

Evaluation of Suicide Story

Final Report

February 2019

John Guenther and Shiree Mack



The Batchelor Institute evaluation team acknowledges the support of MHACA staff, the SSAAG and facilitators during the evaluation period. We also acknowledge the Elders and Traditional Owners of the Countries we visited and stayed on while conducting the evaluation. We thank all participants for sharing their thoughts and insights with us.

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Institute**

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List of abbreviations

ABS	Australian Bureau of Statistics
AI/AN	American Indian/Alaska Native
ASIST	Applied Suicide Intervention Skills Training
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
EQ	Evaluation Question
LGA	Local Government Area
LPP	Life Promotion Program
MHACA	Mental Health Association of Central Australia
NT	Northern Territory
NTPHN	Northern Territory Primary Health Network
SSAAG	Suicide Story Aboriginal Advisory Group



Stories of healing

Suicide Story has impacted on our own traditional culture, it's an amazing thing. Every few months when I go to facilitate a workshop it's usually at the time I need it. 'Cause I've been going through a few things myself, and I need to take a deep look and fix myself too. To me, Suicide Story makes me strong because I realise how important it is for my fire to be burning high if I am going to help anyone else. It makes us look at our own traditional lifestyles, where a lot of our healing will take place.

Dorrie Wesley

Executive summary

Introduction

Suicide Story came about in response to the growing recognition of the problem of suicide in remote Northern Territory communities. In 1998 MHACA established the Life Promotion Program (LPP) to respond to the issue of suicide. In 2001, the LPP began using Applied Suicide Intervention Skills Training (ASIST) but found that the program was not suited for Aboriginal people. The need for a focused program built around Aboriginal cultural safety, coupled with a learning process that connected with Aboriginal people, became apparent. The name 'Suicide Story' first appeared in 2008 following the creation of a series of locally developed resources. In 2010 the program was launched and trialled in three central Australian sites.

Funding from the Australian Government allowed for a further eight workshops and two train the trainer workshops. In 2011 the Suicide Story Aboriginal Advisory Group (SSAAG) was established to provide cultural advice and guidance for the program. A Facilitator's manual was completed, and the program continued with funding from the Northern Territory Government and more recently, the Northern Territory Primary Health Network. Since its establishment the program has been delivered on more than 45 occasions in 23 communities in the Northern Territory, Western Australia and South Australia.

The concept of 'Our Way' used by Suicide Story expresses the culturally safe foundations that ensure that knowledge and skills shared through the workshop processes are relevant for Aboriginal people. Requests for the program must come from community members (see Appendix 1, page 81). Once the necessary consultations are completed, a pre-visit to the community is conducted to ensure that everything is in place for the workshop. Once a date is confirmed a three-day workshop is delivered by trained Aboriginal facilitators in community.

A community plan emerges from this to support actions towards making the community suicide safe. A follow-up visit is arranged at least three months after the workshop to determine how the plan has progressed.

This report presents findings from an evaluation of the Suicide Story suicide prevention program. The evaluation was funded by the Northern Territory Government. The evaluation was conducted during 2018 by Batchelor Institute of Indigenous Tertiary Education. The evaluation aimed to assess the program's impact, inform the future development of the program, consider the indicators of impact and determine how to strengthen the role of trained facilitators. The evaluation was guided by a Steering Group comprising representatives from the SSAAG, MHACA, Northern Territory Government, members of the Batchelor Institute evaluation team and an academic researcher, independent of MHACA and Batchelor Institute.

About the evaluation

Three evaluation questions guided the evaluation.

EQ1: Is [and how is] the program producing its desired impact [resilience and suicide prevention] at the community [and individual] level?

EQ2: How can the impact be strengthened with follow up [or other] processes?

EQ3: How can community plans/safety plans be better utilised, monitored and enacted post-workshop delivery?

We used a qualitative methodology with participatory approaches to respond to these questions. We interviewed 30 stakeholders associated with or with an interest in the program. We also drew from qualitative monitoring and evaluation data gathered internally by staff over four years and documents such as workshop reports, annual reports and

several historical documents generated since 2008. In addition, we reviewed participation data captured by staff since 2013. All the evidence collected was added to an NVivo (qualitative analysis software) project which we used to identify key themes emerging from the data in response to the evaluation questions.

Key findings

We found strong evidence of impact from the program. Resilience was expressed both individually and socially through:

- Stronger skills to better respond to grief, trauma, and the needs of those who may be contemplating suicide;
- Greater awareness of the signs of suicidal thoughts;
- People talking about suicide more openly, with less stigma associated with the term;
- People helping each other;
- Greater confidence to act and intervene as required; and
- Empowerment, self-awareness and strength.

We found several factors that support these outcomes:

- A focus on cultural safety;
- The priority of community ownership;
- Having Aboriginal facilitators trained and leading workshop sessions;
- Sharing knowledge and stories;
- Restoring hope;
- Using local language;
- Maintaining program integrity, ensuring local protocols are adhered to;
- A focus on 'both ways' training; and
- The importance of reducing stigma associated with suicide.

One concern for several respondents was the tension between cultural governance provided by the SSAAG and management provided by MHACA. There was a strong view that to ensure that integrity of the program, as one run by and for Aboriginal people, it should be moved under the umbrella of an Aboriginal community-led organisation.

We found several ways that the program could be strengthened for greater impact.

First, we saw that more attention to planning and coordination could be brought to the pre-visits. Second, we observed that the way the workshop was conducted aligned well with the evidence of good practice found in the literature. Minor updates of resources used are required to ensure the presentations used are current. Third, we see considerable room for more focused attention on the follow-up element of the program, which currently has little capacity to build on the strength of the workshop outcomes. More time supporting the community with its plan is required. Fourth, greater impact could be achieved through expansion. Running more programs in more places has the potential to strengthen the cumulative impact of the program and equip more people with skills and knowledge to make their communities more suicide safe.

Another need identified was for a targeted youth program. Expanding the program will require additional resourcing. One of the challenges with expansion is ensuring that the program remains community controlled and informed by Aboriginal people to maintain its integrity. The SSAAG, which is currently comprised of members from the Northern Territory, should consider expanding its representation to include those from other regions, and those with particular expertise to meet the governance needs of an expanding program. Fifth, the program needs more trained facilitators. While 38 facilitators have been trained, only 13 of these have been involved in more than one workshop delivery. This represents a capacity constraint for the program.

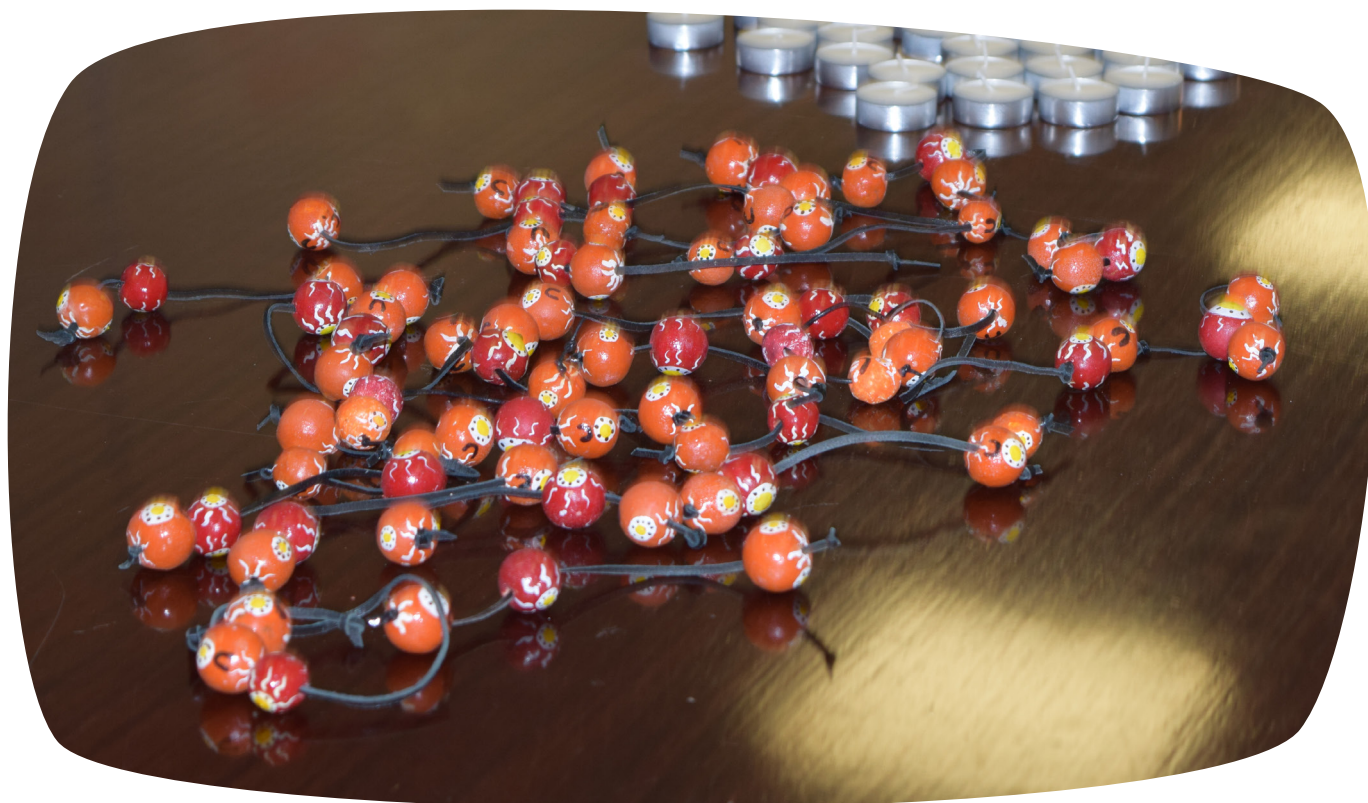
As noted earlier, follow-up is an area for improvement requiring additional resourcing. The community plans are integral to the program, but little attention is given to supporting these beyond a single visit to the community after the workshop. We see the need for identification of Community Champions who can be paid and called on to support the process of enacting community plans. Coupled with this, there is a role for a Community Development Coordinator whose role would support community actions towards suicide safe communities. We suggest that these functions should be trialled before being incorporated into the program.

Recommendations

The following 15 recommendations emerge from the evaluation.

1. We recommend that the Suicide Story workshop remain essentially as is, but with minor updates to resources and content as required.
2. We recommend that in conjunction with Suicide Story staff, MHACA management develops a customised professional learning plan to address identified skills gaps of staff.
3. In the context of workplace health and safety, we recommend that staff safety and wellbeing procedures be reviewed, noting particularly the need for safe travel to remote locations.
4. In conjunction with MHACA management staff, we recommend that the Program Manager's role more intentionally focus on strategic relationship development with a view to strengthening the perceived value of the program to existing and future funders, and to other suicide prevention stakeholders.
5. We recommend that the role of the Program Officer more intentionally focus on strategic relationship building, coordination and networking with community-based services in order to strengthen the support networks for community members.
6. We recommend that the pool of trained Aboriginal facilitators be expanded and strengthened to meet the growing demand for the Suicide Story program in communities.
7. We recommend that while MHACA and the SSAAG continue working on program development opportunities, the SSAAG considers options towards bringing Suicide Story under the umbrella of an Aboriginal community-led organisation.
8. We recommend that the SSAAG establishes a strategic planning process with Recommendation 7 in mind.
9. Following on from Recommendation 8, we recommend that the SSAAG recruit new members to fill in skills gaps it identifies.
10. As part of the Strategic Planning process, MHACA, with support from the SSAAG, should begin to explore ongoing and additional funding options.
11. We recommend that MHACA, with support from the SSAAG, more proactively engages with policy bureaucrats, politicians and senior experts in suicide prevention with a view to building financial and political support for the program.

12. Assuming that the SSAAG accepts and works towards Recommendation 7, we recommend that MHACA develops a transition plan and begins to work with the SSAAG in good faith towards that end.
13. We recommend that the MHACA, in conjunction with the SSAAG, pursues new project funds to trial the concept of a Suicide Story Community Development Coordinator and a Suicide Story Community Champion
14. We recommend that the SSAAG in conjunction with MHACA explore the potential for a set of culturally safe youth suicide prevention resources which would work alongside the existing Suicide Story program while at the same time applying for funds to continue the program as is.
15. We recommend the inclusion of a more critical post-workshop review process to ensure learnings can be better captured in workshop reports, and so that specific follow-up actions are documented.



..... Suicide Story Beads of Support
..... (Safety, Stories and Support)



Stories of hope

Around 3 months after a workshop delivery, the Program Officer travels back to the community to follow up with participants and hear their reflections from the workshop. They often share how they are able to recognise the 'worry signs'. On one occasion, when the Program Officer spoke to a man from a remote community, he shared that he sat with his nephew who was suicidal and he stated, "because of the workshop, I knew how to respond, and I had the confidence to support him through this hard time—he is now doing really good."

Introduction

Suicide Story is a suicide prevention and community capacity building program developed specifically with and for remote Aboriginal communities in the Northern Territory. The program content was developed through the teaching and guidance of Aboriginal people and centres on the specificities of Aboriginal protocols and suicide. Program workshops are delivered by local Aboriginal facilitators trained in the Suicide Story content and 'both-ways' learning. The program uses cultural paradigms to guide participants through the process of understanding suicide and reducing stigma so that participants can effectively identify and respond to the suicidal risk signs within their communities.

Suicide Story was developed by the Mental Health Association of Central Australia (MHACA) in partnership with local Aboriginal people of the Northern Territory. A Suicide Story Aboriginal Advisory Group (SSAAG) ensures cultural safety and storytelling integrity through workshop deliveries. The program recognises the importance of utilising a localised and culturally specific approach to suicide prevention that respects the needs and issues of each community. As a program model following the practices of cultural integrity, the program includes both pre-and post-community visits; a process that has been identified as integral to community healing and development.

This report presents the findings of an evaluation of Suicide Story. The evaluation was conducted by Batchelor Institute of Indigenous Tertiary Education led by John Guenther and supported by local community researcher, Shiree Mack. The evaluation was conducted through 2018 during the tenth year of the program's operation. The report presents findings from the evaluation against a background of relevant literature and makes recommendations based on a discussion of the findings.

The evaluation was conducted with funding from the Northern Territory Government.

Aims of the evaluation

The evaluation aims to:

1. Assess the impact of the program on an individual level
2. Assess the program's relevance and impact at the community level (particularly in terms of community development)
3. Inform the program to improve implementation into the future
4. Consider and test alternative indicators of impact (including the logic of the program and its causal mechanisms)
5. Understand how to strengthen the role of trained facilitators for professional/ community development

Out of scope in this evaluation was an assessment of the cost of the program or aspects of financial management of the program. Funding as an issue was raised in the evaluation and is tacitly included as part of Aim 3.

Background and history

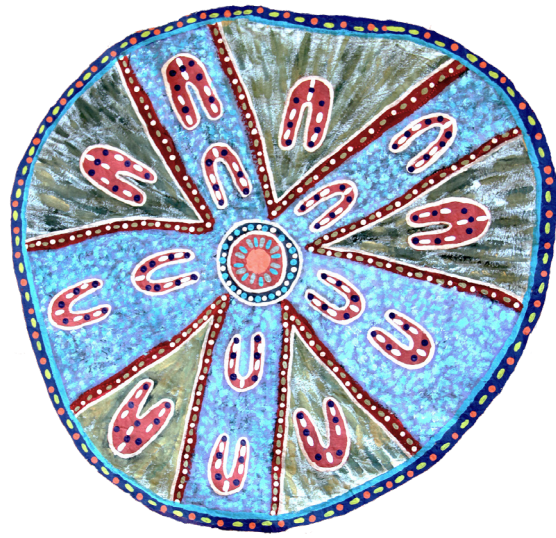
The demand for suicide prevention programs arises very simply from the tragedy of lost lives. The statistics about suicide (see Statistical background, page 24) represent people. At the launch of Suicide Story in 2010 Laurencia Grant commented on the rationale for Suicide Story:

It would be fairly true to say that there is not one Aboriginal family in the NT that has been spared the loss of a family member by suicide. Some people have witnessed a death by hanging in their communities... In my role, I receive notification of every death that occurs by suicide in Central Australia. On average 10 to 12 deaths occur each

year and approximately 80 per cent of these deaths are of Aboriginal men between the ages of 20 and 40 years. (Grant, 2010, p. 39)

The history of the program goes back to 1998 when MHACA established the Life Promotion Program (LPP) as a response to the increasing prevalence of suicide in central Australia. One of the strategies used by LPP was to deliver Applied Suicide Intervention Skills Training (ASIST). This was built on a Canadian model. MHACA staff recognised that this program was not suitable for many Aboriginal people and from about 2004 staff at MHACA began actively pursuing a model of training that would resonate with Aboriginal people in central Australia. In 2006, following several visits to Santa Teresa where local people were already engaging in conversations about suicide, local artist Mia Mulladad painted what would become the logo for Suicide Story (see Figure 1 below).

Figure 1. Suicide Story painting by Mia Mulladad



Then in 2008 a series of 22 drawings was commissioned, representing the 'worry signs' of suicide (Figure 2). The name 'Suicide Story' was adopted in 2008. In 2009, the MHACA Annual Report described Suicide Story as follows:

This culturally specific training tool is now in its final draft form and due for completion in late 2009. Aimed at helping reduce the incidence of suicide in remote and regional communities, it draws on a collection of interviews with Aboriginal people from across Central Australia including Alice Springs, Santa Teresa, Yuendumu, Tennant Creek and also Gove Peninsula. In the past year drawings, animation and film have been added to the resource which will be launched in January 2010. (Mental Health Association of Central Australia, 2009, p. 18)

Figure 2. Worry signs: extracts from Sue McLeod's drawings



Suicide Story was officially launched on March 3, 2010 in Alice Springs. The program was trialed in eight communities in the period to the end of 2011. In 2010, the Centre of Remote Health was commissioned to conduct an evaluation of the 'Suicide Story DVD' (Lopes et al., 2010). The authors concluded that the resource should be incorporated into a 'well facilitated suicide prevention workshop, including support and involvement

of local cultural consultants and Indigenous implementers' (Lopes et al., 2012, p. 232). They also encouraged ongoing evaluation of suicide prevention programs.

In 2011, the Suicide Story Aboriginal Advisory Group (SSAAG) was established to:

- Advise on how to train, support and mentor Indigenous trainers
- Advise on criteria for trainers and story tellers
- Recommend potential trainers and or story tellers
- Provide advice/ recommendations on the selection of suitable cultural consultants/ advisors
- Provide feedback on criteria for the cultural advisors
- Be committed ambassadors of the Suicide Story Program
- Advise/ identify potential Regional Ambassadors for the Suicide Story Program (Mental Health Association of Central Australia, 2011, p. 2).

Since then Suicide Story has developed and is described by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) as a case study example with 'promising practice' (Dudgeon et al., 2016). ATSISPEP's meta-evaluation of suicide-prevention programs assesses the program as follows.

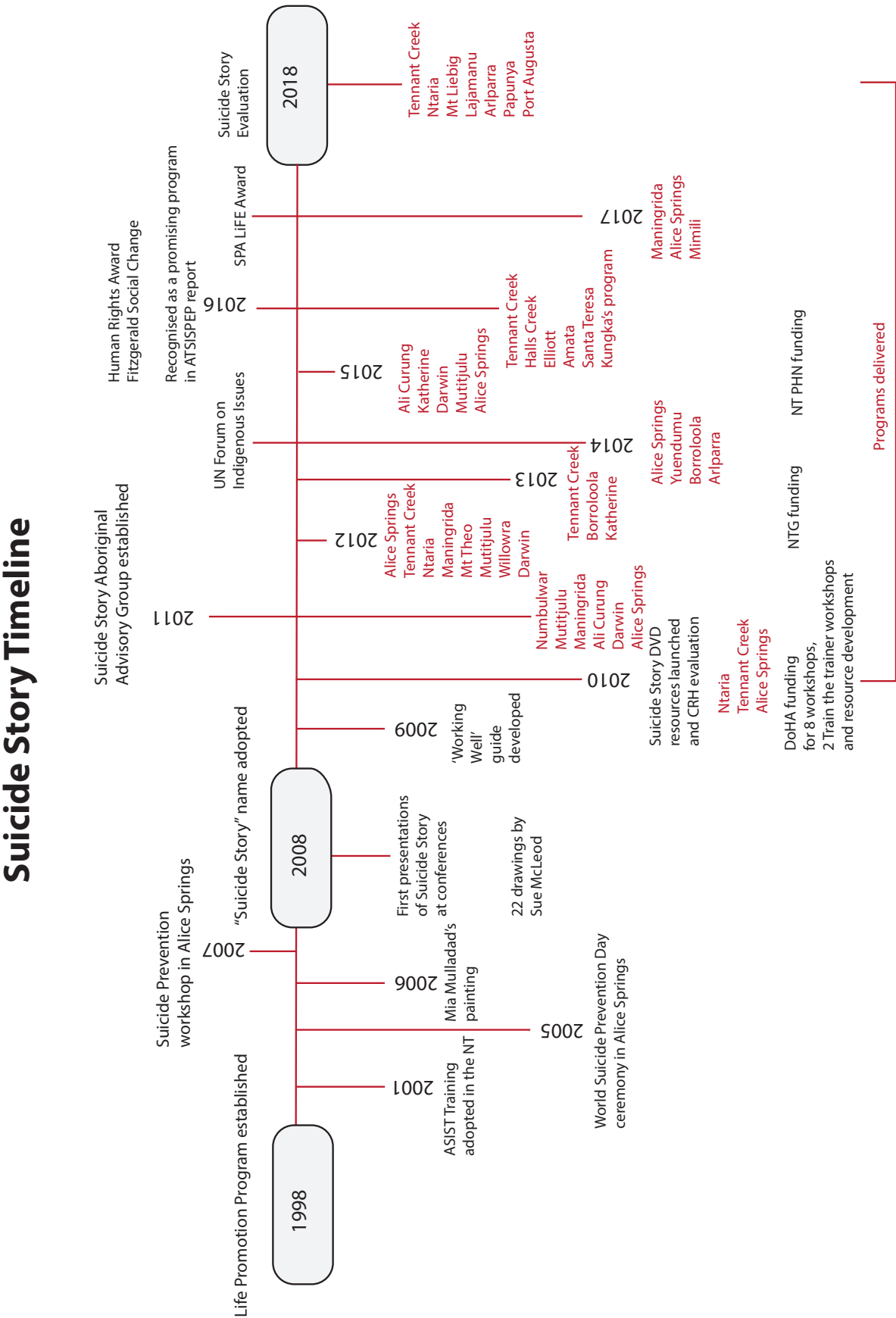
Suicide Story drew on a strong theory base of what works in suicide prevention training. The program has been adapted to be culturally responsive. This is a very organised, well-structured and designed program with a clear set of deliverables and reflexive practices. The program is flexible, dynamic and accommodates different learning styles, languages, traditions, issues, levels of readiness and still progresses through the nine stages. It is designed on a program logic and approach that adheres to the need for alignment with culture, localised approaches, utilisation of local people, respect for elders, spiritual and cultural values. It seeks to empower communities and individuals to identify the issues in their communities and lives and the ways to address them, including the service providers and programs already in their communities. (University of Western Australia, 2016a, p. 110)

In 2016 the program won the Northern Territory Fitzgerald Human Rights Award for Social Change (Roussos, 2016) and in 2017, the LiFE Award for the Aboriginal and Torres Strait Islander category (Suicide Prevention Australia, 2017). With the support and guidance of the SSAAG, the program was refined with much of the development work completed by 2016. The program has continued with the support of the Northern Territory Government and the Northern Territory Primary Health Network (NTPHN), and since beginning, has been run in 23 different communities (see Figure 6). The program celebrated 10 years since its establishment, in October 2018. A detailed timeline is shown below in Figure 3.



Suicide Story Aboriginal Advisory Group Members recipients of the 2017 LiFE Award, Suicide Prevention Australia.

Figure 3. Timeline of key events for the Suicide Story program



Our Way

The aim of Suicide Story is to create culturally appropriate ways for Aboriginal people to address suicide and develop the necessary skills that build suicide-safer communities' (Mental Health Association of Central Australia, 2012, p. 17). Suicide Story is described under the motto of 'Our Way'. Our Way embodies several principles which are articulated in detail in the Facilitator Manual, including:

- Use of appropriate adult learning strategies with a respect for Aboriginal epistemologies and ontologies (Mental Health Association of Central Australia, 2012, pp. 36-43)
- A commitment to 'both-ways' learning (Mental Health Association of Central Australia, 2012, p. 25)
- A philosophy and practice of 'cultural safety' (Mental Health Association of Central Australia, 2012, pp. 26-29) often using story-telling as the medium for communication
- Working in local languages (Mental Health Association of Central Australia, 2012, p. 34)

'Our Way' reflects an intent to draw from Aboriginal knowledge systems, values and ways of being rather than relying on non-Indigenous assumptions about what matters, how knowledge is shared and translated into practice. Suicide Story is however based on evidence gathered from both traditional indigenous¹ contexts (in Australia and internationally) and western disciplines, for example from the field of psychology. Primacy is however given to local ontologies, axiologies and epistemologies.

