



ATSISPEP

# The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)

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## Kimberley Roundtable Report

Thursday 27th August 2015  
Durack Room, Mangrove Hotel  
Broome, Western Australia

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The School of Indigenous Studies  
The Poche Centre for Indigenous Health



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### Executive Summary

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) has undertaken a series of national community Roundtables to ensure Aboriginal and Torres Strait Islander input to the overall Project and to gain specific information about contributing factors to suicide; what works and has not worked for suicide prevention and what strategies are needed to support communities in suicide prevention. This regional Roundtable included the Kimberley region and was held in Broome. It was co-hosted by the Kimberley Aboriginal Medical Services Council (KAMSC), and held at the Mangrove Hotel in Broome on August 27th, 2015. This was attended by 33 participants from diverse professional and community backgrounds. The majority of participants, 78%, were Aboriginal.

The Kimberley Region is located in the far north of Western Australia with a population of about 36,800 people (ABS, 2013). At 46%, the Kimberley has one of the highest proportions of Aboriginal and Torres Strait Islander populations in the country, and also the highest concentration of remote Aboriginal and Torres Strait Islander communities in the nation (ABS, 2013).

The Kimberley's Aboriginal and Torres Strait Islander population is much younger than the non-Indigenous population, with nearly 44% aged under 20 years old (ABS 2011). The major towns in the Kimberley region are Broome, Derby, Fitzroy Crossing, Halls Creek, Roebuck, Kununurra and Wyndham. Aboriginal and Torres Strait Islander people constitute 82% of the Halls Creek shire, 55% of the Derby-West Kimberley shire, 71% of the Roebuck area, 42% of the Kununurra shire and 28% of the Broome shire (ABS, 2013).

Self-harm and suicide numbers and rates have increased in the Kimberley. In ten years from 2000, there were approximately 100 Aboriginal and Torres Strait Islander suicides, but Western Australia as a whole has witnessed an increase with suicide now the second leading cause of death. (ABS, 2016) In general, Western Australia constitutes about one quarter of the Aboriginal and Torres Strait Islander national suicides despite that Western Australia forms just 14% of the nation's Aboriginal and Torres Strait Islander population. Between 1999 and 2006, there were 96 Aboriginal and Torres Strait Islander suicide deaths in the Kimberley. The suicide rate during this period was disturbingly four times that of non-Indigenous people in the region (Department of Health Western Australia, 2009).

The participants who attended the ATSISPEP Kimberley Roundtable in Broome felt strongly that Governments must prioritise addressing the social determinants that influence Aboriginal and Torres Strait Islander health and wellbeing. Further, the majority of participants urged for local solutions to be fully supported and that these solutions should not only be Aboriginal and Torres Strait Islander led, but that the workforce facilitating the solutions should be predominately local Aboriginal and Torres Strait Islander peoples.

The following themes emerged from the Roundtable discussions:

- The Impact of Social Determinants
- The Need for Empowerment of Families and Communities
- Mental Health Issues
- Trauma
- Lack of Services and Responses
- The Need for Local Solutions and Leadership

### ATSISPEP Background

Suicide among Aboriginal and Torres Strait Islander people is significantly higher than in the wider Australian population. Aboriginal and Torres Strait Islander suicide occurs at double the rate of other Australians, and there is evidence to suggest that the rate may be higher (Australian Institute of Health and Welfare, 2014, 2015). Suicide is one of the most common causes of death among Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander people between the ages of 15 to 34 are at highest risk, with suicide the leading cause of death, accounting for 1 in 3 deaths. Suicide is a complex behaviour with many causes. For Aboriginal and Torres Strait Islander peoples there are specific cultural, historical, and political considerations that contribute to the high prevalence, and that require the rethinking of conventional models and assumptions.

In response to the urgent need to address the high rates of Aboriginal and Torres Strait Islander suicide across Australia, the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP), a comprehensive national project, was funded by the Australian Government through the Department of the Prime Minister and Cabinet to establish the evidence base about Aboriginal and Torres Strait Islander suicide and formally evaluate the effectiveness of existing suicide prevention services nationally.

A final report will be provided to the Minister for Indigenous Affairs in mid 2016. Concurrently, a culturally appropriate Suicide Prevention Program Evaluation Framework will be developed and trialed. The School of Indigenous Studies at UWA is undertaking the Project, in collaboration with the Telethon Kids Institute and the national Healing Foundation. An aim of the ATSISPEP will be to establish a much-needed evidence base of what works in Aboriginal and Torres Strait Islander suicide prevention.

In summary, ATSISPEP will:

- Undertake a review of the literature (national and international);
- Build on relevant significant reports;
- Collate significant Aboriginal and Torres Strait Islander consultations and subsequent reports in recent times;

- Undertake a statistical spatial analysis of suicide trends over ten years;
- Produce a compilation of resources and suicide prevention programs; and
- Develop and trial a culturally appropriate evaluation framework.

In preliminary findings, key themes of effective programs and services have been identified as those that offer a holistic understanding of health and wellbeing for individuals, families and communities. These successful programs and services also promote recovery and healing from trauma, stress and intergenerational loss; empower people by helping them regain a sense of control and mastery over their lives; and have local culturally competent staff who are skilled cultural advisors. There is community ownership of such programs and services, with significant community input into the design, delivery and decision making processes and an emphasis on pathways to recovery through self-determination and community governance, reconnection to community life, and restoration of community resilience and culture. Using a strengths-based approach, these programs and services seek to support communities by addressing broader social determinants and promoting the centrality of family and kinship through hope and positive future orientation.

