Discussion Paper on a Statewide Aboriginal Suicide Postvention Project

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1. Background

Active Response Bereavement Out Reach, also known as ARBOR, is a postvention program designed to assist people bereaved by suicide. The pilot of ARBOR began in March 2007, and has been funded until August 2009. Funding has come from the Commonwealth Department of Health and Ageing through the National Suicide Prevention Strategy, and the project is being managed by the Telethon Institute for Child Health Research and the Centre for Developmental Health (Curtin University of Technology).

ARBOR was modelled from a successful US program called LOSS, founded by Frank Campbell (1997), and Campbell and colleagues (2004). Like the LOSS program, the ARBOR project aims to reduce the occurrence of complicated grief reactions following suicide by providing early intervention and support during the initial stages following a suicide. The project works closely with other support services and the community to provide support services for people in the community bereaved by suicide.

Since its inception, ARBOR has assisted many families and individuals in the Perth Metropolitan area in accessing the support and resources needed following the completed suicide of a love one. The program offers a range of services to people bereaved by suicide including *home visits*, *peer support*, *counselling* and *support groups*. *Home visits* are where a grief counsellor and a peer supporter visit bereaved families at their home and provide initial support. The *peer supporters* are trained volunteers who have also been bereaved by suicide and are able to provide help by sharing how they worked through their grief, and play an essential role in the ARBOR project. Peer supporters are also available for additional *peer support sessions*. ARBOR also provides *short term counselling* with a grief counsellor for those in need of one-on-one support. Bereaved individuals needing more long-term counselling are assisted in finding an appropriate service that will be able to provide ongoing support. The s*upport groups* provide a safe environment for people bereaved by suicide to share their experiences with other bereaved people.

The ARBOR project is a mainstream service; in that it has been developed for the wider Perth population. However, the program has potential to offer effective service for Aboriginal people bereaved by suicide. A particularly promising aspect is an outreach service that would be delivered at no cost to the consumer. Another strength is its use of peer supporters to be able to help others through their difficult and lonely time.

This paper discusses the complexities of grief, loss and suicide for Aboriginal Australians, and in Aboriginal communities. It recognises that while there are similarities in the process of grief following a suicide for any group, there are also cultural differences, which must be taken into consideration when in service delivery, particularly to Aboriginal people. Therefore this paper also discusses the current status of suicide bereavement support for Aboriginal people, and proposes a state-wide model of Aboriginal suicide postvention in Western Australia.

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2. Literature Review

2.1. Introduction

This paper will describe the general historical context of Aboriginal Australia as this is relevant to any counselling approach with Aboriginal people. Discussion about the local context of ARBOR operations in the Metropolitan area of Perth, Western Australia. Further, as well as the local original Nyungar people of the Perth area, the many other Indigenous cultures from all parts of the country who have located to Perth as the major urban centre also requires inclusion. The differences and diversity among Aboriginal and Torres Strait cultures that make up the Aboriginal population needs to be acknowledged and respected when delivering any service to the community.

Aboriginal suicide attempts and completion rates are different to that of the general population. Characteristics of suicidal and self-harm behaviours are also different and with suicide clusters at certain times and locations, occurring more frequently than in the mainstream population. The cycle of grief and loss for Aboriginal people receives little attention. These differences require different frameworks and interventions driven and informed by Aboriginal people and adapted to local groups in recognition of diversity (Hunter & Milroy, 2008; Elliot-Farrelly, 2004).

When considering any counselling interventions for Aboriginal people counsellors/mental health professionals need to be aware of the complexities in the population that are a result of inappropriate historical practices and that either were a part of historical oppression or at best, inappropriate where the needs of Aboriginal people remained unresolved. There are also important cultural differences that need to be acknowledged, respected and part of any mental health intervention.

A brief overview of relevant services that have worked effectively with other Aboriginal people in colonized counties was considered. This is relevant as the Aboriginal people of other settler countries such as Canada, New Zealand and USA share similarities and issues and a common history of colonisation and dispossession. The effects this explain the common disadvantages suffered. Importantly, effective community based and culturally appropriate solutions from other Indigenous groups may provide particularly useful models for us to learn from. A particularly outstanding example is the approach adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) (a United States of America government department), in addressing American Indians and Alaskan Natives suicide prevention.

Interventions have been put in place in states across America as a result of suicides. Here the government works with and funds local communities to develop models of multidisciplinary approaches and outreach. This approach would work well with what has been proposed in parts of Australia, and developed through consultation with Aboriginal communities. The American models of intervention/education and postvention include a whole of community response and being available in 24 hours. Education programs focus on building the strengths and parenting practices of Aboriginal people (National Suicide Prevention Lifeline; Native American Community Initiative; NREPP SAMHSA's National Registry of Evidence-based Programs and Practices, 2007; Berry 2008).

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It is unfortunate that in Australia suicide bereavement support has not achieved national priority. Due to a lack of funding made available for appropriate or available services, the task of dealing with this issue has been taken up by Aboriginal and Torres Strait Islander community members who have trained workers in working with grief and loss. Aboriginal mental health workers and community members are starting to recognize and share their strengths with each other in coping and dealing with a range of mental health issues, including suicide bereavement support, that are complex and heartbreaking. Various models have been identified as useful in these situations. For instance, Aboriginal community people and counsellors who work with Aboriginal people have seen the value of Narrative Therapy as being the most culturally appropriate, as this is tied to our natural way of healing through 'yarning' (Casey, 2008). In the area of suicide bereavement, community people have struggled to understand and have put in place effective suicide bereavement strategies. Counselling support has been through primary health and mental health workers who require support and training in the area and access to qualified professionals for mentoring and professional support. Indigenous primary health and mental health counsellors are members of the Indigenous community and as such are subject to the same disadvantages faced by others within their families and communities. The workers themselves may well be grieving through suicide and grief and loss of loved ones.

Critical response treatment, like bereavement counselling as offered through ARBOR is essential following a completed suicide (Graham, Reser, Scuderi, Zubrick, Smith & Turley, 2000). However, such services may not be available for Aboriginal people and if so, these services are limited responses that are inadequate. As well as providing counselling for specific issues and ongoing healing, capacity-building communities to provide their own counselling and healing is an essential strategy with long lasting affects.

In a discussion about Canadian First Nation people and suicide, Chandler and Lalonde (in press) discuss the dangers of attempting to aggregate suicides especially with First Nations people and propose:

> "The idea of jamming all these unique peoples together into one catchall common denominator, with an eye toward computing some overall national or provincial suicide rate that is largely empty of meaning and borders on the bizarre" (p. 9).

The authors are conscious of Indigenous diversity and the limitations of representation, particularly as this discussion paper was developed largely from input from Aboriginal people living in the Perth area of Western Australia. Limited input from Aboriginal and non-Aboriginal people from locations across the state including the North West, Wheatbelt and Great Southern regions, the Northern Territory and Queensland was included. While Aboriginal and Torres Strait Islander people do share many fundamental similarities, there are differences in cultural group origins, experiences of local history, location such as urban and remote settings, degrees of cultural retention and reclamation that need to considered in making generalisations. For any suicide bereavement strategy to be effective within Aboriginal communities, it needs to be developed in consultation with Aboriginal people from various localities

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and cultural backgrounds. It should be stressed that must be accepted that the views in this paper are localized and therefore any postvention attempted in other areas must first meet with the approval of and be further developed to fit in with the local people of that area.

2.2. Historical Context – Psychological Impact

Aboriginal and Torres Strait Islander people, as the original inhabitants of this land, have suffered through the effects of colonization and dispossession. While these impacts have varied according to patterns of settlement, all Aboriginal people are living out the consequences of these impacts on their contemporary lifestyles. Disruption to Aboriginal cultural ways have varied, with some groups retaining language and cultural practices and others, particularly Aboriginal people in urban settings in a process of reclaiming these. Past policies, a part of the colonisation process, have had a profound detrimental effect on all aspects of Aboriginal people's lives, and the consequence of this has affected subsequent generations. After settlement, legislation was enacted across the country that resulted in the controlling measures on the lives of Aboriginal people. The Western Australian *Aborigines Act 1905* in this state marked the beginning of a period of formidable surveillance and oppression of Aboriginal people resulting in the forcible removal of children and internment of Aboriginal people onto bleak reserves and into lives of servitude and despair. The *Native Administration Act 1936* consolidated the power of the state over Aboriginal people.

The trauma that Aboriginal people have suffered through colonisation, past policies and ongoing social disadvantage and racism are seen in contemporary situations. Kelvin Gilbert, a Koori academic, summarised the situation of Indigenous people in 1977.

> "[T]hey were hit by the full blight of an alien way of thinking. They were hit by the intolerance and uncomprehending barbarism of a people intent only on progress in material terms, a people who never credited that there could be cathedrals of the spirit as well as stone. Their view of Aborigines as the most miserable people on earth was seared into Aboriginal thinking because they now controlled the provisions that allowed blacks to continue to exist at all. Independence from them was not possible….It is my thesis that Aboriginal Australia underwent a rape of the soul so profound that the blight continues in the minds of most blacks today. It is this psychological blight, more than anything else that causes the conditions that we see on the reserves and missions. And it is repeated down the generations" (Gilbert, 1977, pp. 2-3).

