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Preventing Suicide Among Aboriginal Australians

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OVERVIEW

This chapter begins with an overview of the recent epidemiological trends in suicide and attempted suicide for Aboriginal and Torres Strait Islander and non-Aboriginal Australians and how this compares with the situation in other post-colonial English speaking nations such as Canada and New Zealand. It then reviews studies exploring the historical and social aetiology of suicide and the nature of its occurrence and consequences within Aboriginal community contexts. These studies provide insights into the group, community, situational and inter-generational factors associated with the increased likelihood of suicide and suicidal behaviour in some communities. The life-course study of individuals who develop suicidal behaviour or complete suicide is another source of evidence which has helped explain why some individuals are more vulnerable to stresses which trigger or escalate suicidal behaviour. The phenomenon of suicide 'clustering' in which the idea of suicide, and suicidal behaviour appears to become socially 'contagious' with so-called 'copy-cat' behaviour is then discussed. The chapter concludes with a review of what works in prevention, early intervention and postvention, including proactive bereavement support and containment of suicide clusters, as well as longer-term strategies for community healing following 'outbreaks of suicide' and other collectively experienced trauma.

WHAT IS THE CURRENT SITUATION IN AUSTRALIA?

The June 2010 report of the Australian Senate Community Affairs Reference Committee, '*The Hidden Toll: Suicide in Australia*' recommended that '…the Commonwealth government develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy.' A separate Aboriginal strategy was needed to respond to the dramatic increase in suicide in some regions of Australia; to its different forms and expressions within some Aboriginal communities; and to the disproportionate impact suicide has on families and communities when compared with suicide in the general population.[1]

Suicide is a profoundly distressing event which has highly disruptive effects on the families, friends and communities who are bereaved. While it is well recognised that Aboriginal Australians experience high levels of bereavement stress due to the higher overall rates of premature death, it has been less well recognised that family and community recovery from bereavement through suicide is complicated by its traumatic nature, issues of stigma and the frequency of suicide as a cause of death for Aboriginal people.

While suicide is believed to have been a rare occurrence among the Aboriginal peoples of Australia in pre-colonial times, it has become increasingly prevalent over recent decades.[2-4] Reducing suicide and suicidal behaviour among Aboriginal Australians is now a public health

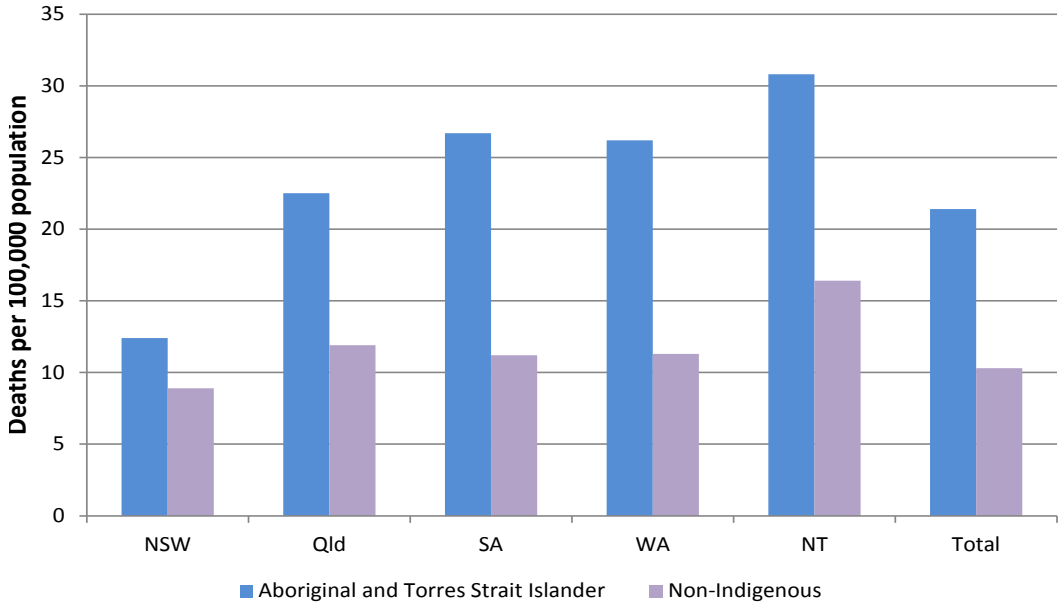
priority for all Australian governments.[5-6] In 2012, the Australian Government commissioned a nationwide consultation process to inform the development of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy which is expected to be announced in mid-2013.

An average of around 100 Aboriginal Australians ended their lives through suicide each year over the decade 2001–2010. In 2010, suicide accounted for 4.2 per cent of all registered deaths of Aboriginal and Torres Strait Islander peoples compared with just 1.6 per cent for all Australians. In other words, suicide was 2.6 times more likely to be the cause of death for Aboriginal and Torres Strait Islander peoples than for all Australians.[7]

The actual rates of Aboriginal suicide are also believed to be significantly higher than the officially reported rates.[3] The reasons suggested for why this should be the case include the misclassification of Aboriginal status on death certificates and other data systems; differences between jurisdictions in their coronial processes; the procedures around reportable deaths (i.e. deaths which must be reported to a coroner); and the strictness with which the legal criteria are applied in arriving at the official determination of the death being suicide.[7-9] To reduce these uncertainties, there have been discussions between all Australian governments and the Australian Coroners' Society to establish a nationally uniform coronial data system, now known as the National Coronial Information System (NCIS), to better inform preventive action through more reliable monitoring of trends, and to improve understanding of the various factors associated with suicide deaths.

Rates of Aboriginal and Torres Strait Islander suicide and non-Aboriginal suicide vary considerably between Australian States and Territories. Figure 9.1 shows that the Northern Territory (NT) had the highest Aboriginal suicide rate of all jurisdictions followed by South Australia (SA), Western Australia (WA) and Queensland (Qld) which are all also substantially higher than the rate in New South Wales (NSW). The extent of this variation may be gauged from the fact that the rate of suicide among Aboriginal people in NSW was lower than that of non-Aboriginal people in the NT.

