# Training for Life:

## Supporting Communities to Reduce the Risk of Suicide. The delivery of Certificate IV in Indigenous Mental Health (Suicide Prevention). Wontulp Bi-Buya College, 2014–2015

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# Table of Contents

## List of Tables



## List of Abbreviations

| | |
|---|---|
| AOD | Alcohol and other drugs |
| ASQA | Australian Skills Quality Authority |
| ATOD | Alcohol, tobacco and other drug |
| IMH | Indigenous Mental Health (Suicide Prevention) Certificate IV |
| TATS | Taking Action to Tackle Suicide |
| WBBC | Wontulp-Bi-Buya College |

# Executive Summary

This report is a review of the delivery of the Indigenous Mental Health (Suicide Prevention) Certificate IV, (hereby known as IMH) has been conducted by Dr Anne Stephens, education sociologist and evaluation expert, the Cairns Institute, James Cook University, Cairns.

As part of the *Community prevention for high risk groups* initiative of the Taking Action to Tackle Suicide (TATS) Package, Wontulp-Bi-Buya College (WBBC) has delivered the IMH in two intakes:

- May 2014 - Nov 2014
- Feb 2015 – Nov 2015

The course was developed by WBBC's College Course Advisory Committee with WBBC Trainer and Course Coordinator, Rev. Leslie Baird. Rev. Baird developed the Strategic Plan for Suicide Prevention in Yarrabah (1995/6). Rev. Baird adapted the Indigenous Mental Health for suicide prevention and cultural suitability, to comply with the Australian Skills Quality Authority (ASQA), in consultation with Indigenous leaders.

As a pilot the IMH course has been highly effective in promoting localised responses to suicide and mental health issues within Australian Aboriginal and Torres Strait Islander communities. The course is transferrable to other delivery settings outside of Cairns.

There have been 60 enrolees. 78% of the total enrolees completed the course. On average, students are over 45 years of age. 85% of enrolees were female in the 2014 intake and 77% in the 2015 intake. Student's average age were 47.4 (female) and 41.8 (male). The average highest level of formal education is year 10. Two students had a degree qualification but most had medium to high literacy needs.

WBBC core mission is to produce empowered community leaders. With the increased awareness of mental health and suicide WBBC students are participants of a staged encounter in which students feel a new or renewed sense of belonging to a network, movement or cause. Graduates have developed personal empowerment and sense of control over their own life circumstance and environment. As each student participant will be active in teaching and mentoring others this is crucial to their own mental health and capability to promote help seeking behaviour and promotion of positive lifestyle choices in others. They emerge with a set of oral and practical skills to work effectively with service providers in existing health and community services or in finding a niche to fill. Six graduates of the 2014 course are now engaged in full-time work having completed the IMH course.

A variation on the original work plan was obtained in 2014 due to unforeseeable delays in course accreditation. The effect of this can be deemed mild as the College managed and adapted to the changes. An advantage of the change was that the College graduated a greater number of students covering a wider range of Australian Aboriginal and Torres Strait Islander communities. With the larger intakes from the wider cross-section of communities, come greater networking opportunities and a larger information web leading to possible funding, employment, public health initiatives and the development of essential frontline workforce capacity.

Implementation timeframes were also amended with an extension granted for funded mental health and suicide prevention programmes through the Federal Department of Health. This will enable the College to deliver the course a third time in 2016. This extension has no bearing on this report but the review of the course and recommendations will be considered by the College.

A participatory action research framework was used to collect qualitative data. Quantitative data was collected via file audits of the College's enrolment records. The study was undertaken with James Cook University ethical approval: H5025.

The evaluation of the delivery and outcomes of the programme reports against the performance statements outlined in the variation agreement. These are to:

1. Promote help seeking behaviour and positive lifestyle choices
2. Promote local responses to suicide and other related issues within communities
3. Facilitate greater networks between service providers and local communities
4. Contribute to the development of local community capacity to address these issues
5. Facilitate access by communities around Australia to appropriate service providers.

The recommendations from this report are as follows:

1. As a replicable pilot programme for the amelioration of suicide and suicide-related harms in Aboriginal and Torres Strait Islander communities, a long-term and sustainable funding allocation be made available to implement the IMH course across Australia.

2. Funding allocation to include the cost of travel and accommodation for students residing in remote areas. This cost component of course delivery is not covered by the Department of Health and may preclude student enrolment if they do not meet the Dept of Prime Minister and Cabinet's Indigenous Tertiary Programs Team eligibility criteria.

3. Funding for remote course delivery. This is also a cost-effective model of course delivery to remote and regional communities, particularly those with high suicide rate and risk factors, to initiate the IMH course as a method of prevention. A precedent exists whereby WBBC staff visit student clusters of 10 or more students, in their location for 2 of the 4 residential modules while the first and fourth (graduation) module are delivered in Cairns. This model ought to be considered in the future delivery of the IMH course.

4. Literacy support needs are medium to very high. Funding to engage additional literacy support personnel for the periods of the residential modules is required, with preference for Indigenous personnel with relevant qualifications.

# Chapter 1. Introduction

WBBC has been providing adult education to Indigenous students from across Australia since 1983. From a strong experience base with theological courses, the College diversified to include training for front-line community service workers. Courses have included the Community Organising and Development Certificate III, Alcohol and Other Addictions, Certificate III; Alcohol and Other Addictions Counselling, Certificate IV, and presently, Addictions Management and Community Development, Certificate IV. The addition of the IMH course complements the repertoires of skills and training opportunities offered at the College, and was immediately well received by its Australia-wide network of past and present students. The course is ASQA accredited and has is approved for ABSTUDY under the Indigenous Tertiary Programs Team: Indigenous Education (Targeted Assistance) Act 2000.

IMH was delivered in two intakes:

- May 2014 - Nov 2014
- Feb 2015 – Nov 2015

Since May to the time of this reports' preparation and delivery there were 60 enrolees. 78% of the total enrolees completed the course. Of these the majority are female and average age is over 45 years. This picture of the WBBC student conforms with their tradition of attracting mature-age Indigenous women and men, in positions of, or aspiring to community leadership, with a desire to improve their personal capacity to serve their community.

