

# The contexts and causes of suicide among Aboriginal and Torres Strait Islander people

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*Suicide is a behaviour or action, not a distinct psychiatric disorder. Like any behaviour, it results from the interaction of many different personal, historical, and contextual factors. Suicide may be associated with a wide range of personal and social problems, and have many different contributing causes in any individual instance. In fact, suicide is only one index of the health and wellbeing of a population, and it is important to view suicide in the larger context of psychological and social health, and wellbeing. Suicide is never the result of a single cause, but arises from a complex web of interacting personal and social circumstances.*

Excerpt from the Executive Summary of: Kirmayer L, Brass G, Holton T, *et al.* (2007). *Suicide Among Aboriginal People in Canada*, Aboriginal Healing Foundation, Canada.

## 1. Introduction

Within a week of the November 2016 launch of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project's (ATSISPEP) *Solutions That Work* report, the Western Australian Parliamentary Education and Health Standing Committee released its *Learnings From the Message Stick* report on Aboriginal youth suicide in WA remote areas.<sup>1</sup>

The WA report contained a chapter titled *Aboriginal Suicide Is Different*, a reference to the title of the 1999 Tatz study on Aboriginal youth suicide.<sup>2</sup> The bookending of almost two decades of investigation by reports that emphasise the *difference* in Aboriginal and Torres Strait Islander suicide compared to other suicides was significant.

That there are differences is important to recognise. Most obvious are:

- **The differences in methods.** A 2016 analysis of 102 Aboriginal and Torres Strait Islander suicides in the Kimberley between 2005 and 2014 found that hanging (asphyxiation by ligature, not usually involving the breaking of the neck) was the method used in 93 per cent of cases.<sup>3</sup>

A 2011 study of 478 Aboriginal and Torres Strait Islander suicides and a comparator 8425 non-Indigenous suicides in Queensland over 1994 and 2006, including by analysis of coronial inquest reports and 'psychological autopsies'<sup>4</sup> (hereon '2011 Queensland study') is a particularly useful source of data about Aboriginal and Torres Strait Islander suicide and will be referred to again in this paper. This reported hanging to be the method in around 90 per cent of Aboriginal and Torres Strait Islander cases, far higher than in the non-Indigenous population where, nonetheless, hanging was the most used method of suicide (about 40 per cent of cases).<sup>5</sup> There was also significant contrast to the much greater variety methods of suicide observed in the non-Indigenous group.<sup>6</sup>

- **The difference and rapid increase in the rates of suicide reported between the Aboriginal and Torres Strait Islander and non-Indigenous population.** Among the former, suicide is a relatively recent phenomenon with few precedents prior to the 1960s.<sup>7</sup> Yet fifty years later, the Aboriginal and Torres Strait Islander suicide rate is twice that of non-Indigenous people.<sup>8</sup>
- **The differences in age groups who are attempting and completing suicides.** Suicide is a major public health concern in both the Aboriginal and Torres Strait Islander and non-Indigenous populations. Overall in 2015, suicide was the leading cause of death among all people 15-44 years of age, and the second leading cause of death among those 45-54 years of age.<sup>9</sup> But the peak age of Aboriginal and Torres Strait Islander suicide is 30-34 years for males and 20-24 years for females;<sup>10</sup> and this is three times the rate for non-Indigenous people of the same ages.<sup>11</sup> In contrast, the highest proportion of suicide deaths of non-Indigenous males occurs among those 40-44 years of age, while for females it is the 45-49 year age group.<sup>12</sup>

Further, when considering the suicide deaths of all Australians under 18 years, Aboriginal and Torres Strait Islander people accounted for 30 per cent of deaths over 2007 -2011 despite comprising only three to four per cent of the total age group population.<sup>13</sup> Aboriginal and Torres Strait Islander 15-24 year olds are over five times as likely to suicide as their non-Indigenous peers.<sup>14</sup>

However, the focuses of this paper are, first, the **underlying historical, cultural political, social and economic context** of the situation of Aboriginal and Torres Strait Islander people in contemporary Australia that contribute to many of the above differences. These manifest most obviously at the community level.

The second focus is **the causes or events associated with the suicide of Aboriginal and Torres Strait Islander individuals.** In relation to these factors, much of the literature on suicide in the general population is relevant to the experience of Aboriginal and Torres Strait Islander peoples. But as will be discussed, the underlying historical, cultural political, social and economic context is not, in practice, separable from these causes or events and that contribute to the other patterns of difference discussed above.

This paper comprises four overlapping parts that consider the following contextual and causal factors that contribute to suicide among Aboriginal and Torres Strait Islander peoples:

- Part 1 considers the history of colonisation and the subsequent interactions of Aboriginal and Torres Strait Islander peoples with the social and political institutions of Australian society that have negatively impacted on Aboriginal and Torres Strait Islander community life and, in turn, key population-level protective factors against suicide.
- Part 2, related to the above, considers the specific risk factors that arise in impacted communities with specific risks at the individual level – this includes alcohol and drug use, impulsivity and child neglect and abuse.

- In Part 3, the cumulative impact of stressors is considered, and also the evidence for the impact of specific stressors: family and relationship breakdown, a criminal history/ pending legal matters and unemployment.
- Part 4 looks at mental health and the accessibility of the Australian mental health and suicide prevention services to Aboriginal and Torres Strait Islander people at risk of suicide.

From the start however, it should be understood that this paper's four-part structure is an artificial construct, designed to tease out the complex and inter-connected contexts and causes of suicide for analysis. In practice, all or some in various combinations and with varying emphasis might contribute to the suicide of Aboriginal and Torres Strait Islander individual.

### **Part 1 – Colonisation and Community**

The broad context of today's high Aboriginal and Torres Strait Islander suicide rates is the traumatic disrupting effect of colonisation and its aftermath on communities.

It is noteworthy that prior to the 1950s and 1960s there are few if any reports of Aboriginal and Torres Strait Islander suicide.<sup>15</sup> Its emergence as a population health issue has been connected, in particular, to the closing of reserves, and the end of formal legally encoded racial discrimination.