We continue to see the effects in family violence; drug and alcohol abuse; child and elder abuse; parents that lose their children through intervention from the state; excess of mental health issues; high mortality; shorter life spans, the loss of elders; and high suicide rates, mostly of young men. The traumas suffered during the process of colonisation, the loss and disruption of cultural traditions and loss of land still affects Aboriginal people today. There is a profound sadness that has not eased through time.

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The national *Overcoming Indigenous Disadvantage Report: Key Indicators 2005/2007 Reports* (Steering Committee for the Review of Government Services) shows that Indigenous people are the most disadvantaged group in Australia. Against a background of social disadvantage, Indigenous people suffer continuing levels of excess mortality and ill health. For example;

- The life expectancy of Aboriginal and Torres Strait Islander people is around 17 years lower than that of other Australians;
- Suicide death rates are much higher (up to 2.5 times higher than others)
- Homicide death rates are 6 times higher;
- Aboriginal and Torres Strait Islander people are 12 times more likely to be hospitalized for assault than other people;
- Both men and women experience more than double the victimization rates than others, and
- Aboriginal and Torres Strait Islander people, both men and women, are over four times more likely to be in hospital for alcohol-related mental and behavioural disorder than other people.

Torres Strait Islander people, whilst having their own distinctive culture, share many of the same disadvantages as Aboriginal people (Australian Bureau of Statistics 2006).

Colonisation has had many negative consequences for Indigenous people. One of the most profound has been the removal of Aboriginal children from their families. Most Aboriginal families have experienced removal of children or displacement of entire families into missions, reserves or other institutions. This was a widespread phenomena across the nation and as many as one in ten Indigenous children were forcibly removed from their families and communities in the first half of the 20th century. Various reports such as the *Bringing Them Home Report* (Human Rights and Equal Opportunity Commission, 1997) have shown that in certain regions, at different times the figure may have been much more. In that time, not one Aboriginal family escaped the effects of forcible removal, and most families have been affected over one or more generations. The transgenerational effects of the policies of forced removal of Aboriginal children on Aboriginal emotional and social wellbeing are profound and enduring. Many of the current issues faced by Aboriginal people today are the result of past practices and loss, as well as ongoing racism and discrimination at individual and institutional levels. Hunter and Milroy (2006) in examining Aboriginal and Torres Strait Islander suicide in context proposed that as well as culturally appropriate strategies, research and interventions are required, social changes leading to the empowerment of Aboriginal and Torres Strait Islander families and communities is of fundament importance.

Aboriginal culture prior to colonisation had characteristics and a range of mechanisms that addressed conflicts in relatively healthy ways. Roe (2000) wrote about how in the Aboriginal culture before colonisation, if a person felt negative about another person, they would approach them and express their feelings rather than suppressing it, and this would clear their ‘centre’. In the old days our ways were to resolve conflicts quickly; to get rid of it quick or it will kill you. Nowadays, Aboriginal people are not expressing themselves in a healthy way and the arguments that occur are at times blown out to include the entire family and can become what is termed “family feuding”.

In his discussion about Aboriginal youth suicide, Roe (2000) wrote:

> "…we have to look at the group that is vulnerable – alienated, kicked out of school, and put in a corner feeling they're no good....this leads to a sense of hopelessness, lack of confidence and self-esteem that is also handed down from parent to child. Many young people especially Aboriginal males have turned to alcohol and drugs as a means to create a new form of male identity, one that is thrill seeking, violent and different to the authority of senior Aboriginal men and White society alike" (p. 400).

Furthermore, disadvantage and exclusion for young Aboriginal people may make them more vulnerable to situations such as family violence, family dysfunction, family discord, and interpersonal tension within the home, which has been associated with suicidal behaviour (Kosky, Silburn & Zubrick, 1990; Graham et al., 2000; Hunter & Harvey 2002). These issues are not unique to Australia. There are many similarities seen in other settler countries where the Aboriginal people have been colonised, such as New Zealand, Canada, United States and Hawaii (Hunter & Harvey, 2002). In both North America and Australia it has been found that families with significant issues such as cross-generational problems of alcohol, conflict, parental absence and loss have also experienced suicide 'clusters' within the family and community. Suicide cluster refers to the occurrence of two or more completed suicides that are non-randomly bunched in space or time (Joiner, 1999), such as series of completed or attempted suicides in the same town, community, or school for example. There is ample evidence that Aboriginal communities are particularly vulnerable to suicide clusters (Graham et al., 2000; Elliot-Farrelly, 2004; Hansssens, 2008).

2.3. Complexities of Suicide, Grief & Loss

Kelly, Dudgeon, Gee and Glaskin (forthcoming) reviewing measures of Aboriginal and Torres Strait Islander social and emotional well being, concluded that Aboriginal people suffer wide spread grief and loss. The high rate of preventable mortality impacted across the Indigenous population and increases the risk of developing high levels of psychological distress. The NATSIH Survey 2004-05 found 4 out of 10 Indigenous adults (47%) had lost a family member or friend in the last 12 months. Aboriginal and Torres Strait Islander respondents were almost two and a half times more likely (ratio 2.4) to report having lost loved ones compared to other Australians (AIHW, 2006). Further, almost one in two (47%) Aboriginal and Torres Strait Islander adults had attended a funeral in the last 12 months (ABS, 2004).

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Aboriginal and Torres Strait Islander people died at 4 times the rate of other Australians from conditions that would not have resulted in death if timely and effective health care had been available in the primary care system. This included deaths from suicide (8% of preventable deaths) (AIHW, 2008, p. 543). Avoidable deaths due to social and emotional issues such as violence, suicide and alcohol-related disease occurred at a higher rate than for other Australians. This was highest in the Northern Territory and Western Australia: 10 and 9 times the rate of others (AIHW, 2008, p. 544).

Loss and grief was the largest single factor to impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Each year, Aboriginal and Torres Strait Islander people grieved for twice as many deaths per head of population as other Australians. Many deaths involved infants, children, young adults, and men and women in their prime and were sudden, unexpected and preventable (i.e. more traumatic). Many were a result of sub-standard primary health care. Extended family networks served to extend grief across communities and regions, and the cost of funerals would have depleted the financial reserves and resources of family networks. Data measuring the impact of grief and loss on the development of high levels of psychological distress is not available in the NATSIHS 2004 – 05 or elsewhere (Kelly et al., forthcoming).

Aboriginal people have suffered through the effects of colonisation and oppression. Due to early mortality there has been a significant loss of the older generation and much younger people have to take on the responsibility of families and communities. Local communities and families are relatively close knit and connected with each other. The death of an Aboriginal person not only impacts on the immediate and extended family, but has effects to the entire community. For many people and communities, loss and grief are continuous. After one funeral and associated grieving, another death may quickly follow in a short space of time. As a result of high amounts of stress, multiple deaths and losses in the community, Aboriginal people often experience stronger and longer lasting reactions.

Due to these multiple deaths and losses within whole communities, it seems that people have stopped talking to each other. The experience of one author, who has worked extensively with Aboriginal families in Perth metro and surrounding areas, is that Aboriginal people are extremely sensitive to the needs of others and their losses and traumas. In turn means they are reluctant to talk about their issues, as they perceive this to be a burden to others already weighed down with their own issues. As a consequence it seems that people are tending to internalize their issues and not talk it out with each other. This may lead to feelings being suppressed and often comes out in self-destructive ways (Roe, 2000).

Aboriginal suicide appears to be due to impulsivity and correlated with alcohol use, as opposed to mental disorders (Hunter & Harvey, 2002). Hanging has emerged as the common method of suicide for Aboriginal people, and has been linked to the cluster character of suicide deaths in Aboriginal communities (Hunter, Reser, Baird & Reser, 1999). This is compounded by the fact that many have had the incidence of suicide or even witnessed a suicide, particularly as children, as part of their life experience. Thus, suicides may be perceived as common and somewhat normative in Aboriginal

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communities (Hunter, Reser, Baird, & Reser, 1999). Therefore, there is a greater exposure of the Aboriginal community to suicide, which seems to differ to the exposure in the mainstream community (Hunter & Harvey, 2002).

Given that people who are bereaved by suicide are more at risk of suicide, coupled with increased numbers of Aboriginal young people being exposed to suicide, Aboriginal communities are likely to be at increased risk of cluster suicides (Graham et al., 2000; Hunter & Harvey, 2002). Therefore the need for culturally appropriate suicide bereavement support becomes more of an imperative. Community members and children are been traumatised by suicides of family and known community people. Members of the community are particularly concerned about the children in the families of those who take their own lives. Solutions to these concerns include parenting support and skilling for some vulnerable community members. There are concerns that as the adults struggle to cope with loss and deal with their own grief, the children are ignored and left out of the grieving process (members of Nyungar community - personal communication, 2008).

In relation to suicide and risk factors there is not one single risk issue that can be applied for all Aboriginal people. There are important differences in suicide not only between Non-Aboriginal and Aboriginal groups but also between difference Aboriginal communities and groups (Hunter & Harvey, 2002). It is necessary to consider the locality and cultural background of the individual and community in which they live to understand the specific needs of any individual, family or community group. Often a suicide affects an entire community, and extends links outside of the location and requires a community response (Graham et al., 2000).

