicide clusters is particularly important.

6. That the WA Government work with the Commonwealth Government and other stakeholders to introduce more effective surveillance systems to allow monitoring of progress in reducing all forms of suicidal behaviour and to monitor the prevalence of risk and protective factors that influence suicidality.

7. That the WA Government support research initiatives that address the identified gaps in evidence on suicide prevention within Aboriginal and Torres Strait Islander communities including research into new approaches suicide prevention. The needs of LGBTI Aboriginal and Torres Strait Islander young people is a particular area for further research. Initiatives should be properly evaluated wherever possible. ATSIPEP is developing a culturally appropriate evaluation framework to measure the effectiveness and appropriateness of Aboriginal and Torres Strait Islander suicide prevention initiatives. Consideration should be given to adopting this framework to evaluate future youth suicide initiatives in WA.

The public health context

What are suicidal behaviours?

Suicide is best considered as part of a spectrum of suicidal behaviours that encompasses suicidal ideation, planning, suicide attempt and suicide. Self-harm can also be part of this spectrum although many people who self-harm do not wish, or intend to take their life, but rather self-harm to manage their psychological pain and distress.[1]

How common are suicide and suicidal behaviours?

Self-harm is prevalent among young people. The most recent national Child and Adolescent Survey of Mental Health and Wellbeing (2015) revealed that around one in ten 12–17 year-olds reported they had engaged in self-harming behaviour.[2] Suicidal ideation, planning and attempts are also prevalent. The 2015 child and adolescent survey found that one in forty young people (2.4%) had attempted suicide in the previous 12 months[3] while the adult version of the national mental health survey conducted in 2007 found that in the 12 months prior to interview, 2.4 per cent of the population aged 16-85 reported some form of suicidality.[4] The adult survey also revealed that at some point over their life, around 13 per cent of Australians aged 16-85 years experienced suicidal ideation, four per cent made suicide plans and just over three per cent had attempted suicide.[5]

Suicide is also tragically common. In 2014, 2,864 Australians died by suicide.[6] This equates to around eight deaths by suicide each day. Among those who took their life, 374 were from Western Australia (WA) and WA continued to record a suicide rate higher than the national average (14.4 per 100,000 compared to 12 per 100,000). Many people who die by suicide are in the prime of their life. In 2014, 362 young Australians aged 15-24 took their life. Suicide is the leading cause of death among young people aged 15-24 and accounts for around a third of all deaths in this age group.[7] Just as concerning are suicide deaths among children and younger adolescents. Between 2010-2014, 407 children and adolescents aged 5-17 died by suicide, 61 of whom were from Western Australia.

What causes people to suicide?

The reasons behind suicidal behaviours are complex. A broad range of factors increase risk while other protective factors can reduce the likelihood.[8] Ultimately, suicidal behaviour occurs when the psychological distress, hopelessness and isolation that a person is experiencing is greater than the coping strategies and social supports they have to deal with these feelings.[9]

Mental health conditions are a significant contributing factor. The adult national mental health survey in 2007 found that suicidality in the previous 12 months was reported by almost nine per cent of people with a 12-month mental disorder. This was three and a half times higher than suicidality in the general population. Western Australian coronial data found that 35 per cent of men and 60 per cent of women who died by suicide had experienced a diagnosed psychiatric disorder in the preceding 12 months.[10] Some research suggests that mental illness may be present in 90 per cent of suicide cases[11] although other researchers question the validity of this data, as it is underpinned by the psychological autopsy methodology.[12] The likelihood of suicidal behaviours varies according to the type of mental health condition (e.g. depression). It also increases significantly if a person experiences multiple mental health conditions.

Suicidal behaviours vary by demographic characteristics. Females are more likely to self-harm and attempt suicide compared to males, but males make up three quarters of all suicide deaths. Data consistently shows that the prevalence of suicide is higher in remote, rural and regional areas than in major cities and there are

also marked regional differences in rates of suicidal behaviour in non-urban areas.[13] According to the 2014 Cause of Death ABS Data the suicide rate among children and adolescents living in other parts of Western Australia was almost three times higher than those living in Perth.[14] LGBTI young people also experience increased risk of self-harm and suicidal behaviour. This is strongly related to rejection, harassment, abuse and discrimination.[15]

Other general risk factors for suicidal behaviours include: substance misuse; social isolation; psychosocial crises such as a relationship breakdown; bullying; adverse early life experiences including physical and/or sexual abuse; personality factors, such as impulsivity and perfectionism; poor coping and problem solving skills; and socioeconomic factors such as unemployment, low income and limited education[16,17,18 19 20]. While self-harm is not always associated with a desire to die, people who self-harm are at increased risk of attempting suicide or dying by suicide than the general population. Previous suicide attempts are another major risk factor for future suicide attempts and suicide. Young people in out-of-home care and young people in immigration detention or juvenile justice facilities are also at higher risk.[21]

Contagion is also an issue.[22] Some young people, especially those who are already experiencing difficulties and life stresses, may identify with the person who has suicided. This may normalise the behaviour, and contribute to thinking that suicide is an option. According to the Queensland Commission for Children and Young People and Child Guardian (2011) as many as 42 per cent of child suicides could be related to contagion. Internationally, it has been estimated that between one and five per cent of all suicides by young people occur in the context of a cluster.[23] Studies have shown that adolescents are the age group most affected by suicide contagion.[24] A Canadian study with adolescents aged 12 – 17 years has shown that young people who reported the suicide of a schoolmate were significantly more at risk of suicide than those with no exposure, with the effect most prominent in the youngest age group.[25]

Aboriginal and Torres Strait Islander youth suicide

What is the prevalence of suicidal behaviours among Aboriginal and Torres Strait Islander people?

As with other health issues, a significant gap exists between the mental health of Aboriginal and Torres Strait Islander people and non-indigenous people. This discrepancy is particularly stark in relation to psychological distress, hospitalization rates for intentional self-harm and suicide.