So why would this result in increased suicide? First, because in practice the lifting of legal discrimination was not enough to redress the deep poverty and lack of even basic health and associated services that characterised life on the reserves. In short, Aboriginal and Torres Strait Islander remained socially excluded from the benefits of political, social and economic life<sup>16</sup> (as discussed in Part 2).

Second, because this enabled Aboriginal and Torres Strait Islander peoples to access both welfare and alcohol without restriction. Hunter and Milroy (2006) contend this led to widespread dysfunction in many communities leading to a period of 'normative instability' compounded by alcohol abuse.<sup>17</sup> They also explain the underlying psychological processes through which broader historical, socio-economic and community factors may become internalised, arguing that Aboriginal and Torres Strait Islander self-destructive behaviours reflect vulnerability stemming from internal states informed by both individual experience and collective circumstance.<sup>18</sup>

Particularly influential in explaining the relationship between the collective functioning of Indigenous communities and suicide rates in them are two studies by Chandler and Lalonde among British Columbian (Canadian) First Nations' young people. These focused on community-level protective factors against suicidal behaviours: in particular community empowerment and cultural continuity as, in practice, inseparable protective factors.<sup>19</sup>

In their first study (1987 – 1992) cultural continuity was defined according to six key

interconnecting indicators of self-governance and cultural maintenance:

- achievement of a measure of self-government;
- have litigated for Aboriginal title to traditional lands;
- accomplished a measure of local control over health;
- accomplished a measure of local control over education;
- accomplished a measure of local control over policing services; and
- had created community facilities for the preservation of culture.<sup>20</sup>

In this study, Chandler and Lalonde mapped suicides in all 197 communities or 'bands' in British Columbia and found that communities that achieved all six markers had no cases of suicide among young First Nations people. Conversely, where communities achieved none of these protective markers, youth suicide rates were many times the national average.<sup>21</sup>

A second study (1993 – 2000) included two other indicators and found similar results to those of the first study. The additional indicators were:

- a measure of local control over child welfare services; and
- that they are characterised by having elected band councils composed of more than 50 percent women.<sup>22</sup>

Community empowerment and cultural continuity are now considered in an Australian context.

### *Community Empowerment*

In Australia, colonisation required the exercise of all forms of state power to control the lives of Aboriginal and Torres Strait Islander peoples combined with a massive influx of non-indigenous people. Today, Aboriginal and Torres Strait Islander peoples comprise a three percent minority within Australia, with concurrent limited political power.<sup>23</sup>

The right to self-determination of Indigenous peoples (including Aboriginal and Torres Strait Islander peoples) in post-colonial settings is broadly understood as the right to self-governance.

This has been formally recognised in the 2007 UN *Declaration on the Rights of Indigenous Peoples*, supported by Australia in 2009.<sup>24</sup> Aboriginal Community Controlled Health Services are emblematic of the exercise of the above right within the health system, but the consistent application of the self-determination principle in the overarching political and policy-development spaces, which involves the Australian state sharing power with

Aboriginal and Torres Strait Islander peoples in decision-making that impacts upon them, is contested.<sup>25</sup>

At the community level, the disempowerment experienced at the national level is often reflected.

As discussed by Tsey *et al* (2012), governance refers to 'evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve things that matter to them.'<sup>26</sup> In Aboriginal and Torres Strait Islander settings, each community is different and good governance is defined by culturally based values and normative codes about what is 'the right way' to get things done in terms of legitimacy, leadership, power, resources and accountability.<sup>27</sup> In contrast, poor governance is identified by factors such as corruption, favouritism, nepotism, apathy, neglect, red tape and self-serving political leaders and public officials.<sup>28</sup>

Data on Aboriginal and Torres Strait Islander peoples' experience of community and community governance has only just started to be collected. The 2014–15 Australian Bureau of Statistics (ABS) *National Aboriginal and Torres Strait Islander Social Survey* (NATSISS) reported that in remote areas, only about half of respondents felt their local community had strong leadership.<sup>29</sup> Only one-quarter (26 per cent) reported they could have a say within their community on important issues, all or most of the time, while 51 per cent felt they could have a say within their community a little or none of the time.<sup>30</sup> Sixteen per cent of respondents felt that their community was a worse place to live at the time of the survey than it was 12-months prior to the survey.<sup>31</sup>

Empowerment at both the individual and community level has been central to efforts to reduce Aboriginal and Torres Strait Islander suicide to date. In particular, the ongoing National Empowerment Project (NEP) that aims to empower communities by education in identifying and addressing challenges (including those associated with suicide) and supporting their capacity for self-governance and organisation to address those challenges.<sup>32</sup>

### *Cultural Continuity*

Cultural continuity is an important concept in Indigenous suicide prevention in part because inherent in the concept is that young people have a sense of their past and their cultures and draw pride and identity from them. By extension, young people also conceive of themselves as having a future (as bearers of that culture).<sup>33</sup>

With reference to the Aboriginal and Torres Strait Islander social and emotional wellbeing concept, culturally defined family and kin relationships; community relationships; the role of Elders, cultural practice; connection to country; and spirituality and ancestors are considered as elements of cultural continuity and thus – it can be extrapolated - protective factors against suicide.<sup>34</sup> [The social and emotional wellbeing concept is otherwise assumed knowledge in the reader.]

As such it is of concern that there is evidence for 'disconnection' from these protective factors being experienced by a significant minority of Aboriginal and Torres Strait Islander peoples both in community settings and otherwise. Noteworthy is that:

- *Social contact/ community support.* The NATSISS 2014–15 reported that about 17 per cent of respondents, from both non-remote and remote areas, did not have weekly face-to-face contact with family or friends living outside their household.<sup>35</sup> Further, that about eight per cent of respondents said they were unable to get support from outside their household in a time of crisis.<sup>36</sup>
- *Family and friends.* The NATSISS 2014–15 reported about 18 per cent of overall respondents said they were unable to confide in family or friends living outside their household: 13 per cent of remote living people and 35 per cent of non-remote living people.<sup>37</sup>
- *Removal from family.* In 2012-2013 in the ABS Australian Aboriginal and Torres Strait Islander Health Survey, just over half (54 per cent) of respondents aged 15 years and over reported that they and/or a relative had been removed from their natural family. Those who were removed from their family were more likely to have high levels of psychological distress (35 per cent) than those never affected by family removals (26 per cent).<sup>38</sup>
- *Influence of Elders.* The NATSISS 2014–15 reported about half of Aboriginal and Torres Strait Islander children aged 4–14 years were not in contact with a leader or elder on weekly basis. The corresponding proportions in non-remote areas were about three quarters of children aged 4 -14.<sup>39</sup> Only about half of adult respondents agreed that leaders in the community had time to listen and give advice (52 per cent).<sup>40</sup>

