

1 Context

The June 2010 report of the Inquiry into Suicide in Australia by the Senate Community Affairs References Committee *The Hidden Toll: Suicide in Australia* noted the high rates of suicide among Aboriginal and Torres Strait Islander peoples, differences in the pattern of suicidal behaviour and its disproportionate impact on families and communities. Recommendation 27 of the report recommended that:

“...the Commonwealth government develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy...” (SCARC, 2011).

The report also recommended that this strategy should:

- develop the capacity of communities and community organisations to provide local leadership and resources to enable Aboriginal and Torres Strait Islander peoples to take on the challenge of preventing suicide;
- provide postvention support to families and communities bereaved through suicide;
- be based on evidence and should provide professional support for effective practice; and
- be supported by the resources of all levels of government and across the whole of government.

In its response to the report the Australian Government acknowledged the unacceptably high rates of suicide amongst Aboriginal and Torres Strait Islander populations and supported the recommendation by announcing in September 2011, the establishment of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group (the Advisory Group) to guide the development of the Strategy (list of members at Appendix 1). The Advisory Group’s role was also to provide critical advice to Government on the investment of funding to be provided through the Taking Action to Tackle Suicide package for suicide prevention activity specific to the needs of Aboriginal and Torres Strait Islander peoples. An important piece of work that was completed by the Advisory Group during its tenure is the development of key principles to guide government investment in suicide prevention for Aboriginal and Torres Strait Islander communities. These principles underpin this Strategy and are listed on page 25.

Development

Following an open tender process, the Menzies School of Health Research was engaged in May 2012 to develop the Strategy in consultation with Aboriginal and Torres Strait Islander peoples and stakeholders across Australia, seeking public input into the development of the Strategy and assisted by the National Aboriginal Community Controlled Health Organisation.

Extensive consultation undertaken in the development of the Strategy included community forums and a national workshop. A [summary of the community forums and the outcomes of the national workshop](http://www.indigenoussuicideprevention.org.au/) can be accessed on the website at: <http://www.indigenoussuicideprevention.org.au/>.

Aboriginal and Torres Strait Islander suicide: Origins, trends and incidence

While suicide is believed to have been a rare occurrence among the Aboriginal and Torres Strait Islander people of Australia in pre-colonial times, it has become increasingly prevalent over recent decades, accelerating after the 1980s, albeit with variations in rates and in geographical distribution from year to year (ABS, 2012).

For example, the Royal Commission into Aboriginal Deaths in custody (RCIADIC, 1991) drew attention to the links between substance misuse and mental health disorders in the years and months before most of the deaths that it investigated. It also highlighted the disproportionate number of these deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children. The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged by the Commission as contributing to the heightened risk of mental health problems, substance misuse and suicide. (*Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*; 2010).

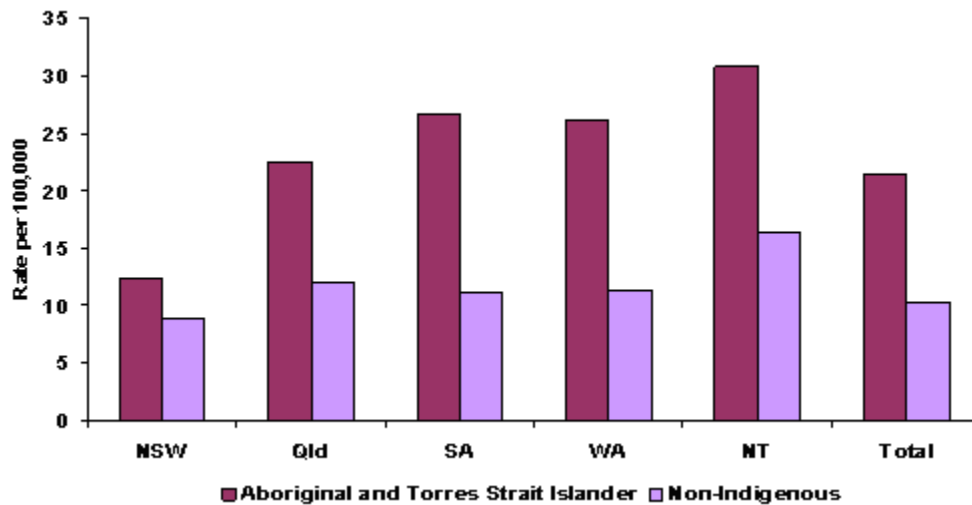
The mobility of Aboriginal and Torres Strait Islander peoples between remote communities and regional centres, particularly in the more remote areas is another anomaly of Aboriginal and Torres Strait Islander suicide that needs to be recognised. This means that these locations need to be considered as part of a larger system when considering the occurrence of suicide and its impact on communities.

The age distribution of the Aboriginal and Torres Strait Islander population is much lower than that of the non-Indigenous population because of higher child-to-adult ratios and shorter than average life expectancy. This has important implications for understanding the psychological impact of suicide on families and the available community response capacity in terms of supports and services for treatment and prevention. It is also relevant to another distinct feature of Aboriginal and Torres Strait Islander suicide: the phenomenon of 'suicide clustering', where an unusual number of suicides and episodes of suicidal behaviour occur in close proximity to one another within a particular community or region (*Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*; 2010).

It should also be noted that there have been significant peaks and clusters of suicides in some regions in the context of a generally wide distribution across most states and territories, particularly those with significant remote populations. There are significant fluctuations in rates from year to year in some states (De Leo et al, 2011).

Reducing suicide and suicidal behaviour among Aboriginal and Torres Strait Islander peoples is now a public health priority for all Australian governments (SCRGSP, 2009; 2011). The most recent Australian Bureau of Statistics (ABS) data on suicide in Australia reported that an average of 100 people of Aboriginal or Torres Strait Islander origin ended their lives through suicide each year over the 10 year period from 2001-2010 (ABS, 2012). In 2010, suicide accounted for 4.2% of registered deaths of Aboriginal and Torres Strait Islander peoples (NSW, Qld, WA, SA and NT combined). After adjusting for the different age profiles of the two populations, the suicide rate of Aboriginal and Torres Strait Islander peoples was 2.6 times the rate for non-Indigenous Australians.

Figure 1: Age-standardised rates of suicide by jurisdiction and Indigenous status, NSW, QLD, SA, WA and NT, 2001-2010⁷



Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 *Suicides Australia, 2010*

The 2012 ABS data for the period 2001-2010 show the overall (all ages) rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females. However, there was also significant variation in the age-standardised rates of Aboriginal and Torres Strait Islander and non-Indigenous suicide between the five jurisdictions having reliable Aboriginal and Torres Strait Islander mortality data. Due to small numbers it is difficult to detect significant variation by geography. Figure 1 shows that the Northern Territory appears to have the highest Aboriginal and Torres Strait Islander suicide rate of all jurisdictions, followed by South Australia, Western Australia and Queensland, all with substantially higher rates than New South Wales.⁸

Aboriginal and Torres Strait Island peoples also take their own lives at younger ages than non-Indigenous Australians, with the majority of suicide deaths occurring before the age of 35 years. Figure 2 shows that in the period 2001-2010, the greatest difference in rates of suicide between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians was in the 20-24 years age group for females and the 25-29 years age group for males.

⁷ Age-standardised rates take into account differences in the size and structure of the population and are therefore more reliable for comparison purposes.

⁸ NOTE: Due to small numbers recorded in VIC and Tasmania, data for these states are not shown to protect privacy.

Figure 2: Age-specific suicide rates by Indigenous status and sex, NSW, QLD, SA, WA and NT, 2001-2010



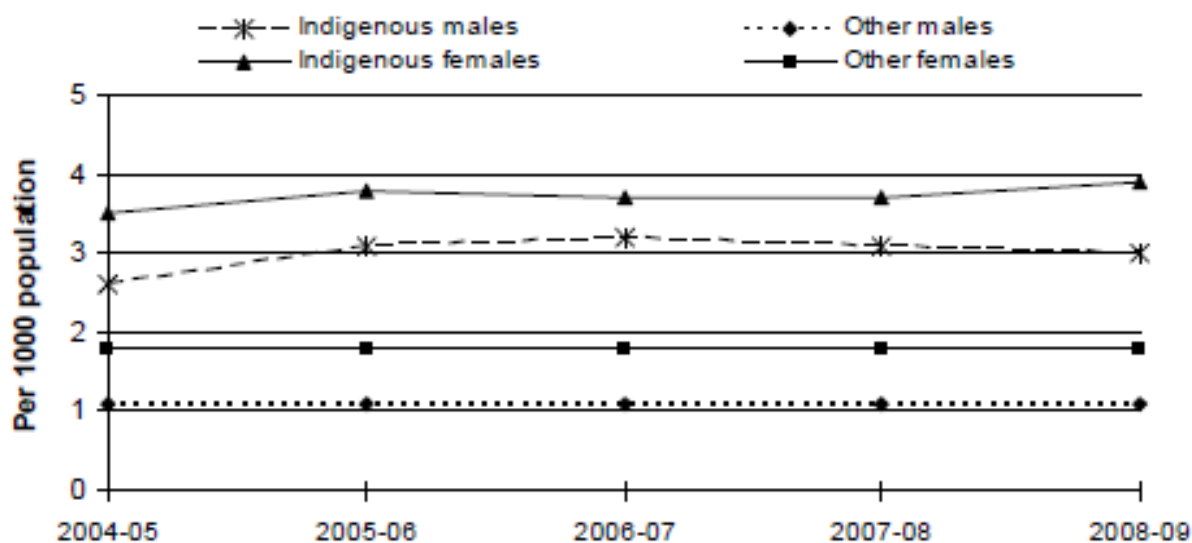
Source: Australian Bureau of Statistics (2012) Catalogue 3309.0 *Suicides Australia, 2010*