National data suggests that one-third of Aboriginal and Torres Strait Islander adults report high/very high levels of psychological distress, which is nearly three times the rate for non-Indigenous Australians.[26] Between 2004-05 and 2012-13 hospitalisation rates for intentional self-harm increased 48 per cent among Aboriginal and Torres Strait Islander people while the rates for non-indigenous Australian's stayed relatively stable.[27] Nationally in 2012-13, after adjusting for differences in population age structures, the rate of hospitalisation for intentional self-harm among Aboriginal and Torres Strait Islander Australians was around two and a half times the rate for non-Indigenous Australians.[28] Among Aboriginal and Torres Strait Islander people, the rate of hospitalisation for intentional self-harm is higher for females than males, and higher in remote areas than other areas.[29]

Nationally, Aboriginal and Torres Strait Islander people are almost twice as likely to die by suicide as non-indigenous people.[30] In Western Australia the suicide rate among Aboriginal and Torres Strait Islander people is 3.3 times higher than among non-indigenous people (3.2 times higher for Aboriginal and Torres Strait Islander males and 3.8 times higher for Aboriginal and Torres Strait Islander females compared to non-indigenous males and females).[31] Around one quarter of suicide deaths among Aboriginal and Torres Strait Islander in Australia occur in WA despite the fact that WA accounts for just 14 per cent of the nation's Aboriginal and Torres Strait Islander population.[32]

Suicide is the second leading of cause of death among Aboriginal and Torres Strait Islander children between the ages of 1-14 and it is the leading causing of death between the ages of 15-34 years.[33] Suicide accounts for one in three deaths among people aged 15-34.[34] Aboriginal and Torres Strait Islander people aged 14 years and under are 8 times more likely to suicide than non-Aboriginal children.[35] Between 2001-2010 the suicide rate among Aboriginal and Torres Strait Islander males aged 15-19 was 4.4 times higher than for young non-indigenous males, and 5.9 times higher among 15-19 Aboriginal and Torres Strait Islander females compared to young non-indigenous females.[36] Moreover, 34 of the 61 deaths of children and adolescents aged 5-17 that occurred in WA involved an Aboriginal child or adolescent and from 2010-2014, the suicide rate among Aboriginal and Torres Strait Islander children in WA aged 5-17 was 18.9 deaths per 100,000.[37]

There are significant regional variations in suicide rates. The Kimberley Roundtable Report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) notes that WA has seen a big increase in suicides. The Kimberley region in particular has seen a dramatic increase in suicide deaths, particularly over the last five years, with yet to be published data suggesting two suicide deaths are occurring each month among Aboriginal and Torres Strait Islander people in the region.[38] 'Clusters' of suicide appear to be a particular feature in some Aboriginal communities[39] with a high proportion of suicide clusters in Australia occurring among those under 20 years of age (5.6%) and among Aboriginal and Torres Strait Islander people (16.4%), with those living in the Northern Territory, Queensland, Western Australia and remote areas most at risk.[40]

Why Aboriginal and Torres Strait Islander young people die by suicide at higher rates?

The reasons for the overrepresentation of Aboriginal and Torres Strait Islander young people among people who suicide are complex, and vary across regions and communities. Some of the risk factors that contribute to suicide among Aboriginal and Torres Strait Islander people are similar to those shared with non-Indigenous people, as described above. However many risk factors are unique to Aboriginal and Torres Strait Islander people or occur far more commonly in the lives of Aboriginal and Torres Strait Islander people.[41] Key factors include:

- the impact of colonisation and intergenerational trauma caused by previous government policy (e.g. Stolen Generations)
- loss of culture and identity
- unemployment and other forms of social exclusion and inequity leading to alienation and a lack of a sense of purpose in life
- discrimination and racism
- lack of recognised role models and mentors outside the context of sport
- living in overcrowded, substandard or insecure housing
- persistent cycle of grief and 'bereavement overload' due to high number of deaths in communities
- substance misuse among some people (drug and alcohol)
- experience of neglect, abuse or trauma within the family
- exposure to interpersonal conflicts and family violence or family breakdown
- animosity and jealousy manifest in factionalism
- sexual assault and abuse
- sense of hopelessness and feeling trapped
- familial 'transmission' of suicide risk, particularly involving parents or siblings.[42] [43] [44]

It is important to note that many Aboriginal and Torres Strait Islander people experience multiple, simultaneous risk factors rather than just one in isolation. The 2014-15 National Aboriginal and Torres Strait Islander Social Survey found that almost 70 per cent (68.4%) of Aboriginal and Torres Strait Islander people experienced at least significant stressor in the last 12 months.[45] Based on the 2012–13 Aboriginal and Torres Strait islander Health Survey and the 2011–12 National Health Survey, Aboriginal and Torres Strait Islander people aged 15 years and over were 1.4 times as likely as non-Indigenous people to have experienced one or more of these specific stressors in the previous year.[46]

Some have suggested that Aboriginal youth suicide is more likely to occur in the context of conflict, relationship breakdown and anger and a greater degree of impulsivity is involved in Aboriginal youth suicide compared to suicide among non-indigenous young people.[47] However, in some cases an immediate 'precipitating' stressor is not apparent, or may appear to be relatively minor.[48]

The experience of racism is risk factor worth specific focus, particularly as it relates to late adolescence and early adulthood which are times of heightened vulnerability to the psychological distress caused by racism. Over half (56%) of Aboriginal and Torres Strait Islander people who experience discrimination report feelings of psychological distress.[49] Research in the Northern Territory (NT) found a significant association between interpersonal racism and depression among Aboriginal and Torres Strait Islander Australians. It is of particular concern therefore that the most recent National Aboriginal and Torres Strait Islander Social Survey (2014-15) shows that one third (33.5%) of Aboriginal and Torres Strait Islander people felt they had experienced unfair treatment as a result of racism.

These risk factors can present a challenge to the traditional Western medicalisation of suicide, pointing to historically, politically and socially mediated factors within communities.[50] It is also important to note that risk factors for suicide and suicidal behaviours for Aboriginal and Torres Strait Islander people may differ not only from risk factors for non-Indigenous people but between different regions and communities and it is not always possible to generalise from one community to another.[51] [52] Ultimately however, distressed individuals are often part of distressed communities and a whole of community approach to risk reduction needs to be adopted.[53]

Another potential contributor to the increase rates of suicide among Aboriginal and Torres Strait Islander people relates to the services available to Aboriginal and Torres Strait Islander people. Two main issues are evident – a relative lack of services and/or a lack of culturally appropriate services. As noted above, in addition to informal support, people at risk of suicide – particularly those with an underlying mental health and/or substance misuse condition – can benefit from access to relevant supports and services provided through the health and community sectors. As with all communities, positive outcomes rest on peoples' ability to access the right services at the right time. Availability, affordability and acceptability are all important.

