THIRRILI

Defining and addressing Aboriginal and Torres Strait Islander trauma, grief and postvention

Literature Review

2 February 2018

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ABBREVIATIONS

AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSISPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
FWB	Family Wellbeing Empowerment (Program)
GEM	Growth and Empowerment Measure
HMA	Healthcare Management Advisors
LBS	Living Beyond Suicide
NICRS	National Indigenous Critical Response Service
OECD	Organisation for Economic Co-operation and Development
PTSD	Post-traumatic stress disorder
SA	South Australia
SEWB	Social and emotional wellbeing
US	United States (of America)
UWA	University of Western Australia
WA	Western Australia

EXECUTIVE SUMMARY

The ways in which Aboriginal and Torres Strait Islander individuals, families and communities grieve is different from non-Indigenous grieving in important ways. Complex kinship systems and tight-knit families mean that grieving is often done at the community level. However, due to the ongoing trauma from a history of dislocation from family, country, culture and community, Aboriginal and Torres Strait Islander families experience grief more frequently and intensely than non-Indigenous Australians.

This review examined Australian and international literature to identify how trauma and grief are defined by Aboriginal and Torres Strait Islander people and how postvention, trauma-informed practice and community capacity building can promote healing, resilience and social and emotional wellbeing.

A major finding of this literature review was the paucity of evidence to support the effectiveness of postvention programs in preventing suicide. The gap in evidence is even more pronounced for programs targeting Aboriginal and Torres Strait Islander people. Further gaps exist in research around healing and social and emotional wellbeing techniques in the context of trauma recovery. More evaluations of suicide prevention programs must be undertaken to strengthen the evidence base and inform effective strategies.

Other key findings of the review are presented below, under three themes.

DEFINING AND RESPONDING TO TRAUMA

Summary of Key Findings	
Key Finding 1:	Aboriginal and Torres Strait Islander people are at an increased risk of experiencing prolonged, multiple exposures to traumatic events (complex trauma).
Key Finding 2:	Aboriginal and Torres Strait Islander people are at an increased risk of experiencing prolonged, multiple exposures to traumatic events (complex trauma).
Key Finding 3:	Aboriginal and Torres Strait Islander people are at an increased risk of experiencing prolonged, multiple exposures to traumatic events (complex trauma).
Key Finding 4:	Aboriginal and Torres Strait Islander people are at an increased risk of experiencing prolonged, multiple exposures to traumatic events (complex trauma).
Key Finding 5:	Trauma-informed practice is achieved by organisations framing every aspect of their service delivery through a ‘trauma lens’.

Key Finding 6:	Trauma-informed practice must promote safety, self-control, healthy relationships and recovery and be delivered in culturally competent ways.

DEFINING AND RESPONDING TO GRIEF

Summary of Key Findings	
Key Finding 7:	Aboriginal and Torres Strait Islander grief is different from non-Indigenous grief in complex and far-reaching ways which are often under-recognised and poorly understood by mainstream health workers and policy-makers.
Key Finding 8:	How an Aboriginal or Torres Strait Islander person, family or community grieves depends on their cultural beliefs, customs, kinship systems and attitudes to death and loss.
Key Finding 9:	Certain customs associated with Aboriginal and Torres Strait Islander grief can impact the bereaved family's financial and housing stability, intensify feelings of blame and guilt and increase the risk of suicidal behaviour.
Key Finding 10:	Postvention is widely accepted as a vital component of suicide prevention.
Key Finding 11:	Studies examining the effectiveness of postvention programs in reducing suicides in people bereaved by suicide are limited, of poor-quality and mostly descriptive in nature.
Key Finding 12:	It is important that any postvention program includes provision for an independent evaluation of the program's effectiveness to build the evidence base.
Key Finding 13:	Current postvention guidelines are presented by Postvention Australia and include best practice approaches to service delivery, workforce support and awareness raising.

BUILDING RESILIENCE, SOCIAL & EMOTIONAL WELLBEING & COMMUNITY CAPACITY

Summary of Key Findings	
Key Finding 14:	Community participation and cultural continuity are key factors in promoting individual and social resilience.
Key Finding 15:	Community capacity building must be informed by a community's needs, engage community members at all points of design and delivery and focus on a community's strengths to empower themselves.

Summary of Key Findings	
Key Finding 16:	We Al-li and the Family Wellbeing Empowerment Program are effective in supporti capacity building in Aboriginal and Torres Strait Islander communities.
Key Finding 17:	There is a lack of high quality evidence to support the use of healing techniques and programs to promote trauma recovery.
Key Finding 18:	Descriptive studies suggest effective healing programs promote and value Aboriginal and Torres Strait Islander knowledge and practices, are strengths-based and focus on storytelling to help contextualise traumatic experiences.
Key Finding 19:	Community participation and cultural continuity are key factors in promoting individual and social resilience.

INTRODUCTION

PURPOSE AND STRUCTURE

Thirrili Ltd (Thirrili hereafter) is responsible for the roll-out and delivery of the National Indigenous Critical Response Service (NICRS). The NICRS:

- provides a critical response to support individuals, families and communities affected by suicide-related or other trauma that is culturally responsive to their needs, and
- strengthens community capacity and resilience in communities where there have been high levels of suicide to better recognise and respond to critical incidents and strengthen service system coordination.

Thirrili engaged Healthcare Management Advisors (HMA) to undertake a literature review exploring concepts of trauma and grief in the context of postvention, healing and trauma-informed practice. It is intended the findings of this review will:

- support the continuing development of Thirrili's service model for the NICRS
- inform the development of resources to build the capacity of service providers in delivering culturally responsive postvention services, and
- serve as a source of information for Thirrili staff to refer to when preparing presentations or articles.

The NICRS service model builds upon the work of the University of Western Australia (UWA), who first piloted the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Critical Response Project. The ATSISPEP Critical Response Project was funded by the Department of Prime Minister and Cabinet and operated across Western Australia (WA) from June 2014 to March 2017. The Project worked closely with Aboriginal and Torres Strait Islander communities and stakeholders to deliver a state-wide critical response service for Aboriginal and Torres Strait Islander families across WA and trial a community development model across selected WA sites.

The Report of the Critical Response Pilot Project identified several learnings, including:

- the importance of providing a service that complements rather than duplicates existing services
- the value of having an independent advocate to navigate complicated systems to relieve strain on bereaved families
- the need for a coordination role in critical responses to bring together often fragmented and siloed services and programs, facilitate better communication and coordination across levels of government and ensure families can receive long-term care if required
- the need to train and employ community members in suicide prevention and critical response activities and work with Aboriginal and Torres Strait Islander community-controlled organisations
- the need for improved cultural safety among mainstream service providers, and
- the need to integrate critical response services and suicide risk-reduction in the broader suicide prevention activities in Aboriginal and Torres Strait Islander communities.

This literature review aims to build upon UWA's practice wisdom and the range of effective suicide prevention activities identified in the ATSISPEP Final Report, *Solutions that work: what the evidence and our people tell us*. [1]

The major findings of the literature review are provided for eight research areas, organised under three key themes:

Defining and responding to trauma

1. Defining trauma in the context of postvention support and other traumas.
2. Identifying children's understanding of and memories of suicide / or other traumatic events, and principles of good practice in working with children having regard to the stages of brain development in children (e.g. 0-3, 3-7, 7-11, and 11+).
3. Identifying good practice principles associated with trauma informed practice.

Defining and responding to grief

1. Nature of grief and grieving in Aboriginal and Torres Strait Islander communities.
2. Defining postvention / bereavement support and principles of good practice.

Building resilience, social and emotional wellbeing and community capacity

1. Building individual, family and community resilience amongst those affected by suicide.
2. Identifying principles of good practice related to community capacity building in Indigenous communities.
3. Building individual, family and community social and emotional wellbeing /healing in the context of Indigenous suicide.

These research areas were identified by Thirrili as being important to developing its model of care with regard to the principles of good practice in the literature.

METHODOLOGY

Due to the complexity and breadth of research areas addressed in this literature review, a rapid evidence assessment method was adopted. This borrows from Pawson's model of realist synthesis, in that the main purpose of the review is to contribute to the building of explanatory theory through a process of information synthesis. [2] This approach is particularly applicable to a research field which is descriptive rather than intervention-based. In the absence of experimental research on whether interventions achieve their desired outcomes, realist synthesis aims to investigate why and how an intervention may work.

