



National Aboriginal and Torres Strait Islander Leadership in Mental Health

Intentional self-harm and suicidal behaviour in Aboriginal and Torres Strait Islander children and young people

Submission of the National Aboriginal and Torres Strait Islander Leadership in Mental Health to the inquiry of the National Children's Commissioner into intentional self-harm and suicidal behaviour in children

Key messages

- The Aboriginal and Torres Strait Islander population is a young population – approx. one in three were under-15 years of age in 2011.
- When comparative data is available, these young people are experiencing significantly higher levels of stress, suicidal ideation and suicide (up to six times the national average) than their non-Indigenous peers. This suggests that Aboriginal and Torres Strait Islander children and young people should be a priority group for any national attempt to reduce child and youth suicide and self-harm.
- Suicide is a complex behaviour with many causes. For Aboriginal and Torres Strait Islander peoples, including children and young people, there are specific cultural, historical, and political considerations that contribute to the high prevalence, and that require the rethinking of conventional models and assumptions.
- How to prevent suicide is poorly understood for both the general population and Aboriginal and Torres Strait Islander peoples, including their children and young people. There is a need for further research in this area. Aboriginal and Torres Strait Islander peoples should lead those parts of this research agenda that touch on suicide in their communities.
- It is possible to discuss emerging best practice (or promising practice) in Aboriginal and Torres Strait Islander suicide prevention based on expert opinion and experience. This includes across three levels of intervention:
 - For those at immediate risk of suicide. Culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander children and young people at risk of suicide is particularly important. Training Aboriginal people to provide such services is one way to achieve this; ensuring non-Indigenous workers are culturally competent is another. Services should be delivered through Aboriginal Community Controlled Health Services where possible.
 - For at risk groups, particularly children and young people. In a preventative approach, the

developmental factors that can pre-dispose a person to suicide must be addressed at a relatively early age.

- For whole communities including their children and young people. There is a high level of need for a range of culturally appropriate and locally responsive healing, empowerment and leadership programmes and strategies that build social and emotional wellbeing and resilience and could prove to be effective long term strategies for addressing suicide risk factors. Building on cultural strengths and supporting self-determination is likely to be a core component of any program. Importantly, the content, design and delivery of programs need to have legitimate community support, and be culturally appropriate, locally based and relevant to people's needs. This requires engagement and partnerships with communities.

Introduction

Thank you for this opportunity to make this submission to your inquiry and for an extension to the deadline for making our submission.

NATSILMH's aim is to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples by advocating and providing advice and leadership in these areas. It also aims to reduce the high rates of suicide among Aboriginal and Torres Strait Islander peoples.

NATSILMH coalesced around a core group of senior Aboriginal and Torres Strait Islander people working in social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, the Australian mental health commissions or other nationally important mental health bodies. For further information about us I refer you to our website: www.natsilmh.org.au that is expected to open in early-to-mid June 2014.

We begin our submission with a brief overview of some relevant data and then proceed to answer five of the eight questions you have posed to stakeholders.

A young population under stress

Aboriginal and Torres Strait Islander peoples have survived a process of colonisation that destroyed whole groups of people, cultures, languages, and their traditional economic and political life. Through these times a connection to culture was critical for survival. And cultural reclamation has been a major defining movement for Aboriginal and Torres Strait Islander peoples over the past decades.

Aboriginal and Torres Strait Islander peoples are diverse, spread out across a vast continent, with many language groups, cultures, traditions and experiences. Too much focus on diversity however can mask collective elements of Aboriginal and Torres Strait Islander peoples' experience: a shared cultural history and ancestry in over 250 language groups that suffered invasion by a colonising power. Decimation, dispossession and displacement are in historical memory. The forcible removal of children from their families was a part of the colonising process. Although some underreporting might be expected, it is telling that eight percent of Aboriginal and Torres Strait Islander peoples report being removed from their families in the 2008 Australian Bureau of Statistics' National Aboriginal and Torres Strait Islander Social Survey. And almost four in ten Aboriginal and Torres Strait Islander peoples report removals of family members from their extended families.¹

Based on the 2011 Census, the Australian Bureau of Statistics (ABS) has estimated that the resident Aboriginal and Torres Strait Islander population of Australia as at 30 June 2011 was 669,900 people, or 3% of the total Australian population (ABS, 2013).²

The Aboriginal and Torres Strait Islander population at 30 June 2011 had a younger age structure than the non-Indigenous population, with larger proportions of young people and smaller proportions of older people. The median age of the Aboriginal and Torres Strait Islander population at 30 June 2011 was 21.8 years, compared to 37.6 years for the non-Indigenous population.³

Nationally, more than one in three Aboriginal and Torres Strait Islander peoples were under 15 years of age (36%), while 4% were aged 65 years and over. The age profile of the Aboriginal and Torres Strait population varied only slightly between the states and territories.⁴

In addition to having a much higher proportion of young people, as set out in the text box below, a consequence of colonisation as it operates in contemporary Australia is that those young people are experiencing significantly higher levels of stress, suicidal ideation and suicide than their non-Indigenous peers where that comparative information is available. At minimum, this suggests that Aboriginal and Torres Strait Islander children and young people should be a priority group for any national attempt to reduce child and youth suicide and self-harm.

1. Why Aboriginal and Torres Strait Islander children and young people engage in intentional self-harm and suicidal behaviour.