Successive WA State and Commonwealth Governments have worked to improve Aboriginal and Torres Strait Islander people's access to mainstream primary and specialist mental health services and to improve the appropriateness of care provided in these settings through cultural awareness training and the embedding of Aboriginal and Torres Strait Islander liaison workers. In addition, some additional mental health resources have been provided to Aboriginal Community Controlled Health Organisations (ACCHOs) to meet the needs of particular groups (e.g. Bringing them Home and Link Up workers). However it is still evident that Aboriginal and Torres Strait Islander people are not accessing available services in proportion to their needs, and they receive proportionally less specialised care for mental health conditions than non-Indigenous people.[54] For example, evaluation of the Access to Allied Psychological Services (ATAPS tier 2) shows there has been a small increase in the number of general practitioners delivering services for Aboriginal and Torres Strait Islander people across the country but not a substantial change in the number of referrals.[55] It is also unclear how well mainstream phone, web and email counselling services for children and young people cater to the needs of Aboriginal and Torres Strait Islander youth. Kids Helpline has supported almost 700 Indigenous children (2011 figure), however there is no published evaluation on the service's effectiveness. The web-based service Reach Out! which has been accessed over six million times since 1998, does not collect data on the number of contacts by Aboriginal and Torres Strait Islander young people. While *beyondblue* has seen an increase in calls since the launch of our Stop. Think. Respect. 'Invisible Discriminator' campaign, the number of people identifying as Aboriginal and Torres Strait Islander who contact the *beyondblue* Support Service remains relatively low. Aboriginal and Torres Strait Islander peoples' use of services and experience of care is also impacted by additional barriers such as racial discrimination and resultant lack of trust in mainstream services, cultural and language barriers and inadequate stigma-reduction measures.[56]

More locally within WA, participants in the Kimberley Roundtable noted a number of major limitations with existing mental health services including: no or poor after hours availability; a lack of culturally appropriate care; lack of follow-up following a suicidal crisis; lack of post-vention support to families and communities following a suicide death; and understaffing and under-resourcing of services in the local area. National and local initiatives to build the capacity of the Aboriginal and Torres Strait Islander health workforce and increase access to culturally-safe and appropriate health care for Aboriginal and Torres Strait Islander peoples need to continue. Poor cross-cultural clinical practices, especially those linked to inadequate communication, are commonplace and affect quality of care.

A lack of leadership, coordination and accountability between various government departments and levels of government has also been proposed as a factor hampering progress. The WA State Coroner has conducted several inquests relating to suicide deaths among Aboriginal and Torres Strait Islander people in WA including inquests into: five suicide deaths in Oombulgurri between 2005-06; 22 deaths in the Kimberley between 2007-08; and five suicide deaths in Balgo between 2008-09. These reviews revealed several common issues including: the extremely high number of suicide deaths when considered on a per capita basis; significant health problems experienced by Aboriginal people in the areas under investigation, such as problems relating to substance misuse; child abuse; low levels of educational attainment; the extremely poor living conditions of people in the area; a relative paucity of crucial services, such as mental health and drug and alcohol services; and a lack of leadership and accountability.[57] [58] [59] Indeed, in his report on the 22 deaths in the Kimberley the WA State Coroner noted that: "in addition to Commonwealth funding, the State is providing $1.2 billion each year for services and programs targeted to indigenous people in Western Australia which is allocated to 22 government agencies under 16 Ministers."[60] p.23 Yet he found that there was no identified individual or organisation monitoring performance of the various government agencies to ensure that outcomes were being improved.

What are the protective factors that counteract this risk?

Whilst significant risk factors for suicidal behaviours remain all too common in the lives of young people from Aboriginal and Torres Strait Islander communities, there are also numerous examples of resilience in the face of adversity and protective factors that strengthen young people and put them at reduced risk. Connection to land, culture, spirituality, ancestry and kinship networks are commonly identified by Aboriginal and Torres Strait Islander people as factors which protect social and emotional wellbeing, mitigate the impact of stressful circumstances on individuals, families and communities and increase resilience.[61] [62] Indigenous language retention and revitalisation also has a significant preventative effect, and local health initiatives to strengthen young people's positive identification with culture and enable social and economic participation have been a key recovery feature in communities with high rates of suicide.[63] 'Cultural continuity' factors such as self-government, actively pursuing land claims, education services and existence of cultural facilities have been identified in studies among indigenous communities in the USA and Canada.[64]

Framework for Intervention

Reducing the Aboriginal youth suicide rate in WA is likely to require a mix of strategies targeted to the whole WA population, as well as those specifically tailored for young Aboriginal people.

General approaches to suicide prevention

While the evidence for effective suicide prevention interventions relevant for the whole population remains incomplete there is nevertheless a considerable degree of agreement about what actions are required to impact on suicide risk. A number of evidence based approaches to suicide prevention have been identified including: reducing access to lethal means; responsible media reporting; community awareness programs; gatekeeper training; school based suicide prevention programs; training of general practitioners and frontline staff; psychotherapy and follow-up for individuals with a recent suicide attempt.[65] [66] [67] Any single intervention on its own is insufficient to prevent all suicides and a combination of approaches is required that are implemented in an integrated manner on a regional and State wide basis. This needs to be coupled with continuing efforts to design, implement and evaluate new strategies. The following interventions should be considered core elements of a comprehensive suicide prevention model.

- **Preventing the onset of mental health conditions is critical.** There is an overwhelming body of evidence about the importance of environmental factors in-utero, infancy, childhood and the teenage years on a person's mental health. Adverse environmental experiences early in life – including socioeconomic disadvantage, poor attachment, adverse family environments and exposure to neglect, abuse, conflict and violence – have lifelong effects on mental and physical health.[68] [69] [70] A strong and explicit focus on preventing mental health conditions is required that focuses on preventive action early in life, when the individual, community and environmental risk factors for mental health conditions are most influential, and when most instances of mental health conditions commence. Prevention programs need to address the known socially determined risk factors, such as poverty, abuse, violence and discrimination/racism, as well as increasing protective factors to build resilience.

- **Restricting access to lethal means** – this incorporates a range of strategies including: controls over the availability of firearms; design of pharmaceutical containers; modifications to gas supply; and cliff, bridge and rail barriers.[71]

- **Responsible media reporting** – this includes avoiding detailed descriptions, sensationalism and glamorisation, using responsible language, minimizing the prominence of suicide reports, educating the public about suicide and available treatments, and providing information on where to seek help.[72] The Australian Government's Mindframe National Media Initiative (MindFrame) encourages responsible, accurate and sensitive representation of mental health conditions and suicide in the Australian mass media. MindFrame includes advice on the safe and responsible reporting of suicide and mental health conditions in LGBTI communities.