The paper inclusion criteria were as follows:

- Australian and international literature published between 2008-2018
- both grey literature and peer reviewed studies, and
- papers with a specific focus on Indigenous communities of the Pacific Rim (including Australia, America, Canada and New Zealand) as a priority over papers concerning non-Indigenous populations.

Search terms varied with each research question, but at a minimum included:

- suicide OR self-harm OR depression OR anxiety OR trauma OR stigma OR alcohol OR “alcohol abuse” OR drug OR “drug abuse” OR “self-harm” OR wellbeing OR social OR “transgenerational trauma” AND
- Indigenous OR Aboriginal and Torres Strait Islander OR Aboriginal OR Maori OR “Native American” OR “American Indian” OR “Inuit” OR adults OR youth OR adolescents OR colonization OR colonisation OR racism AND
- Australia OR “New Zealand” OR Canada OR “North America” AND
- prevention OR postvention OR promotion OR program OR service OR policy OR intervention OR education OR strategy OR resource OR support OR “through care” AND
- evaluation OR “evaluation framework” OR efficacy OR effectiveness OR engagement OR outcome OR monitoring OR implementation OR acceptability AND
- healing OR “social and emotional wellbeing” OR SEWB.

MedLine (PubMed), PsychINFO, Cochrane library and Google Scholar were used as primary paper search engines. Pertinent journals including the Aboriginal and Islander Health Worker Journal and the Australian and New Zealand Journal of Psychiatry, were searched to identify papers. Several papers were identified through a process of reviewing the reference lists of seminal literature and national policy documents.

Quality of evidence

High quality research into interventions that provide healing or trauma-informed services to Aboriginal and Torres Strait Islander people in the context of suicide postvention is very limited. Several authors have identified gaps in the evidence base supporting the role of postvention services within suicide prevention initiatives. [3, 4] These gaps are even more pronounced in initiatives providing postvention or healing services to Aboriginal and Torres Strait Islander people. The evidence base is so limited, it has been suggested that any postvention initiative include a robust methodology and provision for evaluation of the program to concurrently build the evidence base. [4]

In the absence of intervention studies, this literature review has synthesised descriptive articles and the findings of other literature reviews to identify key issues around trauma, grief and methods of recovery, best practice principles and promising initiatives.

TERMINOLOGY

For the purposes of this paper, the term ‘Aboriginal and Torres Strait Islander’ is used to identify the Indigenous peoples of Australia, which comprise many nations and cultures. ‘Aboriginal’ is occasionally used in this paper to describe programs that specifically cater to Aboriginal people, as opposed to Torres Strait Islander people. ‘Indigenous’ is a collective term and is used in this paper to describe native peoples from other countries, where a more specific name (e.g. Native American) is not given. Use of the term ‘Aboriginal and Torres Strait Islander’ to describe the communities, families and individuals targeted by the programs discussed in this paper is not intended to generalise findings to all Aboriginal and Torres Strait Islander people, as each community has distinct needs and ways of healing.

FINDINGS

DEFINING AND RESPONDING TO TRAUMA

This section synthesises the findings of recent research on the concept of trauma as it applies to Aboriginal and Torres Strait Islander people and communities and best-practice principles of trauma-informed services. Aboriginal and Torres Strait Islander children are at particular risk of experiencing trauma and current statistics point to alarming disparities in the suicide rate of Aboriginal and Torres Strait Islander children under 17 years compared to non-Indigenous children. Therefore, it is important the NICRS model of care includes an evidence-based approach to working with children who have experienced trauma.

Defining trauma in the context of postvention support and other traumas

The Trauma Centre of Australia defines trauma as

> *'a psychological wound that has occurred due to a person's perception of a stressful event.' [5]*

The stressful event involves an actual or perceived threat to the person's physical or emotional wellbeing and may include episodes of significant ill-health, family breakdown, the death of a family member, unemployment, homelessness, financial stress, violence and racism, among others. [6] Responses to the stressful event may include intense fear, helplessness, horror or disordered behaviour (particularly in children). [7] The literature generally differentiates between Type 1 and Type 2 trauma. Type 1 trauma relates to acute trauma after a single stressful event, whereas Type 2 trauma is complex and results from multiple, chronic and prolonged stressful events that often begin early in life. [8] Aboriginal and Torres Strait Islander people are at a higher risk of experiencing complex trauma than non-Indigenous Australians. [9]

According to the 2013 *Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS) of approximately 13,000 Aboriginal and Torres Strait Islander people, 30% of Aboriginal and Torres Strait Islander adults experienced *high to very high* levels of psychological distress – 2.7 times the rate of non-Indigenous Australians [6]. High levels of psychological distress are significantly linked to exposure to multiple stressors or traumatic events, typical of complex trauma [10].

According to AATSIHS findings, exposure to traumatic stressors was common among Aboriginal and Torres Strait Islander people between 2012-13 with 73% of participants having experienced (or a family member experienced) at least one stressor in the preceding 12 months. Common stressors reported by Aboriginal and Torres Strait Islander people included the death of a family member or friend (37%), a serious illness (23%), unemployment (23%) and mental illness (16%). Non-Indigenous Australians experienced these same stressors, but Aboriginal and Torres Strait Islander people were 1.4 times more likely to experience at least one stressor. Similarly, a study by Nadew [11] of 271 Aboriginal participants from Western Australia found that almost all (97.3%) participants had been exposed to traumatic events. The same group of participants also had a lifetime prevalence of 55.2% for post-traumatic stress disorder (PTSD), 20% for depression and 73.8% of participants met diagnostic criteria for alcohol abuse or dependence.

A study by Ralph *et al* linked exposure to trauma and suicidal ideation in 747 West Kimberley Aboriginal adolescents (n=327), young adults (n=40) and adults (26+ years, n=77) and non-Aboriginal adolescents (n= 283). [12] The study found that in comparison to non-Aboriginal adolescents, Aboriginal adolescents reported significantly increased exposure to *direct* (trauma occurring to self) and *secondary* (witnessing trauma occurring to others) trauma. Aboriginal adolescents were four times more likely than non-Aboriginal adolescents to have a family member commit suicide (29% Aboriginal compared to 8% non-Aboriginal). Multiple regression analysis revealed suicidal ideation and previous suicide attempts were significantly predicted by exposure to direct trauma and PTSD.

Research by Atkinson described in Atkinson *et al* [13] contends trauma can be passed through generations (intergenerational trauma), whereby abuse incurred during childhood increases the likelihood of perpetuating abuse and *destructive behaviours* as an adult. Traumatic events have been a feature of history for Aboriginal and Torres Strait Islander people through the experience of the Stolen Generations, removal and dislocation from country, language and culture, and the continuing presence of racism institutionally and in the broader population. A study by Priest *et al* found self-reported exposure to racism was a significant predictor of suicide risk (odds ratio = 2.32, P=0.01) for Aboriginal and Torres Strait Islander people. [14] These studies suggest that Aboriginal and Torres Strait Islander people are disproportionately exposed to traumatic events and the consequences of historical trauma, which has repercussions for the mental health and suicide risk of future generations.

Understanding the pervasiveness of historical and current exposure to traumatic events among Aboriginal and Torres Strait Islander communities is vital for developing trauma-informed practices and programs. Good practice principles for trauma informed care are discussed at the end of this section.

Key Finding 1:	Aboriginal and Torres Strait Islander people are at an increased risk of experiencing prolonged, multiple exposures to traumatic events (complex trauma). Exposure to trauma is significantly associated with suicide risk.

Identifying children's understanding suicide/ traumatic events and principles of good practice

From 2011 to 2015, the suicide rate of Aboriginal and Torres Strait Islander children aged between 5 and 17 years was more than five times that of non-Indigenous children. [15] The experience of childhood trauma, whether by neglect, abuse or the death of a family member by suicide are associated with early onset of suicide attempts in young people. It is important to understand the experience of childhood trauma and its ongoing developmental, behavioural and emotional effects in order to work effectively with bereaved children. This section presents findings on recent research into children's experience and understanding of trauma, the ongoing effects of trauma and best practice principles to guide interactions with traumatised children.