It is important to recognise what is distinctive about Aboriginal and Torres Strait Islander peoples in order to identify important gaps in knowledge, and to guide the development and adaptation of culturally appropriate strategies of suicide prevention. The following description of suicide was written about Aboriginal peoples in Canada but it applies, in broad terms, to the situation of Aboriginal and Torres Strait Islander peoples in Australia:

Suicide is a behaviour or action, not a distinct psychiatric disorder. Like any behaviour, it results from the interaction of many different personal, historical, and contextual factors. Suicide may be associated with a wide range of personal and social problems, and have many different contributing causes in any individual instance. In fact, suicide is only one index of the health and wellbeing of a population, and it is important to view suicide in the larger context of psychological and social health, and wellbeing.

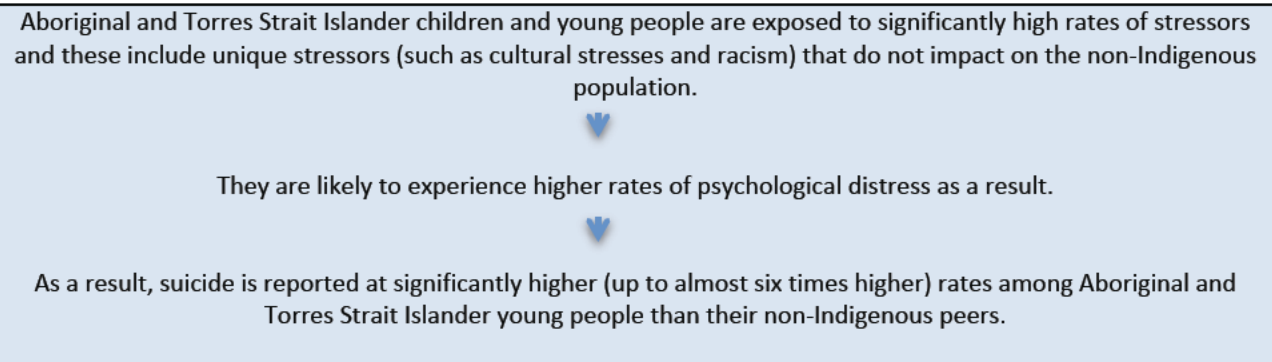
Suicide is never the result of a single cause, but arises from a complex web of interacting personal and social circumstances. From the perspective of prevention, the contributors to suicide can be thought of in terms of risk factors that increase the likelihood of suicidal behaviour, and protective factors that reduce it. These risk and protective factors include: the physical and social environments; individual constitution, temperament, or developmental experiences; interpersonal relationships; alcohol and substance abuse; suicidal ideation and previous suicide attempts; and co-existing psychiatric disorders. The individual factors that affect suicide in Aboriginal people are no different than those found in other populations and communities, but the prevalence and interrelationships among these factors differ for Aboriginal communities due to their history of colonisation, and subsequent interactions with the social and political institutions of Canadian society.

Suicide is just one indicator of distress in communities. For every suicide there may be many more people suffering from depression, anxiety, and other feelings of entrapment, powerlessness, and despair. At the same time, every suicide has a wide impact affecting many people—family, loved ones, and peers who find echoes of their own predicament, and who sometimes may be prompted to consider suicide themselves in response to the event. The circle of loss, grief, and mourning after suicide spreads outward in the community. In small Aboriginal communities where many people are related, and where many people face similar histories of

personal and collective adversity, the impact of suicide may be especially widespread and severe.

Although much of the literature on suicide in the general population is relevant to the experience of Aboriginal people, there are specific cultural, historical, and political considerations that contribute to the high prevalence, and that require the rethinking of conventional models and assumptions.⁵

A narrative can be constructed to simplify the above picture and help us to understand the high rates of suicide among Aboriginal and Torres Strait Islander children and young people.



This narrative is supported by the data in the text box below.

Young people and stressors

A family stressor is an event or circumstance that a person considers has been a problem for them, or someone close to them. In the 2012–13 *Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS 2012-13)*, among approximately 13,000 respondents, 73% of Aboriginal and Torres Strait Islander peoples age 15 years and over reported that they, their family or friends had experienced one or more stressors in the previous year.⁶

For Aboriginal and Torres Strait Islander young people age 15 – 24 years, the most common reported stressors were the death of a family member or friend (31%); inability to get a job (24%); serious illness (19%); pregnancy (16%); mental illness (12%); and trouble with the police (12%).⁷

Youth concerns – Mission Australia Youth Survey 2013

- Almost one in five young Aboriginal people indicated they did not feel safe in their neighbourhood compared to one in 11 non-Aboriginal young people
- When asked about personal concerns, young Aboriginal people said they were extremely or very concerned about drugs (15% versus 8%), alcohol (14% versus 6%) and gambling (10.5% versus 3.5%) at higher levels than young non-Aboriginal people.⁸
- Young Aboriginal people are notably less likely to feel they can choose to go to university (45% versus 74%), travel (24% versus 43%) or get a job (42% versus 50%) after high school than their non-Aboriginal peers.⁹
- Young Aboriginal people are more likely to be looking for work than their non-Aboriginal peers (45% versus 33%).¹⁰ Getting a job was ranked as either extremely or very important by almost one in two young Aboriginal people compared to one in three non-Aboriginal people.¹¹
- One in five Aboriginal respondents did not have someone (not living with them) to turn to for support in a time of crisis compared to 1 in 10 non-Aboriginal respondent.¹²

Stressors on children

- In the 2008 National Aboriginal and Torres Strait Islander Social Survey, about two-thirds (65%) of Aboriginal and Torres Strait Islander children (aged 4–14 years) were reported to have experienced at least one stressor in the previous 12 months.¹³
- Among those who had been exposed to stressors, 40% had experienced just one stressor, 14% had experienced at least three types of stressors and 12% had experienced five or more stressors.¹⁴
- The most common types of stressors reported were death of close family member/friend (22%), problems keeping up with school-work (20%) and being scared/upset by an argument or someone's behaviour (19%).¹⁵
- The average daily number of full-time Aboriginal and Torres Strait Islander adult prisoners in Australia in the September quarter 2013 was 8,551, comprising 7,753 (91%) males and 798 (9%) females.¹⁶ This puts significant strain on Aboriginal and Torres Strait Islander families.

