Managing Directors Report

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The recent death of a 10 year old Aboriginal child by suicide in a remote part of the Kimberley made everyone stand up and take notice of the issues facing Aboriginal people in Australia today.

That a child should choose death instead of life is not a circumstance that should ever be a reality for any parent and as a community we cried tears of pain for this family.

Since this time we have had the WA Parliamentary Inquiry into Suicides in Aboriginal Communities (2015); a Suicide Prevention Round-table in the Kimberley with the Federal Minister for Health, Sussan Ley; and we also now have a petition on change.org for a Royal Commission into the issue. This has followed what appears to be an endless stream of government policies, frameworks and most soberingly a Coronial Enquiry into a spate of 21 Suicides in the Kimberley in 2011 and a further Coronial Enquiry announced in May 2016. Still the suicide rate continues to climb as noted by Fiona Stanley:

Former Australian of the Year Fiona Stanley says action, not more inquiries or summits, is what's needed to address the escalating indigenous suicide rate. The Prime Minister Malcolm Turnbull has asked his Health Minister Sussan Ley to host a summit on the issue in the Kimberley in northern Western Australia. Just under a decade ago Professor Stanley gave extensive evidence to a coronial inquest into Indigenous suicides in the Kimberley. The distinguished child health expert argues the coroner's recommendations remain valid and urges the current crop of lawmakers to read it.

Having spent a considerable amount of the past 20 years working at the pointy end of suicide prevention and intervention, this issue is of particular passion to me and it is fair to say that I have gone to my fair share of funerals for many of my relations and community who have taken their own lives.

Quite simply I am frustrated that this issue has been approached in a piecemeal and reactive manner which has failed our communities.

My own personal journey in suicide prevention started back when John Pat a local young Aboriginal man from my traditional land, Roebourne, Western Australia was killed in custody. This sparked the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in 1990. The impacts of this Inquiry have certainly not changed the face of deaths in custody with the recent death of Ms Dhu in police custody.

Ms Dhu was a Yamaji woman who was in police custody as a result of unpaid fines and remained there for five days until her death from pneumonia and septicaemia. The coroner stated she was treated in an inhumane manner in custody leading to her death. The premier defended the police who treated her inhumanely saying that they had a difficult job to do.

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We were all as disgusted by this as we were frighteningly not surprised. It appears that there is significant currency in undertaking Inquiries which in and of themselves convince the public of a 'course of action' which in reality have no real outcome. It is experiences like these which create a backdrop of pain and marginalisation that is unfortunately all too familiar for Aboriginal people.

The interesting thing regarding the RCIADIC however, was that it actually took on its own role in suicides effectively being lost in the politics of what was happening to our people in police custody.

The prevailing view was that Aboriginal people were not killing themselves; they were being killed in custody.

Bear in mind, that this is against the reality that suicide as a concept was not known of prior to 1964 – it simply does not fit with traditional Aboriginal practices in that there is an external attribution made to the concept of death.

That being, that one's life and death path is determined by ancestors; by our dreaming – by external forces. Suicide as a predominately internal 'life and death' weigh up does not fit this reality. So, the sum result of all of this was that suicides could not be discussed or even mentioned until it got to the stage that suicides then became rife in those impacted communities to the extent that it became a cycle of constant bereavement and crisis. As some of you may be aware, IPS has undertaken a considerable amount of work in this area and this is detailed in this edition of our IPS Membership magazine Jilya. All of this work has been in the absence of government or any funding. Our research is self-funded. Our unique programs self-funded; our psychometric screening tools for at risk Aboriginal people self-funded; a reasonable number of our training programs are provided for free to Aboriginal people and we are now in a reality in which our Whole of Community Suicide Intervention Programs which are considered to be amongst the world's best practice do not have funding and often delivered at substantially reduced costs, no costs, or not delivered at all. Many people ask me the reasons for this. My response is the same as it has been for the past twenty years. Programs, tests, and assessments that are developed uniquely for a specific cultural group are not popular. The one size fits all approach is considerably more popular and has created a series of knock on effects which has resulted in a failure to determine best practice efforts and mobilise these programs into chronically impacted communities.

It is my view that the focus to addressing the escalation in suicides should focus across five inter-related areas. First, there exists a dearth of research information about the true nature and extent of Aboriginal suicides and suicide behaviours within Australia. As a result, there needs to be strong consideration of the representation of suicide by the media and by our leadership. This is particularly given the evidence that links media reporting of suicides to increases in suicide deaths and therefore any misrepresentation has clear implications in increasing the suicide rate. For example, in response to the high rates of suicide amongst Canadian Aboriginal people, Canadian researchers (Lalonde, 2006) monitored youth suicide rates in 196 First Nations in British Columbia for 21 years.

His data suggests suicide is not a universal epidemic but rather, a tiny fraction of communities bear the heaviest risk. Amongst First Nations in B.C., more than 90 per cent of suicides occur in only about 10 per cent of communities.

In the Australian Aboriginal space the available data speaks to a similar pattern. For example, Hunter has described how around 50% of the Aboriginal people living in Qld live in the far north of Qld but account for almost 66% of all Qld Aboriginal suicides. On the other end of the equation, it is of note that the vast majority of Aboriginal people reside in NSW (31.1%) and yet have the lowest rate of suicide at 12.4 per 100,000. Despite this, it is of concern that we see consistent headlines which speaks to a suicide 'epidemic' or 'crisis' facing all Aboriginal people and communities. This is not only factually inaccurate based upon the available data, but it is my view that it has created greater problems than provided solutions.

Specifically, evidence supports the fact that representation has the very real potential to create a self-fulfilling prophecy in which suicide is presented to Aboriginal people as being a 'normal' response to life, relationship and personal stressors (Westerman, 2012, conference proceedings) and is inconsistent with Mindframes ethical guidelines for the reporting of suicides in the media. