The context and causes of the suicide of Indigenous people in Australia

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Abstract

When comparing suicide in the Aboriginal and Torres Strait Islander (Indigenous) population to that in the non-Indigenous populations of Australia, there are significant differences in the rates of suicide and the age groups at risk of suicide. The etiology of these differences includes a history of colonisation and its aftermath including a burden of intergenerational trauma in the Indigenous population. It also includes contemporary disadvantage and discrimination. These not only impact on Indigenous family and community life but also on potential sources of social and emotional wellbeing and resilience that help protect Indigenous individuals against suicide. They also result in the greater exposure of Indigenous families and individuals to trauma, and other risk factors associated with suicide. Further, they underpin those families and individual's lower access to culturally appropriate mental health and suicide prevention services and programs. Although there is a degree of commonality between the specific causes associated with the suicide of Indigenous and non-Indigenous individuals, the burden and the accumulation of underlying trauma, risk factors and specific causes in the case of Indigenous individuals results in higher rates of suicide. The increasing Indigenous suicide rate suggests that the overall current approach to Indigenous suicide prevention is not working. Innovative Indigenous community-led, strengths based approaches should be supported in the context of a different national approach. This includes, in addition to targeted responses to Indigenous individuals and population groups at risk of suicide, empowering communities to address their challenges, including those associated with suicide. It includes empowering communities to heal intergenerational trauma at the individual, family, community-level. It includes strengthening culture and sources of resilience to protect against suicide at the community level.

Introduction

Prior to the 1960s there are few reports of Indigenous suicide (Hunter & Milroy, 2006). Yet in contemporary Australia, the Indigenous suicide rate is currently twice that of the non-Indigenous (Steering Committee for the Review of Government Service Provision [SCRGSP], 2016). In particular, Indigenous young people under 18 years of age are significantly over-represented in suicide cases of that age group (National Children's Commissioner, 2014).

Indigenous Australia is made up of two distinct cultural groups. Mainland Aboriginal peoples, who were hunter-gatherers, have inhabited the continent for at least 50,000 years and have different languages and cultures. Torres Strait Islander peoples are a different cultural group who make up around 10 per cent of the Indigenous population and practiced agriculture in addition to hunting and gathering. Both groups suffer similar challenges as peoples recovering form colonisation. A range of cultural differences, particularly a greater collective dimension in the culture and life of Indigenous peoples, is recognised as a key difference between them and the non-Indigenous population in Australia (Gee, Dudgeon, Schultz, Hart & Kelly, 2014). As well as the consequences of colonisation, these cultural differences have implications for Indigenous suicide prevention activity.

With reference to the Australian Indigenous social and emotional wellbeing concept, culturally defined family and kin relationships; community relationships; the role of Elders, cultural practice; connection to country; and spirituality and ancestors are considered among important collective elements of the health and mental health of individuals. Critically, they are considered to be sources of resilience and protective factors against mental health problems and suicide (Gee et al., 2014).

Conversely, as proposed by Hunter and Milroy (2006), some Indigenous people's self-destructive (including suicidal) behaviours reflect vulnerability stemming from internal states informed by both individual experience and the potential internalisation of collective historical, socio-economic and community factors. In particular, experiences of colonization which occurred within only three to eight generations of Indigenous people living today, have a collective dimension and can be connected to the suicide of Indigenous people today.

Although there is a degree of commonality between the specific causes associated with the suicide of Indigenous and non-Indigenous individuals, the broader historical, cultural, political, social and economic context and the accumulation of the associated burden of underlying intergenerational trauma, risk factors and the specific causes that impact on individuals contribute to the higher rates of suicide in the Indigenous population.

Understanding the causes of Indigenous suicide, and the differences between suicide in the Indigenous and non-Indigenous population, is critically important to developing effective Indigenous suicide prevention activity. This is particularly so given the increases in the number of Indigenous suicide deaths over the past five years suggesting things are getting worse, not better, and underscoring the need for different approaches to Indigenous suicide prevention (Dudgeon et al., 2016).

