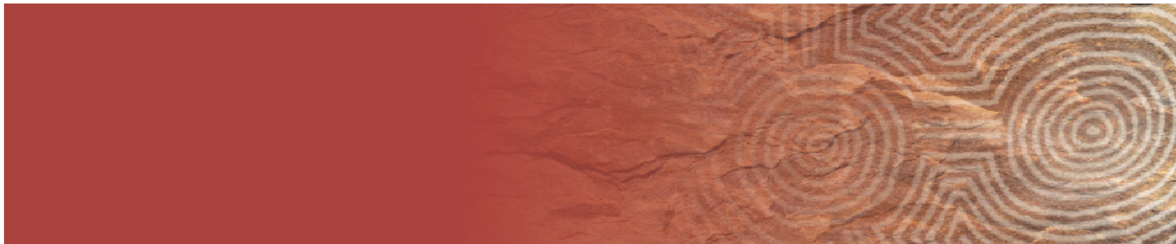

AUSTRALIAN INDIGENOUS PSYCHOLOGISTS ASSOCIATION (AIPA)

A Submission to the Australian Senate Community Affairs References Committee

Inquiry into Suicide in Australia

November 2009

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AUSTRALIAN INDIGENOUS PSYCHOLOGISTS ASSOCIATION (AIPA)

ABOUT AIPA AND INDIGENOUS CONCEPTS OF SOCIAL AND EMOTIONAL WELLBEING

AIPA is committed to improving the social and emotional well-being and mental health of Aboriginal and Torres Strait Islander individuals, families and communities through collaborative change campaigns with Indigenous and non-Indigenous organisations and those committed to 'closing the gap between Indigenous and non-Indigenous health outcomes. Specifically AIPA is working to increase the number of Indigenous psychologists and to lead the change required to deliver equitable, accessible, sustainable, timely and culturally safe psychological care to Aboriginal and Torres Strait Islander peoples in urban, regional and remote Australia.

AIPA believes the term 'social and emotional wellbeing' should be seen as an Indigenous concept that differs in important ways to non-Indigenous concepts of 'mental health'. The Social Health Reference Group (SHRG) for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group - responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* - drew a distinction between the concepts of 'social and emotional wellbeing' used in Indigenous settings and the term 'mental health' used in non-Indigenous settings:

> *'The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment.*
>
> *The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual'* (SHRG, 2004:9).

Social and emotional wellbeing (and 'mental health') forms part of the holistic view of health:

> *'Aboriginal and Torres Strait Islander health is viewed in a holistic context that*

encompasses mental health, and physical, cultural and spiritual health. Land, family and spirituality are central to well being. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognized as well as the broader concepts of family, and the bonds of reciprocal affection, responsibility and caring.

Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's health, mental health problems in particular' (SHRG, *2004).*

Risks to the social and emotional wellbeing of Aboriginal and Torres Strait Islander people have been identified as:

> *'Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage'* (SHRG, 2004:9).

Protective factors for Indigenous social and emotional wellbeing have been identified as connection to land, culture, spirituality, ancestry and family and community. These factors can serve as a unique reservoir of resilience and recovery in the face of adversity and moderate the impact of stressful circumstances on social and emotional wellbeing at the individual, family and community level.

In its paper 'Living On The Edge: an Overview of Factors Impacting on the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People: Risk and Protective Factors and Serious Psychological Distress', AIPA has collated epidemiological data to support the Indigenous-identified determinants of social and emotional wellbeing and the development of serious psychological distress, which has

been linked to an increased risk of suicide (Kelly, Dudgeon, Gee & Glaskin in press). The National Aboriginal and Torres Strait Islander Health Survey 2004-05 (NATSIHS) showed over one quarter of adult Indigenous respondents reported serious psychological distress, and were twice as likely than other Australians to report this: 27% compared to 13% across all age groups. The influence of the determinants of Indigenous social and emotional wellbeing and the impact on resilience and increased risk of suicide require further investigation.

INTRODUCTION

The Royal Commission into Aboriginal Deaths in Custody first brought national attention to the growing problem of suicide among Indigenous Australians (RCADC, 1991). The report drew attention to the links between substance misuse and mental health disorders in the years and months prior to most of the deaths. It also highlighted that just under half of those who died in custody had a history of being removed from their natural family. The inter-connected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged as contributing to the heightened risk of mental health problems and suicide. The rate of suicide in prison was actually similar to that shared by all Indigenous people: the number was high because the number of Aboriginal people in the justice system was disproportionately high. The commission made broad recommendations for Australian governments to address the underlying social, economic and political circumstances - including the over-representation of Aboriginal people in the justice system.