The highest age-specific rate of Aboriginal and Torres Strait Islander suicide was among males between 25 and 29 years of age (90.8 deaths per 100,000 population), four times the rate for non-Indigenous males. For Aboriginal and Torres Strait Islander females, the highest rate of suicide was in the 20-24 age group (21.8 deaths per 100,000 population), five times the non-Indigenous female rate for that age group. For the non-Indigenous population, the highest rate of suicide occurred among males between 35 and 39 years of age (25.4 deaths per 100,000) and for non-Indigenous females (6.6 deaths per 100,000) at consistent rates across the age groups between 35 and 54 years of age.

The prevalence of self-harm presents a different picture, with rates of hospitalisation for intentional self-harm many times higher than the rate of completed suicide for both Aboriginal and Torres Strait Islander and non-Indigenous persons, with females hospitalised at higher rates than males (Figure 3). In 2008-09, the rate of hospitalisation for non-fatal intentional self-harm was higher for Aboriginal and Torres Strait Islander peoples (3.5 per 1000) compared to non-Indigenous people (1.4 per 1000) (SCRGSP, 2011: 7.68). For this same period, a higher rate of hospitalisation for non-fatal, intentional self-harm was recorded for Aboriginal and Torres Strait Islander females (3.9 per 1000) compared to Aboriginal and Torres Strait Islander males (3.0 per 1000), with both rates higher than hospitalisation rates for non-Indigenous males and females. Hospitalisation for self-harm was also higher in remote areas (4.1 per 1000) compared to major cities (3.5 per 1000) (SCRGSP, 2011: 7.68). A recent survey found that the estimated proportion of the population that would self-injure at some point in their lifetime for Aboriginal and Torres Strait Islander peoples was 17.2%, which was 2.2 times that reported by non-Indigenous participants (OR 2.2, 95% CI 1.5-3.3) (Martin et al, 2010: 15). Because of limitations in sampling (random telephone survey), this study almost certainly

significantly understates differences in lifetime prevalence of self-injury between Aboriginal and Torres Strait Islander and non-Indigenous persons.

Figure 3: Age-standardised non-fatal hospitalisations for intentional self-harm, NSW, VIC, QLD, WA, SA and public hospitals in the NT.



Source: SCRGSP, 2011: 7.68

Social and Emotional Wellbeing

Suicide is a multidimensional issue, which has a devastating impact on individuals and families and ongoing implications for the communities in which they live. High rates of suicide among Aboriginal and Torres Strait Islander peoples are commonly attributed to a complex set of factors which not only includes disadvantage and risk factors shared by the non-Indigenous population, but also a broader set of social, economic and historic determinations that impact on Aboriginal social and emotional wellbeing and mental health. The Social Health Reference Group for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group (2004) responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009* draws an important distinction between the concepts of 'social and emotional wellbeing' used in Aboriginal and Torres Strait Islander settings and the term 'mental health' used in non-Indigenous settings.

Aboriginal and Torres Strait Islander peoples view health in a holistic context that encompasses mental health, physical, cultural and spiritual health. Land is central to wellbeing and when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health persists. Additionally there is no single Aboriginal and Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. These differences should be acknowledged and universal prevention strategies, which promote strong, resilient communities focusing on restoring social and emotional wellbeing should be implemented through the development of locally developed strategies in a way that is supported.