In particular, strengths based responses that work to empower communities to strengthen their cultures, address their challenges, restore community functioning and heal intergenerational trauma at the individual, family, community and population level are required in addition to targeted responses to individuals and groups at higher risk of suicide within the Indigenous population. Because of the greater collective dimensions of Indigenous life, it is proposed that such community-level responses will also support individual resilience and thereby have the potential to protect against suicide. (Dudgeon et al., 2016).

Colonisation and its Contemporary Impacts

Intergenerational Trauma

During colonisation, following an initial wave of frontier warfare, massacres and dispossession, a second wave (from the mid to late nineteenth century onwards) involved the dispossession of Indigenous people onto reserves and their

subjection to legal regimes that controlled all aspects of their lives (Gee et al., 2014). This included the forcible removal of thousands of Aboriginal children to be assimilated into non-Indigenous society, a practice that has been characterised as genocidal (Human Rights and Equal Opportunity Commission, 1997). These events are not only historical memories but have consequences in the lives of contemporary Indigenous individuals and families. A 2008 Indigenous population survey reported 12 per cent of respondents aged 45 years and over (i.e. born before 1963) had personally experienced separation from their family (Australian Bureau of Statistics [ABS], 2010).

The longer-term consequences of such removals include mental health and health impacts on those directly involved (ABS, 2010). More broadly, the intergenerational transmission of trauma in the contemporary Indigenous population is an ongoing effect of forcible removals and indeed the wider colonisation process. By this, unacknowledged or unresolved trauma in previous generations is linked to dysfunction within an extended family in later generations (Atkinson, 2002). The mechanisms by which trauma is transmitted down generations could include impacts on children resulting from weakened attachment relationships with care givers, challenged parenting skills and family functioning, parental physical and mental illness, and disconnection and alienation from the extended family, culture and society (Milroy, 2005). These effects are compounded by exposure to high levels of traumatic incidents and stressors in the present (Milroy, 2005).

Community Functioning

Atkinson (2012) associates intergenerational trauma with compounding Indigenous community dysfunction characterised by violence between community members, anti-social behaviours and forms of abuse that might in themselves contribute to suicide. However, the association between intergenerational trauma and suicide, including by such mediating factors, is yet to be significantly explored. The devastating impacts of intergenerational trauma on Indigenous community functioning should be the subject of further research including in the context of suicide prevention.

Hunter and Milroy (2006) associate the relatively recent emergence of suicide as an Indigenous population health issue to with the closing of reserves and the end of formal legally encoded racial discrimination. In practice, the lifting of legal discrimination did nothing to address the underlying trauma associated with Indigenous peoples' experience of colonisation to that point in time. Further, while Indigenous individuals were formally made equal before the law and suddenly able to access both welfare and alcohol without restriction, they remained socially excluded from the benefits of political, social and economic life, including from accessing the health and mental health services of the time. This led to a period of what has been referred to as 'normative instability' that persists in some communities. It is proposed that this community dysfunction and further disempowerment and loss of control within an ongoing context of unresolved legacies of colonisation forms the background to high Indigenous suicide rates and other characteristics of Indigenous suicide as a population health issue today (Hunter and Milroy, 2006).

The work of Chandler and Lalonde's studies (1998, 2008) among almost 200 British Columbian (Canadian) First Nations' communities is important in viewing the relationship between the collective functioning of contemporary Indigenous communities and the suicide rates among their young people. The studies focused on community-level protective factors against suicidal behaviours: in particular self- determination defined according to key markers:

- a measure of self-government;
- have litigated for Aboriginal title to traditional lands;
- a measure of local control over health;
- a measure of local control over education;
- a measure of local control over policing services; and
- community facilities for the preservation of culture.
- a measure of local control over child welfare services; and
- elected band councils composed of more than 50 percent women (Chandler & Lalonde, 1998, 2008).

The studies found that communities where all of these markers of self-determination were present had no cases of suicide. Conversely, where communities had none of these markers, youth suicide rates were many times the national average (Chandler & Lalonde, 1998, 2008). Such studies suggest the importance of community empowerment, self-determination and cultural reclamation in Indigenous community functioning and this has important implications for suicide prevention in Australia.

Social Determinants and Indigenous Suicide

Despite the achievement of legal equality by the 1960s, part of the aftermath of colonisation in contemporary Australia is the persistence of institutional racism and discrimination against Indigenous people and the related concept of social exclusion. McLachlan, Gilfillan, and Gordon (2013) classified Australian population groups using a Social Exclusion Monitor comprising 29 indicators across seven key life domains. With this, they assessed that people at highest risk of experiencing deeper or multiple forms of disadvantage included not only Indigenous people as a group, but also population groups among whom Indigenous people are over-represented when compared to non-Indigenous people. These include groups who are also often socially excluded in their own right including those dependent on income support, those living in public housing, unemployed people, people with a long-term health condition or disability, and people with low educational attainment.

While the associations between these social determinants of health and mental health and Indigenous suicide rates needs to be the subject of further research, it is proposed that Indigenous peoples' greater exposure to stressors and traumatic incidents, their experiences of interpersonal racism; and associated use of alcohol and drugs and other factors are relevant mediating factors - as discussed below.

Exposure to Life Stressors
Associated with social exclusion and disadvantage is greater exposure to life stressors. The most frequently reported stressors reported

in a 2012-2013 Indigenous population health survey (2012 – 13 Indigenous Survey) were the death of a family member or friend (reported by 37 per cent of respondents); serious illness (23 per cent); inability to get a job (23 per cent); and mental illness (16 per cent) (ABS, 2013).

Such life stressors are shared experiences between the Indigenous and the non-Indigenous populations. However, there is evidence for Indigenous peoples' greater and simultaneous exposure to multiple life stressors. In the 2012-2013 Indigenous Survey, 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more life stressor in the previous year. That rate is 1.4 times that reported by non-Indigenous people (ABS, 2013).

Researchers report that 1.9 – 2.6 overlapping stressful life events are associated with low or moderate psychological distress, with between 3.2 and 3.6 events associated with high or very high psychological distress (Australian Institute of Health and Welfare [AIHW], 2009). Further, Chamberlain, Goldney, Delfabbro, Gill and Dal Grande (2009) reported that those with high and very high psychological distress measured by the Kessler K-10 scale were 21 and 77 times more likely, respectively, to be experiencing suicidal ideation.

In the 2012-2013 Indigenous Survey, 30 per cent of respondents over 18 years of age were assessed with having high or very high psychological distress levels in the four weeks before the survey: nearly three times the non-Indigenous rate (ABS, 2013a).

Current literature suggests that, suicide might be associated with chronic depression (Harris & Barraclough, 1997). Also in the 2012-2013 Indigenous Survey, 12 per cent of Indigenous respondents reported feeling depressed or having depression as a long-term condition; compared 9.6 per cent in the total population (AIHW, 2015). Further, over 2008 – 2013, depression was the most frequently reported mental health related problem managed by GPs among Indigenous clients (AHMAC, 2015).

While in an Indigenous context, the associations between exposure to stressful and traumatic incidents, psychological distress and trauma and

suicide requires further research, particular causes of Indigenous suicide, with significant impacts on younger Indigenous people as indicated, have been identified as:

- Relationship problems (either conflict with a partner or relationship breakdown/separation).
- Broader familial and interpersonal conflict.
- Bereavement. Younger males were significantly at risk.
- A criminal history and pending legal matters. Younger males were significantly at risk.
- Unemployment and the inability to get a job. Again, younger males were significantly at risk. (De Leo, Sveticic, Milner, & Mackay, 2011).

