



# **Indigenous Lived Experience of Suicide : Literature Review**

Centre of Best Practice in Aboriginal and Torres  
Strait Islander Suicide Prevention

October 2018

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## Glossary: Acronyms and Definitions

**ACCHS:** Aboriginal Community Controlled Health Services

**ATSISPEP:** Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project

**CBPATSISP:** Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

**Cultural Determinants:** Promote a strengths-based approach using strong connections to culture and country to build identity, resilience and improved outcomes

**Cultural Safety:** An environment which is safe for Indigenous people with shared respect, shared meaning, shared knowledge and experience, and dignity

**Healing Foundation:** Aboriginal and Torres Strait Islander Healing Foundation

**Indicated Interventions:** Activities aimed at individuals who have been identified as at risk of suicide, or who have attempted suicide

**Indigenous:** Used in this report predominantly to refer to Aboriginal and Torres Strait Islander people. Where used to refer to Indigenous people of other nations, this is specifically addressed.

**LGBTQI+SB:** People identifying as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Sister Girl or Brother Boy

**LiFe Framework:** Living is For Everyone Framework

**NATSILMH:** National Aboriginal and Torres Strait Islander Leadership in Mental Health

**NATSISPS:** National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

**NGO:** Non-government Organisation

**NHLF:** National Health Leadership Forum

**PHN:** Primary Health Network

**Postvention:** Interventions to support and assist those bereaved by suicide

**Primary prevention:** Activity to prevent a completed suicide or a suicide attempt occurring but in the context of an Indigenous community-wide approach

**Primordial prevention or interventions:** Aim to prevent the risk factors for suicide and include interventions addressing upstream risk factors

**SPA:** Suicide Prevention Australia

**SEWB:** Social and Emotional Wellbeing

**Universal interventions:** Usually refers to a suicide prevention activity aimed at the mainstream, whole and 'well' population.

**Social determinants of health:** The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life (WHO)

**TKI:** Telethon Kids Institute

**WHO:** World Health Organisation



## Executive Summary

In the past fifty years, Indigenous suicide has emerged as an area of increasing concern across Australia, with Indigenous Australians being more than twice as likely to die by suicide than non-Indigenous Australians (ABS, 2018). This literature review examines the question *how is Aboriginal and Torres Strait Islander lived experience of suicide the same or different to that of other Australians?* It also seeks to determine which, if any, supports are required to empower the inclusion of Aboriginal and Torres Strait Islander lived experience experts in the suicide prevention field. In reviewing the literature on this topic, we sought to identify any gaps in this field in order to better inform research, programs, and policies on suicide prevention in the future.

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) provided a comprehensive basis for the review. The ATSISPEP findings and recommendations show that mental health and suicide prevention activities need to be owned by Indigenous people, be culturally informed and be led by the community. Aboriginal and Torres Strait Islander communities must be the drivers of identifying their needs and leading localised solutions. It is therefore critical to involve Indigenous peoples with a lived experience of suicide in relevant program development, informing policy agendas and cultural governance to ensure the best outcomes for communities. ATSISPEP outcomes, including both the final report *Solutions that Work: What the Evidence and Our People Tell Us* (Dudgeon et. al., 2016) and the National Empowerment Project (NEP), led the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATISIP) and the Black Dog Institute to establish the Aboriginal and Torres Strait Islander Lived Experience Project (the Project).

As with ATSISPEP, the Project employed a participatory action research (PAR) approach that was integral to its success. Aboriginal researchers and facilitators led the Project, providing shared values and cultural understandings throughout. In a PAR process, the connections between the Aboriginal researcher(s) and Aboriginal community are inseparable. Research findings are first at the community level to determine accuracy and appropriateness and to ensure the integrity of the Project. At every stage, activities are founded on a process of Aboriginal-led partnership and collaboration between researchers and Aboriginal participants. Therefore, research outcomes and recommendations, guided by meaningful and genuine collaboration with Indigenous lived experience experts, contribute to a gap in existing knowledge regarding culturally responsive suicide prevention. These contributions culminate in a final report, where participants were invited to be co-authors, ensuring that community ownership over the research, and the collaborative nature of the Project were sustained. The Project developed a communication and dissemination strategy that ensured outcomes in the final report are presented in a manner that effectively translates to improved processes, policy, services and programs for Aboriginal and Torres Strait Islander specific suicide prevention. This in turn enables the development and delivery of culturally responsive service provision for suicide prevention strategies, programs and evaluation measures. Importantly, outcomes determine how those with lived experience can continue to remain included in an empowering way. Key stakeholders and service providers, both Indigenous and non-Indigenous, are able to utilise this emerging knowledge in an effective way to the benefit of Aboriginal and Torres Strait Islander peoples and communities. This inclusion of Indigenous lived experience expertise is vital to the potential success of frameworks and suicide prevention strategies and programs, including national policy.

## Introduction

This literature review examines the question *how is the Aboriginal and Torres Strait Islander lived experience of suicide the same or different to that of other Australians*, and surrounding issues of genuine involvement of Indigenous peoples within the suicide prevention field. It intends to inform relevant stakeholders, from community-led suicide prevention initiatives to national policy makers, of the research and literature around lived experience expertise in Indigenous suicide prevention. Guided by outcomes and recommendations from both the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) and the Aboriginal and Torres Strait Islander Lived Experience Project (the Project) this review contributes to a gap in existing knowledge regarding culturally responsive suicide prevention.

## Background

Suicide has emerged in the last fifty years as a major cause of Indigenous premature mortality and has major implications to the overall social and emotional wellbeing of communities. Indigenous peoples die by suicide at a greater rate (5.5%) than non-Indigenous Australians (2%) (ABS, 2018). Death by suicide was the 5<sup>th</sup> leading cause of death for Indigenous peoples, and the 13<sup>th</sup> leading cause of death for non-Indigenous people (ABS, 2018).

Within the Indigenous population there are particular groups that are even more vulnerable, including children and young people (National Children's Commissioner, 2014). In 2017, suicide was the leading cause of death for Indigenous peoples between 15 and 34 years of age, with over three times the rates of death by suicide than non-Indigenous Australians in this age bracket (ABS, 2018). Other vulnerable groups include members of the LGBTQI community, and individuals that have had contact with the justice system. Furthermore, the majority of Indigenous people who die by suicide are men, but there is an ongoing concern for the increasing number of women who die by suicide (ABS, 2018).