Figure 9.1: Age-standardised Suicide Rates by Aboriginal status—NSW, Qld, SA, WA and NT, 2001–2010[i]

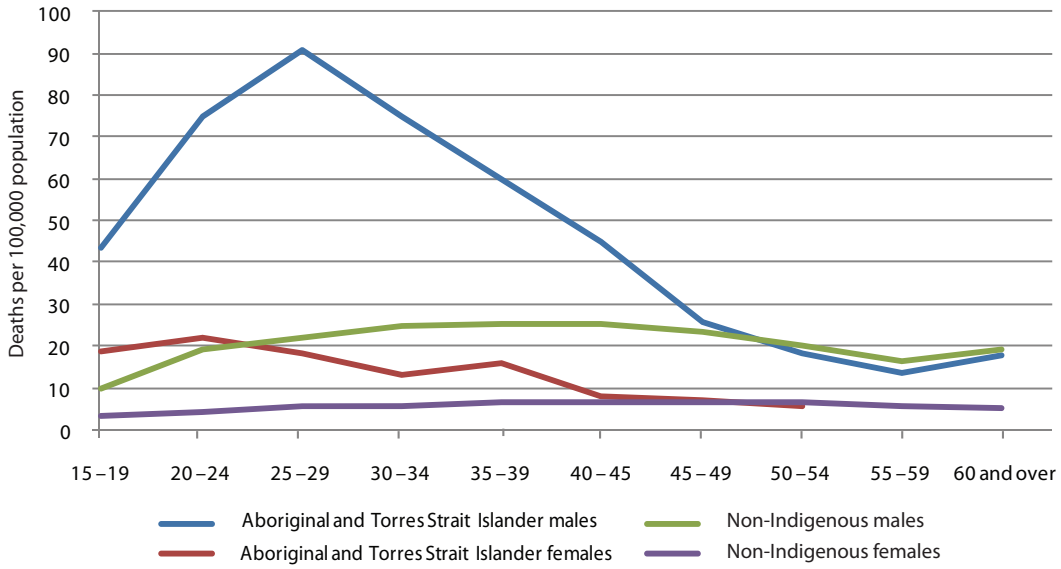


i Age-standardised rates take into account differences in the size and structure of the population and are therefore more reliable for comparison purposes.

Source: Australian Bureau of Statistics (2012).[4]

Suicide generally occurs at much younger ages among Aboriginal persons than in the general Australian population, with most suicide deaths occurring before the age of 35 years. Figure 9.2 shows that, over the years 2001–2010, the greatest difference in rates of suicide between Aboriginal and Torres Strait Islander peoples and non-Aboriginal people was in the 15–19 years age group for both males and females.

Figure 9.2: Age-specific Suicide Rates by Aboriginal Status and Sex—NSW, Qld, SA, WA and NT, 2001–2010



Source: Australian Bureau of Statistics (2012).[4]

The highest age-specific rate of Aboriginal and Torres Strait Islander suicide was among males aged 25–29 years (90.8 deaths per 100,000 population). For Aboriginal and Torres Strait Islander females, the highest rate of suicide was amongst 20–24 year-olds (21.8 deaths per 100,000 population). For the non-Aboriginal population, the highest rate of suicide occurred among males aged 35–39 years (25.4 deaths per 100,000) and among females (6.6 deaths per 100,000) across the age groups from 35 to 54 years of age.

A worrying increase in the occurrence of suicide at earlier ages has also recently been noted among NT Aboriginal and Torres Strait Islander children and young people between the first and second half of the 2001–2010 decade. Robinson et al (2012) reported that among NT Aboriginal and Torres Strait Islander children aged 10–17 years, the age-specific rates of suicide increased from 18.8 per 100,000 for the years 2001–2005 to 30.1 per 100,000 for the years 2006–2010.[10] Over the same period, the rate of suicide among NT Aboriginal and Torres Strait Islander youth aged 18–24 years decreased from 99.9 to 69.9 per 100,000. For NT Aboriginal and Torres Strait Islander females aged 15–19 years, the suicide rates were 5.9 times higher than those for non-Aboriginal females in this age group, while for males the corresponding rate ratio was 4.4 times higher. In older age groups, the rate ratios for suicide deaths of Aboriginal and Torres Strait Islander and non-Aboriginal peoples are lower, with similar rates of mortality observed from the age of 45 years and above.[4]

In terms of the actual number of suicide deaths, Table 9.1 shows that Qld had the highest overall number (311) of Aboriginal and Torres Strait Islander suicides over the period 2001–2010, followed by the NT (225), WA (176), NSW (157) and SA (77). The data in this table also show the occurrence of suicide among Aboriginal and Torres Strait Islander peoples in Capital City Statistical Divisions and other urban and rural areas was much less frequent than in more remote 'rest of state' areas.

Table 9.1: Number of Suicide Deaths and Age-standardised Suicide Rates by Geographic Region, Jurisdiction and Aboriginal Status, 2001–2010

	State or Territory of Usual Residence					
	NSW (No.)	*Qld (No.)*	*SA (No.)*	*WA (No.)*	*NT (No.)*	*Total (No.)*
Aboriginal						
Capital City Statistical Division	54	64	35	49	47	249
Other Urban (a)	41	84	n.a.	10	n.a.	135
Rest of state/territory	62	163	42	117	178	562
Total state/territory deaths	**157**	**311**	**77**	**176**	**225**	**946**
Rates per 100,000 population	***12.4***	***22.5***	***26.7***	***26.2***	***30.8***	***21.4***
Non-Aboriginal						
Capital City Statistical Division	3,576	1,883	1,282	1,643	167	8,551
Other Urban (a)	1,209	1,622	n.a.	192	n.a.	3,023
Rest of state/territory	1,176	1,151	468	401	52	3,248
Total state/territory deaths	**5,961**	**4,656**	**1,750**	**2,236**	**219**	**14,822**
Rates per 100,000 population	***8.9***	***11.9***	***11.2***	***11.3***	***16.4***	***10.3***

n.a. = not available for publication.

