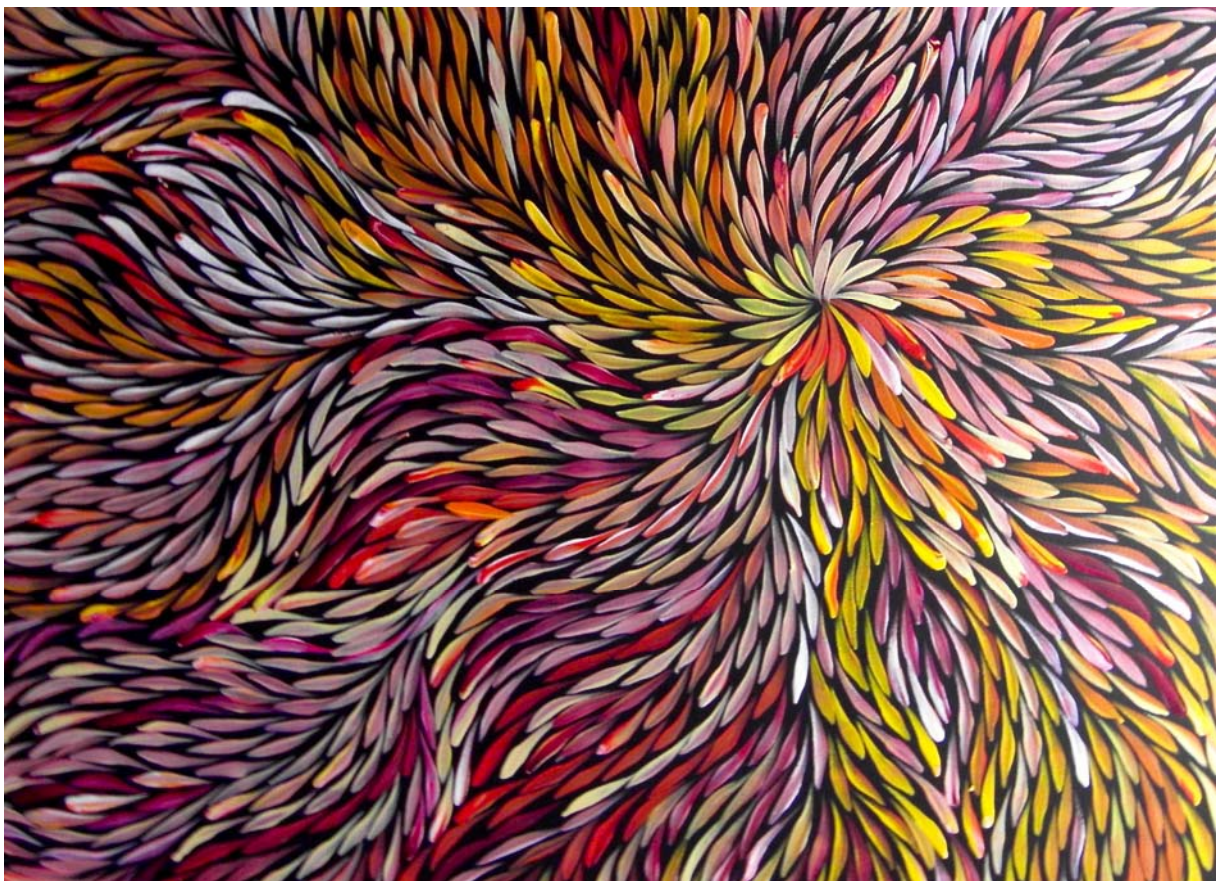


Identity, Voice, Place

Suicide Prevention for Indigenous Australians - a Social and Emotional Wellbeing Approach

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“The Mental Health of a Nation is judged by the care with which those most in need are assisted to regain control of their own lives”

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Introduction

The *National Mental Health Plan 2003-2008* recognises that influences on mental health and social and emotional wellbeing occur in the events and settings of everyday life. The complex interplay of biological, psychological, social, environmental and economic factors at the individual, family, community, national levels must be acknowledged and addressed if we are to effectively promote and support population-based approaches to social emotional, cultural and spiritual wellbeing. For Aboriginal and Torres Strait Islander people, the concept of health and wellbeing is inextricably linked to a holistic understanding of life itself.

This broader understanding of health is outlined in *Ways Forward*:

Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health...This holistic concept does not merely refer to the 'whole body' but is in fact steeped in the harmonised interrelations which constitute cultural wellbeing.

The *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009* reaffirms and expands upon the concept of health as multi-dimensional and recognises the strengths, resilience and diversity of Aboriginal and Torres Strait Islander communities. This is supported by the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009* which states that recognition of cultural differences is essential if we are to deliver services to Aboriginal and Torres Strait Islander people that do not compromise their legitimate cultural rights, practices, values and expectations.

The determinants of Aboriginal and Torres Strait Islander social, emotional, cultural and spiritual wellbeing are complex and reflect factors acting across the developmental continuum at individual, family community and societal levels. Suicide in Indigenous Australians is an equally complex issue, and a relatively new phenomenon. It occurs in communities across Australia in a sporadic way and is difficult to predict at both the individual and community levels. As with other Indigenous societies across the world, it

appears that many of the approaches emerging from western research programs and incorporated into programs designed to prevent suicide, either do not work for Indigenous Australians, or are inappropriate when translated to Indigenous Australian communities.

This research reviewed all of the available research, literature, and relevant available unpublished materials across a range of fields in an attempt to find solutions that might work for Aboriginal and Torres Strait Islander communities. We also discussed the issues and took advice from a large number of key informants both in Australia, but also in New Zealand, Canada and the United States. The intent was to devise a framework for Indigenous suicide prevention in Australia that might be relevant, acceptable, fundable, manageable, and successful. As with many before us, we concluded that social, cultural, emotional, and spiritual wellbeing as building blocks toward overall mental wellbeing are likely to be crucial in reducing suicide in Indigenous Australians, and that social reform to help rediscover Identity, Voice and Place, is likely to be more important than measures taken to improve pathways to care.

Executive Summary

1. This literature review is based on 9 Key Principles, consistent with existing Australian and International declarations, frameworks, policy, plans and strategies.
2. There is considerable rhetoric in the area of suicide prevention for Indigenous Australians, but very little in the way of local evidence-based practice or practice-based evidence to drive interventions.
3. Our recommendations derive from the best available evidence (both national and international) in promotion of social and emotional wellbeing, and prevention of suicide through early intervention in social, family, personal and biological determinants along the trajectory to suicide. Recommendations will need considerable goodwill and commitment to ensure translation into culturally meaningful practice in diverse communities.
4. The estimated resident number of Indigenous Australians (June 2006) is 517,200 including 463,900 Aboriginal Australians, 33,100 Torres Strait Islander Australians and 20,200 people identifying as both Aboriginal and Torres Strait Islander, altogether comprising 2.5% of the total population (ABS&AIHW, 2008).
5. Best available data indicate that overall mortality rates among Indigenous males and females are almost three times higher than for non-Indigenous Australians, and there is a 17-year gap between life expectancy at birth for Indigenous and non-Indigenous males and females (59 v 77 yrs and 65 v 82 yrs respectively) (ABS&AIHW, 2008).
6. Among Indigenous Australian males, overall suicide rates are almost three times higher than suicide rates for non-Indigenous Australian males, with biggest differences in younger ages (ABS&AIHW, 2008). Suicide rates among Indigenous Australian females aged 10-24 are five times the rate of other Australian females, although in age groups 45-54 and over, suicide rates are similar or lower compared to rates for non-Indigenous Australian females.
7. In 2000-02 suicide rates in Aboriginal and Torres Strait Islander Australians were highest in remote areas of Australia (55 per 100,000), lower in inner and outer regional areas (37 per 100,000 and 35 per 100,000; respectively) and

lowest in major cities (16 per 100,000). Highest suicide rates were found in DOGIT communities (68 per 100,000) - twice the overall Indigenous Australian rate (30 per 100,000). Suicide rates are lower in Torres Strait Islander Australians (18 per 100,000) (Partnerships Queensland, 2006).

8. Of serious concern is the high and increasing rate of suicide among Indigenous Australian children and adolescents (Commission for Children and Young People and Child Guardian Queensland, 2007). In 2006-07, Aboriginal and Torres Strait Islander Australian children and adolescents accounted for 39% youth suicide victims in Queensland, despite comprising only 6% of the youth population.
9. The situation of Indigenous Australians looks grim even by comparison to other Indigenous populations (Freemantle et al., 2007), and not much has changed since 1995 when Ring observed that “expectations for life for Indian populations in Canada and the United States, and for the Maoris in New Zealand are at least 10 years more than for Australian Aborigines, an enormous difference” (Ring, 1995; p. 228).
10. According to Kunitz (1994), the particularly bad mortality and morbidity status of Aboriginal Australians can be traced back to two factors concerning how governments have dealt with Native peoples across history: signing of treaties and the level of responsibility for Indigenous affairs (see page 33 onwards).
11. Average expenditure on health for Aboriginal and Torres Strait Islander Australians is \$4,718 per capita, approximately 17% higher than for other Australians (\$4,019). However, this level of expenditure is not sufficient to match the needs related to higher levels of morbidity (ABS&AIHW, 2008), nor the cost of delivery particularly to rural and remote communities.
12. In our review of relevant policies and strategies, some include special cultural considerations for Indigenous Australians, others provide direction, targets and strategies for all Australians. Our view is that considerable affirmative action is required to enable Indigenous Australians to reach equity with all other Australians. In particular, affirmative action is necessary in the areas addressed, for instance, under Outcome 6 of the Queensland Government Suicide Prevention Strategy (2003-2008), the first 3 dot points of which state:
 - Engage Indigenous communities in identifying the cultural, historical and spiritual factors which may influence suicide and suicidal behaviour;

- Promote approaches to enhance self-esteem and capacity to enable individuals and communities to connect with a value system based on identity, place, people and land;
- Develop partnership approaches with communities to strengthen local responses to complex issues, including drug and alcohol use, interpersonal conflict, violence, and grief and loss¹.

It appears from our discussions with key informants that there is still a long way to go to achieve any of this.

13. We note with some dismay in our summation of the Australian literature on Indigenous Australian suicide (page 38 onwards), our inability “at this time, to identify empirical studies which could provide further evidence or a theoretical framework to explain the protective impact of these factors and their application to social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians”. A case can be made that when we develop protective programs against suicide for Indigenous Australians, at this time we are using a mix of guesswork, a literature replete with rhetoric, and translations from International literature. We acknowledge there are a number of community driven Aboriginal Australian programs which appear to be effective, but for which a culturally relevant research base still needs to be confirmed.
14. Despite obvious and significant cultural, socio-economic and historical differences between and within Indigenous populations in New Zealand, Canada and the United States, in general, suicide rates and suicide risk are highest among young Indigenous males; the age of Indigenous suicide deaths is decreasing; suicides tend to cluster, and a significant role is played by alcohol in suicidal behaviour. Indigenous suicides appear to have their roots in ‘collective despair’, related to persisting social disadvantage, cultural and social exclusion and destruction of cultural continuity and identity. Clearly these core themes must inform our understanding, as well as preventive practice in Australia.
15. The majority of international suicide prevention programs in Indigenous communities are either not well evaluated or are not reported in the published literature. A 2001 review, in the United States, identified 9 programs, including 5

¹ Each of these are known to be distal risk factors in the life trajectory to suicide

suicide-specific programs, and 4 programs addressing related mental health and wellbeing issues, such as alcohol and substance abuse, and teen pregnancy. There were disappointing conclusions: “information on the effectiveness of suicide preventive intervention programs among American Indians/Alaskan Native communities is scarce.... generalizability of the results is somewhat limited” (Middlebrook et al., 2001; p. 140). A more recently published report *Suicide among Aboriginal People in Canada* (Kirmayer et al., 2007) presents a more comprehensive and updated list of promising suicide prevention programs with a focus on Aboriginal Canadian communities (see page 44 onwards).

16. In searching for solutions to suicide in Indigenous Australians, it is better to build on existing initiatives like those in Appendix Two, rather than wipe the slate clean and pretend that the international literature that does exist has some magic formula that can be transposed to the Australian environment.
17. Despite wide recognition and acknowledgment of the importance of Indigenous holistic concepts of self, health, and social and emotional wellbeing, there is a lack of consensus regarding its operationalisation and measurement (Kowal et al., 2007). In addition, to date, there is a paucity of studies and program evaluations across Australia to indicate which initiatives and frameworks are effective in development of social and emotional wellbeing in Indigenous Australians.
18. There is clearly an urgent need for increased training of Indigenous Australians at all levels of the Mental Health workforce to ensure a critical mass of workers steeped in local culture and acceptable to local communities. We recommend the recently published National Aboriginal and Torres Strait Islander Health Council document ‘A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people’ which is relevant here (Commonwealth of Australia, 2008).

Recommendations for Action and Investment in Suicide Prevention for Indigenous Australians, based on a social and emotional wellbeing framework

To provide consistency with other current Australian and Frameworks and Strategies, we have chosen to use the Mrazek and Haggerty (1994) Spectrum for Intervention focusing mainly on Universal, Selective and Indicated areas; those areas most consistent with a Population Health perspective on prevention.

Universal approaches

1. Toward equal opportunity

It is noticeable that many national and state documents refer to Aboriginal and Torres Strait Islander “peoples”. On the one hand, this may properly identify people at higher health risk than non-Indigenous Australians, but on the other hand may divide Aboriginal and Torres Strait Islander Australians from other Australians and either create, or enhance possibilities for, stigmatisation. We recommend the universal adoption in Government publications of the terms ‘Indigenous Australians’, ‘Aboriginal Australians’, ‘Torres Strait Island Australians’, or ‘Aboriginal and Torres Strait Island Australians’ (where appropriate²) to underscore the fact that the original owners of our land are citizens of Australia³, and therefore entitled to levels of health and social and emotional wellbeing applicable to all Australians.

2. Consensus and agreement on Recommendations for Action and Investment

To move toward a unified understanding of Indigenous Australian suicide, to gain commitment to the Recommendations, and agreement on where Investment may be targeted, a convocation (or ‘yarning’) process will need to be funded at different community levels:

- All identified Indigenous Australian groups and committees within Government and the bureaucracy, with Commonwealth representative committees and groups who work with and for Indigenous Australians;

² In all subsequent text we use the term ‘Indigenous Australians’ unless we seek to be more specific; we mean no disrespect to anyone. Simply stated, we sought to reduce the number of words and make the text as readable as possible. Where we quote from others who have used alternative terms, we retain their terminology.

³ Arabena (2006) has taken the debate around this issue much further in her model of a ‘Universal Citizen’.

-
- Elders and/or broad senior representation from all recognisable communities and groupings of Indigenous Australians. The venue or venues for this part of the convocation process will have to be carefully considered to maximise commitment from relevant parties, and there be a need for a series of meetings to confirm agreement. The methods by which information is shared between member groups must also be given serious consideration;
 - Representatives of those professions relevant to development of social and emotional wellbeing and/or suicide prevention, and already involved in Indigenous Australian communities, as well as representatives from all government and all non-government organizations managing or developing relevant health or welfare programs.

Proposed Outcomes:

1. Indigenous Australian commitment to the Recommendations
2. General agreement on where investment may be targeted
3. General agreement on what constitutes Aboriginal Australian Resilience
4. General agreement on an approach towards Suicide Prevention based on Social and Emotional Wellbeing
5. General agreement on the specific steps to be taken.

3. Training for the Indigenous Australian Mental Health Workforce

There remain large disparities between Indigenous communities in terms of a trained mental health workforce with the capacity to contribute locally to both building social and emotional wellbeing, creating knowledge about signs of mental health problems and suicide potential, and providing crisis care or access to care in their own community. Attempts to build local capacity seem to be haphazard, and one community often does not know what is happening elsewhere or what the possibilities are for training. In fact many key informants were able to describe a local program, but did not know of programs being developed elsewhere. There is a need for a critical mass of workers steeped in, and situated in, local culture, and acceptable to local communities. We recommend:

- Engagement of relevant workforce planning groups to review how to increase of Indigenous Australians numbers at all levels of the Mental Health workforce, and
- That, as a priority, training programs become better coordinated across Australia.
- Increased funding be provided to existing training programs to allow them to fill known gaps and enhance the capacity of all communities to sustain mental health and/or suicide prevention programs – whether these are about cultural, social and emotional wellbeing or about greater awareness of mental health issues, and pathways to care.
- Development of funding formulae [for workforce needs] based on population needs weighted for Aboriginal and Torres Strait Islander populations, rural and remote locations and other relevant variables (*Key Direction 30.2, Australian Mental Health Plan*).

Proposed Outcomes:

1. Sufficient Indigenous professional capacity to
 - 1.1. sustain development and implementation of programs toward Social and Emotional Wellbeing at the local level;
 - 1.2. coordinate local training in Mental Health First Aid, ASIST, Drop the Rock and other relevant programs where evaluation shows them to be effective;
 - 1.3. provide relevant crisis management at the local level for suicidal people.
2. Sufficient local awareness of mental health systems and how these are accessed.

4. *Mapping of Services*

Based on our research and discussions with key informants, there remains a need for careful mapping of suicide prevention and Social and Emotional Wellbeing development programs in communities to clarify who funds what for whom, in which communities, who coordinates the programs, and where capacity needs to be enhanced? This is a crucial exercise to prioritise values, clarify duplication, and identify gaps where additional funding might be appropriate and lead to solid outcomes. We recommend funding of a taskforce with capacity to dialogue with Indigenous Australian communities

and groupings to discover what programs exist and where, how they are funded, how coordinated, and where there is capacity to provide apparently successful programs in a culturally appropriate way to other communities.

Proposed Outcome:

A sufficient range of programs for each and every local community to enable development of Social and Emotional Wellbeing, and the prevention of suicide.

5. Research

As we noted in the Executive Summary, a case can be made that when we develop protective programs against suicide for Indigenous Australians, at this time we are using a mix of guesswork, a literature replete with rhetoric, and translations from International literature that may not provide best practice based on a sound evidence base about Indigenous Australians. Our review demonstrates a clear need to contribute to improved knowledge about which programs work in which communities, under what culturally appropriate circumstances, with what initial resource development, and with what ongoing funding to maintain community capacity to sustain programs and their evolution at the local level.

We recommend provision of dedicated funding to a representative (Indigenous and non-Indigenous Australian) expert group to explore and advise state wide and local programs on culturally cogent and appropriate ways of working with communities to evaluate programs, and more formally contribute to the specific knowledge base in Australia of what reduces suicide and its precursors in Indigenous Australians and in their communities.

Further, we recommend funding a culturally appropriate program of research which pairs Indigenous and non-Indigenous researchers to gain the best available evidence in the areas of promotion, prevention and early intervention, specifically to drive relevant and culturally situated and appropriate programs of prevention. This might include:

- 5.1 A review of potential impact of disturbances (e.g. incarceration) in the Indigenous Australian family functioning and parenting skill to clarify whether a program of improvement is needed, and how such a program could be developed and implemented in a culturally appropriate manner.

-
- 5.2 In discussion with relevant Indigenous organisations, development of a number of trial programs in the area of improving Social and Emotional Wellbeing, to determine what impact this has on grief and loss issues, suicide, substance misuse, family violence, and child abuse. While increased funding to Aboriginal Controlled Community Health Services may be an important direction to take, (see Action Area 4.1.2, *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004-2009*), it is at this point in our narrative unclear just which programs would provide the most benefit. Clearly such trial programs would need to observe the criteria we have provided for ethical practice in this area, and would gain from discussions with an expert group on culturally appropriate evaluation if we are to contribute to the accepted knowledge base in Australia.
- 5.3 Little research exists into trajectories to suicide in Indigenous Australians, particularly in younger suicides. We do have some information from psychological autopsy of recent young suicides in Queensland, as well as specific surveys from Western Australia. There is an urgent need for a program of culturally sensitive research to determine the pathways to suicide in young Indigenous Australians, specifically to determine risk factors for suicide, protective factors against suicide, and key proximal indicators, which might lead to evidence based programs of prevention and intervention. Further to improved clarity about pathways, funding could be allocated to salutogenic programs in schools, or other youth-focussed programs targeting culturally appropriate changes in the pathways.

Proposed Outcome:

Clarification of specific points along the trajectory to suicide in young people, where targeted funding might have some impact in reducing youth suicide rates in Indigenous young Australians.

- 5.4 There remains a need to examine how methodologies which might be inherent in knowledge systems (Emic) can be developed to, as it were, 'hear the system speak', or allow the system to look at who they are. There is urgent need for work to define how traditional forms of Emic knowledge can be translated in a

culturally acceptable manner, but also made available in a format that would be acceptable to 'western' science. If this could be achieved, it would be a valuable outcome in its own right, but would also assist the process of ongoing funding from relevant national and state bodies.

Proposed Outcome:

Knowledge remains owned by communities, but an acceptable framework for translation allows publication in national or international journals, which can turn the rhetoric into the reality of funded, cogent and locally acceptable programs based, not on opinion, but on evidence based practice as it is understood around the world.

Selective approaches

As previously noted, arguments can be mounted that discount Selective Prevention as being in the area of population health strategy, or suggest it is the domain of state or local health services. However, every Indigenous community can be said to be a group at increased risk for suicide because of the history of Indigenous communities. Even small communities can be considered for population-style universal strategies. We argue that both Selective Prevention and Indicated Prevention demand a sufficient level of capacity on the ground, relevant to each community, and as highly trained as possible. Item 3 under Universal approaches then becomes crucial for success of *these* programs.

5.5 We recommend that:

- All existing suicide prevention programs available in Indigenous Australian communities be prioritised according to currently available evaluation and expert consensus, and that additional funding be provided to:
 - Ensure existing programs can survive and be sustained;
 - Ensure successful programs are culturally adapted for other communities;
 - Evaluate programs to the best of local ability, within culturally acceptable parameters, and utilising evaluation expertise from existing experts in;
 - Discuss implications of programs in detail at convocations (see above).

5.6 Several programs for which good evidence exists should be made available to every Indigenous community, and could form the basis of work for local trained Aboriginal Health Workers. For example:

- *Mental Health First Aid* (Kitchener & Jorm, 2006), and/or
- *ASIST (Applied Suicide Intervention Skills Training, Living Works)*.

5.7 From emerging evidence there is urgent need for culturally informed interventions targeting Aboriginal Australian prison inmates and young Aboriginals in youth detention centres; these could reduce suicide rates in these at-risk populations. Programs need to provide careful transition back into communities with ongoing support of social and emotional wellbeing. In addition, funding needs to be provided for programs to rebuild understanding of culture, educational status, a sense of role and purpose, and transition to meaningful work.

5.8 It is clear from the literature that alcohol and other substance abuse play a large role in pathways to suicide, both for young people and for older suicides. There is a need for programs developed specifically for community-based Indigenous young Australians in the areas of awareness of risks and problems associated with abuse, and strategies for changing behaviour. Funding should be made available to trial and evaluate programs - which might be based in supporting developing resilience through awareness of culture and improved identity *or* might lead to intervention in high risk young people who currently abuse alcohol and other substances.

5.9 A corollary of the need for alcohol abuse reduction relates to Foetal Alcohol Syndrome in Indigenous communities. Foetal Alcohol Syndrome (FAS) is the most common preventable cause of mental retardation and is due to alcohol use in the first trimester of pregnancy. FAS has long term implications for education, social relationships and mental health problems, and burden on families and communities. Rates are said to be 10 times higher in Indigenous communities. Heightened awareness, education and Early Intervention reduce rates (Senate Select Committee on Regional and Remote Indigenous Communities - September 2008⁴).

⁴ http://www.aph.gov.au/senate/committee/indig_ctte/reports/2008/report1/c05.htm

The Review

Key Principles

This Report is based on the following key principles from a review of the policy and literature, as well as consultations with key informants judged to be expert in the field (see from page 72 onwards for in-depth discussion):

1. Community Empowerment
2. Recognition of Human Rights, Transgenerational Trauma, Loss and Grief
3. Development of Individual, Family and Community Social and Emotional Wellbeing
4. Acknowledgement and Recognition of Aboriginal and Torres Strait Islander Diversity and Importance of the Local Context
5. Direct Involvement of Community Members and Development of Local Workforce
6. Ensuring Program Sustainability and Organization Capacity
7. Evidence- or Theory-Base for Programs
8. Appropriate Program Evaluation
9. "Researching Ourselves Back to Life"

Overall, the principles involve a commitment to improve mental health status in Indigenous Australians to eliminate any differences between their social and emotional wellbeing and that of the rest of the Queensland population. The principles acknowledge the holistic and relational concept of health (social, emotional, cultural, spiritual) so important in Aboriginal and Torres Strait Islander culture, and are consistent with a wide range of existing policy and other documents:

- *Universal Declaration of Human Rights* (United Nations, 1948)
- *United Nations Declaration on the Rights of Indigenous Peoples* (UN, 2008)
- *Prevention of Mental Disorders: Effective Interventions and Policy Options. Summary Report* (World Health Organization [WHO], 2004)
- *Promoting Mental Health: Concepts, Emerging Evidence, Practice* (WHO, 2005a)
- *Living Is For Everyone (LIFE) Framework: A Framework for Prevention of Suicide in Australia* (Commonwealth of Australia, 2007)

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- *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003)
 - *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* (Commonwealth Department of Health and Aged Care, 2000)
 - *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013* (Australian Government Department of Health and Ageing, 2003)
 - *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004-2009* (National Aboriginal and Torres Strait Islander Health Council, 2004a)
 - *Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research* (National Health and Medical Research Council, 2003).
 - *Keeping research on track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics* (National Health and Medical Research Council, 2005).
 - *Guidelines for ethical research in Indigenous studies* (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2000)
 - *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008* (Queensland Health, 2003a) and *Reducing Suicide: Action Plan: Queensland Government Suicide Prevention Strategy 2003-2008* (Queensland Health, 2003b)
 - *Queensland Mental Health Policy Statement: Aboriginal and Torres Strait Islander People* (Queensland Health, 1996)
 - *Queensland Plan for Mental Health 2007-2017* (Queensland Government, 2008)

It is important to recognise the particular place of the *Ottawa Charter for Health Promotion* (WHO, 1986), adopted at the First International Conference on Health Promotion in 1986 and a basis for development of *Jakarta Declaration on Leading Health Promotion into the 21st Century* (WHO, 1997) and *Bangkok Charter for Health Promotion in a Globalized World* (WHO, 2005b). Ottawa Charter defines health promotion as “the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life; not

the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to wellbeing” (p. 1). Health promotion can be achieved through building healthy public policy, creating supportive environments, strengthening community actions, development of personal skills, appropriate reorientation of health services and moving into the future.