Exposure to Traumatic Incidents And Childhood Abuse

Research also indicates an association between situational trauma and suicidal behaviors at least in the general population. For example, higher rates of suicide have been observed among Vietnam veterans who have been wounded and/or exposed to traumatic incidents, with higher risk associated with higher exposure to combat trauma (Bullman & Kang, 1996). Nadew (2012) assessed the exposure to traumatic incidents, prevalence of Post-Traumatic Stress Disorder (PTSD) and alcohol use among 221 individuals in remote Western Australian Indigenous communities. Of the sample, it was assessed that 97 per cent of participants had been exposed to traumatic incidents over the course of their lifetimes. Of these, about 55 per cent were assessed with PTSD and 20 per cent for major recurrent depression. Further, about 74 per cent of participants overall, and 91 per cent of those with PTSD, met diagnostic criteria for alcohol use related disorders, abuse and dependence.

All forms of childhood abuse significantly increase the lifetime risk of suicidal ideation and suicide attempts. Research further suggests that the link is strongest in cases of sexual abuse (Legislative Assembly, Parliament of Western Australia [LAWA], 2016). Cashmore and Shackel (2013) also report that sexual victimisation, both in childhood and beyond, is a significant risk factor for suicide attempts among both men and women. Whilst the actual prevalence of child

sexual assault by Indigenous children status is not known, data from incidents that are recorded by police suggest it is a significant problem (SCRGSP, 2016).

There is also strong association between high rates of suicide among young people after leaving care (LAWA, 2016).

The association between the experience of interpersonal and other forms of racism and suicide requires further research to be understood and particularly in the Australian Indigenous population. However, from United States studies with African American populations, it is proposed that experiences of racism and the vicarious experience of racism can reinforce a perceived need for constant vigilance that can become traumatisation (Carter, 2007; Chou, Asnaani & Hofmann, 2012; Williams, 2015).

Alcohol and Drug Use

In Australia, it has been reported that impulsiveness is a "distinct feature of Aboriginal suicide which is commonly linked to excessive alcohol consumption" (LAWA, 2016, p.6). However, impulsivity and its relationship to suicidal behaviour is a complex issue that cannot be simply attributed to alcohol and drug use. Impulsivity has also been associated with an individual's lack of ability to self-manage their untreated trauma (LAWA, 2016). Trauma among Indigenous people in Australia has itself been associated with alcohol and drug use (Nadew, 2012).

In the report of the inquiry into Aboriginal youth suicide in remote areas, the Legislative Assembly of Western Australia (2016) reported suicide is the most common cause of alcohol-related deaths among Aboriginal men and the fourth most common cause amongst Aboriginal women. Further, it reported high levels of alcohol and drug misuse have been noted in almost all documented Aboriginal suicide clusters, with many of the affected individuals being either intoxicated or in severe withdrawal.

Exposure to Suicide

A recent Australian study reported that suicides by Indigenous people were significantly more likely to occur in a cluster than suicides by non-Indigenous people and this was the case among

both Indigenous young people and adults (Robinson, Too, Pirkis & Spittal, 2016). It has also been noted that exposure to suicidal threats, attempts and suicide within the family or by close associates was a common factor in suicide clusters (Hanssens, 2010). Further, that cultural and family obligations to participate in relatively high numbers of funerals and grieving rituals may also magnify the cumulative impact of these distressing events and perhaps overwhelm normal recovery processes (Silburn et al., 2014).

Indigenous Peoples' Lower Access to Mental Health Services and Programs

Lower Access of People at Risk Of Suicide To Services

In general population suicide research, people who have already attempted suicide are considered to be at the highest risk of suicide (at forty times increased risk) than any other population group. Further increased risk was related to the recency of a previous attempt, the frequency of previous attempts, and isolation (Harris & Barraclough, 1997). Yet an Indigenous person who has recently attempted suicide or who is at risk of suicide is less likely to be able to access the services they need than a non-indigenous person in the same position.

Some researchers have suggested that the evidence shows that a significant number of Indigenous suicides are pre-meditated and in many cases intent had been communicated prior to death. As such, not only were these people to some degree identifiable to friends but also potentially to family and mental health and suicide prevention service providers (De Leo et al., 2011). Yet in their analysis of over 400 Indigenous suicide deaths in Queensland over 1994 and 2006, De Leo and colleagues (2016) found that only 23.3 per cent of Indigenous cases had received treatment from a mental health professional in their lifetime, compared to 42.3 per cent of a non-Indigenous sample; and only 10.1 per cent of Indigenous cases were seen by a mental health professional in last three months prior to suicide, compared to 25.6 per cent of non-Indigenous cases.