The author of the report finds that despite significant and unavoidable delays to the project's commencement, subsequent alterations to the original project outcomes have not been adversely affected. This is due to management actions by the College to alter the work-plan and delivery schedule; the change in student recruitment strategy from targeting particular and discreet communities to a general-entry enrolment policy, and, continued high-support and personal interaction with students to modify individual learning plans to meet each student's ability. It is important to note that the average level of formal education across the cohort is year 10, with one as low as year 5. This is, however, regarded as typical and regular for the College staff who are adept and experienced in training students with limited command of literacy and/or numeracy. The pedagogical approach to training and course delivery is cognisant of Indigenous learning styles and adapted for cultural appropriateness and acceptability (Stephens, 2014; Stephens, Baird, Turpin, & Tsey, 2012).

The following discussion is presented in the following structure. Chapter 2 provides an overview of the methodology used to undertake this 2 year evaluation. Chapter 3, Outcomes, reports against the TATS Package performance statements for the activities funded to be delivered via WBBC. This discussion is organised under three themes: (1) Student recruitment and implementation, (2) Learned strategies for suicide prevention, and (3) Post-course student outcomes. Chapter 4 provides key learnings and recommendations.

# Chapter 2. Methodology

An action research approach to collect and collate qualitative and quantitative data was employed for this evaluation project. The techniques used are summarised in Table 1 below. Qualitative data collections enable researchers to explore the pedagogical processes that bring into effect the outcomes reported in this evaluation. The research is grounded in the experience of its participants, both students and the trainers with both 'local' and 'insider' knowledge obtained over two years of continuous observation and data collection.

Between 2014 and 2015 the evaluator undertook an estimated 32 hours of classroom observation, six days of block teaching visits to interview students and observe classroom practice, and up to 20 interview hours of one-on-one and focus group discussions with students. Interviews were conducted using an informal yarning approach to maximise the student's comfort with the researcher and minimise forced responses. The conversations were guided but did not seek to restrict students from sharing the thoughts that came to mind at the time of the interview. Six post-course interviews were conducted (10 percent of enrolees). The students were selected according to their having completed the course, and represented either a student cluster (from an Aboriginal community or urban area such as Cairns or Brisbane) or a single student living in a remote community.

Each module contained an optional evaluation questionnaire. These were collated by the course coordinator at the end of each training block, however, these had a low response rate, with some blocks returning just 6 students' responses. Included in the compilation of data were the Course Coordinator's interim reports, including regular dialogue concerning the progress, obstacles or issues impeding programme implementation, and review of the student withdrawals and reason's cited for their early withdrawal from the course.

An enrolment file audit collated both quantitative data pertaining to student enrolment, completion and retention. A demographic profile of the student cohort is presented below drawn from College files detailing students' educational attainment, employment status and their motivation and reasons given for enrolling in the course.

All data was stored in NVIVO (QSR International, 2012) and a thematic constant, comparative analyse technique deployed to enact the emergence of overarching themes and sub-themes. Interview transcripts and questionnaires were coded against these themes to develop a picture of the student motivation for undertaking the course, learning and skill development, experience of the training course, and post-course utilisation of new learned skills and knowledge. These findings were then correlated to the TATS Package performance statements and are presented in the Chapter 4.

Trainers and College staff were not present during interviews and all students' participation was voluntary. Each participant provided their informed consent to be interviewed. Identifying information from student's files was removed from transcripts/questionnaires. Students comments appear throughout the report in indented italics. The study was undertaken with James Cook University ethical approval: H5025.

The methods employed, however, cannot ameliorate for two sources of bias—researcher perception and student responses. The researcher declares an active interest in preserving and enhancing WBBC, and as such, is mindful of the need to think critically of the College organisation, course mode of delivery and effectiveness of its outcomes. Opportunities for critical reflection upon the emerging issues were taken regularly with WBBC staff.

The researcher has also been aware of the potential for students to answer questions that conceal negative opinions of either staff or fellow students. Active listening, watching attentively to body language cues, allowing for long periods of silence between asking a question and hearing a response, and avoidance of suggestive statements or clarifying the question unless asked to do so, were strategies used to help interviewees feel comfortable in saying what they wished to say.

**Table 1: Methods of data collection**

- Interviews with current trainers, other relevant staff/stakeholders conducted over two years
- Enrolment file audit
- Focus groups and individual semi-structured, face-to-face and telephone interviews conducted with over 26 students at intervals determined by attendance at teaching and learning blocks in Cairns
- Evaluation questionnaire in training module workbooks
- Researcher observation

# Chapter 3. Outcomes

*I love this course. My ambition is to go to uni.*

This chapter discloses the findings of the qualitative and quantitative analysis of the collected data methods outlined in the preceding chapter. The findings are reported under three over-arching core themes to have emerged from the data. These are:

1. Student recruitment and implementation
2. Learned strategies for suicide prevention, and
3. Post-course student outcomes.

## 3.1 Student recruitment and implementation

### 3.1.1 Origin of students

In relation to student recruitment, the original funding application cites the following objective:

> *To recruit 15 – 20 community leaders and concerned residents to complete the Certificate IV in Indigenous Mental Health (Suicide Prevention)*

This outcome was exceeded (see 3.1.2 below). It was originally envisaged that students would be recruited from the following targeted communities:

First round of delivery: July 2013 – June 2014
- Yarrabah, Far North QLD
- Kowanyama, South West Cape York, QLD
- Palm Island, North QLD
- Wujal Wujal, Far North QLD

Second round of delivery: July 2014 – June 2015
- Kalgoorlie, Kalgoorlie–Boulder WA
- Charleville, South West QLD
- Lismore, Northern NSW
- St Pauls, Torres Strait, QLD

The initial recruitment strategy targeted the above communities with strong representations from Yarrabah and Torres Strait. Individuals and pairs of students also attended from Kalgoorlie, South East Queensland and North West NSW.

The actual origin of students is presented in Table 2 below. It reflects an intake from a wider number of communities than originally anticipated.

Clusters of students, defined as over 5 students from the same community, came from Yarrabah, Thursday Island, Cairns and Broome.