Program overview

Suicide Story includes several structural elements which are outlined in Figure 4 below. Before Suicide Story is delivered, a community or organisation must complete a request form (See Appendix 1, page 81). Requests are considered by the SSAAG and program staff. Decisions in response to a request are made based on community consultations, cultural consultations, need, scheduling requirements, commitment and capacity to respond. At all stages, engagement with communities only happens where appropriate permissions have been obtained from Traditional Owners or Elders.

Program staff then arrange a pre-visit to make arrangements for facilities, confirm dates for the workshop and meet with stakeholders. Suicide Story staff then arrange for trained facilitators (two males and two females) to deliver the program. Where possible, facilitators include some who will either be from the community or at least have a connection to the community through kinship ties.

Delivery of the three-day workshop follows. The workshop is structured according to a program which includes interactive activities, video presentations, role plays and demonstrations, reflections and sharing of stories. Topics covered include:

- Should we talk about suicide?
- Why is suicide a problem in Aboriginal communities?
- How big is the problem?
- How would you know if someone was at risk of suicide?
- What leads to people thinking about suicide?
- What can families and communities do to create a suicide safer community?
- What gets in the way of helping?
- What are good ways to support people at risk?
- How might people heal after a death by suicide?
- How can we keep the helper safe too?

An important component of the workshop is the development of a community plan that is designed to identify supports and actions that can make the community more suicide-safe. Pre- and post-workshop evaluation tools are used to assess changes in knowledge and feelings. The workshop uses a 'fire story' metaphor to bring together the various components of the workshop. The fire metaphor allows for a common language to be used with participants during and after the workshop. Participants are often asked "How is your fire burning?" Depending on the context, the program can be delivered to a small group of six, up to a larger group of 30. Facilitators take turns in leading activities with more experienced facilitators mentoring those with less experience.

After the workshop, Suicide Story staff (sometimes with facilitators) conduct a follow-up visit to the community to review the community plan and

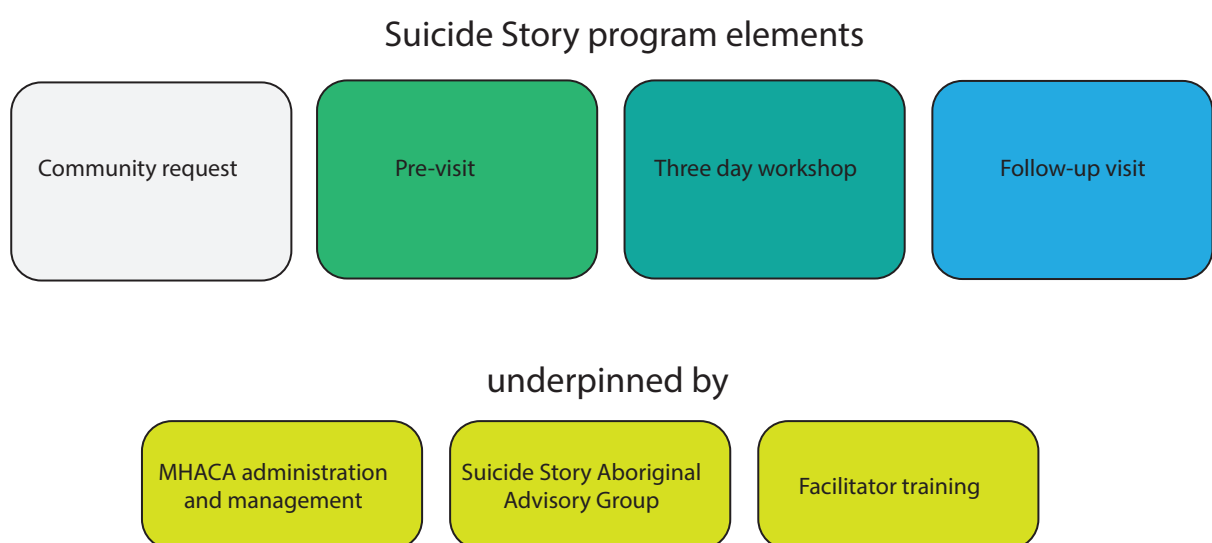
.....
¹ We use the term indigenous (lower case) to refer to First Nations peoples internationally. We use the term Aboriginal and Torres Strait Islander to refer to Australian First Nations peoples, except where we quote someone else. We use the term Aboriginal to refer particularly to people in communities where Suicide Story programs have been run.



Facilitators role playing
the 'Rock Wall' Activity

determine what has happened since the workshop. The follow-up visit occurs at least three months after the workshop to allow time for the community to act on their plan. Exact timing of the follow-up depends on other factors such as cultural business, competing priorities and sometimes weather conditions. After the follow-up, a report is prepared on the program in that community, with a summary of what occurred and some reflections on the impact.

Figure 4. Suicide Story program structural elements



The elements of Suicide Story shown in Figure 4 are underpinned by strong foundations and pre-conditions (See Appendix 2, Figure 24), without which the program would not be possible. MHACA has played a pivotal role in the development of the program and continues to provide strong administration and management for the program. MHACA auspices the financial resources that come from the funding bodies which are currently the Northern Territory Government and the Northern Territory Primary Health Network (PHN). Suicide Story staff (the Program Manager and Program Officer) are employed by MHACA.

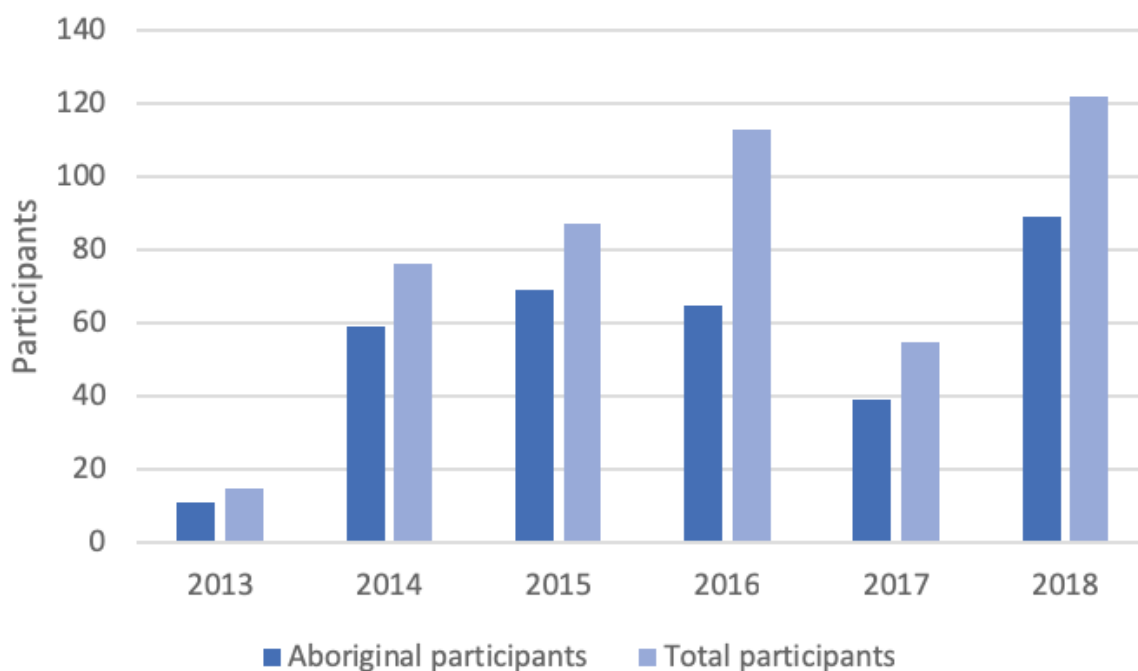
The Suicide Story Aboriginal Advisory Group (SSAAG) provides cultural governance of the program. All activities of Suicide Story are planned and implemented with guidance from the SSAAG. The SSAAG in collaboration with the program staff monitor, evaluate and review all workshop deliveries and provide assistance with community relationship building.

New facilitators are recruited through the workshops and are provided with training. Having a pool of trained trainers is important for the sustainability of the program. Each year facilitator training is offered to those who have volunteered to be part of the team. To date 38 facilitators have been trained.

Program activity: Participation, communities and facilitators

Figure 5 shows workshop participation by year. For the years prior to 2013 there are no reliable attendance records. The data for the first half of 2013 was not systematically recorded or collated. From September 2013 onward (the starting point for the chart), records are more consistent and show a breakdown of participants and completions for 27 separate workshops. These records show a total enrolment of 528, of which 468 participated and 393 completed. A total of 71 per cent of all participants were Aboriginal or Torres Strait Islanders. Workshop participant numbers varied from six up to 42 during this period, with an average of 17 people in each workshop.

Figure 5. Participant numbers for workshops conducted between 2013* and 2018



* For 2013, records of attendees were collated from September.

Figure 6 maps where workshops have been conducted. Note that several communities have had multiple programs delivered. These include Darwin, Alice Springs, Katherine, Tennant Creek, Borroloola, Arlparra, Ntaria, Mutitjulu, Maningrida and Ali Curung.

Figure 6. Suicide Story workshop locations (2009-2019)



Since 2014, data about facilitator involvement in workshops has been collected. Of 38 trained facilitators, 13 have participated in no workshops, 12 have participated in one workshop, and 13 have participated in two or more. On average, facilitators have contributed a total of 17 weeks (85 people days per year) to Suicide Story workshops each year. Further, 29 facilitators have been involved in at least one pre-visit, and 10 have been involved in at least one follow-up visit.



Stories of community ownership

There are times when communities go out of their way to make sure Suicide Story 'belongs' to them. This was highlighted in one top end community workshop where the 'in-kind' support went beyond what was expected. The community pulled together and provided a vehicle for the team, waived the accommodation fee, invited them to dinner, and took them to special places in the community. This kind of support made everyone feel welcome and comfortable, and demonstrated how collaborative work makes a difference to how the program runs.



Literature review

We commence our review of literature with a brief summary of available statistics relevant to the Northern Territory in particular. Next we draw on Australian and international peer reviewed literature to examine what ‘culturally appropriate’ means in the context of suicide prevention programs in indigenous communities. We then consider what the literature suggests ‘outcomes’ of such programs are.

In the last three sections we look for evidence in the literature that relates to important elements of Suicide Story: literature that supports ‘Our Way’, that shows how programs are governed and that shows effective processes of building community resilience.

Statistical background

In Australia, suicide is the tenth most common cause of death among males, but in the Northern Territory, in many regions it ranks in the top four causes. Male deaths from suicide exceed female deaths by a ratio of about 3:1 (Australian Institute of Health and Welfare, 2017). In 2017 in the Northern Territory there were 38 male and 13 female deaths by self-harm (ABS, 2018). The standardised death rate for death by intentional harm by Aboriginal and Torres Strait Islanders is 2.4 times the rate for non-Indigenous people—28 Aboriginal and Torres Strait Islanders died as a result of self-harm in 2017 compared to 23 non-Indigenous people. The problem is worse for younger people. In the Northern Territory, the rates for suicide are about seven times the national average.

The Northern Territory's Indigenous 25 to 34-year-olds had the nation's highest suicide rate over 2008 to 2012. Among this age group in the Northern Territory, the suicide rate was 68.9 per 100,000. (Dudgeon et al., 2016, p. 8)

Data reported by the Australian Institute of Health and Welfare (2018) shows that in the five year period to 2016, there were 159 males and 65 females who died by suicide in the Northern Territory. Of these, 43 males and 20 females were from very remote parts of the Territory.

Suicide among Aboriginal and Torres Strait Islander people has long been recognised as a concern. The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Department of Health and Ageing, 2013) adopted a strategic national approach to preventing suicide. It identified six action areas: 1) building strengths and capacity in Aboriginal and Torres Strait Islander communities, 2) building strengths and resilience in individuals and families, 3) targeted suicide prevention services, 4) coordinating approaches to prevention, 5) building the evidence base and disseminating information; and 6) standards and quality in suicide prevention. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) arose from concerns that the Strategy should have impact. The Final Report of ATSISPEP (Dudgeon et al., 2016) comments that ‘There is surprisingly little evidence about what works in general population suicide prevention, let alone an Indigenous-specific prevention’ (p.1) . It identified several factors that were found to contribute to successful programs. Importantly its first recommendation argued that:

All future Indigenous suicide prevention activity should ... include a commitment to, and a provision for, the evaluation of the activity and the dissemination of findings to further strengthen the evidence-base. (Dudgeon et al., 2016, p. 4)

Suicide Story is one attempt developed in the Northern Territory, to address the concerns raised above.

What does 'culturally appropriate' mean in the context of emotional resilience and contextually responsive local programs?

Suicide Story claims to be built on strong foundations of 'cultural safety' (see Introduction, page 14) and 'Our Way' attempts to engage people in 'culturally appropriate' ways (See Our Way, page 18). The definitions of 'culturally appropriate' or 'culturally safety' vary considerably in the context of program delivery for indigenous communities. Most of the literature presented in this section draws specifically from suicide prevention research.

Adaptations of mainstream approaches

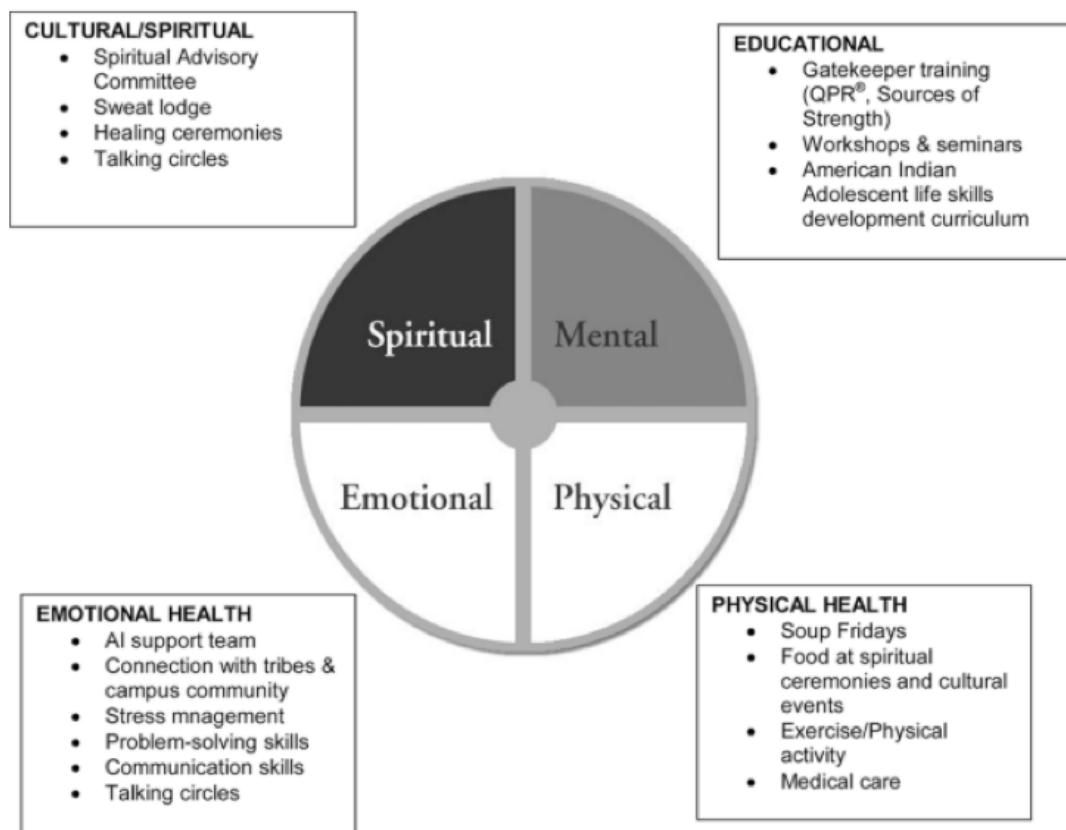
In some cases existing mainstream strategies are adapted to suit the local cultural context (see for example Le and Gobert (2015) with an adaptation of 'mindfulness' and Kitchener and Jorm (2008) for an adaptation of 'mental health first aid'). In some studies engagement in the research is connected

to a community-based participatory developmental approach (Allen et al., 2009; Cwik et al., 2016; Hallett et al., 2017; Henry et al., 2012; Isaak et al., 2010) sometimes using empowerment principles (Cox et al., 2014) or social change agendas (Fanian et al., 2015) as opposed to 'intervention' (Wexler et al., 2015a). Wexler et al. (2016) add a dimension described as a community of practice, built on 'Indigenous Adult Learning as an organising framework' (p. 117).

Culturally embedded and legitimate

In other cases, the process is fully integrated into existing cultural and social structures and philosophies, such as the model shown at Figure 7, which relates to a program for American Indians (Gray & Muehlenkamp, 2010). Other programs are similarly built on a foundation where the social infrastructure of culture and the 'sacred' is central to activities (Rasmus et al., 2014). There is a suggestion by some that culture is treatment or prevention (Walker & Bigelow, 2015). In the Australian context this view is reflected in the Elders Report (Culture Is Life, 2015) and many initiatives highlighted in the ATSIPEP report, Solutions that Work (Dudgeon et al., 2016).

Figure 7. Medicine wheel model of culturally integrated prevention. Source Gray and Muehlenkamp (2010, p. 184)



In other cases, cultural legitimacy is contingent on program teams representing the population. In an evaluation of an American Indian program, Langdon et al. (2016) report that

Due to the field coordinator's expertise in previous research and the community, she was successful in nurturing community relationships, recruiting, and interacting with participants; and exercised a strong understanding of the importance of confidentiality (p. 460).

Community control is recognised as an important underpinning element of programs designed for/by indigenous peoples (Dudgeon et al., 2016; Lewis et al., 2014). For example, from the 'People Awakening' project, a partnership between university researchers and Alaskan Native communities

The approach stresses a community-controlled process flowing from Indigenous values and beliefs, leading to the creation of a culturally congruent process of intervention development, and to community ownership, that in turn leads to prevention activities that impact intermediate and ultimate outcomes. (Allen et al., 2014b, p. 108)

Grief, loss and the impact of colonisation

The connections to historical and ongoing experiences of grief, loss and trauma are also reflected in the thinking about culturally appropriate prevention programs. Garrett et al. (2014) discussing interventions for Native American youth suggests that

recognizing and addressing historical trauma also provides a starting point for the design of ethnically-specific preventive and therapeutic interventions taking into account the historical experience of colonization and current social and political issues facing a tribal community. (p. 478)

This assessment is not restricted to the North American context and is reflected in other Australian (McEwan et al., 2009) and international studies (Malone et al., 2017), some of which talk about traditional healing practices (Taylor et al., 2014). From the Maori context, Lawson-Te Aho (2013) describes 'soul healing' as a process for transformation. In the central Australian context this can mean involving ngangkari, as suggested by Togni (2017).

What are the outcomes of programs and what does their causal logic look like?

We now turn to consider the outcomes of suicide prevention programs as found in the research literature. We first consider resilience as a specific outcome, and then review literature describing programs that show changed behaviours. Then we turn attention to outcomes in response to causes and determinants.

Resilience

The literature reviewed targets research on suicide prevention programs. Resilience, a feature of most programs reviewed, was connected to several related concepts. Ridani et al. (2015) in their study of 67 Australian programs, associated resilience with **well-being, coping mechanisms, hope** and **connectedness**. In their study of social and emotional wellbeing at Yarrabah (Queensland) McEwan et al. (2009) connect resilience to **problem solving**. Taylor et al. (2014) and Garrett et al. (2014) add reduced isolation and healing together with **reversing impacts of trauma**. Gray and Muehlenkamp (2010) associate resilience with skills and **strengthened relationships**. Redvers et al. (2015) specifically connect **mental wellbeing** to resilience. Lewis et al. (2014) describe resilience in terms of '**cultural pride, connectedness, and collective self-esteem**' (p. 77). Fanian et al. (2015) summarise resilience as a '**capacity to navigate**':

In the context of exposure to significant adversity, resilience can be understood as "both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways" (p. 2)

The definition and other associated terms listed above are not exhaustive, but they do capture a sense of the breadth of what resilience might look like.

Suicide-related behaviours

The research literature includes a number of systematic reviews which identify strategies designed to prevent suicide and related behaviours. Clifford et al. (2013) identified three mechanisms driving interventions: community prevention, gatekeeper training, and education. Of these, two community prevention interventions were found to

have a positive **impact on suicide completions or gestures** (behaviours that indicate intent). Another community prevention program reported increased **protective behaviours**. The outcomes reported for gatekeeper and education programs were mainly described in terms **of knowledge, problems solving and communication skills**. The authors comment that the connections between increased knowledge and reduced suicide are not explored in these studies. In another systematic review of youth suicide interventions Bennett et al. (2015) found no evidence that programs for youth were effective in reducing suicide related behaviour. In terms of the causal logic employed, the authors found several proxies used to point to effectiveness. These **included suicide-related hospitalisations, reports of self-harm, missed treatment appointments, improved identification of suicidal patients and improved gatekeeper knowledge and skills**. Similarly, Harlow et al. (2014) examining culturally appropriate programs designed to prevent suicide among indigenous youth report several proxies for effectiveness including **participant satisfaction, increased knowledge, questionnaire responses and assessments based on psychometric instruments**. Nasir et al. (2016), reporting on six gatekeeper training programs identified through a systematic review, found that most outcomes were related **to satisfaction, knowledge, desire to help people at risk and increased skills and confidence**. They found one program (also reported in Harlow et al. 2014) that had a positive impact on **hopelessness and suicidal ideation**.

While not a systematic review, an examination of 67 Australian suicide prevention programs designed for use with Aboriginal and Torres Strait Islander communities documented by Ridani et al. (2015), provides a comprehensive overview of reported outcomes and processes used. Consistent with the systematic reviews discussed above, the most frequently reported outcomes included **increased suicide awareness and readiness to help a person at risk, improved protective factors such as resilience, and improved help-seeking behaviour**. The authors noted that only one program (You Me—Which Way) measured and reported **reduced suicide ideation**, despite more than one-quarter of programs claiming reduced suicide rates.

Despite the large number of evaluations that have been conducted there is general agreement in the literature that a) the causal connections from program activity through to intermediate outcomes and

suicide prevention are largely unreported; and b) the measurement of suicide-related behaviour outcomes is rarely considered. One very simple reason for this is the difficulty associated with accessing and verifying reported deaths by suicide (Campbell et al., 2016). Attribution to program outcomes may be even more problematic.

Focusing on causes and determinants

In some of the literature, a culturally responsive approach demands measures connected to local cultural and philosophical frameworks, rather than extrinsic and objective indicators. In the example from Gray and Muehlenkamp (2010) cited earlier, the measurement of change was connected to the elements of medicine wheel framework (Figure 7). In other cases, the outcomes to be addressed are not so much connected to the 'obvious' measures of ideation, attempts and completions, but on the **apparent root causes of suicide, such as forced cultural assimilation and the concomitant cultural discontinuity** that manifests itself in suicidal behaviours (Jacono & Jacono, 2008). LaFromboise and Malik (2016), discussing evaluation of culturally appropriate American Indian/Alaska Native (AI/AN) prevention programs note that:

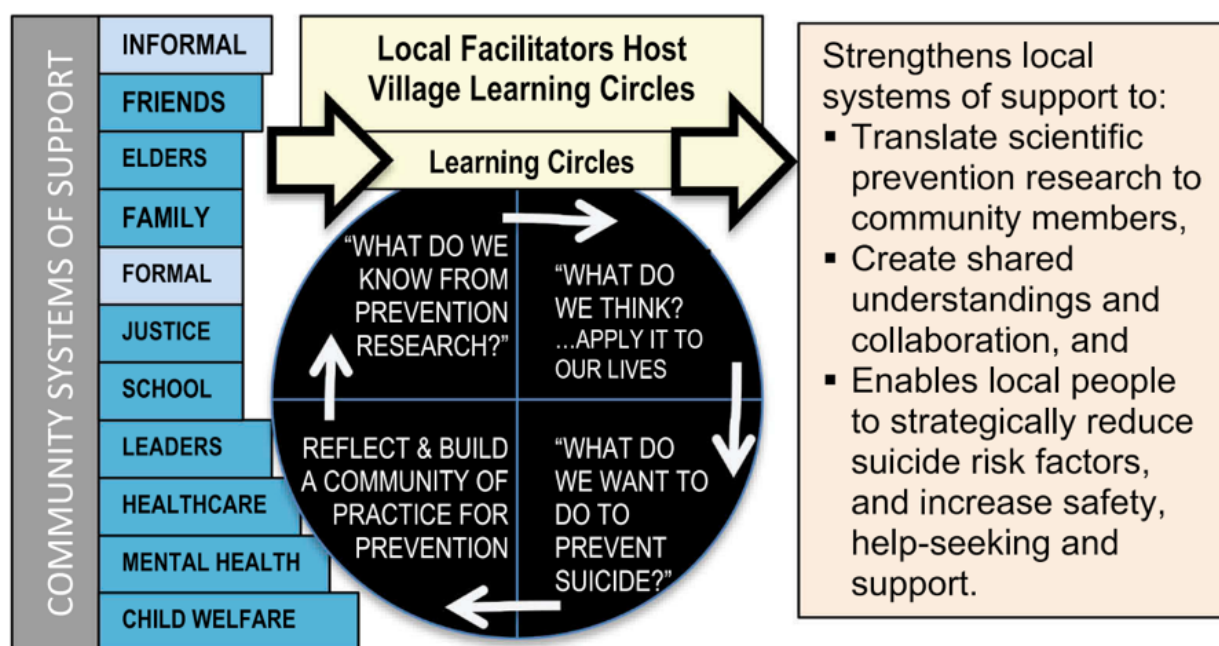
The specific demands of scientific inquiry may sometimes be at odds with the preservation of traditional ways of life. The requirements of funding agencies regarding evidence-based prevention programs oftentimes overlook the value of such traditional knowledge. This system leaves many AI/AN communities at a disadvantage and may force them to adopt intervention implementation and evaluation styles that are disrespectful of AI/AN protocol and at odds with tribal sovereignty (pp 237-238).

