DISCUSSION PAPER TO SENATE COMMITTEE INQUIRING INTO SUICIDE PREVENTION IN AUSTRALIA:

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The impact of suicide on the Central Australian Aboriginal community

a) the personal, social and financial costs of suicide in Australia

The very high rate of suicide over the past fifteen years, within some families on remote Central Australian Aboriginal communities, means that there are few people without personal stories of loss. Threats of suicide is now used as a threat by some young people to get attention and access to money for alcohol and other drugs from other community members. The trauma of past suicides, and the fear of suicidal and self harming behaviour, impacts on the decision-making for many families.

b) the accuracy of suicide reporting in Central Australian Aboriginal community,

Many communities do not have resident police. There can be delays in reporting suspicious death, particularly of itinerant people with a history of substance misuse. When the cause of death is a motor vehicle accident, a person wandering away into isolated areas, or other ambiguous dangerous acts, it is unusual that these deaths are recorded as suicide. Many suicidal deaths of community members occur when people are away from their home community and are intoxicated in Alice Springs, Tenant Creek or at a highway alcohol outlet. Often the other people around are similarly intoxicated. Many of the witnesses have English as a second or subsequent language. Often they have a poor history with the police. Some people are unlikely to volunteer information to the police. There are also cultural reasons that people don't volunteer information. Additionally there can be serious consequences for people because of a death being attributed as suicide and people are reluctant to have this role of saying the death was suicide. [see the discussion paper below]

It can therefore be difficult for police and coroners to collect good background information as to intentionality. As a consequence there can be a significant under-recording of suicide. There is also poor data on self harming behaviour on most communities; and some variations across the States and Territories around recording suicide. Data on Central Australian Aboriginal communities crosses into SA and WA border regions..

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;

There has been some useful training provided through Life Promotions, Life Line [ASIST workshops] and now through the NT Suicide Prevention Strategy that has improved the effectiveness of many staff working in government agencies and NGOs when these staff are responding to requests to intervene with people at risk of suicide. But the very high turnover of staff in these agencies, [particularly staff in remote settings] means that we need to continue to deliver regular training opportunities.

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;*

As stated above there has been some useful training and awareness campaigns provided through Life Promotions, Life Line [ASIST workshops] and now through the NT Suicide Prevention Strategy that has improved the awareness of many staff working in government agencies and NGOs when these staff are responding to requests to intervene with people at risk of suicide. There has also been attempts to engage community members in Suicide Awareness workshops. But it is expensive to deliver programs in remote settings. It has been difficult to develop better and more appropriate suicide awareness material

e) *the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;*

As above there has been some useful training and support programs developed and delivered regularly in recent years. This has helped. But as said above, the high turnover of staff and the common complaint of staff overload means that we need to continue to provide effective training opportunities.

f) *the role of targeted programs and services that address the particular circumstances of high-risk groups;*

For many years Central Australia has been fortunate to have the Life Promotion service auspiced by the Mental Health Assn of Cent. Australia. We has also had Life Line providing training opportunities in ASIST. We also had some suicide prevention projects in remote areas funded through the National Suicide Prevention Framework. Continuing to build on these projects would be useful. The discussion paper attached explores ways of enhancing locally based services to address some of the underlying stresses that leads to the continuing very high levels of suicide in remote Aboriginal communities.

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

See discussion below for areas where it would be useful to research issues to get better data

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

The NSPS Board have done some very effective work in developing responses that have reduced the fatality of some self harming approaches. It has also developed good data on what assists in supporting individuals with suicidal idealation and/or people at higher risk of suicide. They have worked well in developing State, Territory and regional strategic plans; and in providing advice to all levels of Government.

In the past Central Australian Aboriginal Congress had representation at the National Consumers and Experts Sub-Committee of the NSPS through the Aboriginal Medical Services Assn of the NT [AMSANT]. But the NSPS sub-committee was struggling to have much input up the line into the NSPS Board and DOHA . It seemed more useful to disband and use other networks. So the sub-committee voted to disband. At a broader level the barriers for the involvement of a Central Australian Aboriginal community representative is the expense, time away from the workplace, the logistics of being involved and the existing overload on SEWB workers.