Table 2: Location of students 2014 and 2015 intakes

| | |
|---|---|
| Atherton, Far North QLD | Malanda, Far North QLD |
| Bamaga, Cape York | Mossman, Far North QLD |
| Bourke, Central Western NSW | New Mapoon, North West Cape York QLD |
| Brisbane | Perth, WA |
| Broome, Northern WA | Quilpie, South West QLD |
| Cairns | Rockhampton, Central QLD |
| Cunnamulla, South West QLD | Sydney, NSW |
| Gladstone, Central QLD | Toowoomba, South West QLD |
| Goodooga, North West NSW | Thursday Island, Torres Strait QLD |
| Hervey Bay, Central Qld | Weipa, North West Cape York |
| Kalgoorlie, Kalgoorlie–Boulder WA | Yarrabah, Far North QLD |
| Kuranda, Far North QLD | |

### 3.1.2 Enrolee profile

The Course Coordinator reported feeling overwhelmed by the level of interest in IMH in late 2013. In 2014 up to 47 tentative enrolments were accepted by the College. IMH enrolled a total of 60 students in 2014 and 2015. 34 students commenced in 2014 and 26 commenced in 2015. Of these a total of 47 completed which is 78.3% of the cohort. WBBC's stated goal was to see 80% of students graduate.

On average, students are over 45 years of age. Female is 47.4 and male 41.8. The youngest student was a female, aged 24. The oldest was a female, 75. One in five students were male, with 85% female in the 2014 intake and 77% female in the 2015 intake. The average highest level of formal education is year 10. Two students had a degree qualification. One student enrolled to enhance his opportunity to be accepted into University. Most students had medium to high literacy needs.

There are three reasons given for student withdrawals mid-way. These are for personal family reasons, (i.e. death or illness in the family), course expulsion for inappropriate conduct (i.e. substance or alcohol misuse during residential block study periods), and employment (Joseph, Munro, & Baird, 2015). Of the 13 withdrawals, two were due to employment, three were course expulsion and the remaining were due to personal matters. One student returned in 2015 after being unable to complete her training in the 2014 intake.

Reliable data concerning pre-enrolment employment status was not available. However the file audits of the College's enrolment records revealed that up to 20% of the cohort were likely engaged in full or part-time employment in the community service sector at the time of enrolment. With 12 students reporting they were actively seeking full or part-time employment, it is likely that up between 10 and 20% of students were unemployed. 21 of the 60 students aged over 55 years of age, or 35% of the cohort, enrolled to enhance their skills as community leaders and mentors.

### 3.1.3 Motivation for enrolling

Three primary reasons were cited by students in terms of their motivation to enrol in the IMH certificate course. These were skills training to enhance community leadership and mentoring skills; to gain employment in a relevant sector, and expand awareness and understanding of suicide prevention and mental health. Other reasons cited were for personal development and course completion. The following sample of comments was drawn from students' enrolment files, when asked to give their reason for wanting to undertake the IMH course.

> *There have been a number of young people committing suicide and self harming in my home community. So by undertaking this course, I want to be able to culturally appropriately help my communities*.

> *I heard about the course from a past student and have always been interested in mental health. My background is in counselling and community development. This course will improve my skills with my current employment.*

> *I want 'grassroots' perspectives on how to assist families in my communities and how to deal with mental health and suicide prevention.*

> *I have been down this path. The feeling I felt at the time was not knowing where to turn for help. Not wanting to burden our children with worry and them seeing the important, strong person in their lives actually cave. Because young people in our culture find this action as the only way of handling their life problems.*

> *I need to know more about suicidal prevention in our youth. As much knowledge as possible.*

### 3.1.4 Course structure

The IMH Certificate IV was accredited with the ASQA to deliver the following modules. They were delivered in four residential blocks held in Cairns. Local study signifies course work completed between residential blocks. The course represents between 500 – 550 hours, over one year.

**Table 3: Course structure**

| | |
|---|---|
| BLOCK 1 | Introduce hope and healing: moving beyond trauma |
| | Support adult children of alcoholics |
| Local study | Project 1: Research adult children of alcoholics |
| | Project 2: Research addiction |
| | Apply first aid |
| BLOCK 2 | Work effectively in mental health settings |
| | Apply understanding of mental health issues |
| Local Study | Research Mental Health Issues |
| | Research recovery processes |
| | Engage respectfully with young people B |
| BLOCK 3 | Establish and maintain communication and relationships to support the recovery process |
| | Assess and respond to individuals at risk of suicide |

| | |
|---|---|
| Local Study | Establish and maintain communication and relationships |
| | Community Project 4: Research/Support DFV needs |
| | or<br>Project 5: AOD work experience 2 |
| | Assess and respond to individuals at risk of suicide B (110) |
| BLOCK 4 | Conduct assessment and planning as part of the recovery process |
| | Assess and respond to individuals at risk of suicide |
| | Provide crisis intervention and support to those experiencing domestic and family violence |
| | Work effectively in the alcohol and other drugs sector |
| Local Study | Conduct assessment and planning as part of the recovery process |
| | Assess and respond to individuals at risk of suicide |
| Elective units | Work effectively in the alcohol and other drugs sector |
| | Support community action |
| | Recognise and respond appropriately to domestic and family violence |
| | Work effectively with young people and their families |
| | Work with clients with complex alcohol and-or Other drugs issues |

The course prepares students with a holistic perspective of Indigenous community-wide mental health. Suicide cause and prevention, alcohol, tobacco and other drug (ATODs) misuse and community and domestic violence are emphasised. According to the course coordinator, Rev. Lesley Baird, ATODs was revisited due to the perceived link between alcohol and drug use in community and suicide ideation.

The course contains industry skill development including counselling and relationship support, research and First Aid. Mamu Aboriginal Health service in Innisfail, and the Mossman Gorge Wellbeing Centre and Primary Health Care Services, and the Gurriny Yealamucka Health Service of Yarrabah, were visited to speak to staff about the management of community controlled Indigenous health services, and the primary care of community mental health.

### 3.1.5 Issues arising during the implementation phase

A variation in the original objective of the course between the original proposal and course delivery affected the following proposed outcome:

> Students will develop a community-wide suicide early identification and prevention strategy in consultation with community members, Traditional Owners, Elders and complementary agencies/initiatives.

As noted above the course structure was originally predicated on delivery in up to 8 discreet communities. In which case the students in each community were to work collectively to create and enact a whole-of-community suicide prevention plan. Thus it cannot be reported that for the eight above mentioned communities this goal has been achieved.

The cause of this variation was due to the unforeseen delay in the time taken by ASQA to accredit the course, and this was a circumstance beyond the control of the College. The problems were reported to the Federal Department of Health in 2013 and agreed variations to the work plan and outcomes were made. The changes culminated in a shift in the emphasis of training outcomes from a whole-of-community plan to implement, to preparedness to work with mental health clients as individuals living within a community and the development of essential frontline workforce capacity. This is a strategic shift that preserves the accredited course modules and core structure.