While one of the clear aims of many programs is to support those who are at risk of suicide, another aim, which is sometimes ignored in evaluation reports and research papers, is the **impact of programs on those in communities who are grieving**. One paper, which discussed an arts-science initiative with Irish Travellers, concluded that a response to 'perpetual grief' was an important outcome: '[The initiative] also incorporates being present to the pain of others, acceptance of death by suicide and offers consolation around individual and collective grief' (Malone et al., 2017, p. 11). It is within this context of grief, trauma and oppression that a language of

'healing' emerges in the literature as an outcome of programs (Barker et al., 2017; Gone, 2010; Lawson Te-Aho, 2013; Lewis et al., 2014; Togni, 2017).

Wexler and colleagues (Wexler et al., 2015a, 2015b; Wexler et al., 2016; Wexler et al., 2017a) have focused on facilitated education programs to effect community-led responses for suicide prevention. Figure 8, drawn from their work highlights a community collaborative initiative, where the process is sharing information and the outcome is community-led strategies. Their reported evaluation suggests positive effects in terms of **knowledge, ideas and intention to act**.

Figure 8. Promoting community conversations about research to end suicide
Source: (Wexler et al., 2017b)



Among the papers that are based in epidemiological approaches, sometimes using the language of 'epidemic' (Gray & Mason, 2015) the discussion turns to addressing 'risk factors' (Bennett et al., 2015; Clifford et al., 2013; Collins et al., 2017) social, historical and political determinants (Cox et al., 2014; Hatcher et al., 2017) and behavioural determinants such as alcohol abuse and drug use (Allen et al., 2014b; Moniruzzaman et al., 2009). Measurement of outcomes then is often achieved through assessment on the basis of a test or scale (Allen et al., 2009; De Silva et al., 2016; Mohatt et al., 2014; Shand et al., 2013). Concerns of some authors also turn to the poor quality of evidence to show what works (Redvers et al., 2015). What can happen then is that the language of 'psychosocial treatment' uses culture as a 'consideration' in measurement rather than an integrating support (Goldston et al.,

2008). The language used here is clearly contrary to approaches that draw on traditional knowledge systems and story-telling approaches to gathering evidence of impact.

While cultural approaches may sometimes be at odds with epidemiological measurement approaches, 'determinants' cannot be ignored when responses to suicide are considered, a point noted in the ATSIPEP report:

In Indigenous communities such conditions are associated with poorer mental health and higher exposure to traumatic and stressful life events with resulting psychological distress and trauma... that is, in turn, associated with suicide. (Dudgeon et al., 2016, p. 18)

ATSISEPP also recognises the importance of addressing 'community challenges, poverty and social determinants' as well as 'alcohol/drug use reduction' (p. 16) as recognised success factors for primordial suicide prevention.

As noted later in the section on 'Building community resilience' (Figure 11, page 33) there are numerous issues that individuals, families and communities face including health, employment, violence, racism, housing, financial issues and more (Cox et al., 2014). Identity challenges are also associated with these determinants. For example, from Alaska:

Persistent and unresolved trauma arising from shared colonial experience has resulted in loss of cultural practices, an assault on individual and collective identities, and disruption of parent-child relationships. This experience is one key element in a constellation of social determinants of the chronic social and health problems many Alaska Natives are experiencing. (Lewis et al., 2014, p. 64)

One cannot ignore the legacy of intergenerational trauma as a factor contributing to suicide (Moniruzzaman et al., 2009; Wexler et al., 2015a).

What is the underpinning evidence for 'Our Way' and how can this be articulated?

Earlier, we articulated 'Our Way' as four inter-related principles of practice:

- A commitment to 'both-ways' learning
- A philosophy and practice of 'cultural safety' often using story-telling as the medium for communication
- Working in local languages
- Use of appropriate adult learning strategies with a respect for Aboriginal epistemologies and ontologies.

'Both-ways' is a particularly Australian concept often used by Aboriginal people to express the coming together of two epistemological frames of reference. Both-ways is a philosophy of education

that 'brings together Indigenous Australian traditions of knowledge and Western academic disciplinary positions and cultural contexts, and embraces values of respect, tolerance and diversity' (Ober & Bat, 2007, p. 69). While the broader definition is supported in the international literature reviewed, several Australian papers express support for this philosophical approach (Culture Is Life, 2015; Dudgeon et al., 2014; Lopes et al., 2012; McEwan et al., 2009; Togni, 2017).

'Cultural safety', similarly is a term used more in Australian literature reviewed (Dudgeon et al., 2016; Lopes et al., 2012; Togni, 2017), though related concepts are used to articulate foundations of some programs in the international literature (Harlow et al., 2014; Wexler et al., 2015c) including 'safe spaces' (Fanian et al., 2015) and the process of sharing stories in 'sharing circles' (Isaak et al., 2010), 'learning circles' or 'community conversations' (Wexler et al., 2017b see also Figure 8 above), 'circles of strength' (Gray & Muehlenkamp, 2010), and through 'culturally congruent' processes (Allen et al., 2014b). All these are consistent with culturally safe practice. Processes of telling stories are commonly described (Fanian et al., 2015). Garrett et al. (2014) describe the transformative process of sharing in the context of programs for Native American youth:

A transformation often occurs when Native people come together around food—family members often laugh, tease each other, and share stories. Many tribal oral traditions communicate important life lessons through the subtle humor expressed in the stories (p. 476).

Rasmus et al. (2014) specifically discuss the importance of 'bidirectional' knowledge sharing in the context of researchers and communities working together. Local language use is associated with the 'thinking work' of Anangu in the Uti Kulintjaku Project, documented by Togni (2017) and diagrammatised in Figure 9, below. Suicide Story, while not the same as Uti Kulintjaku, uses similar processes. The outcomes presented correspond quite well with many of those in Suicide Story. For example, Suicide Story uses 'genuine two way learning', creates a space for a language to develop around suicide, and supports healing, empowerment and confidence.

Figure 9. Conceptual model for Uti Kulintjaku, the Path to Clear Thinking (Togni, 2017, p. 272)



While not necessarily reflected in outcomes, the practice of using one's own language is identified in several Australian programs discussed by Ridani et al. (2015). There is some recognition in the international literature that speaking a traditional language is an important element of resilience and a cultural protective factor (Barker et al., 2017) and an important element of healing practices (Walker & Bigelow, 2015).

Wexler et al. (2016) stands alone in the literature to articulate an organising framework for 'Indigenous adult learning' (p. 117) based on principles of community grounded epistemologies within programs. The principles emphasise collaborative inquiry, sharing stories, reflecting on meaning and relevance. These are consistent with the principles described in the Suicide Story Facilitator Manual (Mental Health Association of Central Australia, 2012, p. 36).

How are programs managed/governed/led/structured?

The guidance of ATSISEPP is informative for a starting point on the issue of governance:

In practice, the involvement of Elders cannot be separated from community leadership and this is particularly so for cultural elements in responses. Elders are best placed to ensure that interventions meet cultural governance and that responses in general are delivered within a cultural framework.

Generally, suicide prevention activity should aim to employ community members. Peer-to-peer context is a common feature of several successful programs, particularly those aimed at young people. Such an approach provides an opportunity for suicide prevention activity to address community unemployment rates and to create

culturally relevant jobs and long-term employment for community members. (Dudgeon et al., 2016, p. 2)

It could be argued that a culturally safe program is indeed one that by definition includes strong elements of elder involvement, culturally congruent decision-making, and respect for local leadership protocols (see for example Allen et al., 2014b; Hatcher et al., 2017; Le & Gobert, 2015). Local advisory groups are mentioned (without explaining functions) in some studies (see for example Allen et al., 2009; Fanian et al., 2015; Hallett et al., 2017; Henry et al., 2012; Isaak et al., 2010) and are supported by ATSISEPP (Dudgeon et al., 2016). Some in the literature reviewed, argue that community control is an important resilience factor.

For example;

The implication is Native communities that are able to preserve their cultural past and additionally, able to exert local control over their present and future lives through enhanced self-determination, have significantly lower suicide rates. (Lewis et al., 2014, p. 74)

Aligned to aspects of control, is broad community support and ownership (see for example Fanian et al., 2015 in youth programs). Allen et al. (2009) argue that high levels of community ownership underpin community readiness for a program, and allow it to transition into a community development process rather than an intervention. Figure 10 summarises the stages they argue for.

Figure 10. Allen et al.'s (2009) stages of community readiness

Table V. Stages of community readiness.

1.	No awareness: issue not recognized as a problem
2.	Denial / resistance: issue recognized but not as occurring locally
3.	Vague awareness: local concern recognized, but no immediate motivation to confront
4.	Preplanning: recognition of concern but efforts unfocused
5.	Preparation: active planning and modest community support
6.	Initiation: effort justified by community and activities underway
7.	Stabilization: activities supported by leadership with trained and experienced staff
8.	Confirmation/expansion: efforts in place, community supports expansion, local evaluation
9.	High level of community ownership: sophisticated knowledge, evaluation, application of model to other issues

It is important to note that the literature reviewed generally does not prescribe a particular form of governance. Rather, it promotes principles of community-led leadership, cultural control and local ownership.



Building community resilience

In the context of Suicide Story activities, ‘resilience building’ is integrated in the workshop and the community follow-up visit. An important element of the workshop is the development of a wish list. The follow-up community visit is at least in part designed to support the community’s plans for action. The follow-up concept provides limited resources and does not promise to be ongoing. But in an ideal world, how might community resilience be strengthened?

We noted earlier (see page 26), that resilience has several attributes, often associated with individuals and their relationships with others. However, the literature on community resilience building is generally associated with sociological terms such as ‘capability’ (Wexler et al., 2014), ‘capacity building’ (McCalman et al., 2016), ‘community development’ (Dudgeon et al., 2016), ‘empowerment’ (Cairney et al., 2017), ‘partnerships and collaboration’ (Allen et al., 2014a) and ‘social capital’ (Ledogar & Fleming, 2008). The question of how resilience is built extends beyond suicide prevention programs, and so some of the literature that follows may not specifically relate to suicide prevention. Attention is however focused on resilience building in indigenous communities—how they determine to survive.

The concept of ‘capability’ derives from Amartya Sen’s philosophies described in terms of freedom, agency and pluralism, coupled with human rights. According to Sen capability is ‘the opportunity to achieve valuable combinations of human functionings—what a person is able to do or be’ (Sen, 2005, p. 153) and importantly, for Suicide Story, capability is linked to wellbeing (Sen, 1993). According to Klein (2016) while the language of capability has crept into Indigenous policy rhetoric, the term is often limited by equating capabilities as a set of ‘essentials’ (e.g. employment and qualifications) coupled with responsibilities. Yap and Yu (2016) suggest that operationalising capability in Aboriginal and Torres Strait Islander communities requires a reconsideration of functions in terms of local values and priorities, which may reconceptualise what capabilities count for wellbeing.

Learning does however play a critical role in the development of capability generally (Walker et al., 2007). In the context of remote Aboriginal communities of the Northern Territory, adult learning plays an important role in reframing identity, enhancing agency and enabling people to exercise choices (Disbray & Guenther 2017; Guenther, 2006;

Sushames, 2006). Learning is quite different from ‘training’, which often fails to deliver the promise of increased capacity (Guenther & McRae-Williams, 2015). Nevertheless, in the context of suicide prevention programs and other programs designed to improve resilience, training, learning, education and skills can be an important component (Stephens & Monro, 2018). ‘Empowerment’ is often associated with wellbeing and resilience and often this is achieved through some kind of educative program (Tsey et al., 2009), and particularly programs that affirm culture, Country and language (Ganesharajah, 2009; Healing Foundation, 2015; Wilson et al., 2018).

Programs and structures that support and facilitate culturally safe intergenerational knowledge exchange are also important for building resilience and wellbeing (Arnott et al., 2010; Yap & Yu, 2016). However, as Prout (2012, p. 326) notes: ‘Cultural knowledges are also transferred through informal relational, and ceremonial practices, and these forms of learning and education are generally not measured in wellbeing frameworks’. Nevertheless, for communities to become more resilient, the normal cultural processes that enact this kind of knowledge exchange, are fundamental for resilience. There is an important lesson here for those programs that might target ‘youth’, and that is that wellbeing in these contexts is bound up in bringing together senior knowledge holders with younger people (Bond, 2010; Douglas, 2011; Yiriman Project, 2015).

More often than not, community resilience building requires collaborative partnerships (Ridani et al., 2015). In part this is sometimes because the ‘capacity’ of the communities to establish and run programs on their own, is limited by their size, resources and specific expertise, such as research capacity (Allen & Mohatt, 2014). The partner organisations providing the necessary capacity may or may not be Aboriginal controlled but the direction for the partnership should be local and built on mutual respect and trust (Disbray & Guenther 2017; Godinho et al., 2015; Hoffmann et al., 2012) and may require a considerable time commitment and ‘adaptivity’ from the outside organisation (Arnott et al., 2009). Dudgeon et al. (2016) however, do suggest that partnerships should be between Aboriginal Community Controlled organisations and communities in order to be effective. One of the purposes of partnerships is to find ways of overcoming the social and cultural determinants that contribute to suicide risk. Wexler et al. (2015a, p. 896) note that ‘Investigating locally derived, empowering approaches to research will inform efforts to engage with Indigenous communities to promote productive,

endogenous, and sustainable change'. One approach used by the National Empowerment Project, identifies key issues for families, individuals and communities (see Figure 11) through consultations and then develops empowerment strategies to address these (Cox et al., 2014). These strategies are designed 'to support culture and promote healing, empowerment and leadership' (p. 348).

Figure 11. What people say are issues confronting individuals, families and communities (Cox et al., 2014, p. 347)

Ranking	Individuals	Families	Communities
1	Health and/or mental health	Drugs, alcohol, gambling	Drugs and alcohol
2	Employment	Health and/or mental health	Employment
3	Drugs and alcohol	Family	Violence
4	Family	Financial issues	Health and/or mental health
5	Children and/or young people	Employment	Youth
6	Violence	Violence	Family
7	Personal issues	Housing	Accessing services
8	Housing	Communication breakdown	Housing
9	Racism and/or discrimination		Racism and/or discrimination

In summary, building community resilience is not a quickfix that can be effected easily by adding resources to fill a deficit. Holistic approaches are required. A 'capabilities' approach that is directed from the community concerned, and which is rooted in cultural values and norms, is required. It will most likely require a partnership which involves long term trusted commitment. Learning is an integral part of resilience building, and in particular learning that incorporates intergenerational transmission of knowledge. Building resilience also requires recognising and responding to the impacts of colonisation and the consequences of intergenerational trauma, which in turn are reflected in many of the social determinants of risk. In the context of Suicide Story as a suicide prevention program, the issue of determinants is partly addressed in community safety plans, though we would not expect to see substantial changes in indicators related to 'issues' identified in Figure 11. However, with the primary focus of the program on the workshop we would expect to see strong

evidence of intergenerational and cultural knowledge exchange and evidence of partnership formation. The question of long-term trust and commitment is reflected in the continuity and consistency provided through the SSAAG and through the repeated times that workshops are delivered in many locations.

The literature cited in this review points to a substantial evidence base on which underpins the Suicide Story program. The program draws on elements of effective suicide prevention programs that include a primary focus on cultural safety, learning, sharing knowledge, building resilience, and community ownership. The ingredients of good practice are reflected in many aspects of the program. These ingredients also point to a theory of change and causal logic (see Figure 12 and Figure 13 in the Methodology) that should produce the desired outcomes. The task of the evaluation is in part to provide the evidence for these outcomes.

Methodology

The evaluation is built principally on qualitative methodological approaches drawing on narratives, observations and critical reflexive practice. As such it is a 'naturalistic inquiry' (see for example Patton, 2015) where the purpose is to explore the phenomenon under investigation—in this case the Suicide Story program—to provide learnings that will formatively shape the program's future direction. Importantly too, the evaluation adopts a participatory approach such that the staff, SSAAG and facilitators act as co-researchers to inform the conduct of the evaluation: 'what distinguishes participatory evaluation from other types of evaluation is having evaluators working in partnership or in collaboration with members of the program community, broadly defined' (Goodyear et al., 2014, p. 103). The collaboration means that elements of the evaluation from design (for example in the creation of a theory of change) through data collection (for example in organising and participating in evaluation activities), analysis and dissemination of findings involve contributions from multiple stakeholders. The evaluators in participatory research are not passive bystanders though, and will use their expertise and knowledge to guide the process, acting as critical friends—outsiders that work collaboratively with insiders (Groh, 2018; Guenther et al., 2017; Liamputtong, 2010)—throughout the evaluation process. Importantly in what can be a contested intercultural space, evaluators need to take time to 'hear', not just listen (Osborne, 2014).

The evaluation is informed by 'realist' approaches (Westhorp, 2014). The realist informed focus recognises the complexity of causal pathways from inputs, processes through to outputs and outcomes or impact, noting the significance of context and the multiple potential mechanisms that either enhance or detract from intended outcomes, echoing the realist manifesto of 'what works for whom in what

circumstances ... and why' (Pawson, 2013, p. 15). Mechanisms in this methodology are a mixture of observable and unobservable actions, events and phenomena that demonstrate a causal connection between the activities and the outcomes (Patton, 2015, pp. 585-586). They are sometimes referred to as the 'triggers' that turn activities into outcomes (Dalkin et al., 2015). We describe mechanisms in our findings as support factors—the things that make the program work. One of the other key features of realist approaches is the use of theory to inform the process and findings. Part of this is achieved through hypothetical theory of change models that are developed before data collection commences and which can then be used to test the causal assumptions of the program. In the case of this evaluation, the program staff worked with the evaluator in 2017 to work through the processes and outcomes of the program.²

Evaluation questions

Evaluation questions is to provide a frame of reference, taking account of the aims, the program's logic and theory of change, and the intended evaluation project outcomes. In answering these questions we also respond to the aims of the evaluation as set out on page 14.

EQ1: Is [and how is] the program producing its desired impact [resilience and suicide prevention] at the community [and individual] level?

Related to Aims 1 and 2, the assumption behind this question is that the program works according to the logic presented in Figure 12. However, in testing this assumption, we explore how people associated with Suicide Story perceive the outcomes—in doing so we explore the possibility of alternative impact

² At the time of writing a comprehensive logic model developed in 2013 was uncovered. Because of its late discovery we were not able to draw on it in the current evaluation, though we have reviewed it.

indicators as suggested by Aim 4. We also explore the mechanisms (support factors) that underpin outcomes and consider the barriers to effectiveness.

EQ2: How can the impact be strengthened with follow up [or other] processes?

In our consideration of this question we explore what could be improved and what future directions should be pursued, as per Aim 3 of the evaluation and particularly in relation to the role of program facilitators (Aim 5).

EQ3: How can community plans/safety plans be better utilised, monitored and enacted post-workshop delivery?

The last question, also related to Aim 3, concerns the development of community plans as a product of the workshops. As part of this the analysis considers post-workshop processes, which build on the plans.



Logic model development

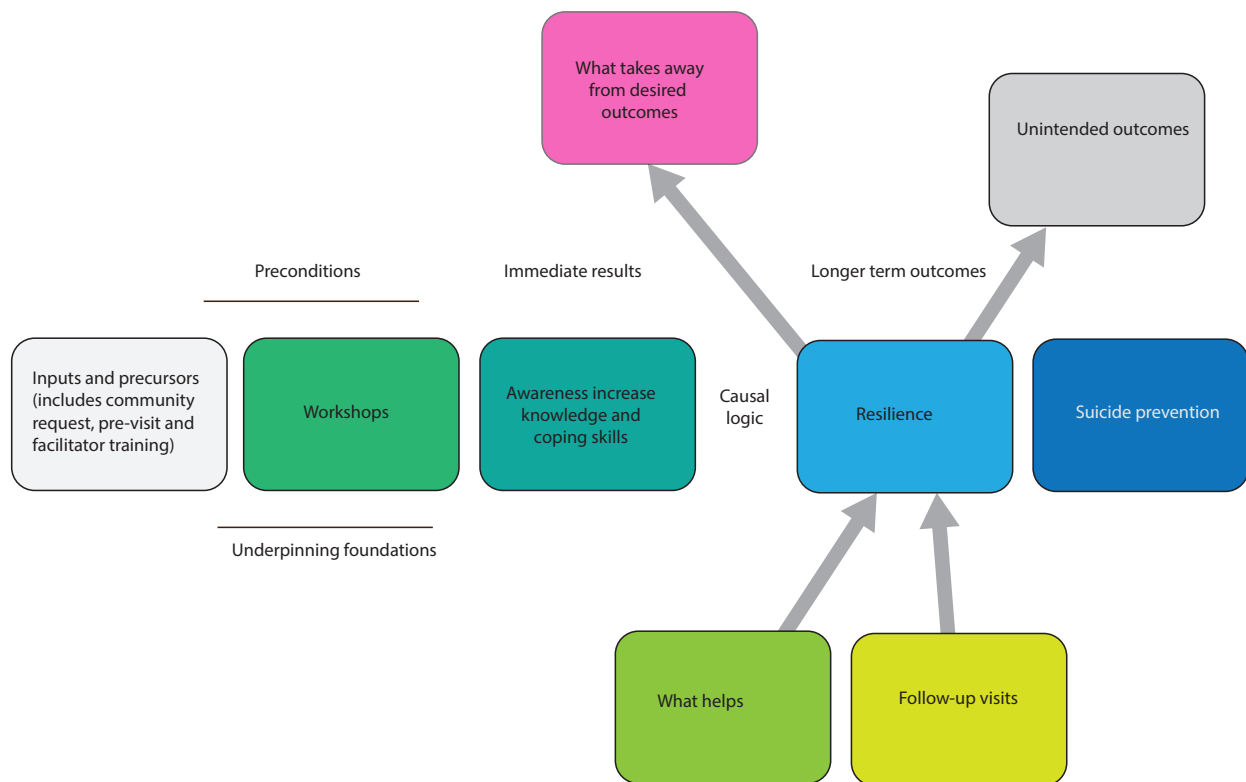
Prior to the commencement of the evaluation a workshop was held with Suicide Story staff to consider what the theory of change might be for the program. The overarching model shown at Figure 12 below was our attempt to place the program within a bigger system and recognise 1) the importance of the pre- and follow-up visits, 2) the presence of potential enabling and disabling factors, and 3) the possibility of unintended outcomes. Recognising that it is impossible to measure impact in terms of suicides prevented, we turned our attention to what the program did to increase resilience as a longer term outcome, noting that resilience is often used as a precursor to or indicator of reduced suicide risk (see Resilience, page 26). In the context of Suicide Story, we sought to understand what resilience might look like (see also Appendix 2, Figure 25). These elements of resilience are expressed individually and through the community and while noting that the literature differentiates on this basis, we make no attempt to do so in our analysis, because they are so intrinsically linked. We determined that resilience is indicated by:

- Confidence, hope and courage
- Belonging to a support network
- An environment where it is safe to cry (expressing grief and sadness)
- People asking for help, and others checking if you are OK
- Healing, going out on country
- Sharing, story-telling, song
- Care, love and responsibility
- Strong culture, law, kinship and ancestors
- Talking about something that is stigmatised, having a language to talk about suicide
- Having goals and plans for the future; acting on community safety plans
- People committing to make the time to come to workshops

Many of the studies we examined in our review of the literature focused on measures associated with suicide-related behaviours and knowledge or awareness (see page 26). We envisaged that these behaviours are likely to be an immediate product arising from the workshop whereas resilience is also supported by follow-up visits.