- **Community awareness programs** – community awareness and education initiatives delivered through website, media, social media and marketing channels can be used to ensure maximum reach and exposure to relevant information.

- **Gatekeeper training** – a gatekeeper is anyone who is in a position to identify whether someone may be contemplating suicide. It is important that gatekeepers, such as teachers and those working in youth

services, have the right knowledge and skills to identify young people at-risk of suicide, and support them to access the care they need. Suicide prevention training of front line staff, including police, ambulance and other first responders, is also important. Training should aim to develop participants' knowledge, attitudes and skills for identifying individuals at risk, determining the level of risk, and then referring at-risk individuals for treatment.[73] Culturally appropriate training programs such as Aboriginal Mental Health First Aid should be emphasised.

- **School based suicide prevention programs** – this may include initiatives targeted to the promotion of good mental health and prevention of mental health conditions, as well as to suicide more specifically. It is essential that early childhood settings and schools are safe and inclusive environments, value diversity, and respond to individual and environmental risk for mental health. This will not only benefit the mental health of students, but it will also enhance their ongoing connection and engagement with school, and contribute to better academic achievement and staff morale.[74,75,76,77] Educators also have a critical role in supporting young children to build the necessary competencies, skills and resilience to support good mental health[78] – for example solving problems, communicating effectively, regulating emotions and managing stress, exercising regularly, having a balanced diet, getting enough sleep and avoiding harmful levels of alcohol and other drugs. Schools also play an important role in assisting young people with suicidal behaviours or mental health conditions to seek assistance and to recover. Schools also need to make reasonable adjustments to support students experiencing a mental health condition to ensure they stay connected to their peers and to the school and study. These activities are best undertaken within a whole of school approach to mental health promotion that focuses on the mental health and wellbeing of all students, not just those experiencing mental health conditions, such as the Australian Government Department of Health KidsMatter Early Childhood program for early childhood education and care (ECEC) services, KidsMatter program for primary schools and the MindMatters program for secondary schools, which are currently managed by *beyondblue*.[79,80]

- **Training of general practitioners and frontline staff** – GPs are an important first port of call for people experiencing psychological distress and suicidality. Research suggests that education and training initiatives to improve GPs ability to recognise and manage mental health conditions and suicidality, can help to reduce risk and improve outcomes.[81]

  Improving access to psychological treatment for individuals with a mental health condition or a recent suicide attempt – All suicidal behaviour requires urgent and serious attention. All too often, young people who experience suicidality are not taken seriously, or do not receive the prompt attention they require and deserve. Intervention that occurs only when suicide risk is 'imminent' represents a systems failure and highlights missed opportunities for earlier intervention that may have helped to de-escalate risk. Early intervention for suicidality and associated mental health conditions is therefore critical. A range of psychotherapies have been demonstrated to reduce the risk of self-harm suicide attempts and suicide including cognitive behaviour therapy and dialectical behaviour therapy.[82] Increasing access to evidence-based psychological therapies is therefore crucial across the whole spectrum of psychological distress and suicidality. Improving the capacity of the mental health service system to respond to the needs of people who have experienced trauma through trauma informed psychological care is also important. Mental health services should be delivered within a stepped-care framework, which enables people to obtain the type and intensity care that meets their needs.

  At present the majority of young people with suicidal behaviours and/or with mental health conditions do not access professional services.[83] The most common barriers to seeking help are: stigma; concerns about confidentiality and trust; poor mental health literacy; a preference for 'self-reliance'; lack of

confidence in the efficacy of treatment; and lack of knowledge of available services.[84,85,86] People's beliefs and culture also impact their attitudes and behaviour towards seeking help and the types of treatment they prefer to access. A lack of access to affordable and accessible services and long waiting lists is also a barrier, particularly in some geographic areas (e.g. regional, rural and remote). Dismissive, judgemental and/or discriminatory attitudes of health professionals, is another problem. Many young people report that self-harm or other suicidal behaviours are not taken seriously by health professionals, particularly in emergency departments.[87] This may adversely impact on their willingness to seek assistance in the future. Improving help-seeking requires attention to increasing young people's and parents' understanding of mental health conditions, tackling the stigma and discrimination associated with suicidal behaviours and mental health conditions, as well as generally improving access pathways to care.

Digital technologies have an important role given their relative ease of access. Young people are increasingly obtaining information on health problems online. A wide range of digital and technology based mental health promotion and treatment, apps, devices and programs have entered the market over the last decade. Increasing young people's access to these tools and services is just as important to increasing access to face-to-face intervention. Digital and online solutions need to be evidenced based and culturally appropriate. Furthermore, to be accessible, the digital divide particularly in rural and remote communities needs to be addressed through improvements in the quality of internet connection and accessibility of computers and devices. Other ways to deliver psychological therapies are also worth exploring, particular those that have the capacity to decrease stigma such as the *beyondblue* pilot NewAccess program (see Appendix Two). Crisis telephone lines also play a useful role. The evidence for their effectiveness is variable however this may reflect the methodological complexity of undertaking research on such services, rather than on the services.[88]

- **Follow up for individuals with a recent suicide attempt** – a previous suicide attempt is the most significant risk factor for suicide. The first few months post-attempt is a particularly high risk period. Given the strong association between suicide attempts and subsequent suicide, it is important to ensure that people who have attempted suicide receive appropriate follow-up and are supported to develop a safety plan and access informal and formal evidence-based care. At present, many young people who present to health care providers following self-harm or suicide attempt receive poor care and report being treated in a stigmatising way.[89] In addition, follow-up may be absent, poorly communicated, poorly coordinated or poorly timed. As a result, many young people either do not attend appointments or attend only briefly and are lost to follow-up. This needs to be addressed.

- **Being exposed to suicide heightens the risk of contagion and therefore postvention services and resources need to be made available for all young people exposed to the suicide** – both those directly known to the person who suicided, and also those who may not have known the young person, but who may have heard about the suicide.

- **Supporting family and friends of people at-risk of suicide** is an additional component of a comprehensive suicide prevention framework.

Tailored approaches to suicide prevention for Aboriginal young people

In addition to implementing the strategies outlined above across the whole population, it is essential that a more tailored approach to suicide prevention is developed for Aboriginal and Torres Strait Islander young people.