Bullying

- In the NATSISS 2008, rates of bullying were higher among children living in non-remote areas, where 12% of children had experienced bullying compared with 7% of children in remote areas.¹⁷
- Of those children who had been bullied, 34% said that their school attendance had been affected. More than one-third of children (38%) reported having trouble making friends, playing with other children or taking part in sport/leisure activities at school as a result of the bullying behaviour.¹⁸
- Children who had been bullied were more likely than those who had not been bullied to have problems sleeping (31% compared with 20%).¹⁹

Contemporary impacts of forcible child removals

The Western Australian Aboriginal Child Health Survey 2004 (WAACHS) reported that the children of Aboriginal carers who had been forcibly separated from their natural family by a mission, the government or welfare:

- were 2.3 times more likely to be at high risk of clinically significant emotional or behavioural difficulties after adjusting for age, sex, remoteness and whether the primary carer is the birth mother of the child.
- were more likely to be at high risk of clinically significant emotional symptoms, conduct problems and hyperactivity.
- had significantly higher rates of overall emotional or behavioural problems in the 6 months prior to the survey.
- had levels of both alcohol and other drug use that were approximately twice as high as children whose Aboriginal primary carer had not been forcibly separated from their natural family²⁰

Multiple and severe exposure to stressors can lead to psychological distress.

The WACCHS 2004 surveyed approx 5300 Aboriginal children: around 25% of WA's Aboriginal and Torres Strait Islander child population and 15% of WA non-Indigenous children as a comparator. Based on the survey it estimated:

- 26% of Aboriginal children aged 4 to 11 years were at high risk of clinically significant emotional or behavioural difficulties, compared with 17% of children in the non-Aboriginal population from the same age group.
- For Aboriginal children aged 12 to 17 years, 21% were at high risk of clinically significant emotional or behavioural difficulties, compared with 13% of children in the non-Aboriginal population from the same age group.²¹

The factor most strongly associated with high risk of clinically significant emotional or behavioural difficulties in children was the number of major life stress events (e.g. illness, family break-up, arrests or financial difficulties) experienced by the family in the 12 months prior to the survey.²²

In the NATSISS 2008, children who experienced stressors reported lower rates of excellent/very good health than those who had not experienced stressors (73% compared with 83%).²³ Children who experienced stressors also reported to have missed more days at school in the last week (29% compared with 21%).²⁴

In the AATSIHS 2012–13, respondents over 18 years of age were asked questions about their feelings, and the frequency of those feelings, to indicate levels of psychological distress. Based on this, the survey reported 30% of respondents over 18 years of age as having high/very high psychological distress levels in the four weeks before the survey interview.²⁵ In our estimation, the finding of higher rates of psychological distress among people over 18 could be expected to apply to those in younger age groups.

Suicidal thoughts and suicide attempts among Aboriginal young people

The 2004–05 *Western Australian Aboriginal Child Health Survey* included a sample of 1480 ‘young people’ (age 12–17 years).²⁶ Among these, in the 12-months prior to the survey, it reported:

- An estimated 15.6% had seriously thought about ending their own life. Significantly fewer males had had suicidal thoughts (est. 11.9%) compared with females (est. 19.5%). There were no statistically significant differences between young people in major cities, regional areas and remote and very remote areas.²⁷
- Being female, at high risk of clinically significant emotional or behavioural difficulties or being exposed to family violence, experiencing racism, and having low self-esteem or friends who have attempted suicide were all associated with suicidal thoughts. These variables are also associated with each other.²⁸
- An estimated 6.5% had tried to end their own life: 9% of females and 4.1% males. The proportion of young people who had attempted suicide was significantly lower in areas of extreme isolation (1.2 per cent). All other areas had similar proportions of young people attempting suicide.²⁹

Suicide

There were 996 Aboriginal and Torres Strait Islander suicide deaths registered across Australia between 2001 and 2010. Suicides accounted for 4.2% of all registered Aboriginal and Torres Strait Islander deaths in 2010, compared with 1.6% for all Australians. The overall Aboriginal and Torres Strait Islander suicide rate was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females.³⁰

The greatest difference in rates of suicide between Aboriginal and Torres Strait Islander people and non-Indigenous people was in the 15–19 years age group for both males and females. Suicide rates for Aboriginal and Torres Strait Islander females aged 15–19 years were 5.9 times higher than those for non-Indigenous females in this age group, while for males the corresponding rate ratio was 4.4.³¹

2. The incidence and factors contributing to contagion and clustering involving Aboriginal and Torres Strait Islander children and young people.

Suicide clusters are a particularly distressing face of the Aboriginal and Torres Strait Islander suicide problem. Each suicide has a wide impact affecting many people—family, loved ones, and peers who may be prompted to consider suicide themselves in response. But in small Aboriginal and Torres Strait Islander communities where many people are related, and where many people face similar histories and challenges, the impact of suicide may be especially widespread and severe.

For example, over 2007, 21 deaths by suicide occurred in the Kimberley region of WA: 13 in the small community

of Fitzroy; five in Oombulgurri; and five in Balgo. A Coronial inquiry found that appalling social and economic conditions, combined with high levels of alcohol and cannabis use were associated with the suicides.³²

While we are not in a position to provide information about the age of those who committed suicide, we would expect that many were young people and young adults, in line with nationally gathered data on suicide among Aboriginal and Torres Strait Islander peoples.