Overall, there is evidence that because of lack of access to, or use of, primary mental health care according to need, Indigenous peoples with mental health problems are significantly overrepresented in other parts of the health and mental health system (AIHW, 2015a).

Aboriginal Community Controlled Health Services

Critical to improving access to health and mental health services is the development of trauma-informed, culturally safe general population services with culturally competent staff and, in particular, the expansion of Aboriginal Community Controlled Health Services (ACCHSs) (that are based in communities and governed by communities through a majority Indigenous elected board) to deliver mental health services to Indigenous peoples.

Where ACCHSs exist, studies suggest the community prefers to, and does, use them (Panaretto, Wenitong, Button & Ring, 2014).

With appropriate resources, an ACCHS is able to implement a culturally competent and comprehensive primary health care model based on the culturally shaped, holistic concepts of health understood by the communities they serve (Gee et al., 2014). Ideally, these will include integrated health, mental health and alcohol and other drug services, as well as social supports. However, significant service gaps in these areas are reported (AIHW, 2015b).

Apart from ACCHSs, for general population services to better support their Indigenous clients at risk of suicide, culturally safe service environments must be established. These have been defined as "environments that are spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need" (Williams, 1999, p. 213). Further, non-Indigenous practitioners should not only be clinically but also culturally competent. To that end, practitioners should consider local Indigenous cultural competence training as a starting point.

The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project's (ATSISPEP) Solutions that Work report included examples of success factors identified in indicated service

responses to Indigenous people at immediate risk of suicide or who have attempted suicide. In addition to ideally being located in, or working through, an ACCHS, and being trauma-informed, culturally safe and providing culturally competent practitioners, success factors for indicated services included:

- *24-hours-a-day, seven-days-a-week services* including that operate during identified critical risk periods such as Christmas time.
- *Time protocols* whereby a person at risk of suicide should be able to see someone within a minimum standard time.
- *Follow up.* It is critical that services assertively follow up and provide continuing care to people at risk or attempted suicide.
- *Clear referral pathways* – between health services, support services and other providers (Dudgeon et al., 2016).

Access to cultural healers and the involvement of Elders and cultural activities as a part of ongoing individual treatment should also be included as important potential elements in individual treatment (Dudgeon et al., 2016).

Postvention support where a person has died by suicide or in a traumatic way, should be available to provide support to the family members and kin of the deceased at a time of great need, but also to prevent imitative suicidal behaviours (Dudgeon et al., 2016).

Conclusion – a different approach to Indigenous suicide prevention

If it is accepted that the increasing Indigenous suicide rate shows that the current overall approach to Indigenous suicide prevention is not working, then it is time for a different national approach to Indigenous suicide prevention that responds at the community level and ensures Indigenous community level control - in addition to targeted responses. Only in this way can the underlying causes of Indigenous suicide be properly addressed and protective factors from culture, family and community restored.

Indigenous- led, strengths based approaches to suicide prevention that include community-level

cultural renewal, healing activities and support to address community challenges should be a part of a different national approach as set out in the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy that is yet to be fully implemented (Department of Health and Ageing, 2012).

Culture

Indigenous Elders have expressed concerns about youth suicide and see that reasons for the high rates of suicide among Indigenous youth could be due to a lack of cultural education that directly affects their connection to culture, community and country. This is in part because of an overemphasis on efforts to provide a western education and to learn English, sometimes at the expense of traditional cultural knowledge and learning language (Culture is Life, 2013).

Further, a range of culturally focused responses to suicide supported by Elders suggests that cultural education for young people (including spending time with Elders, and on country) and, more broadly, cultural reclamation activities in communities has a significant role to play in Indigenous suicide prevention. The Elders propose that a foundation of cultural education will help protect young people from feelings of hopelessness, isolation, and being 'lost between two worlds' that could lead to suicidal behaviours (Culture is Life, 2013).