In their report titled 'Hear Our Voices', Dudgeon et al. provide an overview of findings from various inquests, inquiries, consultations and evidence reviews relating to Aboriginal suicides in the Kimberley region over the last two decade. They also describe the many initiatives that have been implemented over the last 20 years, driven by local community members, the WA and/or Commonwealth government and their strengths and limitations.[90]

In August 2015 the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) undertook a roundtable consultation in Broome to consider the causes and potential solutions for curbing the growing number of suicides in the Kimberley region. The roundtable was co-hosted by the Kimberley Aboriginal Medical Services Council and was attended by 33 participants, the majority of whom were Aboriginal, and who came from diverse professional and community backgrounds.[91] The findings of the Roundtable reflect many of the issues and proposed solutions articulated in the 'Hear Our Voices' report.

Collectively, these reports – and other reports including those on other issues such as child abuse – highlight similar themes and propose similar principles for improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and for suicide prevention initiatives more specifically.[92] [93] [94] [95] These principles are outlined in more detail below.

Promote community ownership and self determination

A key component of Close the Gap is partnership and self-determination. Aboriginal and Torres Strait Islander people and communities repeatedly emphasise that only approaches driven within the community will be successful. Solutions must therefore be led by Aboriginal and Torres Strait Islander people and enable them to provide significant input into the design, delivery and evaluation of any proposed intervention. The role of community elders must be respected. The *Elders' Report into Preventing Indigenous Self-Harm and Youth Suicide* released in 2014 as part of the Culture is Life campaign promoting community solutions to Indigenous youth suicide advocates for support for Elders to maintain and pass on cultural knowledge to young people and reconnect them to Country.[96] It is also imperative that the voices of young people are heard and they are involved in the design and delivery of youth specific programs.[97] Wherever possible programs and services should be provided through Aboriginal community owned and controlled agencies.

Mainstream agencies, such as *beyondblue* need to work in collaboration with Aboriginal community controlled health organisations and community based service providers, peak bodies, schools, research institutes and respected peoples and Elders rather than trying to assume ownership themselves. They also need to acknowledge and respect the diversity of Aboriginal and Torres Strait Islander communities across Australian and recognise the complexities of identity and that people may identify with a number of communities.

Adopt a focus on empowerment

Aboriginal and Torres Strait Islander people stress the importance of becoming strong culturally and spiritually and establishing more equitable power relations. Aboriginal and Torres Strait Islander people need to be empowered to recognise and address sources of oppression through initiatives that promote cultural

identity, self-worth and autonomy and increase people belief in their ability to control and change their own, and their community's life circumstances by challenging social injustices. It is important to address the feelings of powerlessness that result from young people's exposure to historical and intergenerational traumas that have been left unaddressed.[98] Empowerment initiatives take a strengths based approach that focus on Aboriginal peoples' inherent strengths not deficits. They also take a bottom up, rather than top down approach, whereby support is given to the individual or the community's own solutions in addressing problems.[99]

Adopt a focus on equity

Successful initiatives must focus on addressing the social determinants that contribute to poor mental health and/or suicide including exposure to trauma, chronic illness, unemployment, homelessness, incarceration and poverty. Many Aboriginal and Torres Strait people live in crowded housing or are homeless, lack employment opportunities and live in poverty. The suicide rate among Aboriginal young people is unlikely to fall unless these issues are addressed. The principle of 'health equity' recognises that, for Aboriginal and Torres Strait Islander people to achieve comparable health outcomes to non-indigenous people, they may need more and/or different programs and services to those for non-Indigenous communities. Additional resources may be needed to reflect this different level of need.

A focus on health equity also recognises that even within Aboriginal and Torres Strait Islander communities there may be some groups who are more exposed to risk factors to suicide and need additional supports. These may include sexuality and gender diverse Aboriginal and Torres Strait people and those involved in the justice system particularly those incarcerated and recently released from incarceration. Bonson has noted that the social and emotional wellbeing of Aboriginal and Torres Strait Islander people who are sexuality and gender diverse remains relatively under-researched and he argues that their needs must be given much greater attention.[100]

Adopt a holistic focus

The risk and protective factors for Aboriginal emotional and social wellbeing are located as much at the community level as at the individual level. Identity and culture, and culturally determined relationships to land, family, kin and community are great sources of mental health and resilience to Indigenous Australians. A strengths-based, holistic approach that champions the centrality of family and kinship and connection to land, language, cultural identity and community needs to inform all relevant initiatives. The Hear our Voices project emphasised the need to rebuild self and rebuild family.[101] The participants at the ATSISPEP Kimberley Roundtable concluded that successful suicide prevention programs are those that "promote recovery and healing from trauma, stress and intergenerational loss; empower people by helping them to sense of control and mastery over their lives; and have local culturally competent staff who are skilled cultural advisors."p.4

Build capacity within Aboriginal communities

It is important that Aboriginal leaders be enabled and supported to lead community efforts and be consulted and involved in decision making about the programs and services provided in the local community. Initiatives are also required that provide opportunities for Aboriginal and Torres Strait Islander people to develop the skills to manage or deliver services on behalf of their community. This should include continued support for roles right across the health workforce including social and emotional wellbeing workers, Aboriginal Health workers and clinical and medical positions. With young people the most successful strategies use peers, youth workers and less formal community relationships to connect young people with cultural care systems. Programs that involve elders mentoring and taking young people 'On-Country' are also considered valuable by community members.

Improve cultural competency in mainstream services

While many Aboriginal and Torres Strait Islander people may prefer to utilise programs and services provided through Aboriginal community controlled agencies, many will also continue to utilise mainstream services. It is therefore critical that mainstream services provide safe and culturally appropriate services, for example by ensuring all staff are involved in cultural competency training and anti-racism initiatives. Programs need to be culturally-based and incorporate traditional elements into their content and healing processes.[102]

Clarify roles and responsibilities

Greater collaboration is required between government and communities. Dudgeon et al note that: "although many governments strongly espouse the goal of working in partnership with communities, there is ample evidence in this Report's background materials to show there is a lack of knowledge or skill about how to put this goal into practice."[103] p.51 The authors recommend that policy makers, service providers and funding groups adopt an enabling role where they support flexibility, creativity, action learning, innovation and diversity. A focus on good governance, collaboration, integration and accountability is necessary.