A 2011 report *Suicide of Children and Youth in the Northern Territory* reviewed 18 Coronial inquests with the finding of death by suicide in people under 18-years of age in the Northern Territory over 2006-2010.³³ This reported that:

The strength of evidence about family transmission of suicide suggests that it may be possible to specify mechanisms for the rapid increases in rates of suicide and the clustering of suicides within Aboriginal communities. These include the following:

1. Exposure of Indigenous people to multiple sources of adversity, beginning in early child development and including impaired parenting, neglect and abuse, early loss, chaotic family situations and changes of caregiver, with adversities recurring throughout later development;
2. Exposure to high levels of early stress related to impaired impulse control and poor tolerance of stress;
3. Exposure of children to family and network burden of suicide: suicide threats, attempts and completions by parents and other related kin;
4. Adolescents attempting suicide impulsively reacting to criticism, rejection or attack by kin (including refusal to meet demands for money or other items); reacting to conflict in relationships with boy- or girlfriends;
5. Adolescents and young adults, including young parents, threatening suicide in the course of conflicts relating to demands over access to money, alcohol or marijuana;
6. Young males mainly in 20-35 year age group in crises of attainment relating to failure in relationships, lack of employment and opportunity, trouble with police and other issues in contexts of chronic heavy drinking and substance abuse.³⁴

3. The barriers that prevent children and young people from seeking help.

There is little available evidence on this topic. However, it could be expected that many of the issues that act as barriers to Aboriginal and Torres Strait Islander peoples in general accessing health services would also prevent young people and children seeking help. This includes lack of available services and access to services for reasons of distance, expense, language and so on.

Where services are available it would appear that children and young people are accessing them, although because need is hard to quantify it is not clear if total needs are being met. For example, in its response to questions at Senate Estimates in 2011 -12, Headspace reported that about 10 per cent of its clients 12 – 25 years of age over 2010-11 were Indigenous.

A service-by-service breakdown, presented in Appendix 1, suggests strong demand (significantly above proportional representation) for youth mental health services not only in the Kimberley, central Australia and the Top End, but also in Sydney and urban centres. While not all of these clients would be presenting with suicidal ideation it does suggest a high level of demand where services child and youth mental health services available.

One of the important contributions the Aboriginal and Torres Strait Islander Mental Health Advisory Group made to suicide prevention was to develop a set of *Operational Guidelines Access To Allied Psychological Services Program (ATAPS) Aboriginal and Torres Strait Islander Suicide Prevention Services*.³⁵ We believe these guidelines for suicide prevention services for people who have attempted, or are at risk of, suicide hold great promise including beyond the ATAPS scheme. This is because they ensure a culturally appropriate service at the very time when a vulnerable Aboriginal and/or Torres Strait Islander person is likely to need it most. This includes, in particular, for young people and children for whom a mainstream service may otherwise be particularly daunting.

Guidelines for ATAPS suicide prevention services for Aboriginal and Torres Strait Islander peoples.

These included quality indicators for services to:

- provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their live and to mitigate the reverberations from suicide in the client's community;
- be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety;
- establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations; and
- be based on Aboriginal and Torres Strait Islander peoples' definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.³⁶

The guidelines establish that a high quality, culturally competent service will be made available by ensuring:

- Aboriginal and Torres Strait Islander peoples that are providing services should have the appropriate level of skills and qualifications to deliver services;
- Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples are provided with opportunities to develop the appropriate level of skills and qualifications to deliver services; and
- non-Aboriginal and Torres Strait Islander professionals and administrators have undertaken mental health cultural safety training that perpetuates the National Practice Standards within a social and emotional wellbeing framework, and promotes the appropriate skills, knowledge, and attitudes required to optimally deliver mental health services to Aboriginal and Torres Strait Islander peoples, including those of the Stolen Generation.³⁷

In part, whatever barriers to services exist will be remaining in place because mainstream services collecting data on Aboriginal or Torres Strait Islander status across general health and social conditions continues to be inconsistent -- despite being considered mandatory in many states. This also undermines our ability to better understand or respond to suicidal behaviour or other forms of distress. Improving identification of Aboriginal and Torres Strait Islander peoples should be a high priority for all governments and community services providing care to people. Financial rewards and penalties could be applied to services reporting 'unknowns' and random audits could be applied to services to determine accuracy of the 'known' within data sets as a routine quality control measure.

4. The types of programs and practices that effectively target and support Aboriginal and Torres Strait Islander children and young people

Very few Aboriginal and Torres Strait Islander suicide prevention programs, and in particular dedicated child and youth programs, have been formally evaluated. Such an evaluation is necessary before we can begin to identify 'what works'. What follows is an extract from the 2013 Close the Gap Clearinghouse report *Strategies to minimise the incidence of suicide and suicidal behaviour*³⁸ that summarises formally evaluated programmes to date. The first, an evaluation of a program based in Yarrabah, is an example of a community-based program that aims to improve the wellbeing of the whole community as an address to suicide. These types of programs are also discussed further on in our submission.

A summary of formally evaluated Aboriginal and Torres Strait Islander suicide prevention programmes

There are few evaluations of Indigenous-specific suicide prevention programs in Australia. The Australian Psychological Society notes:

Notwithstanding the acknowledged problems of undertaking program evaluation or outcome research, this is clearly a priority in a confusing cross-cultural domain where multiple contextual and situational health determinants complicate any simple causal picture, and where the efficacy of many programs has been called into doubt (APS 1999:33–34).