The Charter indicated that *health improvement requires a secure foundation in the following prerequisites* - Peace, Shelter, Education, Food, Income, A stable eco-system, Sustainable resources, and Social justice and equity.

Literature search strategy

The Report is based upon review of literature regarding suicide and suicide prevention, and other relevant material on mental health promotion in the context of social and emotional wellbeing of Aboriginal people and Torres Strait Islanders in Australia, and in Indigenous peoples in Canada, USA, and New Zealand. Review of literature on Aboriginal and Torres Strait Islander Australians encompasses published articles (including reviews), funding body reports and project reports where appropriate. Review of *international literature* is based upon published review articles and major reports from Canada, USA, and New Zealand.

Published literature was searched through PubMed, PsycINFO, Australian Indigenous HealthInfoNet, and Web of Science using the following keywords: “indigenous” OR “aboriginal” OR “atsi” AND “indigenous suicide” OR “aboriginal suicide” OR “suicide prevention” AND “australia*”. Lists of references of retrieved articles were searched to identify further material. Unpublished literature, including community organisation reports, project protocols and reports, workshop reports and conference proceedings were identified through Internet search engines using key words listed above and accessed online. Other material was identified through searches of online Aboriginal and Torres Strait Island health bibliographies and research and public policy centres and Australian Government departments. Additional published and/or unpublished resources were identified through consultations with other Key Informants and Experts (see Appendix One).

Policy Review on Suicide Prevention, Mental Health and Social and Emotional Wellbeing in Aboriginal and Torres Strait Islander Australians

This section provides a review of government policies and strategies related to suicide prevention, mental health and social and emotional wellbeing in Indigenous Australians⁵⁶. Some policies and strategies include special cultural considerations for Indigenous Australians, others provide direction, targets and strategies for all Australians. Our overall conclusion is that considerable affirmative action is required to enable Indigenous Australians to reach equity with all other Australians.

Reducing Suicide: Queensland Government Suicide Prevention Strategy 2003-2008 (Queensland Health, 2003a) and Reducing Suicide: Action Plan: Queensland Government Suicide Prevention Strategy 2003-2008 (Queensland Health, 2003b)

The Queensland Government Suicide Prevention Strategy recognises Indigenous Queenslanders as a priority group for suicide prevention, including Indigenous people in custody. The strategy identifies seven Outcome Areas, some with special considerations for the Aboriginal populations (in particular, Outcome Six):

Outcome Area One: Enhanced community capacity to promote and maintain social, emotional, cultural and spiritual wellbeing across the lifespan.

Outcome Area Two: A more knowledgeable community, able to take responsibility and implement risk reduction strategies.

Outcome Area Three: Greater system-wide knowledge, capacity and skills to ensure services are able to intervene early and respond effectively to suicide and suicidal behaviour.

Outcome Area Four: Enhanced treatment and support services that are responsive to people who are at high risk of suicide and suicidal behaviour.

Outcome Area Five: A coordinated system of care across sectors, between Departments, services and individual providers.

⁵ Funding for the original review was provided by Health Promotion Queensland. The review could ultimately benefit from inclusion of policies from other states of Australia.

⁶ In this section we have retained the original (although inconsistent) terminology in relation to Indigenous Australians used in the documents we quote.

Outcome Area Six: Service responses across the spectrum of interventions that are culturally sensitive and consider the needs of Aboriginal and Torres Strait peoples, including the following strategies:

- Engage Indigenous communities in identifying the cultural, historical and spiritual factors which may influence suicide and suicidal behaviour (*Outcome Area One*);
- Promote approaches to enhance self-esteem and capacity to enable individuals and communities to connect with a value system based on identity, place, people and land (*Outcome Area One*);
- Develop partnership approaches with communities to strengthen local responses to complex issues, including drug and alcohol use, interpersonal conflict, violence, and grief and loss (*Outcome Areas Two, Three and Four*);
- Enhance primary health and mental health services for Indigenous peoples to promote mental health and prevent mental illness (*Outcome Areas Two and Three*);
- Improve access to specialist mental health services (*Outcome Areas Four and Five*);
- Enhance the capacity of communities and front line workers to recognise and respond to risk at the individual and community level (*Outcome Areas Two, Three and Four*), and
- Develop partnerships with Indigenous peoples to improve data collection, research and evaluation and sharing of best practice approaches across communities and sectors (*Outcome Area Seven*).

Outcome Area Seven: Evidence-based policy, program and service development.

COMMENT: *Outcome Area One* goes to the heart of this review. Together with *Outcome Area Two* it informs and guides our recommendations on Actions needing to be taken. *Outcome Area Four* evokes comments similar to those in our responses to the Commonwealth of Australia (2008) Principles 3, 5, 6 and 7.

The overarching guiding principles underlying the Strategy (all applicable to suicide prevention in Indigenous Australians) are presented in Table 1 (below).

Table 1. Principles underlying Queensland Government Suicide Prevention Strategy (Queensland Health, 2003a)

1. A focused and collaborative government approach.
2. Active partnership development across sectors.
3. A range of interventions and responses from a focus on wellbeing and prevention, through to improved access to care and relevant services, to postvention.
4. Continuous learning, implementation of agreed best practice and further development of the body of evidence.
5. Sustainable outcomes that build on existing infrastructure.
6. Culturally appropriate actions responsive to the needs of local communities.
7. Contextually sensitive and targeted actions that respond to particular needs of urban and rural areas, and regional profiles.
8. Do no harm.

Queensland Mental Health Policy Statement: Aboriginal and Torres Strait Islander People (Queensland Health, 1996)

The Policy Statement recognises Aboriginal and Torres Strait Islander people as a priority group which calls for specific strategies to ensure equal access to appropriate mental health services and to improve the standard of treatment provided there. The Policy identifies seven Key Areas for action and recommends a number of strategies under each of the Areas:

Area One: Culturally appropriate service provision.

Area Two: Participation and partnership.

Area Three: Needs based criteria for service provision and resource allocation.

Area Four: Workforce planning and development.

Area Five: Information, monitoring and evaluation.

Area Six: Community education and support.

Area Seven: Across government approach to the provision of key social and infrastructure services.

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Queensland Plan for Mental Health 2007-2017 (Queensland Government, 2008)

The Plan includes Aboriginal and Torres Strait Islander (ATSI) populations among high suicide risk groups. The Plan supports strategies aiming to reduce suicide risk and mortality and supports programs building individual and community resilience and capacity in the ATSI populations (*Priority One: Mental Health Promotion, Prevention and Early Intervention*) and aims to improve mental health services available to these populations, including employment of ATSI mental health workers and supporting specialist hubs of expertise (*Priority Two: Integrating and Improving the Care System*). “Improved capacity to respond to the mental health needs of Aboriginal and Torres Strait Islander people” is among the Plan outcomes envisaged for the year 2017.

COMMENT on *Queensland Mental Health Policy Statement* and *Queensland Plan for Mental Health 2007-2017*

Area Four of the Policy Statement is relevant to comments made on the *LiFE Framework* principles 3, 5, 6 and 7. There is a clearly a need to adopt a program of affirmative action. As part of this we recommend review of the possibilities for training of Indigenous Australians at all levels of the Mental Health workforce. *Priority Two* of the Plan cannot be achieved without a critical mass of workers steeped in local culture and acceptable to local communities.

Living Is For Everyone (LiFE) Framework: A Framework for Prevention of Suicide in Australia (Commonwealth of Australia, 2007)

The current national framework for suicide prevention in Australia recognises Aboriginal and Torres Strait Islander populations as a group at high risk of suicide. The framework indicates six Action Areas with several special considerations for the Aboriginal and Torres Strait Islander population:

Action Area One: Improving the evidence base and understanding of suicide prevention, including application and continuing development of the research and evidence base for suicide prevention in Aboriginal and Torres Strait Islander communities (Outcome 1.3).

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Action Area Two: Building individual resilience and the capacity for self-help, including development and promotion of programs that enhance help-seeking in Aboriginal and Torres Strait Islander communities (Outcome 2.2).

Action Area Three: Improving community strength, resilience and capacity in suicide prevention.

Action Area Four: Taking a co-ordinated approach to suicide prevention.

Action Area Five: Providing targeted suicide prevention activities, including support for interventions for groups identified as high risk, including men in Aboriginal and Torres Strait Islander communities (Outcome 5.3).

Action Area Six: Implementing standards and quality in suicide prevention.

Although no special consideration for Aboriginal and Torres Strait Islander Australians is provided in the principles and aims of the framework, these will clearly apply to all Australians. All programs developed under the framework, including those targeting Indigenous Australians should aim to build stronger individuals, families and communities, increase individual and group resilience to traumatic events, and increase community capacity to identify and respond to needs. They should support the individual and community capability to respond quickly and appropriately, and to provide a coordinated response and smooth transitions to and between care. The framework principles are presented in Table 2.

Table 2. Principles underlying *Living Is For Everyone (LiFE) Framework* (Commonwealth of Australia, 2007).

1. Suicide prevention is a shared responsibility across the community (including families and friends), professional groups, and non-government and government agencies.
2. Activities should be designed and implemented to target and involve: the whole population; specific communities and groups who are known to be at risk of suicide; and individuals at risk.
3. Activities need to include access to clinical or professional treatment for those in crisis and support for people who are recovering and getting back into life.
4. Activities must be appropriate to the social and cultural needs of the groups or

populations being served.

5. Information, service and support need to be provided at the right time, when it can best be received, understood and applied.

6. Activities need to be located at places and in environments where the target groups are comfortable, and where the activities will reach and be accessible to those who most need them.

7. Local suicide prevention activities must be sustainable to ensure continuity and consistency of service.

8. Suicide prevention activities should either be, or aim to become, evidence-based, outcome focused and independently evaluated.

9. Suicide prevention activities should first do no harm. Some activities that aim to protect against suicide have the potential to increase suicide risk amongst vulnerable groups. Activities need to respect the context, health, receptivity and needs of the person who is feeling suicidal.

10. Activities need to be sensitive to the broader factors that may influence suicide risk – the many social, environmental, cultural and economic factors that contribute to quality of life and the opportunities life offers – and how these vary across different cultures, interest groups, individuals, families and communities.

11. Services for people who are recognised as suicidal should reflect a multi-disciplinary approach and aim to provide a safe, secure and caring environment.

COMMENT: *Principle 1* creates complexity and confusion. Who coordinates programs (funded at multiple levels) to ensure synergy and avoid duplication at the community level? Careful mapping of programs in communities is needed to clarify who funds what for whom, the coordination, duplication, and gaps requiring funding.

Principles 3, 5, 6 and 7 reflect problems for Indigenous communities resulting from remoteness, isolation and relative inaccessibility. Funding provided on a per capita basis may lead to many small communities missing out in terms of all four principles. A program of affirmative action is needed to ensure all Indigenous Australian communities have access to services which, while culturally appropriate, meet standards which can be expected by any Australian. A corollary is that there is a need for training programs providing a critical mass of culturally relevant staff to communities.

National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003)

The National Plan recommends that mental health care should be responsive to the particular needs of Aboriginal and Torres Strait Islander consumers, families and carers, and communities, and indicates the need for investment in the Aboriginal and Torres Strait Islander health workforce. The plan acknowledges that mental health reforms must occur in concert with other developments in the broader health sector. Among the 34 Outcomes and Key Directions, several have special application to Aboriginal and Torres Strait Islander Australians. These include:

Key Direction 3.4: Support antidiscrimination initiatives aimed at identifying and combating the impact of racism on the wellbeing of the Aboriginal and Torres Strait Islander people.

Key Direction 6.2: Promote activities aimed at reduction of risk factors and strengthening of protective factors for suicidal behaviour for the general community and for groups of high suicide risk, such as Aboriginal and Torres Strait Islander people.

Outcome 16: Improved access to services for Aboriginal and Torres Strait Islander people, which encompass:

Key Direction 16.1: Include Aboriginal and Torres Strait Islander people in mental health policy-making and planning.

Key Direction 16.2: Deliver mental health care through partnerships between mental health services and Aboriginal and Torres Strait Islander-specific health service, with Aboriginal and Torres Strait Islander people taking a lead role through the Social and Emotional Wellbeing Framework Agreement Partnership Forums.

Key Direction 16.3: Facilitate access for Aboriginal and Torres Strait Islander people to mental health services, which may include recognising the importance of early intervention in the primary care setting, increasing outreach services, and improving access to psychiatrists.

Key Direction 16.4: Improve the cultural appropriateness and safety of mental health service options for Aboriginal and Torres Strait Islander people, through enhancing knowledge of risk factors for Aboriginal and Torres Strait Islander people, improving cultural awareness for the mental health workforce,

addressing workforce issues for Aboriginal and Torres Strait Islander health and mental health workers, and supporting community initiatives.

Key Direction 16.5: Improve linkages between mainstream mental health services and general practitioners, and Aboriginal and Torres Strait Islander health services and drug and alcohol services.

Key Direction 16.6: Support the implementation of the Social and Emotional Wellbeing Framework, once agreed upon.

Key Direction 16.7: Drawing on the Social and Emotional Wellbeing Framework and this Plan, support the development and implementation of State and Territory Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Plans.

COMMENT on *Key Directions 16.2 and 16.3:* An issue for discussion here relates to the place of diagnosable mental illness in Indigenous Australians and whether this is of biological origin (as with all other racial origins) social origin (given the marked level of social exclusion which exists), or historical (related to long term traumatisation from results of the Stolen Generation). Either way we recommend clarification of accessible and appropriate pathways to care which, while culturally aware, do not use culture as a block to high quality rapidly accessed psychiatric services where needed. This will foster Early Intervention in the context of a whole population.

Outcome 22: Improved coordination between the mental health sector and other areas of health, such as child and adolescent services, general adult services, aged care services, drug and alcohol services and Aboriginal and Torres Strait Islander health services which encompass:

Key Direction 22.2: Improve continuity of care between Aboriginal and Torres Strait Islander health services and mental health services through local planning and partnerships.

Key Direction 25.2: Include Aboriginal and Torres Strait Islander community, consumer and carer representatives on appropriate committees through the Aboriginal and Torres Strait Islander Framework Agreement Partnership Forums.

Key Direction 28.4: Support improvements in the effectiveness and quality of mental health services, through the development of complementary outcome

measure and instruments for specialist sectors and particular groups, such as Aboriginal and Torres Strait Islander people.

Key Direction 29.1: Identify, monitor and disseminate information about effective models of service and partnerships that improve service responsiveness to Aboriginal and Torres Strait Islander people.

Key Direction 29.2: Improve the usage of Aboriginal and Torres Strait Islander identifiers in health data collection.

Key Direction 30.2: Develop funding formulae based on population needs weighted for Aboriginal and Torres Strait Islander populations, rural and remote locations and other relevant variables.

Key Direction 33.5: Increase the proportion of Aboriginal and Torres Strait Islander mental health workers within the mental health workforce and provide appropriate support and career structures.

National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Commonwealth Department of Health and Aged Care, 2000)

The National Plan recognises the Aboriginal and Torres Strait Islander population as a priority group for its initiatives across the lifespan and in coordination with initiatives for related priority groups, for example people living in rural and remote areas. The Plan aims to promote mental health, and prevent and reduce mental health problems and mental disorders among Aboriginal and Torres Strait Islander peoples through reduced social disadvantage, racism and oppression, mental health literacy, culturally appropriate initiatives determined by local communities, community capacity to be resilient to adversity, enhanced protective factors for mental health problems and mental disorders, reduces risk factors for mental health problems and mental disorders, especially around issues of loss, trauma, incarceration, violence and substance misuse, awareness of mainstream services of the impact of cultural issues on the mental health of Aboriginal and Torres Strait Islander peoples, and links between mainstream and Aboriginal Community Controlled Health Services.

The Plan indicates six *Outcome Indicators* for all priority groups, including Aboriginal and Torres Strait Islander people:

Outcome Indicator One: Reduction of mental health problems and symptoms as these relate to a range of symptomatic presentations and disorders, including anxiety,

depression, postnatal depression, substance misuse, conduct disorder and behavioural disorders, suicide and self-harming behaviours, eating disorders, psychosis, and dementia.

Outcome Indicator Two: Increased mental health, wellbeing, quality of life and resilience.

Outcome Indicator Three: Increased mental health literacy.

Outcome Indicator Four: Improved family functioning and parenting skills.

Outcome Indicator Five: Enhanced social support and community connectedness.

Outcome Indicator Six: Increased investment in evidence-based programs relevant to promoting mental health and preventing and reducing mental health problems and mental disorders by governments and non-government agencies.

The following outcome indicators are recommended specifically for Indigenous populations:

1. Reduced racism and discrimination for Aboriginal peoples and Torres Strait Islanders;
2. Improved capacity for Aboriginal and Torres Strait Islander communities to be self-determining and resilient;
3. Reduced socioeconomic disadvantage, violence, incarceration, family separation, substance misuse, depression and anxiety for the Aboriginal and Torres Strait Islander communities, and
4. Reduced suicide and self-harm for Aboriginal and Torres Strait Islanders who are incarcerated.

The Plan indicates eight *Process Indicators* for all priority groups:

Process Indicator One: Increased monitoring and surveillance of mental health problems, mental disorders and risk and protective factors, including social and family functioning.

Process Indicator Two: The presence of evidence-based programs related to promotion, prevention and early intervention for all priority groups.

Process Indicator Three: Increased early identification of mental health problems and mental disorders and appropriate referral.

Process Indicator Four: Increased community education related to mental health.

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Process Indicator Five: Increase in public policy and practices that promote mental health in all relevant settings (including family, education, workplace, recreation, and community).

Process Indicator Six: Increased professional education and training.

Process Indicator Seven: Increased inter, intra, and multisectoral collaboration and partnerships.

Process Indicator Eight: Increased mental health research and evaluation activities.

In addition, the following process indicators are recommended specifically for the Aboriginal populations:

1. Aboriginal community ownership of programs;
2. Torres Strait Islander community ownership of programs;
3. Increase in culturally appropriate mental health promotion, prevention and early intervention initiatives;
4. Joint planning between Aboriginal Community Controlled Health Services and mainstream organizations;
5. Increase in Aboriginal peoples and Torres Strait Islanders professionally trained and employed in health and education settings.

Of special interest is identification of *Media* as a key strategic group in the Plan. It recognises how media present Indigenous Australians and communities impacts on non-Indigenous prejudice and discrimination, and recommends a media strategy to promote positive messages on social/cultural diversity, to reduce discrimination and prejudice.

COMMENT regarding *Process Indicator Two*: This is problematic in that our review and discussion reveal that there is considerable rhetoric in this area, but very little in the way of practice based evidence or evidence based practice to drive interventions. We recommend culturally appropriate programs of research which paired Indigenous and non-Indigenous researchers to gain best available evidence in the areas of promotion, prevention and early intervention specifically to drive relevant and culturally appropriate programs of prevention (*Process Indicator Eight*). In the context of this review, the aim of the Plan (while inclusive and wordy) does cover the territory we have aimed to cover. *Indicators Two* and *Three* relate to this document, and challenge us to understand the enormity of the task if we are to realistically achieve the outcome.

Outcome Four: This is critical to SEWB of future Indigenous Australians. Review of the complexity of Indigenous Australian family functioning and parenting skills would clarify how these may be influenced in a culturally appropriate manner.

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013 (Australian Government Department of Health and Ageing, 2007)

This is the second Implementation Plan against the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* (National Aboriginal and Torres Strait Islander Health Council, 2004b)⁷ which aims among other things to strengthen the service infrastructure essential to improving access by Aboriginal peoples to health services and responding to substance misuse, mental disorder, stress, trauma and suicide, and recognises improving emotional and social health and wellbeing with particular emphasis on addressing mental health problems and suicide among its immediate priority areas for government action.

COMMENT: The National Strategic Framework and Implementation Plan lay out the context and content of what is necessary to improve Indigenous health. They underscore our recommendations on a program of affirmative action to enhance services, and training for long-term culturally appropriate service provision. *Key Result Area Four* in the Implementation Plan is Social and Emotional Wellbeing.

National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being 2004-2009 (National Aboriginal and Torres Strait Islander Health Council, 2004a)

Two *Key Strategic Directions*, including relevant *Action Areas* of the framework are directly applicable to suicide prevention in Aboriginal Australians:

⁷ The first report back under the implementation plan of the National Strategic Framework is *Aboriginal and Torres Strait Islander Health Performance Framework 2006 Report*. Canberra: AGDHA. Available at: http://www.dhs.vic.gov.au/pdpd/koori/downloads/healthperformanceframework_112006.pdf.

The latest report (Australian Government Department of Health and Ageing (2008). *Aboriginal and Torres Strait Islander Health Performance Framework. Report Summary*. Canberra: AGDHA) will be released at the end of 2008.

Key Strategic Direction 1: Focus on children, young people, families and communities

Key Result Area 1.3: Responding to grief, loss, trauma and anger.

Action Area 1.3.6: Acknowledge and recognise the causes of individual and community anger and provide effective programs to reduce the risk of violent behaviour and self-harm.

Key Strategic Direction 4: Coordination of resources, programs, initiatives and planning.

Key Result Area 4.1: Providing optimal funding and coordination in order to improve Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing.

Action Area 4.1.2: Increase mainstream funding to Aboriginal Community Controlled Health Services to operate mental health and social and emotional wellbeing programs to respond to grief and loss issues, suicide, substance misuse, family violence and child abuse.

COMMENT: While increased funding to Aboriginal Community Controlled Health Services may be important (see *Action Area 4.1.2*, National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009), it is at this point in our narrative unclear just which programs would provide the most benefit in providing mental health and social and emotional wellbeing programs to respond to grief and loss issues, suicide, substance misuse, family violence and child abuse. We would recommend discussion with Aboriginal Community Controlled Health Services to fund trials in the area of improving social and emotional wellbeing, to see what impact this has on grief and loss issues, suicide, substance misuse, family violence and child abuse. Clearly such trial programs would need to observe criteria we have provided for ethical practice in this area (see Appendix Two).

Indigenous Suicide in Australia

Health and Welfare of Indigenous Australians

The estimated resident number of Indigenous Australians as at June 2006 was 517,200 people, including 463,900 Aboriginal people, 33,100 Torres Strait Islanders and 20,200 people identifying as both Aboriginal and Torres Strait Islander, altogether comprising 2.5% of the total Australian population (Australian Bureau of Statistics & Australian Institute of Health and Welfare [ABS&AIHW], 2008). Twenty eight percent (28%) of Indigenous Australians (146,400 people) live in Queensland and they comprise 3.6% of the population of the state (ABS&AIHW, 2008). Based on the Remoteness Area classification, 26% of Indigenous Australians in Queensland live in major cities, 20% in inner regional areas, 32% in outer regional areas, 8% in remote and 14% in very remote areas (ABS, 2007b).

Geographical location has an impact on health and welfare of Indigenous Australians. The *Baseline Report* (Partnerships Queensland, 2006) shows differences between the status of Aboriginal people living in major cities, inner and outer regional and remote/very remote locations, and Torres Strait Islanders, including health factors, disability, cultural strength, mortality, and family and community wellbeing. Overall, people living in Aboriginal Deed-of-Grant-in-Trust (DOGIT) communities in Queensland face the most difficult conditions across a range of health and welfare indicators, including non-fatal and fatal suicidal behaviour.

A detailed discussion of the welfare and health status of Aboriginal and Torres Strait Islanders is beyond the scope of this Report. However, it should be noted that the *Social Justice Report 2005* (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005) “detailed the poor state of Indigenous health and Indigenous health inequality as compared to the rest of the population. It set out how the ‘right to health’ could guide government action on Indigenous health, and recommended that all governments of Australia commit to a campaign to achieve Indigenous health and life expectation equality within 25 years. In order to achieve this goal, the report recommended that governments commit to achieving equal access to primary health care and health infrastructure for Indigenous Australians within 10 years” (Calma, 2007; p. S5).

To date “there is some evidence that ATSI people do not have the same level of access to many health services as other Australians and this can adversely impact on their health outcomes. The relatively poor health status and high mortality and morbidity rates among Indigenous Australians points to the need for more health services and a greater per capita investment of health resources for this population.” (ABS&AIHW, 2008; p. 187). In 2004-05, the average expenditure on health goods and services for Aboriginal and Torres Strait Islander Australians was \$4,718 per capita, approximately 17% higher than the expenditure for other Australians (\$4,019). This level of expenditure is not sufficient to match the needs of Aboriginal and Torres Strait Islander people, who have high levels of morbidity and whose mortality rates are more than twice the rates for non-Indigenous Australians (ABS&AIHW, 2008).

Mortality in Indigenous Australians

Considerable caution is required regarding mortality data (including suicide) of Indigenous Australians. There are numerous problems with data quality and availability, including identification of Aboriginal status, differences between States and Territories regarding coronial procedures and data collection systems, and classification of the external causes of mortality and morbidity (ABS&AIHW, 2008; Moller, 1996). In Queensland, information on Aboriginal status of the deceased on death certificates has been required only from January 1996 onwards and, prior to this, it was not possible to determine the injury death rate in Aboriginal and Torres Strait Islander populations (Moller, 1996).

Available data indicate that overall mortality rates among Indigenous males and females are almost three times higher than for non-Indigenous Australians, and there is a 17-year gap between life expectancy at birth for Indigenous and non-Indigenous males and females (59 v. 77 years and 65 v. 82 years; respectively) (ABS&AIHW, 2008). The five leading causes of death in Indigenous Australians are: (1) diseases of the circulatory system; (2) injury; (3) neoplasms; (4) diabetes and other endocrine, metabolic and nutritional disorders, and (5) respiratory diseases. Over the period of 2001-2005, external causes of mortality, such as accidents, suicide and assaults represented 16% of all deaths among Indigenous Australians (compared with 6% of deaths in the non-Indigenous population). In the same period, Torres Strait Islander Australians were less likely to die from external causes including injury (10%) than Indigenous Australians

overall (16%); however, they were more likely to die from cancer (21% versus 15%) (ABS&AIHW, 2008).

