Closing the gap
clearinghouse

Australian Government

Australian Institute of Health and Welfare

Australian Institute of Family Studies

Strategies to minimise the incidence of suicide and suicidal behaviour

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Summary

What we know

- The mental health and wellbeing of Aboriginal and Torres Strait Islander people has been severely affected by the impact of colonisation, relocation of people to missions and reserves, transgenerational grief and trauma resulting from the removal of children, racism and continued socioeconomic disadvantage.

- Suicide is an extremely distressing event that can profoundly disrupt the family, friends and communities of those who take their own lives.

- The Indigenous suicide rate is not accurately known due to quality issues with Indigenous deaths data and Indigenous population estimates. Available data indicate that the Indigenous suicide rate is about double that of the non-Indigenous population.

- Almost 4 in 5 Indigenous people who complete suicide are males, with the highest suicide rates occurring in younger age groups.

- Indigenous suicide can be associated with alcohol or other drug use and chronic mental illness, so these are appropriate targets for intervention.

- There are few evaluations of Indigenous-specific suicide prevention programs in Australia. A number of effective non-Indigenous-specific programs have been shown to be culturally appropriate and acceptable to Indigenous people.

What works

- Community programs that focus on the social, emotional, cultural and spiritual underpinnings of community wellbeing can be effective in preventing suicide.

- A culturally adapted brief intervention comprising motivational care planning, has been effective in improving wellbeing and decreasing alcohol and cannabis dependence among Indigenous people with chronic mental illness, in three remote communities in northern Australia.

What doesn't work

- Programs that are not culturally competent and do not have a high level of Indigenous ownership and community support are unlikely to be effective.

What we don't know

- How important Indigenous language retention is in preventing youth suicide in Australia.

- How effective good practice Indigenous-specific programs, such as Alive and Kicking Goals!, Indigenous Mental Health First Aid and Indigenous community gatekeeper training, are in preventing suicides.

- To what extent Indigenous people at risk of suicide use telephone crisis lines and web-based counselling services and forums.

- How effective non-Indigenous specific holistic mental health services (such as headspace) are in treating mental illness among Indigenous young people.

- Whether providing long-term follow-up care to Indigenous people who have attempted suicide or have been discharged from acute mental health care prevents suicides.

- Whether training primary health care practitioners to better recognise and treat depression prevents Indigenous suicides.

- Whether screening programs such as Signs of Suicide can be culturally adapted for Indigenous people.

> Some of the content in this resource sheet may cause sadness and/or distress to the reader. If you need support, please call Lifeline on 13 11 14.

Introduction

This resource sheet provides a review of policies and programs that aim to prevent suicide and suicidal behaviour. Suicidal behaviour refers to actions that can result in death, such as taking an overdose or deliberately crashing a car. The scope of this resource sheet does not include self-injury that is part of the cultural grieving process ('sorry business').

While it is known that high levels of mental health and wellbeing decrease the risk of suicide (Zubrick et al. 2005), programs to promote mental health and wellbeing are also not considered in this resource sheet, as they are the subject of a separate resource sheet *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people* (CtG 2013). Effective mental health promotion programs include cultural healing programs, culturally appropriate mental health services and the Indigenous Hip Hop program. Also important are Indigenous adaptations of effective mainstream programs such as the Resourceful Adolescent Program, MindMatters (a mental health promotion program for secondary schools) and the Triple P-Positive Parenting Program.

Suicide is strongly associated with the use of alcohol and other drugs (Hanssens 2008; Hunter et al. 1999; OSCWA 2008). Strategies to reduce alcohol and other drug-related harm are also not included as they are the subject of a separate resource sheet *Reducing alcohol and other drug related harm* (Gray & Wilkes 2010).

This resource sheet considers suicide prevention policies and programs that have been implemented in both remote and non-remote parts of Australia and internationally. It assesses their strengths and limitations and their actual, or likely, effectiveness in relation to Indigenous Australians.

Background

The impact of colonisation, relocation of Indigenous people to missions and reserves, the grief and trauma resulting from the removal of children, ongoing racism and continued socioeconomic disadvantage have had severe effects on the mental health and wellbeing of Aboriginal and Torres Strait Islander people (Swan & Raphael 1995). Trauma can also have transgenerational effects whereby traumatised people may behave in dysfunctional and violent ways, which then contribute to traumatising subsequent generations (Atkinson 2002). The Clearinghouse resource sheet *Trauma-informed services and trauma-specific care for Indigenous Australian children* provides further information on the effects of trauma (Atkinson forthcoming).

Suicide is an extremely distressing event that can have profoundly disruptive effects on the family, friends and communities of those who take their own lives (Purdie et al. 2010). While suicide is believed to have been a rare occurrence among Indigenous Australians in pre-colonial times, since the late 1970s it has become increasingly prevalent and is now an issue of major concern for many Indigenous communities (Elliott-Farrelly 2004; Hunter et al. 1999).

The incidence of suicide among Indigenous people is known to be substantially higher than for the non-Indigenous population, but the exact difference is difficult to establish conclusively. This is due to data quality issues with Indigenous deaths data and Indigenous population estimates (ABS 2012).

Based on data collected over 10 years from 2001 to 2010 from New South Wales, Queensland, South Australia, Western Australia and the Northern Territory, the Australian Bureau of Statistics (ABS) estimates that the Indigenous suicide rate is approximately double the non-Indigenous rate. The rate for Indigenous males was 33.0 per 100,000 compared with 16.5 for non-Indigenous males, while the rate for Indigenous females was 8.7 per 100,000 compared with 4.5 for non-Indigenous females (ABS 2012).

Data from the Queensland Suicide Register for the period 1994 to 2006 indicate that the difference is somewhat smaller, with the Indigenous suicide rate in Queensland being 70% higher than the non-Indigenous rate (De Leo et al. 2011).

The ABS data showed that almost 4 in 5 (79%) of the Indigenous people who died by suicide were male (ABS 2012). Indigenous suicide rates (per 100,000) for young males aged 15–19 (43.4) and 20–24 (74.7) were 4.4 and 3.9 times the corresponding rates for non-Indigenous males. Suicide rates (per 100,000) for Indigenous females aged 15–19 (18.7) and 20–24 years (21.8) were 5.9 and 5.4 times the corresponding rates for non-Indigenous females (ABS 2012).

From 25 years of age, the difference between Indigenous and non-Indigenous suicide rates decreases progressively with increasing age. Indigenous people aged 45 and older have similar suicide rates to non-Indigenous people (ABS 2012).

Trends in Indigenous suicide rates cannot be accurately estimated (ABS 2012), however available data indicate that the Indigenous suicide rate is unlikely to have declined significantly from 2001 to 2010. In contrast the non-Indigenous suicide rate has decreased significantly over this period (AIHW 2013a).

Because of variations in the quality of Indigenous identification data by geographical classification, Indigenous suicide rates in major cities cannot be reliably compared with rates in regional and remote areas (AIHW 2013b).