Figure 12. Pre-evaluation conception of Suicide Story theory of change

Overarching summary of theory of change

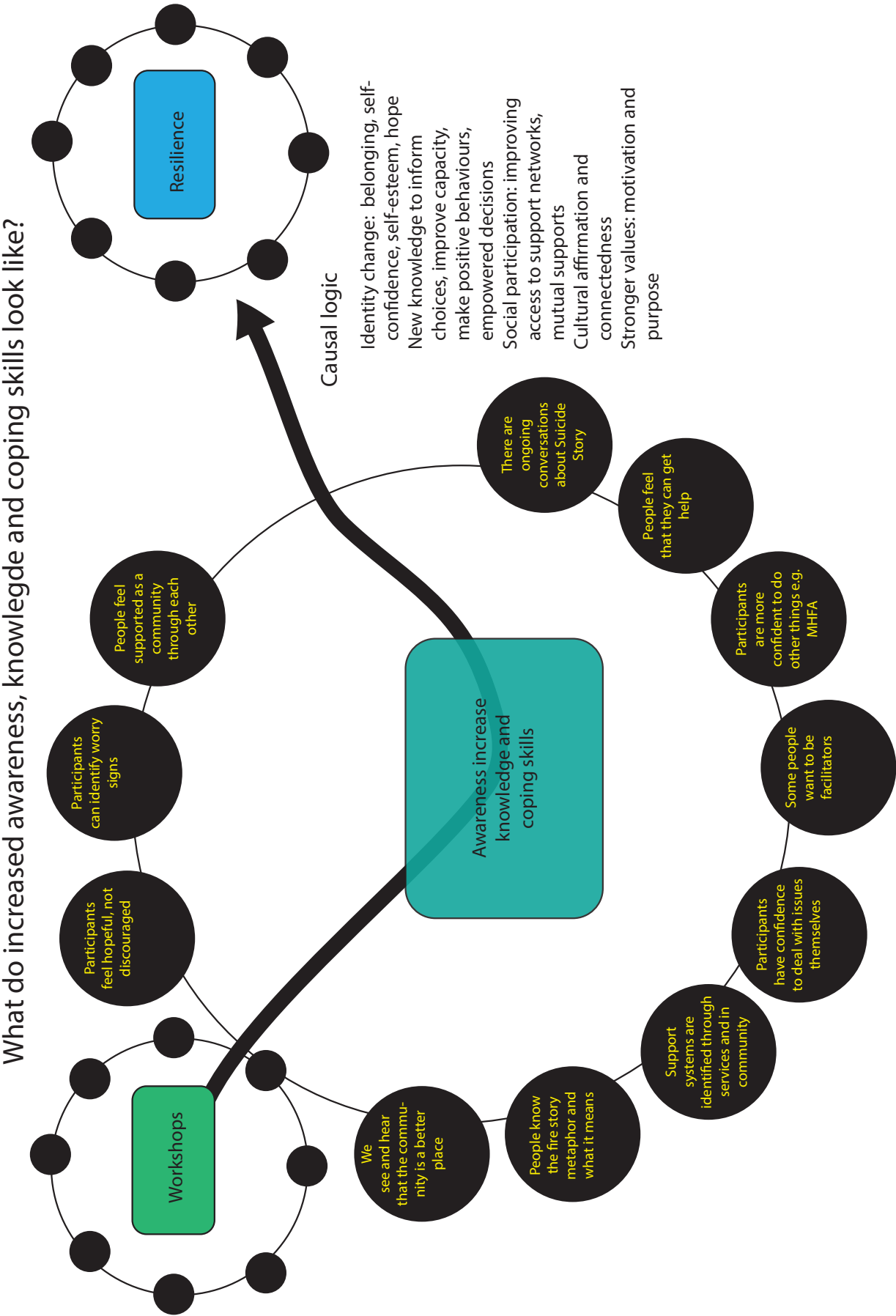


We envisaged that the logic of change is underpinned by cultural and cosmological influences, sociological influences, ontological identity formation, epistemological learning dynamics and axiological values (See Appendix 2, Figure 29 for more detail). We recognised that questions of ‘where I belong’, ‘who I am’, ‘what choices I can make’, ‘what motivates me’ and ‘what I believe’ expressed (often tacitly) by participants will be addressed in the program. The answers to these questions lead to responses that reflect resilience, for example through self-confidence, knowledge and awareness, motivations and intentions and cultural affirmation (See Appendix 2, Figure 29 for more detail). We also hypothesised what the causal logic would look like suggesting that increased resilience is a product of 1) identity change; 2) new knowledge; 3) social participation; 4) cultural affirmation; and 5) stronger values, though not necessarily in that order. The structure and content of the workshops raise awareness and offer tools for participants to find new ways of dealing with grief, loss and trauma associated with suicide and then be able to respond to it. We envisaged that the indications

of effectiveness in the workshop are found in the participants, for example showing signs of hope and courage, being able to identify worry signs, knowing the fire story metaphor and knowing that they can get help (see Figure 13). It is important to note that the foundations of the workshop are strongly built on cultural knowledge, safety and understanding and on local epistemologies, ontologies and axiologies (see also Appendix 2 Figure 24). As such, we are mindful that the language of linear causal pathways from inputs to outcomes, may be at odds with more traditional axiologies and ontologies, which as we have seen in the literature are often represented in circular forms.

The logic model also recognised that there are potential barriers to effectiveness (what takes away from desired outcomes). We identified several potential inhibitors including lack of funding, peer group influences, disempowerment, housing standards, alcohol and drugs, lateral violence and stigma associated with suicide and mental health. A full list is provided in Appendix 2, Figure 26.

Figure 13. The causal logic from awareness and knowledge through to resilience



Data collection and sampling

Data for this evaluation came from several sources. Formal interviews were conducted with 30 respondents. These included past and recent participants, facilitators, past and present MHACA staff, the SSAAG, and funders. Notes from informal consultations, site visits, participant workshop activities, and a facilitator debriefing session were also collated. The evaluation team observed workshops conducted at Tennant Creek, Arlparra and Lajamanu. We also accompanied staff and facilitators on pre-visits to Papunya and Kintore and follow-up visits to Mt Liebig, Papunya and Ntaria. Interviews and consultations were also conducted in Darwin and Alice Springs.

Additional data was taken in the form of historical reports and documents, workshop reports, MHACA

annual report and other relevant internal documents as provided by MHACA staff.

Workshop data collection spreadsheets from 2013 (when data was reported in a consistent format) were also drawn on, as were internal pre- and post-workshop evaluation data. We also examined the pre- and post-fire charts (see Figure 14), which are an internal assessment tool for gauging how participants feel during the workshop. At the start of the workshop participants are asked to place an avatar on the chart for each of a series of questions, in terms of whether their fire is 'hot', 'warm' or just 'embers' (cool). While this may seem like an imprecise way of measuring change, it makes sense to participants and as the workshop progresses, the fire metaphor is repeatedly referenced.

Figure 14. Example of pre- and post-fire chart



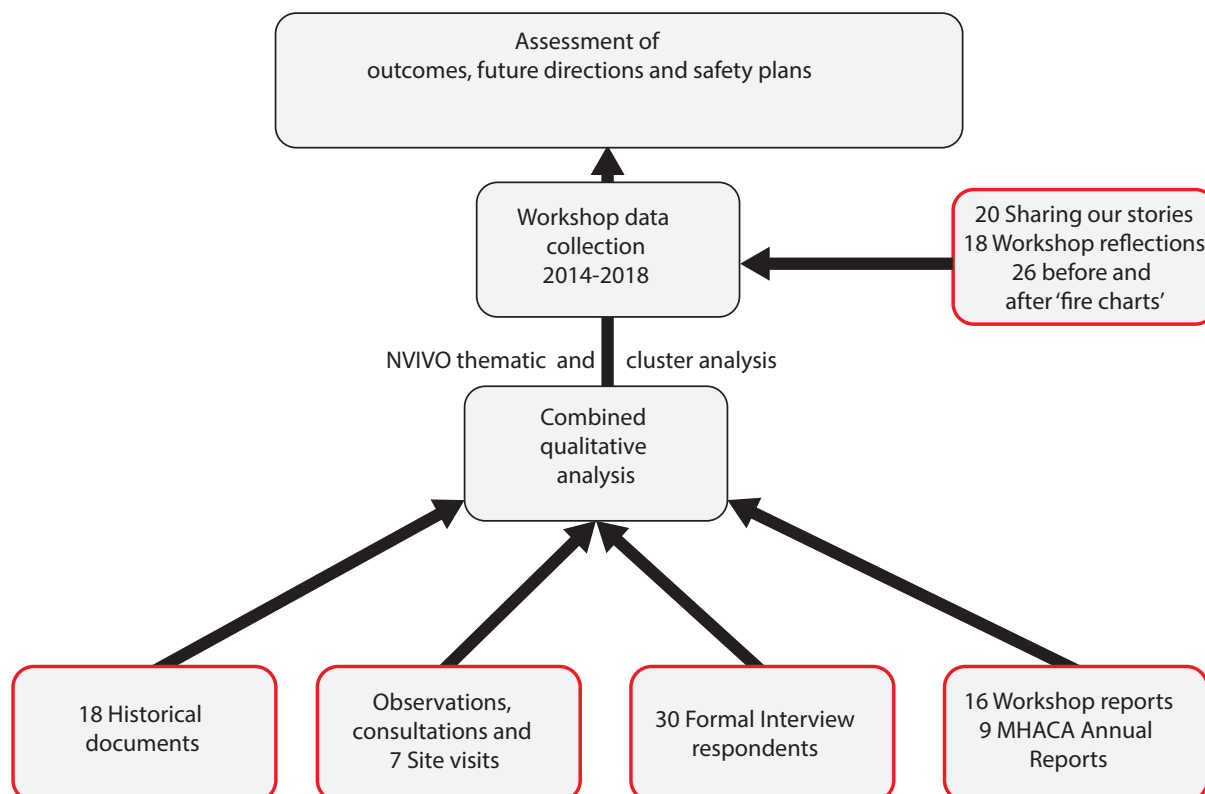
Two additional internal evaluation tools were assessed: 'Sharing our stories' (completed at the start of the workshop) and 'Reflections' (completed at the end of the workshop), both of which ask participants to identify 'worry signs' (See Appendix 3, page 91 for sample forms). We take this as a proxy for the level of awareness in participants, before and after the workshop.

Analysis process

All qualitative data from reports, observations and notes from consultations, transcribed interviews, historical documents, workshop activities and workshop evaluations, were collated into a single

NVivo project for analysis as represented in Figure 15. In the first instance NVivo was used to identify themes that emerge from the data. The themes were grouped under headings corresponding to the evaluation questions: Outcomes and impact (EQ1), future directions for improving outcomes, including overcoming barriers (EQ2), and issues relating to follow-up and safety plans (EQ3). While the analysis process was initially carried out by the evaluation project leader, others were drawn in (including the community researcher, MHACA staff and SSAAG members, Steering Group) through iterative participant, critical friend, audience and expert review activities in the writing up phase of the project (see Patton, 2015, Chapter 9).

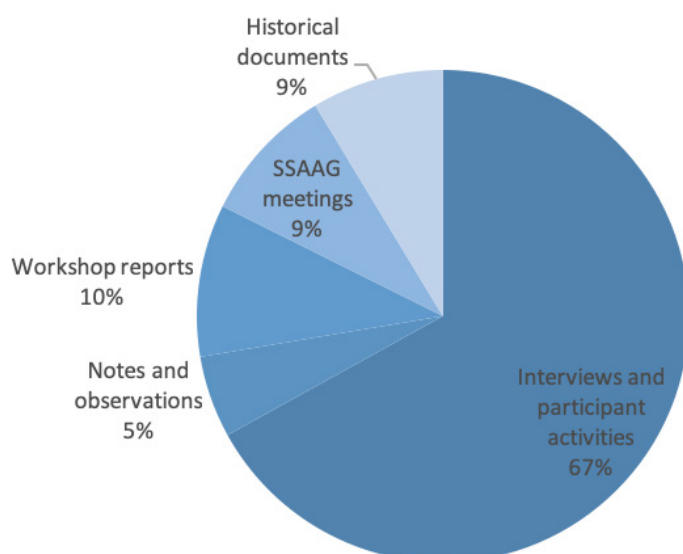
Figure 15. Data sources and analysis process



Where does the data in this evaluation come from?

Most of the data that relates to impact assessment, program improvement and community safety plan development comes from formal interviews. Figure 16 shows that almost three-quarters of the data presented in the Findings relating to the evaluation questions comes from sources generated in the evaluation through interviews, workshop participant activities, observations and notes.³ While there is considerable material in the historical documents, the workshop reports and SSAAG meeting minutes, these documents were often not concerned with answering the current evaluation questions. Historical documents and Annual Reports were mostly useful for constructing the timeline as shown in Figure 3.

Figure 16. Data sources used for analysis of impact, program improvement and plans



³ We have not included data from internal evaluation here as it is analysed separately.

Ethical clearance and conduct

The evaluation of Suicide Story gained ethical clearance through the Central Australian Human Research Ethics Committee (Reference CA-18-3089). The researchers are bound by the principles of ethical conduct of research (National Health and Medical Research Council et al., 2007) and evaluation (Australasian Evaluation Society Inc., 2013) and in particular the protocols that relate to Aboriginal and

Torres Strait Islander people (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2012). As a consequence this report is written to ensure the privacy and confidentiality of participants. Quotes used are deidentified and information that may be considered harmful or compromise confidentiality is not included. We are also not able to disclose which organisations were involved or what roles respondents have. Images of people in this report are used with permission from those involved.

Original painting by Artist
Mia Mulladad



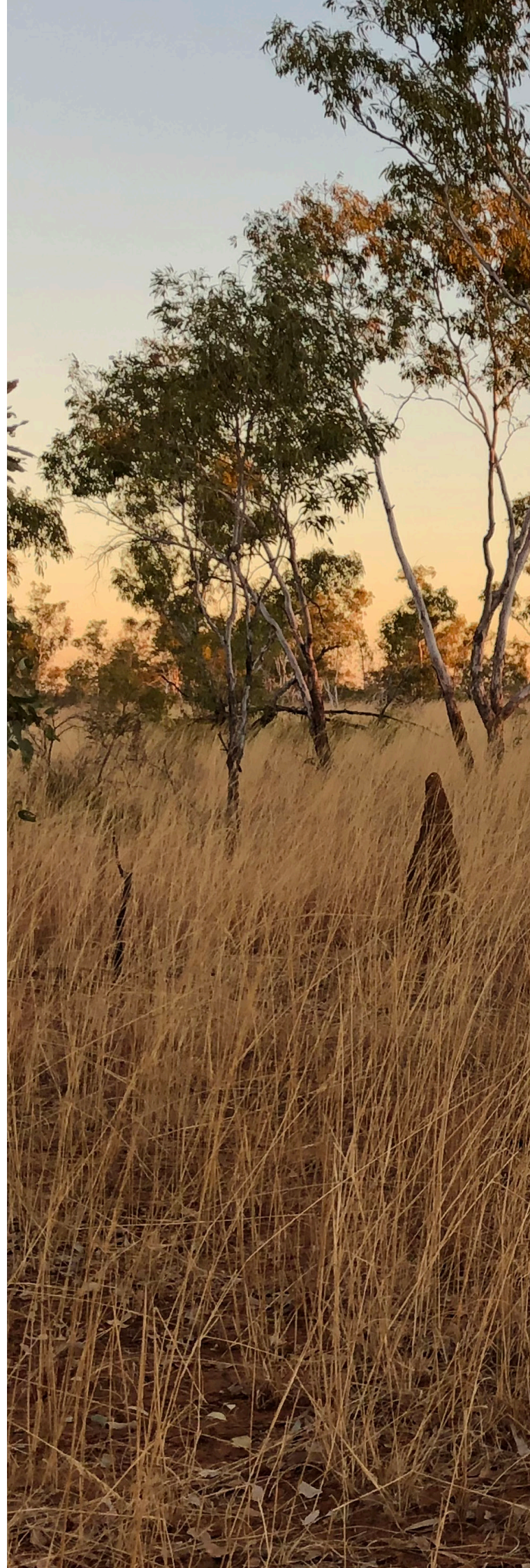
Limitations

The methodology and the findings of this evaluation have several limitations. Firstly, as a qualitative study, based on one program, the findings are designed for Suicide Story. While there may be findings that resonate with other programs or suicide prevention initiatives, we do not claim that the findings can be generalised to the field of suicide prevention more generally.

Secondly, while we sought responses from a range of stakeholders, the bulk of responses presented here come from people who are fairly close to the program. While this might be perceived as bias, their views are fundamentally important to an assessment of the program and these people are best placed to advise the evaluation.

Thirdly, while we consider impact, the question of effectiveness in terms of lives saved cannot be answered using the methodology employed. Even aside from the limitations of the methodology employed here, the attribution of lives saved to any program would be difficult because of the multiple factors that contribute to suicide.

Fourthly, we found that gathering participant responses was not straightforward. We attempted a series of workshop related activities in one location but discovered that participants found it hard to describe the impact of the program because for most, they were experiencing it for the first time. Another issue was that when we visited communities on follow-up visits, participants were hard to find. Therefore, the participant voice is not as strong as we would have liked it to be, though the internal evaluation data does provide very important participant perceptions, and we have drawn on these.





Stories of resilience

Suicide Story facilitators all work with a strength-based approach and believe that communities have the solutions to their own issues.

Participants and facilitators of the workshop have all been touched by suicide and have lost someone close to them to suicide or have seen firsthand suicide attempts in their communities. Despite this pain, they work through this grief and turn it into a positive to continue to support people, help to support safe communities and prevent suicides.

Findings

We present findings in this section grouped around the key issues of impact, future directions and barriers, and community safety plans and follow-up. The analysis draws on all data sources shown in Figure 15, however internal evaluation data is only used for impact assessment purposes. Quotes from participants come primarily from interviews. In this section we make no attempt to reflect back on the literature or to comment on the implications of the findings. We leave that for the Discussion and Recommendations section (page 60).

Impact assessment

Program impact was assessed using a combination of data gathered through interviews and documents provided to the evaluation. We sought to understand how participants, program staff, the SSAAG, facilitators, and external stakeholders viewed the outcomes or impact coming from the program. We distinguished outcomes from the success factors that contributed to outcomes. We assessed change as measured by before and after fire charts (see Figure 14), sharing our stories (see Figure 30) and reflections (see Figure 31), and workshop data. Each analysis will be presented separately.

Internal evaluation data

Before reporting on data gathered from interviews, we present an assessment of internal evaluation data gathered since 2014 and collated by program staff. Figure 17 represents an analysis of the pre and post-fire charts (see Figure 14). The fire chart has three zones; one that is close to the fire on the orange background (hot), another highlighted in maroon (moderate) and one highlighted in dark blue (cool). Participants place up to six 'avatar' markers on the chart in response to the six questions displayed to show how their fire is. The closer to the fire, the stronger they feel.

For each of 25 workshop pre and post fire chart assessments, we counted the markers in each zone. The shift in perception is indicated by the pre and post change for both 'hot' and 'cold'. The number of participants reporting that they were close to the fire, on average more than doubles, while the number of those saying they are a long way from the fire drops by more than 80 per cent. The exercises are designed to assess participants' perceptions about their awareness and knowledge, and their confidence to be able to assist others in the community.

Figure 17. Pre and post-assessment of fire charts for 25 workshops



The program assesses participants' ability to identify worry signs at the start of the workshop using the Sharing our Stories tool and at the end using the Reflections tool (Refer to Appendix 3 for these tools). Participants are asked to list 'worry signs' that they think are a sign of suicide risk in someone. The change from Sharing our Stories to Reflections is an indication of knowledge or awareness.

Workshop participants learning the important concepts of the program



Figure 18. Identifying worry signs, change from 'sharing our stories' to 'reflections' (2014-2018)

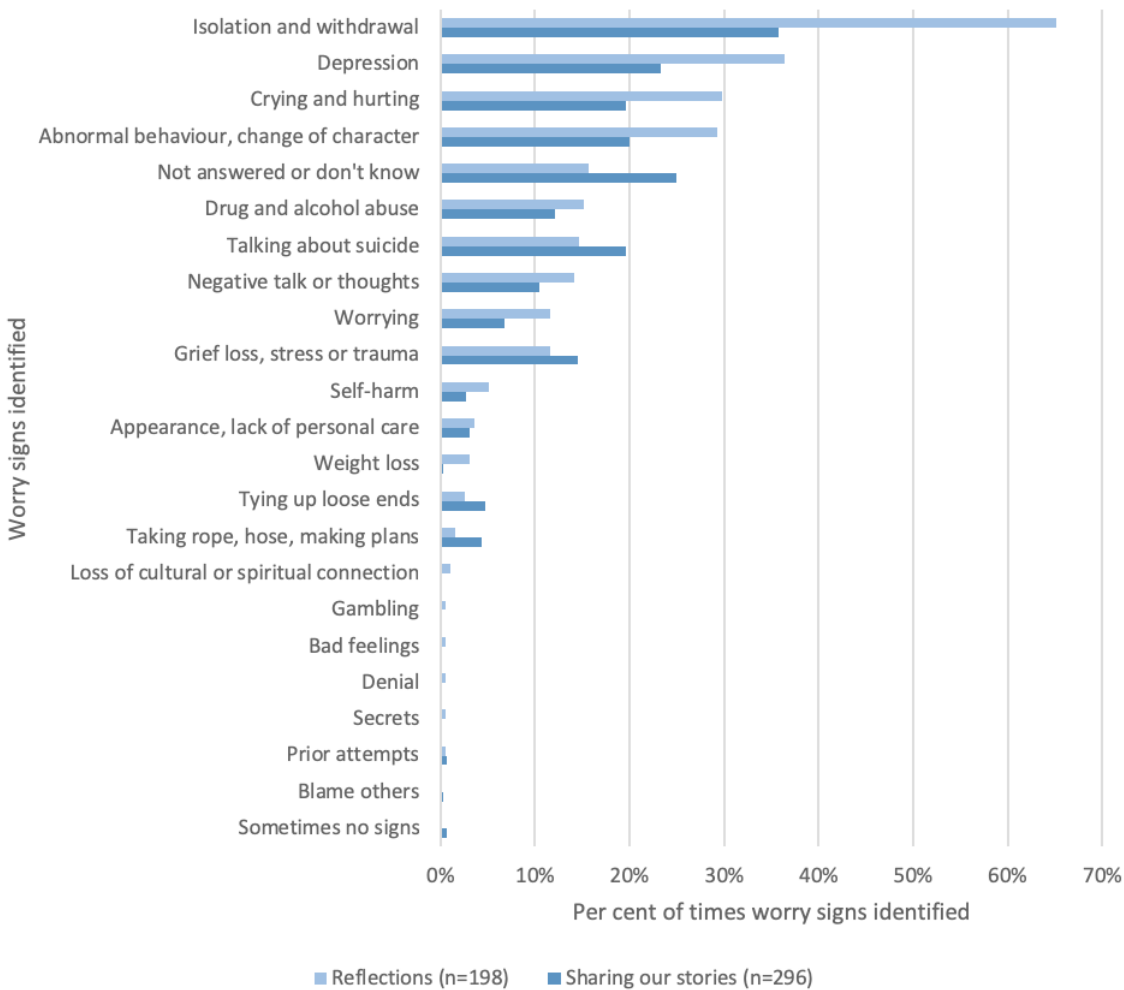


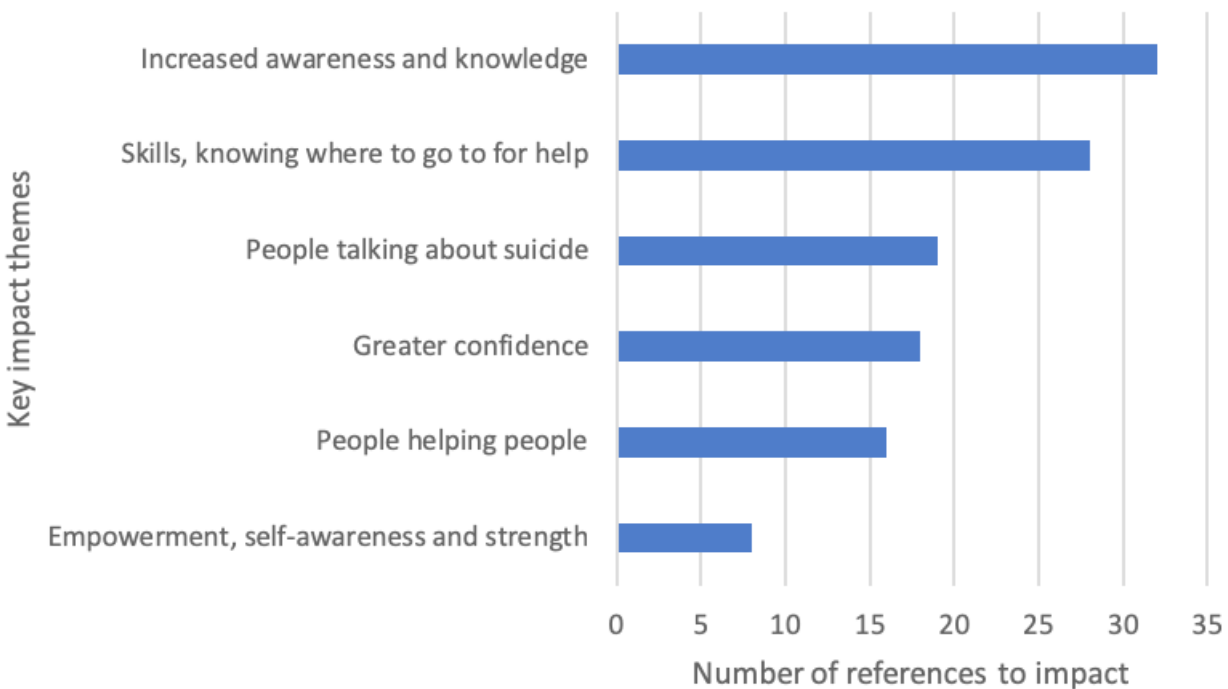
Figure 18 represents analysis of data from these two tools as a percentage of times worry signs are identified. Representing the numbers as percentages takes account of the drop-off in participation from beginning to end of the workshop. Overall there is a clear growth in participants' identification of worry signs. For example, at the start of the workshop, 36 per cent of participants describe isolation and withdrawal as a worry sign. At the end on average, 65 per cent are able to list this sign. There is also a reduction (from 25 per cent to 15 per cent) of times that worry signs are not able to be identified. In the small number of instances (e.g. 'talking about suicide') where the proportion of identified 'worry signs' decreased, this is probably due to a rethink or reprioritisation of that issue (e.g. is talking about suicide necessarily as much of a worry?).