Elevated mortality rates (including suicide) have also been reported in other Indigenous populations worldwide, such as the Maori in New Zealand, American Indians and Alaska Natives in the US, and the Aboriginal people in Canada (Freemantle, Officer, McAullay, & Anderson, 2007; Hill, Barker, & Vos, 2007; Ring & Firman, 1998; Stevenson, Wallace, Harrison, Moller, & Smith, 1998). Still, the situation of Indigenous Australians looks grim even in comparison to other Indigenous populations (Freemantle et al., 2007), and not much has changed since 1995 when Ring observed that “expectations for life for Indian populations in Canada and the United States, and for the Maoris in New Zealand are at least 10 years more than for Australian Aborigines, an enormous difference. Maori adult death rates are falling at a *faster* rate than for whites in New Zealand, and the gap in the expectation of life between the United States Indians and the United States whites is now only three years, whereas in Australia, the gap in the expectation of life between Aboriginal communities and the total population in most states is the best part of 20 years” (Ring, 1995; p. 228).

The Indigenous peoples in Australia, New Zealand, the United States and Canada share some similarities: they have been colonized by the British, exposed to genocide, racism and discrimination, and currently are citizens of liberal Western democracies (Kunitz, 1994; Kunitz & Brady, 1995). At the same time, there have been differences regarding the history of colonization and current social and political practices which can account for the disparities in the health status among Indigenous groups. According to Kunitz (1994), the particularly bad mortality and morbidity status of Aboriginal Australians can be traced back to two factors concerning the ways governments have been dealing with the Native people across history: signing of treaties and the level of responsibility for Indigenous affairs. Although treaties signed by colonizing powers have been notoriously breached, at least they gave Native peoples in New Zealand or the United States legitimization for claims for land, reparation, and services. No such treaties have ever been signed in Australia.

Regarding the level of responsibility for Native people’s affairs, Kunitz (1994) observed that “(...) no matter how difficult the relationship between the indigenous peoples and the federal government, from the perspective of indigenous peoples it is still preferable to control by state governments. Having state governments assume

responsibility for native affairs is not unlike using a fox to guard the chickens, for state governments have even more direct conflicts of interest over land rights than do federal governments” (p. 28). Again, in Australia the responsibility has been mostly at the state/territory level.

Epidemiology of Indigenous Suicide

In 2001-05, suicide was the leading cause of death from external causes for Indigenous Australian males (35% of such deaths), and the second leading external cause of death for Indigenous Australian females (18% of deaths) (ABS&AIHW, 2008). Among Australian males, the overall Indigenous suicide rate was almost three times higher than that suicide rate for non-Indigenous males, with the biggest differences in the younger age groups of 0-24 and 25-34 years. The suicide rate among Indigenous Australian females aged 0-24 was five times the rate of non-Indigenous females, and in age groups 45-54 and over the suicide rates were similar or lower than the rates for non-Indigenous females.

In 2002-04 in Queensland, Indigenous Australian suicide accounted for approximately 6% of all suicide deaths (De Leo, Klieve, & Milner, 2006). The overall suicide rate in Indigenous Queenslanders was almost twice that of non-Indigenous (25 per 100,000 v. 15 per 100,000; respectively) and the majority of Indigenous suicides (74%) were under the age of 35 years. Highest rates were observed among males in the 15-24 and 25-34 years groups (108 per 100,000 and 56 per 100,000; respectively); both almost three times higher than corresponding rates for non-Indigenous males.

Regarding geographic location, in 2000-02 suicide rates in Aboriginal and Torres Strait Islander Australians are highest in remote areas (55 per 100,000), lower in inner and outer regional areas (37 per 100,000 and 35 per 100,000; respectively) and lowest in major cities (16 per 100,000). Highest suicide rates were found in DOGIT communities (68 per 100,000) - twice the overall Indigenous Australian rate (30 per 100,000). Suicide rates are lower in Torres Strait Islander Australians (18 per 100,000) (Partnerships Queensland, 2006).

Of special concern is the high and increasing number of suicides among Indigenous Australian children and adolescents (Commission for Children and Young People and Child Guardian Queensland, 2007). In 2006-07, 6 of the 19 children and

young people who completed suicide in Queensland were of Aboriginal or Torres Strait Islander origin, including 5 deaths in the 10–14 age group and 1 death in the 15–17 age group. The majority were males (5 deaths). Aboriginal and Torres Strait Islander children and adolescents accounted for approximately a third of young suicide victims, despite comprising only 6% of the state youth population. There was an increase in comparison with findings reported from the period of 2005-06, where Aboriginal and Torres Strait Islander children accounted for 20% of child suicides. In 2006-07 the rate of suicide among Indigenous Queensland children was seven times greater than for non-Indigenous children (22 per 100,000 and 3 per 100,000; respectively).

Hanging has been the most common method of Indigenous suicide and attempted suicide in Queensland and across Australia since the mid-1980s (Boots et al., 2006; Cooke, Cadden, & Margolius, 1995; Davidson, 2003; Hunter, Reser, Baird, & Reser, 1999; Kosky & Dundas, 2000). In Queensland in 2002-04, hanging accounted for 90% Indigenous suicides (De Leo et al., 2006). Indigenous suicides by hanging are of special concern due to easy availability and high lethality of the method, and its acquired deep political and cultural meaning linked to the Report of the Royal Commission into Aboriginal Deaths in Custody (1991). There is a pattern of high risk for impulsive young Indigenous males under the pressure of interpersonal problems and under the influence of alcohol, who choose this common popular and culturally and politically meaningful method with a fatal or a non-fatal result (Hunter et al., 1999).

One of the particular features of Indigenous Australian suicide is temporal clustering of deaths in certain geographical areas and communities, a pattern reported in Queensland (Hunter et al., 1999; Reser, 1989a) and in the Northern Territory (Hanssens, 2007a; 2007b; Hanssens & Hanssens, 2007; Parker & Ben-Tovim, 2002). In the late 1990s, Hunter and his colleagues (1999) examined the distribution of suicide through time in one of the Northern Queensland communities and found an aggregation of suicide deaths, with gaps of several years between the aggregates. The possible first cluster of three suicides in the span of as many months occurred in 1986-1987, and a more significant and extensive cluster lasted between June of 1991 and November of 1996 (17 suicides). The “epidemic-like” pattern of Indigenous Australian suicide may be related to “the dense social and interpersonal networks that exist within and between Aboriginal communities in the north (...). Once established in a community’s consciousness, suicide becomes another possibility in a behavioural repertoire,

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interacting with other constructive and destructive means of coping” (Hunter et al., 1999; p. 78). However, in understanding Indigenous Australian suicide a deeper understanding of social determinants may be required.

Regarding non-fatal self-harm, Queensland Health hospital separation data for 2002-03 and 2003-04 show that Aboriginal and Torres Strait Islanders were almost twice as likely to be admitted to a hospital following an episode of self-harm than non-Indigenous people (2.5 per 1000 v. 1.5 per 1000) (Partnerships Queensland, 2006). Aboriginal and Torres Strait Islander Australians living in remote locations were at significantly higher risk than Aboriginal and Torres Strait Islander Australians in major cities, inner and outer regional areas. People living in the Torres Region had the lowest rates of hospital admission for self-harm, while people in Aboriginal DOGITs had the highest admission rates.

The Western Australian Aboriginal Child Health Survey (Zubrick et al., 2005) showed that 9% of Aboriginal girls and 4.1% of Aboriginal boys aged 12-17 made a suicide attempt in the 12 months prior to the study. Suicidal ideation was almost twice as prevalent among young females as among young males (20% v. 12%), an overall 16% of young people having thoughts about ending their own life in the previous 12 months. Unfortunately, no comparable data regarding suicidal ideation and attempts among young Indigenous Queenslanders is currently available.

High suicide risk among Indigenous people in contact with the corrective system warrants special attention, especially in the aftermath of the Royal Commission on Indigenous Deaths in Custody (1991) which had a significant social and political impact on the way Aboriginal suicide is perceived in Aboriginal communities and the mainstream culture (Hunter 1989; Reser, 1989a, 1989b). The Royal Commission into Aboriginal Deaths in Custody addressed the critical role that policing and incarceration play in Aboriginal and Torres Strait Islander community life. A greater proportion of the Aboriginal and Torres Strait Islander population are in prison or ex-prisoners, a group that is highly vulnerable to self harm and suicide both inside jail and in the weeks after release (Cunneen, 1997).

The proportion of Indigenous Australians in the prison population is very high: in 2007 Indigenous prisoners comprised a quarter of the prison population in Australia (24%) and in Queensland (26%) (ABS, 2007a). There are multiple reasons for the overrepresentation of Aboriginal Australians in the inmate population, such as systemic

bias in policing and judicial systems, social and economic disadvantage, high rates of crime in the communities, early contact with juvenile justice system and high rates of re-offending (Coffey et al., 2004; Krieg, 2006; Weatherburn, Fitzgerald, & Hua, 2003), but a detailed discussion of these issues is beyond the scope of this Report.

The overall mortality and suicide rates of both Aboriginal and non-Aboriginal inmates are high (Dalton, 1999) and suicide has been reported as a leading cause of death in prisoners after release from jail, especially among Indigenous and non-Indigenous males (Stewart, Henderson, Hobbs, Ridout, & Knuiman, 2004). Aboriginal adolescents in custody are as likely as their non-Aboriginal fellows to attempt suicide, and given their over-representation among people in custody they comprise a high risk group requiring special attention (Lawlor & Kosky, 1992). Culturally-specific interventions targeting Aboriginal inmates (Tongs, Chatfield, & Arabena, 2007) and Aboriginal youth in detention centres (Letters & Stathis, 2004) could reduce the mortality rate in these at-risk populations.

Risk and Protective Factors for Indigenous Suicide

Despite the fact that suicide is currently a significant cause of death among Indigenous Australians, there has been very little research looking at risk and protective factors for Indigenous suicide. This section presents an overview of what is known about suicide in Aboriginal and Torres Strait Australians; however, much of the literature on the subject presents opinions and theoretical understandings of the subject rather than empirical data. Moreover, due to the changing nature of Indigenous suicide, studies and analyses published over a decade ago should be viewed with some caution. Aboriginal and Torres Strait Australians are a diverse population regarding language and culture, historical experiences (for example, mission times, DOGIT communities), levels of acculturation, living arrangements and access to services, and current knowledge regarding suicidal behaviour across a range of Aboriginal and Torres Strait peoples is practically non-existent, and urgently required if we are to reduce current rates.

Historically, suicide was very rare in traditional Aboriginal and Torres Strait Islander Australian societies, although recorded instances of Aboriginal suicide occurred first in the times of colonial expansion and involved the suicides of women and their children who threw themselves from cliffs to avoid capture by parties of white men (Coe 1989; Read 1988; Salisbury & Gresser, 1971).

Available sources on Indigenous Australian suicide state that until the mid-1980s suicide risk among Aboriginal and Torres Strait Islander people was very low or even non-existent (Burvill, 1975; Eastwell, 1987; 1988; Jones, 1972; 1973; Jones & de Horne, 1973; Kidson & Jones, 1968). For example, in Western Australia, Jones and de Horne (1973) found no suicide cases in a period of 10 years in a survey of a population of over 2,000 Indigenous people. Eastwell (1988) in his study of recorded cases of death in Arnhem Land in Northern Territory in 1957-1987 found two cases of suicide in a population of over 5,000 people. Burvill's (1975) study reported 18 cases of attempted suicide among Aboriginal people in Perth in 1971-1972. According to the literature published at that time, the low incidence of suicide could be attributed to high levels of support provided by extended families, existence of culturally sanctioned outlets for hostility, external attribution of blame, and presence of complex mourning rituals (Eastwell, 1985; Jones, 1972).

A dramatic increase in the incidence of suicide among Indigenous Australians started in the 1980s. An analysis of mortality in Northern Territory in 1981-2002 showed that the rates of suicide among Indigenous males increased by 800% (Measey, Li, Parker, & Wang, 2006) and in South Australia a 10-fold increase in Indigenous suicide was observed over the period of 1981-1988 (Clayer & Czechowicz, 1991). In Western Australia, the proportion of male deaths due to suicide increased almost 6-fold from, from 0.5% of all deaths in 1957 to 2.9% of all deaths in 1986 (Hunter, 1988a). In Queensland, Indigenous Australian suicide rates have been approximately twice as high as the non-Indigenous suicide rates since 1990 (Baume, Cantor, & McTaggart, 1998; Cantor & Slater, 1997; De Leo & Evans, 2002; De Leo & Heller, 2004; De Leo et al., 2006)⁸.

Hunter (1990a; 1991a; 2006) has proposed a socio-historical frame to explain the increase in Indigenous suicide (especially in young males) observed since the mid-1980s. According to his observations, "Aboriginal suicide was rare before the late 1980s, before which it tended to be men in their third and fourth decades in non-remote areas. That changed with the Royal Commission into Aboriginal Deaths in Custody, which

⁸ Statistical information should be treated with caution due to small Aboriginal and Torres Strait Islander population numbers and relatively small numbers of suicide deaths, problems with identification of the Aboriginal and Torres Strait Islander status and possible misclassification of some deaths, for instance, accidental death instead of a suicide. Official suicide rates *may actually under-report* the incidence of Indigenous suicide in Queensland and Australia.

investigated deaths in detention, one-third of which were suicide. The intense media focus informed constructions of hanging that fore-grounded oppression, associating 'meaningfulness' with hanging. Since then, suicide has increased in the wider Aboriginal population, the highest rates being teenage and young adult males, now increasingly in remote populations, sometimes taking on 'traditional' meanings. But, the patterns continue to change. In the first months of 2004, four children aged 12 and 13 died by hanging in four communities in Far North Queensland. (...) Across Indigenous Australia the 1970s ushered in turbulent social change that has been described as 'deregulation'. This most immediately impacted young adults for whom onerous controls were lifted, with entry into the cash economy through welfare, and unrestricted access to alcohol. However, while discriminatory legislation was revoked, other barriers, less tangible but robust, persisted, what has been called 'cultural exclusion'. (...) Suicide did not increase until the late 1980s - some fifteen years delayed (...). These were teenagers and young adults - the children of that earlier generation exposed, as young adults and new parents, to deregulation and its social consequences. The young suicides were from the first generation to have been raised in that environment of unremitting instability. Not only were they at risk of self-harm but also petrol-sniffing, sexual abuse (as victims and perpetrators) and self-destructive confrontations with increasingly reactionary authorities." (Hunter, 2006; p. 9)⁹. [The original version of the quote was extensively referenced. We refer the reader to the original].

Alcohol and cannabis abuse, impulsivity, and disruption of major interpersonal relationships have been repeatedly identified as major triggering factors for Indigenous suicide (Hanssens, 2007a; Hunter, 1988a, 1988b; 1991b; Parker & Ben-Tovim; 2002; Tatz, 2001). These factors seem to operate in a context of a "lifestyle of risk" or an elevated potential for harm encompassing a range of risky behaviours, such as substance abuse, non-suicidal self-harm and impersonal violence and "clearly, risk is elevated for those individuals, particularly males from their teens through to the fourth decade of life, who are members of communities in which suicide has become common -

⁹ Hunter (2006) has also observed that for the young Indigenous children "self-harm is no longer uncommon and its visibility in remote communities exposes children - from other children wandering the streets with cans of petrol, to violence to self and others, to threats, acts and representations of suicide. Indeed, among the child hanging-deaths described earlier, all had been exposed. They belong to the first generation in which many children's early development includes exposure to the threat or act of self-annihilation" (p. 9).

the best indicator is at a social or community level, what [can be] called the ‘community at risk’” (Hunter et al., 1999; p. 75).

The role of psychopathology and psychological factors in relation to suicide in Indigenous Australians is not clear; there are some data to support the notion that depression, psychosis, substance abuse and “classical” warning signs of suicide can be detected in Indigenous victims of suicide. For example, an analysis of coronial records for Indigenous and non-Indigenous suicide deaths in the Top End (Parker & Ben-Tovim, 2002) showed that suicides in both populations were often preceded by expression of suicidal intent, signs of abnormal behaviour such as depressed mood and aggression, alcohol abuse and a formal diagnosis of mental illness.

The Western Australian Aboriginal Child Health Survey (Zubrick et al., 2005) identified a range of risk factors for suicidal ideation in Aboriginal youth which resemble risk factors for non-aboriginal children and adolescents, including history of exposure to family violence, low self-esteem, significant emotional and behavioural difficulties, having friends who attempted or thought about suicide, smoking cigarettes, using of marihuana and alcohol, and exposure to racism. Depression, anxiety, poor coping with stress and problem solving skills, as well as impulsivity, might increase the risk of suicide in Indigenous Australian adolescents and young adults (Henderson, 2003; Westerman, 2002a).

Other studies, observations and discussions downplay the role of psychopathology and psychological factors in Indigenous suicide, and instead focus on the impact of socio-cultural and economic factors, both current and experienced by the Aboriginal and Torres Strait Islander people in the past, such as genocide and racism (Tatz, 2001), trans-generational trauma and the impact of “Stolen Generations” (Atkinson, 2002; Human Rights and Equal Opportunity Commission, 1997), dependence of individuals and communities on the welfare system (Hunter, 2006), and easy access to alcohol and other harmful substances (Barber, Punt, & Albers, 1988; Hanssens, 2007a; Shore & Spicer, 2004). For example, members of the “Stolen Generations” and their progeny are in high risk groups for a range of conditions including mental illness, self-harm and suicide, and there are reports of witnessing the suicides of children in institutions and work stations (Healey, 1998; Huggins, 1998; Kilroy, 2008; May, 1994; Robinson, 2008; Terszak, 2008). The utter disempowerment experienced by people subjected to domination results in social illnesses described as learned helplessness and

lateral violence which result in ennui, hopelessness, self hatred, addictions, family violence, depression, self harm and suicide (Briscoe, 2003; Copland, 2005; Wesley-Esquimaux & Smolewski, 2004).

The destruction of Indigenous Australian culture has resulted in ongoing grief, despair and confusion including the disruption of traditional gender roles (especially for men), cultural values and pride, disruption of kinship networks and support systems, and confusion of people forced to balance between two, often irreconcilable cultures. These factors are very strongly linked to Aboriginal and Torres Strait Islander suicide (Adams & Danks, 2007; Reser, 1991; 2004). According to Tatz (2001), the dynamics and risk factors for Indigenous Australian suicide are not comparable with those observed in the general population in Australia or any other Western country, and “Aboriginal suicide is different. (...) *Aboriginal suicide has unique social and political contexts, and must be seen as a distinct phenomenon*” (Tatz, 2001; p. 10)¹⁰.

Very little has been written on protective factors for Aboriginal suicide in Australia. As previously mentioned, early studies linked low suicide rates before the mid-1980s to external attribution of blame, high levels of support provided by extended families, effectiveness of culturally sanctioned outlets for hostility and complex mourning rituals (Eastwell, 1985; Jones, 1972). Recently, Westerman and Vicary (2001) suggested a list of protective factors for Indigenous youth suicide, including the role of temperament and coping skills, family and external factors and positive contact with peers. According to the Western Australian Aboriginal Child Health Survey (Zubrick et al., 2005), high household occupancy level and living in extremely isolated locations might protect Indigenous Australian children from developing significant emotional and behavioural difficulties. Sport and recreation programs in Indigenous communities may strengthen social cohesion, improve school attendance, and serve as powerful protective factors against juvenile crime, substance abuse, violence and self-harm (Beneforti & Cunningham, 2002; Cunningham & Beneforti, 2005). Traditional Aboriginal and Torres

¹⁰ Publication of Tatz’s book was followed by a series of polemics (e.g., Goldney, 2002; Reser, 2004) and such an approach to Indigenous suicide seems quite controversial. On one hand, it rightly stresses the importance of socio-cultural, political and historical factors, including the history of genocide and current racism and discrimination, in aetiology of suicide in Indigenous Australians. On the other hand, it may contribute to marginalisation of Indigenous suicide as a subject of scientific research and practical prevention initiatives, and result in the denial of the role of individual risk factors, including depression, substance abuse, and lack of resilience and problem-solving skills, which could become targets of effective interventions, including school-based programs.

Strait Islander ceremonies and spirituality also may have a potential to protect against suicide (McCoy, 2007; Tse, Lloyd, Petchkovsky, & Manaia, 2005).

However we have been unable, at this time, to identify empirical studies that could provide further evidence or a theoretical framework to explain the protective impact of these factors and their application to social and emotional wellbeing of Aboriginal and Torres Strait Islander Australians.

Suicide in Indigenous Peoples: An International Perspective

Suicide in Indigenous Peoples in New Zealand, Canada and the United States

“Wherever there has been dispossession, we see in the disposed populations significant damage in health, in education levels and in social wellbeing. And dispossession of one’s land is not the only form of dispossession. Native peoples have been dispossessed of their labour, language, culture, and religious beliefs as well. We are only beginning to comprehend the consequences of what occurred long ago and still continues throughout the world” (Bird, 2002; p. 1391). Indigenous people worldwide suffer from persistent social disadvantage, inferior health status and high mortality, including suicide.

Despite obvious and significant cultural, socio-economic and historical differences between and within Indigenous populations in New Zealand, Canada and the United States, several recurring themes and patterns in suicide mortality and morbidity can be identified and will be presented in this section. In general, suicide rates among Indigenous populations are elevated in comparison to non-Indigenous populations in respective countries, suicide risk is highest among young Indigenous males, age of Indigenous suicide deaths is decreasing and suicides tend to cluster. There is a significant role of alcohol in suicidal behaviour in Indigenous populations. Indigenous suicides have their roots in ‘collective despair’ related to persistent social disadvantage, cultural and social exclusion and destruction of cultural continuity and identity.

In *New Zealand*, suicide rates among the Maori are high, especially in the younger age groups: young Maori males and females die of suicide at higher rates than their non-Maori peers and Maori males have high rates of hospital admissions for suicide attempts. The older age groups (over 45) are relatively protected against suicide and suicide is very rare in Maori aged over 60 (Beautrais, Wells, McGee, & Oakley Browne, 2006; Beautrais & Fergusson, 2006; Coupe, 2000).

In *the United States*, American Indians and Alaskan Natives of all ages have the highest rates of violent death among all ethnic groups (31.4 per 100,000 in 2005) and suicide is the second leading cause of death among the young American Indians in the 15-24 year age group, and the third leading cause of death in the 10-14 year age group (LaFromboise & Lewis, 2008). Suicide risk is especially high among American Indian and Alaska Native young males (Echohawk, 1997; 2006). Over the period of 1999-2003 in

Alaska, suicide was the leading cause of death among Alaska Natives aged 15-24 (Wexler, Bertone-Johnson, & Fenaughty, 2008).

In *Canada* in 2000, the First Nation suicide rate was twice the overall Canadian rate (24 per 100,000 v. 12 per 100,000; respectively) and from 1999 to 2003, the suicide rate in Inuit regions averaged 135 per 100,000 - 10 times the national rate (Kirmayer et al., 2007). Indigenous suicide in Canada is most prevalent among young people (mostly males), and in 2000, 22% of all youth deaths (10-19 year-olds) and 16% of all early adults deaths (20-44 year-olds) were due to suicide (Kirmayer et al., 2007).

Indigenous suicides often occur in clusters. A study of suicide in a South-western American Indian tribe of 12,000 individuals found a cluster of seven suicide deaths and attempts by hanging in the period of 40 days, all deaths among young people aged 13 to 28 years (Wissow, Walkup, Barlow, Reid, & Kane, 2001). Wilkie, Macdonald, and Hildahl (1998) reported a suicide cluster in an isolated Canadian Manitoba First Nations community of approximately 1,500 individuals where in period of three months, six young people aged 14 to 25 committed suicide and nineteen aged 12 to 23 attempted suicide (mostly by hanging).

Alcohol has been identified as a major risk factor for suicide in Indigenous people. In Canada, a study on Indigenous suicide in British Columbia found that 74% of suicide victims were intoxicated at time of death, and alcohol was detected in 80-90% of Indigenous people in Alberta who died by suicide (Royal Commission on Aboriginal Peoples, 1995). In the United States, American Indians have the highest prevalence of substance dependence and abuse among the racial and ethnic groups (McFarland, Gabriel, Bigelow, & Walker, 2006) and a study on suicide among American Indian decedents in New Mexico found alcohol in 69% of suicide victims (May et al., 2002).

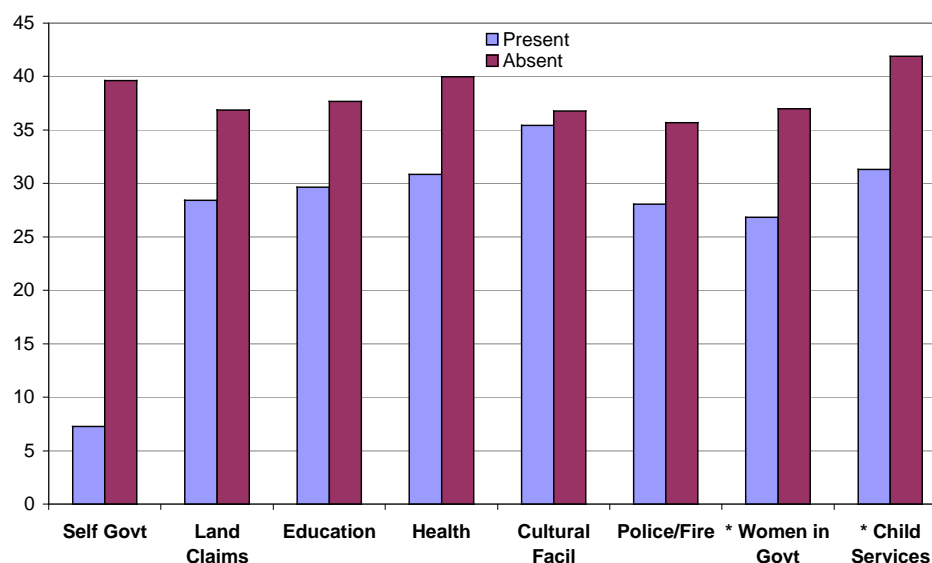
Individual risk factors, including psychopathology, alcohol and drug abuse, history of childhood trauma, abuse and neglect, interpersonal problems and other negative life events, hopelessness and inability to solve problems and cope with stress play an important role in suicide in Indigenous peoples (e.g. Enns, Inayatulla, Cox, & Chayne, 1997; Kirmayer et al., 2007; LaFromboise, Meddoff, Lee, & Harris, 2007; Strickland, Walsh, & Cooper, 2006). It is impossible to consider Indigenous suicide without taking into consideration socio-historical factors and issues of cultural identity and continuation in Maori (Beautrais et al., 2006; Coupe, 2005; Skegg, Cox, & Broughton, 1995), American Indians and Alaska Natives (EchoHawk, 1997; LaFromboise & Meddoff,

2004) and the First Nation peoples in Canada (Chandler & Lalonde; 1998; Leenaars, 2006).