In each community and region and at the State level, a governance structure for suicide prevention initiatives is required that involves all key stakeholders, including young people. The governance framework should emphasise:

- the leadership role to be played by the Aboriginal and Torres Strait Islander people
- outline the structures, resources and processes which ensure that all individuals and organisations can be represented, 'have a say' and be involved in designing solutions.
- describe the decision-making processes, particularly focusing on allocating, controlling and using resources and defining project objectives, outcomes and priorities
- set clear responsibilities for all individuals and organisations involved, with mechanisms in place to track accountability

Improve access and coordination of services

As noted, many Aboriginal and Torres Strait Islander people, particularly those in remote areas, lack access to appropriate services and supports that address their emotional, social and economic wellbeing. Furthermore, in many cases the relevant services do not work effectively together. Service fragmentation is a problematic feature of the Australian mental health service system, which in part occurs because of the lack of clarity and coordination between Commonwealth and State/Territory services. It is crucial therefore that roles and responsibilities of each level of government and each stakeholder involved in suicide prevention are clearly articulated. Partnerships are also required between mainstream services and Aboriginal controlled services.

The 'social model of health' acknowledges the broad social determinants of mental health and emphasises the need to work in different settings to reduce risk factors and enhance protective factors. Working in collaboration with local communities, governments need to adopt an explicit focus on multi-sectoral action, which recognises that responsibility for mental health is across multiple portfolios – including education, employment, housing and justice – and a cross-sector rather than a health-service centric approach is likely to be more successful. Action (or inaction) in one portfolio can influence outcomes in others. It is therefore important to ensure synergy and identify opportunities to improve the efficiency and effectiveness of programs and services between different portfolios as well as between different levels of government.

Set targets and outcome measures

Initiatives should be data driven. This may require better ways to measure and monitor progress, including 'real time' data on self-harm and suicide attempts through ambulance attendance and hospital admission data, as well as ongoing information about suicide provided through the coronial system. Understanding the

incidence and risk and protective factors profiles for suicide is also important to developing meaningful prevention and intervention strategies. Accurate statistics through improved surveillance and data collection are required to support suicide prevention strategies, including their development, implementation, evaluation, and accountability for achieving outcomes.[104] The National Committee for Standardised Reporting on Suicide has identified priorities and plans for achieving standardised and accurate reporting of suicide (for more information, see: https://suicidepreventionaust.org/project/national-committee-for-standardised-reporting-on-suicide-ncsrs/). A national database, that provides standardised information across all states and territories, will improve the usefulness and impact of data on self-harm and other suicidal behaviours and deaths by suicide. As a national data collection and community consultation project led by Aboriginal and Torres Strait Islander researchers, we recommend that ATSISPEP findings relevant to the WA context be considered in relation to the needs of young Aboriginal and Torres Strait Islander people. Qualitative data is also important and mechanisms are required to gain regular feedback from program beneficiaries to ensure that any specific initiative is appropriate, responsive to people's needs, and effective.

Address gaps in the evidence base

Numerous gaps in the evidence base have been identified including: suicide risk and variation across regions and settings; effectiveness of early intervention and prevention strategies; effectiveness of treatments; and gaps in service provision and use of mental health services by at-risk groups.[105] More research is required to understand the factors specific to the Aboriginal and Torres Strait Islander people that influence the risk of suicide and how these actually contribute at an individual level and how they can be changed.[106] More controlled studies using planned evaluations and valid outcome measures are required to measure the impact of Aboriginal and Torres Strait Islander youth suicide programs.[107] For example, gatekeeper training such as Applied Suicide Intervention Skills Training (ASIST), where people are trained to recognise and identify those at risk of suicide and assist them in getting care, has been used in a number of Indigenous communities. However there is a lack of evidence about its efficacy. ATSIPEP is developing a culturally appropriate evaluation framework to measure the effectiveness and appropriateness of Aboriginal and Torres Strait Islander suicide prevention initiatives. Consideration should be given to adopting this framework to evaluate future youth suicide initiatives in WA.

Case studies

Many of the principles described above are reflected in initiatives already piloted or embedded in Aboriginal communities in WA. Dudgeon et al. provide examples of several effective initiatives.[108] While the list below is not intended to be exhaustive, it highlights some potentially useful interventions. Governments are encouraged to refer to lists of successful initiatives to inform future funding initiatives.

National Aboriginal and Torres Strait Islander Leadership Group in Mental Health (NATSILMH) consists of a core group of senior Indigenous people based in, or associated with, the Australian mental health commissions, and was launched during a two-day roundtable event held in June 2014. NATSILMH identified six steps to closing the Indigenous mental health gap (Appendix One).

Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) This project is evaluating the effectiveness of existing suicide prevention services and programs. The project is also exploring the potential of the Crisis Response Team model to respond quickly and competently to communities in need following a suicide. ATSISPEP is expected to provide a report to the Minister for Indigenous Affairs by mid-2016 making recommendations for improvements to existing services and programs, and recommendations about alternative evidenced-based service and program delivery models, where indicated by evaluation. *beyondblue* encourages the WA Government to take the recommendations of this seminal project into consideration when formulating its response to Aboriginal Youth Suicide.

National Empowerment Project works with 11 partner sites across Australia to develop and deliver local empowerment, healing and leadership programs.[109]

The Yiriman Project auspiced by the Kimberly Aboriginal Law and Culture Centre, commenced in 2000. It takes young people, accompanied by elders, on trips back to country, to immerse them in the stories, song and knowledge that are their cultural heritage. This builds young people's confidence and improves their self-worth, and is considered to have helped curb suicide, self-harm and substance abuse in the participating communities. [110] [111]

The Family Wellbeing program, which was initiated by Aboriginal people, has suitability as an approach to healing and empowerment that is able to accommodate a range of different cultural contexts, circumstances and needs and educational aspirations

The Black Rainbow project aims to support Aboriginal GLBTI youth at risk of suicide. The project provides a positive message for Aboriginal people while at the same time allowing those GLBTI Aboriginal youth with an outlet to embrace culture and themselves.

headspace began developing Yarn Safe in 2013 and in late 2014 launched the 'Got a lot going on? No shame in talking it out' Indigenous youth-led multimedia campaign. The campaign targets young Aboriginal and Torres Strait Islander young people and tackles stigma, provides information on mental health and promotes headspace services.[112]

iBobbly smartphone/tablet application was designed to support suicide prevention amongst young Indigenous people. The aim of the project is to target youth suicide risk to offer an evidence based intervention that is readily accessible, and to evaluate the effectiveness of the intervention using a randomised-controlled trial.[113]

Alive and kicking goals: Women's reference group video project (WA). This short video provides an introduction to the Alive and kicking goals suicide prevention women's reference group project. The project aims is to breathe hope back into families, communities, people and country through capacity building, resource development and peer-education (https://www.youtube.com/watch?v=yvPVnEgT33s).