In summary, both the internal assessment tools analysed here show strong evidence for improved knowledge and awareness as a result of the Suicide Story workshop. The fire chart also suggests increased confidence among participants, to be able to respond to someone who is at risk.

External evaluation data

Figure 19 summarises the most frequently reported impacts from Suicide Story. To generate this chart (and subsequent charts like it), we have counted all of the references that respondents make to a particular theme. Much of the data presented here comes from interviews. Most impacts are described in terms of individual skills, knowledge, awareness and increased confidence talking about suicide, confirming the data gathered from internal evaluation tools as shown above. The chart also shows themes relating to people helping people and empowerment, self-awareness and strength. Other themes were mentioned in the data, but were reported less than five times. They include healing, cultural awareness for non-Indigenous people, resilience, lives saved, and Training for Trainers as an outcome itself.

Figure 19. Key themes relating to Suicide Story impact (n=139)



The descriptors of Figure 19 often come together in participant responses. For example, in this response we see elements of people talking, gaining awareness and knowing where to go to for help.

With me it was good to see, we touched someone about suicide, what to do, where to go and look for help, not being afraid to ask for help... a lot of people who come here don't know enough about suicide, who they can talk to, trust, that's what I have found, they need to trust someone, especially when they are talking to us [about] the stories that come out of this program.

And from another respondent there is a similar bringing together of these impacts: awareness of warning signs, knowing how to help and talking about suicide.

I've seen people to getting to know about the warning signs of suicide, now they know how to help, with the different activities we show the different ways of helping people. There is a lot of things stopping people asking for help. A lot of people being educated. The word suicide is actually getting used.

And from another stakeholder observer we see a focus on awareness of risks supported by follow-up action

I think it's helped people feel that they can identify when risks are present, I can see that with one of my staff who spoke to me about one of her family members. I said, yes, I think you are right and go ahead and do what you need to do...

And from another perspective we can see an emphasis on people 'helping each other' and having people to go to in the community:

I think even the community plan as well, I have seen communities stick to that community plan, getting people to realise that you've got that connection at home to help each other. It can be community members who are first on the scene, usually a first person who comes along, that safety plan [is] in place, [having] other people in the community they can go to, [it] is good.

And finally, from an employer perspective, we see the value of being aware of 'trouble' and then being able to help.

It's more about recognising trouble. That's what it is. Recognising that someone has an issue, not just driving past. This job has built people's confidence. It's about caring for your community members, old, young, everyone, my motto is everyone in the community is your brother, sister, grandfather, everybody is related, that's how you have to look at everybody. Everybody is somebody to you and that's how you have to treat them.

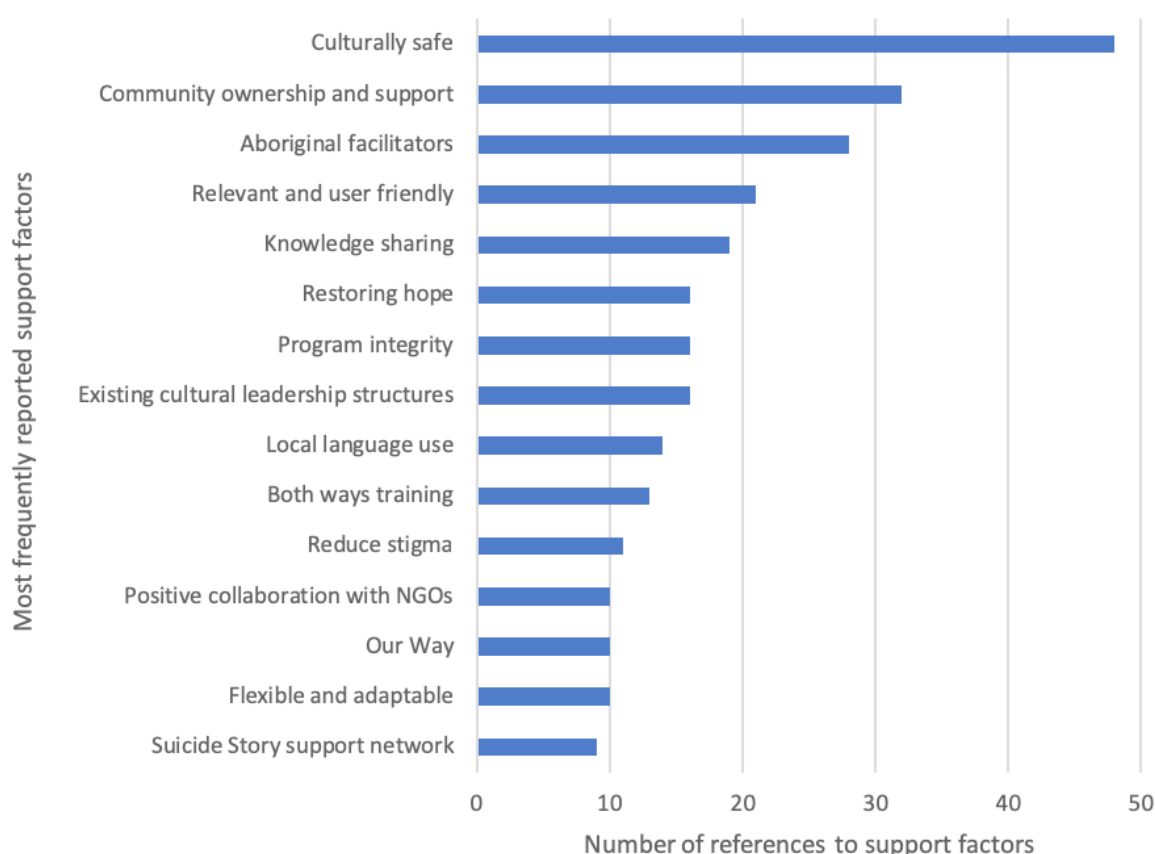
The above quotes quite neatly capture the importance of knowledge and awareness, people helping others, of people knowing who to go to for help, having the confidence to do what needs doing, and ensuring that everybody is cared for. In the main these impacts are described at the individual level. However, when people help people, there is a social or community aspect to the impact. Similarly, when a critical mass of individuals have the capacity to act, gained through knowledge and skills, the impact extends beyond the individual to the broader social networks those individuals engage with.

Support factors: what makes Suicide Story work

Often, when asked about impact, respondents would discuss what Suicide Story should do or how it works. We let the conversations go as naturally as possible so as not to interrupt people's thoughts, and of course there is sometimes a blurry distinction between how the program works (or the support factors) and the outcomes. Figure 20 shows the most frequently reported support factors.

Most commonly reported support factors were described in terms of cultural safety, community ownership and support, having Aboriginal facilitators, sharing of knowledge and stories and restoring hope. The latter theme emerged mainly from historical documentation examined and did not figure prominently in interviews.

Figure 20. Key themes relating to Suicide Story support factors (n=358)



Cultural safety is a theme that comes out strongly in the early developmental literature of the program, and it remains strong in respondents' minds as they think about how and why it works. In this quote we see several support factors come together: cultural safety, 'developed and delivered by Aboriginal people', 'both ways training' and 'reducing stigma'.

I do like what is coming out , the beauty of it being an initiative, developed and delivered by Aboriginal people throughout the NT, making sure cultural safety is a big part of it, there is a lot of both ways training that happens, living in both worlds stuff, we just try to get people to understand suicide more and reduce the stigma.

Cultural safety as it is described by respondents, includes several interconnected factors as discussed below:

I thought about being safe, cultural way, connecting with country out there, for that strength, and for guidance too, connecting with one another, for safety and strength, in that cultural way.

Several people talked about the creation of a safe environment where it is okay to talk about something that is otherwise taboo.

[It's] creating the place for communities to think about it, how they can own it, talk about it in a way that doesn't cause harm in their local community. It's that setting where it's likely that you can have that impact.

In our observations of the program, cultural safety was always the top priority of the team. It was reflected in a number of ways. The team often checked with people to ensure they felt comfortable, and in the event that someone became upset, there was always a team member available to provide comfort and reassurance. The pace of the program too gave people time to think and reflect and indeed the structure of each day appeared to help people peacefully and slowly take information in and respond to it appropriately. Affirmations and positive feedback were embedded in the processes. The notion of safe space was echoed in a workshop report from 2017 where a participant is quoted:

...local providers in Alice Springs have been working in collaboration with each other in some cases. When these workers open the doors, and create a safe place for youth, it is a part of that [suicide] prevention because they know when something's not right they can reach out to us.

Importantly, that last comment recognises the role that a collaborative approach can have so that suicide prevention is not just a job for Suicide Story and its participants, but it involves service providers, employers and community members all working together. The sense of ownership is reflected in this comment:

it's very good because the package is done by us, delivered by us Aboriginal people, it makes sense for our mob, we can adapt to our audience and participants, no matter where we go...it's hard sometimes but the good thing is it's from us and we understand it.

The commitment to community led responses, supported by the Suicide Story program is also reflected in this extract from a conversation with respondents:

Its showing that committment... we have finished this training, this is what this community wants, its our commitment to them to pass it on so that you can see what it is, their solutions to their problems...

Its not about dictating the terms, no, let the community dictate their own terms

Embedded in this concept of community ownership are Aboriginal facilitators. While it was not possible to have a local facilitator in every workshop, we observed that there were always family connections between the team and the participants. We also saw the significance of having both male and female facilitators—men were most comfortable getting alongside other men and women with women. Facilitators helped create the safe space described earlier. Asked about the future directions for the program, one respondent was quick to point to the important role of the facilitators:

Keep the Indigenous facilitators in...because community relates better to countrymen.

One of the important elements that local facilitators brought to the program was being able to speak in language. For many respondents this was fundamentally important:

They want to do it in their own language, which makes [the program] stronger too.

Our observations suggest that having Aboriginal facilitators delivering the program makes it meaningful and relevant. They create a shared understanding of the content and understand the context from which participants come. One respondent described how it 'connects' people:

I think it connects to things that are around us, in the natural environment like the fire story, the rock wall, things we already know that we are familiar with in our everyday lives... the rock wall reminds me of that from that training, the things around us, it connects, it reminds me of the Suicide Story program when someone is at risk. In the past the training [was] delivered by non-Aboriginal people. There [weren't] any reminders there, everything went over our head, but with Suicide Story it really connects with you, that's what's different with our programs...

There were many other support factors that respondents raised, which will not be discussed in detail here. For example, there were several comments from people about the importance of specific aspects of the program delivery, such as its flexibility, how it allows time for people to process information, how it adapts to the cultural demands of communities, how it reduces stigma, and how it connects well with other supports in the community. The 'both ways' approach used in the training is also recognised as an important factor.



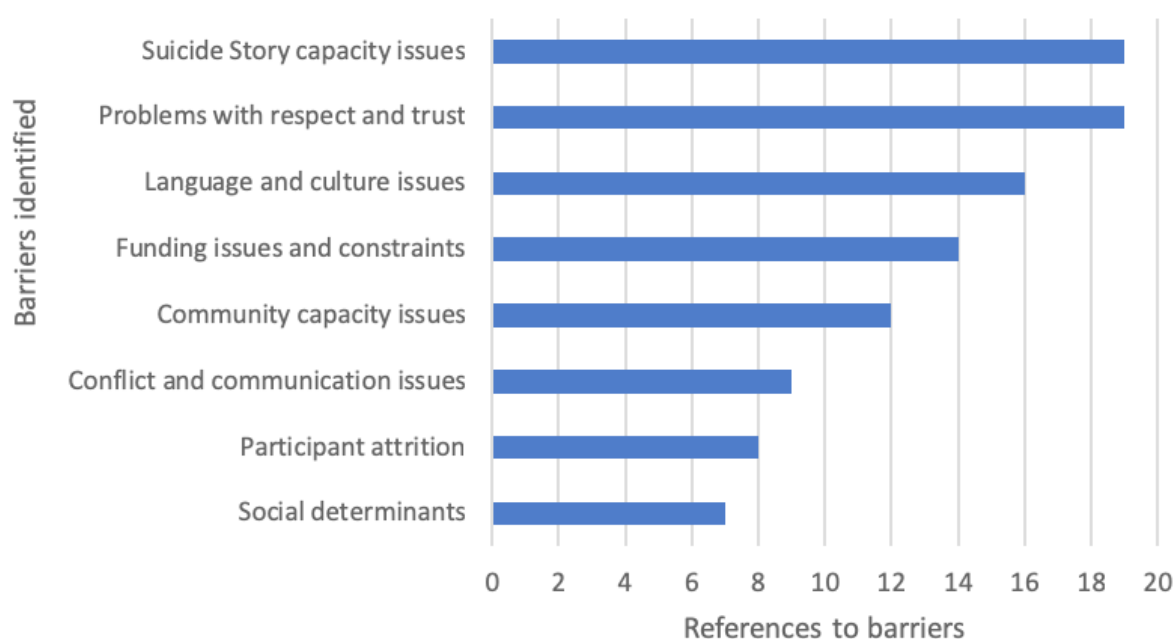
Strengthening the impact of Suicide Story

When discussing the potential strengthening of Suicide Story, many respondents discussed barriers—that is they were commenting on a barrier that could be removed to make the program more effective. Some talked directly about program improvement, and others talked more about future directions in general, but first we will present findings in relation to barriers.

Barriers

Figure 21 lists the main themes identified as barriers to effectiveness. Beyond what is shown in the chart, a smaller number of references related to training issues, follow-up issues, lack of consultation, time and timing issues and the threat of loss of program fidelity.

Figure 21. Barriers to effectiveness (n=132)



The capacity issues were described in terms of stresses and pressures to deliver workshops and staff not having the capacity to meet community demands. The availability of trained facilitators was also seen as a capacity issue (see also discussion on future directions, Figure 22):

The biggest barrier is the facilitators; the same mob going out all the time; some of these mob, can't go out all the time, we get tired.

Echoing this is another respondent commented:

The facilitators is what we struggle with at the moment. To improve that aspect, having a strong facilitator pool, [is] one of our goals... to create a strong team, that's the most challenging thing to do with the model the way it is and the resourcing how it is. If we can't expand that we will go round in circles.

We noted earlier (see Program activity: Participation, communities and facilitators, page 20) that over time, 38 facilitators have been trained but about one-third have not been involved with delivery and only one-third have delivered the program more than once. While this dynamic is probably to be expected, it means that the actual pool of available facilitators is much smaller than is theoretically possible.

The issue of respect and trust was multidimensional. At one level there were issues arising in workshops. For example, this was reflected in non-participants being disrespectful to facilitators. We observed times during delivery when a non-participant would interrupt and take a participant out without notice. We also saw an instance where a meeting was rescheduled to coincide with program delivery, and everything had to be put on hold for a whole morning. While the intention might not be to be disrespectful, these interruptions suggest a relatively low priority given to the program in these instances. At another level there were perceived issues of trust and respect between the SSAAG and MHACA, both ways. Some of the issues of distrust are historical, though pinning the issues down was at times difficult—reference to specific causes of the mistrust were veiled. From

what we could see, much of the distrust expressed by SSAAG members and facilitators relates to relationships between previous managers and the SSAAG, or decisions made which at times were clearly perceived as disrespectful, or the turnover of managers—which made it difficult to build trusting relationships.⁴

In terms of language and culture issues, there were frequent comments, particularly in the workshop reports about delays and interruptions caused by funerals or sorry business. Language barriers were noted sometimes. Further, particularly for non-Indigenous respondents, being able to understand family and kinship systems was seen as a challenge.

Funding issues and constraints were discussed in terms of inadequate funding to provide services where they were demanded. Some respondents perceived that the funding was 'seed funding' rather than ongoing funding for continuing service delivery.

...the setup of the pre visits, the training and the post visits, really add to our effectiveness, still [It's] sad that we can't get some ongoing funding, still always seed funding, still jumping through hoops, we know we are delivering a cultural program you got to be thankful for what we've got.

Another respondent described funding as 'drip feeding'. There is a perception that Suicide Story, mostly by people who have not seen the program, is expensive. However, the basis for that perception was not clearly articulated to the evaluators, beyond a simplistic assessment that it only delivers half a dozen workshops in a given year.

The issue of community capacity relates in part to the multiple demands on people's time. For example, we observed instances where a program participant had to leave the workshop because of their cultural responsibilities in the community. Also, when it came time to enact the community plan, key people who would normally lead the process, were often called away. But it goes beyond this. The capacity to respond is limited by what some respondents said was 'grief upon grief', or as one respondent indicated:

.....
⁴ No quotes are provided in relation to trust to ensure confidentiality of respondents.

A big challenge...in our communities [is] there is so much death whether its suicide whether its old age, so much death it's continuous, so our cycle of healing never comes to a full close before someone else passes away...

The other barriers listed in the chart are typical of any program or workshop activity where there are elements of negotiation and where participation is important. Conflicts arise as a result of miscommunication, participants drop out unexpectedly or some other issue related to social determinants interrupts the flow of planning and

delivery (see Appendix 2, Figure 26 for details). It should be noted that many of the barriers we observed are out of the control of program staff. They do however affect the efficiency of delivery, and explain why workshops and community visits are sometimes delayed or deferred and why participant numbers are perhaps not as high as might be expected, and why enrolments do not translate into participants, which in turn do not translate into completions (see Figure 5).

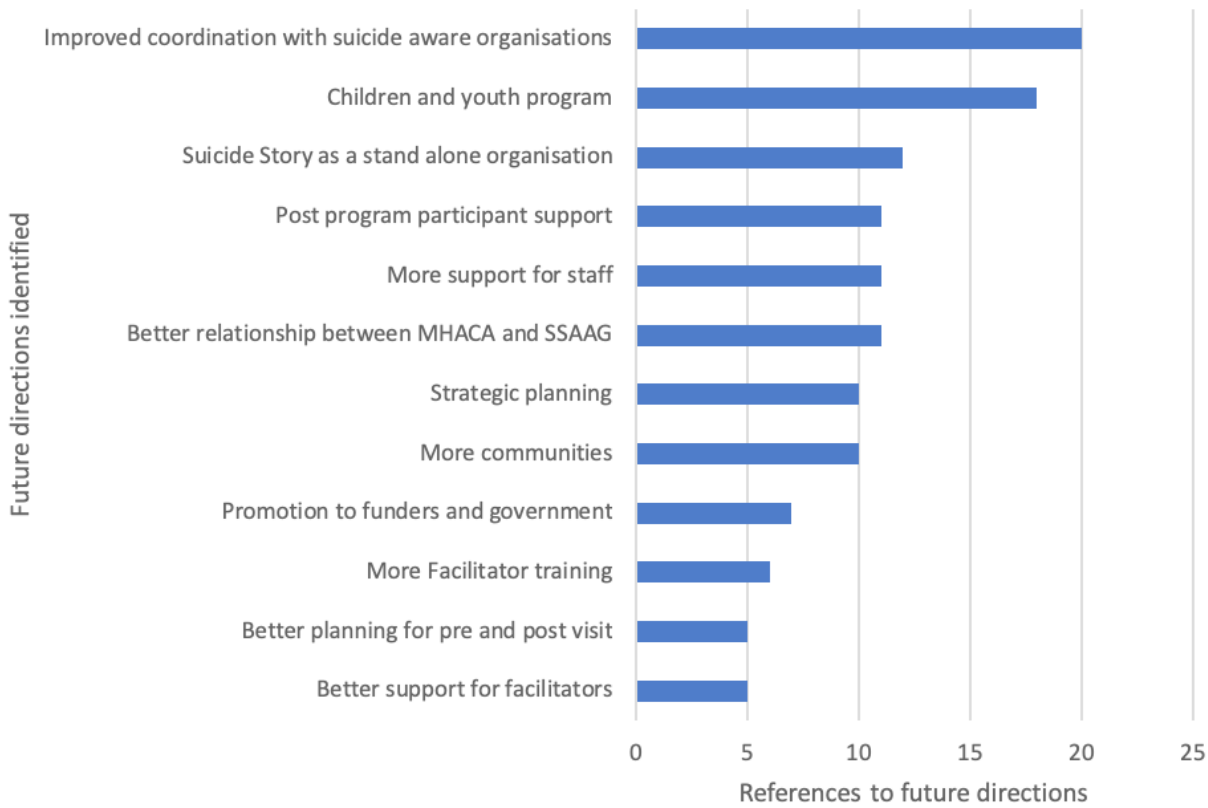
Values underpinning 'Our Way' ...



Future directions

Figure 22 lists the future direction themes raised.

Figure 22. Future directions for Suicide Story (n=156)



The highest priority was for improved coordination with suicide aware organisations. In some cases, this was described as a response to the perceived problem of coordination with the wrong people or organisations in communities. For example, one respondent believed that the right cultural authorities in their community had not been consulted, ahead of program delivery. In other cases, it was described in terms of a need to engage more broadly, for example with health, drug and alcohol or community development organisations, and at other times it was about building and maintaining strong networks and partnerships. One community stakeholder commented:

I think it's important to link in with select service providers and have a strong relationship with them.

Another respondent commented:

...the link between substance abuse and suicide is strong, alcohol is a significant factor, 70%... I would like us to build some partnerships to get that discussion happening.

Our observations of pre- and post-visits suggest that at times the connections with community organisations are more opportunistic than they are strategic. That said, where the partnership connections are strong (e.g. Night Patrols, MacDonnell Regional Council) they appear to facilitate a range of positive and supportive outcomes, such as access to staff, accommodation and useful local information.

A perceived need for a program targeted at children and youth arose several times in the data, though support for this was mainly from external stakeholders rather than from staff or the SSAAG. One external stakeholder described the need she saw in her school work environment:

There is a big need I work in the school, as you are aware, the school is full of traumatised kids, there are probably four there that I would point to as at risk, and as a community...we don't seem to get the support we need here. Earlier this year we had some attempts. I was told quite clearly it wasn't successful so we couldn't access the support. None of us are qualified and that scares me.

Of course, when workshop participants see a need, it is not necessarily up to Suicide Story to meet that need. However, participants do see need more clearly in response to their experience in the program. For example, another respondent saw a youth suicide prevention program as a logical extension of the main program:

We could grow it as a package, there is more we can branch off, like the youth side.

And another external stakeholder also commented:

I know there has been talk about youth focus that would be great, I think it's great for services to keep to their integrity but expand as well.

Our observation of the workshops is that few young people are engaged in the program. However, this does not mean that youth are not supported through adults who participate. The workshop content, in its articulation and discussion of 'worry signs' clearly depicts young people and young people feature in video presentations.

The discussion about Suicide Story being a stand-alone entity was often brought up in connection with concerns about the relationship between the SSAAG and MHACA management. The point though is that most people who raised this wanted to see an improved working relationship between SSAAG and MHACA management (see earlier discussion on trust and respect, page 51). In part it appears that some of the concerns are historical and have not been fully disclosed to the evaluation. However, beyond asserting the need for greater autonomy and direction over the program, there was little discussion in the data about how the program would be funded or managed.

The call for strategic planning was raised several times in the historical documents we analysed. However, when asked for future directions, one respondent commented:

If we were confident enough to do a 10 year plan for Suicide Story, [it] would be around getting to every single Aboriginal community in the NT, delivering at least 2 times, and having facilitators in these communities speaking language...

Our observations concur with this need. At present, the program is under pressure to deliver more workshops to more communities, which is a result of

increased demand (as reflected in the growth shown at Figure 5, page 20). However, the resources for the program have remained more or less constant for several years. From our perspective as evaluators, a strategic planning process could well be helpful in re-evaluating the resource requirements for the program and for establishing a forward-looking vision.

There was a range of other suggestions identified by respondents. For example, some respondents wanted to see more communities covered (consistent with the strategic planning comment above); others wanted more facilitator training; others wanted more support for facilitators and there were some calls for better planning in the pre-workshop and follow-up phases of the program.

Program improvement

Consistent with EQ2, we asked interview respondents how they thought the program could be improved. Figure 23 highlights the main themes raised in relation to this. Most of the points raised were in part a response to identified barriers or future directions. For example, where funding was seen as a barrier to effectiveness (see Figure 21) the key to overcoming this was to ensure better resourcing and or long-term funding for the program. Some respondents also raised the need for more staff, more professional learning and better support for community members (particularly in the follow-up phase). In relation to the latter point, one respondent observed:

... what I notice is, our when our people talk about suicide, safe communities, it only goes for a little while after we have delivered, then it's all forgotten.