There are many complexities and determinants associated with suicide and self-harm and the most successful responses have been those fostering the unique strengths and resilience of Aboriginal and Torres Strait Islander individuals, families and communities and by those, which have been embedded in cultural practice and delivered for durations. With young people the most successful strategies have been using peers, youth workers and less formal community relationships to provide ways in which to negotiate living contexts and to connect them with their cultural values, care systems and identity.

### ATSISPEP Roundtables

As part of the Project, a series of Roundtables are being conducted in a number of regional sites on a range of emerging themes. The Roundtables complement the current review of literature in the area, and intend to utilise a community consultation methodology to affirm the results of the literature and program reviews and to seek further information. This methodology ensures that the Aboriginal and Torres Strait Islander community is informed about the Project and have input, that information gathered is contextualised from the community through representation at the Roundtables, and that information is relevant to rapidly changing social and political environments. Responsiveness is a key concern in the evaluation process hence the ATSISPEP series of Roundtables is a mechanism that incorporates ongoing reciprocal discussion between senior community members and the researchers engaged in the Project process.

The first community consultation was held in early 2015 in Mildura in regional Victoria, an area with reported high levels of suicide. A further regional consultation has been held in Darwin, Northern Territory and this one in Broome in the Kimberley. Subsequent to these regional Roundtables, additional community consultations will be held in Cairns, Queensland, Adelaide, South Australia and in the Shoalhaven area of New South Wales. The three initial regions were chosen as the sites for the community consultations because of the high reported incidence of suicide in these regions or, alternatively, because of the substantial progress reported in reducing previously high rates of suicide in these areas.

As well as regional Roundtables, themed national Roundtables engaging Aboriginal and Torres Strait Islander youth, sexuality and gender diverse people identifying as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI) and those involved in the justice system have also taken place and will provide valuable ‘front-line’ perspectives of the central issues involved for each of these groups. The feedback from Roundtables to date have reinforced the initial findings of the literature review and preliminary data analysis and demonstrated the complexities involved in identifying vulnerable groups in the community.

The purpose of the Roundtables is to recognise what communities need to assist them in the prevention of suicide and to hear community perspectives and first-hand experiences of suicide prevention services and programs to help confirm and refine existing research findings of *what works and why*.

Recognising that there are even more vulnerable groups within Aboriginal and Torres Strait Islander groups, which is overall a vulnerable group, the Project undertook to target identified vulnerable groups which include Aboriginal and Torres Strait Islander youth; those identifying as sexuality and gender diverse; and those involved in the justice system, in particular, those re-entering communities following incarceration. Other workshops and Roundtables took place around topical issues. For instance, a meeting about determining the need for, and development of, a critical response service for suicide and trauma was held in Perth with Commonwealth and West Australian state governments, stakeholders, academics, community groups and relevant services. Other topical issues such as the role of clinical factors in suicide and measuring suicide and self-harm will also take place as part of the Project.

These consultations will enable the Project to:

- Gain further feedback and input on the Project work to date;
- Listen to the different experiences with suicide prevention programs and services across Australia to further identify what works and why;
- Identify programs that have previously been assessed as effective and seek community perspectives on access to these programs, whether they consider they may be relevant to their communities and, if so, what would be needed to support effective implementation; and
- Determine where programs are already in use, what changes could be made to further improve them.

### Section One: Roundtable Report Background

The aims of this Roundtable report are to identify the major issues of concern to community members, professionals and workers in Kimberley Aboriginal and Torres Strait Islander communities about suicides in the region. Their comments are directly organised around contributing factors to suicide and self-harm, the impact of suicide on individuals, families and communities, and the capacity for addressing suicide. This Roundtable worked in partnership with Kimberley participants to ensure that they were informed about the objectives of the

Project and to ensure their input from a Kimberley Aboriginal and Torres Strait Islander perspective. The Roundtable process involved facilitators and participants identifying issues and in many instances grouping these. The value of this process ensures that Kimberley Aboriginal and Torres Strait Islander people themselves are recognised as the experts in this area, and ensures the voices of that group within the Aboriginal and Torres Strait broader community is heard. The process is valuable for a number of purposes:

1. To ensure that the voices of the Kimberley Aboriginal and Torres Strait Islander community are valued and present;
2. To ensure ownership of the issues;
3. To ensure that new insights involving Kimberley populations are recognised;
4. To connect the voices of the Kimberley community directly to evolving policy wherever possible and appropriate; and
5. To guide further development of ideas found in current reports and literature to supplement Kimberley participants' concerns that emerged in the Roundtable.

### Roundtable Context

The principles used for direction in identifying the concerns and context of the Roundtable commentary come primarily from the six action strategies listed in the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (Department of Health and Ageing, 2013) and the nine guiding principles listed in the introduction to the national *Social and Emotional Wellbeing Framework* (Social Health Reference Group, 2004). In addition there are a number of other research publications and major reports informing the approaches taken by ATSIPEP and the Roundtables that can be found in the overall report.

The principles from the *Social and Emotional Wellbeing Framework* (2004), (hereon called the *Framework*), are based on a platform of human rights and recognise the effects of colonisation, racism, stigma, environmental adversity, and cultural and individual trauma. They also acknowledge the diversity of Aboriginal and Torres Strait Islander identity and cultural experience and the centrality of family, kinship and community. The *Framework* recognises that Aboriginal and Torres Strait Islander culture has been deeply affected by loss and trauma, but that it is a resilient culture. It also recognises that Aboriginal and Torres Strait Islander Australians generally are resilient and creative people, who focus on a holistic experience of mental and physical health, working through cultural, spiritual and emotional wellbeing and seeking self-determination and cultural relevance in the provision of Health Services for themselves and their communities.