A child's memory and ability to verbally exhume and resolve a traumatic experience is highly dependent on the age of exposure. A child's verbal development at the time of experiencing trauma is critical to the child's ability to later recall their experience. [16] An article by Fivush examines memory formation and recall of children exposed to traumatic events. [16] Fivush cites a seminal study by Terr which examined the memory and verbal recall of children aged between 1 and 5 years who had experienced a traumatic event. [16] While all child participants showed evidence of remembering the event (e.g. through the development of related fears), only children aged from 3 years at the time of the trauma could give full verbal accounts of the event. Children exposed to trauma between 18 and

36 months could give patchy accounts and children exposed to trauma under the age of 18 months could not verbally recall the event. In young children (under 18 months), the event is not verbally accessible but may still have lasting cognitive and behavioural impacts. A limitation of Fivush's research was its focus on public trauma (e.g. events that happened in public such as a car accident, which do not involve secrecy or shame). Fivush hypothesises that children who are unable to discuss their traumatic experience whether due to shame or due to underdeveloped verbal abilities at the time of the event, may experience recurring and unresolved fragments of memory associated with highly negative effects. Other authors support this hypothesis, with Bath identifying self-reflection and the opportunity to develop stories to contextualise a traumatic event is critical to trauma recovery. [8]

There is an extensive body of research examining the impact of exposure to traumatic events upon a child's brain and behavioural development. Perry, cited in Bath, stated that traumatisation causes children to 'reset their normal level of arousal', producing a constant sense of alarm even when stressors are not present. [8] A heightened state of arousal is associated with chronically elevated levels of the stress hormone cortisol, which has been shown to impact neurodevelopment in children with long lasting effects.

A review by Carrion and Wong of studies presented at the National Summit for Stress and the Brain at Johns Hopkins University found children aged 8 to 14 years who had experienced trauma and exhibited post-traumatic stress symptoms had chronically elevated levels of cortisol in the brain, which is known to have deleterious effects on the development and function of the hippocampus and prefrontal cortex. [17] In the brain, the hippocampus is responsible for new learning and memory formation, while the prefrontal cortex controls attention and stimuli-response association (the ability to associate behaviour with rewards and perform goal-oriented actions). [17] Both sections of the brain are fundamental to forming memories and learning.

Children who are exposed to trauma can have an impaired capacity to learn and concentrate, develop trusting, healthy relationships, regulate behaviour and employ self-soothing strategies. [18] Without these skills, children may develop self-destructive behaviours in adulthood such as aggression, violence, substance misuse, suicidal ideation and inactive lifestyles. [19] According to the Healing Foundation, the cyclical nature of experiencing trauma and projecting trauma onto others is the mechanism by which intergenerational trauma continues. [20]

In response to the common impacts of trauma such as distrust of others, capacity to form trusting relationships, chronic stress and difficulty regulating emotions and behaviour, Bath identifies 'three pillars of trauma-informed care' to inform interventions for traumatised children, including:

1. **The development of safety:** it is widely accepted that creating a safe environment to facilitate open communication about trauma is vital to healing. [8] Atkinson *et al* identify establishing a safe and trusting environment is the single most difficult challenge for service providers working with remote Aboriginal and Torres Strait Islander communities. [19] Service providers not known to the community, that are unfamiliar with the complex relationships that exist in the community and / or employ non-Indigenous staff face the greatest challenge in establishing safe spaces. [19]
2. **The promotion of healing relationships:** people who work with children who have experienced trauma have a responsibility to build positive relationships with children to demonstrate reciprocal trust and respect. Positive relationships are necessary to promote healing and facilitate feelings of safety and resilience. [8] Many traumatised children will associate adults with negative emotions which can lead to antisocial behaviours. Dwyer *et al* suggest workers adopt relationship-based practices when working with young children (aged 0-8 years) and families. [21] These include physical cues such as maintaining eye contact, using frequent touch such as holding or rocking the child and sitting on the floor with the child. Work with families should take place in a comfortable environment (e.g. the home), be conducted in the families' preferred language and encourage family participation. Because many traditional cultural practices

are rhythmic and repetitive, the Healing Foundation note Aboriginal and Torres Strait Islander people recognised the need for calm and contained environments long before there was supportive evidence. [20]

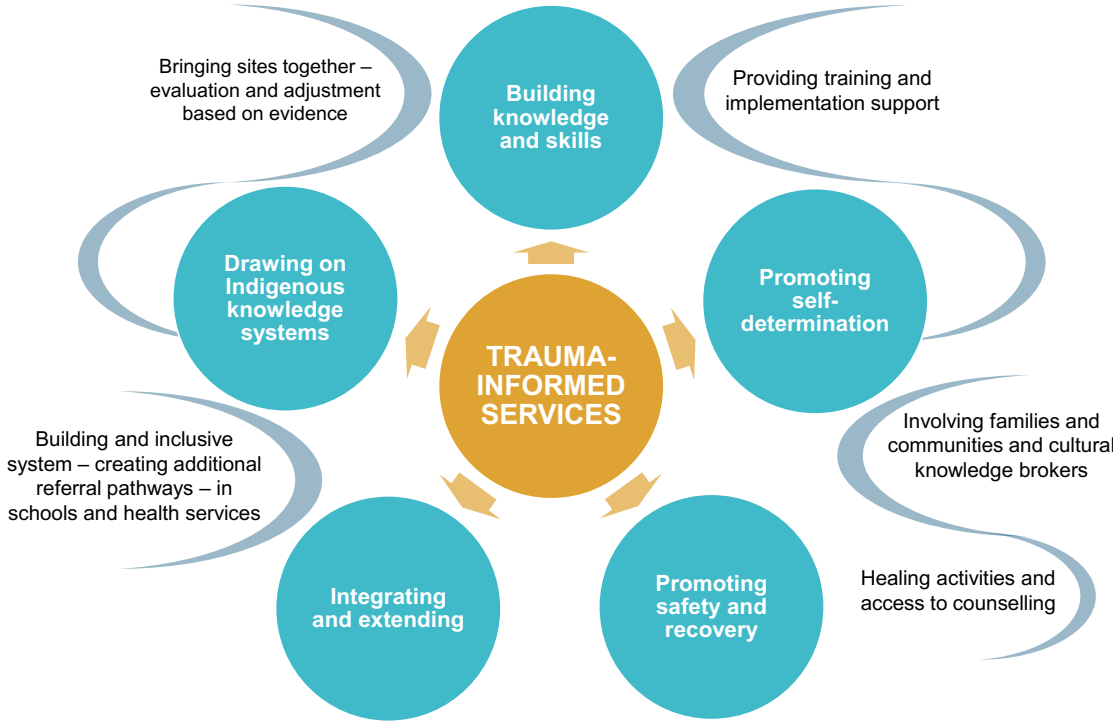
3. **The teaching of self-management and coping skills:** the diminished capability to regulate one's own emotions and impulses is a long-term consequence of trauma often continuing into adulthood. Bath notes talking, story-telling and active listening promote self-reflection and rational processing of feelings and is a critical element of trauma recovery. [8]

The Healing Foundation recommends the use of trauma-informed practice to promote healing from trauma in children. [20] Illustrated in

Figure **1**, the Healing Foundation provides trauma-informed programs for Aboriginal and Torres Strait Islander children that adopt the following best practice strategies:

- drawing on Aboriginal and Torres Strait Islander knowledge systems on child-rearing and healing to empower families to take responsibility for growing strong and resilient children
- promoting safety and recovery for Aboriginal and Torres Strait Islander children and youth through instilling cultural pride, identity and opportunities to participate in cultural life
- building knowledge and skills among Aboriginal and Torres Strait Islander service systems through training, resources and support, and
- prioritising critical reflection and evaluation of programs to facilitate sharing of knowledge and application to other communities and young people.

FIGURE 1: USING TRAUMA-INFORMED APPROACHES IN PRACTICE



Source: Adapted from The Healing Foundation [20]

Key Finding 2:	In children, verbal capacity and stage of brain development at the time of experiencing trauma influences how children remember and recall traumatic events.
Key Finding 3:	Experiencing complex trauma in childhood can have lasting impacts on brain development, which impacts learning, cognitive performance and regulation of emotions which can persist into adulthood.
Key Finding 4:	When working with children exposed to trauma, it is important to create a safe space, model and encourage healthy relationships and educate on self-management and coping strategies to regulate emotions.