In relation to the latter point, Niezen's account of a suicide cluster in Canadian Inuit communities recognised the protective and life affirming function which 'cultural continuity' plays in strengthening young people's self-identity and sense of connectedness with family and community. In particular, he observed that patterns of increasingly self-destructive behaviour in young people appeared to be more prevalent in those communities where there was a disengagement of young people from older generations and the absence of almost any opportunities for productive and creative activity.<sup>41</sup>

Niezen observed that young people in communities where individual and community identities are fragile, and where they are cut off from the positive example and social persuasion of older generations, are likely to gravitate to a peer group of similarly disconnected youth.<sup>42</sup> Tatz's (1999) study discussed the sense of hopelessness among Aboriginal and Torres Strait Islander young men he considered to be at risk of suicide and suggested a similar pattern of disconnection from guidance.<sup>43</sup>

Already, in Australia, the NEP places a strong emphasis on leveraging cultural strengths, involving Elders and supporting a community's cultural renewal on its own terms as a major part of its work within communities.<sup>44</sup>

While the implications of cultural continuity as a concept are yet to be fully explored, including their application in Aboriginal and Torres Strait Islander settings, and in urban settings, support for cultural continuity is a highly productive line of policy development in relation to suicide prevention (and more broadly, Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing) based on cultural maintenance and, where necessary, reclamation.

### *Social exclusion*

Part of the aftermath of colonisation is interpersonal and other forms of racism and discrimination and the related concept of **social exclusion** that contribute to the broader context of high Aboriginal and Torres Strait Islander suicide rates. The 'socially included' have been defined as having the resources, opportunities and capabilities they need to:

- Learn (participate in education and training);
- Work (participate in employment, unpaid or voluntary work including family and carer responsibilities);
- Engage (connect with people, use local services and participate in local, cultural, civic and recreational activities); and
- Have a voice (influence decisions that affect them).<sup>45</sup>

In contrast, social exclusion is a position of collective or individual powerlessness that can result from a combination of linked problems such as unemployment, discrimination, poor skills, low incomes, poor housing, high crime, bad health and family breakdown.<sup>46</sup>

Social inclusion considered as empowerment follows the example of Amartya Sen who defines poverty in terms of *low capabilities and functionings*. Sen argues that poverty ensues when individuals or collectives lack certain minimum capabilities. Low capabilities can translate into outcomes such as inadequate incomes or education, poor health, low self-confidence, and ultimately a personal or collective sense of powerlessness or helplessness.<sup>47</sup>

In 2013, the Productivity Commission classified Australian population groups using a Social Exclusion Monitor. This comprised 29 indicators across seven key life domains including those that related to personal power: including access to material resources, employment, education and skills, and health and disability, to assess their 'deep and persistent disadvantage.'<sup>48</sup>

Between five and six percent of Australians enter income poverty in any given year, and a similar proportion exit.<sup>49</sup> But the risk of a person remaining *persistently* in disadvantage increases with its duration. For example, on average the likelihood of a person exiting income poverty who had experienced poverty for six or more years (in the previous nine years) is around two thirds less than someone who had experienced income poverty for one or two years. Not surprisingly, employment is a catalyst for moving out of disadvantage.<sup>50</sup>

The Productivity Commission assessed that people at highest risk of experiencing deeper or multiple forms of disadvantage in 2010 included not only Aboriginal and Torres Strait Islander people as such, but also population groups among whom Aboriginal and Torres Strait Islander people are over-represented when compared to non-Indigenous people: those who are dependent on income support, those living in public housing, unemployed people, people with a long-term health condition or disability, lone parents and people with low educational attainment.<sup>51</sup>

For Aboriginal and Torres Strait Islander people *per se* it was assessed that overall 10.8 per cent of the population were in a state of deep and persistent social exclusion between 2001 and 2010. At the end of that decade, in 2010, 9.1 per cent of Aboriginal and Torres Strait Islander peoples were estimated remain in that state,<sup>52</sup> compared to approximately five percent in the general population.<sup>53</sup> This represents a reduction of only 1.7 per cent over the decade.

Not only do community-wide issues (for example, alcohol and drug use) involve individuals, but as discussed above and as Hunter and Milroy propose, collective self-perceptions can be internalised by young Aboriginal and Torres Strait Islander people and provide a context for specific risk behaviours and other factors associated with suicide.

In practice, the line between community level contributors to suicide and factors associated with individual suicides can be hard, if not impossible, to draw with any sense of precision. Indeed, social exclusion provides a context for many of the individual risk factors and causes discussed in Parts 2 and 3 below.

## **Part 2: Individual risk factors**

### *Alcohol and drug use*

The 2011 Queensland study examined toxicology reports for 216 Aboriginal and Torres Strait Islander and about 3600 non-Indigenous suicide cases for the period 1998 – 2006.<sup>54</sup>

The commonest prescription medication found in 7.4 per cent of Aboriginal and Torres Strait Islander suicide cases were benzodiazepines<sup>55</sup>: with sedative, sleep-inducing and muscle-relaxant properties. But compared to the drug being reported in 27 per cent of non-Indigenous cases,<sup>56</sup> usage associated with suicide is relatively small.