*The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (2013), (hereon called the *Strategy*), is a specific response to the suicide statistics. An accompanying funded implementation plan has yet to be released by the Department of Health. In seeking to ensure that Aboriginal and Torres Strait Islander communities are supported locally and nationally to reduce the incidence of suicide and suicidal behaviour, and related self-harm, the *Strategy* aims to reduce risk factors across the lifespan, to build workforce participation of Aboriginal

and Torres Strait Islander people in fields related to suicide prevention, and to effectively evaluate programs.

A brief list of goals for increasing early intervention and building strong communities nominated by the *Strategy* includes building strengths and capacities in Aboriginal and Torres Strait Islander communities, and encouraging leadership and community responsibility for the implementation and improvement of services for suicide prevention. A strong emphasis is placed on the strength and resilience of individuals and families working through child and family services, schools and health services to protect against risk and adversity.

On this basis, the *Strategy* contends that it is necessary to act in four main areas. Firstly, it is essential to have culturally appropriate, targeted suicide prevention strategies that identify individuals, families and communities at higher risk through levels and expressions of disadvantage such as poverty, alcohol and drug abuse and histories of abuse or neglect. Secondly, it is also necessary to co-ordinate approaches to prevent suicides including those incorporating health, education, justice, child and family services, child protection and housing, and third, it is necessary to build the evidence base on suicide prevention activities and dissemination of that information to identify relevant research, address gaps in information and recommend strategies on the basis of records. Finally, there needs to be a safeguarding of standards of practice and high quality service in the area of suicide and suicide prevention in Aboriginal and Torres Strait Islander communities and an assurance that preventative activity will be embedded in primary health care.

Both the *Strategy* and the *Framework* are based on extensive consultation with representatives from Aboriginal and Torres Strait Islander communities. The essential shared values and the themes considered necessary for effective programs and services include:

- Acknowledgement of trauma as a significant element of ongoing mental health issues for some individuals, families and communities;
- The need for cultural relevance in the development and implementation of programs;
- Self-determination in the development and delivery of suicide prevention and related mental health programs;
- The need to centralise research and build a strong, coherent knowledge base on Aboriginal and Torres Strait Islander suicide prevention, intervention and postvention; and
- The necessity of understanding the holistic physical, mental, social and spiritual approach to Aboriginal and Torres Strait Islander suicide prevention within the communities.

While establishing foundational principles, the community consultation and research undertaken by the *Strategy* and ATISISPEP also highlight gaps in information that require further research and analysis to clarify information and develop questions around methodological approaches.

1. Gathering statistics presents very specific challenges due to problems with and Torres Strait Islander identification, and

variations in data sources, such as the National Coronial Information System, the Queensland Suicide Register, and other administrative systems. Shared protocols that ensure adequate and consistent reporting nationally are required.

2. The priorities and needs of Aboriginal and Torres Strait Islander communities should be central. Questions could be asked about what services and programs, if any, are in place and are they adequate? Do these services and programs work together to reflect the broad, inter related and holistic nature of the realities of communities?

The preceding brief summary provides an overview of significant emerging principles that are concerned with respecting a holistic model of culture and health for all Aboriginal and Torres Strait Islander peoples. The building of individual, family and community resilience, and improving safety factors throughout the life cycle is facilitated by addressing violence, abuse, alcohol and drug problems, and supporting the increased participation of Aboriginal and Torres Strait Islander community members and professionals in any initiative that concerns them, particularly in suicide prevention. These values were fundamental in a shared framework that underpinned the Roundtable dialogues and the Roundtables also enabled Aboriginal and Torres Strait Islander community members and professionals, and non-Indigenous experts to come together and provide a focused discussion within the complexity of Indigenous experience.

### Background Kimberley Roundtable

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) has undertaken a series of national community Roundtables to ensure Aboriginal and Torres Strait Islander input to the overall Project and to gain specific information about contributing factors to suicide; what works and has not worked for suicide prevention and what strategies are needed to support communities in suicide prevention. This regional Roundtable in Broome was co-hosted by the Kimberley Aboriginal Medical Services Council (KAMSC), and held at the Mangrove Hotel in Broome on August 27<sup>th</sup>, 2015. The Roundtable was attended by 36 participants who came from diverse professional and community backgrounds. The majority of participants, 78%, were Aboriginal.