Good practice principles in delivering trauma informed care

As described above, acute or ongoing (complex) trauma can have severe and long-lasting effects. Aboriginal and Torres Strait Islander people are at an increased risk of experiencing trauma due to a range of factors described previously. It is vital organisations that work with trauma-affected groups look at all aspects of care or service delivery through a 'trauma lens' to provide trauma-informed practice. As Haythornthwaite and Hirovnen point out, if trauma is overlooked, unresolved trauma can reduce the effectiveness of healing or support services and place participants and workers at risk of further harm. [9] Fallot and Harris note the experience of trauma changes the way individuals access services or seek help. [22] Often, people who have experienced trauma develop adaptive behaviours to protect them from further harm, such as withdrawing from others, aggression or dissociation. Such antisocial behaviours can negatively impact help seeking and foster distrust in support services. Atkinson differentiates between two types of trauma-informed practice: trauma-informed services that directly address trauma and its effects through their services; and trauma-specific care, which provides a therapeutic approach to treating trauma. [7] This section will focus on trauma-informed services, as therapeutic or clinical responses to trauma are beyond the scope of this review.

Despite a recent increase in the body of evidence regarding trauma, several authors have identified a lack of quality research on the impact of trauma-informed practice on health and wellbeing, particularly in Aboriginal and Torres Strait Islander communities. [23, 24] Atkinson cited programs funded by the Healing Foundation as key providers of trauma-informed healing services including traditional healing, education on managing trauma, grief and loss and workforce capacity building. [23] However, evidence supporting the effectiveness of these trauma-informed programs in addressing trauma is anecdotal. [23]

US trauma experts Fallot and Harris identify five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment. These guiding principles have formed the basis of several sets of guidelines and tools, including:

- Atkinson, *Trauma-informed services and trauma-specific care for Indigenous Australian children* [23]
- Kezelman and Stavropoulos, *'The Last Frontier' – Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*, [24] and
- Guarino *et al, Trauma-informed organisational toolkit.* [25]

The central tenet of trauma-informed practice is an organisation's commitment to understanding and responding to trauma and its impacts in all aspects of service delivery. Bloom and Farragher state 'creating a trauma-informed culture in and of itself could help staff and clients make better recoveries than has previously been possible'. [26] The *Trauma-specific organisational toolkit* provides a useful self-assessment tool for organisations to evaluate their

service delivery against these best practice principles and identify practical changes to improve services and outcomes for the vulnerable people they support.

In the context of organisations working with Aboriginal and Torres Strait Islander communities, Atkinson identifies eight core principles for trauma-informed practice:

1. **Understand trauma and its impact on individuals, families and communal groups** – this is achieved by organisations developing and adopting trauma-informed policies and providing ongoing trauma-related training and support to staff.
2. **Promote safety** – individuals and families who have experienced trauma require safe spaces to promote healing. Creating a safe emotional environment involves making people feel welcome, providing information about the service in their preferred language and being responsive and respectful of their needs.
3. **Ensure cultural competence** – including competence of the service offering and workforce to effectively and respectfully interact with different cultural groups. A lack of cultural competency in service providers can lead to re-traumatisation and disassociation with services.
4. **Support client's control** – trauma survivors are supported to strengthen their sense of control and autonomy. Service systems are established to ensure individuals are fully informed about all aspects of the treatment or service they are receiving and to provide opportunities for individuals to actively participate in the healing process.
5. **Share power and governance** – decision making is shared across all levels of the organisation. Consumers are involved in the design and evaluation of programs and practices.
6. **Integrate care** – coordinating the services and supports required to help individuals, families and communities to heal.
7. **Support relationship building** – trauma-informed services facilitate safe, authentic and positive relationships to assist healing and recovery (e.g. through peer support).
8. **Enable recovery** – through a strengths-based approach, the service empowers individuals, families and communities to take control of their own healing and recovery. [25, 22, 7]

Key Finding 5:	Trauma-informed practice is achieved by organisations framing every aspect of their service delivery through a 'trauma-lens'.
Key Finding 6:	Trauma-informed practice must promote safety, self-control, healthy relationships

DEFINING AND RESPONDING TO GRIEF

This section brings together recent literature on definitions of grief in the context of Aboriginal and Torres Strait Islander ways of grieving and in the event of suicide. Best-practice principles in responding to grief through postvention support are also addressed.

Nature of grief and grieving in Indigenous communities

Recent articles emerging in the United States (US) point out general differences in grief after a death by suicide as compared to other deaths. The *US National Postvention Guidelines* developed by the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention identify four distinct dimensions of bereavement after suicide:

- ambiguity about the motivation of the deceased

- perceived preventability of the death
- stigmatisation of suicide, and
- the traumatising nature of self-inflicted death. [27]

These factors differentiate grief after suicide from grief experienced after deaths by other causes (e.g. cancer) and may lead to intense feelings of abandonment, rejection, guilt and failure in the bereaved. These feelings, in addition to the trauma of suicide exposure may result in a more intense and longer grieving process. [27]

The magnitude and complexity of grief experienced by Aboriginal and Torres Strait Islander people and communities is often under-recognised and poorly understood by mainstream health workers and policy makers. [28] Australia as a whole has been referred to as a 'death-denying society', within which conversations of death and grief are difficult. Hanssens notes many complex factors which influence the way death is discussed by Aboriginal and Torres Strait Islander people, which include:

- cultural beliefs of the family, clan or community, depending on whether they are traditional Aboriginal and Torres Strait Islander people, urban Aboriginal and Torres Strait Islander people or Christian Aboriginal and Torres Strait Islander people
- extended family, moiety and kinship systems which dictate responsibilities and cultural obligations
- the taboo nature of discussing death (e.g. widely held cultural beliefs restricting the use of a deceased person's name), and
- the sense of hopelessness these discussions can provoke if not handled sensitively. [29]

While the concept and act of grief will vary for different Aboriginal and Torres Strait Islander people, Westerman's article *'Grieving Aboriginal way'* describes how Aboriginal people tend to navigate grief and common cultural practices. [30] Common feelings associated with grief include numbness, shock, sadness, depression, anger, blame or wanting to blame others, guilt, regret and longing to return to country to grieve. Returning to country is important aspect of Aboriginal grief. For many cultures, returning home to pay respects and participate in 'sorry time' is an obligation and considered the proper way to grieve. After someone has died, many Aboriginal people try to find a reason for the death. In some circumstances, a community may believe that a person is to blame for the death and they may receive 'payback'. This can heighten feelings of guilt and regret after the event of a suicide. Aboriginal people may have visions or hear the spirit of a person who has died. According to Westerman, grief may intensify in the period after 'sorry time' when family members leave; a key time to provide postvention support. Milroy, cited in Hanssens, coins 'malignant grief' to describe a phenomenon where stress, grief and loss are persistent and irreconcilable and result in bodily reactions such as physical pain and headaches and is exacerbated by substance misuse. [28] Milroy notes Aboriginal and Torres Strait Islander people can die of this grief by suicide or other means.

Hanssens adds that due to the collective, community approach to grief, inability to participate in 'sorry time' or attend the funeral due to financial, health or other reasons can contribute to a perception that an individual had something to do with the death. This can result in casting blame, and may be a suicide risk factor. [29] However, the community approach to grief is also a protective factor against psychological distress, as community connectedness is associated with better outcomes. [31] Other issues that complicate grief experienced by some Aboriginal and Torres Strait Islander people include customary exclusion of family members from the house or place where a person has died. This can place additional stress on the bereaved family who must find alternative accommodation or on other family members who must accommodate the bereaved family. According to Hanssens,

> *'the cultural safety of [Aboriginal and Torres Strait Islander] people after a completed suicide or other sudden death depends entirely on the effective coordination of support with [Aboriginal and Torres*

Strait Islander] families involving bereavement support services, church and community groups, housing authorities and financial institutions'. [29]

Key Finding 7:	Aboriginal and Torres Strait Islander grief is different from non-Indigenous grief in complex and far-reaching ways which are often under-recognised and poorly understood by mainstream health workers and policy-makers.
Key Finding 8:	How an Aboriginal or Torres Strait Islander person, family or community grieves depends on their cultural beliefs, customs, kinship systems and attitudes to death and los.
Key Finding 9:	Certain customs associated with Aboriginal and Torres Strait Islander grief can impact the bereaved family's financial and housing stability, intensify feelings of blame and guilt and increase the risk of suicidal behaviour.