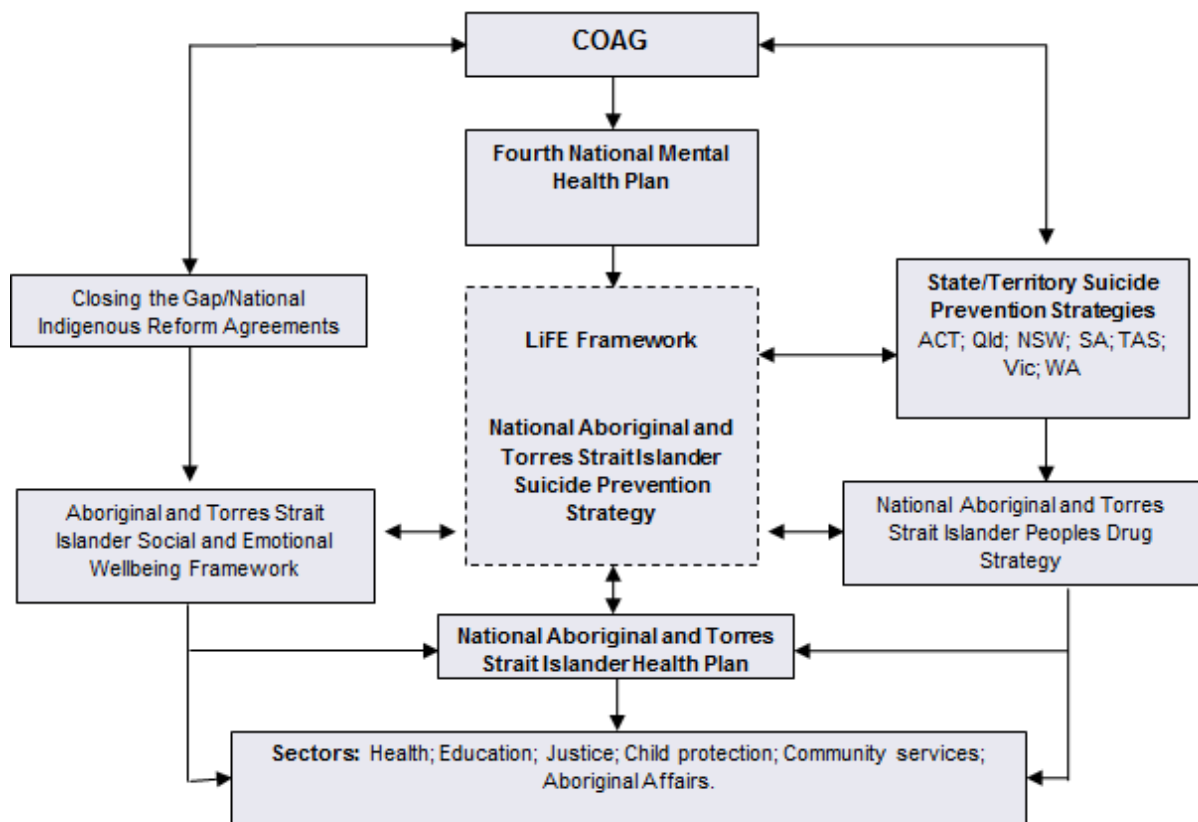
In this context the Social Health Reference Group concluded that:

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. 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.

(Social Health Reference Group, 2004, page 9)

Figure 4: Policy context of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy



Suicide prevention: Changing the discourse

Participants at community consultations consistently called for community-focused, holistic and integrated approaches to suicide prevention, with intervention strategies that reduce the likelihood of suicide and related problems over the lifespan. This is consistent with evidence emerging from research, which now shows that environmental and biological influences shape brain development in early life and have much greater effects on adult outcomes in physical and mental health and social and emotional wellbeing than was previously understood. Within this overall context account needs to be taken of the risk and protective factors for Aboriginal and Torres Strait Islander peoples which may have different characteristics to that of the rest of the population. For example, the effect and impact of chronic disease and poor physical health, broader social determinants and the relationship this has to social and emotional wellbeing. This knowledge has led to a new emphasis on investment in activities to strengthen the capacity of communities to prevent psychosocial and behavioural problems in childhood and adolescence.

A greater proportion of prevention effort needs to be invested “upstream” in preventive policies and services which build community, family and individual resilience. This can be achieved by a strategic alignment of policies and targeted investment in early prevention in health, family and children’s services, education and mental health at key points across the lifespan. Strategies to support

children's social and emotional learning including issues relating to Aboriginal and Torres Strait Islander individual identity, to improve self-regulation and resilience can reduce vulnerability to future outcomes, including antisocial behaviour, mental illness, social withdrawal and suicide, alcohol and drug misuse and crime.