(a) 'Other Urban' is derived from the Statistical Districts of a state or territory. South Australia and the Northern Territory do not have Statistical Districts and therefore 'Other Urban' could not be calculated.

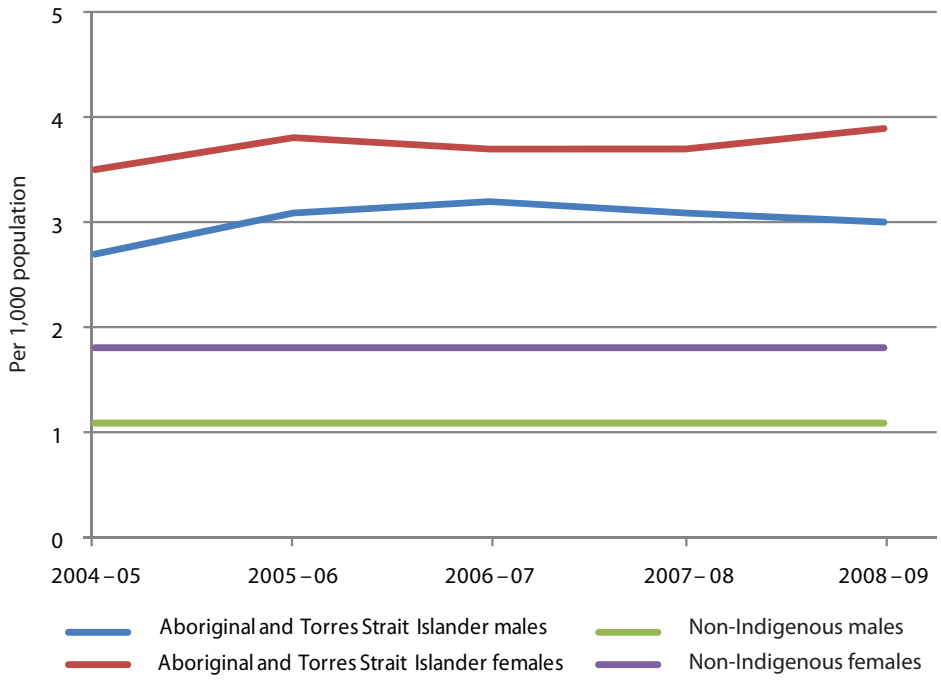
Source: Australian Bureau of Statistics (2012).[4]

By comparison, the rates of suicide over the past three decades among Canadian First Nations people (i.e. Indians with registered and non-registered status, Metis and Inuit) have also been consistently higher than in the general Canadian population.[11] In 2000, the overall First Nations suicide rate was 24 per 100,000 which was twice the general population rate of 12 per 100,000. However, the suicide rate within Inuit regions over the period 1998–2003 averaged 135 per 100,000—over 10 times the national rate. In the United States between 1998 and 1999, the rate of death by suicide for the American Indian population was 19.3 per 100,000 which is around 1.5 times the general population of 11.2 per 100,000. In New Zealand, similar overall rates of suicide were recorded for Maori and non-Maori up until 1987. However, significant increases in Maori suicide have occurred subsequently—particularly among the age group 15–29 years. In 2007, the age-standardised rate of suicide deaths was 16.1 per 100,000 population for Māori, compared with 9.9 per 100,000 for non-Māori. The suicide death rate for Māori youth (15–24 year-olds) in 2007 was 28.1 per 100,000 compared with the non-Māori rate of 12.3 per 100,000. While suicide death rates have declined for non-Māori since 1996, there has been no significant change in the higher rates for Māori.[12]

Suicide Attempts and Intentional Self-injury

Obtaining reliable data on suicide attempts is problematic due to the difficulties of establishing (and reliably recording) whether the motivation of a person's non-fatal intentional self-harm was suicide or some other reason. Data on non-fatal intentional self-harm hospital admissions from five Australian jurisdictions for the period 2008–2009 show higher rates for Aboriginal Australians (3.5 per 1,000) compared to other Australians (1.4 per 1,000). These data also show Aboriginal females make more non-fatal suicide attempts (3.9 per 1000) compared with Aboriginal males (3.0 per 1000).[13]

Figure 9.3: Age-standardised Non-fatal Hospitalisations for Intentional Self-harm—NSW, Victoria, Qld, WA, SA and public hospitals in the NT



Source: Steering Committee for the Review of Government Service Provision (2011)[13]

A recent population-based Australian survey found that the lifetime prevalence of any form of self-injury for Aboriginal people was 17.2 per cent, which was 2.2 times (95 per cent Confidence Interval: 1.5–3.3) that reported by non-Aboriginal participants.[14] This showed a distinctly different age-specific pattern for Aboriginal and non-Aboriginal self-injury. Among the 15–24 year age group, Aboriginal females are about 30 per cent more likely to report having harmed themselves intentionally than Aboriginal males; and both male and female Aboriginal rates are around double those of their non-Aboriginal counterparts. For those aged 25–44 years, Aboriginal males and females had very similar rates (8.5 and 9.0 per 1,000 persons respectively). These rates are around 2 to 3 times higher than those of non-Aboriginal males and females (2 and 3 per 1,000 persons respectively). Finally, among the 45–64 years age group, the rate of Aboriginal self-harm was 3 per 1,000 which is still around three times higher than among non-Aboriginal males; while the Aboriginal female rate was 1 per 1,000 which is 30 per cent lower than the comparable rate for non-Aboriginal females (1.3 per 1,000). [14]

Regional Differences in Rates of Suicidal Behaviour

Given the differences in the geographic distribution between Australia's Aboriginal and non-Aboriginal populations, and the wide diversity of socio-economic and cultural living circumstances, it is not surprising that there are marked regional variations in the occurrence of Aboriginal suicide. Hunter has described how approximately one-half of the Aboriginal people living in Qld live in the far north of Qld but they accounted for almost two-thirds of all Qld Aboriginal suicides.[15] Furthermore, just three communities with less than 20 per cent of the far north Qld region's Aboriginal and Torres Strait Islander population accounted for 40 per cent of Qld's Aboriginal suicides.[16]

The mobility of Aboriginal people between remote communities and regional centres—particularly in the more remote areas of Northern and Central Australia—is another difference. The extensive kinship relationships between Aboriginal people across quite dispersed

communities can mean that they function as a larger regional system when considering the occurrence of suicide and its impact on communities. The average age of the Australian Aboriginal population is much lower than that of the non-Aboriginal population, due to higher adult-to-child ratios and shorter life expectancy. This has important implications for understanding the psychological impact of suicide on families and the available community response capacity in terms of supports and services for treatment, support and prevention.