Indigenous suicide and “collective despair, or collective lack of hope” (Royal Commission on Aboriginal Peoples, 1995) has been related to persistent social disadvantage, cultural and social exclusion (Hunter & Harvey, 2002; Hunter & Milroy, 2006), breakdown of cultural continuity (Chandler & Lalonde, 1998; Chandler & Lalonde, in press) and lack of cultural identity (Coupe, 2005). Chandler and Lalonde (1998) applied the concept of cultural continuity to explain the significant differences in incidence of youth suicide among different groups of the First Nation people in Canada: “like other potential sources of continuity and discontinuity, cultures too appear to be double-edged swords. At least when they tended to outlive the people who populated them, cultures offered a more ‘mythic’ time-frame that could be relied on to lend a certain age to things. (...) In other times and places, cultures appear to be more a part of the problem than the solution. Certainly this appears to be the case with the various cultures that make up BC’s [British Columbia] First Nations. Here, in addition to all those factors that ordinarily work to undermine cultures and promote their ‘natural’ deaths, the massed forces of government have also actively disassembled aboriginal culture as an explicit matter of official policy” (Chandler & Lalonde, 1998; p. 7).

Figure 1. Community factors and suicide rate (per 100,000).

(Courtesy: Michael Chandler, University of British Columbia)

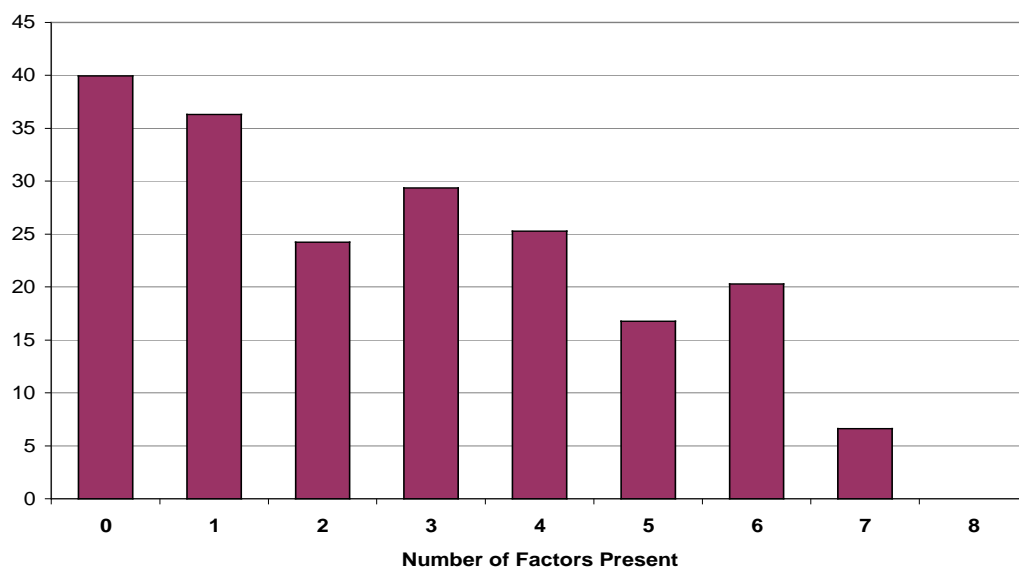


Identity, Voice, Place

Apparently, communities' efforts to rebuild, preserve or reconstruct their cultures by taking control over important areas of life have a protective impact on youth suicide. In British Columbia, Chandler and Lalonde (1998) found an inverse correlation between the number of cultural continuity and identity indicators (including land claims, self-government, community control over education system, health services, cultural facilities, police and fire services) and suicide rates¹¹ (Figure 1 and Figure 2).

Figure 2. Overall suicide rate (per 100,000) by number of community factors.

(Courtesy: Michael Chandler, University of British Columbia)



Suicide Prevention in Indigenous Peoples in New Zealand, Canada and the United States

There seems to be more research and published literature on suicide prevention in Indigenous peoples outside Australia, especially in the United States and Canada, than about suicide prevention for Aboriginal and Torres Strait Islander Australians.

¹¹ An expert in suicide and suicide prevention in Indigenous Australians, Professor Ernest Hunter, has observed that “several years ago one of the authors of the Canadian research (Chris LaLonde) came to Cairns (and to Yarrabah) on sabbatical and we were interested to know if the research undertaken in British Columbia could be replicated in Australia. In fact, it probably cannot. What passes as ‘control’ in Indigenous Australia is of a very different nature to the experience of Aboriginal Canadians. Pervasive welfare dependence, the demise of ATSIC, the vulnerability of community controlled health services, the Commonwealth intervention in the Northern Territory ... all make clear that there are very significant limits to Indigenous control and autonomy in Australia” (Hunter, in press).

Nevertheless, the knowledge regarding the effectiveness of interventions for the American Indians, Alaska Natives and the Aboriginal Canadians is limited.

A comprehensive review of suicide prevention programs in communities of the American Indians and Alaska Natives in the *United States* showed that many programs are developed by the tribes themselves (Middlebrook, LeMaster, Beals, Novins, & Manson, 2001). The majority of programs are local grass-roots initiatives, informal and independent of any centralised planning or control, and relatively few are evaluated and reported in the published literature. The review identified nine programs, including five suicide-specific programs¹² and four programs addressing related mental health and wellbeing issues, such as alcohol and drug abuse and teen pregnancy¹³. These programs in varying degrees addressed the generic factors associated with suicide (i.e. stress, depression, and hopelessness) and culture-specific factors relevant to Indigenous peoples, such as loss of ethnic identity and cultural and spiritual development, cultural confusion and acculturation.

The review led to rather disappointing conclusions: “information on the effectiveness of suicide preventive intervention programs among American Indians/Alaskan Native communities is scarce. There are few descriptions of programs in the literature and even fewer with any type of evaluation effort. (...) As a result of constraints or omissions [in program design and implementation], the effectiveness of the programs cannot be determined. In many cases, the reported effectiveness of the programs is impressionistic. (...) Because many of the programs were developed for the particular communities in which they were implemented, the generalizability of the results is somewhat limited; however, core program components can be tailored to other AI/AN communities, because many of the basic risk factors (e.g., age, family disruption, school conditions) cut across communities. (...) The absence of formal proactive evaluation is indicative of the majority of AI/AN programs that have been reported in the literature. As a result, programs may be implemented that have not been shown to be effective for the AI/AN communities that they are meant to help. The necessity of identifying programs proven to be effective is evident when one considers the limited amount of funding available” (Middlebrook et al., 2001; p. 140).

¹² Zuni Life-Skills Development Curriculum, Wind River Behavioral Health Program, Tohono O'odham Psychology Service, Western Athabaskan 'Natural Helpers' Program, and Indian Suicide Prevention Center.

¹³Blue Bay Healing Centre, Acoma-Canoncito-Laguna Adolescent Health Program, Rainbow Lodge Alcohol Recovery Program, and Positive Reinforcement in Drug Education Program.

In *Canada*, the Advisory Group on Suicide Prevention (2003) found an absence of rigorously evaluated studies and serious gaps in knowledge regarding effectiveness of suicide prevention programs developed for Indigenous people. Based on an earlier review of evidence (Kirmayer, Boothroyd, Laliberté, & Laronde Simpson, 1999), the report identified twenty nine suicide prevention and mental health promotion programs developed specifically for Aboriginal populations or modified to meet their needs. Nine of the programs¹⁴ were recommended as “promising or particularly appropriate models for Aboriginal communities who wish to use a pre-existing program” (Advisory Group on Suicide Prevention, 2003; pp. 43-44).

A more recently published report *Suicide among Aboriginal People in Canada* (Kirmayer et al., 2007) presents a more comprehensive and updated list of promising suicide prevention programs with a focus on Aboriginal communities¹⁵. Each of these programs is either (1) created or driven by the community or (2) adapted by the community in part or as a whole or (3) intended to mobilize the community toward development or implementation of own prevention initiatives. These programs are ongoing, wide-reaching, include an evaluation component, and information about the programs is easily accessible via the Internet or through contact organisations.

The *Special Report on Suicide among Aboriginal People* by the Canadian Royal Commission on Aboriginal Peoples (1995) concluded that only “a comprehensive approach to suicide prevention has any hope of changing the existing picture. A comprehensive approach must include plans and programs at three levels of intervention: (1) those that focus on building direct suicide crisis services, (2) those that focus on promoting broadly preventive action through community development, and (3) those that focus on the long-term needs of Aboriginal people, for self-determination, self-sufficiency, healing, and reconciliation within Canada” (p. 75). The Canadian Advisory Group on Suicide Prevention (2003) suggested a number of specific guidelines for Aboriginal suicide prevention programs, which seem highly relevant to suicide

¹⁴Jicarilla Mental Health and Social Services Program, Community-Based Suicide Prevention Program, Miyupimaatisiiuwin Wellness Curriculum, Let's Live!, Life Skills Training, Programme d'entraide par les pairs (Peer Support Program), Native Parenting Program, Family Workshop: Parents and Problems Parenting Program, and Multimedia CD-ROM: Mauve.

¹⁵Applied Suicide Intervention Skills Training (ASIST), 5-Day Suicide Prevention Training for Aboriginal Communities, White Stone: Aboriginal Youth Suicide Prevention Training for Youth Educators, Community-Based Suicide Prevention Program, Zuni Life Skills Development Curriculum, Jicarilla suicide prevention program, and Northwest Territories Suicide Prevention Training.

prevention and social and emotional wellbeing in Aboriginal and Torres Strait Islander Australians, and thus are presented in Table 3.

Table 3. Guidelines for Aboriginal suicide prevention programs in Canada (Advisory Group on Suicide Prevention, 2003).

1. Programs should be locally initiated, owned and accountable, embodying the norms and values of the local/regional First Nations culture;
2. Suicide prevention should be the responsibility of the entire community, requiring community support and solidarity among family, religious, political or other groups. There should be close collaboration between health, social and education services;
3. A focus on the behaviour patterns of children and young people (up to their late 20s) is crucial. This requires involvement of the family and the community;
4. The problem of suicide must be addressed from many perspectives, encompassing biological, psychological, socio-cultural and spiritual dimensions of health and wellbeing;
5. Programs that are long-term in focus should be developed along with “crisis” responses;
6. Evaluation of the impact of prevention strategies is essential.

In *New Zealand*, the national suicide prevention strategy (Ministry of Health, 2008) includes a Maori component and recommends implementation of culturally appropriate initiatives aiming to reduce the incidence of suicide, especially among young people, and increase health and wellbeing in the Maori population. Such initiatives should be tailored to meet the needs and expectations of the Maori people and should be based on the concepts of health (*hauora*) and support for Maori families to achieve maximum health and wellbeing (*whānau ora*). Unfortunately, we were not able to identify any literature reporting on the effectiveness of suicide prevention programs for the Maori population.

Searching for Solutions: Prevention of Suicide in Indigenous Australians

As presented in detail earlier in this Report, suicide is a cause of significant loss of life in Aboriginal and Torres Strait Islander communities across Australia, especially among young males in their twenties and thirties, and over the last decade it has started to take its toll among Indigenous children and adolescents. Suicide deaths in communities often take place in public places, and due to the close-knit social structure of communities, the victims are known to others. Suicides often happen in “waves” and against the background of other premature deaths due to poor general health, accidents, and interpersonal violence, including domestic violence. In the aftermath of a suicide, the communities are left with the terrifying question “who will be next?”, feelings of guilt and inadequacy (“what’s wrong with us”), and due to lack of services, are bereft of help and support to cope with grief and loss. The risk of accepting suicide as a “normal reaction” to problems and an effective way of expressing anger and emotionally “blackmailing” the environment, underscores the need for postvention.

Despite the general agreement that “suicide among Indigenous Australians is a problem” and “something has to be done”, there is a dearth of suicide prevention programs for Indigenous Australians for which there are rigorous evaluations and evidence for effectiveness (and for which there is accessible literature). The lack of programs and evaluations is partly related to insufficient funding and resources, lack of services and remoteness, but not knowing what should and could be done contributes to the confusion. Cultural and historical differences between communities make it often impossible to use or adapt programs developed in different locations. Suicide remains a cultural taboo subject in some communities and this may stop people from opening the subject and seeking help. Other communities actively seek help after suicide and appreciate the normalization of the grieving experience offered by suicide prevention and postvention programs.

The Western (over)medicalised and (over)individualistic paradigm sees depression as the major contributor to suicide and tends to focus on individual interventions and treatments. However, Indigenous suicide prevention requires a broad approach and understanding, including consideration of social, historical and political

factors. Both reviewed literature and experts in the field stress that *suicide prevention for Indigenous Australians has to have a broad community and family focus*.

A number of suicide prevention and social and emotional wellbeing programs applicable to prevention of suicide have been initiated, developed and implemented either by members of communities themselves or in collaboration with mainstream services and organizations. Appendix 2 presents programs we were able to identify through the literature search and through consultations with experts in the field. Some of the programs were developed especially for Indigenous communities and individuals and used in a number of communities (e.g., Family Wellbeing Empowerment Program, *Toughin' it out* pamphlet). Others are mainstream suicide prevention initiatives modified to suit the needs and characteristics of Aboriginal and Torres Strait Islander people, for instance, Suicide Awareness for Aboriginal Communities and Applied Suicide Intervention Skills Training (ASIST). Some of the initiatives focus on suicide prevention and the aftermath of suicide (e.g., Indigenous community suicide intervention forums, *Healing Our Way* self-help resource) while others are more general and tackle a range of issues, including domestic violence, substance abuse, boredom and lack of meaningful activities in the communities (e.g., Family Wellbeing Empowerment Program). *Mental Health First Aid* (MHFA), a training course for members of the public teaching them to recognise and give assistance in mental health crisis situations has been recently adapted to serve Indigenous Australians, i.e. *Mental Health First Aid for Aboriginal and Torres Strait Islander Communities* (Kanowski, Kitchener, & Jorm, 2008). Given the promising MHFA outcomes and evaluations in the general population (Kitchener & Jorm, 2006) and its great potential in improving social and emotional wellbeing and preventing suicide in Indigenous Australians, the program is mentioned here, although it is not listed in Appendix 2 - no published materials regarding its implementation in Australian Indigenous communities were identified.

There is evidence of effectiveness available for some of the initiatives, either based on anecdotal or clinical evidence from individuals or organisations that run the programs (e.g. Suicide Awareness for Aboriginal Communities, ASIST) or from structured process evaluation (e.g., Family Wellbeing Empowerment Program). In general; however, suicide prevention initiatives for Indigenous Australians are plagued by the same evaluation dilemmas regarding the type of evaluation (i.e. process v. outcome), outcome measures and methodology, as *programs run in the other populations in Australia and*

internationally. Despite a remarkable number of such initiatives in Australia (Headley et al., 2006; Robinson et al., 2006) and in other countries (Beautrais et al., 2007; Goldsmith, Pellmar, Kleinman, & Bunney, 2002), there is limited knowledge regarding their effectiveness.

Unfortunately, some prevention programs are implemented despite lack of any evidence of their effectiveness and in some cases there are strong claims regarding effectiveness of approaches which have never been properly evaluated or might even be harmful, such as no-suicide contracts in clinical practice. On the positive side, the situation is not totally bleak and some types of interventions designed for the general population or selected high risk groups seem to be effective (at least in certain environments) (Beautrais et al., 2007; Goldsmith et al., 2002; Mann et al., 2006). There is an overall consensus that physician education in recognition and treatment of depression, the training of gatekeepers, and limiting access to lethal means of suicide, have an impact on suicide rates. Restricted *availability of lethal means* of suicide, such as guns, toxic substances, high bridges and rail tracks, is frequently linked to significant reductions in overall suicide rates. For instance, in the 1960s in Australia restriction of access to barbiturates was associated with a 23% decline in suicide using this method without an increase in the use of other means (Oliver & Hetzel, 1972).

Other approaches to suicide prevention in the general population or in selected groups at elevated suicide risk appear promising, although there is lack of strong scientific evidence-base to unequivocally prove their effectiveness (Beautrais et al., 2007; Goldney, 1998). These include *clinical interventions* for people with a history of suicide attempts, especially interventions aiming at improved treatment compliance and more efficient follow-up. One aspect of this relates to antidepressant use; where increased prescribing of selective serotonin reuptake inhibitors (SSRIs) has occurred, suicide rates have appeared to fall. However, autopsy studies of people prescribed antidepressants and who later suicide, often show a complete absence of antidepressants in the system prior to death, and recent research has disputed the direct causal effect on suicide rates, noting that rates began to fall prior to the onset of increased use of antidepressants (Reseland et al., 2006). Psychotherapy and psychosocial treatments (eg Cognitive Behavioural Therapy or Dialectical Behavioural Therapy) for mental disorders have also been shown to reduce suicidal behaviour (Brown et al., 2005). Recent work suggests the impact of psychotherapy in community or population studies could be the

availability of psychotherapists (as a proxy for relevant healthcare services) in a community as much as the actual therapy (Kapusta et al., 2009). This work may underpin our recommendation about developing a critical mass of Aboriginal mental health workers in a community.

A wide range of *general population and community-based programs*, such as easy access to crisis centres and counselling, public awareness and education, mental health literacy programs, screening for depression and elevated suicide risk in educational and primary care settings, school-based competency and skill enhancement programs, and support for suicide survivors and communities bereaved by suicide also may lead to positive outcomes; however, there is insufficient or contradictory data regarding their impact on actual rates of suicide.

There is strong evidence linking media reports of suicide to increased suicide rates in Australia (Pirkis et al., 2006) and internationally (Pirkis & Blood, 2001), and decreasing the level of media reporting of suicides and encouraging a responsible covering of the subject is a promising approach to suicide prevention (Fu & Yip, 2008; Mann et al., 2006). Consequently, *national or local guidelines for responsible coverage of suicide* have been developed internationally, including Australian “A resource for media professionals” (Commonwealth Department of Health and Aged Care, 2004). The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (Commonwealth Department of Health and Aged Care, 2000) has also identified the Australian media as a key strategic group and recommends national-level action to develop a media strategy to promote positive messages around social and cultural diversity to reduce prejudice and discrimination towards Indigenous Australians. Such initiatives could support suicide prevention in Indigenous Australians.

One of the most effective, comprehensive, population-based, prevention programs is the US Air Force suicide prevention initiative for active duty military personnel started in 1996 (Knox et al., 2003). This program aims at reducing suicide risk factors and enhancing protective factors, including changing policies and social norms, providing awareness of mental health issues and reducing the stigma of help-seeking. Implementation of the program in late 1990s was associated with a 33% decline in suicide rate as well as reductions in levels of other related outcomes, such as accidental deaths, homicide and incidents of domestic violence among the Air Force personnel. There are 11 sub-programs within this program, and at this point it is not clear whether

it is the help-seeking aspect or the resilience development aspects that are of more importance, or whether the total package is necessary to create change.

This literature review began with the intent to consider the development (or redevelopment) of social and emotional wellbeing as a way forward to reduce the possibility of suicide in Indigenous Australian communities. Unfortunately, the evidence for large-scale population approaches to building protective factors toward reducing suicidality, is still in its early stages.

Social and Emotional Wellbeing in Indigenous Australians

Suicide prevention is an integral part of the holistic view of physical and mental health and social and emotional wellbeing of Indigenous Australians. The Indigenous concept of health is multi-dimensional, embraces all aspects of living and points out the importance of survival in harmony with the environment, including good relationships between families and communities, strong culture, sense of trust, belonging, and participation, and healthy relationships with the land (Grieves, 2007; Kowal, Guntorpe, & Bailie, 2007; Northern Territory Aboriginal Health Forum Emotional and Social Wellbeing Working Party, 2003). According to Kowal et al. (2007), “increase in interest in this area has been in response to the efforts of Indigenous leaders to raise the profile of mental health/Emotional and Social Wellbeing on the national policy agenda, through what has been called the Indigenous Mental Health Movement” and “the term ‘Emotional and Social Wellbeing’ is currently the term used within Aboriginal and Torres Strait Islander health policy to represent an area that includes mental health” (p. 2). The National Aboriginal Health Strategy developed in 1989 with a significant input of Aboriginal and Torres Strait Islander people defined health as:

“Not the physical wellbeing of the individual; but the social cultural wellbeing of the whole community. This is a whole of life view and it includes a cyclical concept of life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as human beings, and thus bring about the total wellbeing of their community.” (National Aboriginal Health Strategy Working Party, 1989; p. X)

The seminal National Consultancy Report *Ways Forward* observed: “Aboriginal people emphasised the strong relationship of mental health and wellbeing to physical health and saw loss of mental wellbeing as contributing in a major way to the poor physical health and health outcomes of Aboriginal people. There is much to suggest that this is indeed a further significant and major contributor to the adverse and deteriorating state of the health of Aboriginal people” (Swan & Raphael, 1995; p. 7). The document defined the concept of Aboriginal and Torres Strait Islander health as:

“Holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to wellbeing. This holistic concept does not merely refer to the ‘whole body’

but in fact is steeped in the harmonised interrelations which constitute cultural wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist” (Swan & Raphael, 1995; p. 19).

The *National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2004-2009* (National Aboriginal and Torres Strait Islander Health Council, 2004a) uses the definition of health developed by the National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party, 1989) presented above, and “recognises that achieving optimal conditions for health and wellbeing requires a holistic and whole-of-life view of health, referring to the social, emotional and cultural wellbeing of the whole community” (p. 3). The Framework is based upon nine guiding principles of *Ways Forward* (Swan & Raphael, 1995; Table 4) and stressed two additional dimensions applicable to Aboriginal and Torres Strait Islander health and wellbeing: the legacy of history and uncertainty about the future.

Table 4. Guiding principles of the *National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2004-2009* (National Aboriginal and Torres Strait Islander Health Council, 2004a; Swan and Raphael, 1995).

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural, and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. Self determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care, and management of Aboriginal and Torres Strait Islander peoples health problems generally and mental health problems in particular.
4. It must be recognised that the experiences of trauma and loss, present since European

invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.

5. The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health, (versus mental ill health). Human rights relevant to mental illness must be specifically addressed.

6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.

7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.

8. There is no single Aboriginal and Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living.

Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in urbanised, traditional, or other lifestyles, and frequently move between these ways of living.

9. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationship between human beings and their environments.

According to the Framework, “the first dimension is the *historical context and its legacy* that underlies the high levels of morbidity and mortality in Aboriginal and Torres Strait Islander communities and continues to contribute to the ongoing difficulty in relationships and Reconciliation. The final dimension is the *future uncertainty* surrounding the unresolved issues of land, control of resources, cultural security, the right of self-determination and sovereignty, as these issues have been recognised as contributing to health and wellbeing and reducing health inequalities in Aboriginal and Torres Strait Islander peoples within the international arena” (National Aboriginal and Torres Strait Islander Health Council, 2004a; p. 7).

Grievés (2007) stressed that the Aboriginal wellbeing is “much more than a health issue” and observed that “the term ‘wellbeing’ is an English term adopted to explain the meaning of an Aboriginal concept that goes far beyond welfare. Unfortunately, the original Indigenous concept is not adequately explained by the term ‘wellbeing’. Professor Judy Atkinson¹⁶ has explained: “There is no word in Aboriginal languages for Health. The closest words mean ‘wellbeing’ and wellbeing in the language of Nurwugen people of the Northern Territory means ‘strong, happy, knowledgeable, socially responsible, to take a care, beautiful, clean’, both in the sense of being within the Law and in the sense of being cared for and that suggests to me that country and people and land and health and Law cannot be separated. They are all One and it’s how we work with and respect each other and how we work with and respect the country on which we live that will enable us to continue to live across generations” (Grievés, 2007; p. 20).

These ways of thinking are difficult for the Western mind to grasp. Historically, we have understood for thousands of years that a healthy mind exists in a healthy body (*mens sana in corpore sano*) and lately health practitioners have grappled with health from a bio-psycho-social perspective. However, this has very rarely included a spiritual dimension. The strength of the connection to land (place) and to forefathers (family history) has not been stressed even if the social dimension does include the family system (often limited in western culture to the immediate family or at most three generations, and certainly not the same as Aboriginal and Torres Strait Islander kinship).

The implications of these are that non-aboriginal health practitioners clearly need extensive training in cultural awareness prior to working with Indigenous people, or in Indigenous communities. Conversely, while this is a minimum requirement, a better long term strategy is to train large numbers of Aboriginal and Torres Strait Islander people in health development, recognition of health problems and disorders and treatment approaches or management.

In some ways some of the early discussions on social and emotional wellbeing in Indigenous Australians set up a situation for which there have been difficulties in finding solutions. We cannot turn back the clock on colonisation, immigration and annexure,

¹⁶ “Healing Relationships between People and Country” an address given at the Wollumbin Dreaming Festival 2002.

genocide, “Stolen Generations”, and artificial community. It is important that as a nation, Australians have been able to say “Sorry” (February 13th, 2008) and it is to be hoped that this can begin a process of reconciliation and healing, and genuinely begin actions towards “Ways Forward”.

Despite wide recognition and acknowledgment of importance of the Indigenous holistic concept (or perhaps an ‘extended’ conception) of health and social and emotional wellbeing, there is lack of consensus regarding its operationalisation and measurement (Kowal et al., 2007). To-date several tools have been developed or adapted to be applied to the Indigenous people in Australia, including the Kessler Psychological Distress Scale (ABS, 2006), the Medical Outcome Short Form Health Survey/SF-36 (ABS, 2006), the Negative Life Events Scale (Kowal et al., 2007), the Strengths and Difficulties Questionnaire (SDQ) (Zubrick & Lawrence, 2006), the Westerman Aboriginal Symptom Checklist-Youth (Westerman, 2002b), and the Western Australian Aboriginal Child Health Survey (Zubrick & Lawrence, 2006).

Many of these tools were developed for use in a particular population, for example, children and adolescents (e.g. Westerman, 2002b) and to measure selected dimensions of wellbeing, for example, the impact of stressful life events (Kowal et al., 2007). There is a continuing need to further develop (or adapt) holistic, reliable and culturally appropriate measures, such as the *Hua Oranga* scale for mental health outcomes specifically in the Maori population in New Zealand (Kingi & Durie, 2001). In the United States, there has been an interesting attempt (Graham, 2002) to find connections between the American Indian relational worldview perspective to wellness and healing (Cross, Earle, Echo-Hawk Solie, & Manness, 2000) and the Western concept of reasons for living measured by the Reasons for Living Questionnaire (Linehan, Goldstein, Nielsen, & Chiles., 1983) and the Reasons for Living Inventory for Adolescents (Osman et al., 1998).