While suicide is the leading cause of death from external causes for Indigenous people, they also experience relatively high rates of intentional self-harm (Robinson, 2011). Trauma, grief and loss, as well as alcohol and substance misuse, have been found to be key factors in suicide deaths (Robinson, Silburn, & Leckning, 2011). In 2017, the Indigenous suicide rate was the highest within the 25-34 year age group, at 52.5 deaths per 100 000 persons (ABS, 2018). A report of the Australian Health Ministers' Advisory Council (2014) and the ATSISPEP research findings confirm the need for:

- Interventions focused on strengthening all domains of social and emotional wellbeing; including culturally based healing programs that connect people with cultural traditions;
- Early interventions to address alcohol and substance misuse;
- Prevention efforts that are evidence based, relevant and address the range of systemic issues that reduce people's capacity to make positive choices to enhance their health, mental and wellbeing; and
- Greater focus on supporting and restoring protective factors, such as community connectedness, strengthening the individual and rebuilding family.

It is evident that policy responses to promote social and emotional wellbeing need to be multidimensional. Such responses must involve a wide range of stakeholders including families and communities, the health sector, housing, education, employment and economic development, family services, crime prevention and justice, and Aboriginal Community Controlled Health Services (ACCHS) (Australian Health Ministerial Advisory Council, 2015). This correlates with the findings of ATSIPEP, which identified the need for a systems approach involving all aspects of community life to be included in suicide prevention solutions. The strategies that build on the strengths, resilience and endurance within Indigenous communities and recognise the important historical and cultural diversity within communities are also recommended (Social Health Reference Group, 2004). There is also a demonstrated need to increase Indigenous community capacity and mainstream workforce capacity to understand, cope with, and respond to, people experiencing trauma, loss and grief. This involves developing skills such as conflict mediation, suicide prevention, mental health, first aid and lateral violence prevention to build a trauma-informed workforce (Healing Foundation, 2014).

## Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSIPEP)

In 2015, the Department of Prime Minister and Cabinet funded the School of Indigenous Studies at the University of Western Australia (UWA) to undertake the Aboriginal and Torres Strait Islander Suicide Prevention Project (ATSIPEP). This was in response to increasing numbers of Aboriginal and Torres Strait Islander people dying by suicide. The work of ATSIPEP was informed by the first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (NATSISPS) and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017 - 2023*. The aim of ATSIPEP was to build an evidence base for Indigenous specific and strengths-based suicide prevention programs and policies. ATSIPEP conducted 12 Indigenous roundtables around Australia; undertook a comprehensive literature review on community-led Indigenous suicide prevention; reviewed evaluated programs and services for suicide prevention; and analysed and reported on 69 previous consultations on Indigenous suicide prevention that took place between 2009-2015. This work culminated in a landmark report *Solutions That Work: What the Evidence and Our People Tell Us* (2016), that investigated and documented what works in reducing suicide rates amongst Indigenous Australians. This work has continued through the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP).

CBPATSISP was one of several national initiatives established to support and work with Primary Health Networks (PHN's) to address suicides. The CBPATSISP consortium partners include the Healing Foundation, Telethon Kids' Institute, HealthInfoNet, and the Menzies School of Health Research. The objectives of CBPATSISP are as follows:

1. Identifying the need for and facilitating innovative new research (including evaluations of unevaluated activity) to support the further identification of Indigenous best practice. This is in partnership with the National Leadership in Suicide Prevention Research;



2. Assessing best practice by Primary Health Networks (PHNs) in planning and commissioning Indigenous suicide prevention activities. This is also in partnership with the National Leadership in Suicide Prevention Research;
3. Working to translate best practice for application in Indigenous communities, community organisations, and by PHNs. This includes developing accessible and appropriate guidance and resource materials. This is also in partnership with the National Leadership in Suicide Prevention Research;
4. Developing an Indigenous-specific adaptation of the systems approach (e.g. European Alliance Against Depression Model) to suicide prevention, based on identified best practice, and aligned with the current overarching approach; and
5. Proactively promoting and disseminating best practice research to ensure accessibility for all stakeholders. Such dissemination includes establishing a research/evaluation directory (clearinghouse). This would include the above being accessible through a website developed in consultation and with technical support from the Australian Indigenous HealthInfoNet. National conferences would also enable effective promotion and dissemination of relevant research. Further, the creation of a responsive education/guidance program tailored to stakeholder needs. This includes:
  - A best practice in Indigenous suicide prevention education program delivered to PHNs with follow up over the life of the program;
  - A complementary education best practice program and resources specifically for Indigenous communities and organisations to help the work effectively with PHNs; and
  - A best practice email advisory service for communities, community organisations and PHNs (CBPATSISP, 2018).

The CBPATSISP also has a partnership with the Black Dog Institute and will undertake a number of activities to support the Commonwealth suicide prevention trials. These include:

1. Ongoing advice and engagement on supporting the national suicide prevention trial sites;
2. To develop an overarching Implementation Guide for a systems-based approach for Aboriginal and Torres Strait Islander communities;
3. Workshop and report to develop an Aboriginal and Torres Strait Islander Lived Experience Framework;
4. A Cultural Governance Framework; and
5. Write and publish four articles on various learnings and themes associated with adaptation of the LifeSpan Framework for Aboriginal and Torres Strait Islander people.

## **Aboriginal and Torres Strait Islander Lived Experience Project**

The Project examined the needs for a specific Aboriginal and Torres Strait Islander lived experience network and framework. One of the aims of the Project involves investigating Aboriginal and Torres Strait Islanders lived experience of suicide and to ascertain if this is different to the lived experience of the mainstream population. The CBPATSISP hosted a workshop in June 2018 bringing together 10 lived experience experts and three organisational representatives to discuss their perspectives on best practices of working with Indigenous peoples in suicide prevention.

This workshop with Indigenous lived experience representatives from across Australia, was in conversations with *Roses in the Ocean*, *Black Dog Institute* and other relevant bodies.