Likewise, opiates, with pain killing and relaxant properties, were found in only 3.2 per cent of Aboriginal and Torres Strait Islander cases compared to 16.4 per cent of non-Indigenous.<sup>57</sup>

In contrast, alcohol was present in almost 60 per cent of Aboriginal and Torres Strait Islander suicide cases at alcohol-blood levels exceeding 0.5mg/100 ml (the drink driving limit), about double the rate of the non-indigenous persons (about 30 per cent of cases); with 25 per cent of Aboriginal and Torres Strait Islander suicide cases having over 0.2mg/100 ml (four times the drink driving limit) in their blood at time of death, compared to seven percent of non-indigenous deaths.<sup>58</sup>



The high alcohol usage figure could indicate that Aboriginal and Torres Strait Islander people are using alcohol as a part of their method of suicide, in part perhaps because of lower access to prescription medications, or use of alcohol over their lifetime. In contrast to the 60 per cent (just under two in three) whose toxicology reports found high alcohol blood levels at the time of death, so-called ‘psychological autopsies’ revealed that only two in five had a reported history of problematic drinking.<sup>59</sup> Cannabis was present in 30 per cent of Aboriginal and Torres Strait Islander suicide cases; almost double the rate of non-Indigenous suicide cases.<sup>60</sup>

*Learnings From the Message Stick*, reported suicide is the most common cause of alcohol-related deaths among Aboriginal men and the fourth most common cause amongst Aboriginal women in contrast to the non-Indigenous population.<sup>61</sup> Further, it reported high levels of alcohol and drug misuse have also been noted in almost all documented Aboriginal suicide clusters, with many of the affected individuals being either intoxicated or in severe withdrawal.<sup>62</sup>

There are two ways of interpreting this data. One is that alcohol and cannabis is being used by a significant proportion (at least up to half) of these cases as part of a suicide method.<sup>63</sup> Another is that use of these substances might be contributing to suicide, including through lowering protective factors against impulsive suicidal behaviour.

*Learnings from the Message Stick* reported that impulsiveness is a ‘distinct feature of Aboriginal suicide which is commonly linked to excessive alcohol consumption’.<sup>64</sup> By this, stressful events such as relational conflict or breakdown (discussed below) may prompt an impulsive suicidal reaction under the influence of alcohol or drugs.<sup>65</sup>

### *Impulsivity*

As reported in *Learnings from the Message Stick*, in some cases an immediate “precipitating” stressor to a suicide is not apparent, or may appear to be relatively minor,<sup>66</sup> or as an act to gain attention.<sup>67</sup> Further, that impulsivity and its relationship to suicidal behaviour is a complex issue that cannot be simply attributed to alcohol and drug use. It is, for example, associated with Fetal Alcohol Syndrome Disorders (FASD) and trauma as discussed below.

FASD is an umbrella term to describe ‘a range of physical, cognitive, behavioural and neurodevelopmental abnormalities that result from the exposure of a fetus to alcohol consumption during pregnancy’.<sup>68</sup> Impulsiveness is also a core component of FASD, together with loss of decision-making ability and inability to predict the outcomes of one’s actions.<sup>69</sup>

The Lililwan Project is a study designed, in part, to estimate the prevalence of FASD and associated factors in an Aboriginal community – the Fitzroy Valley in the Kimberley, Western Australia.<sup>70</sup> About 95 per cent of Aboriginal children born over 2002 - 2003 in the community were involved.<sup>71</sup> FAS or partial FAS (pFAS) was diagnosed in 13 of 108 children, a prevalence of 120 in 1000, or 12 per cent.<sup>72</sup> Prenatal alcohol exposure was confirmed for all children with FAS/pFAS including 80 per cent in the first trimester and 50 per cent

throughout pregnancy.<sup>73</sup> *Learning from the Message Stick* report cited experts who concluded that FASD was ‘absolutely linked’ with suicide in Kimberley communities.<sup>74</sup>

Impulsivity has also been associated with an individual’s lack of ability to self-soothe as a result of untreated trauma.<sup>75</sup> Trauma is not a mental illness but refers to experiences and symptoms associated with particularly intense stressful life events that overwhelm a person’s ability to cope. For children in particular, these can include sexual abuse, as discussed below.

What limited data is available suggests relatively high levels of trauma in the Aboriginal and Torres Strait Islander population. Post-Traumatic Stress Disorder (PTSD) is one manifestation of trauma. A 2008 study of Aboriginal and Torres Strait Islander prisoners in Queensland reported 12.1 per cent of males and 32.3 per cent of females with PTSD.<sup>76</sup>

#### *Family violence and child abuse, children in care*

In his 2014, *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*, the WA Ombudsmen examined the deaths of 36 young people by suicide or suspected suicide and found that:

- 44 per cent were said to have experienced family and domestic violence
- 25 per cent were recorded as having allegedly experienced sexual abuse
- 22 per cent were recorded as having allegedly experienced physical abuse, and
- 33 per cent were recorded as having allegedly experienced one or more elements of neglect during their childhood.<sup>77</sup>

Nationally in 2014-15, the most common reason for substantiation for Aboriginal and Torres Strait Islander children aged 0–17 years was neglect (38.3 per cent) followed by emotional abuse (37.7 per cent).<sup>78</sup>

As noted in *Learnings from the Message Stick*:

*While all forms of abuse significantly increase the risk of suicidal ideation and suicide attempts for young people, research suggests that the link is strongest in cases of sexual abuse. The risk of repeated suicide attempts is reportedly eight times higher for young people with a sexual abuse history than for those without. It has been suggested that sexual abuse could be specifically related to suicidal behaviour because it is closely associated with feelings of shame and internal attributions of blame (without references)<sup>79</sup>*

Likewise, Cashmore and Shackel’s (2012) meta-analysis *The long-term effects of child sexual abuse*, reported that sexual victimisation, both in childhood and beyond, is a significant risk factor for suicide attempts among both men and women.<sup>80</sup>

Whilst the actual prevalence of child sexual assault by Aboriginal and Torres Strait Islander children status is not known, data from incidents that come to the attention of, and are recorded by, police are available. In 2015, Aboriginal and Torres Strait Islander child victims

(aged less than 15 years) of sexual assault accounted for 48.4 per cent (NSW), 54.5 per cent (Queensland), 36.4 per cent (SA) and 38.0 per cent (NT) of sexual assault victims in each jurisdiction.<sup>81</sup>

*Learnings from the Message Stick* also noted the strong association between high rates of suicide among young people after leaving care.<sup>82</sup> It also noted that the rates of child protection in the Kimberley region are, like the rates of suicide in that region extremely high.<sup>83</sup>