DEVELOPING ABORIGINAL FAMILY SUPPORT SERVICES TO IMPROVE OUTCOMES IN SUICIDE PREVENTION IN REMOTE ABORIGINAL AUSTRALIA. IMPROVING TH SUPPORT FOR THE FAMILY SURVIVING & HEALING AFTER A SUICIDE.

written within the Social And Emotional Wellbeing Branch of Central Australian Aboriginal Congress by Christine Palmer, Gerard Waterford and Sue Grant [2008].

Background: Central Australia has many quite different Aboriginal communities. For the purpose of this paper these local Aboriginal communities have been broadly placed into three groups;

- Aboriginal families that live and identify with traditional land outside of urban centres. These families have their local Aboriginal language as first language and English as second or subsequent language. They still practice many aspects of traditional culture. Poor infrastructure investment[1] over time in the areas of housing, employment, health and education and rapid population increases have seen the reduction of opportunities for local residents to access adequate services. These were communities targeted under the National Emergency legislation in 2007.
- Aboriginal families originally from remote communities who have made the transition into urban town camps usually over the past thirty years. They retain links to their community of origin, language and culture. Inadequate infrastructure has reduced the amenities of most town camps to the level where they operate as transient camps between town and remote areas. Again these were communities targeted under the National Emergency legislation in 2007.
- Aboriginal families that are traditional owners of urban centres; or have long intergenerational association with an urban centre through Government missions and/or employment policies.

This paper focuses on the first two groups. It is men from these two groups and men in transition between the two groups that are overwhelmingly represented in the suicide data. It is the families of these men that are requesting additional support with bereavement services; and who are the families targeted for additional suicide prevention programs.

In recent times we have seen alarming data confirming the very high rates of suicide for Central Australian Aboriginal men across the 15 years to 35 year age groups. A brief analysis shows that they are disproportionally men

1. who have grown up in remote Aboriginal communities or in the town camps of Alice Springs;
2. who have English as a second language, and
3. who have attempted to make the transition into an urban lifestyle in Alice Springs, Adelaide and/or Darwin

[1] See appendix 1. ‘A snapshot of the Territory’ complied by CAAC from many sources

Whilst extensive demographic analysis of suicide figures is difficult because of low population, and perceived inconsistencies in recording coronial data, the thrust of the data is replicated across remote and regional Indigenous Australia[2].

Across Central and Northern Australia, there has been a growing awareness of remote area Indigenous distress. In addition to news of the alarming rates of attempted and completed suicide this awareness has grown out of media exposure about endemic poly-drug use patterns, [particularly of petrol sniffing by Aboriginal youth], and stories of increased family violence including the sexual abuse of children.

PROPOSED GUIDELINES FOR DEVELOPING EFFECTIVE FAMILY SUPPORT AND COUNSELLING PROGRAMS TARGETING BEREAVEMENT AND SUICIDE PREVENTION IN CENTRAL AUSTRALIAN INDIGENOUS COMMUNITIES.

1. The cornerstone of any effective local Aboriginal bereavement and suicide prevention services will be the employment of senior Aboriginal people in the delivery of intervention programs. We need to build meaningful and sustainable local Aboriginal employment pathways for senior Aboriginal community members as family support workers, bereavement counsellors, and crisis response team members. This needs to acknowledge the current skills training gaps, the program support deficits, data collection and reporting requirements of successful services, and the known difficulties and obstacles that indigenous workers are going to face in working in these areas over time.
2. Rituals associated with death, funerals and 'sorry business' are very important within Aboriginal culture. It is an area where traditional cultural rules have been steadfastly maintained despite colonisation and dispossession. Mainstream service development plans [even if just into areas of bereavement after suicide] need to be very conscious of the fear that some cultural leaders have of their culture being replaced by non Indigenous service models and non Indigenous 'expertise'. Program development needs to ensure the centrality of respectfully working within an Aboriginal cultural framework. The timing and manner of any planned intervention models needs to be aware and respectful of existing obligations and responsibilities of family under currently practiced cultural processes surrounding funerals and respecting the deceased person.
3. Any effective service needs to be comprehensively linked into existing local health clinics, schools, substance misuse, disability and other family or community service infrastructure. They need also to have effective links to specialist visiting mental health programs, counselling and group work staff and residential rehabilitation services. This includes linkages to outreach family support programs operating within prisons, correctional services, employment, child protection, family violence and legal services.
4. Staff working within bereavement and family support services need the support of local community and family leadership structures. This includes

[2] Suicide in the Northern Territory 1981-2002 Mary-Anne L Measey, Shu Qin Li, Robert Parker and Zhiqiang Wang MJA Vol. 185 No.6 18th Sept 2006. pp 315-319

having clear understandings with community councils, health councils, and Nightpatrol and community policing structures. These community based leadership groups need to support community debate that creates effective understanding about limitations of intervention and protection of particularly indigenous staff from possible payback situations and/or the unreasonable level of demand from some desperate family groups.

5. There is an urgent need to customise and improve the accessibility of information packages in the bereavement and suicide intervention areas. This can perhaps be best done within an action research process similar to that proposed under the Waltcha and Life Promotion initiative that works with communities to develop and customise their own resource packages.
6. There is a need to better understand suicidal death within Aboriginal communities in transition. An active community discussion that stories existing community knowledge would be an effective way of engaging the community in finding and supporting cultural change that reduces substance misuse, self harm behaviour and suicidal idealation within particular sections of the Aboriginal community.
7. Carer groups within the Aboriginal community have a desperate and legitimate need for respite care services. The failure to provide these services is a part of the distress currently experienced by many carers. It is a barrier for people continuing to support and care for high needs and at risk people over time. The respite care service may explore taking carers out of high demand situations [giving people holidays] in addition to providing out-of- community placements for behaviourally challenged and at risk family being cared for.
8. We need to find ways of working well and harnessing the knowledge of groups of grandmothers, mothers and carers. In addition we need to engage with groups of strong men. This will ground service developments within an effective community owned and supported framework.
9. Knowledge about contemporary relationship patterns, extended family parenting systems and separation issues. These are well known triggers for young people spiralling into substance misuse, violence, self harm and attention seeking behaviours in addition to them leading to increased social isolation and depression. This knowledge is important to build effective pathways out of contemporary community stress and dysfunction.
10. We need strategies to address the epidemic of substance misuse, and associated problems with elder abuse.
11. It would be very beneficial to explore and build capacity for communities to hold wider spiritual healing events.

Other Partial Solutions include:

- Preventative and early intervention options need to be explored that engage young people with their families whilst they are still at school. High-risk children should be identified and specific strategies employed with families where children are seen as following a path towards isolation, anti social behaviour and/or substance abuse.
- Substance abuse services need to be developed that can cater for inter-generational family groups.
- There is a need to develop detoxification, residential treatment and longer-term rehabilitation programs that actively explore with the client's carers

and extended family, the healthy re-engagement of these clients within their community of origin. Harm minimisation strategies including crisis accommodation, counselling and support need to be explored.

- Find and establish creditable ways for the proposed bereavement and family support services to build community capacity to take responsibility for community development and leadership within their own communities. This will involve working to tackle entrenched poverty, employment and primary health care infrastructure deficits within remote Aboriginal communities.

Explanations for High Rates Of Indigenous Suicide today:

CULTURAL TRANSITION: According to Colin Tatz's research report titled 'Aboriginal suicide is different'[3] the historical experience of Aboriginal communities in Australia since colonisation provides a framework for understanding contemporary distress within Aboriginal communities.