The CBPATSISP uses the Suicide Prevention Australia (SPA) definition of lived experience:

*SPA defines 'lived experience' as having experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way (Suicide Prevention Australia, 2017).*

The inclusion of those with lived experience is important and SPA outlines the rationale as follows (Suicide Prevention Australia, 2017):

1. People with a lived experience have a valuable, unique and legitimate role in suicide prevention;
2. Lived experience helps change the culture surrounding suicide and to preserve and promote life through compassion and understanding;
3. Inclusion and embracing diversity of individuals, communities and cultures enriches suicide prevention;
4. Empower and support those with lived experience to share their insights and stories with a view to preventing suicide;
5. Utilise our lived experience to educate, promote resilience, inspire others and instill hope;
6. People with lived experience support, advocate for and contribute to research, evidence-based practice and evaluation;
7. All suicide prevention programs, policies, strategies and services will at all levels include genuine meaningful participation from those with lived experience; and
8. Encourage and nurture collaboration and partnerships between organisations and stakeholders.

Further, this Project is guided by the informative document *An Evidence-Based Systems Approach to Suicide Prevention: Guidance on Planning, Commissioning and Monitoring* produced by the Black Dog Institute (2016), designed for use by Primary Health Networks. This document details effective engagement of lived experience experts and highlights their importance in an integrative, multi-level approach to mental health. Lived experience experts are able to contribute in assisting other individuals to work systemically with teams, groups, services, organisations, and governments. Such work may involve clarifying and addressing the ways in which policies and practices can be strengthened to better support communities. Studies examined in the construction of the Black Dog Institute's document support the involvement of lived experience experts. This support stems from recognition that such involvement benefits clients, practitioners, communities and health organisations in a variety of ways, including:

- Mentoring others and acting as role models for recovery.
- Using their expertise to represent needs in the service system.
- Enabling the system to become person-centred, family inclusive, and culturally competent.
- Motivating and informing others.
- Working to increase the effectiveness of stigma-reduction campaigns.



- Demonstrating that people with lived experience can go on to lead independent and productive lives and therefore combating negative biases and stigmas.

A chart outlining possible engagement is included as Appendix One.

The positive impacts of involvement of lived experience experts is compounded when inclusion involves these individuals being compensated for their time and expertise and further, being invited as partners in key decision-making positions. Ways in which organisations can increase meaningful involvement include recruiting individuals with lived experience to:

- Become members of various boards, leaders, other staff, and volunteers.
- Be involved in overseeing or advising changes in the system.
- Review communications aimed at mental health consumers.
- Work as spokespersons and advocates.
- Partner in the development of research and evaluation of suicide prevention initiatives.

Whilst this Project encourages the meaningful involvement of lived experience experts, it is crucial that such involvement is responsible. This refers to service providers remaining mindful of their duty of care to ensuring that lived experience experts remain well and safe and are not harmed by their participation.

The aim of this Project was to engage meaningfully with Aboriginal and Torres Strait Islander peoples with lived experience in suicide. The engagement took place through a workshop with community members. Lived experience experts shared their perspectives on the requirements for working with Indigenous peoples in suicide prevention. These perspectives were informed by the participants' individual experiences and contributed to improving practices in this field. These unique insights by participants of the Lived Experience Workshop are explored in a separate report summarising the outcomes of the Lived Experience Project.

## Emergence of the Lived Experience Voice

This literature review aimed to determine the gaps in the literature of Indigenous lived experience of suicide. It became apparent that this is a relatively new emerging area and the aim was to review what currently exists, in order to identify the gaps and contribute to the knowledge base in this field. Some lived experience groups such as *Roses in the Ocean*, *SPA*, *The Black Dog Institute Centre of Research Excellence in Suicide Prevention (CRESP)*, and *Innowell Lived Experience Advisory Board* include Aboriginal and Torres Strait Islander people in their activities and committees. However, the cultural considerations of empowered inclusion of Indigenous voices needs to be reviewed. This is the core aim of the CBPATISIP Lived Experience Project. Indeed, the meaningful involvement of Indigenous people within research that affects them is crucial. Research within Indigenous suicide prevention must address the need for cultural considerations and inclusion of Indigenous lived experience voices. This is in keeping with the right of Indigenous peoples to be involved in all aspects of service design and implementation. Further, the empowerment of communities is a valuable outcome in itself, with a potential for multiple flow-on benefits.

## ATSISPEP Final Report: The Solutions that Work: What the Evidence and Our People Tell Us

As mentioned previously, the ATSISPEP report was completed in response to increasing numbers of Aboriginal and Torres Strait Islander suicides. The work of ATSISPEP was informed by the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS) and its aim was to build an evidence base for Indigenous specific and strengths-based suicide prevention programs and policies. The final Report to come out of the Project, *Solutions That Work: What the Evidence and Our People Tell Us* (Dudgeon et. al., 2016) informs future work on suicide prevention for Aboriginal and Torres Strait Islander people and communities. The twelve community Roundtables that were held as part of the Project with community stakeholders across Australia provided the opportunity to highlight the most pressing issues and provide valuable insights into what measures are effective in addressing suicide prevention in Indigenous communities.

The Report also provides a detailed picture of Indigenous suicide in Australia. The Report highlights that prior to the 1960s, Indigenous suicide was mostly unheard of, yet in 2017 it was the fifth leading cause of death among Indigenous people (ABS, 2018). It examines the nature of Indigenous suicide and found some groups to be even more vulnerable than other groups. For example, it found that Indigenous children and young people are significantly more likely to complete suicide than the non-Indigenous population - Indigenous young people aged 15-24 years are over three times more likely to die by suicide when compared to non-Indigenous young people (ABS, 2018). Indigenous males who account for 75.8% of Indigenous suicides are also at higher risk than Indigenous females, however, females are an ongoing and growing concern (ABS, 2018). Further, there are significant differences between states and territories and age groups (Dudgeon et. al., 2016).

Success factors that contribute to suicide prevention are identified in the Report. Suicide prevention activities are seen from a population health approach and three types of prevention are identified: universal, selective, and indicated interventions:

- **Universal:** In the universal approach primordial and primary interventions are distinguished. Primordial prevention includes: addressing community challenges including social determinants of health; cultural elements such as social and emotional wellbeing and building identity; and addressing substance misuse. Primary prevention involves: Indigenous specific gatekeeper training; programs raising awareness about suicide risk; reducing access to lethal means; training of frontline staff in identifying signs of depression and suicide risk; access to e-health services and crisis phone services; and responsible media reporting of suicide.
- **Selective:** These interventions are targeted towards at-risk groups such as school aged children or young people and involves: peer-support and mental health literacy programs; culture being taught at school; peer-to-peer mentoring and education on suicide prevention; programs to engage and divert including sport; connecting to culture/community/Elders; and providing hope for the future.
- **Indicated:** Indicated interventions relate to clinical elements including: access to counsellors and mental health support; 24/7 availability of support services; awareness of critical risk periods and responsiveness at those times; availability of crisis response teams after a suicide;

continuity of care; clear referral pathways; time protocols; high quality and culturally appropriate treatments; and cultural competence of staff including mandatory training requirements. (Dudgeon et. al., 2016, p.2).