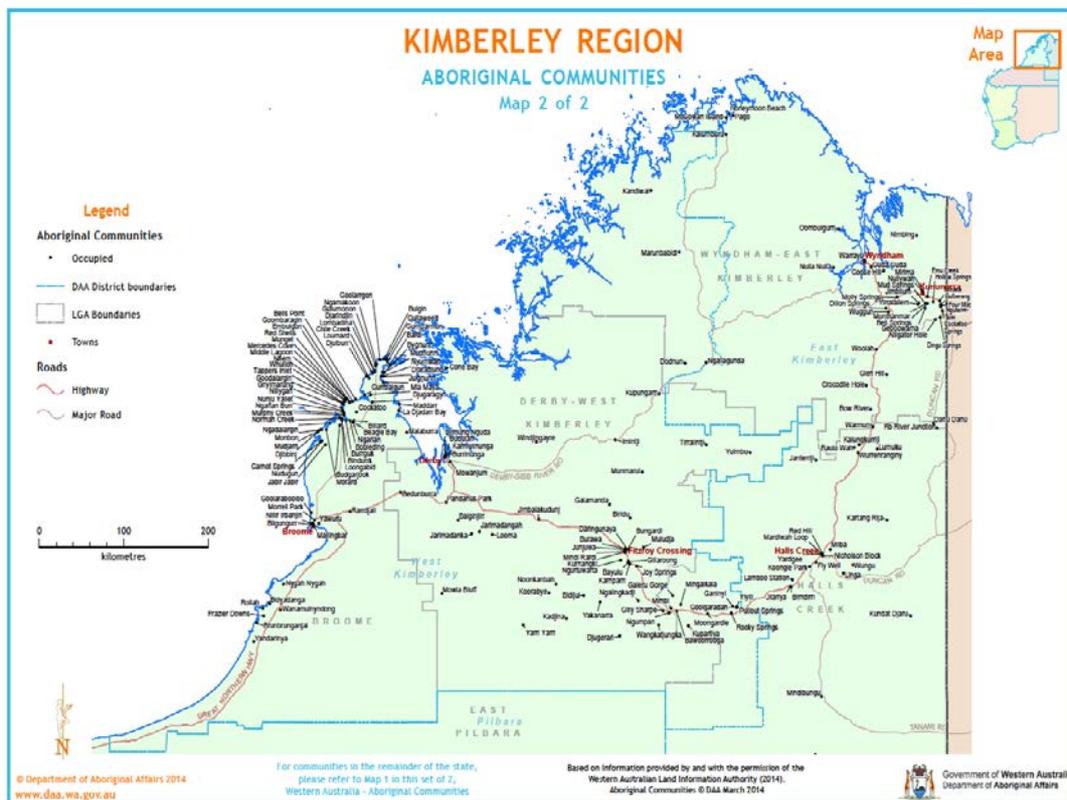


Figure 1: Kimberley Region Aboriginal Communities Map, (Department of Health Western Australia, 2014).

The Kimberley region is located in the far north of Western Australia with a population of approximately 36,800 people (ABS, 2013). At 46%, the Kimberley has one of the highest proportions of Aboriginal and Torres Strait Islander populations in the country, and also the highest concentration of remote Aboriginal and Torres Strait Islander communities in the nation (ABS, 2013). The Kimberley region has the nation’s second highest homelessness rate of 510 homeless per 10,000 population, however, it is indicated that the majority of this homelessness includes Aboriginal and Torres Strait Islander people (ABS, 2012). Adults aged 15-64 years in the Kimberley experience hospitalization for injury and poisoning at three times the state average rate. (Serafino & Anderson, 2015)

The Kimberley’s Aboriginal and Torres Strait Islander population is much younger than the non-Indigenous population, with 43% aged under 20 years old compared with 21% in the non-Indigenous population. (Serafino & Anderson, 2015). The major towns in the Kimberley region are Broome, Derby, Fitzroy Crossing, Halls Creek, Kununurra and Wyndham. Aboriginal and Torres Strait Islander people constitute 82% of the Halls Creek shire, 55% of the Derby-West Kimberley shire, 71% of the Roebuck area, 42% of the Kununurra shire and 28% of the Broome shire (ABS, 2013).

Self-harm and suicide numbers and rates have increased in the Kimberley. In ten years from

2000, there were approximately 100 Aboriginal and Torres Strait Islander suicides, but, according to a report awaiting publication detailed by a Roundtable participant, in the last five years the rate has doubled and there have been more than 100 suicides. Whereas on average there had been a suicide every month, this same research awaiting publication indicates that the average is now two Aboriginal and Torres Strait Islander suicides a month in the Kimberley. All the trends indicate that the situation will worsen. With the male youth suicide rate in the Kimberley sitting at 8 times the state average, and 6 times for females for the period 2007-2011, it is clear that this is not a recent development. From 2002-2011 the suicide rate for young males in the Kimberley aged 15-24 was 135.1 per 100,000 people. (Serafino & Anderson, 2015). The Australian Bureau of Statistics reports a rate of 18.9 deaths by self-harm per 100,000 Aboriginal and Torres Strait Islander children aged 5-17 from 2010-2014 in Western Australia, but does not detail this by region. (ABS, 2016)

In general, Western Australia constitutes about one quarter of the Aboriginal and Torres Strait Islander suicides despite Western Australia forming just 14% of the nation's Aboriginal and Torres Strait Islander population. Between 1999 and 2006, there were 96 Aboriginal suicide deaths in the Kimberley. The suicide rate during this period was disturbingly four times that of non-Aboriginal people in the region (Department of Health Western Australia, 2009).

There was national media attention around the number of suicides in the Kimberley in 2006 – 21 suicide deaths in the year (Hope, 2008). This led to a much publicised coronial inquiry led by Western Australian State Coroner, Alastair Hope. However, the rate of suicide in the Kimberley remains high. It is also likely due to issues relating to under-reporting, that the registered suicide deaths may be an underestimation of the actual number of suicides. Local community leaders, various stakeholders and researchers estimate that the numbers are in fact up to twice as high as the registered suicide deaths. This is yet to be addressed.

There was a strong general theme from the ATSIPEP suicide prevention Kimberley Roundtable about the need for recognition of the role of social determinants of health in health status, mental health and suicide. Participants felt that in order to address Aboriginal and Torres Strait Islander wellbeing, governments must prioritise addressing the influences of social determinants – dire economic inequalities continue between Aboriginal and Torres Strait Islander and non-Indigenous populations with extreme poverty, housing issues and homelessness worsening. The majority of participants urged for local solutions to be fully supported and that these solutions should not only be Aboriginal led, but the solutions should be facilitated by a predominately local Aboriginal workforce.