Another issue that has been identified is a concern about the lack of reliable statistical data of Aboriginal suicides that includes causes of death. For instance, there are anecdotal reports from the Aboriginal community that many suicides may not be officially reported as a suicide, such as cases of car accidents or death by misadventure (members of the Aboriginal community, personal communication, 2009).

2.4. Effective Counselling Practice: Holistic Counselling

Aboriginal people have long held the view that any kind of healing needs to be holistic, taking in the whole person, including their mind, body and spirit as well as an understanding of where a person fits. Joe Roe (2000), an Aboriginal Mental Health worker from the north west of Western Australia, discussed the spiritual effects on the mental health of Aboriginal people and developed an Aboriginal model of counselling, highlighting the need for a holistic approach to healing. For Aboriginal people, the spiritual, emotional, physical and social aspects need to be in balance for people to have good mental health.

The Ways Forward; National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report (1995) states that:

> "Aboriginal concepts of mental health are holistic and are defined as follows: Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of

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> the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities" (p. 20).

This holistic approach can be applied to any counselling setting when working with Aboriginal people, but is especially relevant for suicide bereavement support as this approach takes into account the whole person, including the spiritual which is often missing in other models of counselling, but for Aboriginal people is essential to their wellbeing.

Prior to colonisation, Aboriginal people used story telling to communicate the laws of the community, the correct way to act, family/clan relationships, boundaries, the spiritual world, understandings of the land and people's place in it. For this reason it is important that Aboriginal people are given ample time to speak and will often talk around in circles talking or yarning (Roe, 2000). This is an effective way for Aboriginal people to undertake healing.

Narrative Therapy is one of the approaches that are useful for Aboriginal and Torres Strait Islander people. This approach is centred on the understanding that people are experts in their own lives and views problems as separate from the person. The process involves the therapist working with the client to deconstruct and reconstruct their life stories, towards strengthening self-knowledge and self-belief. Towney (2005) developed a model for working with Aboriginal men, which encourages the use of yarning. Healing comes from retelling stories and reclaiming lost stories, which in turn helps to develop a stronger sense of identity and belonging: 'This is, and always will be, a unique part of our culture which we have been practicing for many years. It connects us to our spirituality. Our spirituality is central to our beliefs' (p. 40). Towney focuses on the yarning to address issues and he listens out for the pointers 'values' in the yarning, which can be used to address issues of grief and loss. While this particular model has been developed for men, it is still relevant for women. This process involved people talking about the things they valued in their lives and the counsellor identifies, validates and affirms key issues that lead to strengthening inner resources such as cultural identity, building self pride, and reducing self destructive behaviours and repairing relationships. Yarning should take place in a safe environment where the client feels comfortable and may be in a place of significance for the people (Towney 2005).

2.5. Effective Counselling Practice: Healing. Grief and Loss

Another narrative therapy approach that has proved useful is a project undertaken by Denborough, Koolmatrie, Mununggirritj, Djumalpi, Dhurrkay and Yunupingu (2006), in Port Augusta. The practitioners with the local Aboriginal community initially undertook a five-day workshop that intended to deal with loss and grief. During this the community were facilitated to identify and reclaim the effective ways within their community and culture to deal with suicide and suicide bereavement. The stories that were told during the workshops were collated and read back to this community, becoming part of the community history. The stories were later shared with another Aboriginal community in the Northern Territory. Feedback showed that the Northern

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Territory community responded to grief and loss in similar ways to the South Australian community. Healthy ways of coping identified between communities were similar.

The following list is a summary of important ways of coping by both the communities when they have dealt with suicide and suicide bereavement. This list might provide basis that could be an appropriate starting place for other postvention strategies in other communities. The list includes the important message of including children and honouring others in the community who provide support through this time.

- **Asking Questions**: When a death seems unfair and wrong, it can make it harder to cope with. It is important to ask questions to make sense of what happened as it shows respect for the person who died.
- **Dreams**: Some of us have dreams in which our loved ones visit us. These images sustain us they convince us we will walk together again one day – our loved one is communicating with us. They are saying they are ok, which can lift the weight from our shoulders.
- **Spirituality**: For some of us, spiritual beliefs and practices are what help us to get through. Faith that one day we will meet again with those who have passed away sustains us.
- **Crying together:** When one of us is feeling low others feel it too. We have skills in feeling each other's pain and suffering. In this way we share grief.
- **Honouring the contribution of key figures in the community**: At times like these it is important to acknowledge work done by key people in the community. It is family members who are there for each other. Even if you just talk about the weather there are key people in the community who keep us connected to each other and to our histories. We need to honour them.
- **Remembering and staying connected to those who have passed away**: We have developed special skills in remembering and staying connected to those who have passed away. We do not forget them; we honour and respect our loved ones.
- **Young one's skills of remembering and staying connected**: We teach the young ones our skills in remembering and staying connected. We pass on the stories to them and remind them of who has passed.
- **Unity**: Sharing grief is important, as unity is healing, especially for young people. We need a united stand, not a divided one.
- **Expression through arts**: Some of us paint, write and record songs as a way of responding to loss. Many people have particular songs to remember their loved one.
- **Our families**: It is our families that support each other the most. Staying connected, laugh with one another and turn to each other when we need. We trust each other and these relationships are sacred to us.
- **Remembering the good times**: It helps to remember the good times of the past. Good memories are precious and sharing stories is important.
- **Acknowledging that people react to grief in different ways**: Some people drink, smoke, and gamble. They do these things to escape the pain. We can't criticise them for this. We need to find ways for them to be able to talk about what they have been going through. We need to help them.
- **Tears and laughter**: For us tears and laughter go together. As well as sharing sorrow together, we also re-tell the funny stories from a person's life.

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- **Young people caring for us**: Young people can feel it when we are upset and might offer comfort. These acts mean a lot to us.
- **They are with us forever**: Because we love them so much, we may grieve forever for those who have died. We will always have them in our hearts and in our minds.

As a result of Denborough et al.'s (2006) research, training was implemented with workers in narrative approaches in responding to trauma and loss. Workers were trained so that they witnessed the rich knowledge and skills of community members that was shown in response to current predicaments. This example highlights the need to work from community strength and any intervention needs to identify and utilise the skills and support systems that the local people already have in place; that is, healthy ways of dealing with the grief and loss following a suicide and building upon this. In this way community people are able to share their stories of what has helped them during times of loss and grief, to have these valued and reaffirmed and thereby ensuring that the initiative is localised and relevant to that community (Denborough et al., 2006).

Denborough et al.'s (2006) research highlights the shared and collective nature of grieving and mourning for Aboriginal people. Participants in the Narrandera Koori Community Gathering (Dulwich Centre, 2002) described similarities in ways of grieving. Aboriginal participants described 'our healing ways' as a process where the whole community comes together; where helping people through their grief is the whole community's responsibility; where everyone can cry together; where children are included in the process; and where everyone re-tell stories about them and talk about the good and funny things the deceased person had done. Participants reported that recovering and honouring these cultural healing ways are vital for the survival of their community and their people's emotional wellbeing, while at the same time passing the tradition and knowledge onto future generations.

A recent Indigenous Healing Forum held in Canberra, there were common themes of connecting to culture and connecting to country as key elements to healing for Aboriginal people. For instance, Maddox and Potter (2008) described Yorgum Aboriginal Counselling Services, which includes practices that embrace culture, promote belonging, and connecting to country. Williams and Brodie (2008) described Authentic Community Training (ACT) and Aboriginal men's grief and healing circles, where there is a focus on returning to 'what our old people knew' and taking care of one's own spirit. Atkinson (2008) spoke about The Healing Circle based at Gnibi the College of Indigenous Australian Peoples, which recognises healing needs to involve important elements such as the experience of safety, community support and communal gathering, culture and ceremony, and a strengthening of cultural and spiritual identity.

2.6. Effective Community Development Practices: Suicide Prevention

It is important to note that there are differences between Indigenous families as well as cultural differences between communities. It is always essential therefore for any suicide prevention or suicide bereavement support to be made as localised and belonging to the community as much as possible. Adopting a community

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development and community driven approach is a key to developing culturally and locally relevant programs for Aboriginal people.

A good example of this process was undertaken by McCormack, Mohammed and O'Brien (2001) in the Cape York Peninsular region. The community requested information and support for suicide attempts and suicide completion, as they felt unprepared to deal with the situation. This project centred around the development of guidelines to ensure members of the community were safe and able to access postvention counselling, to develop strategies, to make referrals to other agencies according to their needs. The aim of the guidelines is to build the community capacity to plan activities, own the postvention plans and be self-reliant to deal effectively with suicide and suicide bereavement. Community members were recognised as 'experts' in their community, through their considerable life experiences with dealing with suicide. As part of the process, health workers describe their roles and skills with community members and shared their knowledge of mental health. They taught others to identify risk factors and about the use of safety plans. This in turn led the community to feel they could approach the health workers and as a consequence, they felt supported and more able to build protective factors. A network of elders, counsellors, family members and peer groups was established to respond to people at risk in the community. Key outcomes of the project included a set of culturally appropriate guidelines developed by the community, community awareness in identifying those at risk, community initiatives such as mental health promotions, identification of local support network, improved relationships with health professionals, critical incident support and debriefing, and bereavement counselling. These outcomes saw the development of a formal protocol for a whole of community support system (McCormack, Mohammed & O'Brien, 2001).