... There are however, several Australian Indigenous programs that have either been shown to be effective in reducing the number of suicides, or have increased the awareness, knowledge and capacity to respond, of community members, peer mentors and service providers.

Yarrabah Family Life Promotion Program—an effective suicide prevention program

In response to the high number of suicides in Yarrabah, Far North Queensland, the community identified suicide as a 'community issue' and an urgent priority in the early 1990s. Initially the focus was on crisis clinical support for individuals at risk of suicide, however over the next 2 years there was a gradual shift to a broader approach that focused on community wellbeing (Hunter et al. 1999).

A component of the program evaluation involved comparing the number of suicides in Yarrabah with the numbers in two comparison communities over the period 1990–96. Based on the results of this analysis, the Yarrabah Family Life Promotion Program was found to be effective in preventing suicides (Hunter et al. 1999).

Data obtained from the Australian Institute for Suicide Research and Prevention for the period 1990–2008 enabled investigation of the longer-term impact of the program (AISRAP personal communication). The data show that after the implementation of the program, there were no suicides in Yarrabah between 1997 and 2000. Between 2001 and 2008 there were seven suicides, but fewer than before the implementation of the program, when 17 suicides occurred between 1990 and 1996.

Prior to 1996, more suicides occurred in Yarrabah than in the two comparison communities, but between 1997 and 2008 there were fewer suicides in Yarrabah than in either comparison community. While the small sample sizes mean that tests of statistical significance are inconclusive and firm conclusions cannot be drawn regarding the effectiveness of the program in preventing suicides, the trends in Yarrabah and the two comparison communities indicate that the Yarrabah Family Life Promotion Program is promising.

Two programs that have not been rigorously evaluated, but suggest good practice, are:

- Alive and Kicking Goals! is a project piloted in the Kimberley, Western Australia. It aims to prevent Indigenous youth suicide through the use of football and peer education. Volunteer youth leaders, who are well-respected sportsmen, undertake training to become peer educators. They educate young people in communities about suicide prevention and lifestyle, and demonstrate that seeking help is not a sign of weakness. At the conclusion of the pilot, 16 young men had become peer educators (Tighe & McKay 2012). The project is ongoing, but its impact on suicide numbers has not been evaluated.
- Indigenous suicide prevention training forums attended by Indigenous people and service providers in the Kimberley and North West regions of Western Australia have been shown to increase attendees' knowledge of depression and suicidal behaviour, their skills in working with depressed and suicidal Aboriginal people and their intentions to help (Westerman & Hillman 2003). While these results were presented as a poster at a suicide prevention conference, rather than in a peer reviewed journal, *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (Purdie et al. 2010) identified the forums as providing culturally appropriate training in suicide prevention. The forums were also identified as promising in the literature review - *Current approaches to Aboriginal suicide prevention* (Kirmayer et al. 2009).³⁹

While it is not possible to identify what works in suicide prevention on the basis of formal evaluations, it is possible to glean emerging best practice from the opinions of communities who have addressed suicide, experts and those with experience in the field. What follows is a summary of such practice at three levels of intervention:

- For children and young people at immediate risk of suicide
- For at children and young people as an at risk group
- For whole communities, including children and young people.

In relation to the first point, see the previous section of this submission numbered '3' where the importance of culturally competent suicide prevention services is discussed.

For at children and young people as an at risk group

As noted previously, the data highlights the need for suicide prevention services to maintain a focus on working with young people and young adults as a priority group. This is not only in relation to those among those who are immediately 'at risk' but also, in a truly preventative approach, to address the developmental factors that can predispose a person to suicide and can occur at a relatively early age.

The now defunct National Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group, developed the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.⁴⁰ As noted in this:

There is growing evidence that, in order to reduce rates of suicidal behaviour and suicide over the longer term, measures should also be put in place to address the developmental precursors of suicide and suicidal behaviour. These measures should be targeted to reduce the impact of adversities over the lifespan and to support healthy social and emotional development from early childhood through to young adulthood. It is especially important that there is intervention to support children and young people growing up in adverse family environments, to reduce early emotional and behavioural problems.

Preventive responses should include parenting programs and therapeutic interventions for high risk families and children, and a mix of therapeutic, supportive and competency-building or “life skills” interventions for youth in schools or in post-secondary training, as well as for those who are unemployed or entering the workforce. In many contexts, young people leaving school struggle to undertake further training or to stay in work and are in need of counselling and support.

For young people and adults who have been arrested, incarcerated or placed under residential supervision, including mandated residential treatments for drugs and alcohol, the transition back to their communities is often poorly supported. Given that substance misuse, mental health issues and problem behaviours leading to arrest or incarceration commonly co-exist, it is increasingly important that prevention policies focus on their common precursors in human development. There needs to be a shift towards collaborative, cross-sectoral approaches to treatment and prevention to treat both current risk and its developmental precursors.⁴¹

For whole communities, including children and young people

Interventions to prevent suicide among the whole Aboriginal and Torres Strait Islander population including children and young people require acknowledgement of the diversity of community and other settings in which Aboriginal and Torres Strait Islander peoples live. In fact, this diversity necessitates a whole of population approach that is community focused and is flexible enough to accommodate the differences between communities.