Between July 2006 and June 2008, Indigenous people were hospitalised for injuries related to intentional self-harm (including suicidal behaviour) at 2.3 times the rate for other people. The rate for Indigenous males was 2.7 times the rate for other males and for Indigenous females the rate was 2.0 times that for other females (AIHW 2011).

Available statistics in relation to Indigenous deaths by suicide and hospitalisations for intentional self-harm are summarised in Table 1.

Strategies to minimise the incidence of suicide and suicidal behaviour

Table 1: Summary of available statistics and data quality issues in relation to Indigenous suicide rates and hospitalisations for intentional self-harm

Comparison of Indigenous and non-Indigenous suicide rates	Because of the under-identification of Indigenous people in deaths data and the uncertainties inherent in estimating the size and structure of the Indigenous population, accurate comparisons cannot be made between Indigenous and non-Indigenous suicide rates across Australia (ABS 2012)
	While noting the above caveat, available data from New South Wales, Queensland, Western Australia, South Australia and the Northern Territory for the period 2001–10 indicate that the Indigenous suicide rate is likely to be approximately twice the non-Indigenous rate (ABS 2012)
	Based on data for the period 1994–2006, the Indigenous suicide rate in Queensland is estimated to be 70% higher than the non-Indigenous rate (De Leo et al. 2011)
Ratio of male to female Indigenous suicide rates	Almost four to one[a] (ABS 2012)
Suicide rates of young people aged 15–24	The Indigenous suicide rates for 15–19 and 20–24 year olds are estimated to be 4.4 and 3.9 times the non-Indigenous rates respectively for males and 5.9 and 5.4 the non-Indigenous rates respectively for females[a] (ABS 2012)
Suicides by people aged 25 and older	The suicide rates for Indigenous people aged between 25 and 44 decreases progressively with increasing age (ABS 2012)
	For men aged between 25 and 29, the Indigenous suicide rate is approximately four times the non-Indigenous rate, decreasing to 1.8 times the non-Indigenous rate for those aged between 40 and 44[a] (ABS 2012)
	For women aged between 25 and 29, the Indigenous suicide rate is 3.4 times the non-Indigenous rate, decreasing to 1.2 times the non-Indigenous rate for those aged between 40 and 44 [a] (ABS 2012)
	Indigenous people aged 45 and older have similar suicide rates to non-Indigenous people[a] (ABS 2012)
Trends over time in Indigenous and non-Indigenous suicide rates	Because of the under-identification of Indigenous people in deaths data and the uncertainties inherent in estimating the size and structure of the Indigenous population over time, trends in Indigenous suicide rates cannot be accurately estimated (ABS 2012)
	While noting the above caveat, available data indicate that the Indigenous suicide rate is unlikely to have declined significantly over the period 2001–10 (AIHW forthcoming a)
	In contrast, the non-Indigenous suicide rate has decreased significantly over this period, from 12.4 deaths per 100,000 population in 2001 to 9.9 deaths per 100,000 population in 2010 (AIHW 2013a)
Geographic comparisons	Because of variations in the quality of Indigenous identification data by geographical classification, Indigenous suicide rates in major cities cannot be reliably compared with rates in regional and remote areas (AIHW forthcoming b)
Hospitalisations for injuries related to intentional self-harm	Indigenous people are hospitalised for injuries related to intentional self-harm (including suicidal behaviour) at 2.3 times the rate for other people. The rate for Indigenous males is 2.7 times the rate for other males and for Indigenous females, the rate is 2.0 times that for other females (AIHW 2011)

(a) Based on data from New South Wales, Queensland, Western Australia, South Australia and the Northern Territory 2001–10.

Strategies to minimise the incidence of suicide and suicidal behaviour

The high Indigenous suicide rate is believed to be due to risk factors such as poverty, low employment rates, reduced access to services, high rates of imprisonment and domestic violence and issues associated with alcohol and other drugs, as well as trauma and grief resulting from discrimination, removal of children, the premature deaths of community members and loss of cultural identity (DoHA 2007b).

Appendix B summarises some characteristics of Indigenous suicide in Queensland, the Northern Territory and Western Australia.

Recent government initiatives

The section below provides further context for the reader regarding a range of national initiatives in place to promote the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These initiatives are not examined within the body of the paper because they have not been evaluated or do not have publicly available evaluations.

The Aboriginal and Torres Strait Islander Healing Foundation

The community-based healing programs supported by the Aboriginal and Torres Strait Islander Healing Foundation aim to improve emotional wellbeing of Indigenous people, in particular members of the Stolen Generations, and to provide appropriate training for people delivering the healing. The Foundation has been funded for four years until 2012–13.

Programs supported by the Foundation aim to prevent suicide and improve mental health in Indigenous communities by providing healing services and access to traditional healing, education about trauma and how to manage grief and loss more effectively, as well as a professional workforce that can better respond to loss, grief and trauma in these communities.

Since its establishment in 2009, the Foundation has supported 323 wellbeing initiatives, 569 cultural activities and another 692 activities that promote pride in culture. Topics addressed include suicide prevention, depression, violence, incarceration, substance abuse, intergenerational trauma and pathways to healing.

Renewal of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework

The Commonwealth Department of Health and Ageing is leading the renewal of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework, and a cross jurisdictional and expert working group is guiding its development. The Framework is expected to be finalised in early 2013, after an extensive consultation process.

Aboriginal and Torres Strait Islander Suicide Prevention Strategy

The 2010 Senate Inquiry report *The Hidden Toll: Suicide in Australia* called for the development of a separate suicide prevention strategy for Aboriginal and Torres Strait Islander communities within the National Suicide Prevention Strategy.

In response, the Australian Government established the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group in September 2011, to guide the development of a strategy that:

• specifically aims to reduce suicide rates within the Aboriginal and Torres Strait Islander population

• promotes mental health and suicide prevention awareness, suicide prevention activity for all Aboriginal and Torres Strait Islander people and early intervention for Aboriginal and Torres Strait Islander children and young people

- addresses the impact and prevalence of suicide, and particularly suicide clusters, within Aboriginal and Torres Strait Islander communities

- encourages the improvement of the evidence base around Aboriginal and Torres Strait Islander suicide prevention and social and emotional wellbeing

- informs the development of practical and evidence-based resources

- guides future investment around community-based Aboriginal and Torres Strait Islander suicide prevention activities.

Taking Action to Tackle Suicide

The Mental Health: Taking Action to Tackle Suicide (TATS) package is part of the Australian Government's increased effort in suicide prevention, which aims to reduce the tragic toll suicide imposes on individuals, families and communities. As part of the TATS package, $30.2 million in funding is being provided over four years from 2011–12, for the Supporting Communities to Reduce the Risk of Suicide initiative, to support community-led suicide prevention activities that target groups and communities at high risk of suicide, including Indigenous Australians.