APPROACHES TO UNDERSTANDING ABORIGINAL SUICIDE

The first systematic studies of Australian Aboriginal mental health and self-harming behaviour were based in medical anthropology, clinical epidemiology and sociological methods of enquiry.[17-18] However, the historical event which first focused national attention on the growing problem of suicide among Aboriginal Australians was the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).[19] The Commission's final report drew particular attention to the links between substance misuse and mental health disorders in the years and months prior to most of the deaths which it investigated. It also highlighted the disproportionate number of these Aboriginal deaths in custody (over three-quarters) where there was a history of the person having been forcibly separated from their natural families as children. The inter-connected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged by the Commission as contributing to the heightened risk of mental health problems, substance misuse and suicide. The Commission made several specific recommendations for improving police and custodial practice and providing adequate treatment for those with diagnosable disorders whilst in custody and in the 12 months following release from prison.[19] Most of the Commission's practice recommendations were implemented systematically across all Australian jurisdictions over the following decade with a resulting decline in deaths in custody. However, the Commission's broader recommendations for Australian governments to address the underlying social, economic and political circumstances—including the over-representation of Aboriginal people in the justice system—has received considerably less attention.

Hunter's seminal studies of Aboriginal suicide in the Kimberley region of WA and far north Qld since the late 1980s charted the historical impact of colonisation on the role of men in Aboriginal society and the relatively recent emergence of suicidal behaviour as a socio-cultural phenomenon.[20-21] Hunter noted that willed or self-willed death associated with sorcery or physical debility in traditional Aboriginal societies could be considered 'suicide equivalent' phenomena. However these are very different to the increases in deaths by hanging of young men over recent decades. He argued that both phenomena are meaningful but in different ways. He suggested that the former was a socially understood and affirmed consequence of behaviour (transgression) or circumstance (debility); while the latter could be considered as a statement or communication that had meaning in the particular intercultural political context of the Australian society and Aboriginal communities of the 1990s. Understanding Aboriginal suicide therefore demands a consideration of the historical context in which these socio-cultural changes are located.[20-21]

One of the most significant socio-cultural changes in Aboriginal communities associated with increases in suicide has been the disruptive effects of alcohol. Hunter's 1991 discussion of the effects of the extension of drinking rights to Aboriginal people observed that this initially resulted in a rapid increase in Aboriginal deaths due to motor vehicle accidents and homicide. The social disruption of alcohol on Kimberley communities had its most damaging effects on young adults, particularly unemployed men, who were already leading culturally dislocated lives in town camps. His analysis found that it was almost 15 years after the free availability of alcohol that the dramatic increase in suicide and self-destructive behaviours among young (mostly male) Aboriginal adults emerged in the late 1980s. Hunter describes this as: '… the

first generation to have grown up in an environment of widespread drinking and its social consequences'.[20] In his analysis, alcohol was not seen as the immediately contributing factor for these suicides but rather it was the effects of alcohol on the conditions of childrearing which was the more fundamental cause. This hypothesis is supported by another finding of his study—that a history of heavy drinking in the family was more predictive of suicides among incarcerated young Aboriginal men than these men's own alcohol use. Thus, in addressing these problems, it is important to ensure culturally appropriate treatments are available to alleviate individual suffering while also supporting communities to take action in addressing the harm which alcohol causes in the social environments in which Aboriginal children are being raised.

As already noted, the variation of suicide by location and time in these remote regions of northern Australia suggests that socially mediated factors within communities may have a more powerful effect on the likelihood of suicide than the traditional 'medical model' concepts of individual risk inferred from psychological autopsy studies and clinically based investigations of suicidal behaviour. Hunter and his co-authors observe that, given different communities contribute to this excess (of suicide) at different times in '… overlapping 'waves' of suicides', this phenomenon is more indicative of a condition of *community* risk rather than *individual* risk'.[20] This view is consistent with Colin Tatz' critique of 'medicalisation' of Aboriginal suicide as a 'mental health problem' in much of the previous research and reports such as the RCIADIC. This, he argues, has prevented the problem being examined and understood in a proper historical, political and social context and the way in which the processes of 'decolonisation' have undermined the internal values of Aboriginal society and left many Aboriginal youth with a profound sense of frustration, alienation and distress. Tatz' use of the term 'decolonisation' refers particularly to the devastating effects which the removal of direct government controls over Aboriginal affairs in 1972 had in many Aboriginal communities—particularly the inadequate infrastructure and services within what were essentially artificially created settlements.[2]

Tatz further suggests that many of the mainstream social risk factors for suicide simply do not apply to Aboriginal people and their communities. His studies of a range of communities in NSW, the Australian Capital Territory (ACT) and New Zealand identified the following community factors as being most relevant to explaining increases in suicide:

Community Factors Relevant to Explaining Increases in Suicide

- Lack of a sense of a purpose in life;
- Lack of recognised role models and mentors outside of the context of sport;
- Disintegration of the family;
- Lack of meaningful support networks within the community;
- High community rates of sexual assault and drug and alcohol misuse;
- Animosity and jealousy manifested in factionalism;
- The persistent cycle of grief due to the high number of deaths within communities; and
- Poor literacy levels leading to social and economic exclusion and alienation.[2]