The Proppa Deadly project encouraged Aboriginal and Torres Strait Islander people to take action against depression and anxiety through the telling of their own stories across the First Nations community radio sector. This was an initiative of beyondblue working with sixteen (16) radio stations, from metropolitan, regional and remote parts of the country that produced and broadcast personal stories of Aboriginal and Torres Strait Islander men and women sharing their experience and the action each undertook to combat depression and anxiety.

Mental Health First Aid Australia have developed a range of mental health and suicide prevention resources specifically designed for people working with Aboriginal and Torres Strait Islander people. These include:

- Indigenous Mental Health First Aid - Depression.
- Indigenous Mental Health First Aid - Cultural Considerations and Communication Techniques
- Indigenous Mental Health First Aid - Trauma and Loss.
- Indigenous Mental Health First Aid - Problem Drug Use.
- Indigenous Mental Health First Aid - Problem Drinking
- Indigenous Mental Health First Aid - Suicidal Thoughts and Behaviours and Deliberate Self-Injury.
- Indigenous Mental Health First Aid - Psychosis

Appendix One: NATSILMH six steps to closing the Indigenous mental health gap.

Step 1: Closing the mental health gap is recognised as a priority in Indigenous Affairs

- In addition to being important in its own right, closing the mental health gap is important to achieving the Indigenous Affairs priorities of the Australian Government (improved education, employment and community safety outcomes), as well as the COAG Closing the Gap Strategy.
- Priority status could be achieved through introducing mental health targets into the Indigenous Advancement Strategy and the Closing the Gap Strategy (i.e. for reducing psychological distress, hospitalisation for mental health conditions and suicide).
- Bi-partisan, long-term support is essential to the above.
- All existing and committed mental health and suicide prevention funds (including for the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013* and ATAPS) are quarantined from cuts.
- Justice reinvestment principles could be used to provide some of the additional resources needed for improved mental health services, particularly for Indigenous young people.

Step 2: A dedicated plan to close the Indigenous mental health gap is developed

- This should occur through the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2014-19 alongside with the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 and the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy.
- All the above are at the development or implementation stages, and there is a risk of fragmentation and overlap. A dedicated mental health plan should ensure these are implemented in a coordinated, effective and efficient manner.

Step 3: Over time, reinvestment from expensive hospital based treatment towards primary mental health services and prevention and promotion occurs

- This requires empowering, community-based solutions that are culturally appropriate and that include strengthening culture and identity.
- Mental health and SEWB teams based in Aboriginal Community Controlled Health Services (ACCHS) should provide comprehensive primary mental health care services (that include mental health promotion and prevention programs) to Indigenous communities.

Step 4: Culturally appropriate and accountable mental health services are expanded

- ACCHS are the preferred vehicle for the needed expansion of primary mental health services that are culturally appropriate and able to work with a SEWB-model.
- GPs and mainstream services should be required to provide a culturally appropriate primary mental health service and/or treatment when they come into contact with Indigenous Australians.

Step 5: Indigenous Australians are supported to transition across the mental health system

- A model for this is the Statewide Specialist Mental Health Services in Western Australia that are based in health and mental health services and work with Indigenous patients to ensure their culturally appropriate transition from communities to services and back to communities.

Step 6: Australian governments work in partnership with Indigenous mental health leaders, experts and stakeholders in relation to the above 5 steps.

- Bodies like the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, (ATSIMHSPAG), whose mandate expired in December 2014, should continue to be supported to enable the above.

Appendix Two: *beyondblue* resources, programs and services

beyondblue is funded by the Commonwealth Government and all State and Territory Governments, including the ACT, as well as through donations from individuals, philanthropy and corporate Australia. All *beyondblue* resources, programs and services are available free of charge to young people living in the ACT. Relevant initiatives are summarised below.

Aboriginal and Torres Strait Islander resources

beyondblue, in partnership with key stakeholders, has developed a suite of resources specifically for the Aboriginal and Torres Strait Islander people and communities. These include:

- Keeping strong - a flyer for Aboriginal and Torres Strait Islander people Information on the signs and symptoms of depression, and ways to find help and healing for Aboriginal and Torres Strait Islander people.
- Aboriginal and Torres Strait Islander perinatal mental health: A guide for primary care health professionals. When working with families in the perinatal period, health professionals have the opportunity to 'close the gap' and improve outcomes for Aboriginal and Torres Strait Islander people. It is important to recognise the strength and resilience of Aboriginal and Torres Strait Islander women and their families, as well as to be aware and understand the ongoing effects of inter-generational trauma and complex psychosocial issues. This fact sheet provides information for health professionals on working with women

Suicide prevention

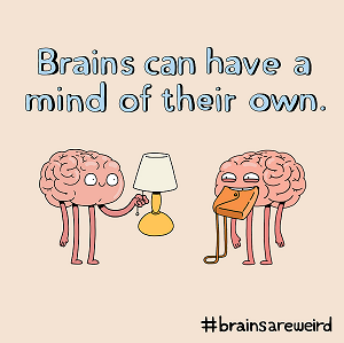
- **The *beyondblue* Support Service** – 1300 22 4636 - www.beyondblue.org.au/getsupport - this Service provides immediate, short-term, solutions-focused support and referral services via a 24/7 telephone service, web chat service from 3pm to midnight, and an email response service.
- **The *beyondblue* Way Back Support Service** – this new, innovative suicide prevention service has been developed to save the lives of one of the population groups most at-risk of suicide – those people who have attempted suicide. The Way Back Support Service delivers person-centred, non-clinical care and practical support after a suicide attempt. Support Coordinators link people who have been discharged from hospital following a suicide attempt into existing health and community-based services and informal supports. This Service is currently being trialled in the Northern Territory, with a second trial site commencing in New South Wales in early 2016 and a third site currently being established in the ACT with the support of the ACT Government.
- **The BeyondNow safety planning app** – this intervention enables people to create a digital safety plan, that includes concrete strategies to use to decrease their risk of acting on suicidal thoughts and harming themselves. This app was launched in early 2016.
- **Have the Conversation resources** – videos and written resources have been developed to help people have a conversation with someone they are concerned about, including people who are worried that someone may be thinking about suicide. These resources are currently available in Victoria. More information is available at: www.beyondblue.org.au/resources/have-the-converation
- **Family guide to youth suicide prevention** - this guide supports parents of young people who may be at-risk of suicide. It includes information and videos on the warning signs and risk factors of suicide; how to

support a young person, including getting help from a health professional; and supporting young people to be resilient. The guide is available at: www.beyondblue.org.au/resources/family-and-friends/parents-and-guardians/family-guide-to-youth-suicide-prevention