The course coordinator has reported that all students continued to be required to develop a whole-of-community strategy for suicide prevention relating to their home communities, yet recognises barriers to the students' effectiveness to operationalise these. Clusters of students from one particular community had the advantage of the shared training experience (see Section 3.2.3 below).

The mode of delivery was also affected. All residential blocks were in Cairns, with the exception of WBBC staff travelling to Broome to deliver residential modules to a significant and highly engaged cluster of students.

A secondary problem that emerged from the delay in accreditation was a subsequent delay to the commencement of teaching. Thus the delivery of the course was condensed from 12 months to six. Whilst no evidence of student withdrawals can be found, WBBC staff reported higher than regular levels of pressure associated with meeting shorten deadlines between teaching modules and residential blocks. These concerns were noted by the College. Resourcing and amendments to the work plan were put in place to prevent similar occurrences in the delivery of the 2015 course.

## 3.2 Learned strategies for suicide prevention

*This is my first course and it is mind-blowing people in the room.*

An intended goal of WBBC to meet the objectives of the TATS programme was to equip students with the skills to develop a community-wide early identification and prevention strategy in consultation with community members, Traditional owners, Elders and complementary agencies/initiatives. As discussed in Section 3.1.5 above, the mode of delivery was adjusted due to delays in course accreditation. However, this objective remained core to the teaching and learning experience of trainers and students.

The comments in Section 3.2.1 to 3.2.4, are drawn from student's own experience of the course. They reflect learning and capacity building in terms of personal and professional development, expanded networks, professional work place practices and the need for sound planning, research, monitoring and evaluation.

They are organised under four themes that emerged from the transcripts of both interviews and focus groups that were conducted during the course. They are:

- Individual skills development for employment or volunteering
- Personal development, leadership and mentoring
- Community networking, and

- Integrated community plans and planning.

### 3.2.1 Individual skills development for employment or volunteering

Students reported learning practical skills to better equip them in counselling positions, including knowing when and where to make referrals, identification of particular mental health issues, the relationship between ATODs and mental health disorder or illness, the indicators of suicide risk, and professionals' legal requirements and obligations.

Suicide ideation

> *A lot of insight and depth to the contributing factors and elements that are associated with client/Individuals who are at risk, especially the different levels of suicide risk.*
>
> *Not only has it changed me, it has opened my mind to areas that I had limited knowledge about. I feel more confident to do things in my community, personal and work life.*
>
> *I'm aware of the triggers and what to expect from people who have attempted suicide or at risk.*
>
> *I have never had a qualification so I have to be careful of what I do and say. So I need to have the qualification.*
>
> *This has given me knowledge and insight into suicide and people at risk.*
>
> *I'm learning that what I'm doing is instinctively right. That sealed it for me. No one can tell me I'm doing it wrong. This is highly relevant to my role as a manager and my workbooks will be at work with me.*

ATODs

> *I've learnt a lot about what drugs and alcohol does to you and some ideas how to prevent the intakes and how to cope with suicide*
>
> *I have learnt what the effects of alcohol and drug addiction have on individual and its ripple effect on family and community.*
>
> *Christmas is not a good time. Footy season. Christian holidays. Easter. Money spending. AOD misuse. Drug abuse has made things so different to what it was before.*
>
> *I have learned something new every day for example, That marijuana stays in the body for around three weeks. Very interesting. That cigarettes are more addictive than heroin! And that respected elders are a very important commodity to have in the community*
>
> *I'm the manager of health and wellbeing unit of [de-identified], a training organisation for indigenous people, migrants and people with complex needs, who have many barriers to employment. 90% of my clients have addictions… I need to do anything in this… to help me understand and develop better practices in addictions dependency.*

Mental Health illness and disorders – recognition, support and referral

> *In our community when there's mental health issue or suicide attempt we volunteer ourselves to go there and see them and see if we can help. If there's someone who needs to be referred to life promotion officers, mental health or doctors, then we refer if the problem is too deep.*

*I have mental health and suicide prevention strategies I use in the community and personally: I have a phone-buddy system. I use my personal experience as an alcoholic. I work with white and black people.*

*A better understanding of people's mental health issues... People who are troubled with life itself. Those people I see the difference between those on medication and those who are not. Not on medication do not suicide.*

*I know the names of the drugs, etc*

*Having dealt with people who have mental health issues, it is good to know that strategies I have used, is similar to what I am learning.*

*I'm learning tools. How to be mindful of people. Understanding of people. Being able to give people the right answer to the question they ask. Show that you can relate to their questions. That's what we're learning here.*

*This course has opened my eyes to new concepts – I know the names of the drugs, disorders, etc.*

[In the Torres Strait Islands]… *People don't talk about it out in the community.*

*Shame is an issue for mental health and suicide.*

*The qualification is helpful to help me to stop our people from wasting their life away. I'm a family support assistant and provide family support for young women.... I see their struggles. I want to help them.*

*I've done this in 3 blocks. 21 books in 3 months. I knew nothing about mental health. I loved my job and asked for help in that.*

Workplace practices

*I have learnt the importance of you being educated on the organization's legislation. To keep accurate records of client's details, and update all the time. This is not only for the client and counsellor but the stakeholder and auditing purposes.*

*I have a better understanding of our workplace … The course is teaching us to work in a team. In the workplace I need to rely on my workmates.*

### 3.2.2 Personal development, leadership and mentoring

Personal empowerment is an object of learning throughout the courses delivered at WBBC. Empowerment strategies can transform people's sense of personal control over their wellbeing and health. It is also an explicitly stated goal of WBBC to produce graduates who possess the characteristics of the empowered person—leadership, empathy and the capacity to work with others towards common goals (Wontulp-Bi-Buya College, 2013). Consistent with other course offerings at the College, student interviews reflect moments of insight and potentially life-transformative change. The College anticipates that graduates will be endowed with a greater sense of control and mastery over their lives, and chose to participate purposefully in the life of their community for social change (Joseph, Munro, & Baird, 2015). The following sample of comments from the interview transcripts reveal individuals' sense of personal transformation and change.