Another commented in relation to follow-up:

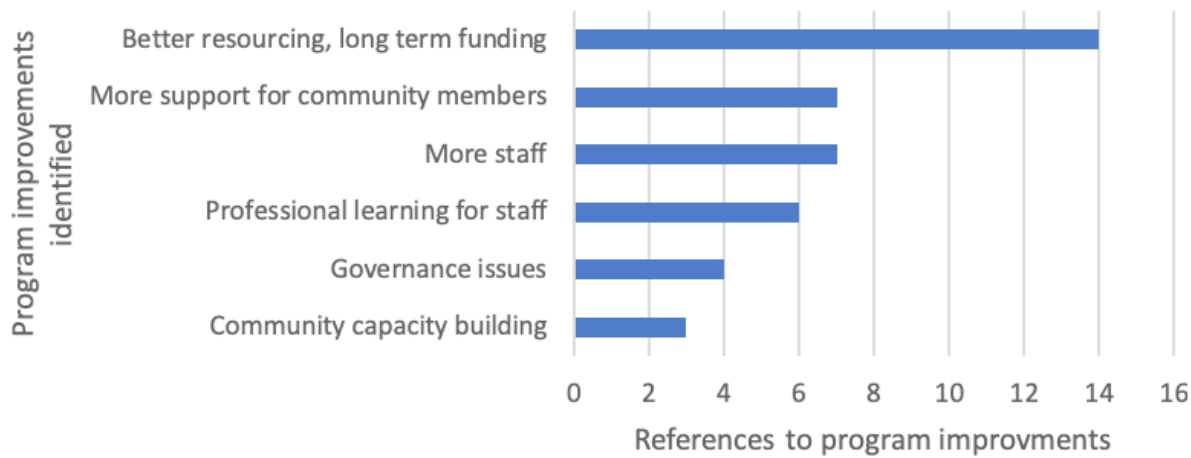
I was hoping the [workshop group] would determine when it wanted to meet and was tasked with following through. They need support and they are a support group for each other.

Other suggestions for change were more muted, but also related to barriers or future directions. For example, the call to address governance issues, is in part a response to the perceived problem of respect and distrust between the SSAAG and MHACA management and the need for improved relationships between them (see Figure 22). The call for community capacity building is likewise linked to the community capacity barriers identified earlier

(see Figure 21). The general lack of responses related to program improvement is also in part a reflection of the general satisfaction respondents have with the program. The developmental work that went into the program at its inception and later with the SSAAG, has led to a view that the foundations of the program

are about right as they are now. Consequently, most respondents want to see the program structure stay as it is now (that is as represented in Figure 4) and the workshop content and delivery method stay as it is now.

Figure 23. Program improvements identified (n=54)



Community safety plans and post-workshop capacity building

We received and reviewed 25 ‘community safety plans’ and ‘wish lists’. The rationale for the plan and the associated activity designed to help participants identify where supports currently exist in communities and how they can be improved, is to lay a foundation for strategic directions to make their communities ‘suicide safe’. Wish lists identify what program participants want in their community and form the basis of ‘action items’ after the workshop. We observed how this unfolded during our workshop visits between June and September 2018. To follow up on the plans, a Suicide Story staff member (generally

the Suicide Story Program Officer), sometimes accompanied by a facilitator, visit the community to provide support and to learn what has happened since the workshop. The timing for this ‘follow-up’ visit varies, but it can be some months after the workshop. The findings of the follow-up visits are then included in the final workshop report.

The summary of issues that follows here, is drawn from several interviews where respondents contributed to the discussion about post-workshop focus of the program. It should be noted that while the interview questions were semi-structured, the conversations we had with participants were free-flowing and reflected multiple perspectives. The headings reflect these perspectives.



... Identifying community support systems and local safety plans

Community Safety Plan works!

Some respondents believed that the Community Safety Plans do work. They point to evidence which shows communities rising to the challenge of the community mapping and planning exercise and responding constructively, to enact their plans. The strongest statements for this evidence comes from people like program staff, facilitators and SSAAG members. For example:

I think for me in my role, I think I am lucky to see, in some cases, the full circle of Suicide Story in community, ...I have seen like where community members have actioned their community plan, safety plan, I have gone to those people, I have heard stories of using their learnings, from the program I had to help the person because of their fire, hearing things like that, it's really rewarding,

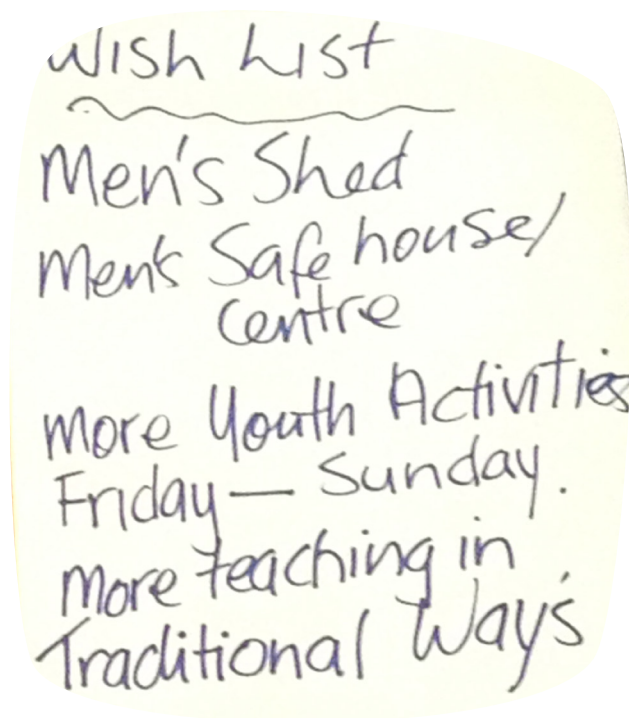
And

At [community] whatever they had on their wish list they had it done, they had the support of the whole community.

And

I think even the community plan... I have seen communities stick to that community plan, getting people to realise that you've got that connection at home to help each other and making them realise that...

At the very least the above statements demonstrate that in its current form, the community mapping exercise, coupled with the wish list and community plan, can work to achieve outcomes desired by the community. However, it is difficult to make an assessment about the impact of these plans as a contributor to suicide prevention.



... Developing community goals 'wish lists'
... to create suicide safe communities

Community Plan may need a more nuanced focus

There were some suggestions that at times a 'Community Plan' may not be appropriate. This is because there are times where clan or kinship groups or sometimes men and women within communities need to make culturally appropriate decisions about where and who to get help from.

The notion that you have a great big community plan is quite a white fella notion, better to have a group of people who have credibility, you don't need 100 people to bring together a plan, if you have those people involved... the extent to which that becomes a community plan, I'm not sure, I haven't seen it...

Further to this, the creation of a 'community safety plan' by a small group of participants who are not able to consult appropriately, has the potential to alienate other groups as this respondent suggests:

So look I think its a great program, but to be honest there hasn't been a thing in the men's group, not much talk about it at all. Those that did go along didn't go to the men's group either. The best feedback would be from them.

Better planning and coordination would make a difference

Our observations of pre-visits, workshops and follow-up visits showed how good planning can come to very little in the face of unanticipated events such as

the local football team winning the grand final (with half the community disappearing for a week as a result) or a death or funeral or a weather event or last minute cancellation of accommodation coinciding with community visits. These 'unanticipated' events are part of the richness and challenge of life and work in communities. Knowing this, it is important to ensure there is a Plan A, a Plan B and a Plan C, if not a Plan D in place. This is a sentiment expressed by the following respondent:

...given the resource intensiveness, you want to be sure that there is proper planning for this to bring the people together.

And from a different perspective in relation to follow-up:

When you have a meeting you set it up in advance, then remind them and remind them again.

Bringing people together is an important strategy for discussion about issues and collective action. The workshop setting is clearly not the space for that broader discussion to happen, but a well-facilitated and planned post-workshop activity could well be the place for this discussion to happen. In addition, this kind of thinking could be introduced into the professional learning activities for staff and into facilitator training. The multi-layered nature of suicide as a problem, involving grief and loss, mental health issues, drugs and alcohol, shame, blame, jealousy—along with others—means that a coordinated approach to prevention can be very helpful. But it does not always happen.

Put more effort into supporting community after the workshops

Several respondents talked about the need for more post-workshop support. One respondent here discusses the need to keep conversations going after the workshop:

...what I notice is, when our people talk about suicide, safe communities, it only goes for a little while after we have delivered, then it's all forgotten. I don't think we are supporting them enough on the ground—our communities enough—to see the importance of keeping them safe from suicide. Not enough follow-up, I don't think there has been any—very little—follow up into those communities after they have delivered those programs.

The suggestions for more support did not imply a need for someone to take over, but rather someone to facilitate. For example, in response to one of those 'unanticipated' events at a follow-up visit, one respondent suggested this:

I think follow-up is something, it can't be a one off... They need support and they are a support group for each other.

The desire to see Suicide Story applied more intensively was expressed by this respondent:

...you could do more forward planning, I would love to see it delivered to all communities in the NT, then follow-ups all the time, its the only way we will get outcomes.

Similar sentiments were expressed by program participants in evaluation workshop activities. They talked about:

- Silos working independently
- Needing ambassadors in communities
- Providing more support for participants.

Follow-up needs more of a community development approach to be effective

There were some (not many) calls for a community development approach for Suicide Story's follow-up processes. For those who did put forward this view, it was not that they believed that Suicide Story should do community development work, but that it should be framed or led within a community development approach, where the strengths of communities could be built.

The challenge with all the post-workshop processes is to ensure that community members hold on to the power to make decisions for themselves rather than relying on external expertise to offer solutions and support. Further, beyond an intention to support the outcomes of the workshop towards greater resilience, what may be required is a clearly targeted role with a defined scope to achieve specific ends. We return to this point later in our discussion on follow-up visits (see page 63).





Stories of community strengthening

After one workshop in a remote community, one of the local organisations involved in supporting the Suicide Story program began to ask how they could support the community's wish list. With the support of Suicide Story staff, the organisation applied for a \$10 000 suicide prevention grant from the Northern Territory Government and was successful. The money is being used to help create a safe space for people in the community to talk to someone when they are feeling sad or isolated. In this case, Suicide Story was a catalyst for ongoing development in the community to help make it suicide safe.

Discussion and recommendations

In this section we first discuss a response to the evaluation questions before considering a number of recommendations.

Responding to the evaluation questions

Before considering recommendations, we return to the evaluation questions in an attempt to provide a succinct response to each, drawing on the evidence we have gathered. We also make links back to the literature where appropriate.

Is [and how is] the program producing its desired impact [resilience and suicide prevention] at the community [and individual] level?

Firstly, we feel it is important to state emphatically that there is ample evidence to show that the program works to achieve desirable impact. We cannot quantify (and have made no attempt to do so) how many lives have been saved. However, we are confident that the program is leading to strong outcomes, consistent with the theory of change we proposed prior to the evaluation (see Figure 12). Evidence from interview respondents points to several individual impacts.

Evidence of individual impact and indicators of impact

We see impact reflected in several ways (see also Figure 19):

- Stronger skills to better respond to grief, trauma, and the needs of those who may be contemplating suicide
- Greater awareness of the signs of suicidal thoughts
- People talking about suicide more openly, with less stigma associated with the term

- People helping each other
- Greater confidence to act and intervene as required
- Empowerment, self-awareness and strength.

These points are the indicators of resilience we envisaged in the 'immediate results' of our theory of change model (Figure 12), and included in the causal logic (Figure 13) and the underpinning theoretical foundations (see Appendix 2, Figure 29). The outcomes are largely consistent with the research literature on effective programs which we discussed earlier (see Suicide-related behaviours, page 26). For example, Nasir et al. (2016) point to increased skills and knowledge, confidence and desire to help others. The ATISPEP literature review on suicide prevention, drawing on the same evidence base concludes similarly (University of Western Australia, 2016b). Ridani et al. (2015) in their comprehensive review of suicide prevention programs in Australia also find effective programs that improve suicide awareness and readiness to help a person at risk. The evidence of people having greater confidence to talk about suicide suggests that the program facilitates a new language that helps people to discuss difficult issues (see also Togni, 2017) consistent with other examples of culturally safe programs discussed in the literature (see Figure 9).

Given this support, there is an existing level of satisfaction with the program and little call for change to the foundations of the Suicide Story program. The workshop is doing what it is intended to do. That said, our observations point to the need for some minor updates to the training manual and the accompanying resources. While all the material is still relevant some of the videos appear somewhat dated now and some may not suit the new contexts that the program is being delivered to.

The current internal evaluation tools and monitoring information provide ample evidence of changes in awareness and knowledge changes as reflected

in the 'immediate results' of the theory of change model. They do not fully capture the more nuanced indicators of resilience that we have been able to identify through the evaluation. However, we see no pressing need to change the internal evaluation tools so long as the program remains as it is currently delivered—the current tools adequately capture the immediate impact of the program while at the same time engaging participants in reflective and meaningful self-assessment activities.

Factors contributing to success

As important as outcomes, for many, the process of achieving outcomes was fundamental to the success of the program. These are the key ingredients and non-negotiables of the program which ensure its integrity is maintained. They include:

- A focus on cultural safety
- The priority of community ownership
- Having Aboriginal facilitators trained and leading workshop sessions
- Sharing knowledge and stories
- Restoring hope
- Using local language;

- Maintaining program integrity, ensuring adherence to local protocols
- A focus on 'both ways' training
- The importance of reducing stigma associated with suicide.

Many of these points describe how Suicide Story works and they contribute to our understanding of what resilience looks like. They fit in the 'What helps' box of the theory of change model we proposed earlier (see Figure 12 and detail in Figure 27) and are consistent with the literature supporting 'Our Way' discussed earlier (see page 29). The model suggests that 'resilience' is the key to the effectiveness of the program (see also Figure 13). But our respondents seldom used the word 'resilience' to describe outcomes of the program. However, the last three dot points on our list of impacts do respond directly to aspects of resilience we identified in the literature such as strengthened relationships (Gray & Muehlenkamp, 2010) and collective self-esteem (Lewis et al., 2014) which relates directly to our findings of increased confidence to act as required. We also found examples of respondents reporting increasing 'connectedness' (Ridani et al., 2015).



⋮ Suicide Story workshop graduates

Resilience and community impact

For many respondents the support factors we listed above represent the resilience we were looking for in our model. While we looked for indications of resilience as products of a process, many of our respondents tacitly described resilience as the process. The linear logic we proposed is probably actually a misrepresentation of a more circular process that is represented in the models of cultural integration proposed by Gray and Muehlenkamp (2010) shown at Figure 7; the learning circle model proposed by Wexler et al. (2017b) shown at Figure 8 and the path to clear thinking proposed by Togni (2017) at Figure 9. The support processes that were described as ‘what makes Suicide Story work’ (page 37)—particularly the element of cultural safety—underpin ‘Our Way’. They are consistent with much of the international literature we looked at earlier (see What is the underpinning evidence for ‘Our Way’ and how can this be articulated?, page 29) where ‘safe spaces’ (Fanian et al., 2015) and the process of sharing stories in ‘sharing circles’ (Isaak et al., 2010), ‘learning circles’ or ‘community conversations’ (Wexler et al., 2017b), ‘circles of strength’ (Gray & Muehlenkamp, 2010), and ‘culturally congruent’ processes (Allen et al., 2014b) are all consistent with culturally safe practice. These processes are not individually enacted. Rather they are part of a collective, social and inherently cultural mechanism that builds resilience at the community level.

Further, perhaps at a more tangible level, the community impact of Suicide Story is reflected in the cumulative impact of the social support network that has been built over time. Over the last 10 years Suicide Story has built a critical mass of trained community members with 393 people having completed the three-day workshop since 2013 and 38 people trained as facilitators, 29 of who have been either involved with workshop delivery or pre and post visits. While we recognise the need to focus more on growing the pool of facilitators into the future (see later discussion on Facilitators, page 64), we also acknowledge the strength of the combined impact resulting from the ongoing delivery of workshops and facilitator training.

In summary, we find that Suicide Story is achieving its desired impact for individual participants and for communities that have engaged with the program, and there is strong evidence for both the immediate outcomes of knowledge, skills and confidence, and the longer-term outcome of resilience.

How can the impact be strengthened with follow-up [or other] processes?

A number of factors limit or inhibit the effectiveness of the program including some that are outside of the control of the program (See Appendix 2, Figure 26). Beyond these constraints there was an array of barriers reported, such as funerals, timing issues, participant attrition, and basic community capacity issues that were seen to be problematic for the program and beyond the control of staff. The notion of ‘perpetual grief’ raised in the literature (Malone et al., 2017) aligns with our respondents description of ‘grief upon grief’ (page 51). Consideration of these factors is important for understanding the limitations of Suicide Story. However, there are also several factors that potentially can be controlled, and these should be considered in the future development of the program.

Pre-visits and planning

We noted earlier (see page 57) that planning and preparation is important at all stages of program delivery. While there was little specific comment in the data about pre-visits, this part of the program is largely about coordination, planning, preparation, consultation and negotiation with communities. Our observations suggest that little time is devoted to the visit (sometimes less than a day), though we cannot comment on the amount of planning that goes into preparation for this—and indeed a few hours may well be enough. However, our observations suggest that the pre-workshop preparation could at times have been more thorough and strategic. In part the limited time spent on pre-visits is a product of pragmatic prioritisation of available capacity though it also may be due to functional prioritisation of the Program Officer and Program Manager roles. Having made these observations, we are not suggesting that the staff do give consideration to planning and preparation—indeed we are aware that sometimes circumstances beyond the control of staff (such as unexpected interruptions due to sports carnivals, cultural business or other unforeseen events). What we are suggesting is that the foundations of a successful program are built on preparation, and that this element of the program does not always receive the attention that is required.

The workshop

It is clear that most of the effort to date has gone into the three-day workshop and getting that right (see Background and history, page 14). From the

beginning, the developers worked hard to build a set of resources and a format that would work. The establishment of the SSAAG in 2011 built on the earlier efforts and there is plenty of reference in the SSAAG meeting minutes to show that the Advisory Group made considerable effort to ensure that the correct processes, resources, training and people were involved in the delivery. Since about 2016 the SSAAG's function seems to have shifted so that it is now more focused on maintaining the integrity of the program's delivery. Relatively little attention has been placed on developing the model to focus on the 'bookends' of the program: the pre-visit/planning and consultation phase and the follow-up phase. While noting this, the workshop as it is, will continue to be fundamentally important to the program's effectiveness into the future.

Follow-up visits

As the program has matured the expectation is that follow-up looks like a one-day visit to communities, to touch base with various stakeholders and participants. However, before going on, it is important to note that most respondents did not conceive of Suicide Story being a fully integrated community development or capacity building program. This is perhaps unsurprising when we consider what 'Our Way' looks like. The literature that supports 'Our Way' (see page 29) does not reflect community development models either. Rather 'Our Way' is a culturally embedded process. Community capacity development may well be a product of the process, but it is much more holistic, consistent with the international literature (see particularly Gray and Muehlencamp's model on page 25) which includes cultural/spiritual healing, education, physical and emotional health.

Program expansion

Respondents did however discuss a number of points that they thought would strengthen the program which are noted in the findings. There was quite a bit of discussion at times in the data about the need to take the program beyond the Northern Territory, and there was also regular talk of making resources particularly for youth. Expansion outside the Northern Territory is already happening through fee for service delivery. This has taken Suicide Story to Halls Creek in Western Australia, and Amata, Mimili and Port Augusta in South Australia.

Further expansion would require additional resourcing and focused attention including;

- Better coordination with suicide aware service providers in community;

- More intentional work with community members post workshop;
- Improving the working relationship between the SSAAG and MHACA;
- Planning towards Suicide Story coming under the umbrella of an Aboriginal Community Controlled Organisation; and
- Staff with dedicated time and appropriate skills to take up the follow-up role more intentionally.

In terms of resourcing, the fee for service model does increase the sustainability of the program and reduces reliance on government funding. However, a complete shift to a fee for service model would be difficult at the moment and ongoing funding is required to make the program sustainable into the future.

Maintaining community control

Assessment of the program's future directions as a culturally safe program for Aboriginal and Torres Strait Islander communities across Australia—and beyond the current scope of a program primarily directed to adults—requires careful consideration, particularly by the SSAAG. The current SSAAG is made up of people from the Northern Territory. Noting that the program has already been conducted in South Australia and Western Australia, the need for cultural advice and input from different contexts may become increasingly important. One of the key drivers of effective governance as noted in the literature is community control—see particularly Allen et al. (2009). Further, in our exploration of 'what helps' the program for the theory of change model (see Appendix 2, Figure 27) we envisaged several community ownership indicators including:

- Communities knowing what they want
- Employing local knowledge
- Cultural strength, using traditional ways

These indicators are largely confirmed in the data (see Figure 20) and therefore should be a primary consideration in the ongoing development of the Suicide Story program. A loss of community ownership may jeopardize the cultural integrity of the program. In addition, assuming MHACA's ongoing role with the program, as an organisation based in central Australia, it may need to consider how it would respond to a geographic expansion of the program. None of these cautions need prevent MHACA or the SSAAG from sharing learnings from their experience to others in different locations so that locally responsive programs can be built on

principles that could be applied more broadly than within the existing geographic reach (as shown at Figure 6).

Staff development

Beyond geographic expansion and more focussed attention on the needs of children and youth, there are some other important areas for strengthening. Staff at times felt considerable pressure to deliver more than they felt capable of. That is, there were times when they felt stretched in their capacity. These feelings are reflected in responses about professional learning for staff represented in Figure 23. Our observations suggest that the roles require a range of reasonably high-level planning, verbal and written communication, reporting, intercultural, coordination and networking skills. Beyond these skills, staff need to be able to work safely in remote contexts, have a range of coping strategies for dealing with grief and loss, and they need to be able to manage time with flexibility and dexterity. We noted that at times, staff have travelled remotely on their own and while this to date has not affected program delivery, there are considerable risks associated with remote delivery that may require a review of training (e.g. Four-Wheel Drive training, remote first aid) and safe work procedures.

We also noted that while staff did their best to work with a diverse mix of stakeholders, there is scope for improving skills as they relate to partnership management, collaboration and coordination. Again, our observation is that in these areas there could be more guidance, mentoring and support to facilitate skill development for staff. The skills required are not necessarily accredited qualifications, though there could be targeted training that may support staff. Given the skill demands of the roles, and given consideration of expansion to develop follow-up activities, or expansion of the geographic scope of the program, it may be that additional staff with particular skill sets need to be recruited. In addition, existing staff, navigating the complex array of networks and partnerships across Aboriginal and mainstream knowledge systems may need additional support, training and mentoring to more effectively fulfil their expected work roles. Specifically, higher level organising, planning, negotiating, relationship management, and partnership development skills would be required.

Facilitators

A further area for improvement arises out of the need for more trained and better support for facilitators (see Figure 22). Aboriginal facilitators are a key to making the Suicide Story program work (Figure 20). However, despite the large pool of potential facilitators (38 having been trained so far) for various reasons the delivery of the program tends to rely on a much smaller pool of available people. As the demand for the program increases, the need for more trained facilitators who are available to take a week out of their time also increases. Beyond workshop delivery, as facilitators are involved with mentoring, promotion (for example at conferences), pre-visits and follow-up visits, there can be a significant time pressure on them to respond to the demand. The primary reason for this is the limited number of available facilitators. Having more trained facilitators will build the capacity of the program to deliver more workshops.

In order to keep pace with the current and probable future demand of the program (particularly considering recent delivery into South Australia), a strategic recruitment and training process could be pursued so that the pool of facilitators includes local people who are located outside the Northern Territory. The limited pool of trained facilitators is a capacity constraint for the program and our observations suggest that program staff are having trouble keeping up with the demands for delivery, follow-up, facilitator training and partnership development/management.





The Suicide Story Aboriginal Advisory Group

The SSAAG is strongly committed to Suicide Story as a program for Aboriginal people. The members' passion and enthusiasm for their work is extraordinary. If Suicide Story is to further develop and move away from MHACA, or align with an Aboriginal community-led organisation, the SSAAG should recruit members that fill potential gaps in their skill set which may include financial management, intellectual property, strategic planning and governance skills that currently are not required. As noted earlier, ensuring that the interests of people outside the Northern Territory are represented is also a key issue for the SSAAG. While changes in future directions for the program need not be immediate, the risk from a demand driven approach to program delivery is that cultural governance may become compromised. A demand driven approach (where communities are asking for programs) is fine when the resources to deliver the program match the demand. However, the risk of compromise arises when the demand (particularly from outside the Northern Territory) exceeds the ability to supply the program with cultural integrity and quality.

How can community plans/safety plans be better utilised, monitored and enacted post-workshop delivery?

We recognise that the cumulative impact of Suicide Story—having run for 10 years with more than 500 participants since 2013—is significant (see discussion on page 62). However, we have also noted that in order to improve the program, a more strategic focus on follow-up is required consistent with 'Our Way'. Community Safety Plans are an important product of Suicide Story. They bring together the knowledge, skills and confidence generated over three days to create a concrete attempt to put into action a plan that the community can use. However, in their current form, the process of development can easily stop at the workshop. The process promoted by Wexler et al. (2017b) shown earlier at Figure 8, while still consistent with 'Our Way', offers an iterative community led approach that allows for holistic development and ongoing learning.

Community Champions

There are examples in the data of communities having taken hold of this activity and having worked through it to develop an appropriate strategy post workshop. However, our observations suggest that without some intentional support, the plans created during Suicide Story might just as likely be parked on a shelf somewhere, never to see the light of day again.