Suicide was not known in traditional Aboriginal society and up until the 1960s was a rarity (Elliott-Farrelly, 2004). However, the 1970s saw an increase in the incidence of suicide and suicidal behaviour. By the 1980s, the situation had become endemic in some Aboriginal communities and in the past decade suicide has become a significant contributor to premature Aboriginal mortality (Hunter et al., 2001).

Between 2002 and 2006 suicide was responsible for 4.7% of all deaths of Indigenous Australians and constituted 8% of deaths due to avoidable conditions (AIHW, 2009). Currently Indigenous people die from suicide at twice the rate of non-Indigenous

Australians. From 2001 to 2005 suicide was the leading cause of death from external causes for Indigenous males. The rate was almost three times that for non-Indigenous males. Suicide is more concentrated in the earlier adult years for Indigenous people compared to others, with the highest rates for both males and females being in the 15-24 years age group. Indigenous males and females are hospitalised for injuries related to self-harm at three and two times the rate of other males and females respectively (Ibid).

The averaged suicide rates among Indigenous males for Queensland, Western Australia, South Australia and the Northern Territory were between three to four times higher than those of non-Indigenous males. The highest rates were among Indigenous men aged 25-34 years. The age-specific rate was 110 per 100,000 in comparison with 30 per 100,000 for non-Indigenous men (ABS, 2008). However, differences in rates are evident between these jurisdictions. For example, within the Northern Territory, Measey et al (2006) found that the suicide rates among the Indigenous males aged 45 or less had increased by 800% over the period 1981 and 2002, while the rates for non-Indigenous males aged 65 or less had increased by 30%. The all ages rate of suicides of Indigenous men in Western Australia had increased by 700% from 5 per 100,000 in 1986 to 35 per 100,000 in 2002, while the comparable rates for non-Indigenous men remained essentially unchanged at around 21 per 100,000.

There is a significant amount of research documenting that the rate of completed suicide among Aboriginal populations occurs at twice the rate of that in the general population. Suicidal behaviour is best understood as a complex interplay between genetic, psychological, environmental, and community factors that requires a multifaceted approach. Furthermore, Aboriginal suicidal behaviour has been conceptualized as multi-layered determinants which have been repeatedly identified by Aboriginal and Torres Strait Islander people as including loss of some culture, history of traumatic events, community factors, individual factors, and family factors (Silberg, Glaskin, Drew & Henry, in press).

To date, few empirical studies have evaluated the factors that increase risk of suicide in Aboriginal and Torres Strait Islander populations and communities, or how these may vary between mainstream populations or within the diversity of Aboriginal and Torres Strait Islander peoples, cultures and communities. There is an even greater shortage of

research on evidence-based interventions for preventing suicidal behaviour in Indigenous communities or individuals or evaluations of the range of interventions that have been applied in Indigenous settings. There is an urgent need for Indigenous-led research to identify the risk factors for suicidal behaviour, utilizing a broad public health approach to preventative interventions. Working with Aboriginal communities to delineate interventions that are most likely to be successful in specific communities is a necessity.

The Need For A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

Most researchers recommend that suicide prevention initiatives should focus on constellations of risk and protective factors. However, it cannot be assumed that the risk and protective factors for suicide are the same across Indigenous and non-Indigenous cultures and populations, or that findings from non-Aboriginal populations can be generalized to Aboriginal populations.

The development of universal, targeted and focused interventions to prevent high levels of suicide in the Indigenous population requires an in-depth knowledge of Indigenous cultures and communities. As mentioned previously, as well as the factors influencing the 'mental health' of all Australians, there are additional factors impacting on the social and emotional wellbeing (SEWB) of Indigenous people. This additional layer associated with the legacy of colonisation and enduring disadvantage contributes to the development of serious psychological distress and associated suicide risk among Indigenous people (Kelly et al, in press). The risks associated with unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage are not shared in equal proportions with the non-Indigenous population. In addition, Indigenous cultural concepts such as connection to land, culture, spirituality, ancestry and family and community can serve as protective factors to moderate the impact of the identified risk factors at individual, family and community levels. The nature of the extended family can offer a range of strategies to monitor and reduce suicide risk in ways that are not available in non-Indigenous wettings. These factors should be integrated into suicide prevention strategies for Indigenous populations and

communities.

Despite evidence of these differences, Aboriginal suicide continues to be addressed under the same framework as the general population by national suicide prevention strategies (Elliott-Farrelly, 2004). Many Aboriginal initiatives continue to be adapted from existing non-Aboriginal models, which are based on non-Aboriginal understandings of suicide, health, healthcare and risk profiles. Others have noted that many Indigenous studies have used culturally unsuitable methodology, contradictory claims and poor reporting (Swan & Raphael, 1995).