Hunter and Milroy have taken this a step further in seeking to explain the underlying psychological processes through which broader historical, socio-economic and community factors may become internalised and how this can lead to the impulse of self-annihilation in vulnerable individuals. They argue that Aboriginal self-harm reflects vulnerability stemming from internal states informed by individual experience and collective circumstance. Most particularly, they highlight the way in which historical forces have impacted on the environment

of family life and in shaping individual identity, health and wellbeing. Thus in considering the meaning of one's life as a narrative or story,

> *…the desire to end one's personal story abruptly, prematurely and deliberately can [therefore] be seen to stem from the complex interplay of historical, political, social, circumstantial, psychological and biological factors that have already disrupted sacred and cultural continuity; disconnecting the individual from the earth, the universe and the spiritual realm—disconnecting the individual from the life affirming stories that are central to cultural resilience and continuity.*[22(p150)]

CULTURAL CONTINUITY AS A KEY PROTECTIVE FACTOR

Chandler and Lalonde's study of five years of data on youth suicide rates in Canadian First Nations communities in British Columbia investigated reasons for the variation in suicide rates between communities which had similar historical backgrounds and levels of socio-economic disadvantage.[23] They identified a number of 'cultural continuity' factors which were significantly associated with lower rates of youth suicide:

'Cultural Continuity' Factors Associated with Lower Youth Suicide Rates

1. Self-government
2. Actively pursuing land claims
3. Existence of education services
4. Tribal-controlled police and fire services
5. On-reserve health services, and
6. Existence of cultural facilities. [23]

Of particular note was the finding that communities with more of these 'cultural continuity' factors had lower rates of suicide among their young people. These ranged from 137.5 per 100,000 for communities where none of the factors were present, to no suicides at all for communities with all six factors. They concluded that 'cultural continuity' as defined in this way, was an important protective community characteristic and appeared to assist young people in maintaining their sense of personal continuity and cultural identity in the face of rapid social and cultural change.

Further studies of the same set of communities investigated whether Aboriginal language knowledge also had a similar protective effect to the original six identified 'cultural continuity' factors.[24] These demonstrated that Aboriginal language knowledge retention and revitalisation was strongly correlated with the six original cultural continuity factors but also had a significant and substantial independent preventative effect. The application of these insights in these communites has led to locally developed healing initiatives aimed at strengthening young people's positive identification with culture and enabling their social and economic participation in community life, and this has been found to be a key recovery feature of communities where high rates of suicide and other self-destructive behaviours have been reduced.[25]

UNDERSTANDING HOW SUICIDE CLUSTERS APPEAR TO DEVELOP

Hunter and Milroy's description of how the idea of suicide may become internalised is particularly relevant to the development of *suicide clusters* where suicidal behaviour and suicide deaths appear to become socially 'contagious' with so-called 'copy-cat' behaviour. A number

of such 'outbreaks' have been documented in Aboriginal and non-Aboriginal Australian communities over the recent decades.[10, 22] These typically involve an unusually rapid increase in the number suicides and occurrences of self-harming behaviour within a community or region over a limited period of time (i.e. several months or a few years). The specific method of self-harm and suicide is typically the same within each cluster. Kral's sociological analysis of suicide clusters in Canada suggested that:

> *the only direct 'cause' of suicide is the idea of suicide and ways to do it, and in order to better understand suicide we need to know more about how ideas are spread throughout society and become part of an individual's repertoire.* [26(p253)]

High levels of alcohol and drug misuse have been noted in almost all documented Australian Aboriginal suicide clusters, with many of the affected individuals being either intoxicated or in severe withdrawal when attempting or completing suicide. The other common underlying community factor is widespread unemployment and limited opportunities for young people developing the skills and self-esteem to take their place as productive adult members of the community. Hanssens has also noted that exposure to suicidal threats, attempts and suicide within the family or by close associates was a common factor in suicide clusters.[25] This was also observed in Robinson et al's study of child and adolescent suicide in the NT.[10] Geographic isolation and complex clan and family relationships are other factors which have been associated with documented clusters. Cultural and family obligations to participate in numerous funerals and grieving rituals may also magnify the cumulative impact of these distressing events and, in extreme cases, result in the family and community load of bereavement stress temporarily overwhelming their normal recovery processes.[26]

Nizen's ethnographic account of a suicide cluster in Canadian Inuit communities in northern Manitoba, sought to explain why suicide rates should vary so dramatically between communities which had common historical backgrounds of cultural dispossession and comparable levels of socio-economic disadvantage. His analysis recognised the protective and life affirming function which 'cultural continuity' plays in strengthening young people's self-identity and sense of connectedness with family and community. However, he also noted two other cultural features which appeared to have played a central role in young people arriving at a self-reinforcing cycle of emotional injury and self-harm. First was the family and cultural obligations to attend prolonged funerals where the collective expression of grief seemed to have become reminders of the collective trauma suffered by the Innu people. Second, and more critical, in his analysis, was the observation that the pattern of increasing self-destructive behaviour in young people appeared to be more prevalent in those communities where there was a disengagement of young people from older generations and the absence of almost any opportunities for productive and creative activity. Young people in communities where individual and community identities are fragile, and where they are cut off from the positive example and social persuasion of older generations, are likely to gravitate to a peer group of similarly disconnected youth. Their group affiliation is then shaped by their shared sense of social alienation which leads them to develop an identity based on the collective normalisation of suffering. This can then go on to their giving a 'positive' (sic) value to self-harm and other self-destructive, high-risk behaviours.[29] The cases studies in Chapter 20 (Hayes and colleagues) and Chapter 21 (Milroy) illustrate this potential pathway.

WHAT WORKS IN PREVENTION, EARLY INTERVENTION AND POSTVENTION?