'Their losses have been catastrophic: a land base, their "country", cultural practices found to be "abhorrent" to white society, decision-making by the elders, discipline and control by elders, birth and mourning rituals, even the traditional employment of men and women as vegetable pickers, or men as railway gangers, fencers or shearers, and much more. These losses are not experienced only by those considered to be traditional people; they have occurred among those Aborigines living in the mainstream suburbs and towns who maintained a strong sub-culture of Aboriginality.' 'Regardless of regional, linguistic, tribal, clan, and "degrees-of-blood" differences, Aborigines were, and are, perceived as *one people*. If there is indeed a one-ness, it lies in a *commonality of history* - victims of physical killing, settler animus, missionary contempt, decimation by disease, legal wardship, and destruction of their social institutions. History, rather than race, colour or culture, has been their unifying and sustaining separateness.'

Tatz writes of the distress in Indigenous communities that has led to 'violence: domestic, interpersonal and now suicidal, a phenomenon virtually unknown in Aboriginal societies until 30 years ago. It has also appeared as sexual assault within families, drug-taking, alcohol abuse and corresponding involvement with the criminal justice system. [4]

FATHERING: Another related explanation is that last fifty years have seen very altered roles played within Indigenous families by Aboriginal fathers. Fifty years ago most Aboriginal fathers in remote Aboriginal Central Australia existed in intact families. There was a mum and dad looking after their kids mostly within a well-known and easy to reach extended family and community. Fathers had established roles within family and culture. The men were often older than their partners and had

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[3] 'Aboriginal suicide is different' : Aboriginal youth suicide in New South Wales, the Australian Capital Territory and New Zealand : towards a model of explanation and alleviation' Colin Tatz Criminology Research Council grant ; (25/96-7) 14 July 1999

[4] Executive Summary 'Aboriginal suicide is different' Colin Tatz Criminology Research Council grant ; (25/96-7) 14 July 1999

already made their way into an adult world prior to their marriage. It was a patriarchal world, where men had a lot of authority and power. These days it can be dramatically different. The age difference between husband and wife is usually small. Relationships and parenting frequently commence as teenagers. Mothers and grandmothers are seen as having much greater power in relation to their children. Their male partners are often left with little power and few roles. If parents separate many children see little of their father or other caring men in their growing up years.

Aboriginal fathering roles have been made more difficult by changes in employment patterns, social security payments, child protection practices and the relocation of many Aboriginal families from a remote and more traditional lifestyle into a more urban and culturally changing lifestyle. Commonly Aboriginal fathers have become forgotten and almost invisible in social planning and thinking. Perhaps as a consequence of difficulties experienced by Aboriginal fathers and government social planning we are witnessing huge increases in separated parents with many more children brought up in women headed households. Fathers after separation are not perceived as having equal status in the care and parental decision making. In a related issue many men and women have more than one relationship. Kids live in blended families with step-brothers and sisters. There are more single fathers, step-fathers, fathers that only see their kids for short visits, and fathers that don't see their kids at all. This can be painful for fathers and rarely works out well for kids.

The lack of successful married relationships, little access to their children, and dislocation from country and extended cultural connectedness sees many Aboriginal men from remote communities living on the edges of overcrowded and alcohol saturated town camps with few if any socially valued roles. These are the men that commit suicide often whilst heavily intoxicated and after many attempts. It is often well known within the community that these men are at very high risk.

Common fatherhood stories repeated by Aboriginal men from remote communities see them describe themselves as being left behind and without hope. Remote area mental health workers, community workers and counsellors describe many Aboriginal men as being at high suicide risk because of the following common features:

- Possible cognitive and physical deficits because of a history of poverty and childhood malnutrition, chaotic parenting patterns made worse by parental and extended family substance abuse patterns. These men often suffer from low self esteem and lack status within their own community.
- Poor family attachment patterns through childhood and adolescence. This can include family history of childhood sexual abuse, transience, neglect, and the involvement statutory child protection and out-of home care services.
- Intergenerational substance abuse patterns. Substances of choice tend to be psychotropic substances [petrol & inhalants], marijuana, and barbiturates]. Because of availability issues and extreme poverty Aboriginal men usually access the cheap and nasty intoxicants often with significant side-effects.
- Historically poor attendance at primary school and early onset behaviour problems. The behaviours range from excessive isolation patterns through to mood swing cycles and violence. They leave school early and are unlikely to continue into further training or employment. They often face long periods with no income because of an inability to satisfy Centrelink income support

requirements, until such time as they are supported to be accessed for disability support payments.