### Section Two: Roundtable Voices

KAMSC co-hosted the Roundtable with a total of 33 participants attending. The majority of people were of Aboriginal and Torres Strait Islander descent. The participants of the Roundtable all brought extensive experience to the forum. The gender representation was 10 males and 23 females. The age of participants was between 20 to 65 years with a significant proportion in their early-mid 40s, and the majority in their 50s so there was broad age group representation. Participants were selected due to their personal experience and expertise in the health/mental health sector and to represent the Kimberley region. Participants came

from a range of positions such as community leaders, community advocates, members of affected families who were also working with service responders, primary and mental health workers, psychiatrists, clinicians, cultural workers, youth workers, family workers, family legal service workers, Standby workers, suicide prevention coordinators, trauma counsellors, land council executives, mentor program coordinators, police, social and emotional wellbeing workers, and on-country program coordinators. The Roundtable intended to draw on experiences from across the Kimberley and, subsequently, reflected both a cross section of different communities and different sections within communities. There was great interest in the Roundtable and the Kimberley participants shared grave concerns about the appalling suicide rates for the Kimberley region. Indeed, on August 27, when the Kimberley Roundtable was convened in Broome, the team and participants were informed of a suicide in Kununurra the prior day. A one-minute period of silence was observed by the Roundtable participants to pay respect.

The methodology of the Roundtable was to discuss subjects in plenary, but also to break into smaller groups to produce lists of concerns. This report recombines the discussion and the prioritising of the groups.

Participants were identified by both KAMSC and the ATSIPEP team's knowledge of those appropriate individuals and stakeholders involved in Aboriginal and Torres Strait Islander health and social and emotional wellbeing. As participants were contacted, they would also suggest other relevant people to attend. Through the use of such networks, a range of appropriate people were contacted to participate. Two members of the ATSIPEP team and a group representative facilitated the Roundtable and all information was recorded. The program consisted of a presentation of the statistics of suicide, identified social determinants of suicide and self-harm, identifying problem areas and outlining the ATSIPEP approach.

Participants were asked a number of questions and from the discussion, and from these a number of themes and sub-themes were derived. The questions were:

- What are the contributing factors (including protective factors) for the high rates of suicides in Aboriginal and Torres Strait Islander communities?
- What works in relation to Aboriginal and Torres Strait Islander suicide prevention in the past and at present?
- What hasn't worked in relation to Aboriginal and Torres Strait Islander suicide prevention in the past and at present?
- What strategies to support communities to address Aboriginal and Torres Strait Islander suicide prevention would be appropriate?

The transcripts from the Roundtable discussion have been analysed by four researchers working on the ATSIPEP Project. The researchers independently looked at the data and then deliberated to reach agreement on the thematic codes. The codes and related quotations were organised and analysed thematically via Excel. The emerging major themes included:

- The Impact of Social Determinants
- The Need for Empowerment of Families and Communities
- Mental Health Issues
- Trauma
- Lack of Services and Responses
- The Need for Local Solutions and Leadership

These themes are discussed in detail.

### The Impact of Social Determinants

This Project recognises the social determinants of health approach, defined by the World Health Organisation (WHO) as:

*The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. (WHO, 2012)*

Social determinants have been recognised as a fundamental issue when addressing Aboriginal and Torres Strait Islander health inequality by many groups particularly the Australian Human Rights Commission. There have been discussions about the connections between low socio-economic status and poverty, and health outcomes. The poor health of Aboriginal and Torres Strait Islander people is not only about disadvantage, but also the non-recognition and non-enjoyment of their human rights and the denial of their distinct cultural characteristics is part of this situation. Dick (2007) stated: *'Indigenous peoples are not merely 'disadvantaged citizens'. The poverty and inequality that they experience is a contemporary reflection of their historical treatment as peoples. The inequality in health status that they continue to experience can be linked to systemic discrimination'* (Dick, 2007, p.2). The influence of the social determinants of health and wellbeing on poor health and mental health has been identified by participants in most Roundtables, and particularly so for the Kimberley Roundtable.

Entrenched poverty was identified by the majority of participants as a predominant underlying factor that leads to self-destructive behaviour and intentional self-harming and to the high rate of suicide in the Kimberley. Remote Aboriginal and Torres Strait Islander communities in the Kimberley have a range of additional stressors or risk factors compared to the larger regional towns and urban populations. These factors are found in the social determinants, such as entrenched poverty, crowded housing and high levels of preventable morbidity and mortality, which also need to be accommodated into suicide prevention strategies.

Participants expressed their concern of the high unemployment rate among Aboriginal and Torres Strait Islander peoples in remote communities and towns. Participants described a lack of opportunities and called for economic inequalities between Aboriginal and Torres Strait Islander and non-Indigenous residents to be addressed.

Comments from participants included:

*Just a concern from me that I'd like to say – It's good that you're working on the suicides but suicide is at the end of it. There are so many issues on the way; home, work issues. Government makes our young jump hoops to be ready for work, to get tickets so to work and they don't get that job that should be there for them. You then look at the non-Aboriginal people in communities and see they have jobs and stuff. But there is no livelihood for our people. All the parts of life are diminished and then we think what do we have to live for? So our youth get tickets and tools and then there is nothing waiting. They think what do they have to live for? We need to build communities so our people have the will to strengthen the youth (Kimberley Roundtable Participant).*

*Welfare reforms will continue to oppress us and for the weak, oppression leads to suicide. Is that not clear? (Kimberley Roundtable Participant).*

*Suicide is the tip of the iceberg – we have to look at unemployment, lack of education, housing issues, overcrowding, homelessness and justice issues. We have to talk about the high cost of living. It's these things – housing, education, all these gaps and pressures that are making our people mentally distressed (Kimberley Roundtable Participant).*

### The Need for Empowerment of Families and Communities

Participants expressed the view that individuals, families and communities should be empowered. Participants expressed their concern that governments are failing to provide adequate funding to social and emotional wellbeing approaches, programs and services, which also include family wellbeing programs. There was a general consensus that a process of empowerment enables the raising of critical consciousness where oppressed groups of people can gain an in-depth understanding of the causes of their problems, how they can respond to these entrenched factors, and how to address the negative impacts. Participants expressed the importance of “dealing from inside the person” and that empowerment becomes the vehicle for people to take action against the oppressive elements in their lives. Participants expressed the importance of individuals, families and communities to identify and to challenge the sense of internalised powerlessness, and to develop opportunities to gain a sense of control within their lives. These outcomes reflect the *Hear Our Voices* report (Dudgeon et. al, 2012), an earlier study undertaken in the Kimberley about suicide prevention.