Lastly, a review of 156 local projects funded under Australia's National Suicide Prevention Strategy (43 were specifically for Aboriginal and Torres Strait Islander people) found that successful projects included certain processes such as understanding contextual factors, investigating participants needs, drawing on sound evidence, developing multi-faceted strategies, garnering stakeholder support, and employing capable staff (Headey et al., 2006). Any service should also consider these issues in development.

2.7. Strengths of Aboriginal People

Notwithstanding the array of difficulties Aboriginal people have faced over the years, Aboriginal people have remarkable strengths and resilience that contribute to endurance and survival.

One of the major strengths of Aboriginal people is the large strongly close-knit extended families. Aboriginal families are complex and often the relationships are different in nature than in non-Aboriginal families. According to kinship systems, close (first) cousins are often referred to as brothers and sisters; some may use the title brother-cousin for more distant cousins. People who grow up in close proximity and have interaction on daily or very regularly are not necessarily closely related will also be considered as family.

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The strength of such large family systems is a strong sense of connectedness, support, attachment and ancestry. It is unusual for Aboriginal people to not have several people that they trust and feel comfortable with in close proximity. When a suicide or other tragedy occurs, the effects are widespread as there are many people who are connected within families and the wider community. Therefore there is always support and people caring for over each other during difficult times such as grief and sorry time. Aboriginal people also have spiritual beliefs and will often be 'visited' by the people who have passed. This can include their appearance in dreams or by other signs including seeing a vision of the person, hearing them or being touched by them. This is a common grief experience for Aboriginal people and should be treated as part of the grieving process.

Aboriginal Psychiatrist, Helen Milroy (2006; 2007) proposed that great strengths of Aboriginal people include having strong kinship relationships and a secure attachment system. The complex kinship system maintains a structured society by determining relationships, behaviour and obligations. Accompanying this, Aboriginal families have a strong sense of inclusiveness and compassion towards each other, based on respect and sharing. Milroy also emphasises the importance of a solid attachment system in the Aboriginal culture, which includes connection and attachment to the land and mother earth; flora, fauna and totems; the dreaming and creator; ancestry and ancestral spirits; spirituality and eternity; and being part of the landscape. This strong kinship and attachment has enabled the remarkable endurance, survival and resilience for the Aboriginal culture and Aboriginal people.

3. Context of Aboriginal Suicides in Western Australia

The following section overviews the statistical data on Aboriginal and Torres Strait Islander suicides in Western Australia. The data is drawn from the Telethon Institute for Child Health Research, Western Australia Coroner's Database on Suicide

3.1. Total Suicides in Western Australia 1997 – 2006 (MCSP, 2009)

In Western Australia, a total of 2604 people completed suicide between 1997 and 2006. Males accounted for 2061 cases and females for 543 cases. Of these cases:

- Aboriginal suicides accounted for 7.4% of the total suicides in the state
- Aboriginal male suicides accounted for 8.8% of all male suicides in the state
- Aboriginal female suicides accounted for 7% of all female suicides in the state

The breakdown of Aboriginal suicides, age specific comparisons, alcohol and drug involvement, psychiatric disorders, professional help, previous attempts and suicides by locations are detailed below (see points 2.2 - 2.10).

3.2. Aboriginal Suicide in Western Australia 1997-2006

A total of 220 Aboriginal people completed suicide between 1997 and 2006 (see table 1). Aboriginal males accounted for 182 cases and females for 38 cases. The age-standardised rate (ASR) for Aboriginal males for the above period was 52.9 per 100,000 (CI: 44.8-60.9) It is however important to note that due to the relatively small size of the male Aboriginal population in Western Australia (2006 = 35,743, ABS), these rates need to be interpreted with caution.

Due to the relatively low number of cases for Aboriginal females during 1997-2006 period, reliable rates were unable to be calculated.

Table 1. Numbers and rates of Aboriginal suicide by gender Western Australia, 1997-2006

Year	Male	Female	Total
1997	8	3	11
1998	25	2	27
1999	26	1	27
2000	18	9	27
2001	18	4	22
2002	16	4	20
2003	14	2	16
2004	16	2	18
2005	15	5	20
2006	26	6	32
Total	**182**	**38**	**220**

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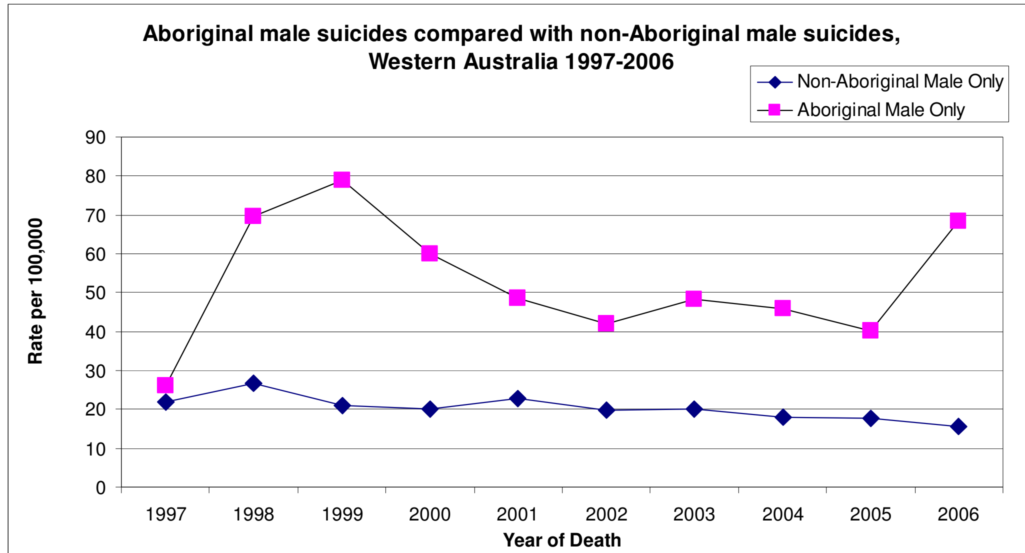
The rate of suicide among Aboriginal males averaged 52.9 per 100,000 population during the 1997-2006 period. This was over 2.5 times higher than the rates of non-Aboriginal males (52.9 v 20.3 per 100,000). See Figure 2

Figure 1. Comparison of Aboriginal male with non-Aboriginal male suicides Western Australia, 1997-2006



3.3. Age specific comparisons

During 1997-2006, Aboriginal male suicides were highest in the 20-24 year age group (153.2 per 100,000, n=43), over four times the rate of non-Aboriginal males in the same age group (31.5 per 100,000, n=213). The rate of Aboriginal male suicides was also high in the 25-29 year age group (127.5 per 100,000, n = 35,) over three times the rate of non-Aboriginal males in the same age group (37.8 per 100,000, n = 259).

Please note that care must be taken when interpreting these rates due to the relatively low number of cases among Aboriginal males within these age groups during the 1997-2006 period, which makes conversion to a rate less reliable.

Suicides among Aboriginal females were most common in the 15-19 year age group (n=9) during 1997-2006.

3.4. Alcohol and other Drug Involvement

During the 1997-2006 period, nearly 60% of Aboriginal males who completed suicide had a blood alcohol reading at the time of death. These levels ranged from 0.011 to 0.358. Blood alcohol readings were present in nearly 60% of Aboriginal females at the time of death, with levels ranging from 0.014 to .423. (Data from blood alcohol tests were either missing or not conducted in 15 of the Aboriginal male suicides and in 3 cases of Aboriginal female suicides)

A current substance usage issue was found in nearly 57% of Aboriginal males. The most commonly used substances by Aboriginal males were alcohol (74%) and cannabis (46%). A current substance usage issue was found in 71% of Aboriginal females. The most commonly used substances by Aboriginal females were alcohol (78%) and cannabis (37%).

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3.5. Psychiatric Disorders – Aboriginal Males

Information from the family and friends of Aboriginal males reported that nearly 30% were noted to have exhibited symptoms of depression in the three months preceding their suicide.

In the 12 months prior to completing suicide, 18.2% (n=33) had a confirmed psychiatric disorder. These disorders included: schizophrenia (36%), drug abuse (30%), depressive disorders (27%) and alcoholism (24%). Of those diagnosed with a psychiatric disorder in the last 12 months of their lives, nearly 73% of them were receiving treatment within the last three months of their lives.

3.6. Professional Help – Aboriginal Males

Nearly 47% (n=83) of Aboriginal males had received some sort of professional help in the 12 months prior to their suicide. This help may not have specifically been for a psychiatric disorder but does reflect contact with health care professionals prior to their suicide. Of those who sought professional help, the most commonly utilised professionals were: General practitioners (65%), Other* (63%), Hospitals (32%), Psychiatrist (19%) and Psychologist (11%). * 'Other' includes health workers, mental health nurses and counsellors.

3.7. Psychiatric Disorders – Aboriginal Females

Information from the family and friends of Aboriginal females reported that nearly 26% were noted to have exhibited symptoms of depression in the three months preceding their suicide.