Mainstream initiatives to reduce suicide and suicidal behaviour in Australia have largely been informed by the National Suicide Prevention Strategy (NSPS) which commenced in 1999 and extended the initiatives of the former National Youth Suicide Prevention Strategy (NYSPS) to include all age groups.[28] The strategic platform of the NSPS is described in the *Living is For Everyone* or *LIFE Framework* published in 2000 and updated in 2007.[29] While all state and

territory suicide prevention strategies are now aligned with the *LIFE Framework*, the state and territory strategies differ in how they address the prevention of Aboriginal suicide. Given the higher rates of suicide in the Aboriginal population in all jurisdictions, it is surprising that these state and territory strategies are mostly focused on targeted approaches with an emphasis on cultural appropriateness of mainstream services and for Aboriginal people and other cultural and language groups. Victoria is currently the only jurisdiction to have developed a separate whole-of-government approach to Aboriginal suicide prevention while there have been calls for similar developments in NSW, SA and WA.

The national *LIFE Framework* is informed by current international research in suicide prevention which highlights the importance of two sets of risk factors. The first are immediate (proximal) individual factors evident in the months, weeks and days before a suicide attempt or suicide. These include the individual's mental state, precipitating circumstances such as recent adverse life stress events and drug and alcohol use. The second set of factors are the longer term (distal) factors, which have a cumulative effect in increasing an individual's risk from early childhood and through the life course. These two categories of risks require quite different prevention strategies and interventions to reduce the occurrence of suicidal behaviour and suicide.[29]

Preventive Early Intervention for Individuals in Distress

Preventive early intervention for distressed individuals showing signs and symptoms of acute suicidal risk generally aim to interrupt the proximal risks for suicide and to stabilise and reduce an individual's level of emotional arousal through physical containment, social support and/or clinical intervention, depending on the assessed level of risk. In communities with limited access to mental health practitioners, community workers may need to make an initial assessment of the risk of suicide or serious self-harm based on their knowledge of the person and their circumstances. However, this should wherever possible be done in consultation with others rather than making potentially life-and-death decisions alone. Direct or telephone consultation with a mental health practitioner can help in reaching a considered decision about the level of monitoring or action needed to ensure safety. This should consider what action and supports need to be in place: immediately (i.e. over the next two hours); in the short-term (over the next two days) or in the longer term (e.g. over the next two weeks). Such assessments usually require speaking directly with the individual and inquiring about their thoughts about ending their life or harming themselves.

A number of culturally appropriate training programs are now available to assist community workers and natural community helpers in making risk assessments of this kind e.g. the *Gatekeeper Training Program*; the *Indigenous Psychological Services Whole of Community Suicide Prevention Forums*; the *Aboriginal Mental Health First Aid Training and Research Program*; and *Suicidal Thoughts, Behaviours and Deliberate Self-Injury: Guidelines for providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person*.[30-32] Training programs such as these aim to develop skills of engaging with highly distressed individuals, increase knowledge of mental health issues such as depression and psychotic behaviour which often underlie suicidal behaviour, and build understanding of the social and clinical supports which can help in reducing suicide risk and prevent crisis situations escalating.

While some programs are designed for helping professionals, others are designed for community members with the aim of ensuring that communities have a number of key individuals who can be relied upon as 'gatekeepers' to link and refer suicidally distressed individuals with the clinical or other supportive interventions which they may need. They particularly stress the importance of 'gatekeepers' learning to recognise the feelings of hopeless, dread and escalating agitation which commonly precedes fatal and non-fatal impulsive suicidal behaviour.

Longer-term Prevention Promoting Resilience

The current national policy framework for suicide prevention also has an increased emphasis on 'whole-of-population' and strengths-based approaches to prevent individuals from becoming at risk in the first place. This is consistent with the evidence on Aboriginal suicide reviewed earlier which suggests the social and community determinants of Aboriginal suicide contributes as much as, if not more than, individually based risk factors. Such universal approaches to prevention have been shown to be particularly effective in addressing issues which arise through multiple risk exposures over time or which are highly prevalent at lower levels of risk. [33]

Improved scientific knowledge of the early-life factors which promote emotional resilience in children and young people is also informing 'strengths-based' policies and increased national investment in 'place-based' (i.e. community) initiatives to better support the development of all children and young people and equip them for managing the challenges of life in 21st century Australia.[34] Other community-based strategies seek to strengthen protective factors (e.g. help-seeking) at the community and family level and to reduce the 'upstream' risks (e.g. alcohol and other drug misuse) that increase the likelihood that an individual will respond to adverse life circumstances with impulsive suicidal behaviour. This is based on the evidence that stresses (such as social disadvantage, racism, family violence, mental health or behavioural problems, as well as traumatic events such as bereavements, relationship breakdown or trouble with the law) have a cumulative biological impact over time.[35]

For each developmental period there is a range of known environmental risks (and preventive opportunities) which should be a priority focus of the agencies responsible for the services most relevant to that stage of development. Developmental prevention approaches have long been advocated as the most cost effective means to reduce early onset conduct disorders, juvenile crime and population rates of incarceration.[36-37] It is now generally recognised that a much greater proportion of the prevention effort should be spent on 'up-stream' preventive policies and services. This will require both community action and resolve and more effective alignment of policy services to ensure that health, family and community services, education, mental health and justice service sectors work together to build community, family and individual wellbeing, capability and resilience.

Proactive Bereavement Support and Containment of Suicide Clusters

The high rates of bereavement suffered by Aboriginal families has become a growing concern in some parts of Australia. Where there is little time to recover from one loss before another has occurred, whole families and communities can be left in a constant state of mourning, grief and bereavement. For some individuals, this can be accompanied by extended grief reactions such as shock, numbness and disbelief. Bereaved family, friends and other community members often see their own distress reflected in the predicament and actions of the deceased person. For more vulnerable individuals, this can trigger their own suicidal thoughts and actions. Ripples of loss, grief and mourning after suicide can spread outwards through the community and to other communities—particularly where families are highly interconnected and there are strong cultural obligations with regard to funerals and observance of sorry business.