*I'm just blown away. I'm learning about myself. My past dysfunction and addictions. About domestic violence. I already knew from experience. But now I'm actually doing the work. My life changed after every time I went to Cairns [residential teaching blocks]. Some of my friends have dropped away and I've had to change my life and how I live my life. Dysfunctional people I've had to disregard. I've learnt about the boundary setting. My life had to change as well. So I can help others. So my whole life has changed. More limits but amazing freedom and a different world has opened to me. My mind has expanded.*

*In this study I learnt a lot more about how addiction affected my people. I want to be able to help my family and community … because of what I've learnt. Substances are not a part of Indigenous culture.*

*It has changed me in some way that is very optimistic. It has made me more aware of the issues that can be and are very confronting to me as an individual. It has made me more aware and respectful of other people's views and opinions in terms of addressing addictions in our communities.*

*Truthfully, doing this study is making me want to address my own addiction to smoking which I really want to give up.*

*It has changed my pain what I've been going through and helped me to understand more about suicidal grief.*

*Through this course I have an awareness of children of alcoholics. It's changed my life.*

*Many are struggling with the books and with the answers. But sometimes it comes back to ourselves and [asking] what are you gonna do about it? This is benefiting you and the community, the clients and services.*

*I think I've faced most of my demons but there are specific things in the book that I've thought, 'I don't know if I can stay in the room. That's really confronting'.*

*Doing this has helped me deal with issues with my children who drink and smoke. Big help to know about the health issues of my people in our community. I'm a grandmother and I need to teach. It is a big responsibility to mentor and teach them what it means to be a woman. It's helping to open my eyes.*

### 3.2.3 Community networking

The College actively fosters the development of student social capital, referred to here as the development of personal, familial and professional networks of individuals and communities (Dale & Newman, 2010). It is of immense value to students helping them to build and utilise a network of co-operative relationships between individuals or groups. The comments below reflect growth of students networks between themselves, as well as their knowledge and understanding of the existing service infrastructure available across Australia.

Learning and networking with students in the course

*I'm local in Cairns. Most [students] are from remote communities. But for people who are isolated to have to deal with this stuff, man you have to take your hat off to them. I've got a new look at what they have to deal with. They're isolated. How can we better service these locations?*

*We have different opinions and ideas from communities nationwide. It is very interesting. Especially the group from [name removed] who have some interesting and varied sharing on addictions in their communities.*

*I've met some people with their different personality they have inspired me. I have been slow to learn [but] seeing this group and the ages [of the students] really encourages me to persevere. I am different because I have learnt something I never saw before and know that it has changed some of my thinking.*

Learning and networking in Aboriginal and Torres Strait Islander communities

*I talked with the resource centre in [name removed] where I went there to interview a lady about the people in the community. I talked to the young people and parents. There's a canteen and a fishing club, teaching the young to go drinking. I suggested [other activities]. They thanked me for my ideas.*

*My work colleagues and I talked to our line manager and person under our line manager. We can set up and be running a program but if there's an emergency that comes up and we need to go, the programme won't be able to run. The only thing we can do is work with you guys.*

*I gather that what they want is for us to go out to all sorts of organisations and find out why organisations are not communicating with each other. Some are on their own and not doing what they are supposed to for their community.*

*I've been a loner. I'm only 3 year old in a field of work that's been going on for some time. I bring this wealth of life experience and I have instantly connected with my clients and make them feel comfortable. They can pour out their troubles to me. I do advocacy. I pick them up when their boyfriends have bashed them. I do everything.*

### 3.2.4 Integrated community plans and planning for the prevention of suicide

There is evidence that students had undertaken widespread community consultation during the course of their studies. This then has engaged students actively in discussions with local service providers in their communities. Many students discussed progress towards future implementation of community plans to deal with suicide in their community.

Initiating and planning for integrated community responses

*I have gained more knowledge that will assist me in my work and also my community. It has inspired me to discuss the possibility of life programme/training to be delivered in community. So that the [location name omitted] people can experience this. It will assist with the issues we are experiencing.*

*I have noticed that the rehab is male only therefore I now see the deficiencies of services and am anxious to do something about it.*

*I've spoken corrective services, orgs, church, elders etc.*

*I'd talk to the service organisations who do family support and Mental Health like Church groups. It is their responsibility to implement those things for family and youth. I think they would listen to me if I had an idea.*

*I want to create a project – a community project to prevent/decrease the use of cannabis, within 10%. Because I see that this has a terrible strong hold more so than other drugs. It's actually like a base drug… So encultured. I understand it. But it's simple to get off and not as detrimental as people think.*

## 3.3 Post-course outcomes

The following comments and findings were obtained from the post-course analysis phase comprising of telephone interviews with 10% of course graduates of the 2014 intake. These interviews were conducted 9 months following course completion.

### 3.3.1 Community plan for suicide response

Past students were found to be active in the implementation of a plan or established process for suicide prevention, or were in a pre-implementation phase.

Taking action

*We provide ongoing support to about 10 people a week. We go to them. We make our clients comfortable so we go to them. Then it becomes a bond. Then we take them to a place where we feel comfortable to talk. If we need to refer we do.*

*[Name omitted] and I and have a flow chart of volunteers. We will need to talk to all our volunteers to see who will be on call and do up that chart. We give it to the police/emergency and [name of organisation omitted] for 10 days. This way, someone is always on call over Christmas.*

*Region very high youth and adult suicide rate. I work for two organisations [names omitted] in their youth counselling programmes (16 – 25 year olds and adults). We're expanding service to counselling of whole families.*

*We have a suicide prevention plan. I'm a [name of Nation omitted] woman. Our mob teach our young our language and culture and take them over to [name omitted] Island. I work with that group.*

*A whole of community suicide plan? That is co-ordinated out of the hospital Mental Health unit. We work closely with them to monitor kids, and at risk youth.*

Initiating and planning for integrated community responses

*There were a number of people from our community in [community name omitted] who did the course. We all talking with each other about it.*

*There is a community plan – but it's yet to be fully implemented.*

### 3.3.2 Employment or volunteerism

There are six documented instances of people obtaining full-time, employment due to their completion of the IMH course (Joseph, Munro, & Baird, 2015). Due to the anonymity and de-identification of data, they were not targeted for post-course interviews.

The interviews conducted revealed the ways in which people are using the skills and knowledge gained from the course in their paid or volunteer capacities. All interviewees identified as being 'employed' in either paid or unpaid work. All recognised their work belonging to the human services sector and all identified their primary target groups as Indigenous individuals, young people and families.