#### *Exposure to suicidal behaviour*

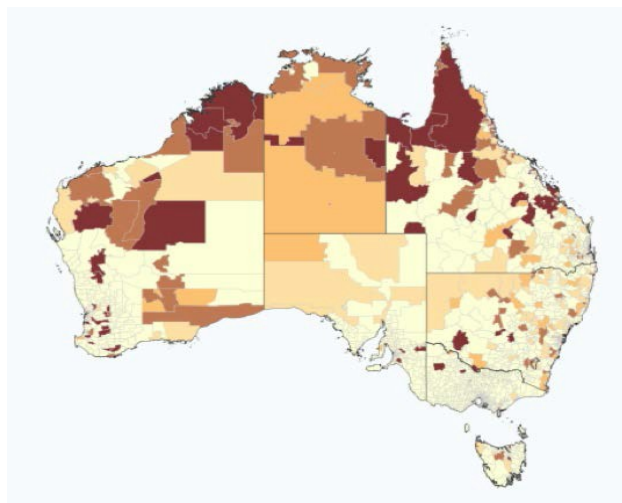
The 2011 Queensland study reported that among Aboriginal and Torres Strait Islander suicide cases, imitation appears to play an elevated role when compared to the evidence for imitative behavior in non-Indigenous cases. In the former, 16.7 per cent had experienced a suicide event in their social network, compared to 8.8 per cent of non-Indigenous cases.<sup>84</sup>

This 16.7 per cent amounted to a sample group of 71 Aboriginal and Torres Strait Islander suicide deaths with a suicide in their social network.<sup>85</sup> Of these, almost 50 per cent had experienced the suicide of a direct relative, 40 per cent the suicide of another relative or a friend, and about one in eight had experienced multiple suicides in their social network.<sup>86</sup>

And among young people, there are reports that a significant percentage of all Aboriginal and Torres Strait Islander suicides in the Northern Territory between 1996 and 2005 are thought to have been part of 'suicide clusters' as a result of 'copy-cat' behaviours.<sup>87</sup> Similarly, in the 2001-2002 *Western Australian Aboriginal Child Health Survey*, among the 16 per cent of 12-17 year olds who reported suicidal thoughts rates were elevated among those who had a friend who had attempted suicide.<sup>88</sup>

Reasons for 'clustering' require further research. However, Aboriginal and Torres Strait Islander suicides in general, and suicide clusters in particular, are characterised by the same choice of method (hanging, as discussed in the Introduction) and often concentrated in geographically isolated areas as illustrated in Diagram 1 below.

**Diagram 1: The numbers of Aboriginal and Torres Strait Islander suicides by postcode, 2001 -12**



A key pattern in Aboriginal and Torres Strait Islander suicide deaths in Australia is their concentration in remote areas as illustrated by ATSIPEP's map of Aboriginal and Torres Strait Islander suicide over 2001 -12 by postcode. The darker the colour, the more suicides have occurred.<sup>89</sup>

Mechanisms implied to increase the risk of suicide imitation (or normalisation) are considered to include: desensitisation of young people towards death and suicide; the visibility of suicides occurring in the communities; and/or communication about these deaths via media or word of mouth.<sup>90</sup>

Copy-cat or imitative suicidal behavior is not unique to Aboriginal and Torres Strait Islander communities. Internationally, it has been estimated that between one and five per cent of all suicides by young people occur in the context of a cluster.<sup>91</sup> While most commonly documented in Aboriginal and Torres Strait Islander communities in Australia, it is also occurring among the non-Indigenous population.<sup>92</sup>

### **Part 3: Specific causes associated with suicide**

Associated with social exclusion and disadvantage is greater exposure to stressful life events. The most frequently reported stressful life events reported by Aboriginal and Torres Strait Islander peoples in the 2012-2013 AATSIHS were:

- death of a family member or friend (reported by 37 per cent of respondents);
- serious illness (23 per cent);
- inability to get a job (23 per cent); and
- mental illness (16 per cent).<sup>93</sup>

These events are shared experiences between Aboriginal and Torres Strait Islander peoples and the non-Indigenous population. However, there is evidence for Aboriginal and Torres Strait Islander peoples' greater and simultaneous exposure to multiple stressful events.

Researchers report that 1.9 – 2.6 overlapping stressful life events are associated with mild or moderate psychological distress, with between 2.6 and 3.2 events associated with high or very high psychological distress.<sup>94</sup> As such it is significant that in 2012–13, 30 per cent of AATSIHS respondents over 18 years of age were assessed with having high or very high psychological distress levels in the four weeks before the survey.<sup>95</sup> That is, nearly three times the non-Indigenous rate.<sup>96</sup> In the same survey, 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life events in the previous year.<sup>97</sup> That rate is 1.4 times that reported by non-Indigenous people.<sup>98</sup>

A 2009 study reported that those with high and very high psychological distress (measured by the Kessler K-10 scale) were 21 and 77 times more likely, respectively, to be experiencing suicidal ideation.<sup>99</sup>

When considering particular individual factors associated with suicide, the 2011 Queensland study' is particularly useful. This reported that two-thirds of the entire sample (both

Aboriginal and Torres Strait Islander and non-Indigenous cases) had records of being exposed to at least one recent stressful life event prior to suicide, with no significant differences observed across age or gender.

It reported the most common stressful life events found to precede an Aboriginal and Torres Strait Islander suicide are:

- conflict with partners (relationship conflict) and family members (familial conflict) or other persons (interpersonal conflict);
- pending legal matters and criminal history; and
- loss of significant persons (bereavement), with a particular focus on exposure to suicide in the social network.<sup>100</sup>

There were also strong associations noted between suicide and unemployment.

#### *Relationship breakdown and death of significant persons*

The 2011 Queensland Study reported the most frequent events preceding all suicide deaths were relationship problems (either conflict with a partner or relationship breakdown/separation), which were reported in 31.1 per cent of Aboriginal and Torres Strait Islander and 29.6 per cent of non-Indigenous suicide cases – roughly the same proportions.<sup>101</sup>

However, the second most common life event reported in Aboriginal and Torres Strait Islander suicides were conflicts, either with family members (familial conflict) or other persons, such as friends, neighbours and colleagues (interpersonal conflict). This was at an elevated rate compared to the non-Indigenous population (13.9 per cent vs. 8.2 per cent).