- Often an admission into a psychiatric admission centre for behaviour problems with psychotic symptoms by their late teens. The diagnosis on admission often queries schizophrenia, drug induced psychosis and disorders of personality.
- Episodic readmission to MHU over subsequent years following a continued pattern of violent behaviour, self harm, substance abuse and erratic behaviour.
- Increased isolation from family networks and friends.
- Increased periods of transience and homelessness.
- Referral for disability case management and support services who have little capacity to accept the referral because of accommodation program wait lists.
- Reduced engagement of mental health funded services over time, as the person's erratic behaviour sees them refused further services because of compliance, effectiveness and worker safety issues.
- Episodic violent behaviour that leads to police involvement, court charges and periods of imprisonment.

Known Suicidal Risk Factors:

It is expected that there will be a higher number of Aboriginal teenagers and younger men from remote areas who will be diagnosed with a dual diagnosis and/or disorders of personality. They are at high risk of suicide. Their behaviour usually includes episodes of self harm and suicidal ideation. The reasons for this include:

- Increased availability and use of mood altering drugs [particularly inhalants, marijuana and speed] by young people in and around most regional centres.
- Ongoing intergenerational stress within many Aboriginal family groups leading to increased family breakdown, and single parent households.
- Increased targeting of health care and rehabilitation accommodation support services in Alice Springs and similar service centres in remote area communities, to client groups where you can get specific outcomes within narrow timeframes. This approach reduces access to the above described pool of men who get denied services because of non-compliance and/or episodic misbehaviour.
- Increased use of sanctions and 'user pays' approaches from Centrelink and other broad based housing, employment and related 'welfare' service providers that see reduction in access to financial support to Indigenous men with a history of non-compliance and/or episodic misbehaviour.
- Increased relative poverty of Indigenous youth and unemployed groups because of lack of public housing and community service infrastructure.

The current experience of the Social & Emotional Wellbeing staff is that we provide limited crisis counselling and advocacy services for an increasing number of young Aboriginal young people from remote areas who are transient and homeless in town. They have often been denied access to specialist psychological support services because of a perceived ineffective engagement and/or client outcomes associated with them attempting to access these services. The clients are transient and homeless so difficult to provide a framework for ongoing support. Language and cultural appropriateness etc can be major barriers. The failure to

address the emotional distress of this client group contributes to ongoing accelerated patterns of poly drug use, self harm and suicidal ideation.

SOME CHALLENGES IN GETTING MORE EFFECTIVE BEREAVEMENT COUNSELLING & FAMILY SUPPORT SERVICE

Aboriginal Cultural Framework for Explaining Suicide.
Payback Systems: Many within the culture traditional Aboriginal family groups seek traditional reasons for any sudden death. These explanations are a part of attributing responsibility and/or blame. People wanted a world that was understandable. So explanations used often gave spiritual powers to people, other family groups, mystical figures and even objects, that were then blamed for causing a tragedy. Senior family members tried to establish a framework for 'payback' as a way of restoring balance between different family groups. In traditional culture when people lived in small family groups and the authority of law and culture was strong, senior law men and women met after an event to give weight to one interpretation of events. This then flowed into controlled and measured 'payback' responses. By today's standards payback punishments, particularly against wives, could often be seen as extreme. But they were largely understood and accepted within the Aboriginal family groups.