Suicide prevention policies

A review of the impact of national suicide prevention strategies in a number of European countries, Canada, the United States, New Zealand and Australia found they were generally associated with decreased suicide rates among young people and men in general, but not women (Martin & Page 2009). The review did not investigate the reasons or mechanisms for this association, or the impact of suicide prevention strategies on Indigenous suicide rates.

Australia's National Suicide Prevention Strategy (NSPS) has four key inter-related components:

- the Living Is For Everyone (LIFE) Framework

- the National Suicide Prevention Strategy Action Framework

- the National Suicide Prevention Program

- a plan for collaborative government action in mental health (DoHA 2012b).

An independent process evaluation of the NSPS was undertaken in 2005, but only the summary evaluation report is publicly available. This report states that the NSPS funded 27 national projects and more than 150 community-based projects, of which 29% identified Aboriginal and Torres Strait Islander people as a primary target group (Urbis Keys Young 2006).

The evaluation was based on an analysis of NSPS funding and activities, a review of material on funded projects, evaluation reports on seven national projects and two clusters of community-based projects, consultations with approximately 100 stakeholders, written submissions, a literature review and analysis of suicide data (Urbis Keys Young 2006).

The evaluation concluded that the NSPS was widely supported by stakeholders, who considered it appropriate to address community need. A New South Wales cluster evaluation found some projects targeting Indigenous communities improved community understanding about mental health. The evaluation concluded that stronger evidence regarding the impact and outcomes of NSPS-funded projects was required (Urbis Keys Young 2006).

A separate review of 156 projects funded under the NSPS was also undertaken, using individual project reports as the primary data source. This review found evaluations in project reports were methodologically too weak to contribute much to the evidence base in suicide prevention. Most of the evaluations were retrospective

opinion-gathering exercises on participant satisfaction with specific activities. Very few involved any data collection on suicide-related outcomes, and fewer still involved any comparison group (Headey et al. 2006).

An evaluation framework for the National Suicide Prevention Program was developed in 2012, comprising agreed data collections, information sharing between projects and performance indicators (DoHA personal communication). A national Indigenous-specific suicide prevention strategy is also currently being developed under the guidance of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group (DoHA 2012a).

Cultural continuity and youth suicide

The rate of Aboriginal youth suicide among the almost 200 Aboriginal communities in British Columbia (Canada) has been found to be extremely variable. During the period 1987–2000, more than 90% of suicides were found to be concentrated in 10% of the communities, while more than half of the communities experienced no suicides (Chandler & Lalonde 2003).

Community suicide rates were not found to be significantly correlated with the location (urban/rural/remote) or the socioeconomic status of the community. However, suicide rates were lower in communities that had achieved a measure of self-government, had title to traditional lands, had a cultural centre and were in control of their community services (Chandler & Lalonde 2003).

Indigenous language retention was an additional marker of cultural continuity that was strongly and independently correlated with suicide rates. Communities in which at least half of the members had a conversational knowledge of their native language experienced no or very low numbers of youth suicides over the period for which data were available, from 1987–2000 (Hallett et al. 2007).
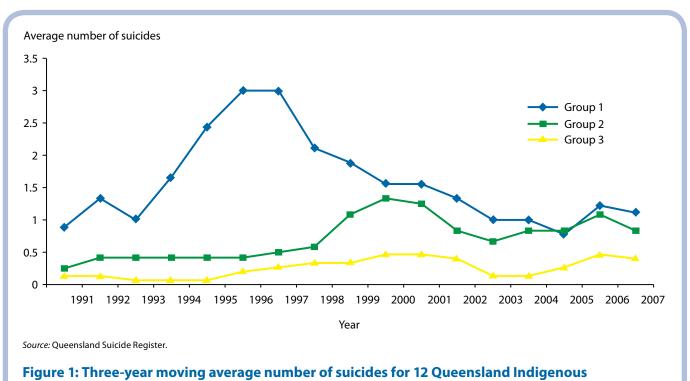
While Canada's First Nations people and Australia's Indigenous people experienced different histories of colonisation, which may result in different legacies of trauma, there is some indication that cultural continuity may also be a protective factor against youth suicide in Australia. The Western Australian Aboriginal Child Health Survey found fewer children whose primary carers were conversant in an Aboriginal language were at high risk of clinically significant emotional or behavioural difficulties. About one in six children (17%) whose primary carers were conversant in an Aboriginal language were at high risk, compared with about one quarter of children whose primary carers knew a few words of an Aboriginal language (28.7%), or did not speak an Aboriginal language (24%) (Zubrick et al. 2005). Whether this translates into decreased youth suicide rates has not been established.

Data on the annual number of suicides in 12 Indigenous communities in Far North Queensland between 1990 and 2008 were obtained from the Australian Institute for Suicide Research and Prevention (AISRAP personal communication). Comparable data were not available for other states or territories.

The Queensland communities were divided into three groups based on the annual number of suicides:

• Group 1: (three communities) experienced 24 or more suicides, with up to six suicides occurring in some years

• Group 2: (four communities) experienced between nine and 16 suicides, with up to three suicides occurring in some years

• Group 3: (five communities) experienced eight or fewer suicides, with a maximum of one suicide in any year. Note that one of these communities experienced no suicides over the entire 19-year period.

Figure 1 shows the average number of suicides per year for the three groups of communities. Three-year moving averages have been used to reduce the annual variability in the data.

Source: Queensland Suicide Register.

Figure 1: Three-year moving average number of suicides for 12 Queensland Indigenous communities, by community group

Over the 19-year period, Group 3 communities experienced fewer suicides than those in Groups 1 and 2, however it is not known whether this was due to cultural continuity or other factors. Furthermore, it is not known whether suicide data for Indigenous communities in other parts of Australia shows a similar pattern of grouping.

The characteristics of Australian Indigenous communities with low youth suicide rates may provide useful guidance on what strategies are likely to be effective in preventing youth suicide.

Effective suicide prevention programs

There are three types of suicide prevention programs—those that build resilience, crisis intervention programs and postvention programs. The Clearinghouse resource sheet *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people* (CtG 2013) provides information on effective programs that build resilience. This resource sheet focuses on crisis intervention and postvention programs.

Crisis interventions include providing mental health first aid, counselling someone who is at imminent risk of attempting suicide (either in person, via telephone crisis lines or the internet), and providing acute psychiatric care.

Postvention programs provide assistance to families, friends, schools, communities and others who have recently been affected by suicide. They aim to reduce distress and prevent psychological disorder and further suicides. Postvention programs are considered to be particularly relevant for small inter-related communities, such as Indigenous communities (APS 1999).

Crisis and postvention programs operate at one or more of the following four levels: the individual (such as providing crisis and counselling services), the family (such as providing support for families after a suicide), the community (such as community development programs and school support programs following a suicide) and

society (such as social justice programs). While the socio-psychological legacy of colonisation places Indigenous communities at increased risk, effective suicide prevention programs can reduce the likelihood of this risk leading to suicidal behaviour, even in the face of continuing social disadvantage (Hunter et al. 1999).

Indigenous-specific programs

There are few evaluations of Indigenous-specific suicide prevention programs in Australia. The Australian Psychological Association notes:

> Notwithstanding the acknowledged problems of undertaking program evaluation or outcome research, this is clearly a priority in a confusing cross-cultural domain where multiple contextual and situational health determinants complicate any simple causal picture, and where the efficacy of many programs has been called into doubt (APS 1999:33–34).

A similar issue has been identified in Canada:

> There is a gap in knowledge about what actually works in the area of suicide prevention. With regard to First Nations populations, we lack rigorous evaluations of programs and interventions as well as basic epidemiological information on risk and protective factors at the individual and community levels (Health Canada 2003:39).

There are however, several Australian Indigenous programs that have either been shown to be effective in reducing the number of suicides, or have increased the awareness, knowledge and capacity to respond, of community members, peer mentors and service providers.

Yarrabah Family Life Promotion Program—an effective suicide prevention program

In response to the high number of suicides in Yarrabah, Far North Queensland, the community identified suicide as a 'community issue' and an urgent priority in the early 1990s. Initially the focus was on crisis clinical support for individuals at risk of suicide, however over the next 2 years there was a gradual shift to a broader approach that focused on community wellbeing (Hunter et al. 1999).

A component of the program evaluation involved comparing the number of suicides in Yarrabah with the numbers in two comparison communities over the period 1990–96. Based on the results of this analysis, the Yarrabah Family Life Promotion Program was found to be effective in preventing suicides (Hunter et al. 1999).

Data obtained from the Australian Institute for Suicide Research and Prevention for the period 1990–2008 enabled investigation of the longer-term impact of the program (AISRAP personal communication). The data show that after the implementation of the program, there were no suicides in Yarrabah between 1997 and 2000. Between 2001 and 2008 there were seven suicides, but fewer than before the implementation of the program, when 17 suicides occurred between 1990 and 1996.

Prior to 1996, more suicides occurred in Yarrabah than in the two comparison communities, but between 1997 and 2008 there were fewer suicides in Yarrabah than in either comparison community.

While the small sample sizes mean that tests of statistical significance are inconclusive and firm conclusions cannot be drawn regarding the effectiveness of the program in preventing suicides, the trends in Yarrabah and the two comparison communities indicate that the Yarrabah Family Life Promotion Program is promising.

Two programs that have not been rigorously evaluated, but suggest good practice are:

- **Alive and Kicking Goals!** is a project piloted in the Kimberley, Western Australia. It aims to prevent Indigenous youth suicide through the use of football and peer education. Volunteer youth leaders, who are well-respected sportsmen, undertake training to become peer educators. They educate young people in communities about suicide prevention and lifestyle, and demonstrate that seeking help is not a sign of weakness. At the conclusion of the pilot, 16 young men had become peer educators (Tighe & McKay 2012). The project is ongoing, but its impact on suicide numbers has not been evaluated.

- **Indigenous suicide prevention training forums** attended by Indigenous people and service providers in the Kimberley and North West regions of Western Australia have been shown to increase attendees' knowledge of depression and suicidal behaviour, their skills in working with depressed and suicidal Aboriginal people and their intentions to help (Westerman & Hillman 2003). While these results were presented as a poster at a suicide prevention conference, rather than in a peer reviewed journal, *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Purdie et al. 2010) identified the forums as providing culturally appropriate training in suicide prevention. The forums were also identified as promising in the literature review *Current approaches to Aboriginal suicide prevention* (Kirmayer et al. 2009).

Effective non-Indigenous-specific suicide prevention programs

The following programs have been evaluated and shown to be effective or promising strategies in the prevention of suicide for the general population. Some of these programs have been implemented with Indigenous populations and found to be culturally appropriate and acceptable to participants and service providers. For the remaining programs, further research is needed to test their effectiveness for Indigenous populations.

Programs to assist those who have attempted suicide

People who have attempted suicide are at high risk of making another attempt. Providing long-term follow-up care to people after a suicide attempt is one of the most effective strategies for suicide prevention (Beautrais et al. 2007).

Psychiatric patients are at particular risk of suicidal behaviour immediately following discharge from in-patient care or emergency departments, especially if they had been suicidal or were involuntary admissions (DoHA 2008).

Examples of effective programs to assist people who have attempted suicide, include sending them postcards after discharge from hospital following a suicide attempt (Carter et al. 2005), providing a 'green card' for emergency access to mental health services (Morgan et al. 1993) and employing counsellors to co-ordinate follow-up services (Beautrais et al. 2007). The applicability and effectiveness of these programs in relation to Indigenous people are not known.

Crisis responses

Mental Health First Aid (MHFA) is help provided to someone who is developing a mental health problem or in a mental health crisis. The MHFA training program was developed to improve the mental health literacy of the Australian community and has been evaluated via a longitudinal study, two randomised controlled trials and qualitative studies. It has been shown to increase participant knowledge of mental health problems, improve their attitudes toward people who experience these problems and increase their helping behaviours. Helping behaviours include asking if the person is suicidal and taking action, listening non-judgementally, giving support and information and encouraging them to get professional help (Kitchener & Jorm 2006).

An Indigenous adaptation of the MHFA training program has been developed under the direction of a reference group, comprising Indigenous health professionals and non-Indigenous health professionals, who specialise in Indigenous mental health and wellbeing. Between March 2007 and November 2008, 199 Indigenous instructors were trained in 17 five-day courses that have been delivered in all Australian states and territories. By November 2008,

trained Indigenous instructors had conducted 155 MHFA courses in their communities. These 14 hour courses were attended by 1,115 participants (Jorm & Hart 2008).

Both the 5 day Indigenous-specific MHFA instructor training program and the 14 hour MHFA community training program were found to significantly increase participants' mental health knowledge and confidence to help people with mental illness (Jorm & Hart 2008). Participants in both training programs stated that the programs were culturally appropriate, empowering for Indigenous people and provided information that was relevant and important (Kanowski et al. 2009).

Suicide crisis lines can be effective in reducing suicidality, hopelessness and psychological pain. A United States study found significant decreases in suicidality during the course of the telephone session, with continuing decreases in hopelessness and psychological pain after 3 weeks. The sample size was 1,085 suicidal callers, of whom 380 agreed to receive a follow-up call after 3 weeks. The 380 callers followed up were aged between 18 and 72. Females represented 70% of callers and 30% were male. Of these, 66% were 'White', 15% were African American, 10% were Hispanic and 3.5% were Native American (Gould et al. 2007).

An Australian study also found significant decreases in suicidality and significant improvements in mental state during the course of telephone counselling sessions provided to 101 children and young people by Kids Helpline counsellors. Of these, 20% were male and 79% were female (King et al. 2003). No other demographic information was collected, so the number or proportion of Indigenous callers is not known.