Relevant to suicide prevention and touching on community functioning is ‘lateral violence,’ a term that describes the way oppressed people, covertly or overtly direct their dissatisfaction sideways toward each other, toward themselves, and toward those less powerful than themselves. It results in people turning on each other as opposed to the systems that exclude and oppress them.<sup>102</sup>

Lateral violence is a spectrum of behaviours that include: gossiping, jealousy, bullying, shaming, social exclusion, family feuding, intra-organisation conflict and, ultimately, physical violence. While not named as such, many elements of family feuding can be seen to constitute lateral violence. Lateral violence was identified in the reports of the NEP as a significant problem in communities.<sup>103</sup>

The 2011 Queensland study also reported that bereavement/loss of a significant person was more common among Aboriginal and Torres Strait islander suicide cases (11.5 per cent), compared to non-Indigenous cases (8 per cent).<sup>104</sup> In particular, 11.7 per cent of Aboriginal and Torres Strait islander males were reported to have suffered a bereavement compared to 7.5 per cent of non-Indigenous males.<sup>105</sup>

In particular, the age-distribution of Aboriginal and Torres Strait islander and non-

Indigenous bereaved persons who suicided was significantly different: about 32 per cent of bereaved non-Indigenous suicide cases were older than 55 years, while in almost four in five of bereaved Aboriginal and Torres Strait islander cases persons were younger than 34 years.<sup>106</sup>

### *Criminal history and pending legal matters*

In June 2015, Aboriginal and Torres Strait Islander peoples comprised 27 percent of all prisoners<sup>107</sup> despite comprising about three percent of the population. The age-standardised imprisonment rate was 13 times greater than for non-Indigenous Australians.<sup>108</sup>

Not often considered is the impact that imprisonment might have on suicide rates. In particular, a potential subject of future research is proposed to be the 2011 Queensland study report of a criminal history in 32.5 per cent of the Aboriginal and Torres Strait islander suicide cases. This was more than twice that recorded in non-Indigenous cases (15.8 per cent).<sup>109</sup>

Pending legal issues prior to death were also reported in the 2011 Queensland study at elevated levels in the Aboriginal and Torres Strait islander suicide death sample when compared to the non-Indigenous sample: at 11.5 per cent compared to 7.5 per cent respectively overall, and among males at 13.7 per cent v 8.4 percent for the non-Indigenous.<sup>110</sup>

Almost half (about 50 per cent) of the Aboriginal and Torres Strait islander suicide cases of males with pending legal issues were of young men – less than 24 years of age. Among the non-Indigenous comparator sample, only 17.2 per cent of deaths were in that age group.<sup>111</sup>

### *Unemployment/inability to get a job*

The 2011 Queensland study reported almost half the Aboriginal and Torres Strait suicide cases in its sample were unemployed at the time of their death, which was almost twice more than in non-Indigenous comparator cases.<sup>112</sup> This mirrors somewhat the unemployment rate itself, at least for Aboriginal and Torres Strait Islander people aged 15–24 years who are among at the highest risk of suicide:

- The NATSISS 2014–15 reported that the unemployment rate for Aboriginal and Torres Strait Islander people aged 15 years and over was 20.6 per cent.<sup>113</sup> The rates and the employment ‘gap’ with the non-Indigenous, were highest among Aboriginal and Torres Strait Islander people aged 15–24 years (31.8 per cent compared with 16.7 per cent for non-Indigenous people)<sup>114</sup>
- The unemployment rate was higher for Aboriginal and Torres Strait Islander people aged 15 years and over in remote areas (27.4 per cent) than in non-remote areas (19.3 per cent). By comparison, the Aboriginal and Torres Strait Islander people unemployment rate in major cities was 14.0 per cent. The states with the highest unemployment rates were Western Australia (26.4 per cent) and Queensland (25.1 per cent).<sup>115</sup>

#### Part 4: Access to services according to need

The final part of the picture is not a cause *per se* but returns us to the contextual factors that are associated with Aboriginal and Torres Strait Islander suicide and ultimately relate to social exclusion. In particular, that an Aboriginal and Torres Strait Islander person at risk of suicide or with a mental health problem is less likely to be able to access the services they need than a non-indigenous person in the same position.

Despite the previous discussion about impulsiveness as a risk factor for suicide, it is noteworthy that the evidence suggests a significant number of Aboriginal and Torres Strait Islander suicides are pre-meditated and in many cases that intent had been communicated prior to death and that these people were to some degree identifiable to friends, family and mental health and suicide prevention service providers:

- The 2011 Queensland study reported that of the 478 Aboriginal and Torres Strait Islander suicides that were the subject of the study, 43.3 per cent involved the person communicating suicidal intent in their lifetime, with 39.1 percent communicating intent in the 12 months prior to death. This includes 25 per cent of the cases having a history of previous suicide attempts; 16 per cent in the previous 12-months.<sup>116</sup>
- In the 2001-2002 *Western Australian Aboriginal Child Health Survey*, 16 per cent of 12-17 year olds reported suicidal thoughts and 39 per cent of these reported an attempted suicide (i.e. about 7 percent of the total sample) during the 12 months prior to the survey.<sup>117</sup>
- Self-harm can be a way of coping with stress and akin to a 'cry for help',<sup>118</sup> but data collections do not distinguish between self-harm for this purpose and attempted suicide. In 2014-2015, Aboriginal and Torres Strait Islander peoples were hospitalised for self-harm at 2.6 times the rate of non-Indigenous Australians.<sup>119</sup> Rates have increased by 55.6 percent since 2004-2005.<sup>120</sup>
- Suicide is also strongly associated with depression. In general population suicide research, people who have already attempted suicide are considered to be at the highest risk of suicide (at 40 x increased risk) than any other population group. Further increased risk was related to the recency of a previous attempt, the frequency of previous attempts, and isolation.<sup>121</sup> In the 2012–13 AATSIHS, 12 per cent of respondents reported feeling depressed or having depression as a long-term condition; compared 9.6 per cent in the total population.<sup>122</sup> Over 2008 – 2013, depression was the most frequently reported mental health related problem managed by GPs among Aboriginal and Torres Strait islander clients.<sup>123</sup> The 2014–15 NATSISS asked whether respondents were happy 'all', 'most', 'some', 'little' or 'none' of the time. Nationwide, 9.2 per cent of Aboriginal and Torres Strait Islander people reported being happy little or none of the time.<sup>124</sup>