In a similar vein, from Chandler and Lalonde's and other studies, 'cultural continuity' theory has developed that proposes that Indigenous people (and particularly young people) that have a sense of their past and their cultures will draw resilience-building pride and identity from these, as well as this awareness strengthening their sense of connectedness with family and community (Chandler & Lalonde, 1998, 2008; Niezen, 2009). Further, by extension, potentially vulnerable younger people will also conceive of themselves as having a future as bearers of that culture (Chandler & Lalonde, 1998, 2008).

Healing

Examples of Indigenous-led emerging models, healing centres and hubs for healing intergenerational trauma and that focus on culture include: Yawuru (Western Australia);

Yarrabah Aboriginal Medical Service (Queensland); Gallang Place (Brisbane); Yorgum (Perth); We Al-li (northern NSW); Red Dust Healing (central NSW), and Marumali (Sydney), among others. Further, the National Aboriginal and Torres Strait Islander Healing Foundation has developed a number of publications, resources and programs that address intergenerational trauma and healing and that could inform a different approach to Indigenous suicide prevention at the community, family and individual level.

Empowerment

The ATSISPEP Solutions That Work report highlighted the importance of strengths- and community empowerment- based approaches to Indigenous suicide prevention through community developed, community controlled, and community located suicide prevention programs that work with whole communities. That is, in addition to targeted responses to individuals and population groups at risk of suicide. Success factors at this level included:

- addressing community challenges;
- strengthening culture and building identity;
- alcohol and drug use reduction programs;
- community tailored gatekeeper training and awareness-raising programs about suicide risk;
- peer-to-peer mentoring, and education and leadership on suicide prevention;
- programs to engage young people including sport and connecting young people to culture, their country and their Elders; and
- the employment of community members as a peer workforce in suicide prevention activity (Dudgeon et al., 2016).

The ongoing National Empowerment Project provides an example of responses that aim to empower communities by education in identifying and addressing the challenges they face (including those associated with suicide) and supporting their capacity for self-governance and organisation to address those challenges (Dudgeon et al., 2014). In 2016, the Yawuru Corporation in Broome published a report on measuring community wellbeing that could further inform community empowerment-based approaches (Yap and Yu, 2016).

Research

The potential of cultural education and cultural continuity as a protective factor against suicide, particularly among Indigenous young people, should be explored in Australian Indigenous settings as a highly productive line of research and policy development. Overall, there is a need for significant new investment in research into the causes of Indigenous suicide and in particular the potential association between intergenerational trauma and trauma, life stressors, racism and suicide within the context of a different national approach to Indigenous suicide prevention. Further, research building on the work of ATSISPEP to expand the evidence base for Indigenous suicide prevention activity should also take place.

High Indigenous suicide rates in Australia arise from a complex web of interacting personal and social circumstances. While some of the 'causes' associated with suicide among Indigenous individuals might be the same as that in the general population, the prevalence and interrelationships among these factors can differ because of wider contextual factors: colonisation, intergenerational trauma, social determinants and their impacts on contemporary Indigenous communities. Suicide is just one indicator of distress in communities that calls for healing at collective-levels, and particularly at the community level, in addition to the focus on targeted responses for individuals and groups at risk of suicide.

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Professor Calma was the Aboriginal and Torres Strait Islander Social Justice Commissioner at the Australian Human Rights Commission from 2004 to 2010 and the Race Discrimination Commissioner from 2004 until 2009.

In his 2005 Social Justice Report, Professor Calma called for the life expectancy gap between Indigenous and non-Indigenous people in Australia to be closed within a generation, and advocated embedding a social determinants-based approach to public policy around improving Indigenous health, education and employment and in order to address inequality gaps. This call spearheaded the Close the Gap Campaign for Indigenous Health Equality resulting in COAG's Closing the Gap response in December 2007.

Professor Calma has worked for over a decade with the co-authors on Indigenous mental health, social and emotional wellbeing and suicide prevention.

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