> *On pension day when people are drunk, spending money and getting violent. I work with street kids, families and that.*
>
> *Today, I work with the police (voluntary). The course taught me how to help others. To recognise illness, to talk with them not down to them, to get their attention, how to give them help so they know that someone will help them. The help I was giving people was making people too dependent. I now know how to help them to help themselves*.
>
> *I've been asked to do consultancy work in Sydney by a politician.*

Workplace practices

As found in during the course, interviewees gained important new skills to undertake their roles in organisations both professionally and safely.

> *The IMH Certificate taught me knowledge, understanding, and how to approach people. How to help so that I am safe too. It is scary and sad. It can really affect you. Knowing someone is suicidal is delicate. It stops you sleeping. They might harm you. I have been threatened. But it is part of the job/role.*
>
> *It is tiring at times. I now go to loss and grief counselling. You need to keep strong and be fit and well to help people. Training in IMH gives me confidence to do what I do. I offload on staff I trust and feel much better.*

### 3.3.3 Most gained from completing the course

Benefits beyond employment and skills training accrued. Interviewees discussed their personal development and sense of achievement in completing a formal accredited course and being role models for others. The networking with other WBBC students was important as well as new heightened awareness of the causes of suicide and mental health conditions generally.

> *The blocks: That's where most learning was gained. Being in person, hearing others talk and sharing stories of different experiences.*
>
> *I've achieved this myself.*
>
> *I don't feel that they [students] needed the training as they are already mentors and know how to work with their people, but they need to demonstrate self improvement and get the piece of paper that qualifies them to do counselling in community.*
>
> *It is vital information I can use here. Counselling skills, support and mentoring.*
>
> *I've had depression and alcoholism all my life and it's been a personal battle with suicide too. And I've always wondered why? So doing the course helped me understand my personal battle. And it really helped me get over my depression and I've lost 48 kgs.*

*I see mental illness more clearly now. I used to think that person's mad but now I understand the complexity of the problem.*

*I love the learning. I really enjoyed it. I get to talk with students on Face Book. We all keep in touch.*

### 3.3.4 Skills at work

Most interviewees identified counselling as a core role. Working with police, hospital and health services and schools.

*I am a counsellor. I am the Aboriginal Education Officer and Programme Development Officer at our High School. I work with the young people who often have the mindset of suicide. I assist them and talk to them. I now know the signs to look for to support the young people here.*

*WBBC gave me the counselling skills I needed. I applied for and got the support worker position with [organisation name omitted], fulltime. I work with mental health clients and others in the across the Torres Strait Island communities.*

### 3.3.5 Student satisfaction

Students reported high levels of satisfaction when asked during interviews, including providing several suggestions for improvement.

*I'd like to see more structure. More support for students to understand what they have to do… Teach people to prepare themselves to study. Do the work before class. Then we can go though our answers.*

*I'll come back next year to do more Indigenous health and psychology/behavioural studies. What is missed is the spiritual side – to me there's a bigger underlying thing – spirituality and the connections that are disconnected cultural spirit.*

In the 2014 cohort some disruptions to learning caused by anti-social behaviours of several students were reported. They may have been less suited to the classroom environment and requirements of the residential teaching blocks. The College management dealt with the problems swiftly and no further problems in the course delivery were reported. Overall satisfaction with the course trainer was high.

*Les was fantastic. Well paced. He went through everything with us. No unanswered questions and very patient with them who struggled. And we assisted each other. One big family*.

*It was grass roots and culturally appropriate.*

*I don't want a government point of view.*

*The way it's taught – the language is good. Some words are hard. But we need to learn about that. How to see words are put together.*

*However, they like WBBC. They find Les Baird very engaging. They like that the course is Aboriginal motivated.*

Similarly, the College is aware of the medium to high literacy needs of incoming students. A literacy support teacher is available during every teaching block. This service is highly regarded.

One student commented on the after-course care provided by the Course Coordinator.

> *I can also ring the College for advice. I have rung a couple of times when I had to make a report about a situation.*

Several students commented that they will pursue further education pathways as a result of achieving learning success by completing the IMH certificate.

> *I would like to do a lot more [training]. I understand a little more about suicide but I have a lot still to learn. But it opened my eyes to see things differently.*

### 3.3.6 Classroom observation

The residential teaching blocks and continuous support provided between learning blocks, including the use of Facebook to maintain dialogue with students, fosters a strong collaborative, social learning environment. In class, learning activities require students to talk about themselves, conduct interviews with others, read widely and often-times, challenging materials and report their findings within a safe and supportive class setting. Open disclosure promotes trusting and respectful relationships, and an exchange of new attitudes and values.

> *I learnt so much from people from everywhere with issues. I learnt how to relate to people. They talked about their journey.*

Students hold WBBC in high regard in part due to the individualised attention given to each student, particularly those struggling with the emotional weight of the course content. Prior to residential blocks, a risk management strategy is formulated (Joseph, Baird, Turpin, & Munro, 2014) to provide one-on-one as required by students.

Rev. Baird was also observed adopting the role of a 'learner' as opposed to 'the teacher', an assumed role that places the trainers outside the learning experience of the students. In this way, trainers participate in a two-way learning process that removes them from taking a hierarchical position 'over' the community of students. Rev Baird bought a considerable level of personal story and experience to the cohorts in an effort to role model to others and encourages each other to do the same. He capably drew upon the variety of skills and capacity of others in the class, acknowledging the age, talents, experiences and cultural importance of the men and women in the room.

Experiential learning opportunities enhanced the residential block training. Yarrabah's Gurriny Yealamucka Health Service visit was frequently cited by interviewees. The following Case Study concerns the Life Promotion Model at the Yarrabah community. This was discussed often during the two intakes as it was established by Rev. Baird in 1995 and used regularly as a model of best practice. Furthermore, volunteer and paid workers of this programme were in attendance and drew frequently from their work experience and practices. It was the focus of the visit to Yarrabah by both cohorts in 2014 and 2015.

**Table 4: Case study of the Yarrabah Life Promotion model**

The 'Yarrabah Model' is an important model for Indigenous community-wide suicide prevention. Established in the early 1990s it was a practical response to a wave of suicides that deeply affected the Yarrabah community. Led by Rev. Les Baird, a series of community-driven and well attended workshops led to the formation of a crisis intervention group and the Yarrabah Life Promotion Programme. It was premised on the idea that any strategy at Yarrabah would only be successful if it was locally owned and culturally appropriate. There is evidence of reduced suicide incidence and ideation (Hunter).