Communities that have been successful in reducing youth problem behaviours have initiated local action to minimise the early development and progression of social and emotional problems. In these communities, families, schools and organisations support each other in placing a high value on the following:

1. Minimising children's exposure to biological and psychological harmful events such as child maltreatment, family violence and substance abuse
2. Teaching, promoting and actively reinforcing pro-social behaviour, including self-regulatory behaviours and the skills needed to become productive adults of the community and society
3. Monitoring and reducing opportunities for problem behaviour to occur
4. Fostering the development of mental flexibility, problem solving and the capacity for emotional self-regulation and self-reflection in children and young people.

Figure 5: Opportunities for prevention: Modifying causal pathways to youth problems and suicide
(adapted from Robinson et al, 2012)

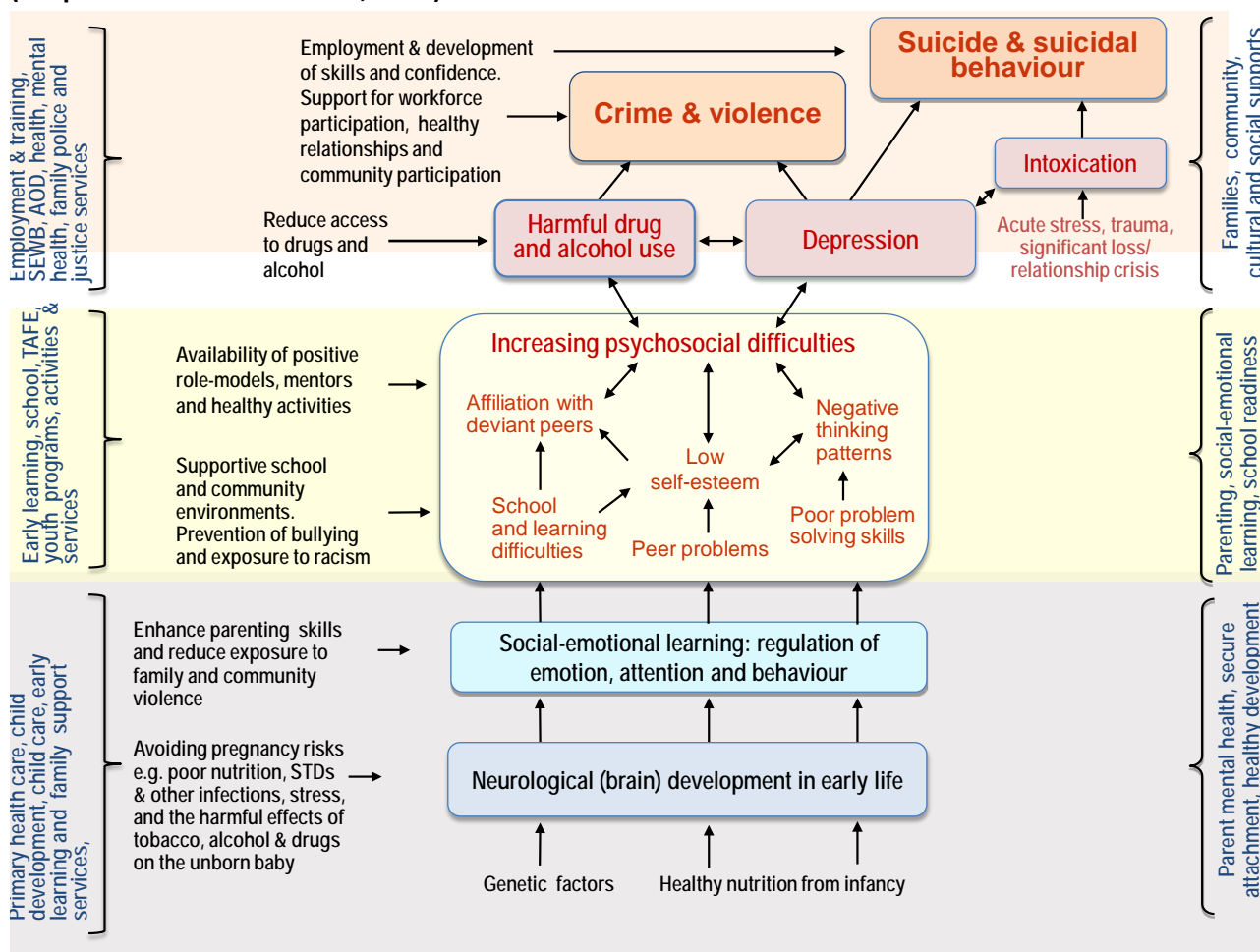


Figure 5 summarises some of the known developmental pathways from conception through to adulthood that research has shown to be associated with an increased likelihood of suicide and other youth problems (O’Connell et al, 2009; Zubrick et al, 2005).