Participants expressed the view that empowered individuals and families would understand the context of their community and of the social and political structures that influence their lives and therefore identify and enact what is required for positive community development. This would lead to control of their environment and to enhanced interactions with service providers, social and political structures. Participants described the importance of empowerment in terms of improved self-worth and autonomy and therefore in terms of identity. This sense of resilience would enhance the ability to analyse problems and strengthen the belief in one's ability to exert control over life circumstances and also to improve the ability to help others.

Participants expressed the view that from a community development perspective,

empowerment strategies such as those under the *Mental Health and Social and Emotional Wellbeing Framework* (Social Health Reference Group, 2004) and similar culturally inclusive, community-led programs and services should be understood by governments as a means for disadvantaged communities to challenge social injustices by developing and strengthening mechanisms of control over oneself, families and communities, and hence over the institutional or structural barriers. Empowerment is relevant to healing for Aboriginal and Torres Strait Islander peoples and redresses the damage from historical social justices and trauma. One participant described the empowering of “individuals and families as having a rippling effect” and that this leads to the sense of interconnectedness with one another, fostering positive relationships and strengthening these positive relationships.

Participants expressed the view that programs designed to foster empowerment should be supported in every community and town by governments. Participants described empowerment as the opportunity for individuals to come to terms with their inner self - a healing journey, and to be able to continue that journey in turn leading them to assist others in their healing. Empowerment is also part of the process of decolonisation which participants expressed is an imperative. The “ripple effect” according to participants, is of particular significance in generating lasting positive impacts on others who have witnessed positive change in individuals. Participants expressed the view that empowerment of individuals and families would be a foundation to community and cultural stability, rehabilitate communities and cultures and address high rates of suicides, self-harming and various dysfunction. In communities where individuals and families have been empowered, local solutions and leadership would in turn be enhanced with a greater prospect of success.

Participants’ comments about empowerment and leadership included:

*We have to look at capacity building, empowerment and leadership on a community, family and individual basis, all at once, holistically* (Kimberley Roundtable Participant).

*I am all for helping the individual, making the individual strong and that person makes the next person strong; how to look after myself, how to look after my family, what is conflict, what causes conflict. A lot of our people don’t know how to manage anger, how to manage conflict. I always believe that we have to start from the seed. I think it’s all great we have a platform and go to government but I am very disheartened to hear the words ‘epidemic’ or ‘on the verge of epidemic’. We need to get services and us to help each other and [start] the rippling effect and we have got to start with the self* (Kimberley Roundtable Participant).

*Building a bit of resilience is a bit of disheartening but it is about ourselves and we need to hear SEWB... It is really basically about self, family and community* (Kimberley Roundtable Participant).

### Mental Health Issues

Participants expressed concern that hospital admission for mental health issues and self-harm rates had increased dramatically throughout the Kimberley. This view is supported by various reports such as the Western Australian Suicide Prevention Strategy (Department of Health Western Australia, 2009). Nevertheless, participants described the rates as an underestimate

of the actual number of self-harm incidents, as many were not admitted to hospitals or health clinics. An increase in psychological distresses, depressions and psychological breakdowns was reported. This correlated the doubling of the rate of suicide among Aboriginal and Torres Strait Islanders in the Kimberley in the last five years.

Participants expressed concern that the capacity of the mental health system and the primary health networks was inadequate to deal with the number of clients and issues. Also there were limitations in terms of cultural appropriateness, to intervene to address the increasing rates of psychological distress, self-harming and suicide attempts. Participants from mental and primary health response services reported that their services were “overstretched”.

Some participants expressed the view that many of the risk and protective factors that impact on Aboriginal and Torres Strait Islander peoples lay outside the ambit of the health and mental health systems. Instead they lay within the social determinants, and required empowering of families and communities, Aboriginal and Torres Strait Islander led local solutions, and in the need for surety of adequate funding levels and other provisions by governments.

Comments from participants about the levels of mental health problems and self-harm:

*Kimberley self-harm events are highest from November to February (Kimberley Roundtable Participant).*

*There is a huge increase in self-harm (Kimberley Roundtable Participant).*

*We try repeatedly, two or three times to follow up with our Aboriginal liaison staff to follow up but it's now a younger and younger age group that suicide is reaching (Kimberley Roundtable Participant).*

*Many are not referred but are walking off the streets asking for help (Kimberley Roundtable Participant).*

*A family member went through mental health counseling and one week later they committed suicide. So, when you discharge them - who is going to look after them when in community? Our communities need to be assisted to play a role to nip it in the bud (Kimberley Roundtable Participant).*

*We have compiled some statistics on self-harms and suicides that we have presented to the senior health bodies... The suicides started to occur only relatively recently. From all the records we could put together they began in the seventies but were not known before then. In the decade from 2000 to 2010, there were in excess of 100 suicides in the Kimberley but in this second decade we are sadly on track to double that number (Kimberley Roundtable Participant reflecting research in a report awaiting publication).*

### Trauma

Participants expressed concern at the increasing rates of self-harm and the high levels of domestic violence in some communities and also felt from anecdotal advice that there are

incidences of unreported child sexual abuse.