Further, there are a number of key recommendations made by the Report, a select few are:

- All Indigenous suicide prevention activities should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care;
- Governments should support the training, employment and retention of Indigenous community members/people as mental health workers, peer workers and so on in suicide prevention activities. In particular, Indigenous young people should be supported and trained to work in suicide prevention activities among their peer group;
- All mental health service provider staff working with Indigenous people at risk of suicide and within Indigenous communities should be required to achieve Key Performance Indicators (KPIs) in cultural competence and the delivery of trauma informed care. These services should also be required to provide a culturally safe environment; and
- Aboriginal Community Controlled Health Services remain the preferred facilitators in communities for suicide prevention activities in their communities, including the provision of primary mental health care services. This includes delivery of programs and services funded to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy through the Primary Health Networks (Dudgeon et. al., 2016, pg. 56). In particular, people with lived experience should be consulted about any program development (Dudgeon et. al., 2016, p. 91).

What these findings and recommendations tell us is that mental health and suicide prevention activities need to be owned by Indigenous people, be culturally informed and led by the community. Aboriginal and Torres Strait Islander communities must be the drivers of identifying their needs and leading localised solutions. It is therefore critical to involve those with a lived experience of suicide in program development, informing policy agendas and cultural governance to ensure the best outcomes for communities.

It is widely acknowledged that the high rates of suicide among Indigenous people involve a complex set of cultural, social, historical and economic determinants that impact adversely on Indigenous social and emotional wellbeing and mental health. In developing an understanding of suicide in this context it is important to understand the definition of health as holistic, this includes the distinctive notion of social and emotional wellbeing accorded mental health:

*The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.*

*Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage. (Social Health Reference Group, 2004, p. 9)*

The key guiding principles that informed the *Solutions That Work Report* include the key principles of the *LiFE Framework* and the nine guiding principles from *The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing [the MHSEWB Framework] 2017-2023*. These underpin the whole-of-life view of health held by Aboriginal and Torres Strait Islander people.

The *MHSEWB Framework* principles guide the delivery of health, mental health and social services, which consider the cultural, social, spiritual, economic and historical and contemporary contexts of Indigenous communities. They require that program service delivery and practices are adapted to local cultural and community contexts to facilitate community engagement, ownership and thereby the likely uptake of prevention initiatives. These principles are:

1. Health as holistic: Encompassing mental, physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that while the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. The right to self-determination which includes community control and empowerment: Projects should be grounded in the community, owned by the community, based on community needs and accountable to the community.
3. The need for cultural understanding: Culturally valid understandings must shape the provision of services and must guide the assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally and mental health problems in particular.
4. Recognition that the experiences of trauma and loss have intergenerational effects: It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects.
5. Recognition and respect of human rights: The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander people's mental health and wellbeing.
7. Recognition of the centrality of family and kinship: In addition to the broader concepts of family and bonds of reciprocal affection, responsibility and sharing.
8. Recognition of individual and community cultural diversity: There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles, and frequently move between these ways of living.

9. Recognition of Indigenous strengths: It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.
10. Programs and strategies must be sustainable, strengths based and capacity building: Projects must be sustainable both in terms of building community capacity and in terms of not being 'one off'; they must endure until the community is empowered.
11. Genuine partnerships: Projects should work in genuine partnerships with local Aboriginal and Torres Strait Islander stakeholders and other providers to support and enhance existing local measures, not duplicate or compete with them. Funding applications need to demonstrate a record of genuine community and stakeholder/provider consultations and a track record of community empowerment.
12. Safe cultural delivery: Projects should be delivered in a culturally safe manner.
13. Innovation and evaluation, community promotion and education: Projects need to build on existing learning, try new and innovative approaches, share learnings, and improve the evidence base to reduce suicide. Projects should share their learnings, and these should be promoted in other communities. (The MHSEWB Framework, 2017)

One of the ATSIPEP Report's key recommendations is that people with lived experience must be consulted when developing suicide prevention programs. It states that a common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and lived experience elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers. In addition, the empowerment of communities is a beneficial outcome in itself, with a potential for multiple flow-on benefits. With community ownership and investment, such responses are also likely to be sustained over time. Further, continuing care programs need to support the development of community and group support networks for those with lived experience of suicide, including those who have attempted suicide and those who have been bereaved by suicide (Dudgeon et al., 2016). <sup>[11]</sup><sub>SEP</sub>

A recent paper *Recent Developments in Suicide Prevention Among the Indigenous Peoples of Australia* (Dudgeon & Holland, 2018), summarises the findings from ATSIPEP and makes recommendations for future work in suicide prevention in Aboriginal communities. The authors state that it is critical to acknowledge the differences in the historical, cultural, political, social and economic experiences of Indigenous peoples, and their cumulative exposure to trauma, psychological distress and other risks to mental health. Further, it is found that these mental health issues are specific and more prevalent amongst Indigenous peoples and communities due to the ongoing impacts of colonisation in Australia including a range of social determinants impacting on the wellbeing of Indigenous peoples today. Working effectively with Indigenous clients also includes being able to establish culturally safe work environments, and the ability of non-Indigenous practitioners to work in a culturally competent and trauma-informed manner. There are also considerations regarding time protocols and client follow-up. Further, post-vention responses might be required. Supporting selective suicide prevention activity among younger people (and other groups at increased risk) and community-level work is an important complement to working with Indigenous individuals at risk of suicide (Dudgeon & Holland, 2018).



## National Health and Medical Research Council Principles and Guidelines

The National Health and Medical Research Council (NHMRC, 2003) have a set of guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research which are vital to consider when undertaking research with people that have lived experience of suicide. The Lived Experience Project subscribes to this set of principles that are concerned with empowering Aboriginal and Torres Strait Islander peoples and communities in the process. The guidelines are listed below:

### ***Reciprocity: Inclusion***

It is important that the voices of Aboriginal and Torres Strait Islander peoples and communities are prioritised and that research and project teams work to build strength, resilience, and capacity among participants and their communities. The Aboriginal and Torres Strait Islander Lived Experience Project employed a participatory action research (PAR) approach that was integral to the Project. Aboriginal researchers and facilitators led the Project, providing shared values and cultural understandings throughout the Project. In a PAR process, the connections between the Aboriginal researcher(s) and Aboriginal community are inseparable. At every stage, activities are founded on a process of Aboriginal-led partnership and collaboration between researchers and Aboriginal participants.