For each developmental period including transition across life stages such as from adolescence to early adulthood, there is a range of known risks that should be a priority focus of those agencies responsible for the services most relevant to that stage of development. At each stage, specific preventive interventions for parents, children, families or youth need to be based on strategies of engagement that acknowledge cultural and individual differences in families and communities.

Working with all communities

Community consultations for the national strategy highlighted the need for a dual focus on:

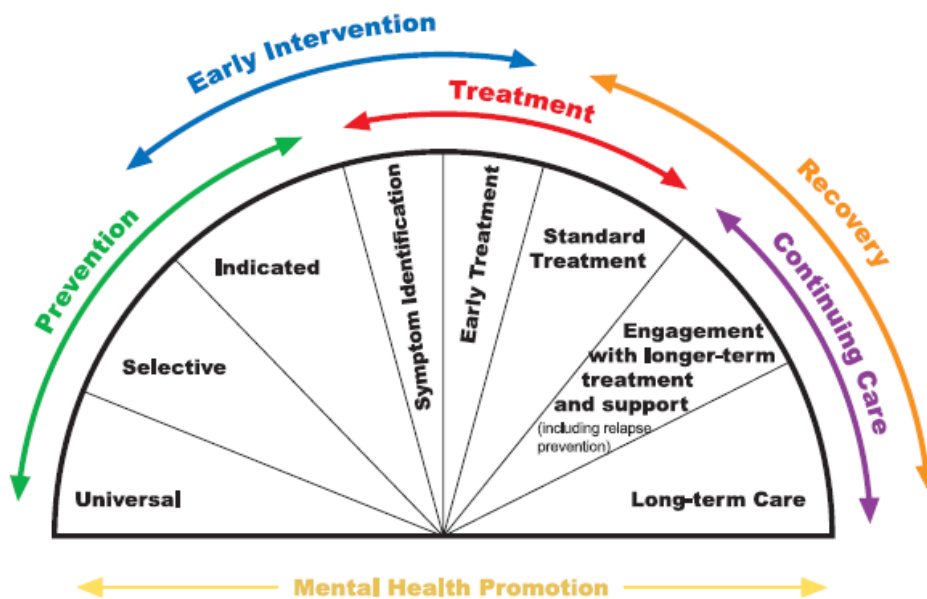
1. Developing the capacity of Aboriginal and Torres Strait Islander controlled services and communities to lead and sustain strengths-based preventive activities and culturally specific approaches to healing and recovery from trauma; and

2. Building the capacity of mainstream services and agencies to be more inclusive and responsive to the needs and circumstances of Aboriginal and Torres Strait Islander peoples in all cities, towns and communities.

National suicide prevention strategies have generally favoured universal actions that have the broadest possible reach. However, for the Aboriginal and Torres Strait Islander Suicide Prevention Strategy, actions should be implemented in a manner that is proportionate to the level of risk and vulnerability in communities and groups within the wider population. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing 2004-2009 principles state that "...there is no one single Aboriginal or Torres Strait Islander culture or group...." and therefore there are different needs across and within groups. Aboriginal and Torres Strait Islander peoples also live in different settings and it is important that these different needs are addressed through locally developed strategies.

A reflection of the importance of local approaches is contained in the Community LiFE Framework for Effective Community-Based Suicide Prevention – Draft for Consultation (2005) developed as part of the Community LiFE project under the National Suicide Prevention Strategy. These classified mental health interventions range from prevention through treatment to continuing care (See Fig 6 below). This scheme classifies mental health interventions as universal, selective or targeted and indicated.

Figure 6: Spectrum of mental health interventions



Source: Community LiFE Consultation Draft (2005), p. 16.

For Aboriginal and Torres Strait Islander peoples, the effort to improve the relevance and reach of universal measures and mainstream services as provided by Aboriginal and Torres Strait Islander community-controlled services needs to be balanced by the implementation of targeted strategies for Aboriginal and Torres Strait Islander communities, vulnerable groups and families. The balance will also vary across circumstances in regions of Australia according to availability of appropriate services and resources.