In one remote Australian region, a pattern of association of suicidal behaviour was observed between four families who together lost 15 members of their family to suicide from 1998 to 2007.[27] The heightened awareness of suicide associated with such levels of bereavement through suicide can be further complicated by unthinking media reporting—particularly when reports give graphic and sensational accounts of the methods and circumstances of the suicide or which fail to respect the rights of privacy of grieving family members. The highly distressing nature of such events highlights the need for developing and maintaining expertise

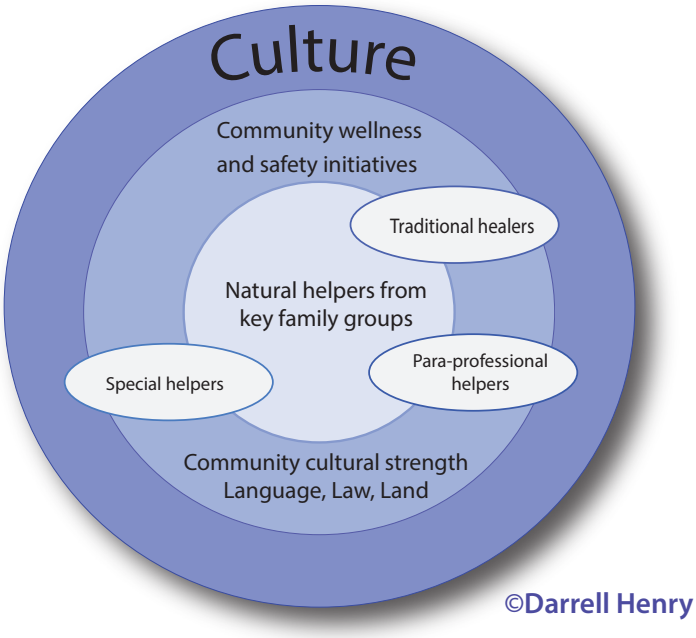
in bereavement support and counselling within communities and Aboriginal community organisations. At the same time, the trauma and additional stresses associated with suicide, may also require emergency additional mental health intervention, as well as consultative support and back-up for 'front-line' community workers and family members caring for suicidal individuals.

AUSTRALIAN ABORIGINAL COMMUNITY HEALING INITIATIVES

Over the past few years a number of Australian communities have initiated local community healing processes in response to the collective trauma of child abuse and multiple bereavements. A notable example is the model of community healing developed by Darrell Henry through his therapeutic support of communities recovering from suicide clusters in the Pilbara, Kimberley and WA Southwest.[38] This integrated community healing model involves a three-level strategic response to suicides and suicidal behaviour which aims to build the capacity of community people as the key 'first-response' service providers, has a primary focus on the implications of suicide for the community, and involves a 'whole community' response (See Figure 9.4).

This model recognises the central and significant role of cultural work in Aboriginal communities. It involves actively supporting culture and working with culture, e.g. using traditional practices such as being taken to country and '*held*' through a formal community process with strong men and women for cultural, spiritual and personal learning. Other examples of the cultural use of this process of 'holding' have been described by McCoy within the context of the Kutjungka region in the southeast region of the Kimberley.[39] Henry suggested that such healing practices could be further enabled by funding support for 'going to country', using or re-creating traditional rituals of healing including the use of smoke, water, stones, leaves and plants to cleanse the spirit and clear aberrant and distorted spirits from the being. While the inclusion of these practices in this model of community healing depends on the availability of natural helpers and recognised traditional healers, this is considered as key to the effectiveness of the other levels of therapeutic work.

Figure 9.4: Henry's Three Level Model of Community Healing and Helping



Henry's next layer of helping involves Aboriginal para-professional workers acting as a bridge between community natural helpers and counsellors trained in mainstream generic counselling methods. These may include Aboriginal health and mental health workers (MHWs) as well as dedicated community counsellors who can provide counselling for trauma; assist in managing critical responses to family violence and disclosures of abuse, etc. Counselling training is seen as advantageous but not absolutely essential for community based workers—particularly in small and remote communities where there are limited employment opportunities and career paths available to them. However, the workers access to various forms of advisory support is considered vital.

While some professional bodies (e.g. the Australian Psychological Society (APS)) have set guidelines for the assessment, diagnosis and treatment of Aboriginal people, including the use of cultural advisers in the interview process, Henry recommends the need for specialist training for adapting psychological and psychiatric methods for their more appropriate use with Aboriginal people and suggests that this level of service could be improved through scholarships and personal support for tertiary training of Aboriginal people in the helping professions; professional mentoring and co-working; and specialist practitioner training delivered in communities. The integration of all three of these layers of this healing model brings together Aboriginal cultural, spiritual and community processes in community healing from trauma. The process is helpful in building cultural respect, strengthening the local social infrastructure as well as creating work opportunities and avenues for professional development and mainstream support where required.[38]

COMMUNITY HEALING AND RECOVERY FROM INTERGENERATIONAL TRAUMA

There is strong empirical evidence documenting the extent and intergenerational effects of Australia's past policies of forced removal of WA Aboriginal children from their natural families on rates of family breakdown, mental health problems and suicidal behaviour among families impacted by these policies.[40-41] Similar increased rates of social and mental health problems have been documented among Canadian Indigenous families affected by abuse and historical trauma which occurred within that country's residential school system.[42]

The Canadian Government's national strategy to redress the individual and collective trauma suffered by Indigenous peoples through their past policies has included support of the establishment of 'Indigenous Healing Centres'. Over the past decade these Healing Centres have proven to be one of the most effective components of the overall strategy. The Healing Centres offer a range of cultural strengthening activities, including traditional and spiritual healing practices as well as complementary and/or mainstream approaches to trauma recovery, health maintenance, and rehabilitation services. The final report of the Canadian Indigenous Healing Foundation concluded that properly funded community administered 'Indigenous Healing Centres' have led to significant reductions in many of the most socially damaging problems (including suicide) in families and communities impacted by the residential schools system.[42]