Kids Helpline now also provides counselling services via email and over the web. In 2010, the service provided counselling to over 60,000 children and young people and some assistance to a further 200,000 others. Only 1% of the counselling sessions in 2010 were with children and young people who identified as Indigenous. Mental health was the most common concern for Indigenous children and young people (Kids Helpline 2010). There has been no published evaluation of the effectiveness of Kids Helpline in assisting Indigenous children and young people to resolve mental health and other issues.

Web-based counselling services and forums may have the potential to assist people and to supplement clinical services. An Australian survey of more than 8,000 young people aged 15–24 found that after family and friends, young people turn to the internet for support. ReachOut!, a web-based mental health service for young people, has been accessed over six million times since its launch in 1998. Online profiling of 1,432 young people conducted in 2006, found that 37% visited ReachOut! at least once a week, and one-third stayed on the site for 20 minutes or longer. Of 279 professionals who completed an online survey, 79% rated the site as an excellent or very good resource to complement their clinical practice (Burns et al. 2007). The number of Indigenous people who access ReachOut! or similar services is not known.

Gatekeeper training

There is strong evidence about the effectiveness of programs that train community members, health centre staff, teachers, police, prison and juvenile detention centre staff, clergy and others to act as 'gatekeepers' by identifying people at risk of suicide and referring them to appropriate services (Beautrais et al. 2007).

The US Air Force Suicide Prevention Program was an integrated program aimed at removing the stigma associated with seeking help for mental health problems, increasing understanding of mental health and changing policies and social norms. It included gatekeeper training, leadership awareness education, improved referral systems and the establishment of multidisciplinary postvention teams. The program resulted in a sustained decline in the number of suicides, as well as decreases in family violence, accidental deaths and homicide (Knox et al. 2003). The impact of the gatekeeper training component of the program could not be assessed separately from the other components.

Applied Suicide Intervention Skills Training (ASIST) is a Canadian-developed gatekeeper training program that is delivered in Australia by a number of organisations, including Lifeline and the Ozhelp Foundation. Evaluations of ASIST found that trainees increased their knowledge and skills after the training, compared with non-trainees. Some trainees also reported increased interventions with people at risk of suicide (Rodgers 2010). ASIST-trained

school personnel reported fewer known suicide attempts than school personnel who had received another type of training and those in the control group. However, as trainees were not randomly assigned to the training and control groups, the results may have been caused by factors other than the training program (Williams et al. 2006).

A 2 year follow-up of 40 participants in **community gatekeeper training workshops** in an urban Indigenous community found that participants' intentions to help, and confidence in their ability to identify someone at risk of suicide, remained high. Fifteen of the participants reported that they had helped someone at risk of suicide since attending the workshops (Deane et al. 2006).

Treating mental illness

The international literature indicates that mental illness is a contributory factor in up to 90% of suicides (Beautrais 2006; DoHA 2008; Mann et al. 2005). It is estimated that up to 40% of Australian Indigenous young people aged 13–17 will experience some form of mental illness in their lifetime (Westerman 2010). The combination of depression and alcohol dependence often leads to suicidal behaviour (Sher 2006).

As there are often cultural differences in communication styles and understandings about health between Indigenous and non-Indigenous people, it is essential that any assessment of an Indigenous person's mental health be undertaken in a cultural context (DoHA 2007). A number of culturally appropriate processes and resources have been developed, including the Mental Health Stay Strong Care Plan Package, a guide for the assessment and management of chronic mental illness among Indigenous people (Menzies School of Health Research 2010).

Training primary health care practitioners to better recognise and treat depression has been shown to decrease suicide rates (Beautrais et al. 2007). A postgraduate educational program on the diagnosis and treatment of depression offered to all general practitioners in Gotland (an island province of Sweden) resulted in a significant decline in the number of suicides. However, a follow-up study undertaken 3 years after the training ended, found the number of suicides had returned almost to the pre-program level. The results suggest that GP educational programs can have a pronounced effect on suicide numbers but have to be repeated approximately every 2 years to achieve a sustained impact (Rutz et al. 1992). The impact on Indigenous suicide rates of training primary health care practitioners to better recognise and treat depression has not been investigated.

The **headspace** program provides support, information and assistance to young people aged 12–25 who are experiencing emotional or mental health issues, including substance abuse. Services are provided in 45 locations in metropolitan, regional and remote Australia. Staff includes youth workers, psychologists, social workers and alcohol and other drug workers (headspace 2012).

An evaluation of headspace found that the service increased the number of young people who accessed mental health services at an early stage of their illness and overall. The evaluation concluded that headspace is effective in improving some young people's mental and physical health, in decreasing their use of alcohol and other drugs and in increasing their engagement with education and work (Muir et al. 2009).

While about one in ten (9.5%) of the headspace clients identified as Indigenous, their outcomes were not analysed separately, so no conclusions can be drawn regarding the effectiveness or cultural appropriateness of the service for Indigenous children and young people with a mental health issue (Muir et al. 2009).

Motivational care planning

A culturally adapted brief intervention comprising motivational care planning has been shown to be effective in improving wellbeing and decreasing alcohol and cannabis dependence among Indigenous people with a chronic mental illness, in three remote communities in northern Australia (Nagel et al. 2009). Details of this project are contained in the Clearinghouse resource sheet *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people* (CtG 2013).

School-based suicide prevention programs

School-based mental health promotion programs have been shown to be effective in promoting resilience among young people. Details of how, why and under what circumstances are contained in the Clearinghouse resource sheet *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people* (CtG 2013).

International reviews of school-based programs that aim to raise student awareness of suicide have found insufficient evidence to conclude that they are effective in preventing suicidal behaviour (Beautrais et al. 2007; Guo & Harstall 2002; Mann et al. 2005). The American College of Preventive Medicine concluded that:

> Blanket educational seminars to all high school students have not been shown to be effective in suicide prevention. In fact they may be counter-productive in some instances, with some suggestion that suicidal adolescents can be disturbed by these classes and have worse outcomes (Ahluwalia 2009).

Programs that screen for suicide risk or mental illness have been implemented in schools, as well as in primary care settings and juvenile detention in the United States and Australia (Esler et al. 2008; Scott et al. 2009; Stathis et al. 2008). People are asked to complete a brief screening questionnaire and those whose responses suggest problems are referred for assessment and treatment. A randomised controlled trial of the **Signs of Suicide** screening program in five United States high schools found significantly lower rates of attempted suicide, greater knowledge and more adaptive attitudes about depression and suicide in students in the intervention group compared to those in the control group (Aseltine et al. 2004). Further evaluations are needed to refine the screening tools to better discriminate between those at risk and those not at risk (Beautrais et al. 2007). Screening tools may also need to be customised for Indigenous students.

Conclusion

There are very few evaluations, either Australian or international, on the impact of Indigenous-specific suicide prevention programs on suicide rates. The Yarrabah Family Life Promotion Program is an example of an effective community-based suicide prevention program that has decreased the number of suicides in the community and in comparison to other communities. There are also Indigenous-specific programs such as Alive and Kicking Goals! that show promise, but their impact on suicide rates has not yet been evaluated.