Defining postvention/bereavement support and principles of good practice

The World Health Organisation defines postvention as

> *'Intervention efforts for individuals bereaved or affected by suicide [that] are implemented in order to support the grieving process and reduce the possibility of imitative suicidal behaviour. These interventions may comprise school-based, family-focused or community-based postventions.' [32]*

Postvention or bereavement support can include individual, family-based, school-based or community-based interventions that aim to reduce stressors for the bereaved. Postvention support may include practical approaches, as in assisting with funeral arrangements or aspects of daily living after a death. Anglicare South Australia (SA) delivers Living Beyond Suicide (LBS), a postvention support service that coordinates volunteer-led home visits to bereaved families and partners with crisis services (e.g. police and ambulance services) to deliver support in the hours and days after a suicide. [33] Support may include:

- providing information on funeral options
- liaising with coroners, courts and police departments
- advocating on behalf of the family for superannuation, insurance or Centrelink matters
- facilitating debriefing sessions for workplaces
- assisting families with household concerns
- providing information on available counselling services, and / or
- sitting with the family as they tell their story. [33]

A study by Goodwin-Smith *et al* found that while rates of suicide were disproportionately high for Aboriginal and Torres Strait Islander people in South Australia, the services offered by LBS were underutilised by Aboriginal and Torres Strait Islander people. [33] A review is currently under way to identify ways to engage Aboriginal and Torres Strait Islander people in the service. [33]

Postvention has long been considered a *'direct form of prevention of future suicides'* in US literature. [34] American clinical psychologist Edwin S. Shneidman's seminal work in suicide postvention stated

> *'the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered'.* [35]

The Australian Senate Inquiry into suicide estimated exposure to the suicide of a significant other resulted in a fivefold increase in individual's risk of suicide. [36] Conservative estimates from Shneidman's work in the 1970s found for every suicide death, six people are severely affected by grief. [35] Recent US research estimates up to 135 people are exposed after a single suicide event. [37] However, it is important to acknowledge these estimates are based on mainstream populations. The number of Aboriginal and Torres Strait Islander people severely affected by or exposed to a suicide event is likely higher, due to the complex kinship systems of Aboriginal and Torres Strait Islander families; the tight-knit nature of communities; and close proximity of families, particularly in remote areas. [29]

Despite robust evidence linking exposure to suicide with an increase in suicide risk, research and investment in effective postvention strategies has been limited. A review of current suicide prevention policies operating in Australian jurisdictions found that while almost all jurisdictions include suicide prevention strategies that recognise the role of postvention within prevention initiatives – except for the policies of Victoria and New South Wales – there is a lack of specific postvention strategies that produce tangible outcomes for Aboriginal and Torres Strait Islander people bereaved by suicide.

There also exists a lack of high-quality, independent studies supporting the effectiveness of postvention initiatives. [4, 38, 3] A systematic review from 2011 identified 16 studies examining the effectiveness of postvention or bereavement support services in reducing further incidences of suicide. [4] Authors Szumilas and Kutcher were unable to identify any studies that found postvention initiatives to be effective. There was weak evidence to support the effectiveness of gatekeeper training in increasing knowledge of crisis intervention in school personnel. A 2017 review found that while there has been a recent increase in interest in the field of suicide bereavement and postvention, studies in this area are often descriptive or theoretical in nature and do not measure effectiveness of existing strategies. [3] The limited evaluation of effective postvention strategies is even more pronounced for at-risk groups including Aboriginal and Torres Strait Islander people. [3] In the absence of current evidence, Szumilas and Kutcher recommend the design of postvention programs should include a robust methodology for the independent evaluation of the program's effectiveness. [4]

The ATSISPEP report, *Solutions that work: what the evidence and our people tell us* identifies a range of community-led suicide prevention initiatives that have been evaluated for effectiveness. [1] The Report identifies the following clinical elements as evaluated success factors for Aboriginal and Torres Strait Islander suicide postvention for indicated or at-risk individuals:

- access to counsellors / mental health support
- 24/7 availability
- awareness of critical risk periods and responsiveness at those times, and
- crisis response teams after a suicide / postvention.

Postvention Australia recently released a set of guidelines for organisations and individuals providing services to people bereaved by suicide. These guidelines are based on international literature and other guidelines developed by the Irish National Office for Suicide Prevention and Turas Le Cheile, and the US Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention. [27, 39] The Postvention Australia guidelines include:

- **postvention service provision**
  - organisational framework that is guided by the ethical principle 'do no harm' and establishes procedures and recording systems and facilitate clear pathways of support.

  - responding to the individual needs of the suicide bereaved
  - provision of culturally sensitive and appropriate services including respect and understanding of the needs of Aboriginal and Torres Strait Islander people
  - provision of appropriate and accurate information and resources
  - engagement with technology and (digital) media to ensure responsible reporting
  - collaboration with other postvention services to promote a coordinated approach and sharing of knowledge and skills.
- **building capacity within the organisation (work force)**
  - personnel and their support to avoid compassion fatigue and vicarious trauma
  - development and implementation of postvention practices within the organisation
  - research and evaluation of the effectiveness of services, using ethical research methods
  - evaluation that is built into service delivery, if possible.
- **awareness and promotion of suicide postvention services more widely**
  - enhancing the resilience of individuals, families and communities to respond to suicide through education, training and group support
  - raise awareness of the impact of suicide and promote suicide postvention service to the community, other services, government and policy makers including advocacy for the needs of people impacted by suicide.

Currently, there are no published guidelines for developing a postvention service for Aboriginal and Torres Strait Islander families and communities. However, a qualitative review of the Living Beyond Suicide program described previously provided many key insights. [33] Goodwin-Smith *et al* conducted focus groups with Aboriginal and Torres Strait Islander people who had been bereaved by suicide, service providers and health workers from four regions of metropolitan Adelaide. Focus groups were held to understand why the LBS service had been underutilised by Aboriginal and Torres Strait Islander people and identify strategies to improve the services' accessibility and cultural appropriateness. Focus group feedback articulated the need for LBS to better address the following issues:

- **Marketing:** promotional material must be widely distributed, in a language that is accessible to everyone and have a 'human dimension', where local workers are pictured and named to help make the service approachable.
- **A 'walking together' model:** a partnership approach to utilise local Aboriginal knowledge of culture and people to ensure the service is accessible to the right people from a stakeholder point of view, rather than a provider point of view. It is vital the service understands local laws and rules regarding grief, which are described previously in this section.
- **Culturally sensitive workforce:** including both male and female, and Aboriginal and non-Aboriginal workers to ensure appropriate staffing when issues of men's and women's business arise or if a family does not want to 'talk inside their community' for confidentiality reasons or fear of payback.
- **Capacity building:** There may not be appropriately trained Aboriginal workers in the service area, so capacity to deliver services should be built within communities to provide cultural up-skilling and improve effectiveness of existing services.
- **Addressing specific needs:** including the needs of people in prison experiencing bereavement and alleviating financial and housing insecurity for bereaved families who may host many people during the grieving period.
- **Outreach-based support** to reduce the need for bereaved families to travel from home to unfamiliar places to access services or liaise with the courts, police or the coroner.

While many of the issues raised by focus group attendees cannot be generalised to all Aboriginal and Torres Strait Islander people, they mark key gaps in mainstream service provision and the importance of talking a 'walking together' approach to service design and delivery.

Key Finding 10:	Postvention is widely accepted as a vital component of suicide prevention.
Key Finding 11:	Studies examining the effectiveness of postvention programs in reducing suicides in people bereaved by suicide are limited, of poor-quality and mostly descriptive in nature.
Key Finding 12:	It is important that any postvention program includes provision for an independent evaluation of the program's effectiveness to build the evidence base.
Key Finding 13:	Current postvention guidelines are presented by Postvention Australia and include best practice approaches to service delivery. Workforce support and awareness raising.