RESPONSE TO THE IMPACT OF SUICIDE ON THE AUSTRALIAN COMMUNITY INCLUDING HIGH RISK GROUPS SUCH AS INDIGENOUS YOUTH AND RURAL COMMUNITIES WITH PARTICULAR REFERENCE TO:

Section a) – The personal, social and financial cost of suicide in Australia:

Indigenous families experience bereavement due to suicide at twice the rate of other Australians. The nature of extended families and the interconnected nature of some communities ensures the grief is transmitted to large numbers of people. It is not uncommon for Aboriginal families and communities to be affected by numerous deaths and suicides within a relatively short period of time. Often there is little time to recover from one loss before another has occurred, leaving whole families and communities in a constant state of mourning, grief and bereavement (Ugle, Glaskin, Dudgeon & Hillman, 2009). The small and close knit nature of Indigenous communities means every suicide has a widespread impact with ripples of loss, grief and mourning extending throughout the community and beyond - particularly where communities are highly interconnected. This can create layers of increased risk within affected communities during the grieving period, and in some situations a 'suicide cluster' can form. The nature of suicide clusters mean they can unfold over time and alongside existing relationship networks, further compounding and extending the grief, loss and distress experienced by the survivors of suicide (i.e. the families and communities) (Ibid).

Adding to this distress is a lack of access to culturally appropriate social and emotional wellbeing services or even mainstream 'mental health' services leaving many Indigenous communities without adequate resources to address the immediate needs of those most at risk. The lack of on-going community wide suicide prevention programs in Indigenous communities means those on the ground are often forced to watch a suicide cluster unfold without the capacity to implement a culturally competent community-wide response. Such a response may include activities such as family and community meetings to raise awareness of the risks and taking vulnerable members away from the community on cultural camps to implement strategies to shore up their sense of identity and community connectedness.

Submission-based suicide project funding prevents the development of a community-wide response to identified risks unique to the Indigenous population (eg cluster formation). Ongoing dedicated funding to a national program would allow for a focused Indigenous population wide approach which would ensure that services are established to contribute to the prevention of suicide and address clusters as they are forming. There needs to be flexible funding available to respond to suicide clusters in Aboriginal communities for quick start-up projects to address this phenomena as it arises.

Section b) The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicide, (and the consequences of any under-reporting on understanding the risk factors and providing services to those at risk):

The actual rates of Indigenous suicide are believed to be higher that the officially reported rates (Elliot-Farrelly, 2004). Contributing factors include the misclassification of Indigenous status on death certificates and other data systems (ABS and AIHW, 1999); differences between jurisdictions in their coronial processes; the procedures around reportable deaths (i.e. deaths which must be reported to a coroner); and the strictness with which the legal criteria are applied in arriving at the official determination of the death being suicide (Harrison et al 2001; ABS, 2006). There is a need to reduce these uncertainties so that accurate risk profiles can be developed to support prevention, to improve understanding of the various factors associated with suicide and to reliably monitor trends.

Currently, risk profiles developed to underpin preventative strategies reflect mainstream risks and priorities rather than those found in Indigenous communities. Consequently, they are or limited utility in Indigenous settings.

Section c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide:

Examples of effective suicide prevention and post-vention programs developed by Aboriginal people specifically for Aboriginal settings are initiatives such as the Yarrabah Life Promotion program in Far North Queensland and the Yorgum Family Counselling service in Western Australia. Both were established in response to high levels of community distress and grief following multiple suicides, both have been evaluated and shown to be effective and both have been identified as 'promising' practice in a range of reports.

However, there is a lack of an established and on-going funding stream for locally-developed suicide prevention programs in Indigenous communities. While established using one-off or short-term funding, often community demand/need will leave the service unable to close. Without a source of on-going funding, the service may limp forward but will be chronically under-resourced and leave staff at risk of burnout. Using the Yarrabah Life Promotion program as an example, despite achieving a precipitous reduction in suicides over a ten-year period and being used as an exemplar around Australia, the program survives on just a small amount of funding from Queensland Health.

Programs such as the Yarrabah Life Promotion Program use a community-wide response framework which includes police, the range of health service providers and a number of community members trained to provide a 24-hr emergency response during periods identified as being high risk. The 'promotional' elements include the provision of education about suicide risks at the individual, family and community level.

Darryl Henry, a Western Australian Aboriginal psychologist, has recently developed a promising three level model of community healing through his therapeutic support to a

number of Western Australian Aboriginal communities recovering from suicide clusters (Henry 2009). This integrated community healing model which involves a strategic response to suicides and suicidal behaviour, includes Aboriginal people as the key 'first-response' service providers. More broadly, the model has a primary focus on the holistic health of the community, and incorporates a community approach to addressing issues.