A community development approach

Communities can include significant diversity. For Aboriginal and Torres Strait Islander peoples, *community* is closely related to the idea of *culture*. There are many shared elements of culture, just as there is also cultural and sometimes linguistic diversity between communities and within communities identifying as Aboriginal and Torres Strait Islander. Confidence in recognition based on cultural identity is a source of strength. Cultural change and discontinuity are also important influences. For example, many people may feel cut off or disconnected from their cultural heritage or community. Many young people may be in conflict with parents and elders and see theirs as the culture of a “new generation”. Culture may mean something different as resource or source of identity for youth in a large city compared with young people in a remote community.

These differences may have different implications for the needs of youth for support and for engagement by services or recognition by elders. Global influences on culture, including new electronic technologies and images are part of the experience and styles of communication of young people. They may shape particular areas of vulnerability, while also representing important opportunities for engagement of the young. The place of sports, the arts, including music, painting and dance in resilience promotion and in encouragement of healthy cultural affirmation of identity are relevant here. These initiatives may occur in conjunction with active development of resilience-building interventions and services to promote mental health and social-emotional wellbeing.

The idea of community is also associated with recognition of leadership and authority based on authentic relationships. Leadership is in part about representation in governance and organisation, and Aboriginal leadership is important in developing partnerships in prevention. However, leadership is also about mobilising participation, engagement, action and ideas within communities, and may come from outside of organisations that are often seen as representing the community.

A further potentially powerful perspective within communities is provided by those families and individuals who have been affected by suicide either directly or indirectly. There are many instances of action networks that have been important catalysts for change to services and policies or who have worked effectively as partners of community services and non-government organisations to strengthen prevention, postvention and life promotion responses. Community and partnership should not be seen solely from the perspective of governments or services. These are some of the reasons why it is important to define what “community” means for the purpose of developing prevention strategies.

The Community Life Framework – Draft for Consultation (2005) sets out a number of principles for planning and decision making at the community level to adopt programs and initiatives that achieve the intended outcomes of reductions in suicide and self-harm in communities in which these occur at high rates. Some of these are:

- **A focus on risk and protective factors**

Prevention should focus on the risk and protective factors faced by the target group and community.

- **Comprehensive, multi-level programs**

Prevention should be undertaken across a range of settings – individual, family, school and community, with multiple components delivered within multiple settings.

- **Effective, evidence-based interventions**

An effective intervention achieves its intended effect in the ‘real world’ (Hawe et al. 1997). Effective interventions are based on available research evidence about their efficacy.

- **Intensive, long-term and developmentally appropriate activities**

Evidence suggests that ‘one-stop’ prevention efforts are not very effective and that the most successful activities are intensive, developmentally appropriate and maintained over time.

- **Community-focused and relevant programming**

Prevention programming should address the specific nature of the problem in the local community or population group. It should be relevant to the community.

- **Culturally appropriate activities**

Prevention should be culturally appropriate – consistent with the cultural identity, communication styles, protocols and social networks of clients and stakeholders (Thomas 2002).