In the 12 months prior to completing suicide, 29% (n=11) of Aboriginal females had a confirmed psychiatric disorder. These disorders included drug abuse (45%) and depressive disorders (27%). Of those diagnosed with a psychiatric disorder in the last 12 months of their lives, 72% of them were receiving treatment within the last three months of their lives.

3.8. Professional Help – Aboriginal Females

Nearly 55% (n=21) of Aboriginal females had received some sort of professional help in the 12 months prior to their suicide. This help may not have specifically been for a psychiatric disorder but does reflect contact with health care professionals prior to their suicide. Of those who sought professional help, the most commonly utilised professionals were: General Practitioners (75%), Other* (52%), Hospitals (30%), Psychiatrist (30%) and Psychologist (5%). * 'Other' includes health workers, mental health nurses and counsellors.

3.9. Previous Attempts

31% of Aboriginal males who completed suicide had previously attempted suicide. A slightly larger proportion (34%) of Aboriginal females who completed suicide had previously attempted suicide.

3.10. Metropolitan, rural and remote variations for Aboriginal people

The majority of all Aboriginal suicides in the 1997-2006 period occurred in the remote area of Western Australia (n=123), accounting for 55.9% of all Aboriginal suicide deaths within the State. The highest rates for Aboriginal male suicides were

in the remote areas of Western Australia (n=109) with an average ASR of 68.8 per 100,000 (CI: 55.3-82.3). Rural areas recorded 27 Aboriginal male suicides with an average ASR of 38.3 per 100,000 (CI: 23.5-53). Nearly a quarter of all Aboriginal male suicides were recorded in the metropolitan area (n=44) with an average ASR of 39.2 per 100,000 (CI: 27.1-51.4)

Table 2. Aboriginal Suicide by Metro, Rural and Remote variations, Numbers by gender, Western Australia 1997-2006

	Male	**Female**	**Total**	**ASR Males**
Metro	44	14	58	39.2
Rural	27	9	36	38.3
Remote	109	14	123	68.8
Not placed/itinerant	2	1	3	
Total numbers	**182**	**38**	**220**	**-**

The Kimberley health region in the remote north of Western Australia recorded a total of 79 Aboriginal male suicides. Aboriginal male suicides in the Kimberley health region accounted for 43% of all Aboriginal male suicides within the State.

Table 3. Aboriginal Suicides, by gender by Health Region Western Australia, 1997-2006 Raw numbers

Health Region	**Male**	**Female**	**Total**
Wheatbelt	4	1	5
Great Southern	5	2	7
Midwest	14	6	20
Goldfields	15	1	16
Pilbara	15	2	17
Kimberley	79	11	90
North Metro	20	7	27
South Metro	24	7	31
South West	4	0	4
Not placed/itinerant	2	1	3
Total numbers	**182**	**38**	**220**

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4. Services for Aboriginal People Bereaved by Suicide

From a review of existing services it appears there are currently no services that specifically target Aboriginal people bereaved by suicide in Western Australia. Some agencies, particularly in the Aboriginal community controlled organisations such as Yorgum Aboriginal Counselling Services and local Aboriginal medical services are likely to have provided some service from social and emotional well-being programs. However, this need remains unfulfilled.

There are several organisations, agencies and practitioners that are currently or have in the past provided support to Aboriginal people bereaved by suicide. Details of these are included and a brief picture of the services offered are provided. These include:

Active Response Bereavement Outreach (ARBOR)
Telethon Institute for Child Health Research & Centre for Developmental Health, Curtin University of Technology – Western Australia

- A Perth based service providing support for people bereaved by suicide.
- Referrals received from the Coroners Counselling Service, external agencies and community/self referrals.
- Provides home visits, peer support, short term counselling, support groups, referral advice and support when returning to work.
- Employment of Aboriginal Grief Counsellors to be able to provide culturally appropriate grief and loss counselling and support.
- Developing a culturally appropriate model of support for Aboriginal people for the Perth Metro area.

Darrell Henry (2009, 2007)
Aboriginal Psychologists/Consultant
Healing & Suicide Crisis Response – Western Australia

- Whole of community approach to addressing needs of individuals, families and community members following suicide cluster/contagions.
- Providing culturally appropriate psychotherapy and counselling to high-risk individuals and groups.
- Emphasis on using 'culture as healing'.
- Identification of strong people within families (natural helpers) and the community (para-professionals), and provide them with training in basic counselling and palliative response skills to be able to better support those in crisis.
- Increasing the capacity of local services to be able to better support the Aboriginal community in the long term.

Standby
United Synergies Ltd. – Western Australia, and other states.

- A Queensland based mainstream community service providing support to people bereaved by suicide.
- Incorporates a coordinated community response referral pathway that provides people and communities bereaved by suicide with access to early intervention and ongoing support.

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- Trauma response team provides 24-hour support via telephone, face-to-face outreach, community visits, group sessions and by invitation.
- Has incorporated some Aboriginal support elements including training programs, community awareness seminars and services in the areas of postvention and traumatic loss including "Who You – Which Way" cross cultural training aimed to increase the knowledge and understanding of the needs of Aboriginal communities in regards to grief and loss, as well as suicide bereavement.
- In June 2009 is funded to trial program in Kimberley and Pilbara areas in Western Australia for two years.

There are several service and agencies in other states that provide effective services to Aboriginal and Torres Strait Islander people bereaved by suicide. A review identified the following as good practices:

Living Beyond Suicide
Anglicare – South Australia.

- Offers immediate emotional and practical support to families in the hours, days and weeks immediately after a loved one's suicide.
- Guide families through the array of systems and services that enter their lives during the distressing time.
- Facilitate referrals to relevant agencies where needed.
- Increase general community awareness of what to do and say to best support families bereaved by suicide.
- Survivor sensitive volunteers and home visits available.
- Predominantly a mainstream service but is establishing an Aboriginal working party to address how Aboriginal families in the Adelaide area are best supported after a suicide and what are the unmet needs.

Suicide Postvention Program
Top End Mental Health Service – Northern Territory.

- Provides grief and loss support for individuals, families, groups (i.e. schools, workplaces, community groups), and whole communities following a suicide.
- Through local community agencies and services identify potential risk groups following a suicide.
- Extended referral process – clients do not need to be or become clients of the mental health service in order access grief and loss support.
- Work closely with local Aboriginal Health Workers and cultural consultants in liaising with families and communities.
- Link at-risk individuals with existing services that can provide long-term grief and loss support, focusing on supporting the workers in key exiting services to be able to provide support to families.
- Able to provide direct individual and family support if needed.

Anacleta Apuatimi (2007)
Tiwi Mental Health Team
Top End Mental Health Service – Northern Territory.

- Culturally appropriate crisis response and bereavement support following a suicide.

- Crisis intervention committee meeting arranged following an attempted or completed suicide involving family from same skin group and police.
- Set plans for supporting at risk community members including mental health and/or drug and alcohol counselling if necessary.
- 'Tiwi' way bereavement counselling and suicide postvention support programs drawing in Tiwi culture.
- Strong men and strong women's groups, healing circles, healing fires and smoking ceremonies.

Leonore Hanssens (2003)
Top End Life Promotion Program 1999-2006
Department of Health and Families & Charles Darwin University – Northern Territory.

- Use of crisis intervention committee model and three-tiered approach to suicide prevention, intervention and postvention.
- Primary (general bereavement support via community members), secondary (active support via allied health professionals and police) and tertiary interventions (referrals pathways to agencies for bereaved families with complicated grief) within the community setting allows a multi-faced and multi-level approach to suicide postvention crisis support and suicide bereavement.
- Advocates for proactive group/community interventions (e.g. youth camps, healing circles) to allow for informal debriefing, indentify at risk individuals, reduce shame/blame/anger/violence within the group, and to protect against suicide contagion and suicide clusters.
- Research evidence supporting the efficacy of approach in preventing imitation, suicide contagion and cluster suicides.

4.1. Gaps in Service Provision

Recognising the need for culturally appropriate support for Aboriginal people bereaved by suicide, ARBOR sought feedback from a range (n=10) of WA based Aboriginal allied health professionals, community members and non-Aboriginal professionals regarding the gaps in service provision and knowledge in this area. The guiding questions and responses are summarised below:

What are the service gaps in Aboriginal Grief and loss counselling and support following a completed suicide?
Generally, responses indicated that there were very few appropriate services for Aboriginal suicide bereavement support and in many areas, nothing at all.

- There are not many culturally appropriate services available.
- Never heard of any services for Aboriginal people.
- No service available in Broome immediately following a completed suicide – no understanding that this time it is needed.
- Not sure what kind of counselling is available or accessible for suicide bereavement.
- There is very little in the way of suicide bereavement counselling/support for families, in some area's only Mental Health agencies who at times get it wrong due to having limited understanding of Aboriginal ways.
- There needs to be more Aboriginal grief and loss counsellors.

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- Lack of funding.

What are the gaps in knowledge about supporting Aboriginal people bereaved by suicide?

Responses indicated that there was a large gap in knowledge about appropriate Aboriginal suicide bereavement amongst professionals including a lack of knowledge about culturally appropriate support amongst non-Aboriginal service providers.