Twenty years later, Life Promotion Officers working in Yarrabah attended the IMH course delivered by Rev. Les Baird. This enhanced the learning opportunities of the cohort in two ways. Firstly, the officers of the programme were able to share one-on-one learnings with the class their experience of working for a well established, whole-of-community plan that has had changes in funding and coordination over the years, but essentially operates on the same model of providing a 24/7 roster of support workers (volunteers) to visit anybody identified as being in distress.

> *[We provide support] to about 10 people a week. We go to them. We make our clients comfortable so we go to them. Then it becomes a bond. Then we take them to place where we feel comfortable to talk. If we need to refer we do.*

Secondly, the close proximity of Yarrabah to Cairns gave Rev. Baird the opportunity to take both cohorts to visit the community and meet with other service organisations integrated within the Life Promotion model. This then gave students the opportunity to understand the governance arrangements, community support for and funding issues pertaining to the management of the model and its longevity in Yarrabah.

The service includes community outreach and education materials: forums, DVDs, workshops, and so on. Whilst acknowledging that the educational materials have been in circulation for many years, they know there is much work to do, particularly in reducing the shame and stigma associated with mental health illness, disorders or suicide ideation. "We need to be more aware, especially the young ones." The school is a particularly important service provider in the whole-of-community suicide prevention plan.

> *The main thing is building relationships with the community. Rapport and trust so that they'll start talking about stuff/what they have been through. Then I can give them tools, they can get counselling. High risk people, including kids, we tell their family, police, psychologists, centre, school etc. We work with families. This is to stop parents blaming themselves. Feeling guilt if something were to happen.*

With so much history and hands-on experience, what benefit was IMH to these students? Overwhelmingly, the students interviewed for this study wanted greater understanding of mental health issues affecting Indigenous people specifically. Secondly, they were interested in ensuring their staff and volunteers were trained to understand the issues, recognise the signs of suicide and know where to refer within the service sector providers in the community. Some participants had

no prior formal qualifications. The certification will assist some to gain future employment. The course taught students the importance of working with co-workers and service providers in community, however, maintaining Yarrabah Indigenous control of the programme was a core concern. One respondent stated that if non-Yarrabah based service providers were to try to deliver this programme, "They may bring in mental health support from outside the community but the local people won't feel comfortable if services come in from Cairns… They won't be comfortable talking to them."

> *If we do get a call out and can spend a couple of hours – a daily yarn with people, it's a big help. You can get to know if they are agitated. But overtime they just want to get things off their chest and they start talking in a good way.*

# Chapter 4. Discussion and concluding comments

The following discussion reports the findings of Chapter 3 against the TATS Package performance statements as outlined in the variation agreement with WBBC of June 2015:

- Promote help seeking behaviour and positive lifestyle choices
- Promote local responses to suicide and other related issues within communities
- Facilitate greater networks between service providers and local communities
- Contribute to the development of local community capacity to address these issues
- Facilitate access by communities around Australia to appropriate service providers.

## 4.1 Promote help seeking behaviour and positive lifestyle choices

A wide range of important skills were developed through the IMH course. The wide suite of oral and practical skills developed by the course-work and collectively (see Table 5 below), enhance personal empowerment and a sense of control and mastery over one's life, environment and circumstances. The participants of this course will be active in teaching and mentoring others in their communities to promote help seeking behaviour and positive lifestyle choices.

> *The programme and courses taught me how to intervene to teach them there are better choices. I get them to see a GP to get referrals*

**Table 5: Summary of core skills gained through the IMH Certificate IV**

- An overview of mental health illness and disorders and common treatments
- Legislation and governance of service organisations
- Workplace health and safety including the mental health of service sector workers
- An overview of counselling skills – group therapy, one on one interview techniques, active listening
- How to identify addictive personality types
- How to identify people at risk of suicide
- Knowledge of where to refer people for support
- How to talk to community leaders, council, Elders and government agencies
- Project planning, research and evaluation skills
- Public speaking, reading aloud and teaching
- In-class leadership and mentoring roles
- Conducting interviews
- Short answer writing
- Consultation – community and target group
- Conflict negotiation

Whilst not core to the outcome of this course, a serious concern for the collective wellbeing of Australian Aboriginal and Torres Strait Islanders is literacy skill development and its connection to health outcomes (Boughton, 2000). Durnan, Beetson and Boughton, reflect on literacy education

and its relationship to socially transformative practices arguing that literacy skills and "how people learn to read, speak and write words" gives people power. The ramifications of which are manifest in self-determination politics and safer communities (Durnan et al., 2013, p. n.p.). It is important to note the contribution of this course to student literacy skill attainment.

## 4.2. Promote local responses to suicide and other related issues within communities

As a pilot course, the Certificate IV in Indigenous Mental Health (Suicide Prevention) has been highly effective in promoting localised responses to suicide and mental health issues within Australian Aboriginal and Torres Strait Islander communities. The course is transferrable to other delivery settings outside of Cairns. For example, Rev. Baird travelled to Broome in 2015 to complete face-to-face training with the cohort enrolled from Broome. All participants completed the course.

The 2014 post-course interviews coupled with interviews conducted during training sessions point to a heightened understanding of the imperative to work within community to develop local responses to suicide prevention. Individuals spoken to reflected their understanding of the problems in their community, and articulated a reasonable response they could take. This included working with existing services, or in finding a niche to fill.

## 4.3. Facilitate greater networks between service providers and local communities

An ongoing strength of WBBC is in developing a network of Indigenous leaders. The teaching blocks in Cairns build social cohesion, friendships and the opportunity to learn from one another. There are a great many cultural distinctions within a cohort as large as the IMH intakes. With communities represented from Western Australia, country NSW, inland and coastal regions in Queensland, as well as Cape York and the Torres Strait Islands. Students value the opportunity to compare and contrast their own experience of Australian Indigeneity, and this inquisitiveness extends beyond the life of the classroom. Students expressed an interest in remaining in communication with people from other communities.

The IMH course fosters the growth of students' social capital. As students were required to research, meet and discuss mental health service provision in their communities, their exposure and influence in their community was widened. Many students commented on the increased awareness of mental health and suicide, which also presents a moment in which students will feel a new or renewed sense of belonging to a network, movement or cause.