BUILDING RESILLIENCE, SOCIAL AND EMOTIONAL WELLBEING AND COMMUNITY CAPACITY

According to learnings of the UWA Critical Response Project and the ATSISPEP Final Report, *Solutions that work: what the evidence and our people tell us*, suicide postvention support services should address risk factors that are fundamental to a community's health and wellbeing in order to reduce suicide rates. [1] Community connectedness has been identified as a protective factor against suicide, and building individual, family and community resilience, social and emotional wellbeing (SEWB) and community capacity is key to suicide prevention. This section discusses approaches to building resilience, SEWB and community capacity.

Building individual, family and community resilience among those affected by suicide

Several authors contend the concept of resilience is based on Western notions of an individual's ability to 'cope' under stress. [40, 41] Fleming and Ledogar define resilience as 'positive adaptation despite adversity'. [42] However, Gale and Bolzan use the term 'social resilience', which moves away from Western concepts of 'self' toward a more collective sense of resilience in Aboriginal and Torres Strait Islander communities. Ungar, cited in McLennan, introduced the dual concepts of resilience as 'both an individual's capacity to navigate to health resources and a condition of the individual's family, community, and culture to provide these resources in culturally meaningful ways'. [40] Ungar argues that the external social environment plays a larger role in facilitating resilience than an individual's internal attributes. [43]

In focus groups described by McLennan, members of the Yaegl community in northwest New South Wales repeatedly spoke of the interdependent nature of individual wellbeing and family and community wellbeing. [40] Community connectedness was identified as a key aspect of resilience, as it engenders both a united sense of grief, but also collective support and healing after a traumatic event. [40] In this way, any intervention to promote resilience must consider family and community resilience in order to promote resilience in individuals.

Chandler and Lalonde linked 'cultural continuity' as a proponent of resilience and suicide reduction among young First Nations people of British Columbia. [31] The authors defined 'cultural continuity' as self-control over aspects of

culture and community, which encompass six markers: self-government; land rights litigation; local control over health, education and police services; and operation of cultural facilities. Chandler and Lalonde mapped suicides in all 197 communities or 'bands' in British Columbia and found that communities that achieved all six markers had no cases of suicide among young First Nations people. Conversely, where communities achieved none of these 'protective' markers, youth suicide rates were many times the national average. An article by Hunter [44] contends that 'cultural continuity' as a protective marker cannot be applied to Aboriginal and Torres Strait Islander communities because the opportunity for self-determination is significantly lacking. Hunter states control of Aboriginal and Torres Strait Islander communities sits not within the community itself, but external governing bodies. For instance, true community control over Aboriginal and Torres Strait Islander health services cannot be fully achieved when such services are largely reliant on government funding to function. Further, self-government is hampered when nationally representative bodies such as the *Aboriginal and Torres Strait Islander Commission* (ATSIC) are discontinued and when the management of communities is delegated to the military as in the Northern Territory Intervention [44]. The findings of Chandler and Lalonde and Hunter's articles suggest community-held control over the affairs of Indigenous peoples is key to empowerment, resilience and a reduction in suicide, at least in young people.

This finding is supported by Gale and Bolzan, who describe a social resilience project that invited Aboriginal young men between the ages of 13 and 19 to identify what social resilience means to them and how they could achieve it in their own community. [41] In interviews, participants noted self-determination and the agency to carry out initiatives was seen as key to achieving resilience. The project supported the group to develop their own initiative, 'Paws Up', a dog-training program which provided the group with a shared goal, a social activity and became a point of pride and respect among the community. While an unconventional approach to social resilience, this project shows the importance of community participation in the formation and direction of initiatives to promote resilience.

The literature review did not identify any resilience interventions in Aboriginal and Torres Strait Islander communities that were subject to evaluations. The literature regarding resilience tends to be descriptive in nature.

Key Finding 14:	Community participation and cultural continuity are key factors in promoting individual and social resilience.

Principles of good practice related to community capacity building in Indigenous communities

The Organisation for Economic Co-operation and Development (OECD) define community capacity building as

> *'… process of enabling those living in poverty to develop skills and competencies, knowledge, structures, and strengths, so as to become more strongly involved in community, as well as wider societal life, and to take greater control of their own lives and that of their communities.' [45]*

Capacity building initiatives for Aboriginal and Torres Strait Islander communities often promote empowerment as a means to increase community participation and control. Whiteside *et al* argue that any effort to close gaps in the broad issues of employment, health, education and social participation must start with individual empowerment and capacity enhancement. [46] Two programs that promote empowerment and healing to facilitate community capacity building are described later in this section.

Lohoar *et al*, writing for the Australian Institute of Family Studies identified six principles of community capacity building. [45] The principles include:

1. **Focus on community needs** through consulting directly with program participants or community members to understand their needs and preferences.

2. **'Bottom up' or 'grassroots' practice** which engages families and communities in decision making and planning of initiatives.
3. **Strengths-based approach** that focuses on a community's collective strengths and how they may be used to overcome community challenges. This is echoed by resilience initiatives that, by using a strengths-based approach, subvert the contextualisation of Aboriginal and Torres Strait Islander communities as 'problematic' or dysfunctional. [41, 40]
4. **Inclusive practice** to encourage partnerships with community members and organisations to secure resources and foster a sense of ownership over decisions made within the program.
5. **Investment in community capacity**, including 'upstream' investment in service network capacity and 'downstream' investment in information transfer, education and training for staff and opportunities to engage families with services and programs.
6. **Aim for sustainability** in both the capacity for services to continue and the capacity of communities to develop the skills and confidence to address their own concerns in the longer term.

The principles described by Lohoar *et al*, aimed to inform community capacity building approaches to child welfare practice and policy. However, they are generally applicable to Aboriginal and Torres Strait Islander communities if delivered in culturally competent ways. Cultural competence refers to services that are sensitive and appropriate to the culture of their clients, are informed by community consultation and embrace strategies that are culturally tailored. [47] Several studies support the importance of cultural competency, whether achieved through the employment of Aboriginal and Torres Strait Islander staff or providing mentorship to Aboriginal and Torres Strait Islander participants in health and wellbeing programs. [48, 49]

The We Al-li program presents an example of community-led capacity building. We Al-li provides trauma-informed education and training to communities and organisations with the aim of empowering workers and community members to facilitate individual and collective healing and wellbeing. [19] The program has a dual purpose of helping workers recognise and heal their own trauma, while equipping them to support others in their community. We Al-li workshops blend transformational learning (i.e. learning about the self, attitudes and beliefs to change behaviour) and practical skill-building to address trauma, violence and community dysfunction. Workshop participants receive formal recognition of attendance which enhances their ability to gain employment within their community or entry to further study. [19] The program has been subject to post-delivery evaluations which suggest reductions in trauma symptoms experienced by the program participants. However, these findings are anecdotal and further research is required to determine whether this promising practice reflects a best-practice model for community capacity building. [7]

The Family Wellbeing Empowerment (FWB) Program, originally developed by the South Australian Government Aboriginal Education Development Branch and now rolled out nationally, provides group workshops that aim to enhance Aboriginal and Torres Strait Islander people's capacity to exert control over factors shaping their health and wellbeing. [50] The FWB model of empowerment identifies four elements of empowerment that are fostered through the FWB, including:

1. **Beliefs and attitudes** around choice, responsibility, positive attitudes, self-esteem and pride, spirituality and values.
2. **Skills and knowledge** developed by sharing stories about life experiences, managing emotions, understanding other people's behaviour, communication skills and helping others.
3. **Agency** including taking responsibility for individual and community healing, planning, improving relationships, helping others and community action.

4. **Outcomes** including healing, growth, better relationships, confidence, engagement in employment and family and community change. [50]

The elements of empowerment described above exist within a complex social environment that presents constraints and opportunities for change. This echoes literature discussed previously, that identifies the complexity of working with Aboriginal and Torres Strait Islander communities that are constrained by the effects of intergenerational trauma and collective grief, but present opportunities for community-level healing. [40]

Tsey *et al* conducted a qualitative study of the FWB Program among adults and children found the Program helped individuals develop attitudes and skills that lead to healthier lifestyle choices, a heightened sense of spiritual identity, greater respect for self and others and ultimately healing. [51] These effects produced wider community change and resulted in enhanced capacity to work together towards shared goals. The Growth and Empowerment Measure (GEM) was developed to assess the impact the FWB Program has on psychological and social empowerment and remains the most sensitive tool for this measurement. [52] Analysis of FWB outcomes using the GEM produced the same findings as Tsey's study. [51]

Key Finding 15:	Community capacity building must be informed by a community's need, engage community members at all points of design and delivery and focus on a community's strengths to empower themselves.
Key Finding 16:	We Al-li and the Family Wellbeing Empowerment Program are effective in supporting capacity building in Aboriginal and Torres Strait Islander communities.