A number of effective non-Indigenous-specific programs have been adapted for Indigenous people. Evaluations found them to be culturally appropriate and important for increasing awareness, knowledge and community response capabilities and for addressing known risk factors, such as alcohol abuse. Examples are Indigenous Mental Health First Aid, motivational care planning and community gatekeeper training workshops. Culturally appropriate processes and resources have also been developed for use with Australian Indigenous people, including the Mental Health Stay Strong Care Plan Package, which is a guide for the assessment and management of chronic mental illness.

A number of effective, non-Indigenous-specific programs from Australia and overseas need to be tested with Indigenous populations. Examples include long-term follow-up care for people who have attempted suicide or are discharged from hospital or emergency department care; suicide crisis lines and web-based counselling services and forums; the ASIST program; training for primary health care providers to better recognise and treat depression; headspace services; and programs that screen for suicide risk and mental illness in schools, primary health care settings and juvenile detention centres.

There is a need for more evaluations of suicide prevention programs to inform policymakers and service providers about what works in Indigenous suicide prevention.

Appendix A

The Closing the Gap Clearinghouse Assessed collection includes summaries of research and evaluations that provide information on what works to overcome Indigenous disadvantage across the seven Council of Australian Governments building block topics.

Table A1 contains a list of selected research and evaluations that were the key pieces of evidence used in this resource sheet. The major components are summarised in the Assessed collection.

To view the Assessed collection, visit <http://www.aihw.gov.au/closingthegap/assessed/>.

Table A1: Assessed collection items for Strategies to minimise the incidence of suicide and suicidal behaviour

Title	Year	Author(s)
An outcome evaluation of the SOS Suicide Prevention Program. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9594&type=ac>	2004	Aseltine RH Jnr & DeMartino R
ReachOut! Innovation in service delivery. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9567&type=ac>	2007	Burns J, Morey C, Lagelee A, Mackenzie A & Nicholas J
Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9595&type=ac>	2005	Carter GL, Clover K, Whyte IM, Dawson AH & Este CD
Two-year follow-up of a community gatekeeper suicide prevention program in an Aboriginal community. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=8670&type=ac>	2006	Deane FP, Cappa K, Jones C, de Ramirez D, Lambert G, Marlow B et al.
An evaluation of crisis hotline outcomes Part 2: suicidal callers. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9593&type=ac>	2007	Gould MS, Kalafat J, Harrismunfakh JL & Kleinman M
Aboriginal language knowledge and youth suicide. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9413&type=ac>	2007	Hallett D, Chandler MJ & Lalonde CE
A mental health first aid training program for Australian Aboriginal and Torres Strait Islander peoples: description and initial evaluation. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9596&type=ac>	2009	Kanowski LG, Jorm AF & Hart LM
Telephone counselling for adolescent suicide prevention: changes in suicidality and mental state from beginning to end of a counselling session. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9592&type=ac>	2003	King R, Nurcombe B, Bickman L, Hides L & Reid W
Risk of suicide and related adverse outcomes after exposure to a suicide prevention program in the United States Air Force: cohort study. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9573&type=ac>	2003	Knox K, Litts D, Talcott G, Feig J & Caine E

Table A1: Assessed collection items for Strategies to minimise the incidence of suicide and suicidal behaviour (continued)

Title	Year	Author(s)
Review of the Applied Suicide Intervention Skills Training program (ASIST). Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9568&type=ac>	2010	Rodgers P
Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=9572&type=ac>	1992	Rutz W, von Knorring L & Walinder J
Headspace evaluation report—independent evaluation of headspace: the National Youth Mental Health Foundation. Clearinghouse summary: <http://www.aihw.gov.au/closingthegap/ItemDetails.aspx?id=8883&type=ac>	2009	Muir K, Powell A, Patulny R, Flaxman S, McDermott S, Oprea I et al.

Table A2 contains a list of related Closing the Gap Clearinghouse resource sheets.

To view the publications, visit <http://www.aihw.gov.au/closingthegap/publications/>.

Table A2: Related Clearinghouse resource sheets

Title	Year	Author(s)
Community development approaches to safety and wellbeing of Indigenous children	2010	Higgins DJ
Reducing alcohol and other drug related harm	2010	Gray D & Wilkes E
Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people	2013	Closing the Gap Clearinghouse
Trauma-informed services and trauma-specific care for Indigenous Australian children	Forthcoming	Atkinson J

Appendix B: Some characteristics of Indigenous suicide in Australia

Some of the content in this resource sheet may cause sadness and/or distress to the reader. If you need support, please call Lifeline on 13 11 14.

This information relates to some known suicides in Queensland, the Northern Territory and Western Australia.

Indigenous suicide is associated with alcohol or other drug use. Nearly three-quarters (71%) of Indigenous hanging victims in the Northern Territory between 1996 and 2006 had positive toxicology results or recent heavy use of alcohol (Hanssens 2008). In Queensland, from 1998 to 2006, two-thirds of Indigenous people who died by suicide had consumed alcohol and more than one-third (38%) had used drugs such as cannabis, amphetamines, inhalants or opiates at the time of their deaths (De Leo et al. 2011). A Coroner's report into the deaths of 22 Indigenous people in the Kimberley found that 15 of them had died by suicide and, of these, 13 had consumed excessive amounts of alcohol and/or cannabis at the time of their deaths. For the remaining two people, suicide appeared to be strongly associated with mental illness (OSCWA 2008).

Most known suicides in Queensland and the Northern Territory by Indigenous Australians were by hanging. Suicides by this method represented more than 90% of suicides by Indigenous people in Queensland from 1994–2007 (De Leo et al. 2011) and 87% of all Indigenous suicide deaths in the Northern Territory between 2001 and 2006 (Pridmore & Fujiyama 2009).

Loss, grief, trauma and bereavement are more of a collective experience in Indigenous communities than in mainstream society. Indigenous people have cultural obligations after the death of family and community members that override all other commitments (Hanssens 2008).

Other issues can compound the grieving process—increased substance use, legal issues, criminal justice issues, institutional racism, domestic violence and sexual and physical abuse (Hanssens 2008). In the aftermath of a suicide, the whole community is vulnerable as a cluster of suicides may occur soon after the initial suicide. Over three-quarters (77%) of Indigenous suicide deaths in the Northern Territory were found to be part of a cluster (Hanssens & Hanssens 2007).

References

ABS (Australian Bureau of Statistics) 2012. Suicides, Australia, 2010. ABS cat. no. 3309.0. Canberra: ABS.

Ahluwalia JS 2009. Suicidal behavior in adolescents: risk factor identification, screening, and prevention. Perspectives in prevention from the American College of Preventive Medicine. Medscape Education Public Health and Prevention.