Identifying the risk and protective factors for suicide, requires an in-depth knowledge of the historic, cultural and economic risk factors at play in each community. These are best known and understood by community residents themselves. As noted by the National Mental Health Commission in its 2013 Report Card:

For those communities more vulnerable to suicide, targeted interventions are needed. We can see the importance of such a tailored approach, which is designed by and with – not for – community members when we look more closely into what is known about effective approaches for suicide prevention among Aboriginal and Torres Strait Islander peoples.⁴²

Aboriginal and Torres Strait Islander peoples describe their physical and mental health as having a basis of ‘social and emotional wellbeing’ originating in a network of relationships (or connections) that includes between the individual and their community traditional lands, family and kin, ancestors and the spiritual dimension of existence.⁴³ Life is understood in holistic terms: with the health of individuals and communities evident not simply by the absence of disease but linked to their ‘control over their physical environment, of dignity, of community self-esteem, and of justice’.⁴⁴

Social and emotional wellbeing can be thought of as a protective factor and a source of resilience against the challenges of life, including those that impact on mental health and can lead to suicide.

From the domains of social and emotional wellbeing, a positive cultural identity has been reported to assist Aboriginal children and young people to navigate being an oppressed minority group in their own country;⁴⁵ and provide meaning in adversity.⁴⁶ As a further example, the Western Australian Aboriginal Child Health Survey 2004 (WACCHS) reported clinically significant emotional or behavioural difficulties were lowest in areas of extreme isolation, where adherence to traditional culture and ways of life was strongest.⁴⁷

Challenges to social and emotional wellbeing can undermine resilience and leave individuals and communities exposed to distress and trauma without a countering protective force.

The ‘Hear Our Voices’ Report on Community Consultations for the Development of an Empowerment, Healing and

Leadership Program for Aboriginal people living in the Kimberley, Western Australia (2012) reported that Aboriginal people have particular conceptions and understanding of healing, empowerment and leadership based on their historical, political and social experiences and cultural values and that there is a high level of need for a range of culturally appropriate and locally responsive healing, empowerment and leadership programs and strategies.⁴⁸

However, programs need to address empowerment in different ways, for different groups and in multiple settings, to accommodate differing levels of need and community, family and individual readiness. Culture was seen as a core component of any program. Importantly, the content, design and delivery of programs need to have legitimate community support and engagement, and be culturally appropriate, locally based and relevant to people's needs. Empowerment programs could prove to be effective strategies for enhancing social and emotional wellbeing and addressing suicide risk factors, especially among young people.⁴⁹

As highlighted in Appendix 2, the National Empowerment Project is an example of a programme that has such a potential: being a method that is able to be applied universally, yet produces results tailored to each community's needs.

We believe the principles set out in the following text box are critical to the success of such programs operating at the community level.

Principles for suicide prevention programmes operating at the community level

- Community control and empowerment: projects should be grounded in community, owned by the community, based on community needs and accountable to the community.
- Holistic: based on Aboriginal and Torres Strait Islander definitions of health incorporating spirituality, culture and healing.
- Sustainable, strength based and capacity building: projects must be sustainable both in terms of building community capacity and in terms of not being 'one off'; they must endure until the community is empowered. For example provide Aboriginal and Torres Strait Islander workforces and community members with tools for awareness, early identification and for responding to self-harm issues within the community.
- Partnerships: projects should work in genuine partnerships with local Aboriginal and Torres Strait Islander stakeholders and other providers to support and enhance existing local measures not duplicate or compete with them.
- Safe cultural delivery: projects should be delivered in a safe manner.
- Innovation and evaluation: projects need to build on learnings, try new and innovative approaches, share learnings, and improve the evidence base.

Cultural continuity

In communities with 'cultural continuity', young people have a sense of their past and their traditions and draw pride and identity from them. By extension, young people also conceive of themselves as having a future (as bearers of that culture).⁵⁰

Research by Canadian Professor Michael Chandler among Canadian Indigenous communities shows that poor cultural continuity can result in communities where young people are at a much higher risk of suicide.⁵¹ While the implications of this research are yet to be fully explored, including their application in Aboriginal and Torres Strait Islander settings, and in urban settings, the research suggests a highly productive line of inquiry and potential policy development in relation to suicide prevention (and more broadly, Aboriginal and Torres Strait Islander

peoples' mental health and social and emotional wellbeing) based on cultural maintenance and reclamation.

Cultural continuity can be understood in broad terms as self-determination and cultural maintenance.⁵² In Professor Chandler's work a range of cultural continuity indicators were identified. These included: self-government; land claims; community-controlled services, (including police and fire services, health services, child protection and education services); knowledge of indigenous languages; women in positions of leadership; and facilities dedicated to cultural purposes. The number of indicators present correlated to decreased suicide rates in communities.⁵³

Professor Chandler's work supports approaches that have been explored in Aboriginal and Torres Strait Islander communities in the past two decades and that have common threads of cultural reclamation and community empowerment running through them.⁵⁴ This includes the National Empowerment Project that is featured in Appendix 2 of this submission.

5. The impediments to the accurate identification and recording of intentional self-harm and suicide in Aboriginal and Torres Strait Islander children and young people, the consequences of this, and suggestions for reform.

Part of the difficulty associated with assessing suicide prevention activity in Australia (let alone suicide prevention among Aboriginal and Torres Strait Islander children and young people) is the lack of baseline information about rates of suicide against which to assess the success of programmes. This is because of differences in reporting standards, difficulty determining intent, delays in coronial verdicts, and insurance- and stigma-related barriers. While we acknowledge that Australia is currently attempting to standardise suicide reporting across the country, the difficulty in establishing an evidence base for what works against such a background is difficult.

In particular among Aboriginal and Torres Strait Islander communities, disaggregation to the local or community level to account for the fact that different communities can have different rates of suicide (from endemic to no recorded cases) is important. This will enable the proper targeting of resources and the identification of policy directions based on what communities with no or little suicide are doing that is different. National, state and territory statistics, or statistics by health jurisdiction, mask these variations and become of limited meaning. In some cases, non-disaggregated data can be positively misleading: in the breach, policy makers and researchers can assume risk factors that have no determining impact on suicide rates (for example, the remoteness of communities).