Today's Indigenous community in Central Australia is much larger and more fragmented. People come from a variety of tribal groups. Many are at quite different stages of transition from their homelands into a more urban existence in town. Traditional authority of senior Aboriginal leaders has been severely eroded. But the sheer weight of population and their connectedness through intermarriage sees many people the Aboriginal community participating in the funeral and 'sorry business' arrangements associated with multiple deaths over most months of the year. The weight of grief and loss within the community is overwhelming. Perhaps because of this, substance misuse and chaotic behaviour is widespread. In particular, groups of young people who take little account of the authority of older, senior people, even those within their immediate family, are often heavily involved in the self harm aspect of showing respect to a deceased person and in making decisions within sorry business processes. It is often the chaotic mob who often make decisions to carry out acts of substance-effected revenge under the guise of it being traditional payback punishment.

Fear of chaotic payback with groups of quite young intoxicated men seeking to randomly punish members of another family group can see potential victims of such payback inventing alternative stories to avoid being blamed almost from the moment that a death or tragedy becomes known. These days contemporary stories or explanations can include shifting the blame to within the victim's family or on to another family, and/or that the death was caused by Kaditja men, spirits, white groups like the KKK and/or what some Aboriginal people see as racist elements within police, health and other government services. For people that might be the subject of payback it can get very mixed up and dangerous. These personal safety fears for self and close family can see potential victims of payback leave town to avoid punishment. Alternatively they develop defensive [even attacking] capacity to stop what they see as unfair payback processes. This can mean organising and authorising their own group of chaotic substance affected group of young men to

take action against the other family. Currently there can be many people deeply concerned about what is happening with the Indigenous community that is labelled ‘payback’. The increasing lack of widespread respect and support for payback processes means that many people are looking for alternatives to payback to deal with punishment and taking responsibility with the community.

FEARS OF BEING BLAMED:

Working in an area that is seen as taking responsibility for working with people at risk of suicide, carries great risk particularly for indigenous workers. We already see this with Aboriginal Mental Health Workers where a person with an identified mental illness commits suicide or dies through other preventable causes. In the event of a person known to be at high risk of suicide actually committing suicide the family of the deceased can blame the workers for failing to prevent the death. This can be a way for family to avoid being held to be responsible themselves. But it can also be a legitimate criticism of the limitations of service provision in the family support and suicide prevention area.

The common method employed by grandmothers, mothers and wives who are the traditional carers within Aboriginal families when they are forced to deal with highly volatile young family members threatening self harm or suicide is often to appease the person The appeasement is often around providing marijuana, inhalants and/or alcohol. On other occasions it includes providing transport and money to enable people to continue an abusive substance misuse pattern. It can also include providing abusive people with access to victims of their abuse. At the same time families attempt to enlist services to intervene. This is usually through the community health clinic. Often the desperate carers are seeking residential rehabilitation and/or therapy options that deal with habituated substance misuse lifestyles and the associated disruptive behaviour of the person within the family. Unfortunately the capacity of community clinics, regional mental health and/or visiting counselling services to respond to family requests for assistance is extremely limited. The above services have major funding and workforce problems. They lack of suitably trained staff and service provision resources generally. Case management within being able to access accommodation and treatment services can be useless. Effective residential rehabilitation services are extremely hard to access and have very limited success with these client groups.

As a predictable consequence of an appeasement approach many at risk young people become increasingly attention seeking and demanding. It works. The messages health and community services give to struggling carers can be very contradictory. On the one hand desperate carers who are often themselves victims of violence, are told to set boundaries to reduce the behaviour. As victims of violence themselves, they are told to escape the abuse or at least set legal constraints on the at risk person accessing them when they are affected by intoxicants. On the other hand suicide prevention workers state that families must take every threat of suicide seriously and do whatever it takes to keep company with the at risk person and to do just about anything to get them through periods of articulated crisis. Carers can feel very vulnerable. If they fail to appease an at risk person and it results in the person carrying out the threat to self harm even suicide, then they not only lose a loved one, and see the terrible impact of this

death across their family group; but then can often face the horror of being blamed and physically punished by the community through the payback processes.