- **Early intervention**

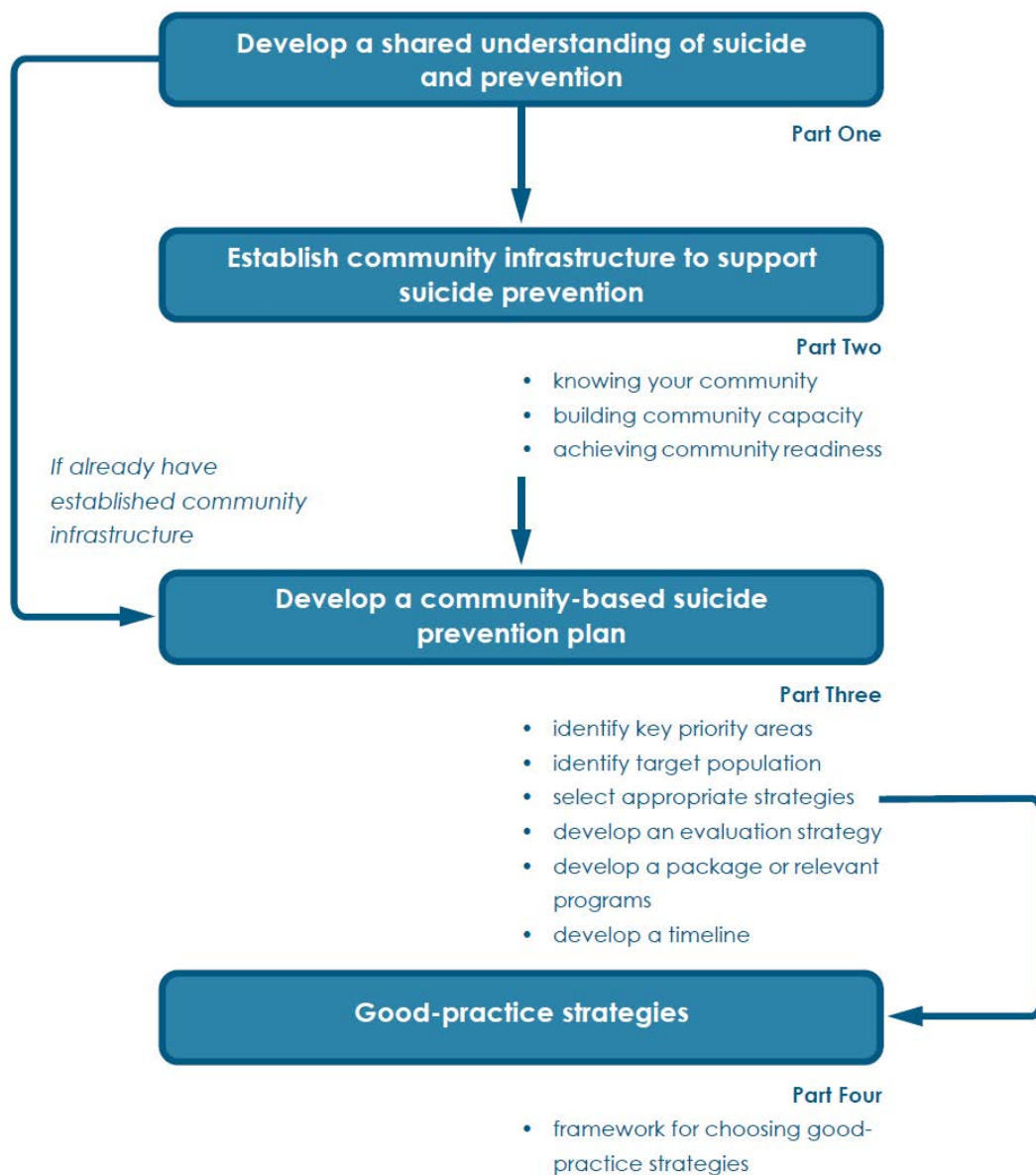
The higher the level of risk in the population group, the more intensive the prevention effort must be and the earlier it should begin. Transition points – preschool, middle school, entering high school, leaving high school and entering the workforce – are times when major setbacks can occur, and that represent natural opportunities for providing supportive interventions.

- **Multi-dimensional capacity-building efforts**

Interventions need to be multi-dimensional, with capacity-building efforts to support them.

This framework illustrates that action needs to be taken at a number of levels, beginning with mobilisation of community understandings of suicide and the options for action, along with planning and development of a community action plan for adoption of strategies that have been shown to be effective and that represent “good practice” (see Figure 7). Finally, there needs to be capacity building, action to develop infrastructure and resources.

Figure 7: Developing a community plan for suicide prevention



Source: Community LIFE Framework for Effective Community-Based Suicide Prevention (2005)

Responding to high levels of suicide in communities

Many Aboriginal and Torres Strait Islander communities across Australia face high levels of suicide and self-harm, some of which occur in marked clusters. In such circumstances, steps need to be taken to mobilise community and organisations to respond to the immediate risk through training and support for community providers, peers and other natural helpers (family members, elders, traditional healers); through the provision of effective and sensitive postvention and bereavement support for people in peer and family networks; through coordinated action to work with and to follow up with individuals in high risk settings; and to build the capacity of community-based services to maintain targeted preventive activity. There is limited evidence for the effectiveness of postvention responses for the reduction of suicide (Szumilas and Kutcher, 2011). Suicide awareness and postvention training, if well integrated into community services and adapted for the needs of

communities and families, are important forms of treatment and follow-up care. However, it is likely that on their own they are not sufficient to prevent suicide at either community or population levels.

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

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

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

Figure 8 suggests that in community settings with high multiple risks, action to respond to the vulnerabilities of high risk groups, such as adolescents and adult males and their families, should be accompanied by long-term prevention strategies targeting the developmental precursors of these sources of difficulty.

Figure 8: Long-term and short-term prevention and early intervention activities in high risk communities