The *Solutions That Work* report highlighted the need for Aboriginal and Torres Strait Islander people with lived experience to have presence in any activity concerned with suicide prevention (Dudgeon et al., 2016). In the Lived Experience Workshop, Aboriginal and Torres Strait Islander community members with lived experience of suicide worked collaboratively with researchers and key stakeholders to bring forward their critical and unique knowledge. These individual contributions, based in expertise through lived experience, informed a report with various recommendations, including discussion of an Indigenous-specific culturally responsive lived experience framework. Participants were invited to be co-authors of any publications that arise from the Workshop, ensuring that community ownership over the research, and the collaborative nature of the Project were sustained.

### ***Reciprocity: Benefit***

Research findings concerning Aboriginal and Torres Strait Islander suicide demonstrate a significant and disproportionate rate of suicide and self-harm amongst the community with a clear need for culturally responsive service provision. Further, a holistic approach that encompasses all facets of social and emotional wellbeing including cultural and whole of community (collective) wellbeing, spirituality, connection to ancestry, land and culture are integral to the potential success of any responses to Aboriginal and Torres Strait Islander suicide prevention. As such, this Project recognised the key requirement of Aboriginal and Torres Strait Islander lived experience experts to guide appropriate suicide prevention strategies and programs for their own communities. In short, this innovative Project instigated Australia's first Aboriginal and Torres Strait Islander lived experience Workshop, informing the development of a lived experience framework for Aboriginal and Torres Strait Islander peoples, by Aboriginal and Torres Strait Islander peoples.



Consequently, research outcomes and recommendations formulated from Aboriginal and Torres Strait Islander participation in this Project contribute to a gap in existing knowledge regarding culturally responsive suicide prevention. Such knowledge assists in culturally responsive and appropriate service provision for suicide prevention strategies, programs and evaluation measures that can be utilised by key stakeholders and service providers to the benefit of Aboriginal and Torres Strait Islander peoples and communities. Importantly, outcomes determine how those with lived experience can continue to remain included in an empowering way. Recommendations for the development of an Aboriginal and Torres Strait Islander lived experience network and framework, and other outcomes of the Project have the ability to influence policy and procedure concerning social and emotional wellbeing in general, in addition to increasing the effectiveness of current Aboriginal and Torres Strait Islander specific suicide prevention strategies nationally. Moreover, by having an Aboriginal-led research collaboration in conjunction with ongoing consultation with Aboriginal and Torres Strait Islander lived experience experts regarding suicide prevention, the outcomes of this research are of national significance for researchers, service providers and Aboriginal and Torres Strait Islander communities.

### ***Respect***

This research was predicated upon respectful partnerships with Aboriginal and Torres Strait Islander peoples and communities. The Lived Experience Project process encouraged the development of genuine partnerships with lived experience experts and involved ongoing engagement whereby participants provided key recommendations and guidance as to the development and dissemination of Project findings. The Workshop process was integral to ensuring that Aboriginal and Torres Strait Islander participants were situated in an empowered and equal position to contribute to recommendations for the development of a culturally responsive lived experience framework for suicide prevention. Further, the Project respects Aboriginal understandings of culture and cultural safety, social and emotional wellbeing, suicide prevention and mental health, and facilitates the inclusion of Aboriginal and Torres Strait Islander knowledges. The research team has considerable experience working in research that is community based, capacity building and empowering. In particular, Chief Investigator Professor Pat Dudgeon led the National Empowerment Project (NEP) that worked with 11 communities across the country, in partnerships with community controlled organisations in each site and with two local co-researchers in each site. Further, Professor Dudgeon also led the ATSIPEP, which held 12 Roundtables nationwide to ensure full and proper participation and consultation.

The development of an Aboriginal and Torres Strait Islander specific lived experience perspective from Aboriginal and Torres Strait Islander lived experience experts is fundamental to this Project and in keeping with the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention's philosophical approach. The inclusion of lived experience knowledge is crucial to this process so that existing frameworks and suicide prevention strategies and programs, including national policy, are better informed. Through the PAR process, research findings are first at the community level to determine accuracy and appropriateness and to ensure the integrity of the Project. Further, the Project developed a communication and dissemination strategy that ensured outcomes in the final report, are presented in a manner that effectively translates to improved processes, policy, services and programs for Aboriginal and Torres Strait Islander specific suicide prevention.

A final report, including recommendations regarding an Aboriginal and Torres Strait Islander-specific lived experience framework and related national network, emerged from the Project findings. Looking forward, the Project recommends that a more detailed and broader consultation with Aboriginal and Torres Strait Islander peoples with lived experience takes place.

### **Equality**

Equality remains at the heart of this Project that intends to advance Aboriginal and Torres Strait Islander lived experience understandings as well as suicide prevention strategies. This Project strongly connects to community, regional, state and national Aboriginal and Torres Strait Islander health priorities and responds to ongoing and consistent needs articulated by Aboriginal and Torres Strait Islander peoples regarding culturally responsive suicide prevention, in particular the ATSISEEP *Solutions That Work* report. *Solutions That Work* highlighted the need for Aboriginal and Torres Strait Islander peoples with lived experience to have presence in any activity concerned with suicide prevention. It found that a common success factor in community-based interventions or responses to Aboriginal and Torres Strait Islander suicide is their development and implementation through leadership and in partnership with Aboriginal and Torres Strait Islander communities. This is not only because responses must address cultural and lived experience elements, but also because of the rights of Aboriginal and Torres Strait Islander peoples to self-determination, including being involved in service design and delivery as mental health consumers.

The research stemming from this Project provides a clear benefit for Aboriginal and Torres Strait Islander communities nationally via the development of culturally responsive skills and knowledge in the area of Aboriginal and Torres Strait Islander suicide prevention.<sup>[1]</sup> An acknowledgement of the diversity of Aboriginal and Torres Strait Islander peoples across the country and within communities was reflected in the recruitment strategy that invited participation of Aboriginal and Torres Strait Islander lived experience experts nationally, from a variety of contexts to ensure information collected appropriately reflects such diversity. In doing so, this Project minimised issues of exclusion to ensure findings that are both generalisable, whilst still allowing for local and specific implementation for each unique context (for example, urban vs. remote).