Section d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide:

Mainstream programs that raise awareness of suicide and encourage help-seeking are likely to have little meaning in Indigenous contexts. At the same time there is a lack of a body of evidence about the prevalence and causes of suicides in Indigenous settings on which to base public awareness messages and programs. The most effective form of social marketing about help-seeking in Indigenous communities (all of which are small) is community engagement and 'word of mouth'. 'Fly in, fly out' or media delivered suicide prevention strategies are less likely to be effective than community based initiatives developed and implemented by local people.

Even if public awareness programs resulted in help-seeking, there is a lack of social and emotional wellbeing services available as part of comprehensive primary health care to respond to help-seeking. While many Aboriginal Community Controlled Health Services provide access to specialised counselling for Stolen Generation survivors, (such as Brining Them Home counsellors and Link-up case workers) only 19 (13%) of the 150 services around Australia have been resourced to provide the general Aboriginal and Torres Strait Islander population with access to additional social and emotional wellbeing counseling services as part of comprehensive primary health care.

Universal access to comprehensive primary health care is crucial in remote Australia where an estimated 92,960 Aboriginal people live in over one thousand communities located on traditional and other lands (ABS, 2007). Only 332 communities have more than 50 permanent residents with 17 communities containing one thousand people or more. None contain more than 4,000 people. Less than half (47% or 41,450) of the Indigenous population in larger discrete communities have access to Aboriginal Community Controlled Health Services that provide social and emotional wellbeing

support as part of culturally appropriate comprehensive primary health care, and importantly, where Aboriginal Health Workers are the first point of contact (ABS, 2007). The remaining 35,737 (43%) of the population in the larger discrete Aboriginal communities has access to 104 state-funded Other Primary Health Services which are administered without community input, not funded to provide comprehensive primary health care, have poor retention of Aboriginal Health Workers, and tend to use nurses to provide care usually provided by doctors in urban settings (ABS, 2007). At the same time rural nurses report a lack of competence to deal with mental health issues (Clark, Parker & Gould, 2005). Only 14 of the Other Primary Health Services (serving a population of 11,344) provide access to a doctor on a daily basis. Only 4 of these are GP's who can provide access to major national programs to address high prevalence disorders such as anxiety and depressions through Medicare subsidised psychological services such as Better Access to Psychiatrists, Psychologists, PBS items etc (AIHW, 2008).

Section e) The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk:

As part of the COAG Action Plan on Mental Health 2006-2011, an adapted Mental Health First Aid training program was implemented nationally for a range of workers in the Aboriginal Community Controlled Health Sector. The 2-Day training course prepared workers to detect those at risk of suicide and to encourage them to seek help. This training fails to take account of the lack of referral points in Indigenous communities as noted above if and when suicide risk is detected, and the reduced access to those with the skills to deliver effective interventions if such an emergency arises.

In any case, mental health literacy programs based on mainstream understandings of mental illness are likely to have limited impact on suicide rates in Indigenous settings, since mental illness is only a small component of a much greater issue: social and emotional wellbeing (SEWB). The Indigenous concept of SEWB needs to be fully articulated or operationalised into community-wide SEWB promotion strategies to address risks to SEWB, the development of serious psychological distress and associated risk of suicide.

Section f) The role of targeted programs and service that address the particular circumstances of high-risk groups:

One of the unintended consequences of the lack of a national Indigenous suicide prevention policy is that Indigenous populations and communities miss the opportunity to implement universal strategies to promote social and emotional wellbeing at a national, regional or community level. Being perennially identified as an 'at-risk' group within the broader Australian population strategies results in the repeated delivery of selective or indicated strategies, where only small pockets of the most vulnerable receive short-term support. Over time this takes on a 'scatter-gun' appearance, where there are multiple, short term projects which reach only small numbers and whatever gains are made during the project are not maintained. The critical balance required to achieve population-level awareness or prevention of suicide across the Indigenous population cannot be achieved using such an approach.

Section g) The adequacy of the current program of research into suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy:

It has yet to be determined what services and interventions are required at a population level to prevent high rates of suicide among Indigenous people. There is an urgent need to develop an Indigenous-specific suicide prevention strategy targeted to the diversity of Aboriginal and Torres Strait Islander people in urban, regional and remote Australia. Generic evidence based universal, selective and targeted strategies for the Indigenous population are required which can be individualized to suit particular regions or communities. This should include the capacity to recognize and respond to the pre-conditions or early indicators of a suicide cluster at a community level and a capacity to screen for serious psychological distress in individuals.

Some early work has been done in this area, for example, Aboriginal psychologist Tracy Westerman has developed a range of indigenous specific training packages and intervention programs focusing on suicide prevention, depression and trauma management (2004).

Section h) The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

For how this applies in Indigenous settings, please see response to Section f.

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