Building individual, family and community social and emotional wellbeing/healing in the context of Indigenous suicide

Social and emotional wellbeing (SEWB) does not solely refer to an individual's mental health, but encompasses the broader influence of an individual's interaction with their environment. The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2017-2023 defines SEWB as a holistic concept, which

> *'results from a network of relationships between individuals, family, kin and community. It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual'. [53]*

High quality, publicly available evaluation data regarding programs and interventions that build individual, family and community SEWB is limited. [54] Day and Francisco undertook a systematic review of psycho-social interventions to improve SEWB in Aboriginal and Torres Strait Islander people. [55] The authors identified several descriptive articles about SEWB but only sixteen intervention studies. Of these, only three have been evaluated more recently than 2008, but were not considered to have been evaluated with scientific rigour. A review by Haswell *et al* supported this finding, identifying very few intervention studies and noting that most of the literature on SEWB is 'problem-focused' rather than solution-based.

From the limited literature available, the National Framework identifies effective approaches as characterised by:

- holistic approaches
- cross sectoral and inter-governmental action

- valuing Aboriginal and Torres Strait Islander knowledges, cultural beliefs and practices
- collaborative working relationships.
- supported active involvement of Aboriginal and Torres Strait Islander communities at every stage of program development and delivery
- clear Aboriginal and Torres Strait Islander leadership and governance for programs
- Aboriginal and Torres Strait Islander staff employed at all levels
- cultural safety policies and procedures
- developing and retaining skilled and committed staff
- sustainable resources
- being strengths based, and
- research and evaluation. [53]

As discussed previously, cultural continuity is a highly protective factor for reducing suicide risk. [31] Cultural continuity and Aboriginal and Torres Strait Islander ways of healing are also central to promoting social and emotional wellbeing. We Al-li, described previously promotes Aboriginal and Torres Strait Islander people to promote healing in culturally meaningful ways. We Al-li blends Aboriginal and Torres Strait Islander and non-Indigenous knowledge systems to pair professional counselling skills with Aboriginal and Torres Strait Islander concepts of healing and wellbeing. Workshops focus on the practice of Dadirri, or deep listening and quiet contemplation, often undertaken on country. Dadirri is an Aboriginal concept that is most similar to Western theories of mindfulness, which promote connection and integration of body, mind and surroundings. [56] A post-delivery evaluation of the program also identified the importance of using storytelling, art, music, dance and theatre to help frame the trauma stories of participants within an individual's life, family, community and across history and country. The We Al-li approach consists of six stages, which occur in circular ways as participants go deeper into their awareness and understanding of their experiences:

1. Creating a culturally safe environment.
2. Finding and telling their stories.
3. Making sense of the stories.
4. Feeling the feelings.
5. Moving through layers of loss and grief, ownership, choices.
6. Reclaiming a return to wholeness.

These stages closely mirror Bath's three pillars of trauma informed care: safety, connections and self-management and coping. [8]

There are many healing programs in operation. In a review of effective programs concerning social and emotional wellbeing, the Healing Foundation identified the following:

- Central Northern Adelaide Health Service Family and Community Healing – focusing on empowerment and reduction of family violence.
- Deadly Vibe – a magazine targeting school-aged Aboriginal and Torres Strait Islander children and adolescents to promote healthy lifestyles and education attainment.
- Yaba Bimbi Indigenous Men's Support Group and Ma'ddaimba Balas Men's Group which provide weekly health education sessions, counselling, support and advocacy and social activities.
- We Al-li, described previously. [57]

The Healing Foundation summarised evaluations of the above programs. However, these tended to be descriptive in nature or not publicly available. The Healing Foundation identified programs that most effectively promoted healing had the following properties:

- developed to address issues in their local community
- driven by local leadership
- based upon well-developed evidence and theory base
- combining both western methodologies and traditional healing in their treatment theory base
- informed about and understand the impact of colonisation and intergenerational trauma and grief
- building upon individual, family and community capacity through the acquisition of knowledge and skills
- incorporating strong evaluation frameworks, and
- with a proactive rather than reactive focus. [57]

Key Finding 17:	There is a lack of high-quality evidence to support the use of healing techniques and programs to promote trauma recovery.
Key Finding 18:	Descriptive studies suggest effective healing programs promote and value Aboriginal and Torres Strait Islander knowledge and practices, are strengths-based and focus on storytelling to help contextualise traumatic experiences.

CONCLUSION

This paper has identified recent literature on concepts of trauma and grief, how these concepts differ for Aboriginal and Torres Strait Islander people and best practice principles for postvention, trauma-informed care, community capacity building and resilience based programs to address grief and trauma.

Most literature presented in this review was descriptive in nature, and explained concepts around grief and trauma. However, the review identified very few intervention studies in the past ten years, examining 'what works' in postvention, trauma-informed care or community capacity building for Aboriginal and Torres Strait Islander families. In line with many other papers, this literature review has identified a need for more evaluations of existing programs and intervention-based studies. A strong evidence base will inform the model of care for the NICRS and similar programs, and will lead to better outcomes for Aboriginal and Torres Strait Islander individuals, families and communities healing from trauma and grief.

REFERENCES

[1] P. M. J. Dudgeon, T. Calma, Y. Luxford, I. Ring, R. Walker, A. Cox, G. Georgatos and C. Holland, "Solutions that work: what the evidence and our people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report," University of Western Australia, Crawley, WA, 2016.

[2] R. Pawson, "Evidence-based policy: the promise of 'realist synthesis'," *Evaluation,* vol. 8, no. 3, 2002.

[3] M. Maple, T. Pearce, R. Sanford, J. Cerel, D. Castelli Dransart and K. Andriessen, "A Systematic Mapping of Suicide Bereavement and Postvention Research and a Proposed Strategic Research Agenda," *Crisis,* vol. 19, pp. 1-8, 2017.

[4] M. Szumilas and S. Kutcher, "Post-suicide Intervention Programs: A Systematic Review," *Canadian Journal of Public Health,* vol. 102, no. 1, pp. 18-29, 2011.

[5] Trauma Centre of Australia, "What is trauma?," c2017. [Online]. Available: http://www.traumacentre.com.au/what-is-trauma/.

[6] Australian Bureau of Statistics, "The Australian Aboriginal and Torres Strait Islander Health Survey: First Results ABS Cat No.4727.0.55.001," ABS, Canberra, 2013.

[7] Australian Institute of Health and Welfare, "Trauma-informed services and trauma-specific care for Indgenous Australian children," AIHW, Canberra, 2013.

[8] H. Bath, "The Three Pillars of trauma-informed care," *Reclaiming Children and Youth,* vol. 17, no. 3, pp. 17-21, 2008.

[9] S. Haythornthwaite and T. Hirovnen, "The relevance of trauma informed care to Aboriginal primary health care services," in *13th National Rural Health Conference*, Darwin, 2015.

[10] Australian Bureau of Statistics, "The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples Oct 2010 ABS Cat No. 4704.0," ABS, Canberra, 2010.

[11] G. Nadew, "Exposure to traumatic events, prevalence of posttraumatic stress disorder and alcohol abuse in Aboriginal communities," *Rural and Remote Health,* vol. 12, p. 1667, 2012.

[12] N. Ralph, K. Hamaguchi and M. Cox, "Transgenerational trauma, suicide and healing from sexual abuse in the Kimberley Region, Australia," *Pimatisiwin,* vol. 4, no. 2, pp. 117-136, 2006.

[13] J. Atkinson, J. Nelson, R. Brooks, C. Atkinson and K. Ryan, "Addressing individual and community transgenerational trauma," in *Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice 2nd edn*, P. Dudgeon, H. Milroy and R. Walker, Eds., Canberra, Department of the Prime Minister and Cabinet, 2014, pp. 289-306.

[14] N. Priest, Y. Paradies, W. Gunthorpe, S. Cairney and S. Sayers, "Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth," *Medical Journal of Australia,* vol. 194, pp. 546-550, 2011.