### **Responsibility**

This Project examined factors involved in culturally responsive suicide prevention from the perspectives of lived experience experts, forming qualitative data that informs recommendations for a lived experience network and/or framework for suicide prevention. As part of this process, researchers engaged in transparent processes regarding the goals of the Project in addition to specific methodology, conduct and dissemination of results and potential outcomes of the proposed research. More specifically, comprehensive measures of support ensured participation in the planned Workshop caused minimal exposure to harm for participants and that culturally responsive supports were available, if required. To this effect, ongoing consultation with Aboriginal and Torres Strait Islander lived experience experts nationally ensured appropriate review and community participation. This continuing feedback process with Aboriginal and Torres Strait Islander lived experience experts ensures the integrity of this project and its outcomes. Reports and papers as outcomes also acknowledge the significant cultural and intellectual contributions of Aboriginal and Torres Strait Islander communities and individuals in every instance. Participants of the Workshop were invited to be co-authors of reports and papers.

### ***Survival and Protection***

The Project contributes to strengthening and improving suicide prevention strategies and services for Aboriginal and Torres Strait Islander peoples nationally. Aboriginal and Torres Strait Islander communities must determine appropriate responses to suicide prevention themselves. As such, self-determination and community ownership of the integral roles of culture and lived experience must be explored within Aboriginal and Torres Strait Islander communities. The research process of this Project safeguards against discrimination and devaluing of Aboriginal and Torres Strait Islander peoples and cultures by engaging in ongoing consultation and feedback from Aboriginal and Torres Strait Islander lived experience experts. This process further supports the critical role of culture within effective and appropriate suicide prevention strategies and ensures that Aboriginal and Torres Strait Islander peoples' unique cultural distinctiveness (and associated service provision requirements) are respected and upheld. Further, Aboriginal and Torres Strait Islander values and perspectives underpin all recommendations to ensure appropriateness and maintenance of Aboriginal and Torres Strait Islander identity.

### ***Spirit and Integrity***

An underlying assumption in CBPATISIP's work is that Aboriginal and Torres Strait Islander disadvantage, high rates of ill physical health and poor mental health, and in particular, high rates of suicide, can be attributed to the ongoing impacts of colonisation. For Aboriginal and Torres Strait Islander peoples, colonisation was, and continues to be, a destructive process that displaces people from their country and their culture. The impacts of colonisation continue to influence Aboriginal and Torres Strait Islander lives as seen in consistently poorer outcomes across health, education, and employment, as well as social exclusion and a lack of recognition of cultural difference. Further, there needs to be recognition that Aboriginal and Torres Strait Islander peoples have great strengths and capacity. This needs to be highlighted and enacted in any research. Processes need to strengthen Aboriginal and Torres Strait Islander direction and inclusion, enact and encourage self-determination, and value culture in order to bring about meaningful outcomes and positive social change. Until recent times, research into Aboriginal and Torres Strait Islander issues was largely exploitative and oppressive, serving the agendas and the priorities of the, usually non-Indigenous, researchers rather than the Indigenous peoples and communities. Instead, this research builds upon the approaches seen in NEP and ATISPEP. As such, this Project takes a decolonising approach where a holistic and whole-of-life view of health and mental health encompasses the social, emotional and cultural wellbeing of the whole community. This includes genuine consideration of, and respect for, distinctive cultural and spiritual relationships, such as connection to land, culture, spirituality, ancestry, family and community, which are of utmost importance. This Project has a strong focus on the immense strength and resilience of Aboriginal and Torres Strait Islander peoples and research outcomes are translated into strengths-based preventatives regarding mental health policies and strategies. As mentioned, only Aboriginal and Torres Strait Islander researchers were involved in the lived experience Workshop. They have considerable experience in the field and a deep commitment to social justice. The shared values between researchers and participants not only ensured a partnership but also a commitment to personal and community level action to renew and protect identity, culture and life.



## Methodology of Literature Review

This literature review used many of the processes and principles of a systematic literature review but had restrictions on the breadth or depth to suit a shorter timeframe. The main research question for the literature review is *how is Aboriginal and Torres Strait Islander lived experience of suicide the same or different to that of other Australians?* Further, *what supports are required to empower inclusion of Aboriginal and Torres Strait Islander peoples?* In searching for literature on this topic, we sought to identify any gaps in the field in order to better inform research, programs, and policies on suicide prevention in the future.

There was a targeted approach in the search of relevant literature. Aboriginal and Torres Strait Islander experts with lived experience of suicide guided the identification of the most relevant papers. Relevant literature was sourced through a systematic search of various databases accessed via the University of Western Australia Library OneSearch database which includes all journal articles; periodicals, and dissertations. Search terms for this literature review included: suicide; self-harm; lived experience; Aboriginal and Torres Strait Islander; and Indigenous. To be included in the review, the document had to be focused on the lived experience of suicide. Documents that were focused on lived experience of mental health only were excluded from this review. Papers related to non-Indigenous lived experience of suicide were included because of the lack of literature specifically on lived experience for Aboriginal and Torres Strait Islander peoples and/or as a comparator for the ways in which Aboriginal and Torres Strait Islander lived experience of suicide is the same or different to that of other Australians.

Seven papers and one dissertation were found on the topic of lived experience of suicide. It was evident that the research on this topic is minimal with considerable absence in the literature. Therefore, it is apparent that further research needs to be conducted about Aboriginal and Torres Strait Islander lived experience of suicide in order to inform and improve practices in Indigenous suicide prevention. The following section examines current literature on lived experience, their findings, and their implications.

## Review Findings

A number of journal articles, dissertations, reports and a periodical were found on the topic of lived experience of suicide including:

- Framework for the Engagement of People with a Lived Experience in Program Implementation and Research: Review and Report for the LifeSpan Suicide Prevention Project (Suomi, Freeman, & Banfield, 2016);
- The Way Forward: Pathways to Hope, Recovery and Wellness with Insights from Lived Experience (National Action Alliance for Suicide Prevention, 2014);
- Lived Experience of Suicide Attempters Critical to Prevention (Mental Health Weekly, 2014);
- The Lived Experience of Adults Bereaved by Suicide: A Phenomenological Study (Begley & Quayle, 2007);

- *Alive and Kicking Goals: Preliminary Findings from a Kimberley Suicide Prevention Program* (Tighe & McKay, 2012);
- *The Aftermath of Aboriginal Suicide: Lived Experience as the Missing Foundation for Suicide Prevention and Postvention* (McAlister et al., 2018);
- *The Lived Experience of Mothers Bereaved by the Suicide Death of a Child* (Lynn, 2011); and
- *Lived Experience: Near Fatal Adolescent Suicide Attempt* (Dougherty, 2010).