Prime Minister Kevin Rudd's 2008 apology to the Aboriginal peoples of Australia for the harm and intergenerational suffering caused by the policies of forced removal and resettlement marked an important first step in the national reconciliation process. It also begged the question of what else was needed in terms of reparation and restorative justice. It was encouraging, therefore, that on the first anniversary of the National Apology, the Australian Government announced that $26.6 million over four years would be allocated for the establishment of a similar healing foundation in Australia. This recognised that healing has always been an important concept and practice for Aboriginal and Torres Strait Islander peoples , and is deeply rooted in culture and should be supported. A committee co-chaired by the Hon. May O'Brien

and Dr. Gregory Phillips consulted nationally about how the foundation should be created and operate. The recommendations from their '*Voices from the Campfires*' report were implemented with the National Aboriginal and Torres Strait Islander Healing Foundation being established as an independent organisation in 2010.[43]

Suicide Story – An Indigenous Community-led Suicide Prevention Program[46]

Suicide Story is an Indigenous-specific suicide prevention learning program. It aims to work holistically with communities in a 2 to 3 day workshop made up of short films, visual aids and culturally appropriate activities with follow-up support. *Suicide Story* was developed for remote communities in the Northern Territory in partnership with local Aboriginal people. The program concentrates on strengthening the skills, knowledge and confidence of communities to prevent and intervene with suicide at a community level. It can complement other suicide prevention programs with a training/education focus. Short films feature the voices of Indigenous people gathered from a collection of interviews from across the Northern Territory including Alice Springs, Santa Teresa, Yuendumu, Tennant Creek, Katherine, Darwin and the Gove Peninsula.

"Suicide Story *is about getting the conversations happening, giving people permission to talk, and giving Aboriginal people more appropriate tools to know how to handle suicidal behaviour in their families and communities*".

Suicide Story engages local Aboriginal facilitators in the delivery of the program; acknowledges that suicide is a very recent problem among Aboriginal families in this region; explores issues such as impulsive suicide, suicide as a threat, blame and payback in their cultural and local context; recognises the importance of learning through sharing stories from other Aboriginal communities and shares learnings through recognisable symbols, images and language. *Suicide Story* explores the history of social injustice and the consequent losses that are relevant to the current problem of suicide, is respectful of different learning styles and preferred learning environments and accommodates varying levels of English literacy.

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Since its establishment, the Healing Foundation has supported a range of community initiated healing initiatives around Australia involving cultural support, community education and skills training in the prevention and healing of trauma. It has also undertaken a nation-wide process of community consultation regarding different ways of working with Aboriginal communities to support the local development, capacity and sustainability of community healing initiatives and centres. This has added to the international evidence from Indigenous healing initiatives in Canada, the USA and New Zealand[42] and the accumulating evidence from the evaluation of promising practices in the culturally informed, locally run community healing programs which the Healing Foundation has supported around Australia.

Insights from the Healing Foundation's community consultations, literature reviews and evaluations have been recently summarised in a report on the establishment, support and evaluation of healing centres.[44,45] The report notes that conventional health and welfare approaches have not resulted in the outcomes that Aboriginal and Torres Strait Islander communities want and are entitled to. It confirms that healing is seen by Aboriginal and Torres Strait Islander peoples as a promising alternative that can be generated from within their own communities. It also stresses the importance of needing to go beyond a narrow focus on the personal symptoms of trauma (e.g. family violence) to the mobilisation of a whole

community response. Given the depth and collective levels of exposure to the trauma from which Aboriginal and Torres Strait Islander peoples are recovering, and the complexity of the challenges this presents, it is clear that a more holistic and collective healing response is needed. Finally the report recognises that acknowledging Aboriginal and Torres Strait Islander history, culture and knowledge, is in itself an important healing and transformative act:

> *Acknowledging colonisation, racism and harmful policies as the common factors underpinning the trauma in Aboriginal and Torres Strait Islander communities provides a more facilitating environment for healing to occur. Healing will often make use of both mainstream and traditional knowledge and practices, but valuing Aboriginal and Torres Strait Islander knowledge and leadership is a prerequisite for adaptive solutions to be developed.*[45(p9)]

AUSTRALIA'S POLICY RESPONSE

After nationwide consultations by the Menzies School of Health Research with the assistance of the National Aboriginal Community Controlled Health Organisation (NACCHO), the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was launched by the Commonwealth Government on 23 May 2013.[47] It emphasises early intervention and building the capacity of communities to respond to suicide.

CONCLUSION

This review of the emergence of suicide and suicidal behaviour as major concerns within the Australian Aboriginal population over the past several decades highlights the depth and complexity of the issues involved. There is clearly no quick or simple solution. What is required is acknowledgment of the level of distress that brings individuals to this point and the heavy toll that suicide takes on families, communities and society. Addressing the individual, community and sociopolitical and historical issues involved requires action on many fronts and on several levels. Linking and enabling these endeavours is vital to restoring the past and creating a future that includes opportunities for individual and communal healing.

RESOURCES

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is available from: http://iaha.com.au/wp-content/uploads/2013/05/MAY-2013-Final-National-Aboriginal-and-Torres-Strait-Islander-Suicide-Prevention-Strategy11.pdf.

The National Suicide Prevention Strategy's LIFE Framework is available from: http://www.livingisforeveryone.com.au/LIFE-Framework.html

REFLECTIVE EXERCISES

1. You are a counsellor in a local community health centre. A member of the local Aboriginal community has approached you because she is worried about her 17 year-old son who has been feeling winyarn (sad) for a long time. Over the past month she has noticed a marked change in her son's behaviour. She says he has been 'flying off the handle' over minor frustrations and become aggressive towards her when she has asked him what's wrong. She has contacted you now because he has begun talking about killing himself over the past few days.

   Taking into account the issues discussed in this chapter:

   a. How would you engage with this family?

   b. What would you need to consider when assessing his level of risk?

   c. Who would you consult when developing a plan of action?

2. Applying Henry's Community Healing Model (Figure 9.4) to work with communities where there has been a high rate of suicide and suicidal behaviour over several years, consider the following:
    a. How would you identify the natural helpers in your community (or the communities you work with)?
    b. What resources (or gaps) exist to support these natural helpers and to link them to the specialist, paraprofessional or traditional healers?
    c. What are the traditional healing practices in your community? Are you permitted to discuss them?
    d. How (if at all) are the traditional healers invited to participate in the mainstream programs and services designed to prevent suicide?

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