Mental health literacy, stigma and help seeking

- **youthbeyondblue** – www.youthbeyondblue.com – *beyondblue*'s website for young Australians aged 12 to 25 includes information on depression, anxiety, bullying, alcohol, self-harm and suicide. A new youthbeyondblue campaign was launched in late May 2015 on digital and social media channels, to encourage young people to find out more about depression and anxiety, reduce stigma, and encourage help seeking through completing a Brain Quiz online.

Brains can have a mind of their own – youthbeyondblue campaign – case study



The primary goal of the *beyondblue* Brains campaign was to prompt young Australians (aged 13 – 17) to act on their mental health by visiting youthbeyondblue.com to access information and resources to support their recovery. Research conducted prior to the campaign suggested that four out of five Australian teenagers think people their age may not seek support for depression or anxiety because they're afraid of what others will think of them. The brain aimed to show teenagers that experiencing depression or anxiety doesn't mean they are weak or weird, it simply means that their mind is giving them a hard time, and there's something they can do about it. The campaign not only aimed to de-stigmatised mental health, but also convert symptoms into compelling reasons to seek help.

The five animations – built around five different symptoms of depression or anxiety – depict a world where teenagers are constantly disrupted, harassed and provoked by their own brains. Producing something that was genuinely entertaining would encourage young people to own and share the content. The aim wasn't to scare people into action – nor was it to trivialise mental health conditions – but to normalise the issue, giving youth permission to investigate their symptoms.

Paid channels utilised for the campaign included YouTube, mobile advertising, XBOX video, Facebook, Twitter and Snapchat – making *beyondblue* the first not-for-profit organisation in Australia to advertise via that channel. To support the campaign, *beyondblue* created social media accounts for The Brain himself. This amplified The Brain's subversive, cheeky character and provided content that young people could relate to and wouldn't feel threatened to engage with.

Overall, the campaign resulted in significant and positive results. There was a 231 per cent increase in web traffic to youthbeyondblue.com in June 2015, and there were 23,675 Brain Quiz (K-10 checklist) completions in June, meaning almost one in four visitors to the site completed the quiz. Feedback from the target audience has also been positive, with young people openly commenting that they relate to the brain situations depicted and are using the videos to explain to friends and family what they're going through.

The Brains campaign demonstrates how *beyondblue* not only increases awareness and understanding of depression and anxiety, but also reduces the stigma associated with these conditions, and gives people the tools to learn more and most importantly, take action to get the help they need.

- **Information and resources** – *beyondblue* has an extensive range of free resources which focus on improving the mental health of every person, at every stage of life. These resources aim to increase awareness and understanding of depression and anxiety, and give people the confidence and skills to

talk about these conditions**. Tailored resources for parents are available**, which includes information to support pregnancy and early parenthood; how to support healthy child development and respond effectively to children experiencing emotional or behavioural difficulties; managing relationship breakdowns and separation; and a guide to support parents of young people who may be at-risk of suicide. Further information is available at: www.beyondblue.org.au/resources/family-and-friends/parents-and-guardians

- **Davo's Man Therapy campaign** – this campaign encourages blue-collar males in regional areas of Australia to take action against depression and anxiety. At www.mantherapy.org.au men can assess their wellbeing, get answers to frequently asked questions about mental health and receive action-oriented advice on dealing with depression and anxiety.
- **The STRIDE project** – *beyondblue*, with funding from The Movember Foundation, has commissioned six research partnerships to demonstrate the impact of digital interventions to reduce the stigma of anxiety, depression, and/or suicide in Australian men aged 30 to 64 years. More information is available at: https://www.beyondblue.org.au/about-us/programs/mens-program/program-activities/reducing-stigma-in-men

Intervention and recovery support

- **SenseAblity** – this strengths-based resilience program is designed for those working with young Australians aged 12 – 18 years. It includes a suite of modules developed to enhance and maintain emotional and psychological resilience. To date, approximately 1,820 secondary schools have ordered the SenseAbility program, which represents approximately 66 per cent of all schools nationally.
- **The Brave Program** – https://brave4you.psy.uq.edu.au – the BRAVE Program is a free, online evidence-based program that helps prevent and treat anxiety in young people aged between eight and 17 years. The program is made up of 10 interactive sessions which use cognitive behaviour therapy techniques to teach young people and their parents how to manage anxiety. The program was developed by the University of Queensland, with funding from *beyondblue*.
- **Online forums** – www.beyondblue.org.au/connect-with-others/online-forums - *beyondblue's* online forums provide an opportunity to receive peer support. There are over 30,000 members of *beyondblue's* forums and an average of 40,000 visitors per month. Research on the impact of the forums has demonstrated that the forums help people to feel less depressed or anxious, encourage people to contact a health professional, and support people to make positive lifestyle changes.
- **Self-management tools and resources** – through the **youthbeyondblue website** young people can learn about depression and anxiety, complete an online depression and anxiety checklist (K-10), and be directed to information and support to help them in their recovery.
- **Low and brief-intensity interventions** – the ***beyondblue* Support Service** provides immediate, short-term, solutions-focused support and referral services via a 24/7 telephone service, web chat service from 3pm to midnight, and an email response service. The *beyondblue* pilot **NewAccess program** is helping people with mild to moderate depression or anxiety to lead their own recovery, prevent their problems from getting worse, and stay out of the health system. It is also creating a new workforce of mental health coaches that can take the pressure off GPs, psychologists and allied mental health workers. Services such as NewAccess will be fundamental in transforming our mental health system, as they will prevent the onset and escalation of mental health conditions, and reduce the burden on higher intensity services. NewAccess is currently being piloted and evaluated in three regions across Australia – Canberra, metropolitan Adelaide, and North Coast New South Wales.

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