We therefore recommend that in addition to greater efforts to record suicidal ideation, suicide and self-harm accurately that community level disaggregation occurs to alert policy makers and communities to suicide clusters and priority locations for suicide prevention activities.

Given the relative lack of evidence-base upon which to build Aboriginal and Torres Strait Islander suicide prevention programs and services, a strengths-focused research agenda to build such is an important part of any comprehensive response to Aboriginal and Torres Strait Islander suicide. In part, this could be evaluating, as much as possible, existing programs.

This should occur under Aboriginal and Torres Strait Islander leadership. Such control of research has become firmly embedded in the guidelines for the ethical conduct of research with Aboriginal and Torres Strait Islander peoples. This reflects not only the human rights of Aboriginal and Torres Strait Islander peoples, but also good practice.⁵⁵

Further, as highlighted by the National Mental Health Commission there is a need to do research differently when it comes to suicide prevention. In particular, to begin to undertake sensitive qualitative research among people who have attempted suicide but survived and the surviving family members and kin of people who have taken their lives. This is in contrast to the epidemiological approaches that dominate research at the moment.⁵⁶

Finally, participatory action research (PAR) should be promoted in Aboriginal and Torres Strait Islander communities. This proceeds through repeated cycles, in which researchers and communities start with the identification of priority issues, originate action, learn about this action and proceed to a new “research and action cycle”. This process is a continuous one that empowers Indigenous perspectives . Participants in PAR projects continuously reflect on their learning from the actions and proceed to initiate new actions on the spot – potentially bringing immediate benefit.⁵⁷

PAR generates knowledge and shared understanding to mobilise collaborative action for change. Central to this is the collective ownership of the research processes and outcomes. In this sense, research becomes a process for change directed by those most affected by the issues being examined. Undertaken correctly, PAR can support the collective ownership of the research process and its outcomes. As noted in Appendix 2 we discuss the National Empowerment Project that is an example of PAR in action with outcomes that include suicide prevention.

Thank you again for providing the opportunity to make this submission to your inquiry. Please note that Mr Chris Holland is the best point of contact for office-to-office communications.

I look forward to hearing from you.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Pat Dudgeon', written in a cursive style.

Professor Pat Dudgeon
Chair
National Aboriginal and Torres Strait Islander Leaders in Mental Health

Appendix 1: Service by service breakdown of Headspace indicating the proportion of Aboriginal and Torres Strait Islander clients 12 – 25 years of age against their representation in the population

Centres	All Clients	Indigenous Serviced Clients	Indigenous Serviced Clients	Population 12-25 yrs	Indigenous Pop 12-25 yrs	Indigenous Pop 12-25 yrs
ACT	892	40	4.5%	83,663	116	0.1%
Adelaide Northern	971	43	4.4%	42,355	1,174	2.8%
Barwon	1454	20	1.4%	47,168	456	1.0%
Central Australia	768	333	43.4%	8,462	4,041	47.8%
Central Coast	1515	129	8.5%	52,332	1,820	3.5%
Central Sydney	975	79	8.1%	52,873	857	1.6%
Central West						
Gippsland	512	23	4.5%	20,705	352	1.7%
Fraser Coast	456	51	11.2%	12,309	551	4.5%
Fremantle	1141	55	4.8%	62,919	1,145	1.8%
Gold Coast	1933	82	4.2%	128,599	2,833	2.2%
Great Southern	195	13	6.7%	9,055	431	4.8%
Hunter	405	49	12.1%	96,677	3,613	3.7%
Illawarra	727	25	3.4%	50,869	1,359	2.7%
Kimberley	339	132	38.9%	6,001	3,119	52.0%
Macarthur	1075	76	7.1%	57,984	1,619	2.8%
Mid North Coast	639	62	9.7%	16,299	2,700	16.6%
Mount Druitt	668	79	11.8%	56,335	1,928	3.4%
Murraylands	394	24	6.1%	5,648	301	5.3%
Northern Melbourne	475	12	2.5%	104,057	979	0.9%
Northern Tasmania	1416	39	2.8%	24,611	937	3.8%
NSW Central West	1031	34	3.3%	12,395	600	4.8%
Peninsula	690	14	2.0%	44,906	378	0.8%
Riverina	1730	145	8.4%	18,168	856	4.7%
Riverland	277	18	6.5%	5,389	186	3.5%
Southern Downs	441	43	9.8%	7,519	331	4.4%
Southern Melbourne	1045	8	0.8%	88,185	196	0.2%
South West Victoria	487	26	5.3%	17,619	302	1.7%
Top End	547	80	14.6%	28,474	6,639	23.3%
Townsville	1023	40	3.9%	22,136	1,408	6.4%
Western Melbourne	1250	17	1.4%	99,325	623	0.6%
Total	25471	1791	7%	1,283,037	41850	3%

Appendix 2: The National Empowerment Project

[An extract from the Executive Summary of the unpublished report of the National Empowerment Project.]

The National Empowerment Project (NEP) is an Aboriginal-led initiative that undertook research with eight Aboriginal communities over 2013. These communities included:

- Western Australia: Narrogin, Perth and Northam/Toodyay;
- Queensland: Cherbourg and Kuranda;
- New South Wales: Toomelah and Redfern; and
- Victoria: Mildura.

The purpose of the project was to have each community identify factors impacting negatively on the social and emotional wellbeing of individuals, families and the community itself. At the same time, each community was asked to identify strategies that could work to strengthen social and emotional wellbeing including through building on cultural strengths. Stage 2 of the project will support communities to implement these strategies.. In so doing, the project aims to increase resilience of individuals and families and hopefully reduce levels of psychological distress and suicide in each of the communities.