- Lack of cultural knowledge from non-Aboriginal service providers – or no acknowledgment of other factors that effect Aboriginal people, leading to Aboriginal people closing down and not wanting to talk about their feelings.
- There are gaps in the service with workers not knowing how to support a person in grief.
- For many Aboriginal people mental health and wellbeing issues may begin from unresolved grief and loss issues, including suicide bereavement.

4.2. Gaps in Training for Workers

ARBOR sought feedback from Aboriginal allied health professionals, non-Aboriginal and Aboriginal community members regarding gaps in training needs for workers supporting people bereaved by suicide. Responses are summarised below:

What training and/or resources would benefit workers in dealing with Aboriginal grief and loss following a completed suicide?

The need for training in grief and loss, understanding Aboriginal cultural ways and appropriate interventions for suicide bereaved Aboriginal people and communities were clearly identified.

- Listening with interest for people who work with Aboriginal people. The Aboriginal Mental Health First Aid course may be a good way to start and perhaps all Aboriginal workers should have this training.
- There needs to be more time given to grieving for Aboriginal people. There should be a model of support for Aboriginal and non-Aboriginal workers, also some training in the differences between categories of self destructive behaviour i.e.; extreme risk taking behaviour; self harming behaviour and suicidal behaviour. Also an understanding of suicide contagion.
- Any training or information on better supporting Aboriginal people bereaved by suicide would be valuable such as mental health training, general counselling Skills and Aboriginal and non-Aboriginal ways of working.
- Training in suicide prevention and the signs to look for, the impact of suicide bereavement and the inclusion of people who have experienced such loss to be in attendance and share their knowledge and experiences
- Training and resources for family and community members in how to identify and support someone who is at risk and/or experiencing difficulties.
- Kids need to be supported and educated about suicide. Given the difficulty in this it may be more useful to have training in the area of dealing with and counselling for children who are bereaved by suicide.
- Training in supporting a person bereaved by suicide for workers with the inclusion of people who have experienced bereavement through suicide.
- For welfare workers (Department of Child Protection, Department of Housing and others) an understanding of grief and loss and how this affects the families and how they deal with the grief and loss as well as other issues that may be

come relevant at times of grief such as tenancy issues, paying rent, damage to the house at the time they are bereaved by a recent suicide.

- Training in remote areas for non-Aboriginal workers in understanding Aboriginal suicide bereavement. This training would have to include needs to be localised with the Aboriginal community in understanding the specific responses of bereavement grief and loss.

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5. Proposed State-wide Aboriginal Suicide Postvention Project

From 1997-2006 there were 220 Aboriginal suicides in Western Australia, accounting for approximately 7.5% of the total suicides in the state (TICHR, 2009). For every death by suicide it is estimated that up to ten people are intimately affected by the loss. The combination of high rates of suicide in the Aboriginal community, the experience of multiple losses to other types of death, and the nature of extended families in the Aboriginal community, means the 'ripple effect' following a suicide is likely to be more wide spread and more devastating for Aboriginal people than in the non-Aboriginal population. This is particularly true in rural and remote areas where clusters of suicides have occurred, leaving the whole community in deep anguish and at increased risk. In rural areas, there is often a lack of services available in the community to be able to support Aboriginal people in their grief or those identified as at higher risk. In the metro area, while there is an array of public health services, these might not be able to appropriately manage the bereavement needs of Aboriginal people, families and communities. Hence, improving the ways in which Aboriginal people bereaved by suicide are supported is essential.

The following is a proposed State-wide Aboriginal Suicide Postvention Project following a suicide and/or suicide clusters. This model takes a community development and community facilitation approach to addressing the individual, family and community needs. This model proposes a state-wide Aboriginal Suicide Bereavement Response Team (ASBRT, working title only) that works in partnership with community members and service providers in responding to the bereavement needs of Aboriginal people. This model is designed to sit alongside ARBOR, which provides support for people bereaved by suicide in the Perth metropolitan area.

Without intending to dilute the focus on suicide prevention, it needs to be recognised that Aboriginal suicide is a consequence of a whole range of factors impacting on the psychological, social and emotional wellbeing of Aboriginal people, which needs to be addressed and perhaps forms a secondary focus of the project. That is, while the proposed model of service will initially begin with a primary focus on suicide prevention/postvention, the project may need to diversity in the services it provides, so that it addresses the systemic issues that perpetuate Aboriginal people being at risk of suicide (e.g. domestic violence, substance misuse, sexual abuse/assault).

This discussion paper and proposed model is the end result of the first phase in the development of a culturally appropriate state-wide postvention project for Aboriginal people in WA. The final phases of the development of the Aboriginal Suicide Postvention Project include further consultation with community members and key stakeholders in the metro and regional areas (see section 6).

5.1. Aboriginal Suicide Bereavement Response Team (ASBRT, working title)

The goal of ASBRT is to respond to individual suicides and identified suicide clusters throughout the State. In addition a community development approach to suicide prevention/postvention will be utilised by the ASBRT, whereby community members

and service providers are up skilled so they can provide ongoing, sustainable and culturally relevant support in their own community.

The aims of ABSRT are to:

- Provide a crisis response to individual Aboriginal suicides and identified suicide clusters throughout the state
- Build relationships and develop the capacity of communities to respond to suicide bereavement throughout the State
- Build relationships and develop capacity of service providers to respond to suicide bereavement throughout the State
- Build stronger relationships between service providers and communities throughout the State
- Facilitate the development of and support local suicide prevention/postvention committees throughout the State
- Identify, train and support peer supporters throughout the State
- Work alongside metropolitan suicide bereavement service

ASBRT will provide expert suicide bereavement consultation, training and support to service providers; training and support to community members; suicide bereavement support to individuals, as well the facilitation of a community response to suicide clusters (see 4.2-4.6 below). Referrals are likely to come from services which work closely with Aboriginal families and communities on a regular basis; by direct invitation of communities, as well as self referrals from individuals and families.

ASBRT will be staffed by a team of allied health professionals who will work as Grief Counsellors. A mixture of male and female Aboriginal allied health professionals (including psychologists, social workers, mental health practitioners) will form a multi disciplinary team. Where possible staff in the multidisciplinary team will be Aboriginal, however it is recognised that this may not always be possible. ASBRT will be based in Perth, but will have the capacity to travel throughout the state on a regular basis for extended periods of time. Ideally a service of this kind should be managed by an Non-Government Organisation (NGO) such as an Aboriginal Community Controlled Organisation (ACCO), however this requires further consultation.

5.2. Suicide Prevention/Postvention Committees

In taking a community development approach, it is important for ASBRT to engage with cultural consultants from the local areas, who will be able to advocate on behalf of the community and also vouch (endorse) for the team. The cultural consultants will play a key role in developing relationships and partnerships in the community and will be able to advise whether the community wishes to engage with ASBRT, and the correct cultural protocols that need to be taken.

It is recommended that the local cultural consultant/s work with ASBRT to establish local suicide prevention/postvention committees made up of local community members, elders and service providers. This committee would have three core functions:

1. To plan for the long term suicide prevention and postvention needs of the community,
2. To serve as a local steering or reference group for the ASBRT and advise the team what training and support the community needs,
3. To coordinate and sustain suicide prevention/postvention interventions in the long term.

It is important to note that any model of support or response to suicide will differ between communities and locations, and as such programs should be tailored to the local culture, services already available, and the needs and wishes of the community. As such, the amount of engagement ASBRT has in a particular community would be dependent on the needs and wishes of the community.

5.3. Building the Capacity of Service Providers

Part of the ASBRT's model of service delivery is to establish strong relationships with key support services in the community. It is important for ASBRT to link in with existing services such as the Statewide Indigenous Mental Health Service and others, as well as suicide prevention programs and initiatives so that good working partnerships can be established. The ASBRT will be able to provide support and training to services to increase their capacity to support Aboriginal people bereaved by suicide. ASBRT would either provide the training to service providers, or play an active role in sourcing the training. If the training is outsourced, the ASBRT in collaboration with local cultural consultants-suicide prevention/postvention committees would peruse the training's content to ensure cultural and clinical appropriateness. Training for service providers may include:

- Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems
- Suicide prevention training for service providers (Basic to Advanced Skills)
- Suicide Bereavement Counselling and Support
- Responding to Suicide Clusters
- How to support Peer Supporters

ASBRT would also provide ongoing professional support, debriefing and consultancy advice to service providers in supporting Aboriginal people bereaved by suicide.

5.4. Building the Capacity of Community Members

In order for lasting changes to occur within the community, it is important to build the capacity of community members and community groups, so they can identify when someone they know is at risk or is experiencing difficulties, and then link them into the appropriate services. ASBRT would either provide the training to community members, or play an active role in sourcing the training from an external provider. If the training is outsourced, the ASBRT in collaboration with local cultural consultants and the suicide prevention/postvention committees would peruse the training's content to ensure cultural and clinical appropriateness. Skills training for community members may include:

- Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems

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- Suicide prevention training for community members
- Bereavement support for the whole community
- Supporting bereaved individuals
- How to refer people in need
- Training in Peer Support

5.5. Suicide Bereavement Support

The long-term goal of ASBRT is to help local service providers and community members support individuals and families bereaved by suicide. Suicide bereavement support that the ASBRT would help facilitate includes:

- Information on services available
- Practical support in the initial days/week/months following suicide/s
- Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems
- Grief counselling and support plans for individuals/family/community including counselling, group meetings, peer support, healing groups and referral advice.