[15] Australian Bureau of Statistics, "3303.0 Causes of Death, Australia," ABS, Canberra, 2015.

[16] R. Fivush, "Children's recollection of traumatic and nontraumatic events," *Development and Psychopathology,* vol. 10, p. 699–716, 1998.

[17] V. Carrion and S. Wong, "Can Traumatic Stress Alter the Brain? Understanding the Implications of Early Trauma on Brain Development and Learning," *Journal of Adolescent Health,* vol. 51, pp. S23-S28, 2012.

[18] Victorian Government Department of Human Services, "Child development and trauma: Specialist practice resource,," State of Victoria, Melbourne, 2010.

[19] J. Atkinson, J. Nelson and C. Atkinson, "Trauma, transgenerational transfer and effects on community wellbeing," in *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing practices and principles*, N. Purdie, P. Dudgeon and R. Walker, Eds., Canberra, Department of Health and Ageing, 2010, pp. 135-144.

[20] Healing Foundation, "Growing our children up strong and deadly: healing for children and young people," Healing Foundation, Canberra, 2013.

[21] J. Dwyer, J. O'Keefe, P. Scott and L. Wilson, "Literature review - a trauma-sensitive approach for children aged 0-8 years," Women's Health Goulburn North East, Goulburn, 2012.

[22] R. Fallot and M. Harris, "Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol," *Community Connections,* vol. 2.2, 2009.

[23] Australian Institute of Health and Welfare, "Trauma-informed services and trauma-specific care for Indigenous Australian children," AIHW, Canberra, 2013.

[24] C. Kezelman and P. Stavropolous, "'The Last Frontier' – Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery," Adults Surviving Child Abuse, Kirribilli, 2012.

[25] K. Guarino, P. Soares, K. Konnath, R. Clervil and E. Bassuk, "Trauma-informed organisational toolkit," Centre for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD, 2009.

[26] S. Bloom and B. Farragher, "Destroying Sanctuary: The Crisis in Human Service Delivery Systems," Oxford University Press, New York, 2011.

[27] Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention , "Responding to Grief, Trauma and Distress: the U.S. National Postvention Guidelines," National Action Alliance for Suicide Prevention, Washington DC, 2015.

[28] L. Hanssens, ""Suicide (echo) clusters" - Are they socially determined, the result of a pre-existing vulnerability in Indigenous communities in the Northern Territory and how can we contain cluster suicides?," *Aboriginal and Islander Health Worker Journal,* vol. 35, no. 1, pp. 14-19, 2011.

[29] L. Hanssens, "Clusters of Suicide ... The need for a comprehensive postvention response to sorrow in Indigenous communities in the Northern Territory," *Aboriginal and Islander Health Worker Journal,* vol. 32, no. 2, pp. 25-33, 2008.

[30] T. Westerman, "Grieving Aboriginal Way," Indigenous Psychological Services, Perth, 2001.

[31] M. Chandler and C. Lalonde, "Cultural continuity as a protective factor against suicide in First Nations youth," *Horizons,* vol. 10, no. 1, pp. 68-72, 2008.

[32] World Health Organisation, "Preventing suicide: A global imperative," World Health Organisation, Geneva, 2014.

[33] I. Goodwin-Smith, N. Hicks, M. Hawke, G. Alver and P. Raferty, "Living beyond Aboriginal suicide: Developing a culturally appropriate and accessible suicide postvention service for Aboriginal communities in South Australia," *Advances in Mental Health,* vol. 11, no. 3, pp. 238-245, 2013.

[34] J. Jordan, "Postvention is prevention - The case for suicide postvention," *Death Studies,* vol. 41, no. 10, pp. 614-621, 2017.

[35] E. Schneidman, "Foreword," in *Survivors of Suicide*, Springfield, IL, Carles C. Thomas, 1972, pp. ix-xi.

[36] Senate Community Affairs Reference Committee, "The hidden toll: Suicide in Australia," Senate Printing Unit, Parliament House, Canberra, 2010.

[37] J. Cerel, "Connecting to the Continuum of Survivorship. Paper presented at the National Suicide Prevention," Unpublished, Canberra, 2016.

[38] Australian Government Department of Health and Ageing, "National Aboriginal and Torres Strait Islander Suicide Prevention Strategy," Commonwealth of Australia, Canberra, 2013.

[39] Console, National Office for Suicide Prevention and Turas Le Cheile, "National Quality Standards for the Provision of Suicide Bereavement Services: A Practical Resource," 2012 [reviewed in 2014]. [Online]. Available: http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/Resources/standardsbereavement.pdf. [Accessed 02 January 2018].

[40] V. McLennan, "Family and community resilience in an Australian Indigenous community," *Australian Indigenous HealthBulletin,* vol. 15, no. 3, 2015.

[41] F. Gale and N. Bolzan, "Social resilience: challenging neo-colonial thinking and practices around 'risk'," *Journal of Youth Studies,* vol. 16, no. 2, pp. 257-271, 2013.

[42] J. Fleming and R. Ledogar, "Resilience and Indigenous Spirituality: A Literature Review," *Pimatisiwin,* vol. 6, no. 2, p. 47–64, 2008.

[43] M. Ungar, "Resilience, Trauma, Context, and Culture," *Trauma, Violence and Abuse,* vol. 14, no. 3, pp. 255-266, 2013.

[44] E. Hunter, "Indicators of psychoses or psychoses as indicators: the relationship between Indigenous social disadvantage and serious mental illness," *Australasian Psychiatry,* vol. 21, no. 1, pp. 22-26, 2013.

[45] Lohoar, S; Price-Robertson, R; Nair, L;, "Applying community capacity-building approaches to child welfare practice and policy, CFCA Paper No. 13," Australian Institute of Family Studies, Melbourne, 2013.

[46] M. Whiteside, K. Tsey, Y. Cadet-James and J. McCalman, Promoting Aboriginal Health: The Family Wellbeing Empowerment Approach, London: Springer, 2014.

[47] S. Flaxman, K. Muir and I. Oprea, "Indigenous families and children: Coordination and provision of services (FaHCSIA Occasional Paper no. 23)," FaHCSIA, Canberra, 2009.

[48] A. Munns, "Yanan Ngurra-ngu Walalja Halls Creek Community Families Program," *Neonatal Paediatric and Child Health Nursing,* vol. 13, no. 1, 2010.

[49] J. Scougall, "Evaluation of the Stronger Families and Communities Strategy: Potential leaders in local communities initiative," FaHCSIA, Canberra, 2008.

[50] L. Monson-Wilbraham, "Watering the garden of family wellbeing: empowering Aboriginal and Torres Strait Islander people to bloom and grow," Lowitja Institute, Carlton South, 2014.

[51] K. Tsey, M. Whiteside, M. Haswell-Elkins, R. Bainbridge, Y. Cadet-James and A. Wilson, "Empowerment and Indigenous Australian health: a synthesis of findings from Family Wellbeing formative research," *Health and Social Care in the Community,* vol. 18, no. 2, pp. 169-179, 2010.

[52] M. Haswell, D. Kavanagh, K. Tsey, L. Reilly, Y. Cadet-James, A. Laliberte, A. Wilson and C. Doran, "Psychometric validation of the Growth and Empowerment Measure (GEM) applied with Indigenous Australians," *Australian and New Zealand Journal of Psychiatry,* vol. 44, pp. 791-799, 2010.

[53] Commonwealth of Australia, "National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2017-2023," Department of Prime Minister and Cabinet, Canberra, 2017.

[54] K. Osborne, F. Baum and L. Brown, "What works? A review of actions addressing the social and economic determinants of Indigenous health. Issues Paper no. 7," Australian Institute of Health and Welfare, Canberra, 2013.

[55] A. Day and A. Francisco, “Social and emotional wellbeing in Indigenous Australians: identifying promising interventions,” *Australian and New Zealand Journal of Public Health,* vol. 37, pp. 350-355, 2013.

[56] R. Carnes, “Applying a We Al-li Educaring framework to address histories of vioence with Aboriginal women,” Kungas Stopping Violence, Alice Springs, 2015.

[57] J. McKendrick, R. Brooks, J. Hudson, M. Thorpe and P. Bennett, “Aboriginal and Torres Strait Islander healing programs: A literature review,” The Healing Foundation, Canberra, 2013.