AIHW (Australian Institute of Health and Welfare) 2011. Aboriginal and Torres Strait Islander Health Performance Framework 2010: detailed analyses. Cat. no. IHW 53. Canberra: AIHW. Viewed 10 March 2012, <http://www.aihw.gov.au/publication-detail/?id=10737420099>.

AIHW forthcoming a. Aboriginal and Torres Strait Islander Health Performance Framework 2013: Detailed analyses. Canberra: AIHW.

AIHW forthcoming b. Indigenous identification in hospital separations data: 2013 Quality report. Health Services Series. Canberra: AIHW.

APS (Australian Psychological Society) 1999. Suicide: an Australian Psychological Society discussion paper. Melbourne: APS. Viewed 4 September 2012, <http://www.psychology.org.au/assets/files/suicide_position_paper.pdf>.

Aseltine RH Jnr & DeMartino R 2004. An outcome evaluation of the SOS Suicide Prevention Program. American Journal of Public Health 94(3):446–51.

ASPAC (Australian Suicide Prevention Advisory Council) & Department of Health and Ageing (DoHA) 2009. The National Suicide Prevention Strategy Action Framework 2009–10 to 2010–11. Canberra: DoHA. Viewed 6 September 2012, <http://www.livingisforeveryone.com.au/Library-Item.html?id=1260>.

Atkinson J 2002. Trauma trails, recreating song lines: the transgenerational effects of trauma in Indigenous Australia. Melbourne: Spinifex Press.

Atkinson J forthcoming. Trauma-informed services and trauma-specific care for Indigenous Australian children. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

Beautrais A 2006. Suicide prevention strategies 2006. Guest editorial. Advances in Mental Health 5(1):16–21.

Beautrais A, Fergusson D, Coggan C, Collings C, Doughty C, Ellis P et al. 2007. Effective strategies for suicide prevention in New Zealand: a review of the evidence. New Zealand Medical Journal 120(1251):U2459.

Burns J, Morey C, Lagelée A, Mackenzie A & Nicholas J 2007. ReachOut! Innovation in service delivery. Medical Journal of Australia 187(7):S31–4.

Carter GL, Clover K, Whyte IM, Dawson AH & D'Este C. 2005. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. British Medical Journal 331:805.

Chandler MJ & Lalonde CE 2008. Cultural continuity as a moderator of suicide risk among Canada's First Nations. In: Kirmayer LJ & Valaskakis GG (eds). Healing traditions: the mental health of Aboriginal peoples in Canada. Vancouver: UBC Press, The University of British Columbia, 221–48.

CtG (Closing the Gap Clearinghouse (AIHW & AIFS)) 2013. Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Resource sheet no. 19. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

De Leo D, Sveticic J, Milner A & McKay K 2011. Suicide in Indigenous populations of Queensland. Brisbane: Australian Academic Press.

Deane FP, Capp K, Jones C, de Ramirez D, Lambert G, Marlow B et al. 2006. Two-year follow up of a community gatekeeper suicide prevention program in an Aboriginal community. Australian Journal of Rehabilitation Counselling 12:33–6.

DoHA (Department of Health and Ageing) 2007. Living is for everyone: suicide prevention in Indigenous communities. Fact sheet 16. Canberra: DoHA. Viewed 4 September 2012, <http://www.livingisforeveryone.com.au/Individual-fact-sheets.html>.

DoHA 2008. Living is for everyone: research and evidence in suicide prevention. Canberra: DoHA. Viewed 3 September 2012, <http://www.livingisforeveryone.com.au/Research-and-evidence-in-suicide-prevention.html>.

DoHA 2012a. Empowering Indigenous communities to tackle suicide. Joint media release by the Hon. Mark Butler MP, Minister for Mental Health and Ageing, Minister for Social Inclusion and Minister Assisting the Prime Minister on Mental Health Reform; the Hon. Jenny Macklin MP, Minister for Families, Community Services and Indigenous Affairs; and the Hon. Warren Snowdon MP, Minister for Indigenous Health. Canberra: DoHA. Viewed 19 June 2012, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb043.htm>.

DoHA 2012b. National Suicide Prevention Strategy. Viewed 3 December 2012, <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-nsps>.

Elliott-Farrelly T 2004. Australian Aboriginal suicide: the need for an Aboriginal suicidology? Australian e-Journal for the Advancement of Mental Health 3(3):138–45.

Esler D, Johnston F, Thomas D & Davis B 2008. The validity of a depression screening tool modified for use with Aboriginal and Torres Strait Islander people. Australian and New Zealand Journal of Public Health 32(4):317–21.

Gray D & Wilkes E 2010. Reducing alcohol and other drug related harm. Resource sheet no. 3. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. <http://www.aihw.gov.au/closingthegap/publications/>.

Gould MS, Kalafat J, HarrisMunfakh JL & Kleinman M 2007. An evaluation of crisis hotline outcomes. Part 2: suicidal callers. Suicide and life-threatening behavior 37(3):338–52.

Guo B & Harstall C 2002. Efficacy of suicide prevention programs for children and youth. Health technology assessment report 26: series A. Edmonton: Alberta Heritage Foundation for Medical Research. Viewed 4 September 2012, <http://www.ihe.ca/publications/library/archived/efficacy-of-suicide-prevention-programs-for-children-and-youth/>.

Hallett D, Chandler MJ & Lalonde CE 2007. Aboriginal language knowledge and youth suicide. Cognitive Development 232(3):392–9.

Hanssens L 2008. Clusters of suicide: the need for a comprehensive postvention response to sorrow in Indigenous communities in the Northern Territory. Aboriginal & Islander Health Worker Journal 32(2):25–33.

Hanssens L & Hanssens P 2007. Research into the clustering effect of suicide within Indigenous communities, Northern Territory, Australia. Paper presented at the National Suicide Prevention Strategy Postvention conference, Sydney, 24–26 May 2007.

Headey A, Pirkis J, Merner B, Vanden Heuvel A, Mitchell P, Robinson J et al. 2006. A review of 156 local projects funded under Australia's National Suicide Prevention Strategy: overview and lessons learned. Advances in Mental Health 5(3):247–61.

headspace 2012. About headspace. Melbourne: headspace. Viewed 31 January 2012, <http://www.headspace.org.au/about-headspace>.

Health Canada 2003. Acting on what we know: preventing youth suicide in First Nations. The report of the Advisory Group on Suicide Prevention. Ottawa: Health Canada. Viewed 5 March 2012, <http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/index-eng.php>.

Higgins D 2010. Community development approaches to safety and wellbeing of Indigenous children. Resource sheet no. 1. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. <http://www.aihw.gov.au/closingthegap/publications/>.

Hunter E, Reser J, Baird M & Reser P 1999. An analysis of suicide in Indigenous communities of North Queensland: the historical, cultural and symbolic landscape. Canberra: Department of Health and Aged Care. Viewed 4 September 2012, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-a-indigsui>.