The Project is an exemplar of the application of participatory action research in Aboriginal and Torres Strait Islander communities. This is an empowerment-based research approach that gives a voice to communities to identify factors impacting on social and emotional wellbeing, and supports them to take community-identified action to benefit their communities.

The main findings from this research are:

First, while the eight communities were very different in size, location, history and levels of remoteness, all identified a similar range of challenges, although the priority allocated to each challenge varied considerably.

Issues identified as impacting negatively on social and emotional wellbeing included:

- problems with youth;
- family disharmony/feuding/violence;
- substance abuse;
- mental health issues;
- the intergenerational and trans-generational impacts of forced child removals;
- racism;
- lack of education;
- lack of employment;
- lack of housing
- lack of transport; and
- lack of services.

Second, along with similar challenges, all eight communities identified a similar set of actions required to strengthen the cultural, social and emotional wellbeing of individuals, families and the community itself; and in particular, to overcome the challenges impacting negatively on community wellbeing and contributing to distress and suicide.

Common themes included:

- To strengthen communities:
 - by focusing on youth – by providing activities, drop in centres, camps, by connecting youth to elders, by providing health promotion and education sessions, parenting programmes, and by restoring sporting competitions;
 - by strengthening the sense of community - through shared activities and community events such as fun days, competitions and projects;
 - by supporting self-determination;
 - by supporting men’s and women’s groups;
 - by providing access to employment, education, housing and transport; and
 - by addressing family violence and substance abuse;

- To strengthen families:
 - by restoring and strengthening positive relationships and connections within and between families through shared activities (as above, this will also help to restore sense of community);
 - by providing a range of life skills programmes such as those addressing communication skills, dealing with conflict, and healthy lifestyle;
 - by providing programmes to address family violence and substance abuse;
 - by providing access to education/training and transport.

- To strengthen individuals:
 - by restoring and strengthening connections to culture, family and community;
 - by focusing on youth (as above);
 - by focusing on health;
 - by providing a range of life skills programmes, such as on communication skills and building self-esteem, and that include mentors and role models; and
 - by providing programmes that address family violence and substance abuse issues.

Critically, participants also said they wanted to be involved in designing and delivering any subsequential programmes for their communities.

While identifying common issues and solutions, each community also differed in the emphasis it gave to each issue. While some communities prioritised the need to address social and emotional wellbeing problems (such as family violence and substance abuse) others gave priority to addressing the social determinants (such as lack of education, employment and transport).

Key stages in the history of the NEP included:

- The earlier research and publication of the Kimberley Empowerment Project *Hear our Voices Report* (Dudgeon et al 2012), and its recommendations for empowerment, healing and leadership programmes as a tool for preventing suicide and psychological distress. This approach was taken to a national level in the NEP.
- The establishment of a National Advisory Committee comprising experts and leaders in social and emotional wellbeing and related areas, with terms of reference that included oversight of all significant NEP activity.
- The NEP Team building relationships with eight communities and formal relationships with Aboriginal partner organisations in each.

- The NEP Team, with the help of partner organisations, selecting two people in each community to be employed as Community Consultant Co-researchers (co-researchers).
- The co-researchers, with training and support from the NEP Team, undertook community consultations in each site that involved focus groups and interviews.
- The co-researchers, with training and support from the NEP Team, delivered a two-day cultural, social and emotional wellbeing workshop with the purpose supporting community members to exert greater control over their social and emotional wellbeing. In this participants were asked to consider ways to strengthen their connections to the domains of social and emotional wellbeing: that is to family, community, country, spirit and spirituality, body, mind and emotions. In particular, participants were asked to identify and focus on the strengths they found within each domain and to identify actions they could take to strengthen their connection to these protective factors.

Stage 2 will involve further work to support individuals to work on some of the risk factors in the domains of social and emotional wellbeing, to restore some of the 'losses' and to further strengthen their connection to protective factors. As participants grow stronger, it is hoped their psychological distress will decrease and their resilience will increase, with an accompanying decrease in the risk of suicide.

A further important element of the NEP process involved participants considering how empowerment programmes could be developed. These are intended to support each community to exert greater control over its social and emotional wellbeing by taking the steps each identified as necessary to address or minimise risk factors and increase the benefits of protective factors at individual, family and community levels. An additional purpose of these programmes is to increase resilience and reduce psychological distress and rates of suicide in the community.

Participatory action research as a method for working in Aboriginal and Torres Strait Islander communities has merit. Participatory action research (PAR) has been used successfully in Aboriginal and Torres Strait Islander contexts as an engaging research approach to strengthen and empower communities.

The success of NEP in engaging communities confirms the appropriateness of this approach in the development of a universal, context specific health promotion and primary prevention strategy for reducing suicide and psychological distress in communities. That is, PAR builds on the cultural strengths identified at an individual, family and community levels in order to address the risk and protective factors within groups and to enhance their social and emotional wellbeing. This allows for diversity among communities to be recognised and avoids the pitfalls of 'one size fits all' approach.

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- ⁸ Mission Australia, 2013, Youth Survey 2012, <http://www.missionaustralia.com.au/daily-news/2842-survey-finds-young-aboriginals-feel-more-unsafe-concerned-about-alcohol-drugs-and-gambling-than-other-youth>
- ⁹ Mission Australia, 2013, Youth Survey 2012, <http://www.missionaustralia.com.au/daily-news/2842-survey-finds-young-aboriginals-feel-more-unsafe-concerned-about-alcohol-drugs-and-gambling-than-other-youth>
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