Below the findings and implications of the papers are examined in detail.

The Australian National University (ANU) undertook a review and report titled *Framework for the Engagement of People with a Lived Experience in Program Implementation and Research: Review and Report for the LifeSpan Suicide Prevention Project* (Suomi et al., 2016). Here it is established that end users of health services must participate in the design and implementation of the services they use. This is because they are able to identify and communicate the needs of their group more effectively than an individual with no lived experience. Moreover, the Report states that:

*...active involvement has demonstrable positive effects on people with lived experience of the condition or topic of a study, including feeling heard and empowered, learning new skills and increased trust in researchers* (Suomi et al., 2016, p. 1).

The Report also states that the inclusion for those with lived experience can have negative implications if undertaken incorrectly. There is genuine concern that the exploration of complex traumas experienced by Indigenous lived experience experts could potentially exacerbate such trauma, if investigated without necessary care. Therefore, further work is needed to learn and improve processes and practice of including those with lived experience.

Suicide Prevention Australia has a set of guiding principles that the Framework (Suomi et al., 2016) has incorporated for the engagement of people with lived experience of suicide. These principles were noted earlier in this document.

It is important to question whether these principles are applicable for Aboriginal and Torres Strait Islander people and communities and to also consider what would best reflect their experiences. Potentially, these principles can also apply to Aboriginal and Torres Strait Islander people if their specific needs and cultural differences are examined in the first instance. Although Suicide Prevention Australia does involve Indigenous people in their work, this set of principles may have evolved from a non-Indigenous framework and therefore it is critical to examine them with an Indigenous lens.

The Report also discusses how to engage with people with lived experience of suicide. It proposes that there should be a systemic approach at four levels: individual; service program; organisational; and a policy and strategy level. Each level should include:

*...a set of strategies that are relevant to the design, management, deliver, and evaluation. This approach aims to provide opportunities and platforms for people with lived experience to be involved at each level* (Suomi et al., 2016, p. 15).

Further, how healthcare research should be conducted and how to plan for ongoing stakeholder involvement and engagement is discussed. There are three dimensions to consider when conducting research with stakeholders: which stakeholders to involve; at what stages of research they should be involved; and the level of involvement for each stakeholder at each stage. These factors can be considered when planning research with those with a lived experience of suicide, ensuring that stakeholder engagement is well considered and not merely an after-thought.

The National Action Alliance for Suicide Prevention (NAASP) in *The Way Forward: Pathways to Hope, Recovery and Wellness with Insights from Lived Experience* (2014) found that:

*...this long neglected area of lived experience can help save lives and provide hope to millions of people who survive a suicidal crisis each year (NAASP, 2014, p.8).*

A recurrent theme highlights that those with the most knowledge about suicide are those that have lived experience and are therefore in the best position to inform policy and advocate for change. The Report states that the area of lived experience has barely been accessed or documented and there is a need to build knowledge in this area, in order to help those experiencing suicidal thoughts and those who try to end their lives in better ways. Further, the engagement of individuals with lived experience in the development of suicide prevention strategies is a key aspect to improving practical suicide prevention on the ground. The NAASP has established a set of core values that should be adhered to when working with those who have survived suicide. These core values are:

- Fostering hope and finding meaning and purpose in life;
- Preserving dignity and countering stigma and discrimination;
- Peer support;
- Community connectedness;
- Engaging family and friends;
- Respect of cultural and spiritual traditions;
- Promotion of choice and collaboration in care; and
- Providing timely access to care and support (NAASP, 2014, p. 16).

The Report also provides a set of recommendations for working with those with lived experience of suicide. These recommendations are:

- Suicide prevention and behavioural health care organisations need to engage, hire, and/or collaborate with peer support professionals. Beyond work as peer support professionals, attempt survivors should be included as key partners in a wide range of suicide prevention efforts;
- Developing, evaluating, and promoting programs specifically intended to help the family and friends of survivors of suicide;
- Medical and behavioural health providers to integrate principles of collaborative assessment and treatment planning into their practices;



- Providers of crisis or emergency services to develop formal partnerships with organisations which offer peer support services and especially organisations that are operated or driven by people with lived experience;
- Hospitals and providers of crisis services to establish formal strategies for ensuring continuity of care by helping people transition to community supports; and
- Suicide prevention and behavioural health groups to engage survivors of suicide in developing, implementing and evaluating efforts (NAASP, 2014, p. 11).

The periodical *The Lived Experience of Suicide Attempters Critical to Prevention* (2014) is primarily a response to NAASP's *The Way Forward Report* and supports the recommendations made about the need for integrating the knowledge of individuals with lived experience in suicide prevention activities. It is proposed that health systems should make suicide prevention a core part of care and that organisations should engage and collaborate with peer support professionals, such as those with lived experience, to work and build on suicide prevention efforts. Most importantly, the article states:

*...peers contribute a sense of worth and meaning to those who have been on the journey* (Mental Health Weekly, 2014, p. 3).

*The Lived Experience of Adults Bereaved by Suicide: A Phenomenological Study* (Begley & Quay, 2007) is a research study based in Ireland that conducted eight in-depth interviews with adults who have a lived experience of suicide (bereaved). The study enlisted family members of individuals that had died by suicide. Four main themes from the interviews of those with a lived experience of suicide emerged: controlling the impact of suicide; making sense of the suicide; experiences of meeting new people after the suicide; and how the suicide personally changed their lives.

The study concluded that there is still much to be understood about the grief processes associated with suicide and how this is different from bereavement following other types of traumatic death. Lived experience bereavement can be different in a number of ways:

*...however, there is agreement that psychological processes such as an ongoing search for meaning, blame, guilt, rejection, and a perceived lack of social support are distinguishing factors in suicide bereavement* (Begley & Quay, 2007, p. 26).

Finally, Begley and Quay caution that those bereaved by suicide are a high-risk vulnerable group and require appropriate and effective support networks.