The problem of appeasement and consequent demanding behaviour is growing. Suicide and self harm threats have become much more normalised. Equally there have been such a high number of suicides in many family groups that the fear associated people actually carrying out their threats is also growing. People tell stories of hearing teenagers say to parents ‘give me money for gunja or I’ll kill myself. Strangers begging in the street ask for money saying that if you don’t give them the money they will commit suicide. Some serious community leadership and allocation of effective services is required to reverse current suicide trends. Bereavement groups are seen as the best way of establishing a framework for community leadership to develop in this area.

Cultural taboos about using the name of deceased persons.
Most grief and loss counselling and group work rely on being able to engage the grieving person in discussions that explore their relationship with the deceased. Within strict traditional Aboriginal culture there is a constraint on using the name of a deceased person. Invoking the name is seen as interfering with the spirit of the deceased person returning to their place in the spirit world. You risk calling them back and then having an unsettled spirit adrift in the community. Each traditional language group has a word that is substituted for the name of a deceased person. The substitute word indicates that as an act of respect the name cannot be spoken. How long the word is substituted for deceased person’s name is a measure of the respect and the closeness of the relationship of the people to the deceased person.

This particular taboo highlights the difference between traditional Aboriginal cultural grieving practices and contemporary models of providing grief and bereavement counselling. Other cultural constraints on using contemporary bereavement counselling processes are many and varied.

Despite these cultural differences there are an increasing number of senior traditional Aboriginal family members identifying unresolved grief as an important component of suicidal idealisation and high risk behaviour within their community. They want to work with bereavement counsellors to develop ways of culturally appropriately providing individual and group bereavement counselling in ways that best support the cultural safety concerns of participants and staff [particularly Aboriginal staff].

The challenge for counselling and group-work staff and potential participants can be to work through the embedded beliefs of those people within the Aboriginal family and community who continue to be deeply offended by what they see as an erosion of culture within contemporary bereavement practices. They can influence and effectively stop participants from attending silencing them. They can work to have counselling programs withdrawn from communities where they are seen as not respecting or offending against culture.

To progress the development we need to engage with senior cultural leaders. To do this well we need to develop better information packages on grief and

bereavement programs. We also need to open up a broader discussion around high risk behaviour and how best to prevent suicide. Similarly we need to build information resources that explain mental illness, organic cognitive and behavioural problems and the short, medium and longer term effects of substance misuse across the various intoxicants currently in use. Despite numerous requests for Aboriginal language multi-media information packages we still lack them.

RELIGIOUS INFLUENCES: For many traditional Aboriginal families traditional cultural practices have already incorporated some aspects of local Christian belief systems. They also have adapted traditional cultural practices to the realities of day-to day Aboriginal family experience. There is considerable diversity of views within the group of regional Aboriginal leaders about the ongoing role of Christian organisations in tackling suicide prevention work. The churches also have their own history of dealing with self harm and suicide that can see church leaders impose their sanctions to silence debate about how best to deliver effective intervention programs.

Some local Aboriginal leaders identify the historical adoption of Christian practices and the establishment of religious institutions in remote Aboriginal communities as being major influences in underpinning the declining authority and status of traditional Aboriginal culture and leadership over time. They see the contemporary churches as part of the continuing spiritual demoralisation of Aboriginal community aspirations. Others see the church as a major part of cultural revival. Certainly a lot of the key local Aboriginal leadership in the fight against substance misuse have a strong Christian belief system that they identify with their personal salvation.

The debate about the effectiveness of developing bereavement and suicide prevention services that are based on imported models of treatment and that operate in urban cities delivering their programs to a largely non Indigenous population, is unlikely to work well in remote Aboriginal Australia. This is similar to discussions about the usefulness of Christian spirituality when tackling Indigenous suicide prevention work. When governments decide to tackle the need to develop effective bereavement and suicide prevention services locally they will need to acknowledge and work within the diversity of community and family opinions on these issues. Programs will have to be actively adapted to the cultural context that they operate within.