Unfortunately, to-date there is a paucity of studies and program evaluations across Australia to indicate which initiatives and frameworks are effective in development of social and emotional wellbeing in Indigenous Australians (and applicable to suicide prevention), including projects addressing depression (Leggett & Krom, 2005; Thomson, Krom, Trevaskis, Weisssofner, & Leggett, 2005). A systematic review of international literature on mental health promotion in Indigenous populations, including Aboriginal and Torres Strait Islanders, Aboriginal Canadians,

Americans Indians, Alaska Natives, and African Americans (Clelland, Gould, & Parker, 2007) identified a number of interventions¹⁷. These included programs promoting mental health, mental health literacy, quality of life and resilience, initiatives targeting increased social support and community connectedness, parenting and family functioning skills programs, and initiatives aiming at reduction of racism, oppression and discrimination.

The conclusions of the review were somewhat disappointing: due to scarcity of published material and paucity of well-conducted evaluations, “it is problematic to draw conclusions as to the efficacy of such interventions” (Clelland et al., 2007; p. 214). It was quite clear; however, that to-date programs focusing on individuals outnumbered interventions addressing the broader social and policy contexts and many of the programs were community driven. Such initiatives involved Indigenous people in design and implementation of programs to make them culturally relevant and appropriate and to ensure the community control over the initiative.

Suicide Prevention and Social and Emotional Wellbeing in Indigenous Australians

Prevention of suicide in Indigenous Australians is closely related to the holistic concept of health and wellbeing. Indigenous suicide has its origins in individual, family, community and transgenerational risk factors as well as the challenging and difficult every-day living conditions rooted in the historical and cultural trauma, including the history of genocide and the on-going racism and discrimination. Only a holistic and comprehensive approach to suicide prevention targeting a range of factors, including better services and care for individuals, families and communities at risk of self-harm, community development and empowerment, strengthening of Aboriginal and Torres Strait Islander culture and identity, and healing of the individual and collective traumas and loss, can lead to positive outcomes and save lives of Indigenous Australians.

¹⁷The review included the Family Wellbeing Empowerment Program and Participatory Action Research implemented in a number of Indigenous communities in Northern Queensland (Tsey et al. 2004a, 2004b, 2005, 2007). The project outcomes are promising: “the use of a long-term (10-year) community research strategy focussing directly on empowerment has demonstrated the power of this approach to facilitate Indigenous people’s capacity to regain social and emotional wellbeing and begin to rebuild the social norms of their families and community” (Tsey et al., 2007; p. S34). The description of the project and evaluation summary is presented in Appendix Two.

The on-going focus on problems in Indigenous communities, much fuelled by the media (Hunter, 1990b; Sheehan, 2001), makes it too easy to forget that Indigenous Australians are “exceptional survivors” (Merritt, 2007; p. 11)¹⁸. Moreover, “Aboriginal society has much to teach the rest of the world about sharing, caring, and human connections - about human survival and wellbeing. It is ironic that these 60,000 years of collective wisdom with respect to mental health and human and ecosystem interdependencies are ignored at the same time that biomedical health sciences are just discovering the importance of supportive and caring connections between people” (Reser, 1991; p. 281).

This section of our Report identifies promising venues for suicide prevention in the context of social and emotional wellbeing in Indigenous Australians which we identified through the review of policies, literature and consultations with experts in the field. These include (1) resilience in Indigenous Australians, (2) early development, family and school-based interventions for Indigenous children and youth, (3) Indigenous Australian culture and identity, and (4) development of Indigenous workforce and services.

Resilience in Indigenous Australians

Resilience can be defined as a dynamic process based on an interaction between risk and protective factors, both internal and external to the individual, which modify the effects of an adverse life event (Rutter, 1985; 1987) and the “personal qualities that enable an individual to thrive in face of adversity” (Connor & Davidson, 2003; p. 76). Resilience is a multidimensional individual characteristic which varies with time, age, gender, culture and context; and it changes depending on life circumstances to which the individual is exposed across the lifespan (Connor & Davidson, 2003). Resilience can be understood as an outcome, i.e. the maintenance of social and functional competence and good mental health in face of adversity, or as a process – how an individual adapts to the

¹⁸A conclusion of a study of wellbeing indicators for Native American children and youth seems highly applicable to the Australian situation: “Native Americans are still discussed in the literature from a deficit and/or problem perspective. (...) The citations that came up most often [in an Internet search] were generally terms describing problems in the individual, family and/or community. Common topics (...) were alcoholism, suicide, gangs, child abuse and neglect, child sexual abuse, violence, boarding school, drugs, substance abuse, homicide, and poverty. Few, if any, strengths or positive indicators of behaviour were listed. It is time for this situation to change and for strengths to be associated with Native Americans” (Goodluck, 2002; pp. 14-15). To paraphrase the last sentence, “it is time for this situation to change and for strengths to be associated with Indigenous Australians”.

difficult conditions. Three broad categories of factors strengthen personal resilience: individual (e.g., personal communication skills, intelligence), social (e.g., supportive families), and societal (e.g., socio-economic status, supportive communities) (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003).

Resilience is frequently mentioned in the context of child and adolescent development, mental health promotion, prevention and early intervention and suicide prevention in both Indigenous and non-Indigenous Australians (Commonwealth Department of Health and Aged Care, 2000; Commonwealth of Australia, 2007). To the best of our knowledge, the concept of resilience has not been studied in the context of suicide prevention and social and emotional wellbeing in Indigenous Australians, although it has been applied to prevention of chronic offending in Indigenous youth (Zubrick & Robson, 2003). Merritt (2007) has even observed that “to date, the term resilience has been a construct based on Western knowledge” and called for development of “an Indigenous perspective on resilience” (p. 12). Moreover, “delving into what resilience is to Aboriginal people is important, but that it should not preclude or divert attention from efforts to address adversity. (...) Adversities arising from social justice and equality issues still need to be addressed” (Merritt, 2007; p. 12).

Indigenous resilience was studied in the American Indians and Aboriginal Canadians, especially in Indigenous adolescents (e.g. Burack, Blinder, Flores, & Fitch, 2007; LaFromboise, Hoyt, Oliver, & Whitbeck, 2006; LaFromboise & Medoff, 2004). In Indigenous populations the concept of resilience can be applied on both a community/nation level and an individual/personal level. In the former understanding of the word, “resilience in the face of adversity is not new to American Indian tribes [and other Indigenous peoples, including Indigenous Australians]. They have survived genocidal practices directed toward them, including a massive redistribution of people away from their homelands and the imposition of the reservation system. They withstood drastic changes in sociopolitical, cultural, and physical environments and the added stress from oppression and hostility. Through it all, many were able to adapt and overcome adverse circumstances” (LaFromboise et al., 2006; p. 194).

On the individual level, Indigenous resilience can be understood as positive outcomes in face of adversity (Connor & Davidson, 2003) or absence of problem behaviours, for example substance abuse, and high levels of pro-social behaviour, such as good school performance (LaFromboise et al., 2006). A study of resilience in

American Indian adolescents showed that a primary risk factor for low resilience was perceived discrimination and protective factors came from multiple contexts, including family, community, and culture (LaFrombiose et al., 2006). The high likelihood of pro-social outcomes was related to having a warm and supportive mother, perceiving community support, and exhibiting higher levels of enculturation, i.e. identification with American Indian culture, participation in traditional activities, and traditional spiritual involvement.

It can be hypothesised that certain features of the traditional culture shared by Indigenous Australians, the American Indians and the Aboriginal Canadians such as extended family, spirituality, and participation in traditional activities can serve as protective factors buffering against the negative consequences of adverse events on individual and community levels and supporting individual resilience (Dudgeon & Oxenham, 1989; Daly & Smith, 2005; Reser, 1991). An Australian study of self-harm among Indigenous and non-Indigenous sole parent females in urban state housing (Radford et al., 1999) provides some support for this hypothesis. Study results showed that Indigenous mothers were at lower risk of self-harm than their non-Indigenous counterparts, and their higher resilience might be related to greater family support and frequency of contact with relatives and “a stronger sense of resistance to, and acquired toleration of, long-term, inter-generational oppression of various kinds” (Radford et al., 1999; p. 83).

Early Development, Family and School-based Interventions for Indigenous Children and Youth

Families and schools seem to be the best settings for programs and interventions targeting resilience and wellbeing in Indigenous Australian children and adolescents (Craven & Bodkin-Andrews, 2006; Eckersley, Wierenga, & Wyn, 2006). There is accumulating evidence that programs for pregnant women and parents of young children, especially nurse home visiting programs, hold significant promise for improving children’s life-course trajectories and for reducing development and health problems (Gluckman et al., 2005; Olds, Sadler, & Kitzman, 2007).

Hunter (2006) observed that “the effects of prenatal environmental factors (including social adversity) on the development of diseases including diabetes and hypertension later in life is well known. Similarly, from conception through infancy,

neurological, cognitive, affective and social development is an interactive process between a phase-sensitive evolving system and the environment. This includes the 'embedding' of experience in biology through processes of selective activation and neural sculpting, and 'reciprocal, co-regulated emotional interactions'. Extensive developmental neurobiology research now also informs our understanding of social gradients in health. Indeed, it has been noted that 'the effects of these early developmental processes can be observed in the health and competence of populations'. Longitudinal studies demonstrate that failure to provide for early phase specific needs is consequential for the later development of serious emotional and behavioural problems, including violence" (pp. 9-10). [The original version of the quote was extensively referenced. We refer the reader to the original].

The Australian study *Footprints in Time: The Longitudinal Study of Indigenous Children* (LSIC)¹⁹ which commenced Wave 1 interviews in April 2008 aims to improve the understanding of the diverse circumstances faced by Aboriginal and Torres Strait Islander children, their families, and communities and to provide a better insight into how a child's early years affect the way they develop and mature. Once completed, the study will provide a valuable data resource which can be used by Australian governments, researchers, service providers, parents and communities.

There are examples of promising school-based resilience enhancing, skill-building and suicide prevention programs for Indigenous youth in Canada and the United States (Kirmayer et al., 2007; LaFromboise & Lewis, 2008) and "youth skill-building programs have been applied to diverse adolescent prevention programs, especially in school-based settings. These programs have focused primarily on the enhancement of competence in youth development work (e.g., self-regulation), as well as the reduction of at-risk behaviours and the prevention of mental health problems. Outcome data from these prevention interventions have been promising, especially when coupled with parent and family training and support" (LaFromboise & Lewis, 2008; p. 346).

Indigenous Australian Culture and Identity

Destruction of culture and spirituality, and problems with identity and cultural continuation, a legacy of centuries of colonisation and genocide, are among the most

¹⁹ http://www.facsia.gov.au/internet/facsinternet.nsf/research/ldi-lsic_nav.htm

significant risk factors for suicide and other indicators of social and emotional ill health in Indigenous Australians (Tatz, 2001; Hunter, 1993), Maori in New Zealand (Coupe, 2005; Skegg et al., 1995), American Indians and Alaska Natives (Duran & Duran, 1995; Wexler, 2006) and Aboriginal Canadians (Kral, 1998).

Simultaneously, as Brady (1995) has pointed out, there is a great potential of “culture as treatment” and “culture in treatment”. The Indigenous culture and identity has an enormous potential for strengthening the social and emotional wellbeing of Indigenous Australians (Brady, 1995; Pattel, 2007; Tse et al., 2005), including prevention of suicide (McCoy, 2007; Petchkovsky, Cord-Urby, & Grant, 2007). Indigenous suicide prevention in New Zealand (Coupe, personal communication, July 2008), Canada (e.g. Jacono & Jacono, 2008) and the United States (e.g. Garrouette et al., 2003) based on traditional cultural knowledge and values underline the importance and high effectiveness of such an approach. However, culture in mental health promotion and suicide prevention must not be treated in a tokenistic way. Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) described two dimensions of cultural sensitivity: the surface structure and deep structure. “*Surface structure* involves matching intervention materials and messages to observable ‘superficial’ (thought nonetheless important) characteristics of a target population²⁰. (...) The second dimension, *deep structure*, has received less attention and can be more elusive. Deep structure sensitivity requires understanding the cultural, social, historical, environmental and psychological forces that influence the target health behaviour in the proposed target population. Whereas surface structure generally increases the ‘receptivity’ or acceptance’ of messages, deep structure conveys *salience*. Surface structure is a prerequisite for feasibility, whereas deep structure determines the efficacy or impact of a program” (Resnicow et al., 1999; pp. 11-12).

Aboriginal and Torres Strait Islander Australians need space to strengthen cultural continuity and identity, and to develop and follow their own wellbeing pathways. Strengthening of Indigenous Australian culture and identity can form a good basis for universal social and emotional wellbeing and suicide prevention programs, as

²⁰“For audiovisual materials, surface structure may involve using people, places, language, music, food, product brands, location and clothing familiar to, and proffered by, the target audience. Surface structure also includes identifying what channels (e.g., media) and settings (e.g., churches, schools) are most appropriate for delivery of messages and programs. With regards to cultural competence, or interpersonal sensitivity, this generally entails using ethnically-matched staff to recruit participants as well as to deliver and evaluate programs” (Resnicow et al., 1999; p. 11).

well as being an outcome indicator for effectiveness of programs. The traditional Aboriginal and Torres Strait Islander culture is imbued with natural protective and wellbeing factors, such as kinship networks and traditional support systems, spirituality, loving, caring, and trust (Reser, 1991). The Elders and traditional healers can play a very important role in strengthening of social and emotional wellbeing in Indigenous Australians (Westerman, 2004).

A qualitative health study exploring the role of Indigenous ceremonies (*kanyirninpa*/holding) in suicide prevention in desert communities in the southeast Kimberley region of Western Australia (McCoy, 2004; 2007) showed that “the desert value of *kanyirninpa*, especially as it is expressed across generations of men, offers one form of protection against that relational and social isolation often noted at the time of self-harm. As a social process, *kanyirninpa* protects young men because it is reflected in multiple and supporting relationships across and within generations. This can be particularly valuable for those who spend their teenage years, and sometimes beyond, exploring a high-risk pathway of autonomy. (...) What the social process of *kanyirninpa* reveals, as does also the research performed by Chandler [and Lalonde] with Native North Americans, is an important link between self-continuity and cultural continuity” (McCoy, 2007; p. S66).

The first step in the journey to effect a social and emotional wellbeing program to alleviate suicide and self-harm in Indigenous Australian communities is to stop disempowering intrusion into these wounded social spaces. The imposition of understanding across cultures (however well intentioned) is based in a culturally embedded violence where only one culture is proposed as possessing ameliorative value. Identity and wellbeing are related and homeostatic features that differ greatly from culture to culture and from individual to individual; such differences are not problematic they are integral and essential to the nature of wellbeing. The imposition of common identity frameworks for wellbeing such as those founded in conceptions of the ‘modern’ and ‘economic’ is an epistemic violence that promotes divisive categorisation and risks further harm to communities and individuals (Nangala, 2008; Spivac, 2003; Sheehan et al., in press).

Culture is best described as a process that constitutes a third party to all engagements and an informative partner in all proposals. Therefore it is problematic to objectify culture as a set of qualities, features or factors which can be quantified in terms

of similarity or difference then generically adjusted and broadly applied. Culture is a process that accompanies and informs life. In Indigenous Knowledge terms each culture is a companion to life for a group of people who live in a specific relationship to the landscape of that culture. This is often described as the holist nature of Aboriginal and Torres Strait Islander culture. This is not accurate; however, because western conceptions of holism do not apply well in this context. Aboriginal and Torres Strait Islander culture is better described as a relational patterning culture, because effective social structures build productive connections and generative separations into this whole through a knowledge management device known as kinship. Kinship patterns the people into their place or Country through instituting necessary and generative individuation into the social system. So Aboriginal and Torres Strait Islander culture is not an open field; each step in culture and cultural renewal must come from within the community charged with responsibility for these complex connections give reciprocal life through their culture to their Country and themselves (Nangala, 2008; Sheehan, 2004). Cultural approaches to social and emotional wellbeing require the development of methodologies that hand over of power to know to those who will experience the future of these communities.

Therefore, cultural solutions require the construction and maintenance of safe and supporting social spaces where groups may examine reactivate and restore their own understandings. In terms of the immense potential for violence, depression and self-harm in Aboriginal and Torres Strait Islander social places such supporting social spaces are essential because they may also afford individuals the psychic space required for positive self imaging and the internal amelioration that only Aboriginal and Torres Strait Islander culture can provide for Indigenous Australians. Clinicians and mental health professionals can be integral to these spaces (Garvey, 2007; Oliver, 2004; Sue, Ivey & Pedersen, 1996).

Homeostasis is the tendency of a living organism to maintain a balance that is both essential to and a feature of wellbeing. If we come to understand a community as a single entity formed by the homeostatic patterning of relations between individuals who are extended beings then we may perceive more effective and culturally relevant directions to promote social and emotional wellbeing. From this Indigenous Knowledge perspective the culture required to ameliorate conditions already exists as a process that is enfolded within community life. Personal and group identities in Aboriginal

places regardless of how they may be distorted by social habitus or historic trauma transmission are essential everyday life giving structures. These existing features are the only potent basis for the ameliorative development of group and individual identity because they are the most generally acceptable and accessible avenues for finding a purpose in life for Aboriginal and Torres Strait Islander people (Sheehan, 2004; Tatz, 2004).

The approach suggested here is not a definitive examination of the features of Aboriginal and Torres Strait Islander identity as a basis for clinical or other health intervention but a more relational context specific approach based on:

- Activating group agency in Aboriginal and Torres Strait Islander places by providing and sustaining a support framework that prompts cultural understanding to articulate itself and become the primary agent in community and individual life.
- Engaging this community life to construct and maintain social and psychic spaces where effectively shared resolutions concerning future possibilities can be made.
- Sustaining the conditions that will support and nurture the positive identities and identifications that emerge from this group agency.
- Lifelong education that builds on emergent strengths enhances the knowledge and skills of Aboriginal and Torres Strait Islander people and empowers them to employ these understandings to live well and contribute positively to their contemporary contexts.
- Programs that recognise and respond to the view that the identity most significant for Aboriginal and Torres Strait Islander social and emotional wellbeing is one that emerges from each group as it addresses and ameliorates its own context.
- Evaluations that position all possible future programs as being responsible for sustaining the pre-eminence of Aboriginal and Torres Strait Islander cultural/community agency in Aboriginal community contexts.

In the contemporary Australian context the seven factors identified in Canadian studies as critical to the elimination of self-harm in Aboriginal communities seem impossible to achieve (Chandler & Lalonde, 1998; Tatz, 2004). Many Aboriginal

communities live in syndemic conditions where connections between social domination, marginalisation and denial combine to ensure that stress, trauma, disease, lateral violence and poverty culminate in pathogenic social conditions (Hammill, 2008). In these places Aboriginal and Torres Strait Islander identity exists in a context where it is laden with trauma and engaged in a constant and impossible struggle for positive self-imaginings. Such is the burden of these conditions at various times especially for Aboriginal men that suicide may be judged to be the only rational and sovereign response available (Tatz, 2005).

The task of alleviating Aboriginal and Torres Strait Islander suicide requires that social spaces be established that are free from the impositions of dominant culture where Aboriginal and Torres Strait Islander identity has an opportunity to flourish and advance the inherent resilience potential of unfettered cultural and social agency.

Development of Indigenous Workforce and Services

As mentioned earlier in this Report, despite the high morbidity and mortality of Indigenous Australians, there is insufficient funding of health services serving this population and numerous barriers in access to health care (ABS, 2004; 2006; ABS&AIHW, 2008). Due to geographical remoteness, some of the Indigenous communities are exposed to “fly-in and fly-out” contact with services; in such situations there is lack of relationship between service providers and the community which contribute to frustration of community members and high burnout rates in health workers. The point of entry of Indigenous Australians into services, especially for mental health problems, is usually late and services focus more on crisis intervention, instead of health promotion, prevention and early intervention (Hunter, 1995).

It is necessary to ensure good access to services for all Australians, including appropriate and culturally safe services for Aboriginal and Torres Strait Islander staff and clients (Australian Health Ministers’ Advisory Council, 2004), proper engagement of Aboriginal clients in mental health services (Farrelly, 2008; Vicary & Andrews, 2001; Vicary & Bishop, 2005; Westerman, 2004), and a deeper understanding of the impact of culture on mental health problems and treatment (Durie, 2004; Hunter, 2008; Janca & Bullen; 2003; Procter, 2005; Sheldon, 2001; Vicary & Westerman, 2004).

Simultaneously, while there is certainly room for service improvement, it is not the quantity or quality of mental health services that is at the root of the tragedy, and the solution is not 'more of the same' (Hunter, in press). According to Hunter (in press), "improvements in the services for Indigenous Australians are necessary and should occur as a matter of course in pursuit of social justice and equity. However, (...) without enabling Indigenous control (not simply an Indigenous veneer or tokenistic platitudes, but Indigenous expertise and effective governance), program and project-based, service 'solutions', regardless of sector, will only result in marginal gains". Development of Indigenous workforce and services is one of the venues for development of Indigenous control and cultural continuity, which as Canadian experience has shown, can be related to lower suicide risk (Chandler & Lalonde, 1998; Chandler & Lalonde, in press).

Currently, Aboriginal and Torres Strait Islander Australians are under-represented in health-related occupations and in graduate courses in health (ABS&AIHW, 2008). In 2005-06, despite comprising 1.9% of the general population over the age of 15 years, they represented only 1% of people employed in the health sector and only 1% of all students completing undergraduate courses in health- and welfare-related fields. Through search of literature and consultations with experts in the field we were able to identify a number of training programs for Indigenous mental health workers and services developed specifically for Indigenous Australians (Appendix Three). A detailed review and evaluation of such programs and services is beyond the scope of this Report; however, even a brief overview can give the reader an idea about the directions of Indigenous mental health force and service development and their outcomes (where information is available) in relation to social and emotional wellbeing in Indigenous Australians

Principles of Good Practice

This part of the Report presents Principles of Good Practice to guide practice in reviewing and funding suicide prevention programs related to development of social and emotional wellbeing in Indigenous Australians (Table 5). These guidelines are based on a review of the literature (Aboriginal Deaths in Custody Counselling Project, 1994, Adams & Danks, 2007; Advisory Group on Suicide Prevention, 2003; Clelland et al., 2007; Elliot-Farrelly, 2004; Farrelly, 2007; Henderson, 2003; Martin, Krysinska, & Swannell, 2008; National Health and Medical Research Council, 1996; Scougall, 1997; Stacey et al., 2007) and consultations with experts in the field.

Table 5. Principles of Good Practice.

Principle One: Community Empowerment

Principle Two: Recognition of Human Rights, Transgenerational Trauma, Loss and Grief

Principle Three: Development of Individual, Family and Community Social and Emotional Wellbeing

Principle Four: Acknowledgement and Recognition of Aboriginal and Torres Strait Islander Diversity and Importance of the Local Context

Principle Five: Direct Involvement of Community Members and Development of Local Workforce

Principle Six: Ensuring Program Sustainability and Organization Capacity

Principle Seven: Evidence- or Theory-Base for Programs

Principle Eight: Appropriate Program Evaluation

Principle Nine: "Researching Ourselves Back to Life"

Principle One - Community Empowerment

Working with Aboriginal and Torres Strait Islander communities needs to be based on community consultation and involvement at every stage of the project. Members of the community should "own the project": the initiative for program implementation should come from within the community and be based on the current needs identified by community members themselves. The community should decide how the program is

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implemented and evaluated, based on direct involvement of community members and development of local workforce (see Principle Five). Community members should be empowered and gain confidence by being involved in the project instead of “being told what to do (again)”. This principle can be summarised in words of a popular slogan “*Nothing About Us Without Us*”.

Appendix Two presents ethical guidelines for conducting research and working with Indigenous communities.

Principle Two - Recognition of Human Rights, Transgenerational Trauma, Loss and Grief

Working with Indigenous Australians requires recognition and acknowledgement of human rights issues, transgenerational trauma, loss and grief, both in the historical context of colonization and genocide (including the “Stolen Generations”), and in the current context of social injustice, neglect and racism. These factors have a serious impact on the everyday life in communities contributing to the prevalent feelings of disempowerment, hopelessness, despair, negativism and resentment. The destruction of traditional Aboriginal and Torres Strait Islander culture and social structure has frequently resulted in breaking down of traditional support systems, undermining of male roles and leadership, rejection of cultural and spiritual values, depression and anomie. Also, loss and grief related to (often premature) deaths of community members and the intergenerational trauma seem to permeate many communities.

Programs leading to positive outcomes in social and emotional wellbeing and suicide prevention have to recognise and target both risk and protective factors in communities. The risk factors plaguing Indigenous communities include poor health status, high premature mortality, unemployment, and overcrowding, substance abuse, interpersonal and domestic violence, and normalization of suicide. These risk factors are related to the general “lifestyle of risk” stemming from historical factors mentioned above and perpetuated by current social exclusion of Indigenous Australians. However, there seems to be a dialectic tension between despair and strength in communities and Indigenous Australians (see Principle Three), and focusing on the problems only can result in harmful negative labelling of Indigenous Australians and internalised racism.

Principle Three - Development of Individual, Family and Community Social and Emotional Wellbeing

In the context of the harsh reality of everyday life for many Indigenous Australians, the holistic concept of social and emotional wellbeing seems to be “pie in the sky”. However, it has to stressed repeatedly that Indigenous Australians are exceptional survivors full of resilience and strength and “a mental health promotion or social emotional wellbeing approach, rather than a diagnostic or problem-based approach to suicide prevention, is required to focus on support pathways, not just clinical pathways (...) communities respond well to the positive approach of mental health promotion for suicide prevention when there is a focus on resilience, coping strategies, wellbeing, and positive personal and cultural identity” (Stacey et al., 2007; p. 251).

Social and emotional wellbeing and suicide prevention programs can be delivered within a spectrum of interventions encompassing a wide range of mental health initiatives, including universal, selective and indicated interventions (Commonwealth Department of Health and Aged Care, 2000; Commonwealth of Australia, 2007). In the Indigenous context, there should be enough resources and willingness to develop and implement a wide range of programs ranging from community development and positive cultural identity, through strengthening of families and development of resilience in children and young adults, to crisis intervention and treatment. There should be a balance between interventions addressing mental health issues and mental health promotion on individual and family levels, and social and economic issues on the community level.