Ideally the local support services, in collaboration with the community, would provide suicide bereavement support to individuals and families, however in some cases this may not be possible (e.g. lack of services, inappropriateness of services, family issues, issues of confidentiality). In these circumstances, the ASBRT would provide the suicide bereavement support in the short term, while at the same time up-skilling local service providers and community members to continue the interventions in the long term. ARBOR is also able to provide support to Aboriginal individuals and families bereaved by suicide in the Perth metropolitan area (see appendix 1 for ARBOR's model of support for Aboriginal people bereaved by suicide).

5.6. Responding to Cluster Suicides

An important role of ASBRT is to provide support to the community in responding to suicide contagion and suicide clusters. Initial support will be provided by ASBRT. The team will also take a community development approach by enhancing the capacity of community members and existing agencies to be able to better support those at risk and those bereaved by suicide. It is extremely important that ASBRT works collaboratively with the community in developing a response specific to the needs, wants and local culture of the community.

Suggested process for a crisis response:

1. With the help of a cultural consultant/s and the local suicide prevention/postvention committee, identify the bereaved and at-risk members in the community, as well as key stakeholders and community members.
2. Arrange meetings with the family, community members, and local community/support services to respond to immediate needs of the individual, family and community.
3. Provide grief counselling and support plans for individuals, family and community (provided in collaboration between local community members, existing services and ASBRT).

- Individual counselling and psychotherapy
- Family meetings and debriefings
- Community workshops, sorry camps, healing circles

4. Training and up skilling of primary, secondary and tertiary support (Hanssens, 2008)
   - Community members (primary) so they can better identify and appropriately refer someone they know is at risk or is experiencing difficulties
   - Local community/support services (secondary) to be able to provide ongoing support and respond in the future, relevant to the local Aboriginal community
   - Higher level agencies such as emergency department staff, psychiatrist, psychologists etc. (tertiary) in clinical risk assessment relevant to the local Aboriginal community
5. Establish referral pathways for community members (primary) to community services (secondary) and agencies (tertiary) (Hanssens, 2008)
6. Identify key local support service/s to take on the lead role in the ongoing support, as well as maintaining the local suicide prevention/postvention committee
7. ASBRT gradually withdraws from community allowing the local suicide prevention/postvention committee and support service/s to continue ongoing support in the community
8. ASBRT provides follow-up support and training to service providers and community members, as per advice of the local suicide prevention/postvention committee and/or cultural consultant/s.

5.7. Flow Chart of Statewide Model

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Aboriginal Suicide Bereavement Response Team (ASBRT)

- 1 x Coordinator
- 6x Grief Counsellors: Aboriginal, non-Aboriginal, male & female
- Based in Perth, able to travel state-wide
- Team responds to individual suicides and identified clusters/contagions throughout the State
- Builds relationships and develops capacity of communities to respond to suicide bereavement throughout the State
- Builds relationships and develops capacity of service providers to respond to suicide bereavement throughout the State
- Builds strong relationships between Service Providers and communities throughout the State
- Facilitates the development of and supports local Suicide Prevention/Postvention Committees throughout the State
- Identifies, trains and supports Peer Supporters throughout the State
- Works alongside the ARBOR Metropolitan suicide bereavement service, and other suicide prevention/postvention initiatives around the State.

Local Suicide Prevention/Postvention Committees

- Local steering group made up of community members and service providers, who meet regularly to respond to the long term suicide prevention/postvention needs of the community
- Advises the ASBRT what training and support is needed.

Building the Capacity of Service Providers

- Establish strong relationships with key service providers in the community
- Building service providers skills and capacity to support people bereaved by suicide
- Provide training in:
  - Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems
  - Suicide Prevention Training
  - Suicide Bereavement Counselling
  - Responding to Suicide Contagion/Clusters
- Ongoing support and consultation
- Ongoing support of Peer Supporters

Suicide Bereavement Support

- Provided by ARBOR in metro area
- Provide grief education
- Information on support services
- Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems
- Facilitate practical issues/support
- Grief counselling and support plans for individuals/family/community
  - Group or individual meetings
  - Counselling
  - Peer Support
  - Healing groups
  - Referral advice

Building the Capacity of Community Members

- Establish strong relationships with key stakeholders and members in the community
- Building community members skills and capacity to support others
- Provide training in:
  - Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems
  - Suicide Prevention Training for Community Members
  - Bereavement support for whole community
  - Supporting bereaved individuals
  - Suicide Bereavement Education
- Identify and recruit Peer Supporters

Responding to Contagion/Cluster Suicides

- Formation of crisis intervention group (family, community, support services) to respond to immediate needs of individuals/family/community
- Provide information & education
- Identifying and acting as first responder to Aboriginal and Torres Strait Islander people with mental health problems Facilitate practical issues/support
- Identification of those at higher risk
- Grief counselling and support plans for individuals/family/community
  - Individual counselling and psychotherapy
  - Peer Support
  - Family meetings & debriefings
  - Community workshops, sorry camps, healing circles

6. Culturally Safe Working Environment

Many Aboriginal workers are prone to burn out. This is due to working with many clients with complex needs, whilst at the same time often supporting their own family with similar complex needs. As a result, Aboriginal worker's professional roles often extend beyond the office, as people they know often approach them for help out of hours and on weekends. These combined factors can dramatically increase the risk of Aboriginal workers feeling burnt out. Therefore it is crucial that Aboriginal workers are well supported in the workplace to ensure their health, safety, and retention. Feelings of isolation can also increase when employers fail to recognise these complex challenges for Aboriginal workers and do not support them accordingly.

6.1. Employment of Aboriginal Grief Counsellors

Due to the intense nature of the work and the differences in grief and loss for Aboriginal people, it is recommended that ASBRT employ a minimum of six Aboriginal Grief Counsellors (three male and three female). This enables culturally appropriate debriefing, peer supervision, and professional support between Aboriginal colleagues with the same level of understanding. It also helps to minimize any isolation that may be experienced by the Aboriginal workers. It is also recommended that Aboriginal clients have access to a male Aboriginal Grief Counsellor and a female Aboriginal Grief Counsellor to address any gender differences that may arise.

6.2. Supervision and Mentoring

Aboriginal Grief Counsellors should have access to supervision and/or mentoring depending on the needs of the worker. Supervision may be in the way of professional supervision where the workers clinical skills as a counsellor are addressed; and/or cultural supervision where the Aboriginal Workers cultural skills are supported. Mentoring might by way of another Aboriginal worker outside of the specific counselling area who has knowledge and understanding of the individual and their needs. Mentoring will also provide the support for issues that affect Aboriginal people in the workforce in general.

6.3. Networking and Peer Supervision

It is important for Aboriginal staff to maintain regular contact with other Aboriginal allied health professionals in the community, through networking and peer supervision. Regular peer supervision and networking enables culturally appropriate debriefing and professional support, while maintaining connections with the community and reducing isolation. It is recommended that the ASBRT Aboriginal Grief Counsellors work closely with the ARBOR Aboriginal Grief Counsellors.

6.4. Counselling and Employee Assistance

Given many Aboriginal people experience multiples losses throughout their lives, combine with the intense nature of working in suicide bereavement and grief and loss, it is important for employers to be sensitive to the emotional wellbeing of their

Aboriginal Grief Counsellors. Therefore it is important for Aboriginal Grief Counsellors to have access to culturally appropriate counselling support (employee assistance program) for their own grief and loss issues.

6.5. Work arrangements

It is important for employers structure work around the local culture. Providing flexible workplace arrangements will enable Aboriginal workers to fulfil family and community obligations such as sorry business – e.g. providing appropriate length of leave for deaths, funerals, mourning, ceremonies and working on grief and loss issues. Also providing leave and flexible work hours for parents and carers.

6.6. Support for further education and professional development

It is important for Aboriginal workers to be given opportunities to enhance their capacity in the workforce and their careers. Aboriginal Grief Counsellor will be supported in expanding their skills and expertise through further education and professional development.

6.7. Collaboration between Aboriginal and non-Aboriginal workers

Aboriginal people working in the allied health sector have a unique set of skills and experiences that are often different to other health professionals. It is vital that the workplace facilitates an environment where by non-Aboriginal workers acknowledge and value the cultural knowledge, skills and differences of their Aboriginal colleagues; and work collaboratively to be able to maximise service provision for their Aboriginal clients. This can be done through **ongoing**:

- Cultural awareness and cultural safety training of all staff,
- Consultation with Aboriginal workers in how to best support Aboriginal clients,
- Consultation with Aboriginal workers in the development of policies, procedures and programs.

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7. Process of Model Development and Community Consultation

In developing this discussion paper of a proposed State-wide Aboriginal Suicide Postvention Project, there were a number of steps the contributing authors undertook.

7.1. Process undertaken

Phase one - Discussion Paper & Model Development

- Conducted a review of current and past literature on suicide, suicide bereavement and postvention for Aboriginal people.
- Met with community members and services (via email, phone, and face-to-face meetings) to discuss suicide bereavement support for Aboriginal people provided by ARBOR.
- Surveyed community members regarding gaps in service provision, knowledge and training needs in Aboriginal suicide bereavement - Responses were collated and feedback to community members for additional input.
- Consulted Aboriginal professionals and service providers working in the field of Aboriginal postvention to discuss their experiences supporting Aboriginal people bereaved by suicide.
- Based on current literature, counsellors knowledge and experience, feedback from Aboriginal professionals, service providers and community members, a discussion paper for the State-wide Aboriginal Suicide Postvention Project was developed including a proposed model of postvention.
- Consultation and feedback regarding the discussion paper and model to be sought from key Aboriginal professionals and Aboriginal academics working in the field and/or with relevant knowledge and experience.
- Based on feedback from Aboriginal professionals and Aboriginal academics, further refinement of the discussion paper and model was conducted which addressed any issues that had been identified – Refined discussion paper and model presented back for verification.
- Identification of potential steering committee (or "Task Force") members for the Aboriginal Suicide Postvention Project who will be able to guide the future development, community consultation and rollout of the State-wide Aboriginal Suicide Postvention Project

7.2. Future Development

Further development and consultation of this proposed model is needed. Consultation needs to be done with Aboriginal professionals in the field as well with various communities across the state to verify the model's utility and cultural appropriateness. It is recommended that this process include the following phases:

Phase two – Sourcing Funding for Community Consultation

- Identification of funding body to finance a project officer/s and roll out of a community consultative process of the Aboriginal Suicide Postvention Project.
- Identification of an organisation that is prepared to take the responsibility for the Aboriginal Suicide Postvention Project.
- Appointment of Aboriginal Suicide Postvention Project officer/s.
- Formation of Aboriginal Suicide Postvention Project Steering Committee.

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Phase three – Planning of Community Consultation

- Planning of community forums state-wide, including metro, rural and remote areas of the State, including:
- Scoping of services already existing in communities that provide suicide prevention and postvention support to Aboriginal people.
- Identification of local elders and cultural consultants in key areas who will be able to advise on the planning and roll out of community forums.
- Follow up of Aboriginal Community Controlled Organisations who participated in the WA State Suicide Prevention Strategy consultation process.
- Direct invitation and commitment of key stakeholders and individuals to attend forums in each area.
- Media (newspaper, radio) announcements inviting Aboriginal individuals and families bereaved by suicide to participate in the consultation process.
- Negotiation of appropriate time to begin workshops in communities, taking local cultural protocols into consideration (i.e. community readiness and willingness, level of trauma and loss, recent deaths/funerals, ceremonies, sorry time etc.)
- Identification of facilitator/s for community forums in each area.

Phase four – Roll Out of Community Forums

- Model of a State-wide Aboriginal Postvention Support workshopped in community forums.
- Information obtained during community consultation is integrated into final Aboriginal Suicide Postvention Project model.
- Refined Aboriginal Postvention Project model is presented back to community for verification.
- Identification of funding body to finance pilot of State-wide Aboriginal Postvention Support.

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8. Impact Evaluation

Prior to the roll out of the Aboriginal Postvention Project, it is important to determine how the project will evaluate its impact in supporting Aboriginal communities following a suicide and/or suicide cluster. The project will need to consider in what ways it achieved its goals in:

- Providing a crisis response to individual Aboriginal suicides and identified suicide clusters throughout the state
- Building relationships and develop capacity of communities to respond to suicide bereavement throughout the State
- Building relationships and develop capacity of service providers to respond to suicide bereavement throughout the State
- Building stronger relationships between Service Providers and communities throughout the State
- Facilitating the development of and support local Suicide Prevention/Postvention Committees throughout the state
- Identifying, training and supporting Peer Supporters throughout the State
- Working alongside Metropolitan suicide bereavement service, and other suicide prevention/postvention initiatives around the State.

There are difficulties in evaluating a state-wide project such as the one proposed. The model has been designed to be flexible enough to deliver different programs and interventions between communities depending on the needs, wants and local culture of the community. This means that there may not be any standard intervention that can be measured with in a "pre-post" type methodology across the whole State. This is also a common challenge when evaluating programs that work with Aboriginal clients, where engagement is sometimes long term and there is no clear "start and finish". However it is possible for the project to evaluate outcomes like:

- The efficacy of the training provided to services providers and community members
- The efficacy of the process of engaging and building relationships with the community
- Communities satisfaction, capacity and knowledge as a result of the project

Data on these outcomes are likely to be best gathered by using a mixture of qualitative and quantitative approaches.

It is recommended that the Aboriginal Postvention Project Steering Committee play an active role in designing the research evaluation so that it is culturally sensitive and includes outcome measures that are relevant to Aboriginal people and the longevity of the project.

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9. Recommendations

This discussion paper is the end result of the first phase in the development of a State-wide Aboriginal Postvention Project. The model proposed here requires ongoing consultation with the Aboriginal community to verify the model's utility and cultural appropriateness. It is recommended that the next phase in the model's development be undertaken, in particular:

- Formation of Aboriginal Suicide Postvention Project Steering Committee ("Taskforce").
- Identify funding body to finance the community consultative process of the Aboriginal Suicide Postvention Project.
- Undergo further consultation state-wide with the Aboriginal community in relation to the Aboriginal Suicide Postvention Project and proposed model of postvention for Aboriginal people.

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Appendix 1

ARBOR Ideal Model of Service for Aboriginal People Bereaved by Suicide in the Perth Metropolitan Area

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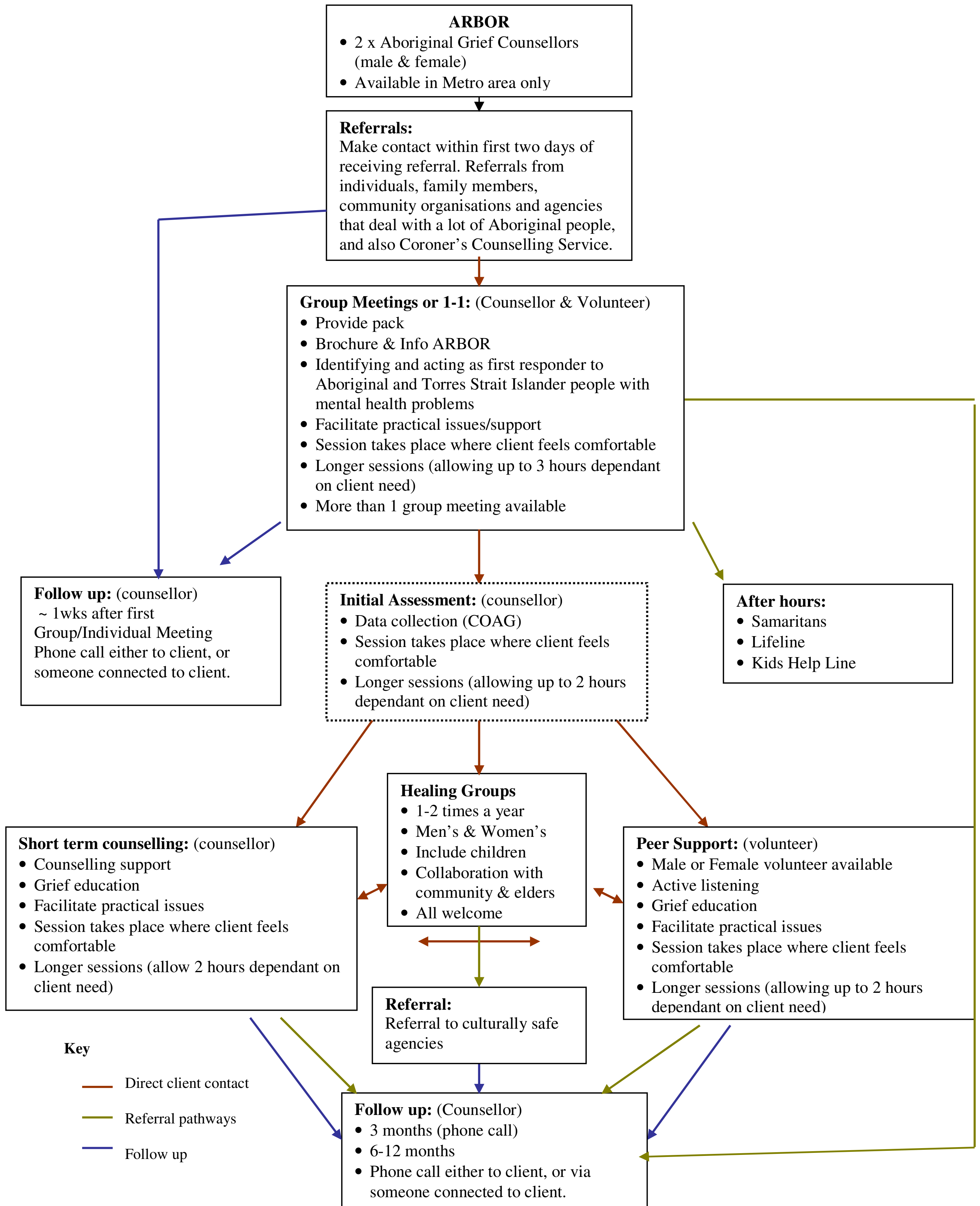

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