Yet the 2011 Queensland study reported the following evidence that suggests significantly more Aboriginal and Torres Strait Islander people at risk of suicide are not accessing the

support and/ or services they needed prior to their deaths when compared to non-Indigenous suicide:

- 20.5 per cent of the Aboriginal and Torres Strait Islander suicide cases had at least one reported mental illness at the time of death, compared with 2,514 (40.4 per cent) of non-Indigenous suicide cases;
- 23.3 per cent of Aboriginal and Torres Strait Islander cases had received treatment from a mental health professional in their lifetime, compared to 42.3 per cent of non-Indigenous;
- 10.1% of Aboriginal and Torres Strait Islander cases were seen by a mental health professional in last three months prior to suicide, compared to 25.6 per cent of non-Indigenous cases;<sup>125</sup>
- 1.9% of Aboriginal and Torres Strait Islander cases had a recorded use of anti-psychotics, compared to 4.4 per cent of non-Indigenous cases.<sup>126</sup>

While usage is improving, Aboriginal and Torres Strait Islander peoples and - it can be extrapolated particularly those at risk of suicide - have relatively low access to/ or are choosing not to use mental health services.

In the 2012–13 AATSIHS, only about one in four (27 per cent) of adults with high/ very high levels of psychological distress, as discussed a known risk factor for suicide, had seen a health professional in response in the previous 4 weeks.<sup>127</sup><sup>128</sup> Primary mental health care is also particularly important for treating depression and can be a gateway to specialist mental health care in severe cases.<sup>129</sup>

As mental health and related problems are reported in the Aboriginal and Torres Strait Islander population at two to three times the rate in the general population, two to three times the rate of usage of primary mental health services might be expected.

In fact, over 2008-2013, 11 per cent of all problems managed by GPs among Aboriginal and Torres Strait Islander clients were mental health related: 1.3 times the rate for other Australians.<sup>130</sup> In 2012-2013, 8 per cent of Aboriginal and Torres Strait Islander people accessed Medicare subsidised mental health care services, (provided by consultant psychiatrists, clinical psychologists, GPs and allied health professionals): the same rate as non-Indigenous people,<sup>131</sup> despite the greater need.

There is evidence that because of lack of access to/ or use of primary mental health care according to need, Aboriginal and Torres Strait Islander peoples with mental health problems are overrepresented in other parts of the health and mental health system. For community based mental health clinics, about 9 per cent of contacts were provided to Indigenous peoples in 2013-14: 3.3 times the non-Indigenous rate.<sup>132</sup> In 2012-13, 1 Aboriginal and Torres Strait Islander people accounted for a disproportionate 9 per cent of mental health-related ED occasions of service. They accounted for 4.9 per cent mental



health-related hospitalisations including specialised psychiatric care in 2012-2013; and 4.1 per cent of all episodes of residential mental health care in 2013-2014.<sup>133</sup>

*Cultural racism* includes actions by institutions that are not overtly racist or believe themselves to be racist but amount to 'the observance and administration of policies, rules and procedures that purport to treat everybody equally, but are unfairly or inequitably administered or applied in dealings with people belonging to a particular racial, ethnic, religious or cultural group'.<sup>134</sup>

Whether evidence of cultural racism or not, the NATSISS 2014–15 reported that nine percent of respondents agreed that their own doctor could not be trusted, 35 percent that hospitals could not be trusted.<sup>135</sup> The 2012-13 ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), reported that 35 per cent of those who reported being treated badly because they were Aboriginal and/or Torres Strait Islander usually responded by subsequently avoiding the person or situation. Such is backed up by other research.<sup>136</sup> About seven per cent of NATSIHS respondents reported that they had avoided seeking health care because they had been treated unfairly.<sup>137</sup>

Critical to addressing cultural racism and improving access to health and mental health services is the development of Aboriginal Community Controlled Health Services and other dedicated (if not community controlled health) services aimed at Aboriginal and Torres Strait Islander peoples.

Yet only about half of Aboriginal and Torres Strait Islander peoples can access/ or choose to use such. At the time of the 2011 Census, the ABS estimates the Indigenous population to number 669,900 persons.<sup>138</sup> In their 2015 Service Reports, the 203 Australian Government funded Indigenous primary health care organisations (IPHCOs) report 323,600 Aboriginal and Torres Strait Islander peoples clients.<sup>139</sup> This includes Aboriginal Community Controlled Health Organisations (ACCHOs) who identify as having about 255,060 Aboriginal and Torres Strait Islander peoples clients.<sup>140</sup> This suggests that IPHCOs had approximately 48.3 percent of the total Indigenous population as clients, and within that cohort the ACCHOs about 38 percent.

Studies have found that for Aboriginal and Torres Strait Islander people 'access to service is critical and, where ACCHOs exist, the community prefers to and does use them.'<sup>141</sup> With appropriate resources, an ACCHO is able to implement a culturally competent and comprehensive primary health care model based on the culturally shaped, holistic concepts of health understood by the communities they serve.<sup>142</sup> However, in the 2015 Service Reports, of the 203 IPHCOs, including ACCHOs, 55 percent reported service gaps for mental health and social and emotional wellbeing; and 47 percent - alcohol, tobacco and drug service gaps.<sup>143</sup>

Where such services do not exist, Aboriginal and Torres Strait Islander people are obliged to rely on general population health and mental health services. As such, it is critical that such services are culturally safe and that its staff, and indeed the organisation itself, is culturally competent to work with Aboriginal and Torres Strait Islander peoples. [These concepts are assumed knowledge in the reader.]