> *We need more programmes. More events. More talking about it. It is not out there in your face. Our faces. We need to recognise it. On the media. More in your face. We can't educate enough. We're continuing on and people are saying we can't do a thing but we can.*

> *It'd be great to see commercials. See the families and see how much it hurts and the sorry business. The kids aren't registering that death is death. Not just people think is accidental but it's the drugs. It's not accidental. They think it's just cutting or hanging. They do it other ways.*

The IMH delivery had to be varied for reasons cited above (see 3.1.5). This variation has been well managed by the College and from it several new benefits to the course outcomes emerge. These

include an increased size and capacity of a critical mass of graduates across communities, who are communicating with each other and their services. With the larger intakes from the wider cross-section of communities, come networking opportunities and a larger information web leading to possible funding, employment and public health initiatives.

## 4.4. Contribute to the development of local community capacity to address these issues

Education is said to be the single largest contributor to determining one's participation in the labour market. Educational qualifications which includes Year 12 and a Certificate II or above reduce the unemployment rate for Aboriginal and Torres Strait Islander people in both full-time and part-time employment categories to a rate less than half that of people who do not have these qualifications (Australian Bureau of Statistics., 2014).

The skills development listed in Table 5 above has translated into new employment opportunities for six individuals in the 2014 cohort. Post-training data for the 2015 intake is not yet available. However, the completion rates for this intake are remarkable with the two withdrawals attributing the causes to personal reasons, and the other due to student misconduct.

According to the course coordinator, students have gained employability skills in communication, teamwork, problem solving, initiative and enterprise, planning and organising, self-management, learning new ideas and how to accommodate change and technology. Students have also obtained a First Aid Certificate. This course, however, is unique in its approach to Aboriginal and Torres Strait Islander issues, by teaching applied skills through a culturally appropriate, competent and sensitive lens. Skilled Indigenous workers in this field are crucial to communities where the post-colonial impact is acute and a major factor in social dysfunction.

> *There's more [problems] out of the outer [Torres Strait] islands. Loss of culture… The issues for us is under-age drinking/smoking drugs/families to families problems. These issues relate to suicide.*

"WBBC is addressing all of these issues in a holistic way through training key personnel who are committed to working with, and for, their communities to help ameliorate these harms and lessen the incidence of mental ill-health/disorders, and therefore lessen the loss of life caused by suicide" (Baird, 2014, p. n.p.).

> *[The course has been] challenging for some but it has to be for some. We need the right people who are qualified. If too easy we'll be damaging our communities by sending out anyone to communities. We pushed each other and supported each other. Want people whose hearts are in it.*

## 4.5. Facilitate access by communities around Australia to appropriate service providers

This performance statement is beyond the scope of this study to address.

# Chapter 5. Concluding comments and recommendations

After two years of continuous monitoring and observation of the delivery and outcomes WBBC's delivery of the IMH certificate, it is clear that there has been widespread community consultation taken place and completed between students, both within and across communities. Students are actively engaging with local service providers in the community to enact individualised, local responses and strategies to ameliorate the pervasiveness of mental health issues.

The success of the course is attributable to several things. One is the age of the cohort. Being on average over 45 years, translates to a set of engaged, concerned citizens, who are already in, or on the cusp of being, their communities' leaders and mentors. Several are professional or quasi-professional community service workers. Many others were active volunteers. The following student makes the interesting observation concerning his work in developing a whole-of-community integrated response plan. He stated that:

> *I've been working on a plan that'll take a couple of years. I'm working with my generation. We need to be role models and mentors. It's up to us. Some of our Elders aren't doing it… The elders are dying fast. We need to find the culture, dance, language, song. And we need to reach out to our youth. They realise they are not the babies but they are not the role models. It's a shock to many.*

The two intakes of this course represented 47 people of 23 communities in Australia. The findings of this report present a picture of highly beneficial, individualised learning, leading to employment opportunities in existing service provision and community infrastructures. However, much more is needed to reduce the stigma and shame of mental health illness and disorder. The following comments three capture the extent of the problem facing these graduates as they return to their communities intent on enacting change.

> *[I've learnt] new stuff. About mental health. I was working with ATODS on [name of location removed] but I didn't know about mental [illness and disorders] and AOD and I need more knowledge about it [and its link to suicide]. Our kids are causing a ruckus. In hospitals [there is] often not a liaison officer and [they] rely on the family and Aunties and need to follow up that this child's in danger. I had an incident with a nephew. But we had no knowledge with him. We need to get to the core issue. But [the course has] helped me. But I can't explain it to Aunties. It can be really damaging [talking about suicide and mental health]. They deal with it their way which means that they don't talk about stuff and are in denial and don't face their own core issues and we have to bring it out and work on that. The pain of going way back to colonisation and finding out where we come from, it hurts and we're fighting to keep our language and song. I learnt about my Grandmother fighting to stay on her land and trying to teach her language and song to children and couldn't. It got lost. We identify through our last names and who is married to who etc., but we don't know all of who we are. If affects us in public ways.*
>
> *Our men in our communities were big staunch warriors. In Western society they are nothing. I grew up in a white home. I grew up racist because I was not educated in aboriginal culture. Western culture is very individualistic and the communities are not. It's a completely different ball park. We have to live in both cultures and educate people to live in both. In our*

*eyes we see them, who they are, when they have culture, song and dance. We see them for who they are. They don't have to have the shame.*

*Government western law. Children wouldn't be doing this if they abide by the cultural lore. The western law has taken our power away to handle our own youth. So the children are lost cause they know they can work it. But they really want those boundaries. Trying to live by spirit and the conflict in each of us is abiding by one Western law and the cultural lore is amazing and we could put a stop to this.*

The recommendations from this report are as follows:

1. As a replicable pilot programme for the amelioration of suicide and suicide-related harms in Aboriginal and Torres Strait Islander communities, a long-term and sustainable funding allocation be made available to implement the IMH course across Australia.

2. Funding allocation to include the cost of travel and accommodation for students residing in remote areas. This cost component of course delivery is not covered by the Department of Health and may preclude student enrolment if they do not meet the Dept of Prime Minister and Cabinet's Indigenous Tertiary Programs Team eligibility criteria.

3. Funding for remote course delivery. This is also a cost-effective model of course delivery to remote and regional communities, particularly those with high suicide rate and risk factors, to initiate the IMH course as a method of prevention. A precedent exists whereby WBBC staff visit student clusters of 10 or more students, in their location for 2 of the 4 residential modules while the first and fourth (graduation) module are delivered in Cairns. This model ought to be considered in the future delivery of the IMH course.

4. Literacy support needs are medium to very high. Funding to engage additional literacy support personnel for the periods of the residential modules is required, with preference for Indigenous personnel with relevant qualifications.

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