Participants expressed concern that there are historical and intergenerational traumas that have been left unaddressed, which has led to widespread feelings of being disempowered and that many people feel trapped in a constant state of powerlessness. Participants expressed concern that the losing loved ones prematurely has been normalised and that families and communities are in a constant state of grief, which perpetuates trauma. Participants expressed a need for Aboriginal and Torres Strait Islander perspectives of therapeutic and transformative healing for individuals, families and communities.

Participants' comments included:

*There are many issues including domestic violence, child sexual abuse... (Kimberley Roundtable Participant).*

*We have had many forums like this and as you know there is much trauma for our young people and I am hoping that the government will listen and start giving long-term funding instead of short-term funding. There needs to be long-term planning (Kimberley Roundtable Participant).*

*A child watching mum getting bashed can drive them to suicide (Kimberley Roundtable Participant).*

*How we going to help one another when we are going through the same things? We are a broken people (Kimberley Roundtable Participant).*

### Lack of Services and Responses

Participants identified gaps in current levels of service delivery, especially for people experiencing psychological distress. Participants expressed their concern at an “increasing disconnection” between service providers and communities. Participants also expressed concern at the lack of services in many communities. They described these gaps that included a lack of after-hours services when people in crisis need them most, especially those considered at high risk of attempting suicide.

Participants expressed their concern that very few organisations are currently offering after-hours contact with individuals who are at high risk. Some participants were disappointed that few organisations had an after-hours phone contact. Participants expressed the view that phone services that offer counseling were deemed “ineffectual”. A participant criticised the provision of only a telephone number because it assumes that in a moment of crisis people are able to reach out for help, whereas they may not feel comfortable making a phone call. They may not remember the 1800 number to ring or have credit on their mobile phone.

There were comments from community participants about the lack of services at many different levels and comments from service providers that they were not resourced to deliver services to meet all community needs. Participants described a “disconnection” between many service providers and communities and that many of the service providers lacked

“cultural appropriateness” or were “lacking local knowledge”. The consensus was that there needs to be identified Aboriginal and Torres Strait Islander community leaders, mentors and liaison officers who are accessible to both high-risk individuals and to service providers. Participants from communities described high levels of a failure among service providers in responding to individuals, families and communities who have reported high-risk distress levels. Participants were disturbed that after reporting suicides that there was no counseling, case management and follow through arranged with affected families and communities. Some participants suggested that the appropriate agencies should be proactive and go out and approach affected families as soon as possible, and ensure support and counseling when the families are ready. Participants described the experience of families that had lost a loved one and who were subsequently “shocked” that no one was there to assist them in the days following their loss.

Participants from stakeholder organisations expressed frustration at government funding criteria, which did not always align with community needs and priorities. They described that they were increasingly underfunded, “overstretched” and restricted in what they can provide and do. They expressed their frustration that they could not provide the levels of case management that they would like to.

The following participants’ comments illustrate this:

*This government needs to understand that it has done a lot of damage with funding cuts (Kimberley Roundtable Participant).*

*The Indigenous Advancement Strategy was a disaster with the majority of funding to non-Aboriginal organisations (Kimberley Roundtable Participant).*

*The government have exacerbated the problems and they need to understand this. They should not make decisions without listening to some of the bodies that are on the frontline (Kimberley Roundtable Participant).*

*Some of us have sat on ministerial boards but we are still here ten years later and they are not listening to us (Kimberley Roundtable Participant).*

A service responder stated, “We respond to all callouts.”

A community stakeholder responded, “Sorry, that is not the reality of our communities. They are not responded to and then they feel like shit and they take their lives. I have called, reported weapons and it was not acted on (Kimberley Roundtable Participant).

*We are not funded even for counseling services... This current government is not thinking community (Kimberley Roundtable Participant).*

*I live in [small town] and we just had a suicide recently and for one family or another in our community there has been a suicide. What I find is that no one goes out and talks to the families whether it’s been a suicide or self-harm. Three girls cut themselves. One girl was cut from hanging but no counseling. Another girl lost her sister but on one helped*

*her, no one went out. We cannot expect family to help when all families are going through these things, these pains. They plead with us to talk to their children... If they get melancholy and then drunk and then they think they want to do it, suicide. There is no follow-up... If family did get support and got counseled and maybe that could change things (Kimberley Roundtable Participant).*

*I am in [small town] and there are no youth centres, no anything, no Headspace, nothing and the kids have nothing if I may say (Kimberley Roundtable Participant).*

*With no disrespect to the various organisations, there is a disconnect between the service providers and communities. The communities are saying that the people are not being listened to (Kimberley Roundtable Participant).*

*Our agency is overstretched because there are too many people to help and because of this there are too few meetings, too few case management meetings and therefore we train up as many people as possible in some suicide prevention skills, counseling. Not enough of us to go round. Not enough funding and whatever contracts with government they are too restrictive (Kimberley Roundtable Participant).*

*The government knew that we had a crisis for several years but had us blindly addressing it when the government needed to respond to it as a big issue in a big way (Kimberley Roundtable Participant).*

### The Need for Local Solutions and Leadership

Participants expressed the need for Aboriginal and Torres Strait Islander led locally based leadership and solutions. They described the need for community leaders to be encouraged and empowered to support and lead their communities. Leaders should come together in protective groups to enable community empowerment and build stronger social networks and community participation. Community leaders should be engaged by service providers at all times and involved in organisational decision-making and enables the positive perception of increased support and community connectedness.