Principle Four - Acknowledgement and Recognition of Aboriginal and Torres Strait Islander Diversity and Importance of the Local Context

“There is great diversity within Aboriginality. (...) although stereotypical views of Aborigines have been perpetuated for a very long time, there is now a growing recognition of the variations and diversity of Aboriginal peoples” (Dudgeon & Oxenham, 1989; p. 1). The diversity mentioned here relates to different Aboriginal and Torres Strait Islander cultures and languages, different social structures and dwelling places both in pre-colonisation and post-colonisation periods. Social and emotional wellbeing and suicide prevention programs not only have to be run in close collaboration with Indigenous Australians and communities (see Principle One), but also have to

acknowledge and allow for diversity and uniqueness and give special consideration for regional differences related to geographical location (i.e., rural, remote and urban setting). Services, organizations and programs must involve and fit the community. Each setting is unique and understanding the “mind of a community”, including its needs, dynamics and formal and informal organisation, requires time and trust. Some programs can be easily adapted to work across a range of communities and settings; other may require rethinking and changes, while others may be effective in one location and population only.

Principle Five - Direct Involvement of Community Members and Development of Local Workforce

As indicated under Principle One, communities should be involved in every stage of development, implementation and evaluation of suicide prevention and social and emotional wellbeing programs, including direct involvement of community members as program facilitators and strengthening of local workforce as a target and an outcome of the program. This should particularly include effective involvement of young people. Such approach supports community development and empowers and strengthens the Indigenous Australians by recognising and acknowledging their knowledge and skills, and giving them a possibility of meaningful employment.

Often programs are initiated from within the community (“work from the heart”), by people who see the need for change and start seeking support from other communities or mainstream organisations. Community members frequently work as unpaid volunteers, but many programs (such as “Drop the Rock”) encompass training, support and employment for community workers. Such programs help to empower Indigenous Australians, both those who act as trainers and facilitators and those in communities, including the elders, who are happy to see Indigenous workers and leaders.

Training of Aboriginal and Torres Strait Islander mental health workers and other professional workforce will help to achieve a critical mass of people who understand the context and needs of Indigenous Australians and can help make a difference. Given the deeply ingrained lack of trust of many Indigenous Australians in mainstream services and organisations, including health services, the justice system and the police, involvement of Aboriginal people in these areas may help to break the

mistrust and increase their use. There is also a necessity of ensuring cultural safety in service organisation and delivery and establishing effective partnerships between Indigenous and non-Indigenous health workers, organisations, and communities based on mutual respect, support and recognition of knowledge, skills, experience and cultural values.

Principle Six - Ensuring Program Sustainability and Organization Capacity

Low sustainability of projects and preponderance of short-term “pilot” projects is one of the notorious problems plaguing Indigenous communities. There is need for sustainable programs delivered by organizations with enough capacity to develop, implement and evaluate the programs. “Negative effects of short-term funded projects that raise expectations then end before their objectives can be realised. In order to build trust and gain good community involvement, particularly in sensitive areas such as suicide prevention, regions need access to dedicated, consistent, long-term resources. Resources are also needed for strengthening workforce capacity within regions - both skills and positions (particularly for Aboriginal workers) - to continue and extend initial work” (Stacey et al., 2007; p. 252).

Principle Seven – Evidence - or Theory-Base for Programs

Best intention, anecdotal evidence and personal or organisational beliefs do not comprise a sufficient base for development and implementation of suicide prevention and social and emotional wellbeing programs for Indigenous Australians (see Principle Eight and Principle Nine). Given the very limited evidence regarding effectiveness of interventions in Aboriginal and Torres Strait Islander communities and the diversity of settings (see Principle Four), it may be truly challenging to provide an evidence-base for some of the programs; however, the suggested initiatives should be at least theory-based, including identification of risk and protective factors, processes and outcomes relevant to the needs of the community.

Principle Eight - Appropriate Program Evaluation

Lack of evaluation of suicide prevention and social and emotional wellbeing programs in Indigenous communities as well as in the mainstream populations is a well known problem contributing to the lack of evidence-base mentioned above. Best intentions and enthusiasm may not be sufficient to develop and implement effective programs, and

there is a danger of wasting financial and human resources on ineffective or even harmful programs. “Clearly, action to prevent suicide cannot wait on definitive research. At the same time, there is an urgent need for evaluation research of intervention programs in Aboriginal communities, since there is a real possibility that some well-intentioned interventions may do more harm than good” (Kirmayer et al., 2007; p. 110).

Evaluation methodology, including the choice of realistically attainable and measurable outcomes, should be culturally informed and appropriate, and decided upon through the process of collaboration with the community. Usually it is not possible within the timeframe of the program to evaluate its effectiveness through its impact on suicide mortality and morbidity, i.e. the number of suicide deaths and attempts. Other more intermediate outcomes may be more appropriate, such as increased involvement in community initiatives aiming at improving social and emotional wellbeing, changes in the environment, increased collective sense of control and empowerment, increased personal skills and knowledge, positive changes in public policy, service organisation, delivery, and utilization.

Principle Nine - “Researching Ourselves Back to Life”

Historically, as a consequence of abusive and culturally disrespectful studies, “research” has become a “dirty word” for many Indigenous Australians and in many communities. Recently, given the success of the Cooperative Research Centre for Aboriginal Health, many Aboriginal and Torres Strait Islander organisations across the country have embraced research with enthusiasm. Many universities have Aboriginal and Torres Strait Islander units, and the National Health and Medical Research Council and Australian Research Council fund and support Indigenous Australian researchers and postgraduate students. Some community organisations fund their own researchers, for example, Winnunga Nimmityjah Aboriginal Health Service in the ACT. Torres Strait Islanders are setting up their own academy of scholars and an academic journal.

Without the good knowledge and proper understanding of the causes and correlates of Aboriginal and Torres Strait Islander suicide and the positive protective factors strengthening social and emotional wellbeing, it is not possible to make any real progress and to save lives. In the words of a Native Canadian Elder, “if we have been researched to death, maybe it’s time we started researching ourselves back to life” (Castellano, 2004; p. 98). Culturally sensitive and appropriate, non-abusive research

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methodologies are being developed, including Participatory Action Research, and Indigenous Australians are “researching themselves back to life” (Foster, Williams, Campbell, Davis, & Pepperill, 2006). Such studies need further support and funding.

References

- Aboriginal and Torres Strait Islander Social Justice Commissioner (2005). *Social Justice Report 2005*. Sydney: HREOC.
- Aboriginal Deaths in Custody Counselling Project (1994). *Reclaiming Our Stories, Reclaiming Our Lives. Aboriginal Health Services, Keeping the Community Strong*. Adelaide: SA Department of Human Services.
- Adams, M., & Danks, B. (2007). A positive approach to addressing Indigenous male suicide in Australia. *Aboriginal and Islander Health Worker Journal*, 31, 28-31.
- Advisory Group on Suicide Prevention (2003). *Acting on What We Know: Preventing Youth Suicide in First Nations: The Report of the Advisory Group on Suicide Prevention*. Ottawa, ON: First Nations and Inuit Health Branch, Health Canada.
- Appleby, M., King, R., & Johnson, B. (1992). *Suicide Awareness Training Manual*. Narellan, NSW: Rose Education Training and Consultancy.
- Arabena, K. (2006). The Universal Citizen: An Indigenous citizenship framework for the Twenty First Century. *Australian Aboriginal Studies*, 2, 36-46.
- Atkinson, J. (2002). *Trauma trails. Recreating song lines. The transgenerational effects of trauma in Indigenous Australia*. North Melbourne: Spinifex.
- Australian Bureau of Statistics (2004). *National Aboriginal and Torres Strait Islander Social Survey 2002. 4714.0*. Canberra: ABS.
- Australian Bureau of Statistics (2006). *National Aboriginal and Torres Strait Islander Health Survey 2004-05. 4715.0*. Canberra: ABS.
- Australian Bureau of Statistics (2007a). *Prisoners in Australia. 4517.0*. Canberra: ABS.
- Australian Bureau of Statistics (2007b). *Population distribution, Aboriginal and Torres Strait Islander Australians. 4705.0*. Canberra: ABS.
- Australian Bureau of Statistics & Australian Institute of Health and Welfare (2008). *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra: AIHW and ABS.
- Australian Government Department of Health and Ageing (2003). *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013*. Canberra: Australian Government Department of Health and Ageing.
- Australian Health Ministers (2003). *National Mental Health Plan 2003-2008*. Canberra: Australian Government.
- Australian Health Ministers' Advisory Council (2004). *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*. Adelaide: Department of Health SA.
- Australian Institute of Aboriginal and Torres Strait Islander Studies (2000). *Guidelines for ethical research in Indigenous studies*. Canberra: AIATSIS.

-
- Barber, J.G., Punt, J., & Albers, J. (1988). Alcohol and power on Palm Island. *Australian Journal of Social Issues*, 23, 87-100.
- Bartik, W., Dixon, A., & Dart, K. (2007). Aboriginal child and adolescent mental health: A rural worker training model. *Australasian Psychiatry*, 15, 135-139.
- Baume, P., Cantor, C., & McTaggart, P. (1998). *Suicide in Queensland. A comprehensive study, 1990-1995*. Brisbane: Australian Institute for Suicide Research and Prevention, Griffith University.
- Beautrais, A.L., & Fergusson, D.M (2006). Indigenous suicide in New Zealand. *Suicide and Life-Threatening Behavior*, 10, 159-168.
- Beautrais, A., Fergusson, D., Coggan, C., Collings, C., Doughty, C., Ellis, P. et al. (2007). Effective strategies for suicide prevention in New Zealand: A review of the evidence. *New Zealand Medical Journal*, 120, 1251.
- Beautrais, A., Wells, J.E., McGee, M.A., & Oakley Browne, M.A. (2006). Suicidal behaviour in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*, 40, 896-904.
- Beneforti, M., & Cunningham, J. (2002). *Investigating Indicators for Measuring the Health And Social Impact of Sport and Recreation Programs in Indigenous Communities*. Darwin: Australian Sports Commission and Cooperative Research Centre for Aboriginal and Tropical Health.
- Bird, M.E. (2002). Health and Indigenous people: Recommendations for the next generation [Editorial]. *American Journal of Public Health*, 92, 1391-1392.
- Boots, R.J., Joyce, C., Mullany, D.V., Anstey, C., Blackwell, N., Garrett, P.M., et al. (2006). Near-hanging as presenting to hospitals in Queensland: Recommendations for practice. *Anaesthesia and Intensive Care*, 34, 736-745.
- Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addiction programs for Indigenous North Americans and Australians. *Social Science and Medicine*, 41, 1487-1498.
- Brideson, T., & Kanowski, L. (2004). The struggle for systematic 'adulthood' for Aboriginal Mental Health in the mainstream: The Djirruwang Aboriginal and Torres Strait Islander Mental Health Program. *Australian e-Journal for the Advancement of Mental Health*, 3.
- Bridge, S., Hanssens, L., & Santhanam, R. (2007). Dealing with suicidal thoughts in schools: Information and education directed at secondary schools. *Australasian Psychiatry*, 15(Supplement), S58-S62.
- Briscoe, G. (2003). *Counting, health and identity: A history of Aboriginal health and demography in Western Australia and Queensland 1900-1940*. Canberra: Aboriginal Studies Press.
- Burack, J., Blinder, A., Flores, H., & Fitch, T. (2007). Constructions and deconstructions of risk, resilience and wellbeing: A model for understanding the development of Aboriginal adolescents. *Australasian Psychiatry*, 15(Supplement), S18-S23.
- Burvill, P.W. (1975). Attempted suicide in the Perth Statistical Division 1971-1972. *Australian and New Zealand Journal of Psychiatry*, 9, 273-279.
- Calma, T. (2007). Creating futures: Influencing the social determinants of mental health and wellbeing in rural, Indigenous and Island peoples. *Australasian Psychiatry*, 15(Supplement), S5-S9.
-

-
- Cantor, C.H., & Slater, P.J. (1997). A regional profile of suicide in Queensland. *Australian and New Zealand Journal of Public Health*, 34, 181-186.
- Castellano, M.B. (2004). Ethics of Aboriginal research. *Journal of Aboriginal Health*, 1, 98-114.
- Chandler, M.J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35, 191-219.
- Chandler, M.J., & Lalonde, C. (in press). Transferring whose knowledge? Exchanging whose best practices? On knowing about Indigenous knowledge and Aboriginal suicide. In D. Beavan, & J. White (Eds.). *Aboriginal policy research*. London, ON: Althouse Press.
- Clayer, J.R., & Czechowicz, A.S. (1991). Suicide by Aboriginal people in South Australia: Comparison with suicide deaths in the total urban and rural populations. *Medical Journal of Australia*, 154, 683-685.
- Clelland, N., Gould, T., & Parker, E. (2007). Searching for evidence: What works in Indigenous mental health promotion? *Health Promotion Journal of Australia*, 18, 208-216.
- Coe, M. (1989). *Windradyne, a Wiradjuri Koorie*. Canberra: Aboriginal Studies Press.
- Coffey, C., Wolfe, R., Lovett, A.W., Moran, P., Cini, E., & Patton, G.C. (2004). Predicting death in young offenders: A retrospective cohort study. *Medical Journal of Australia*, 181, 473-477.
- Commission for Children and Young People and Child Guardian Queensland (2007). *Annual Report: Deaths of children and young people, Queensland, 2006-07*. Brisbane: Commission for Children and Young People and Child Guardian Queensland.
- Commonwealth Department of Health and Aged Care (2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*. Canberra: Mental Health and Special programs Branch, Commonwealth Department of Health and Aged Care.
- Commonwealth of Australia (2004). *Reporting suicide and mental illness. A resource for media professionals*. Canberra: Commonwealth Department of Health and Aged Care.
- Commonwealth of Australia (2007). *Living Is For Everyone (LIFE) Framework: A Framework for Prevention of Suicide in Australia*. Canberra: Australian Government Department of Health and Ageing.
- Commonwealth of Australia (2008). *A Blueprint for Action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*. Canberra: Australian Government Department of Health and Ageing. Online at <http://www.aida.org.au/pdf/Pathways.pdf>
- Connor, K.M., & Davidson, J.R.T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, 18, 76-82.
- Cooke, C.T., Cadden, G.A., & Margolius, K.A. (1995). Death by hanging in Western Australia. *Pathology*, 27, 268-272.
- Copland, M. (2005). *Calculating Lives: The numbers and narratives of forced removals in Queensland 1859-1972*. Unpublished Doctoral thesis, School of Arts Media and Culture, Griffith University, Queensland.
- Coupe, N.M. (2000). The epidemiology of Maori suicide in Aotearoa/New Zealand. *South Pacific Journal of Psychology*, 12, 1-12.
- Coupe, N.M. (2005) *Whakamomori: Maori suicide prevention*. Unpublished Doctoral thesis, Massey University Palmerston North.
-

Identity, Voice, Place

-
- Craven, R.C., & Bodkins-Andrews, G. (2006). New solutions for addressing Indigenous mental health: A call to counselors to introduce the new positive psychology of success. *Australian Journal of Guidance and Counseling, 16*, 41-54.
- Cross, T. L., Earle, K. A., Echo-Hawk Solie, H., & Manness, K. (2000). *Cultural strengths and challenges in implementing a system of care model in American Indian communities. Systems of care: Promising practices in children's mental health*, 2000 Series, Volume I. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
- Cunneen, C. (1997) *The Royal Commission into Aboriginal Deaths in Custody: An overview of its establishment, findings and outcomes*. Canberra: Monitoring and Reporting Section, ATSIC.
- Cunningham, J., & Beneforti, M. (2005). Investigating indicators for measuring the health and social impact of sport and recreation programs in Australian Indigenous communities. *International Review for the Sociology of Sport, 40*, 89-98.
- Dalton, V. (1999). Death and dying in prison in Australia: National overview, 1980-1998. *Journal of Law, Medicine and Ethics, 27*, 269-274.
- Daly, A., & Smith, D., (2005). Indicators of risk to the wellbeing of Australian Indigenous children. *Australian Review of Public Affairs, 6*, 39-57.
- Davidson, J.A. (2003). Presentation of near-hanging to an emergency department in the Northern Territory. *Emergency Medicine, 15*, 28-31.
- De Leo, D., & Evans, R. (2002). *Suicide in Queensland 1996-1998: Mortality rates and related data*. Brisbane: Australian Institute for Suicide Research and Prevention, Griffith University.
- De Leo, D., & Heller, T. (2004). *Suicide in Queensland 1999-2001: Mortality rates and related data*. Brisbane: Australian Institute for Suicide Research and Prevention, Griffith University.
- De Leo, D., Klieve, H., & Milner, A. (2006). *Suicide in Queensland 2002-2004: Mortality rates and related data*. Brisbane: Australian Institute for Suicide Research and Prevention, Griffith University.
- Dudgeon, P., & Oxenham, D. (1989) The complexity of Aboriginal diversity: Identity and kindredness. *Black Voices, 5*, 22-38.
- Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany, NY: State University of New York Press.
- Durie, M. (2004). Understanding health and illness: Research at the interface between science and indigenous knowledge. *International Journal of Epidemiology, 33*, 1138-1143.
- Eastwell, H.D. (1985). Psychological disorders among the Australian Aborigines. In C.T.H. Friedman, & R.A. Faguet (Eds.). *Extraordinary disorders of human behavior* (pp. 229-257). New York: Plenum Press.
- Eastwell, D. (1987). Did Aborigines take their own lives in the old times? *Aboriginal Health Worker, 12*, 29-31.
- Eastwell, H.D. (1988). The low risk of suicide among the Yolngu of the Northern Territory: The traditional Aboriginal pattern. *Medical Journal of Australia, 148*, 338-340.
- EchoHawk, M. (1997). Suicide: The scourge of Native American People. *Suicide and Life-Threatening Behavior, 27*, 60-67.

-
- EchoHawk, M. (2006). Suicide prevention efforts in one area of Indian Health Service, USA. *Suicide and Life-Threatening Behavior, 10*, 169-167.
- Eckersley, R., Wierenga, A., & Wyn, J. (2006). *Flashpoints & signposts: Pathways to success and wellbeing for Australia's young people*. Carlton South: VicHealth.
- Elliott-Farrelly, T. (2004). Australian Aboriginal suicide: The need for an Aboriginal suicidology. *Australian e-Journal for the Advancement of Mental Health, 3*.
- Enns, M.W., Inayatulla, M., Cox, B., & Chayne, L. (1997). Prediction of suicide intent in Aboriginal and non-Aboriginal adolescent inpatients: A research note. *Suicide and Life-Threatening Behavior, 27*, 218-224.
- Farrelly, T. (2007). Aboriginal suicide prevention: Community-specific research and Aboriginal control over interpretation of data. *Aboriginal and Islander Health Worker Journal, 31*, 32-35.
- Farrelly, T. (2008). The Aboriginal suicide and self-harm help-seeking quandary. *Aboriginal and Islander Health Worker Journal, 32*, 11-15.
- Foster, D., Williams, R., Campbell, D., Davis, V., & Pepperill, L. (2006). "Researching ourselves cack to life": New ways of conducting Aboriginal alcohol research. *Drug and Alcohol Review, 25*, 213-217.
- Freemantle, J., Officer, K., McAullay, D., & Anderson, I. (2007). *Australian Indigenous Health - Within an International Context*. Darwin: Cooperative Research Centre for Aboriginal Health.
- Fu, K.W., & Yip, P.S. (2008). Changes in reporting of suicide news after the promotion of the WHO media recommendations. *Suicide and Life-Threatening Behavior, 38*, 631-636.
- Garrouette, E.M., Goldberg, J., Beals, J., Herrell, R., Manson, S.M., & the AI-SUPERPFP Team (2003). Spirituality and attempted suicide among American Indians. *Social Science and Medicine, 56*, 1571-1579.
- Garvey, D.C. (2007). *Indigenous identity in contemporary psychology: dilemmas, developments, directions*. Melbourne: Cengage Learning.
- Garvey, D (2008) A review of social and emotional wellbeing of Indigenous Australian peoples - considerations, challenges and opportunities. Online at http://www.healthinonet.ecu.edu.au/sewb_review
- Gluckman, P.D., Hanson, M.A., Spencer, H.G., & Bateson, P. (2005). Environmental influences during development and their later consequences for health and disease: implications for the interpretation of empirical studies. *Proceedings of the Royal Society, 272*, 671-677.
- Goldney, R.D. (1998). Suicide prevention is possible: A review of recent studies. *Archives of Suicide Research, 4*, 329-339.
- Goldney, R.D. (2002). Is Aboriginal suicide different? A commentary on the work of Colin Tatz. *Psychiatry, Psychology and Law, 9*, 257-259.
- Goldsmith S.K., Pellmar, T.C., Kleinman, A.M., & Bunney, W.E. (2002). Programs for suicide prevention. In S.K. Goldsmith, T.C. Pellmar, A.M. Kleinman, & W.E. Bunney (Eds.). *Reducing suicide: A national imperative* (pp. 273-328). Washington, DC: National Academic Press.
- Goodluck, C. (2002). *Native American children and youth wellbeing indicators: A strengths Perspective*. Portland, OR: National Indian Child Welfare Association.
-

-
- Graham, T.L.C. (2002). Using Reasons for Living to connect to American Indian healing traditions. *Journal of Sociology and Social Welfare*, 29, 55-75.
- Grievies, V. (2007). *Indigenous Wellbeing: A Framework for Governments' Aboriginal Cultural Heritage Activities*. Sydney: NSW Department of Environment and Conservation.
- Guttormsen T., Hoifodt T., Silvola K., & Burkeland O. (2003). Applied suicide intervention: An evaluation. *Tidsskr Nor Laegeforen*, 123, 2284-2286.
- Hammill, J. (2008). *Human rights and human biology: The role of foetal programming and biological embedding as an indicator for poor life outcomes*. Seminar presentation, Centre for Chronic Diseases Research, University of Queensland.
- Hanssens, L. (2007a). Indigenous dreaming: How suicide in the context of substance abuse has impacted on and shattered the dreams and reality of Indigenous Communities, Northern Territory, Australia. *Aboriginal and Islander Health Worker Journal*, 31, 26-34.
- Hanssens, L. (2007b). The search to identify contagion operating within suicide clusters in Indigenous Communities, Northern Territory, Australia. *Aboriginal and Islander Health Worker Journal*, 31, 27-33.
- Hanssens, L., & Hanssens, P. (2007). Research into clustering effect of suicide within Indigenous Communities, Northern Territory, Australia. *Aboriginal and Islander Health Worker Journal*, 31, 6-11.
- Harris, A., & Robinson, G. (2007). The Aboriginal Mental Health Worker Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context. *Australian e-Journal for the Advancement of Mental Health*, 6.
- Headley, A., Pirkis, J., Merner, B., VandenHeuvel, A., Mitchell, P., Robinson, J. et al. (2006). A review of 156 local projects funded under Australia's National Suicide Prevention Strategy: Overview and lessons learned. *Australian e-Journal for the Advancement of Mental Health* 5, 3.
- Healey, K. (Ed.) (1998). *The stolen generation*. Balmain, NSW: Spinney Press.
- Henderson, A. (2003). *Report of the workshop on best practices in suicide prevention and the evaluation of suicide prevention programs in the Arctic*. Iqaluit, Nunavut: Dept. of Executive and Intergovernmental Affairs. Evaluation and Statistics Division.
- Hill, K., Barker, B., & Vos, T. (2007). Excess Indigenous mortality: Are Indigenous Australians more severely disadvantaged than other Indigenous populations? *International Journal of Epidemiology*, 36, 580-589.
- Huggins, J. (1998). *Sister Girl: The writings of Aboriginal activist and historian Jackie Huggins*. St Lucia, Qld: The University of Queensland Press.
- Human Rights and Equal Opportunity Commission (1997). *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Canberra: Australian Government Publishing Service.
- Hunter, E. (1988a). On Gordian knots and nooses: Aboriginal suicide in the Kimberley. *Australian and New Zealand Journal of Psychiatry*, 22, 264-271.
-

- Hunter, E. M. (1988b). Aboriginal suicides in custody: A view from the Kimberley. *Australian and New Zealand Journal of Psychiatry*, 225, 273-282.
- Hunter, E.M. (1989). Commissions and omissions: The wider context of Aboriginal suicides in custody. *Medical Journal of Australia*, 151, 218-223.
- Hunter, E. (1990a). Using a socio-historical frame to analyses Aboriginal self-destructive behaviour. *Australian and New Zealand Journal of Psychiatry*, 24, 191-198.
- Hunter, E. (1990b). Images of violence in Aboriginal Australia. *Aboriginal Law Bulletin*, 2, 2-16.
- Hunter, E. (1991a). Out of sights, out of mind – 2. Social and historical contexts of self-harmful behaviour among Aborigines of remote Australia. *Social Science and Medicine*, 33, 661-667.
- Hunter, E. M. (1991b). An examination of recent suicides in remote Australia: Further information from the Kimberley. *Australian and New Zealand Journal of Psychiatry*, 25, 197-202.
- Hunter, E. (1993). *Aboriginal health and history: Power and prejudice in remote Australia*. Melbourne, Cambridge University Press.
- Hunter, E. (1995). Is there a role for prevention in Aboriginal mental health? *Australian Journal of Public Health*, 19, 573-579.
- Hunter, E. (2006). *Back to Redfern: Autonomy and the 'middle E' in relation to Aboriginal health. Discussion Paper Number 18*. Canberra: Australian Institute of Aboriginal and Torres Strait Islander Studies.
- Hunter, E. (2008). The Aboriginal tea ceremony: Its relevance to psychiatric practice. *Australasian Psychiatry*, 16, 130-132.
- Hunter, E. (in press). Not quite enough: Service solutions or stagnation in Indigenous health. *Arena*.
- Hunter, E., & Harvey, D. (2002). Indigenous suicide in Australia, New Zealand, Canada and the United States. *Emergency Medicine*, 14, 14-23.
- Hunter, E., & Milroy, H. (2006). Aboriginal and Torres Strait Islander suicide in context. *Archives of Suicide Research*, 10, 141-157.
- Hunter, E., Reser, J., Baird, M., & Reser, P. (1999). *An analysis of suicide in Indigenous communities of North Queensland: The historical, cultural and symbolic landscape*. Canberra: Mental Health/Health Services Development Branch, Commonwealth Department of Health and Aged Care.
- Hunter, E., Travers, H., Gibson, J., & Campion, J. (2007). Bridging the triple divide: performance and innovative multimedia in the service of behavioural health change in remote Indigenous settings. *Australian Psychiatry*, 15(Supplement), S44-S48.
- Jacono, J., & Jacono, B. (2008). The use of puppetry for health promotion and suicide prevention among Mi'Kmaq youth. *Journal of Holistic Nursing*, 26, 50-55.
- Janca, A., & Bullen, C. (2003). The Aboriginal concept of time and its mental health implications. *Australasian Psychiatry*, 11(Supplement), S40-S44.
- Jones, I.H. (1972). Psychiatric disorders among Aborigines of the Australian Western Desert. *Social Science and Medicine*, 6, 263-267.
- Jones, I.H. (1973). Psychiatric disorders among Desert and Kimberley people. *Australian Institute of Aboriginal Studies*, 3, 17-20.