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A snapshot of the Northern Territory

- Over the past two decades the Aboriginal population in remote communities has
- grown by approximately 40%.
- Remote Aboriginal communities are growing rapidly and simply do not have the
- same range, level and quality of public funded infrastructure and services that are
- provided in towns of similar size elsewhere in Australia.

Population

- Aboriginal people make up 30% of the NT's population and 12.5% of the national
- Indigenous population
- 38% of the Territory's Aboriginal population is children under 15 years

The Territory has 641 discrete Aboriginal communities

- 9 towns of 1,000 – 2,000 people
- 50 communities with populations ranging from 200 – 999 people
- 570 communities with populations of < 200 people.
- 72% of the Territory's Aboriginal population lives on Aboriginal land outside major towns
- Majority of Aboriginal people do not have good access to mainstream services

Health

- 54% of remote communities have don't have a local health clinic (ABS• 2006)
- 99% of remote communities have no substance abuse service (ABS• 2006)
- End stage renal disease (ESRD) in some NT regions up to 30 times the• national average.
- Projected cost of treatment for ESRD in next 5 years is estimated to be• $50 million
- Underlying causes of chronic diseases is linked to poverty and• disadvantage, poor living conditions, poor nutrition, low birth weight and infectious diseases

Education

- 94% of remote communities do not have a preschool•

- 43% of Aboriginal secondary school enrollments in the NT are registered• as 'ungraded' students (secondary school-aged students who have not achieved Year 7 primary school education)
- Lowest retention rate and participation of all jurisdictions•

3 **Housing**

- Source: Overcoming Indigenous Disadvantage: Key Indicators 2007
- Estimates by Territory Housing to meet• current unmet need is 5,000 dwellings in the next 3-5 yrs
- Total unmet housing and housing related• infrastructure costs is estimated to be $2.3b.

POPULATION BREAKDOWN

Total population estimates for the Central Australian region is about 50,000.

- Alice Springs - 28,000 (plus 2000 permanent Indigenous visitors)
- Tennant Creek – 3,000
- Barkly region – 3,000
- Yuendumu, Papunya, Kintore, Ntaria, Docker R, Imanpa, Aputulu, Eastern Arrentre, Sandover, and Plenty region – 10,000
- NPY homelands of SA and WA – 5,000

- Indigenous population is at least 40% to 50% of the total population with remote areas having 70% to 100% indigenous ratio.

INFRASTRUCTURE CHALLENGES

- An area larger than NSW with a population less than many Sydney suburbs.
- Dirt roads and limited public transport
- Poor housing infrastructure within remote communities including limited accommodation for imported staff into communities
- Small populations scattered across isolated homelands
- More than ten Aboriginal language groups with English as a second language
- Rapid pace of centralised social policy change
- Male Aboriginal employment has reduced over many decades.

APPENDIX 2:

Summary of Suicide Death for Central Australia between Jan 2001 and Jan 2007 *Data compiled by Life Promotions Program –Mental Health Assn of Central Australia 2008*

Age

- Total youth <25: **30**
- Total mature >25: **45**

Gender

- Female: **11**
- Male: **64**

Indigenous & Non-indigenous

- Non-indigenous: **19**
- Indigenous: **56**

Resident Communities

- Alice Springs: **25**
- Tennant Creek **14**
- Remote: **36**

The data available on suicide and self harm in remote Aboriginal communities of Central Australia over the past 10 years show an alarming per capita rate of completed suicide compared with the rest of the Australian community.

- Male Suicide Rates in 2006 remote communities
  - Above 100 per 100,000 and appears to be increasing
  - Mean age of male Aboriginal suicide is 30+
  - Wide disparity between communities

NOTE: More analysis of the data is likely to confirm anecdotal advice that whilst the completed suicide occurs in an urban setting, the primary place of residence of the person and their family is a Central Australian remote Aboriginal community.