*Alive and Kicking Goals: Preliminary Findings from a Kimberley Suicide Prevention Program* (Tighe & McKay, 2012), briefly mentions drawing on the experience of suicide at a community level, in their research. The article states that:

*...there is a concern that a focus on risk factors negatively frames the lived experience of an Indigenous community by constructing suicide in terms of blame and powerlessness. Recent suicide prevention strategies have subsequently focused on enhancing protective factors, such as community connectedness, personal capacity and ownership of the programs. These strategies not only positively frame the community's lived experience but also help to ensure that suicide prevention strategies are more likely to become naturally sustaining.* (p. 240).

*The Aftermath of Aboriginal Suicide: Lived Experience as the Missing Foundation for Suicide Prevention and Postvention* (McAlister et al., 2017) appears to be the most recent publication on the topic of lived experience and was co-authored by a number of Indigenous authors. The authors discuss suicide bereavement and how there is a need to better understand it:

*The bereavement process for an Aboriginal and Torres Strait Islander person is additionally impacted by cultural factors, in that the loss of someone to suicide may trigger feelings of mistrust of the non-Indigenous community and mainstream health and social services that remain culturally insensitive and immersed in colonial attitudes and practices.* (McAlister et al., 2017, p. 52).

One of the authors, Julie Turner, shared her experience about the loss of her 17-year-old daughter to suicide 11 years ago and its profound impact still felt today. She talked about the need for ongoing support outside of the time immediately following the death, and how she had to search interstate to find a support group.

Leilani Darwin, another co-author, recalled how challenging it can be to work within the suicide prevention and mental health sector. Leilani is both bereaved by suicide and a survivor of suicide after several attempts. Her personal commitment and drive to see this issue addressed has had many impacts on her life both positive and negative. Her journey has included navigating the sector and advocating for the rights and needs of Indigenous people with lived experience when she feels that she is often the only person 'at the table' doing so. This has seen Leilani take a lead role in ensuring that there is an evidence base for Indigenous perspectives of sharing and contributing to the lived experience sector.

## Conclusion and Implications

Indigenous suicide is inherently different to mainstream suicide, due to the variety of factors and experiences unique to Aboriginal and Torres Strait Islander peoples in Australia. Historical and ongoing colonisation perpetrated against Indigenous peoples and communities, including forced removal of children, lack of self-determination, social exclusion, and covert and overt racism at individual and structural levels, contribute to Indigenous Australian's unique experiences of suicide. Such factors are not shared by non-Indigenous people, thus demonstrating/reinforcing the innate differences between mainstream and Indigenous suicide.

As the fifth leading cause of death among Aboriginal and Torres Strait Islander people, it is imperative that we begin to listen to individuals, family and communities' experiences of suicide. The CBPATISIP team at UWA undertook a workshop to bring together Aboriginal and Torres Strait Islander people who have lived experience of suicide. This literature review brought together the evidence of best practice of working with Aboriginal and Torres Strait Islander communities and examined literature that focused on the topic of lived experience of suicide. The limited literature that is available demonstrates that lived experience is a critical area to examine, if programs for suicide prevention are to be successful.

Research within Indigenous suicide prevention must address the need for cultural considerations and trauma informed care and include lived experience voices, as it is the right of Indigenous peoples to be involved in all aspects of service design and implementation. Further, the practice of involving people with lived experience at every level has multiple flow on benefits.

The evidence shows that suicide prevention programs need to be owned and led by Indigenous people if they are to be successful. For too long, programs have been developed and consultation with stakeholders has been conducted as an afterthought. Yet, there must be respect, acknowledgement and meaningful inclusion of the voices of people with lived experience, if more successful outcomes are to occur. Furthermore, when people share their lived experience of suicide in a safe environment, it can be part of their healing journey and can also be empowering to others that hear their story. The ability to have a positive influence and explain to service providers what is needed in this space can pave the way for improved programs and services. However, there are extensive cultural considerations that need to be closely examined when working with Indigenous people with lived experience of suicide. Indeed, this is one of the core aims of CBPATISIP in addressing suicide. Some of these considerations include:

- **Stigma and Shame:** Historically, as with mainstream society, stigma and shame were attached to Indigenous suicide. The public attention and discussions that take place now were not a reality in the past. There is much more comfortability around discussing suicide and suicide prevention in recent times.
- **Power Imbalance:** There is a power imbalance between Indigenous and Western culture. Although non-Indigenous organisations may consult with Indigenous people on suicide prevention measures, there is still a feeling of intimidation for some Indigenous people which is a very real barrier to having their needs heard and addressed. Indigenous people are often alone in a variety of meetings including groups, boards and advisories and are often not heard. This can be an alienating and disempowering experience.
- **Support:** There is a need to support people at a local level in voicing their opinions and concerns and sharing their solutions on suicide prevention. There are currently no formal support networks for Indigenous people about their lived experience nor is there a specific national peak representative body to lead this sector. Building peer support programs to encourage the shared voices of Indigenous people that is safe should also be considered.

All of the literature that was examined suggests that genuine and meaningful involvement of those with lived experience of suicide has positive implications on the individual themselves, those that they encounter and on the development of programs and service delivery. There is also a need to further explore how lived experience experts can advocate for and support changes in policy and relevant context direction across Australia. It is paramount that culturally responsive support is made available to both individuals with lived experience, in their participation within the suicide prevention field, as well as to organisations in learning how to best meaningfully engage and empower those with lived experience and their participation. Although there are organisations that currently consult with Aboriginal and Torres Strait Islander peoples, the most effective initiatives are owned and led by Indigenous communities.

As McCallister et al. (2017) suggests:

*Culturally appropriate healing is particularly necessary for Aboriginal and Torres Strait Islander people with lived experience of suicide bereavement. Cultural healing requires a strengths-based approach that acknowledges the community; in this way, the kinship networks that make communities more vulnerable in a time of suicide can also be the community's biggest strength. Aboriginal people are from a collective culture in which communities are built around support and connection, and teaching communities how to appropriately support each other via the input of people with lived experience is essential to a culturally-safe way to support Aboriginal and Torres Strait Islander people. (p. 54).*

Moving forward it is important to consider and refer back to the *Solutions That Work: What the Evidence and Our People Tell Us* (Dudgeon et. al., 2016) from ATSIPEP; the NHMRC guiding principles on working with Aboriginal and Torres Strait Islander communities; and the findings from this literature review.



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# Appendix One: Framework for the Engagement of People with Lived Experience in Suicide Prevention