-
- Jones, I.H., & de Horne, D.J. (1973). Psychiatric disorders among Aborigines of the Australian Western Desert: Further data and discussion. *Social Science and Medicine*, 7, 219–228.
- Kanowski, L., Kitchener, B., & Jorm, A. (Eds.) (2008). *Aboriginal and Torres Strait Islander Mental Health First Aid Manual*. Melbourne: ORYGEN Research Centre.
- Kapusta, N, Niederkrotenthaler, T, Etzersdorfer, E et al. (2009). Influence of psychotherapist density and antidepressant sales on suicide rates. *Acta Psychiatrica Scandinavica*, 119: 236-242.
- Kidson, M.A., & Jones, I.H. (1968). Psychiatric disorders among Aborigines of the Australian Western Desert. *Archives of General Psychiatry*, 19, 413–17.
- Kilroy, K. (2008). Project Interview social and emotional wellbeing in Aboriginal communities. Musgrave Park Aboriginal Cultural Centre. Brisbane
- King, R., Appleby, M., & Brown, C. (1995). *Suicide Awareness for Aboriginal Communities*. Narellan, NSW: Rose Education Training and Consultancy.
- Kingi, T.K., & Durie, M. (2001). *Hua Oranga: A Maori Mental Health Outcome Measure*. Palmerston North: Massey University, School of Maori Studies.
- Kirmayer, L.J., Boothroyd, L.J., Laliberté, A., & Laronde Simpson, B. (1999). *Suicide prevention and mental health promotion in Native communities* (No. 9). Montreal, QC: Culture and Mental Health Research Unit, Institute of Community & Family Psychiatry, Sir Mortimer B. Davis-Jewish General Hospital.
- Kirmayer, L.J., Brass, G.M., Holton, T.L., Paul, K., Simpson, C., & Tait, C. (2007). *Suicide among Aboriginal Peoples in Canada*. Ottawa: Aboriginal Healing Foundation.
- Kitchener, B. & Jorm, A. (2006). Mental health first aid training: Review of evaluation studies. *Australian and New Zealand Journal of Psychiatry*, 40, 6–8.
- Knox, K.L., Litts, D.A., Talcott, G.W., Feig, J.C., & Caine, E.D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal*, 327, 1376-1378.
- Kosky, R.J., & Dundas, P. (2000). Death by hanging: Implications for prevention of an important method of youth suicide. *Australian and New Zealand Journal of Psychiatry*, 34, 836-841.
- Kowal, E., Gunthorpe, W., & Bailie, R.S. (2007). Measuring emotional and social wellbeing in Aboriginal and Torres Strait Islander populations: an analysis of a Negative Live Events Scale. *International Journal for Equity in Health*, 6, 18.
- Kral, M.J. (1998). Suicide and the internalisation of culture: Three questions. *Transcultural Psychiatry*, 35, 221-233.
- Krieg, A.S. (2006). Aboriginal incarceration: Health and social impacts. *Medical Journal of Australia*, 184, 534-536.
- Kunitz, S. (1994). *Disease and social diversity: The European impact on the health of non-Europeans*. New York: Oxford University Press.
- Kunitz, S.J., & Brady, M. (1995). Health care policy for Aboriginal Australians: The relevance of the American Indian experience. *Australian Journal of Public Health*, 19, 549-558.
- LaFromboise, T.D., & Lewis, H.A. (2008). The Zuni Life Skills Development Program: A school/community-based suicide prevention intervention. *Suicide and Life-Threatening Behavior*, 38, 343-353.
-

- LaFromboise, T. D., & Meddoff, L. (2004). Sacred spaces: The role of context in American Indian youth development. In C. Clauss-Ehlers, & M. Weist (Eds.). *Community planning to foster resilience in children* (pp. 45-63). New York: Kluwer Academics Publishers.
- LaFromboise, T. D., Hoyt, D.R., Oliver, L., & Whitbeck, L.B. (2006). Family, community, and school influences on resilience among American Indian adolescents in the Upper Midwest. *Journal of Community Psychology, 34*, 193-209.
- LaFromboise, T. D., Meddoff, L., Lee, C.C., & Harris, A. (2007). Psychosocial and cultural correlates of suicidal ideation among American Indian early adolescents on a North Plains Reservation. *Research in Human Development, 4*, 119-143.
- Laugharne, J., Glennen, M., & Austin, J. (2002). The 'Maga Barndi' mental health service for Indigenous people in Western Australia. *Australasian Psychiatry, 10*, 13-17.
- Lawlor, D., & Kosky, R. (1992). Serious suicide attempts among adolescents in custody. *Australian and New Zealand Journal of Psychiatry, 26*, 474-478.
- Leenaars, A. (2006). Suicide among Indigenous people: Introduction and call for action. *Archives of Suicide Research, 10*, 103-115.
- Leggett, N., & Krom, I. (2005). *Programs and projects addressing depression and the social and emotional wellbeing of Indigenous peoples*. Perth: Australian Indigenous HealthInfoNet.
- Letters, P., & Stathis, S. (2004). A mental health and substance abuse service for a youth detention centre. *Australasian Psychiatry, 12*, 126-129.
- Linehan, M.M., Goldstein, J.L., Nielsen, S.L., & Chiles, J.A. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology, 51*, 276-286.
- MacDonald, M. (1999). *Suicide intervention training evaluation: A study of immediate and long term training effects*. Unpublished doctoral dissertation, Calgary, Alberta: The University of Calgary.
- Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A. et al. (2006). Suicide prevention strategies: A systematic review. *Journal of American Medical Association, 26*, 2064-2074.
- Martin, G., Krysinska, K., & Swannell, S. (2008). The struggle to evaluate prevention programs. *Australian e-Journal for the Advancement of Mental Health, 7*.
- May, D. (1994). *Aboriginal labour and the cattle industry: Queensland from white settlement to the present*. Melbourne, Vic: Cambridge University Press.
- May, P.A., Van Winkle, N.M., Williams, M.B., McFeeley, P.J., DeBruyn, L.M., & Serna, P. (2002). Alcohol and suicide among American Indians of New Mexico, 1980-1998. *Suicide and Life-Threatening Behavior, 32*, 240-255.
- McCoy, B.F. (2004). *Kanyirninpa: Health, masculinity and wellbeing of Desert Aboriginal men*. Unpublished Doctoral thesis, Centre for the Study of Health and Society, School of Population Health, The University of Melbourne.
- McCoy, B. (2007). Suicide and desert men: The power and protection of *kanyirninpa* (holding). *Australasian Psychiatry, 15*(Supplement), S63-S67.

Identity, Voice, Place

-
- McFarland, B.H., Gabriel, R.M., Bigelow, D.A., & Walker, R.D. (2006). Organization and financing of alcohol and substance abuse programs for American Indians and Alaska Natives. *American Journal of Public Health, 96*, 1469-1477.
- Measey, M.-A.L., Li, S.Q., Parker, R., & Wang, Z. (2006). Suicide in the Northern Territory, 1981-2002. *Medical Journal of Australia, 185*, 315-319.
- Merritt, S. (2007). An Aboriginal perspective on resilience: Resilience needs to be defined from an Indigenous context. *Aboriginal and Islander Health Worker Journal, 31*, 10-12.
- Middlebrook, D.L., LeMaster, P., Beals, J., Novins, D.K., & Manson, S.M. (2001). Suicide prevention in American Indian and Alaska Native communities: A critical review of programs. *Suicide and Life-Threatening Behavior, 31*, 132-149.
- Ministry of Health (2008). *New Zealand Suicide Prevention Action Plan 2008-2012: The Summary for Action*. Wellington: Ministry of Health.
- Mitchell, S. (Ed.) (2005). *Mental health and wellbeing: Small grants storybook*. Adelaide: Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet).
- Moller, J. (1996). Understanding national injury data regarding Aboriginal and Torres Strait Islander peoples. *Australian Injury Prevention Bulletin, 14*. Adelaide: National Injury Surveillance Unit.
- Mrazek P.J., & Haggerty, R.J. (1994). *Reducing Risks for Mental Disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.
- Nagel, T., & Thompson, C. (2006). Aboriginal mental health workers and the improving Indigenous mental health service delivery model in the 'Top End'. *Australasian Psychiatry, 14*, 291-294.
- Nangala, S. (2008). Project Interview social and emotional wellbeing in Aboriginal communities.
- National Aboriginal and Torres Strait Islander Health Council (2004a). *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004-2009*. Canberra: Australian Government.
- National Aboriginal and Torres Strait Islander Health Council (2004b). *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*. Canberra: AGDHAC.
- National Aboriginal Health Strategy Working Party (1989). *National Aboriginal Health Strategy*. Canberra, Australian Government Publishing Service.
- National Health and Medical Research Council (1996). *Promoting the health of Aboriginal and Torres Strait Island communities* [Rescinded]. Canberra: Commonwealth of Australia.
- National Health and Medical Research Council (2003). *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. Canberra: Commonwealth of Australia.
- National Health and Medical Research Council (2005). *Keeping Research on Track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*. Canberra: Commonwealth of Australia.
- Norris, G., Parker, R., Beaver, C., & van Konkelenberg, J. (2007). Addressing Aboriginal mental health issues on the Tiwi Islands. *Australasian Psychiatry, 15*, 310-314.
- Northern Territory Aboriginal Health Forum Emotional and Social Wellbeing Working Party, (2003). *NT Aboriginal Emotional and Social Wellbeing Strategic Plan*. Darwin, Northern Territory Government.
-

-
- Olds, D.L., Sadler, L., & Kitzman, H. (2007). Programs for parents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry*, 48, 355-391.
- Oliver, K. (2004) *The colonization of psychic space: a psychoanalytic social theory of oppression*. University of Minnesota Press, London.
- Oliver, R.G., & Hetzel, B.S. (1972). Rise and fall of suicide rates in Australia: Relation to sedative availability. *Medical Journal of Australia*, 2, 919-923.
- Olsson, C.A., Bond, L., Burns, J.M., Vella-Brodrick, D.A. & Sawyer, S.M. (2003). Adolescent resilience: A concept analysis. *Journal of Adolescence*, 26, 1-11.
- Osman, A., Downs, W.R., Koper, B.A., Barrios, F.X., Baker, M.T., Osman, J.R., et al. (1998). The Reasons for Living Inventory for Adolescents (RFL-A): Development and psychometric properties. *Journal of Clinical Psychology*, 54, 1063-78.
- Parker, R., & Ben-Tovim, D.I. (2002). A study of factors affecting suicide in Aboriginal and 'other' populations in the Top End of the Northern Territory through an audit of coronial records. *Australian and New Zealand Journal of Psychiatry*, 36, 404-410.
- Partnerships Queensland (2006). *Baseline Report: Future Directions Framework for Aboriginal and Torres Strait Islander Policy in Queensland 2005-2010*. Brisbane: Department of Communities, Office for Aboriginal and Torres Strait Islander Partnerships.
- Pattel, N. (2007). Aboriginal families, cultural context and therapy. *Counselling, Psychotherapy and Health*, 3, 1-24.
- Patterson, D. (2000). Yarrabah Men's Health Group. *Aboriginal and Islander Health Worker*, 24, 3.
- Petchkovsky, L., Cord-Udy, N., & Grant, L. (2007). A post-Jungian perspective on 55 Indigenous suicides in Central Australia; deadly cycles of diminished resilience, impaired nurturance, compromised interiority; and possibility for repair. *Australian e-Journal for Advancement of Mental Health*, 6.
- Pirkis, J., & Blood, R. W. (2001). Suicide and the media. A critical review. Canberra: Department of Health and Aged Care.
- Pirkis, J., Burgess, P.M., Francis, C., Blood, R.W., & Jolley, D.J. (2006). The relationship between media reporting of suicide and actual suicide in Australia. *Social Science and Medicine*, 62, 2874-2886.
- Procter, N.C. (2005). Parasuicide, self-harm and suicide in Aboriginal people in rural Australia: A review of the literature with implications for mental health nursing practice. *International Journal of Nursing Practice*, 11, 237-2341.
- Queensland Government (2008). *Queensland Plan for Mental Health 2007-2017*. Brisbane: Queensland Government.
- Queensland Health (1996). *Queensland Mental Health Policy Statement: Aboriginal and Torres Strait Islander People*. Brisbane: Queensland Government.
- Queensland Health (2003a). *Reducing Suicide: Queensland Government Suicide Prevention Strategy 2003-2008*. Brisbane: Queensland Government.
- Queensland Health (2003b). *Reducing Suicide: Action Plan: Queensland Government Suicide Prevention Strategy 2003-2008*. Brisbane: Queensland Government.
-

-
- Radford, A.J., Brice, G.A., Harris, R., van der Byl, M., Monten, H., McNeece-Neeson, M., et al. (1999). The 'easy street' myth: Self harm among Aboriginal and non-aboriginal female sole parents in urban state housing. *Australian and New Zealand Journal of Public Health*, 23, 77-85.
- Read, P. (1988) *A hundred years war: The Wiradjuri people and the state*. Sydney: Australian National University Press.
- Reseland, S., Bray, I., Gunnell, D., 2006. Relationship between antidepressant sales and secular trends in suicide rates in the Nordic countries. *British Journal of Psychiatry*, 188: 354-8.
- Reser, J.P. (1989a). Australian Aboriginal suicide deaths in custody: Cultural context and cluster evidence. *Australian Psychologist*, 24, 325-324.
- Reser, J.P. (1989b). Aboriginal deaths in custody and social construction: A response to the view that there is no such thing as Aboriginal suicide. *Australian Aboriginal Studies*, 2, 43-50.
- Reser, J.P. (1991). Aboriginal mental health: Conflicting cultural perspectives. In J. Reid, & P. Trompf (Eds.). *The health of Aboriginal Australia* (pp. 218-291). Sydney: Harcourt Brace Jovanovich.
- Reser, J.P. (2004). What does it mean that Aboriginal suicide is different? Differing cultures, accounts, and idioms of distress in the context of indigenous youth suicide. *Australian Aboriginal Studies*, 2, 34-53.
- Resnicow, K., Baranowski, T., Ahluwalia, J.S., & Braithwaite, R.L. (1999). Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease*, 9, 10-21.
- Ring, I. (1995). An open letter to the President of the Public Health Association. *Australian Journal of Public Health*, 19, 228-230.
- Ring, I.T., & Firman, D. (1998). Reducing Indigenous mortality in Australia: Lessons from other countries. *Medical Journal of Australia*, 169, 528-533.
- Robinson, J., McGorry, P., Harris, M.G., Pirkis, J., Burgess, P., Hickie, I. et al. (2006). Australia's National Suicide Prevention Strategy: The next chapter. *Australian Health Review*, 30, 271-276
- Robinson, S. (2008). *Something like slavery: Queensland's Aboriginal child workers 1842-1945*. North Melbourne, Vic: Australian Scholarly Publishing.
- Royal Commission into Aboriginal Deaths in Custody (1991). *Final Report*. Canberra: Australian Government Publishing Service.
- Royal Commission on Aboriginal Peoples (1995). *Choosing Life: Special Report on Suicide among Aboriginal People*. Ottawa: Canada Communication Group.
- Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598-611.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57, 316-331.
- Salisbury, T., & Gresser, P. J. (1971). *Windradyne of the Wiradjuri: Martial law at Bathurst in 1824*. Sydney: Wentworth Books.
- Scougall, J. (1997). Giving voice: The conduct of evaluation research in Aboriginal contexts. *Evaluation Journal of Australasia*, 9, 53-60.
-

-
- Sheehan, N. (2001). "Some call it culture": Aboriginal identity and the imaginary moral centre. *Social Alternatives, 20*, 29-33.
- Sheehan, N. (2004). *Indigenous Knowledge and Education: instigating relational education in a higher education context*. Unpublished Doctoral thesis, School of Education. University of Queensland.
- Sheehan, N.W., Dunleavy, J., Cohen, T. & Mitchell, S. (in press). *Denatured Spirit: Neo-colonial Social Design*.
- Sheldon, M. (2001). Psychiatric assessment in remote Aboriginal communities. *Australian and New Zealand Journal of Psychiatry, 35*, 435-442.
- Shore, J.H., & Spicer, P. (2004). A model for alcohol-mediated violence in an Australian Aboriginal community. *Social Science and Medicine, 58*, 2509-2521.
- Skegg, K., Cox, B., & Broughton, J. (1995). Suicide among New Zealand Maori: Is history repeating itself? *Acta Psychiatrica Scandinavica, 92*, 453-459
- Spivak, G.C. (2003) *Death of a discipline*. Columbia University Press, New York.
- Stacey, K., Keller, N., Gibson, B., Johnson, R., Jury, L., Kelly, D., et al. (2007). Promoting mental health and wellbeing in Aboriginal contexts: Successful elements of suicide prevention work. *Health Promotion Journal of Australia, 18*, 247-254.
- Stevenson, M.R., Wallace, L.J.D., Harrison, J., Moller, J., & Smith, R.J. (1998). At risk in two worlds: Injury mortality among Indigenous people in the US and Australia, 1990-1992. *Australian and New Zealand Journal of Public Health, 22*, 641-644.
- Stewart, L.M., Henderson, C.J., Hobbs, M.S.T., Ridout, S.C., & Knuiman, M.W. (2004). Risk of death in prisoners after release from jail. *Australian and New Zealand Journal of Public Health, 28*, 32-36.
- Strickland, C.J., Walsh, E., & Cooper, M. (2006). Healing fractured families: Parents' and elders' perspectives on the impact of colonization and youth suicide prevention in a Pacific Northwest American Indian Tribe. *Journal of Transcultural Nursing, 17*, 5-12.
- Sue, D. W., Ivey, A. E. & Pedersen, P. B. (1996) *A theory of multicultural counselling and therapy*. Pacific Grove, CA: Brooks/Cole Pub. Co.
- Swan, P., & Raphael, B. (1995). *Ways Forward: National Consultancy Report On Aboriginal and Torres Strait Islander Mental Health*. Canberra, ACT: Australian Government Department of Health and Ageing.
- Tatz, C. (2001). *Aboriginal suicide is different: A portrait of life and self-destruction* (No. 0855753714). Canberra: Aboriginal Studies Press.
- Tatz, C. (2004). Aboriginal, Maori and Inuit Youth Suicide: Avenues to Alleviation? *Australian Aboriginal Studies, 2*, 15-25.
- Tatz, C. (2005). *Aboriginal suicide is different: A portrait of life and self-destruction* (2nd ed). Canberra: Aboriginal Studies Press.
- Terszak, M. R. (2008). *Orphaned by the colour of my skin: a stolen generation story*. Maleny, Qld: Verdant House.
- Thomson, N., Krom, I., Trevaskis, G., Weisssofner, N., & Leggett, N. (2005). *A scoping study of depression among Indigenous peoples*. Perth: Australian Indigenous HealthInfoNet.
- Tierney, R.J. (1994). Suicide intervention training evaluation: A preliminary report. *Crisis, 15*, 70-76
-

Identity, Voice, Place

- Tongs, J., Chatfield, H., & Arabena, K. (2007). The Winnunga Nimmityjah Aboriginal Health Service holistic health care for prison model. *Aboriginal and Islander Health Worker Journal*, 31, 6-8.
- Tse, S., Lloyd, C., Petchkovsky, L., & Manaia, W. (2005). Exploration of Australian and New Zealand Indigenous people's spirituality and mental health. *Australian Occupational Therapy Journal*, 52, 181-187.
- Tsey, K., Patterson, D., Whiteside, M., Baird, L., Baird, B., & Tsey, K. (2004a). A micro analysis of a participatory action research process with a rural Aboriginal men's health group. *Australian Journal of Primary Health*, 10, 64-71.
- Tsey, K., Wenitong, M., McCalman, J., Baird, L., Patterson, D. Baird, B., et al. (2004b). A participatory action research process with a rural Indigenous men's group: Monitoring and reinforcing change. *Journal of Primary Health*, 10, 130-136.
- Tsey, K., Travers, H., Gibson, T., Whiteside, M., Cadet-James, Y., Haswell-Elkins, M., et al. (2005). The role of empowerment through life skills development in building comprehensive primary health care systems in Indigenous Australia. *Australian Journal of Primary Care*, 11, 16-25.
- Tsey, K., Wilson, A., Haswell, M., Whiteside, M., McCalman, J., Cadet-James, Y., et al. (2007). Empowerment-based research methods: A 10-year approach to enhancing Indigenous social and emotional wellbeing. *Australasian Psychiatry*, 15 (Supplement), S34-S38.
- Turley, B., & Tanney, B. (1998). *SIFTA Evaluation Report*. Melbourne: Lifeline Australia
- United Nations (1948). *Universal Declaration of Human Rights*. Online at <http://www.un.org/Overview/rights.html>
- United Nations (2008). *United Nations Declaration on the Rights of Indigenous Peoples*. Online at http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
- Vicary, D., & Andrews, H. (2001). A model of therapeutic intervention with Indigenous Australians. *Australian and New Zealand Journal of Public Health*, 25, 349-51.
- Vicary, D., & Bishop, B.J. (2005). Western psychotherapeutic practice: Engaging Aboriginal people in culturally appropriate and respectful ways. *Australian Psychologist*, 40, 8-19.
- Vicary, D., & Westerman, T. (2004). "That's just the way he is": Some implications of Aboriginal mental health beliefs. *Australian e-Journal for the Advancement of Mental Health*, 3.
- Weatherburn, D., Fitzgerald, J., & Hua, J. (2003). Reducing Aboriginal over-representation in prison. *Australian Journal of Public Administration*, 62, 65-73.
- Wesley-Esquimaux, C. C., & Smolewski, M. (2004). *Historic Trauma and Aboriginal Healing*. Ontario: Aboriginal Healing Foundation Ottawa.
- Westerman, T.G. (2002a). Psychological interventions with Aboriginal people. *Connect Magazine*. Health Department of Western Australian.
- Westerman, T. (2002b). *Westerman Aboriginal Symptom Checklist-Youth*. Perth: Indigenous Psychological Services.
- Westerman, T. (2004). Engagement of Indigenous clients in mental health services: What role do cultural differences play? *Australian e-Journal for the Advancement of Mental Health*, 3, 1-7.

-
- Westerman, T., & Vicary, D. (2001). Aboriginal youth suicide. In P. Dudgeon, D. Garvey, & H. Pickett (Eds.). *Working with Indigenous Australians: A handbook for psychologists* (pp. 471–479). Perth: Gunada Press.
- Wexler, L.M. (2006). Inupiat youth suicide and culture loss: Changing community conversations for prevention. *Social Science and Medicine*, 63, 2938-2948.
- Wexler, L., Bertone-Johnson, E., & Fenaughty, A. (2008). Correlates of Alaska Native fatal and nonfatal suicidal behaviors 1990-2001. *Suicide and Life-Threatening Behavior*, 38, 311-320.
- Wilkie, C., Macdonald, S., & Hildahl, K. (1998). Community case study: Suicide cluster in a small Manitoba community. *Canadian Journal of Psychiatry*, 43, 823–828.
- Wissow, L.S., Walkup, J., Barlow, A., Reid, R., & Kane, S. (2001). Cluster and regional influences on suicide in a Southwestern American Indian Tribe. *Social Science and Medicine*, 53, 1115-1124.
- World Health Organization (1986). *Ottawa Charter for Health Promotion*. Geneva: WHO.
Online at http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
- World Health Organization (1997). *Jakarta Declaration on Leading Health Promotion into the 21st Century*. Geneva: WHO. Online at http://www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf
- World Health Organization (2004). *Prevention of Mental Disorders: Effective Interventions and Policy Options. Summary Report*. Geneva: WHO.
- World Health Organization (2005a). *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. Geneva: WHO.
- World Health Organization (2005b). *Bangkok Charter for Health Promotion in a Globalized World*. Geneva: WHO. Online at http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf
- Zubrick, S.R., & Lawrence, N. (2006). *Research Paper: Testing the Reliability of a Measure of Aboriginal Children's Mental Health*. 1351.0.55.011. Canberra: Australian Bureau of Statistics.
- Zubrick, S.R., & Robson, A. (2003). *Resilience to offending in high-risk groups: Focus on Aboriginal youth*. Prepared for Criminology Research Council.
- Zubrick, S., Silburn, S., Lawrence, D., Mitrou, F.G., Dalby, R.B., Blair, E., et al. (2005). *Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research

Appendix One: Glossary

This Glossary has been compiled based on glossary of the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (*Auseinet*)²¹, glossaries of policy documents reviewed in this Report, and Mrazek and Haggerty (1994).

Aboriginal: A person of Aboriginal descent who identifies as an Aboriginal and is accepted as such by the community in which he or she lives.

Aboriginal and Torres Strait Islander health: Holistic concept, encompassing mental health and physical, cultural and spiritual health, considering land to be central to wellbeing. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations which constitute cultural wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist.

Health: Health does not just mean the physical wellbeing of an individual, but refers to the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total wellbeing of their communities.

Holistic approach: A holistic approach to health incorporates a comprehensive approach to service delivery and treatment where coordination of a client's needs and total care takes priority. It is an acknowledgement that economic and social conditions affect physical and emotional wellbeing. Care therefore needs to take into account physical, environmental, cultural, and spiritual factors for achieving social and emotional wellbeing.

Illness: An unhealthy condition of body or mind.

²¹ <http://auseinet.com/glossary>

Indicated intervention: A preventive intervention targeted to high-risk individuals who are identified as having minimal but detectable signs and symptoms foreshadowing mental disorder but who do not meet DSM-IV diagnostic levels at the current time.

Indigenous: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community with which he or she is associated.