One of the important contributions the Aboriginal and Torres Strait Islander Mental Health Advisory Group made to suicide prevention was to develop a set of *Operational Guidelines Access to Allied Psychological Services Program (ATAPS) Aboriginal and Torres Strait Islander Suicide Prevention Services*.<sup>144</sup> These included quality indicators for services to:

- provide culturally safe, non-triggering management, treatment and support to Aboriginal and Torres Strait Islander peoples at high risk of suicide or self-harm at a critical point in their life and to mitigate the reverberations from suicide in the client's community;
- be staffed by administrators and clinicians that are trained and understand mental health and suicide prevention cultural safety;
- establish management protocols that reflect the multiple levels of diversity found in modern Aboriginal and Torres Strait Islander populations; and
- be based on Aboriginal and Torres Strait Islander peoples' definitions of health, incorporating spirituality, culture, family, connection to the land and wellbeing and grounded in community engagement.<sup>145</sup>

The guidelines establish that a high quality, culturally competent service will be made available by ensuring:

- Aboriginal and Torres Strait Islander peoples that are providing services should have the appropriate level of skills and qualifications to deliver services;
- Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples are provided with opportunities to develop the appropriate level of skills and qualifications to deliver services; and
- non-Indigenous professionals and administrators have undertaken mental health cultural safety training that perpetuates the National Practice Standards within a social and emotional wellbeing framework, and promotes the appropriate skills, knowledge, and attitudes required to optimally deliver mental health services to Aboriginal and Torres Strait Islander peoples, including those of the Stolen Generation.<sup>146</sup>

These guidelines hold great promise including beyond the ATAPS scheme, which is now being merged into the funding pools of the Primary Health Networks. When applied such guidelines can ensure a culturally appropriate service at the very time when a vulnerable Aboriginal and/or Torres Strait Islander person is likely to need it most.

## **Conclusion**

As this paper has set out to demonstrate, high Aboriginal and Torres Strait Islander suicide rates arise from a complex web of interacting personal and social circumstances.

For those concerned with suicide prevention, the contributors to suicide can be thought of in terms of risk factors at the community and collective level that increase the likelihood of suicidal behaviour, and protective factors (cultural continuity, empowerment) that reduce it.

Further, that while the 'causes' associated with suicide among Aboriginal and Torres Strait Islander individuals are often the same as that in the general population, the prevalence and interrelationships among these factors can differ because of wider contextual factors, not the least of which being colonisation and its aftermath and the ongoing impacts on communities.

In fact, suicide is just one indicator of distress in communities and cannot be meaningfully discussed without considering alcohol and drug use and mental health problems. All can be considered symptomatic of the need for healing at a collective level among other cultural, historical, and political considerations.

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- <sup>107</sup> Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander Prisoners' *Prisoners in Australia 2015*, ABS cat. no. 4517.0. Online publication <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2015~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics~7>. [Verified 12 Dec 2016.]
- <sup>108</sup> Australian Bureau of Statistics, 'Imprisonment rates' *Prisoners in Australia 2015*, ABS cat. no. 4517.0. Online publication: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2015~Main%20Features~Imprisonment%20rates~14> [Verified 12 Dec 2016].
- <sup>109</sup> De Leo D, Svetlicic J, Milner A *et al.* (2011). Above, p.63.
- <sup>110</sup> Above, p.63.
- <sup>111</sup> Above, p.63.
- <sup>112</sup> Above, p.48.
- <sup>113</sup> Australian Bureau of Statistics (2016), *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*, ABS cat. no. 4714.0 (webpage) <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Main%20Features~Labour%20force%20characteristics~6> [Verified 12 Dec 2016.]
- <sup>114</sup> Above.

- <sup>115</sup> Above.
- <sup>116</sup> De Leo D, Svetcic J, Milner A, *et al.* (2011). Above, p.54.
- <sup>117</sup> Zubrick S, Silburn S, Lawrence D, *et al.* (2005). Above, p.340.
- <sup>118</sup> Klonsky E (2006). *The functions of deliberate self-injury: a review of the evidence*, *Clin Psychol Rev.* 2007 Mar;27(2):226-39. Epub 2006 Oct 2.
- <sup>119</sup> Australian Health Ministers' Advisory Council (2015). Above, p.59.
- <sup>120</sup> Steering Committee for the Review of Government Service Provision (2016). Above, p.8.42.
- <sup>121</sup> Harris E, Barraclough B, (1997). 'Suicide as an outcome for mental disorders. A meta-analysis', *The British Journal of Psychiatry* Mar 1997, 170 (3) 205-228; DOI: 10.1192/bjp.170.3.205. (Note that there was significant variations between countries).
- <sup>122</sup> Australian Institute of Health and Welfare (2015). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015*, Cat. no. IHW 147. Australian Institute of Health and Welfare, p.85.
- <sup>123</sup> Australian Health Ministers' Advisory Council (2015). Above, p.59.
- <sup>124</sup> Australian Bureau of Statistics (2016). *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*, ABS cat. no. 4714.0, Table 8A.7.19 Selected indicators of positive wellbeing, Aboriginal and Torres Strait Islander people aged 18 years or over, by State and Territory, 2014-15 (a), (b), (c) (webpage) <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Main%20Features~Social%20networks%20and%20wellbeing~4>. [Verified 12 Dec 2016.]
- <sup>125</sup> De Leo D, Svetcic J, Milner A, *et al.* (2011). Above, p.52.
- <sup>126</sup> Above, p.60.
- <sup>127</sup> Australian Health Ministers' Advisory Council (2015). Above, p.148.
- <sup>128</sup> Above.
- <sup>129</sup> World Health Organization (2015). 'Depression' (webpage) <http://www.who.int/topics/depression/en/> [Verified 12 Dec 2016.].
- <sup>130</sup> Australian Health Ministers' Advisory Council (2015). As above, p.148.
- <sup>131</sup> As above.
- <sup>132</sup> Australian Institute of Health and Welfare, (2015). 'Characteristics of people who use community mental health care services', *Mental Health Services in Australia*, <https://mhsa.aihw.gov.au/services/community-care/client-characteristics/>. [Verified 29 October 2015.]
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