Participants expressed the view that governments should adequately fund locally based solutions, which includes a workforce predominately comprised of local Aboriginal and Torres Strait Islander people. They expressed concern at the high levels of unemployment in their communities, particularly among young adults. They expressed concern at the high rate of employment of external people who in turn do not achieve the required levels of positive engagement with especially young people in these communities.

Participants expressed the view that communities that are funded and supported to develop their own strategies and solutions in turn accumulate a 'control factor' and strengthen their capacity for self-determination and for hope. There is a sense of connectedness and improved communication with loved ones and other community members. Participants expressed the concern that where governments exclusively support service providers but not local community leadership, and where these service providers have low levels of local employees

and especially among their management the community continues to be 'stuck' in their current situation, overwhelmed by their longstanding problems and sense of disempowerment.

Participants described local solutions that work, where some proactive community leaders and Elders mentor young people despite no remuneration or funding – taking them 'On-Country' and provide ongoing support and mentoring. There was a general consensus that 'On-Country' and mentoring programs should be fully supported and adequately funded. To enable empowerment there needs to be the opportunity for change in self – the opportunity for change is a critical component according to participants.

The need for local leadership and empowerment was discussed in detail:

*We Elders have to stay strong and together rebuild the lives of our young ones... We have to come together on these issues (Kimberley Roundtable Participant).*

*The Kimberley needs more Aboriginal leadership programs (Kimberley Roundtable Participant).*

*My development program is for Aboriginal and non-Aboriginal people and we put the emphasis on leadership, empowerment and therefore put the temptations into context. We develop tools for our youth to deal with suicidal ideation (Kimberley Roundtable Participant).*

*(With our program) 90 per cent of our kids come out with no reoffending... (We) need more funds for our organisation to help more of our young people. Ideally we want to roll out (the program) to the whole of the Kimberley but right now we want to increase the help to 1,600 kids... We want to do mentoring and do preventative programs which helps on a bigger scale and which gives the kids the opportunity to engage with community activities. We need structures for our kids instead of them living in a hopeless world where they feel like doing themselves in (Kimberley Roundtable Participant).*

*We have to look at capacity building, empowerment and leadership on a community, family and individual basis, all at once, holistically (Kimberley Roundtable Participant).*

*You need strong leaders in communities. I know some people don't like change but we need strong leaders and to protect these strong leaders with good governance. We need good cultural ways because what is there now doesn't work (Kimberley Roundtable Participant).*

*The current service providers miss the targets. They miss the people and all they want to do is they just want to 'reform' the Aboriginal people when that doesn't work (Kimberley Roundtable Participant).*

### Conclusion

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)

Kimberley Roundtable was the sixth Roundtable in a series of nine national community Roundtables to ensure Aboriginal and Torres Strait Islander input to the overall Project. The outcomes reinforced the majority of themes from the preceding Roundtables. However, the outcomes also highlighted demographically specific information and contributing and protective factors in the Kimberley. The theme of the need for local solutions and leadership was once again raised and agreed on by the majority of the participants. This theme included the need to develop an increased local Aboriginal and Torres Strait Islander workforce that also provided management positions.

Participants came from diverse professional and community backgrounds, however, the majority described the impacts of social determinants as a leading cause of psychological, psychiatric and primary health issues and distresses. According to the majority of participants, mental health issues and the impacts of historical and contemporary traumas could be reduced if communities are supported economically and if self-determination and empowerment was in place for families and communities. Communities with a paucity of services would remain at risk unless this was addressed. Participants felt that loss, grief, trauma and bereavement have become a collective experience for Aboriginal and Torres Strait Islander communities – as if ‘normalised’ – and this collective experience is not a common occurrence in non-Aboriginal communities.

Aboriginal and Torres Strait Islander participants strongly supported adequate investment in existing programs that work such as on-country programs, mentoring and youth leadership, and that they be “rolled-out wherever possible”. Participants expressed the need for Governments to invest in Aboriginal-led social and emotional wellbeing approaches in programs.

The Kimberley’s Aboriginal and Torres Strait Islander population is much younger than the non-Aboriginal population, with nearly 44% aged under 20 years old (ABS, 2011). Participants stated that if adequate investments are not made by Governments immediately, that in the years ahead a young population with the worsening context of extreme poverty indicators would continue to increase the already deplorably high rates of self-harm and suicide in the Kimberley. The Kimberley already accounts for a disproportionately high rate of Western Australia’s and the nation’s overall suicides but also of a disproportionately high rate of Aboriginal and Torres Strait Islander suicides.

Aboriginal and Torres Strait Islander perspectives and concepts of healing, empowerment and leadership must be supported according to the majority of the Roundtable participants. These perspectives and concepts are based on historical, political, social and cultural experiences. There is a high level of need in Aboriginal and Torres Strait Islander communities right throughout the Kimberley. Many participants felt that they are continually discriminated against, excluded and neglected by Governments. Empowerment programs are seen by participants as an effective strategy for enhancing social and emotional wellbeing and for reducing contributing risk factors. Participants stated that empowerment and leadership programs needed to have legitimate community support and engagement in order that they remain culturally appropriate, locally based and relevant to people’s needs.

Participants are concerned by the fact that the Kimberley has come to the nation’s attention because of its exceptionally high number of suicides, particularly among its youth. They are

concerned that if Governments do not comprehensively respond to the exceptionally disproportionate number of stressful life events, the Kimberley's Aboriginal and Torres Strait Islander peoples, and in particular their youth, will perceive this as discrimination and neglect which will exacerbate feelings of chronic inequalities and hopelessness with even more dire outcomes.

The participants identified many existing strengths within the Aboriginal community that needed to be built upon and that are protective factors. These included their culture and identity, family, and their connection to people and country. There was a need to build a sense of hope.

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