Jorm A & Hart L 2008. Aboriginal and Torres Strait Islander Mental Health First Aid (AMHFA) National Pilot Program: 2008 evaluation report. Report to the Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing. Melbourne: ORYGEN Research Centre, University of Melbourne. Viewed 4 September 2012, <http://www.healthinfonet.ecu.edu.au/uploads/resources/18556_18556.pdf>.

Kanowski LG, Jorm AF & Hart LM 2009. A mental health first aid training program for Australian Aboriginal and Torres Strait Islander peoples: description and initial evaluation. International Journal of Mental Health Systems 3:10.

Kids Helpline 2010. Overview 2010. Brisbane: BoysTown. Viewed 22 November 2011, <http://www.kidshelp.com.au/upload/22900.pdf>.

King R, Nurcombe B, Bickman L, Hides L & Reid W 2003. Telephone counselling for adolescent suicide prevention: changes in suicidality and mental state from beginning to end of a counselling session. Suicide and life-threatening behavior 33(4):400–11.

Kirmayer LJ, Fraser SL, Fauras V & Whitley R 2009. Current approaches to Aboriginal suicide prevention. Culture and Mental Health Research Unit Working Paper 14. Montreal: Institute of Community and Family Psychiatry, Jewish General Hospital. Viewed 20 September 2012, <http://www.mcgill.ca/tcpsych/sites/mcgill.ca.tcpsych/files/Report14.pdf>.

Kitchener BA & Jorm AF 2006. Mental health first aid training: review of evaluation studies. Australian and New Zealand Journal of Psychiatry 40(1):6–8.

Knox KL, Litts DA, Talcott GW, Feig JC & Caine ED 2003. Risk of suicide and related adverse outcomes after exposure to a suicide prevention program in the United States Air Force: cohort study. British Medical Journal 327:1376–80.

Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A et al. 2005. Suicide prevention strategies: a systematic review. Journal of the American Medical Association 294(16):2064–74.

Martin G & Page A 2009. National suicide prevention strategies: a comparison. Brisbane: The University of Queensland. Viewed 4 January 2012, <http://www.livingisforeveryone.com.au/Library-item.html?id=82>.

Menzies School of Health Research 2010. AIMhi mental health care plans. Darwin: Menzies School of Health Research. Viewed 21 September 2012, <http://menzies.edu.au/menziesresources/aimhi-mental-health-care-plans>.

Morgan HG, Jones EM & Owen JH 1993. Secondary prevention of non-fatal deliberate self-harm. The green card study. British Journal of Psychiatry 163:111–12.

Muir K, Powell A, Patulny R, Flaxman S, McDermott S, Oprea I et al. 2009. headspace evaluation report: independent evaluation of headspace: the National Youth Mental Health Foundation. SPRC report 19/09. Sydney: Social Policy Research Centre, University of New South Wales. Viewed 4 September 2012, <http://www.sprc.unsw.edu.au/publications/reports#2009>.

Nagel T, Robinson G, Condon J & Trauer T 2009. Approach to treatment of mental illness and substance dependence in remote Indigenous communities: results of a mixed methods study. Australian Journal of Rural Health 17(4):174–82.

OSCWA (Office of the State Coroner, Western Australia) 2008. Annual report 2007–2008. Perth: Office of the State Coroner. Viewed 4 September 2012, <http://www.coronerscourt.wa.gov.au/_files/ar2007-08.pdf>.

Pridmore S & Fujiyama H 2009. Suicide in the Northern Territory, 2001–2006. Australian and New Zealand Journal of Psychiatry 43(12):1126–30.

Purdie N, Dudgeon P & Walker R (eds) 2010. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Canberra: Department of Health and Ageing. Viewed 23 August 2012, <http://aboriginal.childhealthresearch.org.au/kulunga-research-network/working-together.aspx>.

Rodgers P 2010. Review of the Applied Suicide Intervention Skills Training program (ASIST): rationale, evaluation results, and directions for future research. Calgary: LivingWorks Education Inc. Viewed 4 September 2012, <http://www.livingworks.net/userfiles/file/ASIST_review2010.pdf>.

Rutz W, von Knorring L & Wålinder J 1992. Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. Acta Psychiatrica Scandinavica 85(1):83–8.

Scott MA, Wilcox HC, Schonfeld IS, Davies M, Hicks RC, Turner JB et al. 2009. School-based screening to identify at-risk students not already known to school professionals: the Columbia Suicide Screen. American Journal of Public Health 99(2):334–9.

Sher L 2006. Alcohol consumption and suicide. Quarterly Journal of Medicine 99(1):57–61.

Stathis S, Letters P, Doolan I, Fleming R, Heath K, Arnett A et al. 2008. Use of the Massachusetts Youth Screening Instrument to assess mental health problems in young people within an Australian youth detention centre. Journal of Paediatrics and Child Health 44(7–8):438–43.

Swan P & Raphael B 1995. Ways forward: National Aboriginal and Torres Strait Islander Mental Health Policy national consultancy report. Canberra: Australian Government Publishing Service. Viewed 24 August 2012, <http://www.health.gov.au/internet/main/publishing.nsf/content/8AE2DAC350E39315CA257276001CAACA/$File/wayforw.pdf>.

Tighe J & McKay K 2012. Alive and Kicking Goals!: preliminary findings from a Kimberley suicide prevention program. Advances in Mental Health 10(3):240–5.

Urbis Keys Young 2006. Evaluation of the National Suicide Prevention Strategy—summary report. Sydney: Urbis Keys Young.

Westerman T 2010. Engaging Australian Aboriginal youth in mental health services. Australian Psychologist 45(3):212–22.

Westerman TG & Hillman SD 2003. Suicide prevention in Aboriginal communities: a best practice model of community driven prevention. Poster presented at the Suicide Prevention Australia conference, Brisbane, 12–15 June 2003.

Williams F, Hague C & Cornell DG 2006. Evaluation of statewide training in student suicide prevention. Virginia Youth Violence Project. Charlottesville: University of Virginia. Viewed 22 June 2012, <http://curry.virginia.edu/uploads/resourceLibrary/8-2006-APA-evalution-of-student-suicide-prevention-program.pdf>.

Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM et al. 2005. The Western Australian Aboriginal Child Health Survey. Volume 2: the social and emotional wellbeing of Aboriginal children and young people. Perth: Curtin University of Technology & Telethon Institute for Child Health Research. Viewed 27 August 2012, <http://aboriginal.childhealthresearch.org.au/kulunga-research-network/waachs/waachs-volume-2.aspx>.

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Abbreviations

ASIST   Applied Suicide Intervention Skills Training

MHFA   Mental Health First Aid

NSPS   National Suicide Prevention Strategy

TATS   Mental Health: Taking Action to Tackle Suicide package

Terminology

Indigenous: 'Aboriginal and Torres Strait Islander' and 'Indigenous' are used interchangeably to refer to Australian Aboriginal and/or Torres Strait Islander people. The Closing the Gap Clearinghouse uses the term 'Indigenous Australians' to refer to Australia's first people.

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