To maximise the effectiveness of these plans requires a local community champion. This person (or potentially a group of people or organisation) would ideally be identified during the workshop, though it may be difficult for one person to take on this kind of role. However, with support from a Suicide Story staff member, this may be a little easier. Current follow-up arrangements do not allow for the kind of support that is required to develop an action plan.

Community Development Coordinator

We envisage a role for a ‘Suicide Story Community Development Coordinator’⁵ and Suicide Story Community Champions. As suggested above the Champions would be identified as part of the workshop process. The Suicide Story Community Development Coordinator would be a new role designed to support the strengthening of post-workshop action plans. This is not a role that would intervene or provide services, but rather support communities to identify potential interventions and engage appropriate services—the integrity of Suicide Story depends on maintenance of community control, consistent with ‘Our Way’ (see discussion of this in the literature, page 29). This person would liaise with the workshop team members and participants to help identify and support a local Champion. This role would also work with suicide aware community organisations (some of who may have already been involved with the workshop) and with workshop participants to build an actionable plan. The Coordinator could also bring in external expertise if deemed necessary. The Coordinator would build on the current one-off follow-up visit and provide ongoing support over a period of time (say 6 months) to support the community aspirations. It would not be their role to create an action plan for the community. Rather their role would be to support its development and to monitor its implementation.

Post-workshop review process and reports

We see a potential for improvement in the documentation presented in the workshop report. At

the moment workshop reports are written to a fairly standard template that captures what happened, some basic statistics, and some short vignettes specific to the site. They are largely uncritical and do not consider in any depth the challenges faced in delivery, or what went wrong, or how community could be better supported into the future. There is scope to use these workshop reports for critical reflection with a more nuanced reflexive consideration of outcomes and impact. Draft workshop reports can then be used by MHACA management and the SSAAG as a tool for critical review and input. Consideration could be given to expanding the audience of these post-workshop reports to facilitate communication and advocacy to government and other stakeholders. The Community Development Coordinator could also use this critical review process in conjunction with Community Champions to address and reflect on follow-up issues.

Deeper learnings to inform the program’s future development will emerge from this critical review process and potential advocacy opportunities that arise. An action list could be incorporated into the workshop report. A suggested set of more critical questions is provided for consideration at Appendix 4, page 94.

Recommendations

The recommendations that follow are presented for consideration. They emerge from the data collected for the evaluation and come in response to the voices of respondents. The recommendations are grouped by function rather than by evaluation question. However, they should be read in the light of the findings and discussion about strengthening impact and community/safety plans (Research Question 3) and the third aim of the evaluation, about future program improvement.

The Suicide Story workshop

The workshop itself has been developed over a long period of time and there is general agreement that the content and presentation mode is about right and requires little change. It is built on an established evidence base and in terms of the causal logic towards its intended outcome of increasing resilience, we see no need to alter the theory of change from that which is presented in this report (Figure 12). It is also achieving outcomes consistent

.....
⁵ We recognise that the name ‘community development coordinator’ may not be quite right, given the difference between ‘community development’ and ‘Our Way’.

with its stated objectives, notwithstanding its potential for expansion. Some of the video resources are now getting a little dated and require a refresh. In addition, resources that are more sensitive to local contexts should be developed as part of the refresh. The changes are relatively minor and we suggest that staff and the SSAAG review all materials with new contexts of delivery in mind.

Recommendation 1. We recommend that the Suicide Story workshop remain essentially as is, but with minor updates to resources and content as required.

Staff and operational issues

We turn next to staff and operational issues that arise from the evaluation. Staff bear responsibility for ensuring that all elements of the program are delivered with integrity. They also have reporting responsibilities to their MHACA managers. The Program Officer, (currently) as an Aboriginal person, is also expected to draw on and use cultural knowledge. Staff are also responsible for maintaining and building relationships with partners and community groups across the geographical scope of program delivery. They also draft report for funders and are the first point of contact for the program in many, if not most, instances. These multiple functions require a diverse set of skills not necessarily fully developed in existing program staff. In particular we refer here to coordination, negotiation, collaborative partnership development, and higher-level communication skills with stakeholders from governments and funders. This is not to suggest that current staff are not performing adequately—rather, it is to suggest the need for more professional support.

Recommendation 2. We recommend that in conjunction with Suicide Story staff, MHACA management develops a customised professional learning plan to address identified skills gaps of staff.

Coupled with Recommendation 2 we see a need for a review of safety procedures. There are significant health and wellbeing risks for staff and facilitators working remotely for Suicide Story. There have been instances when Suicide Story staff have travelled remotely alone. This should not occur. In addition, we note that for staff involved with the program there is sometimes considerable emotional distress arising from the work they do. Just as there is a need for a professional learning plan, there may also be a need for a staff health and wellbeing plan with tailored supports to meet individual needs, ensuring that potential emotional and psychological stresses are mitigated and managed.

Recommendation 3. In the context of workplace health and safety, we recommend that staff safety and wellbeing procedures be reviewed, noting particularly the need for safe travel to remote locations.

In terms of the Program Manager's role for Suicide Story's ongoing improvement, the findings suggest a need for improved coordination with suicide aware organisations and better promotion to government and funders (see Figure 22). Similarly, Figure 20 points to collaboration with non-government organisations as a support factor for the program. Noting the nuanced connections between collaborative partnerships and community resilience building (see Building community resilience, page 32) we suggest there is considerable scope for developing the Program Manager's role accordingly with support from MHACA management. Managing a network of stakeholders may be seen as a time-consuming process, but partnerships and networks can be fundamentally important for the effectiveness of the program and its sustainability. The Program Manager's role already includes elements of network management, but there is potential for this function to be strengthened and enhanced with appropriate training and mentoring. A professional learning plan should be developed jointly with the Program Manager and his/her line manager.

Recommendation 4. In conjunction with MHACA management staff, we recommend that the Program Manager's role more intentionally focus on strategic relationship development with a view to strengthening the perceived value of the program to existing and future funders, and to other suicide prevention stakeholders.

As with the discussion around Recommendation 4 (for the Program Manager), the Program Officer's role already has a strong focus on building and maintaining networks and relationships in communities where Suicide Story is delivered. In making the following recommendation we are not suggesting that this function is more important than others for the Program Officer. Rather we are suggesting that it requires more intentional focus and to build this will require some professional learning and mentoring support as noted in the discussion (page 64) and also in the findings (see Figure 20). This kind of learning is often not formalised or accredited. Rather it is achieved through modelling, leadership and encouragement. The mentoring may include support from within or outside MHACA and from communities as well.

Recommendation 5. We recommend that the role of the Program Officer more intentionally focus on strategic relationship building, coordination and networking with community-based services in order to strengthen the support networks for community members.

Trained facilitators are fundamentally important for the success of the Suicide Story program as noted in the discussion (see Facilitators, page 64) and in the findings (see Figure 20 and the accompanying analysis on page 49). Ensuring that the pool of available facilitators is maintained and refreshed is an important responsibility for staff. Our observations suggest that in the short term, the pool needs to be expanded and strengthened through training for new facilitators, and refresher training for existing facilitators. This is particularly important to help meet the growing demand for program delivery which is now occurring. In the longer term, the process of building and maintaining the pool of facilitators should include ongoing recruitment and campaigning to encourage and attract potential facilitators into the pool.

Recommendation 6. We recommend that the pool of trained Aboriginal facilitators be expanded and strengthened to meet the growing demand for the Suicide Story program in communities.

Program governance and management

Our next set of recommendations relate to the Suicide Story Aboriginal Advisory Group. The SSAAG has played a vital role in the development of the program since 2011 and increasingly sees itself as the custodian of the program. Several responses in the data were in favour of progressing Suicide Story towards being a stand-alone entity (see Figure 22) and those strong views are the basis of the following recommendation.

It should be noted that this will take quite a lot of planning and preparation and is a medium-term exercise. This could be speeded up if a suitable Aboriginal community-led organisation could be found to host the program. Regardless of the options taken, the transition away from MHACA has implications for program staffing, funding, administration, management as well as governance. With this in mind, any transition should involve negotiation between funders, MHACA and the SSAAG. We are not suggesting that the SSAAG give up its role of cultural advice to the program or its role ensuring cultural integrity or program development. Rather, we are suggesting that its role should be expanded to include management and broader governance functions. Further, we are not saying that this is our preferred option, but rather that it was a strongly articulated goal, which came from our data.

Recommendation 7. We recommend that while MHACA and the SSAAG continue working on program development opportunities, the SSAAG considers options towards bringing Suicide Story under the umbrella of an Aboriginal community-led organisation.

In preparation for this change, the SSAAG must engage in a strategic planning process to ensure the transition is smooth and to ensure that all the financial, governance, management, intellectual property and operational considerations are taken care of. Initially, this process should be externally facilitated with the involvement of both MHACA and the current SSAAG.

Recommendation 8. We recommend that the SSAAG establishes a strategic planning process with Recommendation 7 in mind.

Part of the transition will necessarily involve recruitment of new SSAAG members to meet the skills gaps required to provide direction for the management and governance of the program. The SSAAG's current function, which is to provide some operational guidance and cultural governance would need to change if it were to become a governing body into the future. A priority for the SSAAG will be to ensure continuity of funding.

Recommendation 9. Following on from Recommendation 8, we recommend that the SSAAG recruit new members to fill in skills gaps it identifies.

Future funding of the program must be a high priority for the management body of Suicide Story. Funding sources could include the current major funders (Northern Territory Government and NT PHN) but may also include Australian Government sources, (e.g. the Indigenous Advancement Strategy), corporate sponsors and philanthropic sponsors. Funding is already seen to be a constraint for the program (see Figure 21) and securing better, long term funding is seen as a priority for the improvement of the program into the future (see Figure 23). It should be noted that some of Suicide Story's operational funds come through fee for service delivery. Refining the fee for service model to more adequately cover costs, particularly as follow-up is better integrated into the program, may also be a way of resourcing additional human resources to add to the program's capacity.

Recommendation 10. As part of the Strategic Planning process, MHACA, with support from the SSAAG, should begin to explore ongoing and additional funding options.

The visibility of the program depends on it being in the minds of those who can advocate for it. To some extent this has been achieved with various awards that have highlighted the work of the program, but the time has now come for Suicide Story to be promoted more directly to political leaders, senior bureaucrats and other key stakeholders. This is acknowledged in several responses that are reflected in 'promotion to funders and government' in Figure 22. While noting that engaging with funders is currently MHACA's responsibility, if the transition envisaged in Recommendation 7 is adopted this level of engagement will become important for the SSAAG. Hence our recommendation here is for a joint or collaborative approach.

Recommendation 11. We recommend that MHACA, with support from the SSAAG, more proactively engages with policy bureaucrats, politicians and senior experts in suicide prevention with a view to building financial and political support for the program.

In support of improved MHACA/SSAAG relationships and in the interests of continuity and sustainability, we envisage the need for a transition plan (perhaps in the form of a Memorandum of Understanding) to prepare the way for the SSAAG to transition to becoming a management body under the umbrella of a community-led Aboriginal organisation. This assumes that Recommendation 7 is supported by the SSAAG with a positive commitment.

Recommendation 12. Assuming that the SSAAG accepts and works towards Recommendation 7, we recommend that MHACA develops a transition plan and begins to work with the SSAAG in good faith towards that end.

Future directions

The concept of Community Development Coordinator discussed earlier (see page 60), coupled with the Community Champion roles (page 66), is intended to address the need for improved focus on follow-up (see discussion on page 63). In the first instance, we anticipate that these functions could be funded as a 12-month trial to assess how it may work or indeed if it does work. The roles go well beyond the capacity of current staff (and facilitators), and significantly expands the 'follow-up' element of the program. Indeed the data suggests that more staff are required for improvements in the program to be realised (see Figure 23). In preparation for

the trial, the new roles would need to be clearly defined and differentiated from existing staff roles. Subject to the timing of the transition process, it may be appropriate to defer the implementation of the trial until after the transition is complete. If the transition is relatively quick (during 2019) then this could be pursued by the SSAAG in conjunction with the new host organisation. If the agreed process is longer, the trial could be initiated by MHACA. The roles should be reviewed at the end of the trial.

Recommendation 13. We recommend that the MHACA, in conjunction with the SSAAG, pursues new project funds to trial the concept of a Suicide Story Community Development Coordinator and a Suicide Community Champion

Every person we interviewed acknowledged the need for targeted youth suicide prevention programs. Youth suicide is an important issue in many Aboriginal communities as has been highlighted by recent media stories (for example Winter, 2019). However, the SSAAG, facilitators and staff were not in agreement about what role Suicide Story in its current form, should play in this. Calls for a children or youth suicide prevention program (see Figure 22) came mainly from external stakeholders who saw a gap not being filled by Suicide Story. The gap of course does not justify a response on its own, but we believe some exploratory work could be done to determine if it is possible to have a separate or add-on youth program. The development of a separate youth program would involve a co-design process with youth. While MHACA remains the manager for Suicide Story, the possibility of a youth program or development of youth resources should be worked through collaboratively.

Recommendation 14. We recommend that the SSAAG in conjunction with MHACA explore the potential for a set of culturally safe youth suicide prevention resources which would work alongside the existing Suicide Story program while at the same time applying for funds to continue the program as is.

Separate to but supporting Recommendation 13, we see the need for a more critical post-program assessment process to support and action follow-up issues. This arises from our analysis of workshop reports, which showed little in the way of critical reflection on challenges, failures, risks or future opportunities. The review process requires management and SSAAG input so that learnings from the workshop can be turned into action. We have suggested a set of critical questions that could be applied to the process at Appendix 4 (page 94). Where failures or difficulties have arisen (for example compromises to staff/facilitator safety and wellbeing, or concerns about negative participant experiences) these should be documented. Action arising from the community plan and the workshop more generally should be documented for later review. The learnings (good and bad) can be a powerful tool for advocacy, staff development, communication with key stakeholders and for program improvement.

Recommendation 15. We recommend the inclusion of a more critical post-workshop review process to ensure learnings can be better captured in workshop reports, and so that specific follow-up actions are documented.



Previous SSAAG members and program manager, 2016



Stories of cultural safety

Cultural safety is woven into the fabric of Suicide Story. It shows itself in lots of ways. In one community, due to ongoing grief and loss experienced by the community, the team waited for some months before following up on a request for service, and only after consulting with community, following invitation and with Elder approval. Due to the sensitivities of family groups in the community, it was decided not to conduct a community workshop, but rather have a focused group of participants who were all working with various organisations. The workshop was conducted away from the community in Alice Springs as it was felt that some family groups were not ready and might be confronted or offended by the training, making it unsafe for participants. The participants were grateful for the sensitivity and respect shown to them by the team, and at the end of the workshop showed their appreciation by taking the facilitators out for dinner. Suicide Story is not just a workshop. Rather it builds on relationships, and it builds relationships for resilience.

Conclusions

This evaluation of Suicide Story comes after 10 years of development and implementation. Prior to its initial trial in 2008, a considerable amount of work was carried out to prepare for its launch. We acknowledge that effort. We also acknowledge the support of MHACA and funders, who have shown confidence in the program and allowed it time to develop and grow. Further, since 2011, we acknowledge the vital role of the Suicide Story Aboriginal Advisory Group in providing cultural guidance and strong leadership and support of the program. We also acknowledge the commitment and passion that facilitators and staff have contributed to the program.

The evaluation sought to answer three questions:

1. Is [and how is] the program producing its desired impact [resilience and suicide prevention] at the community [and individual] level?
2. How can the impact be strengthened with follow up [or other] processes?
3. How can community plans/safety plans be better utilised, monitored and enacted post-workshop delivery?

Briefly, in response to these three questions we find that:

There is strong evidence for resilience outcomes emerging from Suicide Story that could reasonably

lead to suicide prevention. The impact of the program is reflected in its ability to create a culturally safe space where participants can learn from each other, find a language to talk about suicide, and identify ways of supporting each other and those at risk of self-harm and suicide.

While the workshop itself is effective and has seen hundreds of participants benefit through increased awareness, the one weak area of the program is in its follow-up processes. There is significant potential to build on the strength of the program with a much stronger follow-up process. Part of this involves working with communities to enact their community plans. At the moment, action depends on the leadership and strength of community members to follow-up on what has been decided on in the workshop. While this works sometimes, there is a good case for additional support from Suicide Story staff. This will require additional resourcing in the form of funding and people.

Improvement of the program depends to an extent on good governance. The evaluation has revealed tensions between the SSAAG and MHACA. While not suggesting that these tensions have compromised the program's effectiveness, we believe that a resolution of the working relationship between the two groups would help establish a stronger foundation for the future vision and strategic direction of the program.



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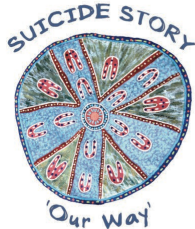
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Appendix 1: Delivery request form



SUICIDE STORY

An initiative of the Mental Health Association of Central Australia

ph (08) 8950 4600 fax (08) 8952 1574 ssstory@mhaca.org.au www.mhaca.org.au
14 Lindsay Avenue, PO Box 2326 Alice Springs NT 0871



MHACA
Mental Health
Association of
Central Australia

Suicide Story Delivery Request Form

Please complete and return this form to the Suicide Story Program at the Mental Health Association of Central Australia (MHACA) to request delivery of the Suicide Story Program for your community, organisation or other group.

This form has been developed by the SSAAG and MHACA staff to assist in prioritising communities in need of support and ensure transparency and fairness in handling requests.

Once MHACA has received a completed *Program Delivery Request Form*, the team will coordinate an introductory community visit to meet with appropriate parties and ensure Suicide Story would meet both community priorities and needs. Following the introductory visit, MHACA and the Suicide Story Aboriginal Advisory Group will prioritise community deliveries and alert selected communities to discuss potential dates for program delivery. Please note as per current funding requirements Suicide Story can only be delivered within the Northern Territory.

Please contact us for more information and/or our free Introductory DVD.

Organisations and Agencies

The funding that Suicide Story receives is dedicated to community deliveries. However, organisations and businesses are invited to submit workshop requests to receive the Suicide Story program under a fee for service agreement. For more information or to schedule a workshop please contact suicide.story@mhaca.org.au

If you would like to speak to a staff member before submitting your request, please contact Suicide Story on p. 8950 4630

Please note that Suicide Story may not be appropriate to deliver too soon after a death by suicide even if suicide prevention is a priority. The community/organisation/agency may need time to grieve and settle before they are ready for the Suicide Story workshop. Please make sure that this request is only submitted after making sure you have sensitively consulted with your community/organisation/agency about whether everyone is emotionally prepared to welcome the Suicide Story program.

Suicide Story Delivery Request Form

REQUEST LOCATION, REGION AND TYPE <i>(Please state where you are requesting delivery from and if you are requesting delivery for a community, organisation/business, or other groups)</i>	PREFERRED DATE OF DELIVERY <i>(please select two dates in order of preference from the Delivery Calendar above for community applications only)</i> 1. 2.
--	---

1. **CONTACT IN COMMUNITY:** Whom is the lead person requesting Suicide Story for their community/organisation/ business/group?
Note: this person will be the key contact and are responsible for ensuring that your community/ organisation/ group are kept informed and consulted about Suicide Story. To operate effectively Suicide Story will need on the ground assistance with organising the logistics for the workshop.,

Contact's Name :	Contact's Address:
Email:	Telephone Number:
<p>1. Do you identify as:</p> <p>Indigenous or Torres Strait Islander <input type="checkbox"/> Other <input type="checkbox"/></p> <p>2. Have you participated in Suicide Story before? No <input type="checkbox"/> Yes <input type="checkbox"/></p> <p>If Yes, please identify what training you attended:</p> <p>3. What is your role in your organization/ agency/ community/group?</p>	

CRITERIA

<p>2. WANT/DEMAND: Who supports this request for Suicide Story? <i>Please enter the names of all those supporting this request from the community/organisation/ business/group, relationship to the community/organisation/ business/group, their contact details. Please include no less than three Aboriginal community members; leaders and elders on this list)</i></p>

3.	<p>NEED</p> <p>Can you tell us of your concerns for your community/organisation/ group or rather why you consider this workshop a need? <i>Please give a summary of the recent history or your community/organisation/group's experiences of suicide and suicidal behaviours. This may include the number of people who have died by suicide, the number of suicide attempts, the extent of suicide threats, observations of suicidal or self-harming behaviour, any other relevant concerns or information.</i></p>
4.	<p>OWNERSHIP</p> <p>Who is committed to providing ongoing leadership both before and after the delivery of Suicide Story in your community/organisation/business/group in relation to suicide prevention? <i>Please list those supporters who are committed to working over a long-term period with the support of Suicide Story to strengthen your community/organisation/business/group to ensure that the work begun with Suicide Story is sustainable and effective.</i></p>
5.	<p>CONTRIBUTION</p> <p>Is your community/ group able to support the workshop financially and/or in-kind? <i>Please explain your position to fund the training, partially fund, or provide any in-kind support for the delivery of Suicide Story. Please note that being unable to contribute DOES NOT mean that you will not receive Suicide Story. Suicide Story operates from a principle of 'give according to capacity and take according to need'. Well-funded communities that are able to financially contribute enable less funded communities to access further support. Business and organisational requests for Suicide Story will be expected to pay for the service. Please contact us for an outline of the fees.</i></p>
6.	<p>RESOURCES</p> <p>What other training, support and/or resources in suicide prevention and intervention has your community/organisation/ business/group received in the last three years? Has your community/organisation/business/group already participated in Suicide Story?</p> <ul style="list-style-type: none"> • •

Suicide Story Delivery Request Form

OTHER RELEVANT INFORMATION

1. EXPECTATIONS

What is your community/organisation/business/ group's expectations of Suicide Story? *Please explain what you hope to get out of your participation in Suicide Story so that we can work to address your needs and want.*

2. LOGISTICS

To enable Suicide Story to run effectively it is good to know what facilities are available.

- Is there an appropriate meeting space for 20-25 people we can use connected to power and with kitchen facilities?

- Are accommodation and bathroom/kitchen facilities available for Suicide Story staff?

- Is there anywhere that can provide food for Suicide Story participants?

- Will interpreting be needed and would there be anyone available for this job?

- Who would be best to support Suicide Story with local cultural advise and make sure the training is culturally safe?

Thank you for your interest. Please submit your request to suicide.story@mhaca.org.au fax to (08) 8952 1574 or post to MHACA PO Box 2326, Alice Springs NT 0871

Your Signature:

Date:

Appendix 2: Additional theory of change diagrams

Figure 24. The contributors to workshop effectiveness

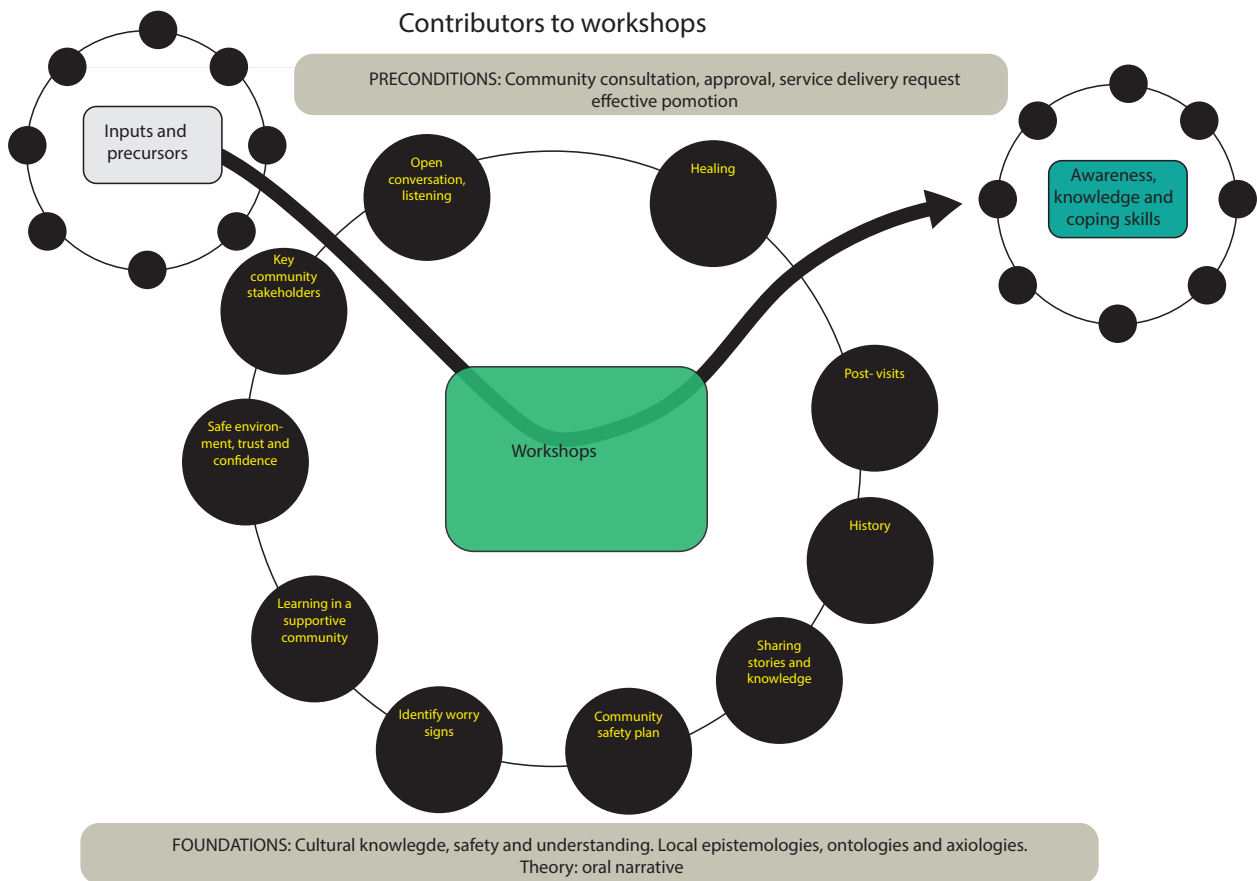


Figure 25. What does resilience look like?