Mental health: Capacity of the individual, the groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective or emotional and relational), the achievements of individual and collective goals consistent with the attainment and presentation of conditions of fundamental equality. Mental health is incorporated into the holistic approach to health care as defined in the definition of health.

Mental health promotion: A process aimed at changing environments (social, physical, economic, educational and cultural) and enhancing the 'coping' capacity of communities, families and individuals, by giving people the power, knowledge, skills and necessary resources.

Prevention : Interventions that occur before the initial onset of a disorder

Protective factors: Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.

Resilience: Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking, and help-seeking.

Risk factors: Factors such as biological, psychological, social and cultural agents that are associated with suicide/suicide ideation. Risk factors can be defined as either distal

(internal factors, such as genetic or neurochemical factors) or proximal (external factors, such as life events or the availability of lethal means - factors which can 'trigger' a suicide or suicidal behaviour).

Selective intervention: A preventive intervention targeted at individuals or population subgroup whose risk of developing mental disorders is significantly higher than average.

Self-injury: Deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Sometimes called non-suicidal self-injury, or self-harm.

Suicidal behaviour: Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

Suicidal ideation: Thoughts about attempting or completing suicide.

Suicide: The act of purposely ending one's life.

Suicide prevention: Actions or initiatives to reduce the risk of suicide among populations or specific target groups.

Torres Strait Islander: A person of Torres Strait Islander descent who identifies as a Torres Strait Islander and is accepted as such by the community in which he or she lives.

Universal intervention: A preventive intervention targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

Wellness: The quality or state of being in good health especially as an actively sought goal

Appendix Two: Acknowledgements

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Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
<p><i>Suicide Awareness for Aboriginal Communities manual and workshop</i> (King, Appleby, & Brown, 1995)</p>	<p>The manual and the workshop are based upon the original Rose Education Suicide Awareness Training Manual (Appleby, King, & Johnson, 1992). The revision follows collaborative work conducted with Indigenous communities and suggestions made by Indigenous workshop participants. The program covers definition of suicide, misconceptions about Indigenous history, incidence of Indigenous suicide, myths and facts about suicide, risk factors and warning signs of suicide, understanding needs, intention, level of danger and distress of a suicidal person, helping and first aid for the suicidal person, helping those bereaved by suicide, understanding and helping high risk groups, and suicide prevention in communities.</p>	<p>The program was a part of the Shoalhaven Suicide Prevention Network (NSW) funded by the Federal Government. The program provided an educational week in the Shoalhaven area during which over 200 people were trained in suicide prevention skills. The program was evaluated 12 months later to estimate the number of people using the acquired skills and the manual, and to ascertain further needs of the community. The program was also conducted and evaluated in Yarrabah (Qld). There was positive feedback from workshop participants and encouraging long-term outcomes, incl. development of support services and resources in the community²².</p>
<p><i>Yarrabah Men's Health Group (Yarrabah Men's Health Initiative)</i> (Mitchell, 2005; Patterson, 2000)</p>	<p>In 1980s and 1990's the Yarrabah community (Qld) experienced a cluster of violent suicides by young men. These deaths prompted a number of local initiatives aimed at suicide prevention and strengthening the community, including the Yarrabah Men's Health Initiative. The program started in 1997 with an aim "to restore men's rightful role in the community using a holistic healing approach,</p>	<p>The key activities of the program include development of a strategy plan focusing on employment, education and training, tradition and culture, leadership and personal development, health services for men, weekly education meetings, bonding activities, hunting and fishing trips, organising referrals from the local magistrate courts, development of business initiatives for men, and support and</p>

²² Personal communication from Margaret Appleby (July 2008).

Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
	<p>encompassing in the program the spiritual, mental, physical, emotional and social aspects of life". Initially, the group was volunteer-based, but over the last decade it has succeeded in securing funds from the Australian Government (see Family Wellbeing Project below) and currently the program is based on a Participatory Action Research intervention model.</p>	<p>partnerships with local and international Indigenous groups. Positive and encouraging outcomes for the community²³ (also, see Family Wellbeing Project below).</p>
<p><i>Family Wellbeing Empowerment Program</i> (Mitchell, 2005; Tsey et al. 2004a, 2004b, 2005, 2007)</p>	<p>The Family Wellbeing Program is a nationally recognised empowerment program for Indigenous Australians. The program was developed in 1993 in Adelaide by a group of "Stolen Generation" survivors. In Queensland, the program has been piloted at several sites including: Hopevale, Wujul Wujul and Yarrabah. The program, as adapted in north Queensland, is a two-step Participatory Action Research targeted broadly at parents and families. The program is based on the process of exploring issues in people's daily lives, recognising own strengths and resources, generating knowledge and taking action to improve own situation.</p>	<p>Evaluation of the Family Wellbeing Program is based on qualitative information collected from program participants. Findings to-date indicate that participation in the program can significantly enhance feelings of control and responsibility for the conditions affecting one's health and wellbeing. Participants report increased levels of resilience, self-worth and hope regarding the possibility of changing one's situation, as well as enhanced problem solving skills and ability to reflect on sources of problems.</p>
<p><i>Healing Our Way self-help resource</i></p>	<p>The project involved development of culturally appropriate, self-help resources for Indigenous</p>	<p>The outcome of the project is development and distribution of three high quality culturally</p>

²³ Personal communication from Mercy Baird (May 2008).

Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
(Mitchell, 2005)	people in Yarrabah (Qld). In 2005 two pamphlets and a DVD containing culturally adapted evidence-based content were developed to present user-friendly information on suicide prevention (“Self Harm”) and postvention (“After a Suicide”). The resources provide information and advice for people who self-harm, their families, community, and people at risk of suicide who present to mental health services and a hospital.	appropriate self-help resources suiting the needs of the Yarrabah community. This outcome was achieved through close engagement with Indigenous partnerships and consumer participation.
<i>Indigenous community suicide intervention forums</i> Indigenous Psychological Services²⁴	Indigenous Psychological Services (IPS) is a private company funded in 1999 in Western Australia. IPS is Indigenous specific and provides a range of specialist mental health services which are unique to the field and are based on substantial research and cultural validation. Indigenous specific suicide prevention forums started in 2002 with the aim of addressing the high rates of Indigenous suicide in rural and remote communities. The forums reflect a whole-of-community approach to intervention and are delivered to service providers, community members and Indigenous youth. The forums are delivered in a longitudinal manner over approximately 12 months, including an introductory phase, a	The program has been extensively evaluated, using structured questionnaires looking at participant suicide prevention knowledge and skills, and their readiness to help a person at risk. Quantitative analysis demonstrated significant gains in participants’ self-reported levels of skill and knowledge.

²⁴ <http://www.indigenoupsychservices.com.au/> and personal communication from Dr Tracy Westerman (May 2008).

Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
	follow-up and a skills consolidation phase. The workshops are being run across Australia, including Queensland.	
<p><i>Toughin' it out. Survival skills for dealing with suicidal thoughts pamphlet</i> (Bridge, Hanssens, & Santhanam, 2007)</p>	<p>The <i>Toughin' it out</i> pamphlet was created in 1998 in an Indigenous service setting to be handed out to service consumers or to be placed with other health promotion material. The publication uses simple and direct language to describe the process of suicidal thinking, ways of coping with crisis, and presents a list of available resources.</p>	<p>The pamphlet has been used in Indigenous health and youth services and schools in Cairns and Cape York area and Northern Territory. It was also used during Applied Suicide Intervention Skills Training/Suicide Awareness workshops. The pamphlet has been well received by counsellors, teachers and students.</p>
<p><i>National Health Interactive Technology Network (HITnet) Development Program²⁵</i> (Hunter, Travers, Gibson, & Champion, 2007)</p>	<p>The National HITnet Development Program is led by University of Queensland in Cairns and promotes health and wellbeing in disadvantaged populations through new media information. The Program began as a proof-of concept study of touch screen technology in two Indigenous health settings. It has subsequently expanded to a number of remote Indigenous communities and developed new platforms and applications to respond to emerging health issues.</p>	<p>This HITnet project shows that kiosk-based approaches are feasible in very remote and challenging environments and are used by community members.</p>
<p><i>Applied Suicide Intervention Skills Training (ASIST) LivingWorks²⁶</i></p>	<p>ASIST is a 2-day interactive workshop in first aid for suicide. The workshop participants learn to recognise the signs of suicide risk and</p>	<p>Positive feedback from workshop participants in Indigenous communities in Queensland²⁷. The program has been evaluated (Guttormsen,</p>

²⁵ <http://www.hitnet.com.au/>

²⁶ http://www.lifeline.org.au/learn_more/livingworks

²⁷ Personal communication from Joan Smith (June 2008)

Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
	<p>respond in ways that increase safety and link people at risk with sources of professional help. The ASIST workshops have been conducted in Indigenous communities in Queensland and other parts of Australia, including Northern Territory.</p>	<p>Hoifodt, Silvola, & Burkeland, 2003; MacDonald, 1999; Tierney, 1994; Turley & Tanney, 1998).</p>
<p>Increasing the Capacity of Local Counsellors “Drop the Rock” Royal Flying Doctor Service of Australia (Qld)²⁸</p>	<p>The program is based on engagement of local services to assist clients experiencing social and emotional wellbeing and mental health difficulties in the five Cape York Peninsula communities (Kowanyama, Pormpuraaw, Aurukun, Lockhart River and Coen). The project aims to enhance local and visiting social and emotional wellbeing (mental health) services by developing or increasing the capacity of local community counsellors to provide basic counselling, support and liaison between clients and visiting services. The community counsellor positions work with visiting mental health personnel engaged in community development initiatives addressing social and emotional wellbeing (mental health) issues by focusing on local strategies. The trainee community counsellors undertake a Certificate 4 in Mental Health (non-clinical) through the Far North Queensland TAFE - an</p>	<p>The program is ongoing.</p>

²⁸ Information obtained from Australian Government Department of Health and Ageing, Queensland State Office

Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
	<p>additional subject has been incorporated into the course which looks at the impact of historical events upon current Aboriginal and Torres Strait Islander culture and communities.</p>	
<p><i>Learning from the experts: Building bridges to implement successful life promotion and suicide prevention expertise across Aboriginal communities</i> Centre for Rural and Remote Mental Health Queensland Ltd. in partnership with James Cook University, University of Southern Queensland, University of Queensland; AISRAP, Griffith University²⁹</p>	<p>A suicide prevention and education project targeting Aboriginal communities in Far North and South West Queensland involving five key projects: (1) establishing Men's support groups in Yarrabah, Hope Vale, Kowanyama, Dalby and Goondir, (2) delivery of the Family Wellbeing Program in Kowanyama, Hope Vale, Dalby and Yarrabah and Lotus Glen Correctional Facility, (3) collection, organisation and analysis of stories from Far North Qld communities and Dalby, (4) implementation of touch-screen kiosks in Hopevale, Dalby, and Lotus Glen and Cleveland Detention Centre and (5) collection, collation and communication of information on community health (injuries, suicides, mental health, alcohol, school attendance etc) in an empowering way.</p>	<p>The program is ongoing.</p>
<p><i>Something Better</i> Queensland Police-Citizens Youth Welfare Association³⁰</p>	<p>The project aims to assist and support young people in Aboriginal communities of Wujal Wujal, Napranum, Hope Vale and Mapoon (Qld) that are at risk of suicide by providing them</p>	<p>The program is ongoing.</p>

²⁹ Ibid.

³⁰ Ibid.

Appendix Three: Suicide Prevention Programs for Indigenous Australians

PROGRAM	PROGRAM DESCRIPTION	PROGRAM OUTCOMES AND/OR EVALUATION
	with exposure to sporting activities outside of their community by a suitably trained and dedicated local Indigenous person.	
<i>Napranum Life Promotion Queensland Police-Citizens Youth Welfare Association</i> ³¹	The project aims to assist and support young people in the Aboriginal communities of Napranum, that are at risk of suicide by providing them with a range of programs including a Breakfast Program, Homework Program, Scouts Program, Parenting Program and a Resume Program - provision of materials and computer access to enable participants to complete resumes.	The program is ongoing.

³¹ Ibid.

Appendix Four. Training programs for Indigenous mental health workers and services developed specifically for Indigenous Australians.

PROGRAM	PROGRAM DESCRIPTION, OUTCOMES AND/OR EVALUATION
<p><i>Aboriginal Mental Health Worker Program, NT</i> (Harris & Robinson, 2007)</p>	<p>In eight remote communities in the Top End of Northern Territory, <i>Aboriginal Mental Health Worker Program</i> was introduced to fund the placement of Aboriginal Mental Health Workers (AMHW) under the clinical leadership of General Practitioners in health centres in remote communities and to contribute to development of a culturally appropriate community-based mental health care service.</p> <p>The program evaluation provided mixed results: “while there are many examples in this program of AMHWs providing highly valued services within their communities, the evaluation showed that the program did not achieve clear commitments to develop mental health practice around the AMHWs’ role. In addition there was variability in levels of local managerial support for the AMHWs, vulnerability to staff turnover and other discontinuities, as well as tensions in views about what the role of the AMHWs should be” (Harris & Robinson, 2007, p. 1).</p>
<p><i>Tiwi Island Mental Health Service, NT</i> (Norris, Parker, Beaver, & van Konkelenberg, 2007)</p>	<p>An overview of services developed in response to the unique mental health needs of a remote Indigenous community on the Tiwi Islands in the Northern Territory presented a number of challenges faced by a community aiming to take a leading role in dealing with mental health issues. The experience of the local Mental Health Service showed that provision of the relevant information and support in decision-making process enabled members of the Tiwi Islands community to identify needs and respond accordingly. Norris et al. (2007) concluded that “the establishment of social governance mechanisms and the long-term commitment by a change agent to facilitate the empowerment process are important keys to success. The main challenge in establishing services in rural Aboriginal communities is to identify and support community strengths, including leaders and cultural practices” (p. 310).</p>
<p><i>Australian Integrated Mental Health Initiative Northern Territory Indigenous stream, NT</i> (Nagel & Thompson, 2006)</p>	<p>A review of changes in mental health service delivery to Indigenous Australians in Top End Mental Health Services under the Australian Integrated Mental Health Initiative Northern Territory Indigenous stream (AIMHI NT) showed the importance of Indigenous of mental health workers in improving delivery of services, including better communication with Indigenous patients.</p> <p>The service audits revealed significant improvements in Indigenous inpatient care between</p>

PROGRAM	PROGRAM DESCRIPTION, OUTCOMES AND/OR EVALUATION
	<p>1995 and 2001 and lead to the conclusion that “Aboriginal mental health workers provide essential services as cross-cultural brokers in the setting of Aboriginal mental illness. The improvements in care found in this file audit coincide with the commencement of employment of Aboriginal mental health workers in the inpatient unit. The AIMHI consultation reveals broad support for employment of more Aboriginal mental health workers in the Top End” (Nagel & Thompson, 2006; p. 291).</p>
<p>Maga Barndi Unit, WA (Laugharne, Glennen, & Austin, 2002)</p>	<p>In Western Australia, a two-year pilot project of delivery of culturally sensitive psychiatric services (Maga Barndi Unit) resulted in a marked increase in service utilisation by local Aboriginal people. Over the project period, the Unit was able to establish a significant local patient base and the majority of the Indigenous patients had not previously accessed mainstream mental health services. The success of the project was related to its location within an Indigenous controlled health centre with good access to Indigenous health workers, as well as a flexible assertive community management approach.</p> <p>According to Laugharne et al. (2002), “it is particularly encouraging that the total number of admissions of Aboriginal people with psychiatric diagnoses to Geraldton Regional Hospital was reduced by 58% in the second year of the project. In addition, we believe that through assertive community follow-up we prevented several patients with serious mental illness having to be transferred to the nearest available “gazetted” beds in Perth and all the associated problems that go with such a procedure” (p. 16).</p>
<p>Aboriginal and Torres Strait Islander Child and Adolescent Mental Health Traineeship Program, NSW (Bartik, Dixon, & Dart, 2007)</p>	<p>The Aboriginal and Torres Strait Islander Child and Adolescent Mental Health Traineeship Program was established in New South Wales in collaboration between Hunter New England Area Health Service (HNEAHS), Hunter New England Aboriginal Mental Health (HNEAMH) and the Department of Psychological Medicine at the Children’s Hospital at Westmead (CHW) with guidance and input from additional collaborators. The program encompasses employment of a child and adolescent mental health worker under professional support and supervision of HNEAHS, a mentoring program provided through HNEAMH, a clinical education and supervision program conducted through the Department of Psychological Medicine, CHW, and formal academic studies in Aboriginal Mental Health.</p> <p>The initial feedback has been positive and shows the program is a promising venue for training of Aboriginal and Torres Strait Islander child and adolescent mental health workers.</p>

PROGRAM	PROGRAM DESCRIPTION, OUTCOMES AND/OR EVALUATION
<p>Djirruwang Aboriginal and Torres Strait Islander Mental Health Program, NSW (Brideson & Kanowski, 2004)</p>	<p>Te Djirruwang Aboriginal and Torres Strait Islander Mental Health Program delivers a three-year Bachelor of Health Science (Mental Health) Degree with exit points at Degree, Diploma and Certificate levels. The Program commenced in November 1993 and is restricted to Aboriginal and Torres Strait Islander people.</p> <p>Since its commencement, the program has contributed significantly to the development of Indigenous mental health workforce. By 2004, 70 students graduated from the course (34 with degrees, 35 with diplomas and one with a University Certificate) and 46 students from across Australia were taking the course in that year. In the conclusion of their presentation of the course, Brideson and Kanowski (2004) stressed that “professionals, their organisations and management groups in the mental health field need to learn to work with Aboriginal people and not to continue to work on them. They are definitely not seeking permission on these issues – they are seeking support to enable them to move into ‘adulthood’ as qualified professionals within the systematic arrangements of the mental health industry. The question that management, services, professions and their educational systems need to ask themselves is, are they doing all they can to alleviate the emotional distress facing your Aboriginal colleagues and communities?” (p. 7).</p>

Appendix Five: Ethical Guidelines for Research in Aboriginal Australian Communities

This Appendix presents ethical guidelines for research in Aboriginal communities which are also applicable to development and implementation of suicide prevention and social and emotional wellbeing programs.

Principles of ethical research in Indigenous Studies (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2000)

A. Consultation, negotiation and mutual understanding

1. Consultation, negotiation and free informed consent are the foundations for research with or about Indigenous peoples.

Researchers must accept a degree of Indigenous community input into and control of research process. It also recognises the obligation on researchers to give something back to community.

It is ethical practice in any research on Indigenous issues to include consultation with those who may be directly affected by the research or research outcomes whether or not the research involves fieldwork.

2. The responsibility for consultation and negotiation is ongoing.

Consultation and negotiation is a continuous two-way process. Ongoing consultation is necessary to ensure free and informed consent for the proposed research, and of maintaining that consent.

Research projects should be staged to allow continuing opportunities for consideration of the research by the community.

3. Consultation and negotiation should achieve mutual understanding about the proposed research.

Consultation involves an honest exchange of information about aims, methods, and potential outcomes (for all parties). Consultation should not be considered as merely an opportunity for researchers to tell the community what they, the researchers, may want.

Being properly and fully informed about the aims and methods of a research project, its implications and potential outcomes, allows groups to decide for themselves whether to oppose or to embrace the project.

B. Respect, recognition and involvement

4. Indigenous knowledge systems and processes must be respected.

Acknowledging and respecting Indigenous knowledge systems and processes is not only a matter of courtesy but also recognition that such knowledge can make a significant contribution to the research process.

Researchers must respect the cultural property rights of Indigenous peoples in relation to knowledge, ideas, cultural expressions and cultural materials.

5. There must be recognition of the diversity and uniqueness of peoples as well as of individuals.

Research in Indigenous studies must show an appreciation of the diversity of Indigenous peoples, who have different languages, cultures, histories and perspectives.

It is also important to recognise the diversity of individuals and groups within those communities.

6. The intellectual and cultural property rights of Indigenous peoples must be respected and preserved.

Indigenous cultural and intellectual property rights are part of the heritage that exists in the cultural practices, resources and knowledge systems of Indigenous peoples, and that are passed on by them in expressing their cultural identity.

Indigenous intellectual property is not static and extends to things that may be created based on that heritage.

It is a fundamental principle of research to acknowledge the sources of information and those who have contributed to the research.

7. Indigenous researchers, individuals and communities should be involved in research as collaborators.

Indigenous communities and individuals have a right to be involved in any research project focussed upon them and their culture.

Participants have the right to withdraw from the project at any time.

Research on Indigenous issues should also incorporate Indigenous perspectives and this is often effectively achieved by facilitating more direct involvement in the research.

C. Benefits, outcomes and agreement

8. The use of, and access to, research results should be agreed.

Indigenous peoples make a significant contribution to research by providing knowledge, resources or access to data. That contribution should be acknowledged by providing access to research results and negotiating rights in the research at an early stage.

The community's expectations, the planned outcomes, and access to research results should be in agreement.

9. A researched community should benefit from, and not be disadvantaged by, the research project.

Research in Indigenous studies should benefit Indigenous peoples at a local level, and more generally.

A reciprocal benefit should accrue for their allowing researchers often intimate access to their personal and community knowledge.

10. The negotiation of outcomes should include results specific to the needs of the researched community.

Among the tangible benefits that a community should be able to expect from a research project is the provision of research results in a form that is useful and accessible.

11. Negotiation should result in a formal agreement for the conduct of a research project, based on good faith and free and informed consent.

The aim of the negotiation process is to come to a clear understanding, which results in a formal agreement (preferably written), about research intentions, methods and potential results.

The establishment of agreements and protocols between Indigenous peoples and researchers is an important development in Indigenous studies.

Good faith negotiations are those that have involved a full and frank disclosure of all available information and that were entered into with honest view to reaching an agreement.

Free and informed consent means that agreement must be obtained free of duress or pressure and fully cognisant of the details, and risks of the proposed research. Informed consent of the people as a group, as well as individuals within that group, is important.

Values relevant to health research ethics (National Health and Medical Research Council, 2003; 20005).

1. *Reciprocity*: A mutual obligation exists among members of the ATSI families and communities to achieve an equitable distribution of resources, responsibility and capacity and to achieve cohesion and survival of the social order. This mutual obligation extends to the land, animals and other natural elements and features. In contemporary settings the value of reciprocity continues in various forms, and may vary between locations. Examples include redistribution of income, benefits from the air, land and sea, and the sharing of other resources, such as housing.

Inclusion: Inclusion, the basis for mutual obligation, describes the degree of equitable and respectful engagement with ATSI peoples, their values and cultures in the proposed research.

Benefit: Benefit in this context describes the establishment or enhancement of capacities, opportunities or outcomes that advance the interests of the ATSI peoples and that are valued by them.

2. *Respect*: Respect for human dignity and worth as a characteristic of relationships between people, and in the way individuals behave, is fundamental to a functioning and moral society. Within ATSI cultures respect is reinforced by and in turn strengthens dignity. A respectful relationship induces trust and co-operation. Strong culture is a personal and collective framework built on respect and trust that promotes dignity and recognition.

Respect of people and their contribution: Respect acknowledges the individual and collective contribution, interests and aspirations of the ATSI peoples, researchers and other partners in the research process.

Minimising difference blindness: Respectful research relationships acknowledge and affirm the rights of people to have different values, norms and aspirations. Those involved in research should recognise and minimise the effect of difference blindness through all stages of the research process.

Consequences of research: Researchers need to understand that research has consequences for themselves and others, the importance of which might not be immediately apparent. This should be taken into account through all stages of the research process.

3. *Equality*: One of the values expressed by the ATSI peoples and cultures is the equal value of people. One of the ways it is reflected is a commitment to distributive fairness and justice. Equality affirms ATSI people's right to be different.

Valuing knowledge and wisdom: ATSI peoples value their collective memory and shared experience as a resource and inheritance. Researchers who fail to appreciate or ignore ATSI people's knowledge and wisdom may misinterpret data or meaning, may create mistrust, otherwise limit quality or may overlook a potentially important benefit of research.

Equality of partners: Ethical research processes treat all participants as equal notwithstanding that they may be different. In the absence of equal treatment, trust among researcher funders, researchers, host institutions, ATSI communities and other stakeholders is not possible. Without such trust ethical research is undermined.

The distribution of benefit: The distribution of benefit stands as a fundamental test of equality. If the research process delivers benefit in greater proportion to one partner in the initiative than other partners, the distribution of benefit may be seen as unequal.

4. *Responsibility*: Central to ATSI societies and cultures is the recognition of core responsibilities. These responsibilities include these to the country, kinship bonds, caring of others and the maintenance of harmony and balance within and between the physical and spiritual realms. A key responsibility within this framework is to do no harm, including avoiding having an adverse impact on others' abilities to comply with their responsibilities. As well, one person's responsibilities may be shared with others so that they will also be held accountable.

Doing no harm: There is a clear responsibility for researchers to do no harm to ATSI individuals and communities and also to those things that they value.

Accountability: Researchers and participating communities need to establish processes to ensure researchers' accountability to individuals, families, and communities, particularly in relation to the cultural and social dimensions of ATSI life.

5. *Survival and protection*: ATSI peoples continue to act to protect their cultures and identity from erosion by colonisation and marginalisation. A particular feature of ATSI cultures and their efforts has been the importance of a collective identity. This collective bond reflects and draws strength from the values base of the ATSI peoples and cultures.

Importance of values based solidarity to ATSI peoples: ATSI vigorously oppose the assimilation, integration or subjugation of their values and will defend them against perceived or actual encroachment. Researchers must be aware of the history and the continuing potential for research to encroach on these values.

Respect for social cohesion: The importance of the personal and collective bond within ATSI communities and its critical function in their social lives.

Commitment to cultural distinctiveness: The cultural distinctiveness of ATSI peoples is highly valued by them. Within the scope of these guidelines, researchers must find ways of working that do not diminish the right to the assertion or enjoyment of that distinctiveness.

6. *Spirit and integrity*: This is an overarching value that binds all others into a coherent whole. It has two components. The first is about the continuity between past, current and future generations. The second is about behaviour, which maintains the coherence of ATSI values and cultures. Any behaviour that diminishes any of the previous five values could not be described as having integrity.

Motivation and action: This means that researchers must approach the conduct of the research in ATSI communities with respect for the richness and integrity of the cultural inheritance of past, current and future generations, and of the links which bind the generations together.

Intent and process: Negotiations with ATSI communities will need to exhibit credibility in intent and process. In many circumstances this will depend not only on being able to demonstrate that the proposal is in keeping with these guidelines, but also on the behaviours and perceived integrity of the proponents of research.

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