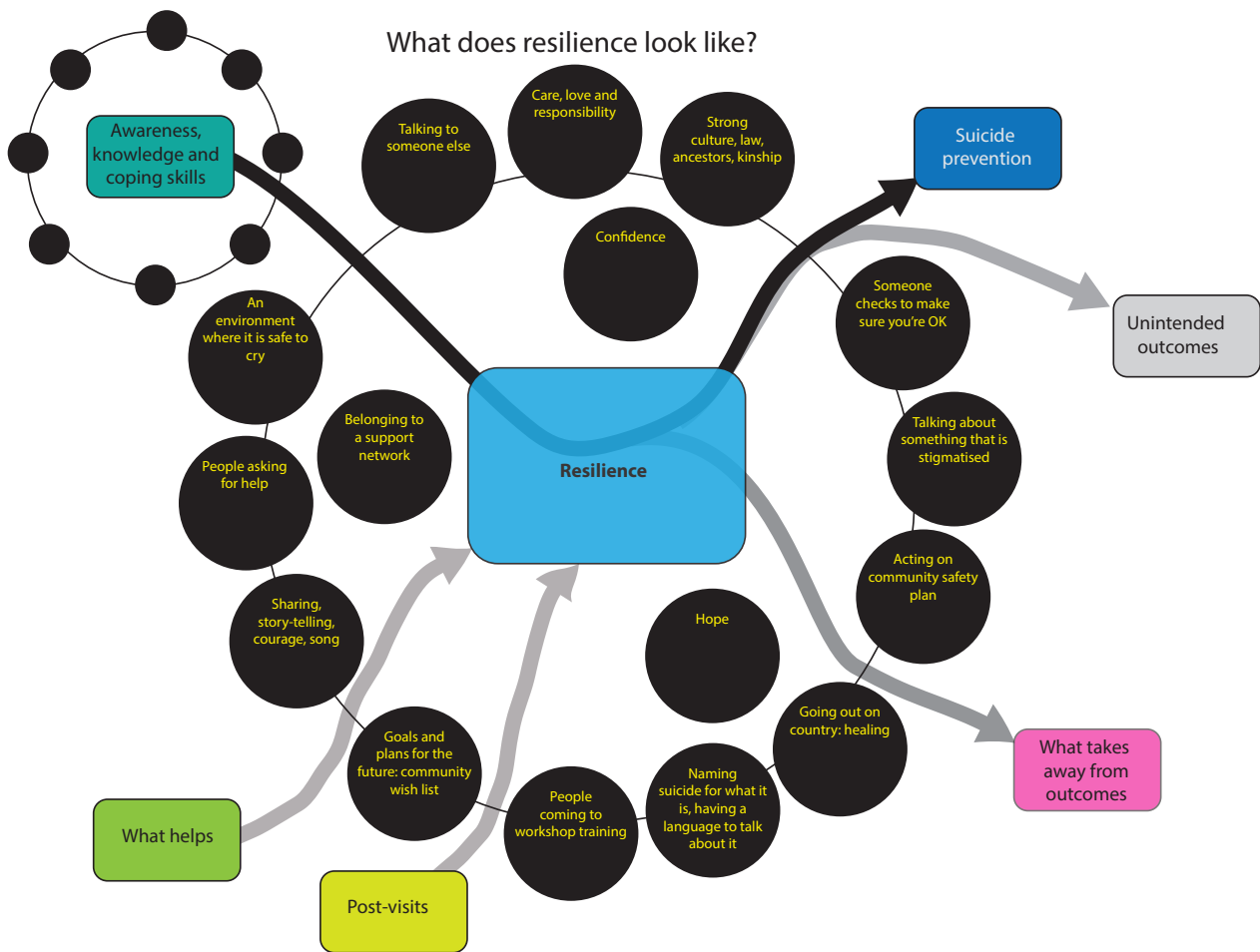


Figure 26. Factors that limit resilience

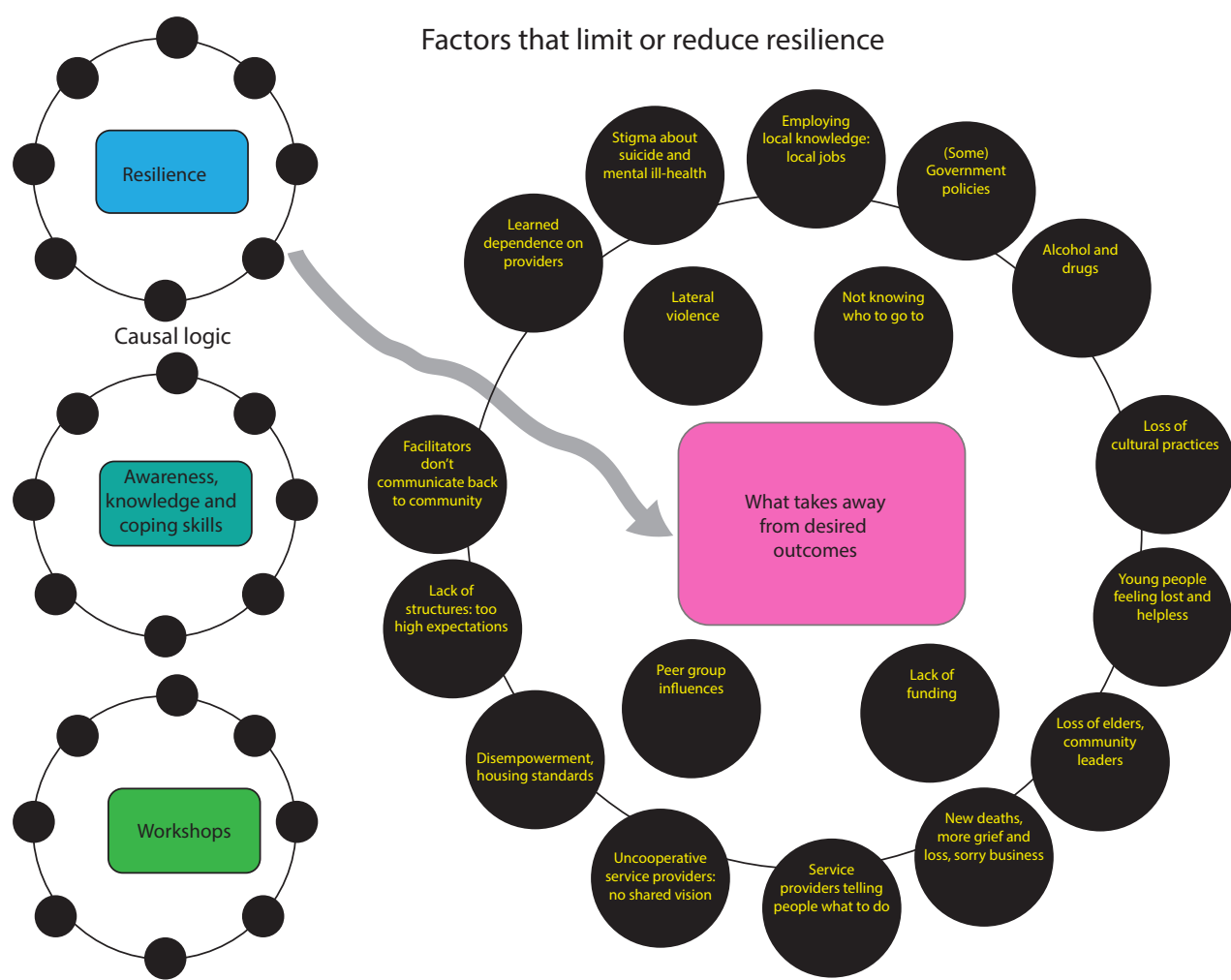


Figure 27. Contextual factors that support resilience

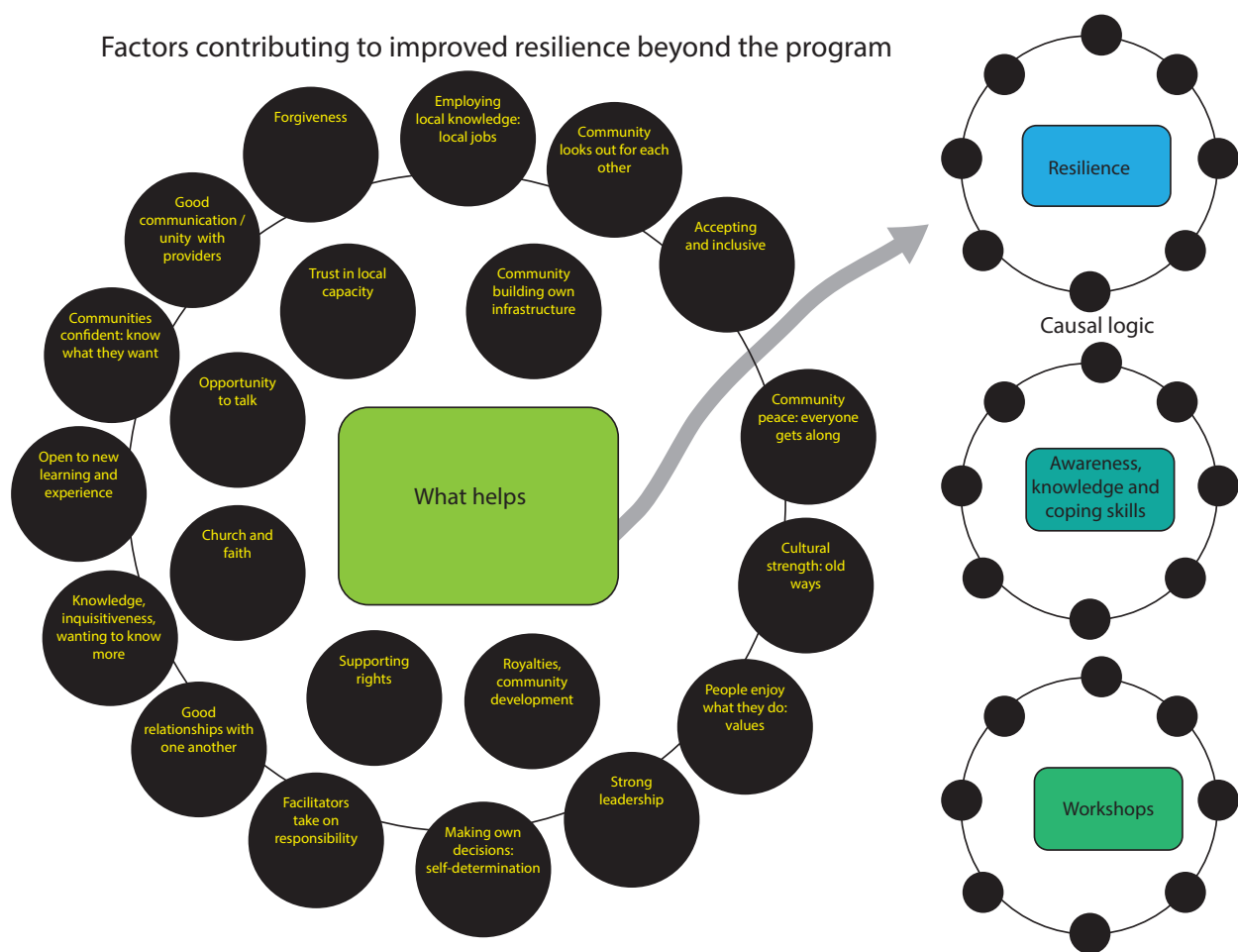


Figure 28. Potential unintended outcomes

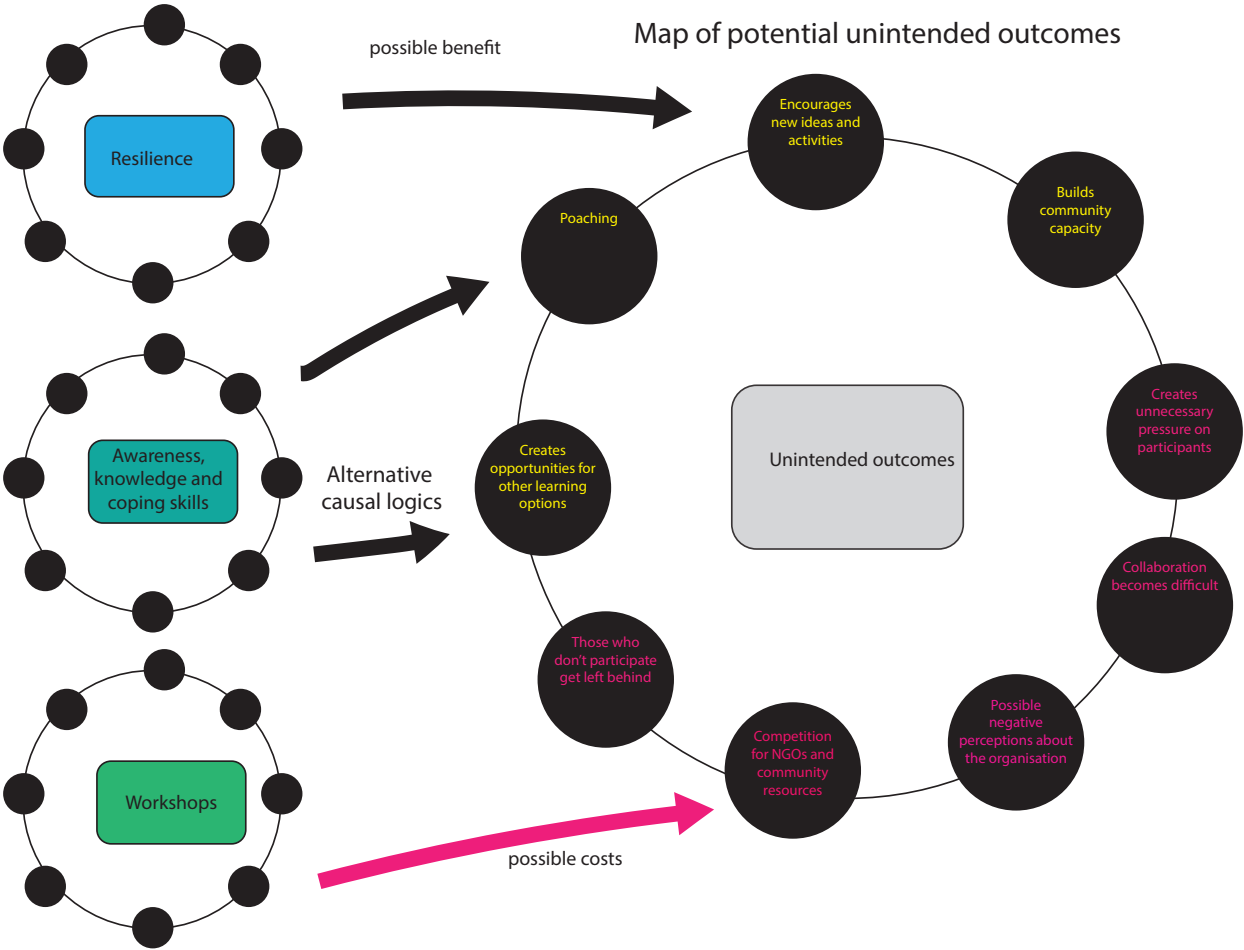
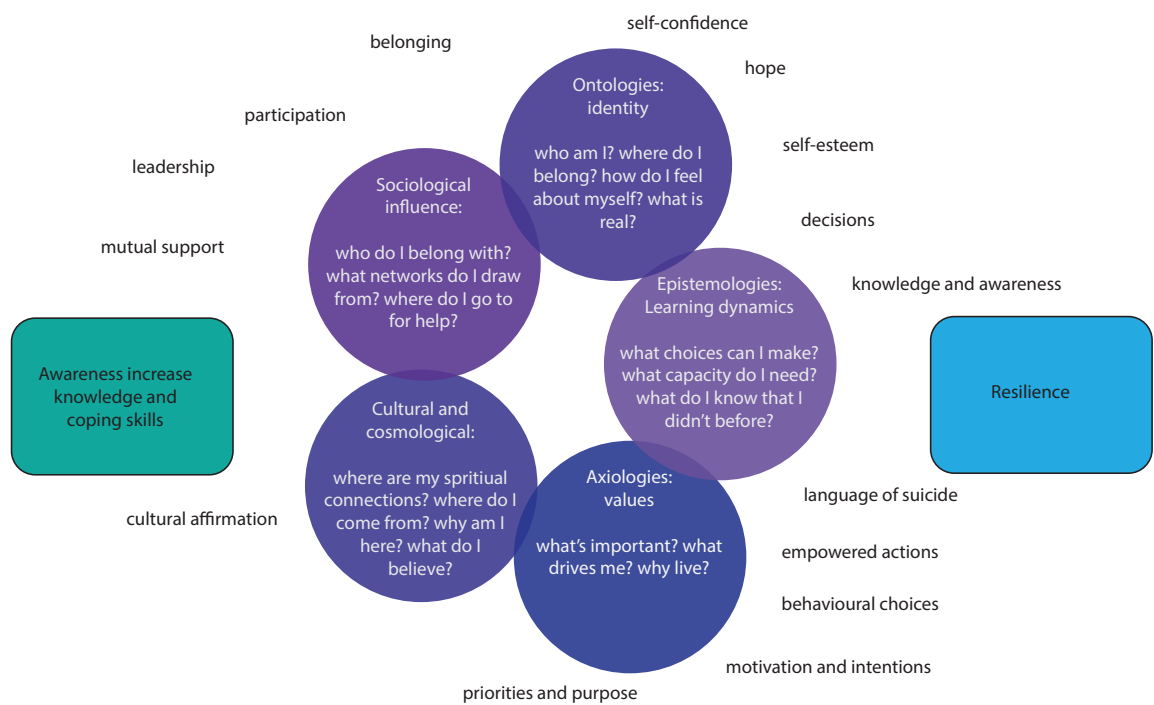



Figure 29. Map of theoretical underpinnings for change from awareness, knowledge and skills to improved resilience

Map of theoretical underpinnings for change from awareness, knowledge and skills to improved resilience



Appendix 3: Internal evaluation forms

Figure 30. Sharing our Stories evaluation tool used at start of workshop



Sharing Our Stories

SUICIDE STORY

An initiative of Mental Health association of Central Australia

SHARING OUR STORIES


Workshop Location:
Workshop Date:

Facilitators/Story-Tellers can clip this sheet on a clip board and roam around asking these questions.

1. Have you shared in suicide prevention programs before? YES NO
2. What does "suicide" mean to you?

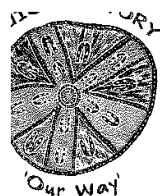
3. Do you know anyone who has died by suicide? YES NO
4. Do you know anyone who has attempted suicide? YES NO
5. Do you know what to do if someone is thinking of suicide? YES NO

6. Can you list any "worrying signs" of suicide?



ph (08) 8950 4600 fax (08) 8953 5577 ststory@mhaca.org.au www.mhaca.org.au
65 Hartley St, PO Box 2326 Alice Springs NT 0871

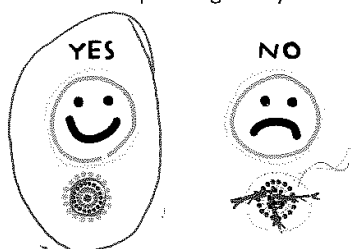
Figure 31. Reflections of our Sharing Together evaluation tool used at the end of each workshop



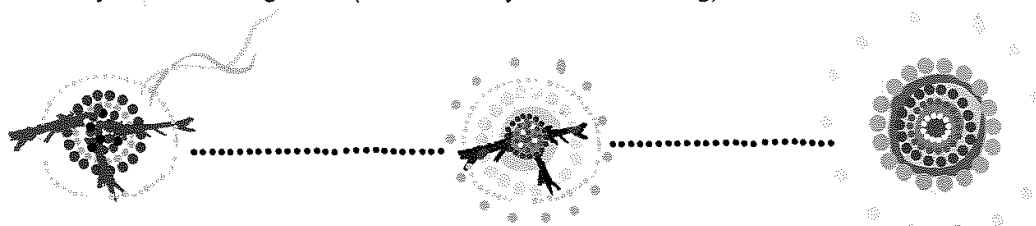
Reflections of our Sharing Together

Yuendumu
April 22-24, 2014

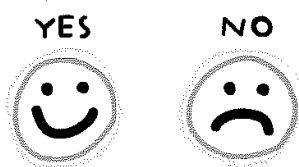
1. Did the workshop strengthen your fire?



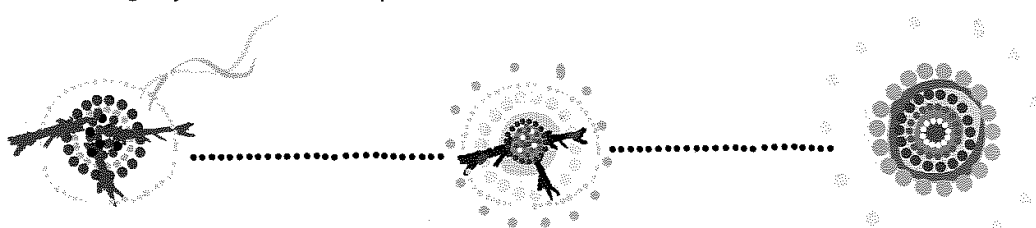
2. How is your fire burning now? (Show where your fire is burning).



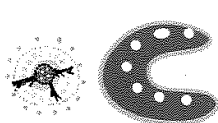
3. Can you spot if someone's fire is low?



4. How strong is your fire to find help for someone in darkness?



5. How strong is your fire to support someone in darkness? (Circle one drawing below).



LOW FIRE



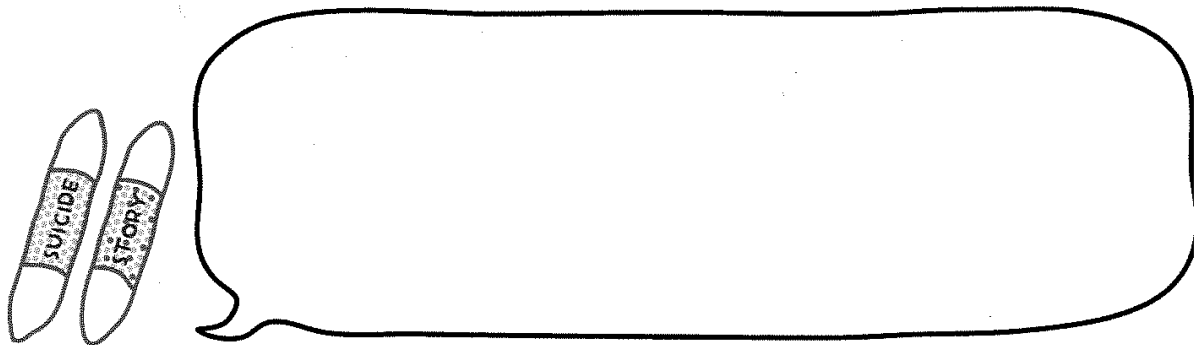
STRONG FIRE



SUPPORT WITH YOUR FIRE

6. Can you list or draw any "worry signs" of suicide?

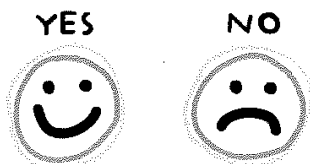
7. What was your strong message from Suicide Story?



8. What things were hard to understand in Suicide Story?



9. Would you ask your friends/family to attend Suicide Story?



YES

NO

Why?



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ph (08) 9550 4500 Email: info@mhaca.org.au

SS: Reflections Of Stories

Appendix 4: Critical questions for use with workshop reports

The current workshop report template includes a framework that includes:

- Basic delivery information (when, where, how many participate, how many completed)
- Comments about improvements in knowledge and changes in affective response including a before and after image of the fire chart
- Presentation of the community safety plan and wish list
- A selection of participant comments
- Identification of barriers
- Acknowledgements

A revised template could respond to the above and also respond to the following questions:

- What evidence did we see that resilience had increased?
- What indicators of change have we seen and how are they expressed? (e.g. hope, confidence, awareness, showing support)
- Were there incidents that compromised staff and facilitator cultural, emotional or physical safety?
- Were there any examples where staff or facilitators felt out of their depth or out of control?
- Were all the facilitators adequately supported?
- Were there instances where participants had a negative experience and how did staff and facilitators respond?
- What evidence was there of participants continuing to work together?
- Have the agencies and services identified in the community plan been engaged by the community?
- What additional supports or actions might be required to support the community?
- Who else needs to be engaged to support the community?
- What are the key lessons that emerged, and what action should Suicide Story or MHACA take to respond to these?
- What actions need to occur, when, and who is responsible for following these up?

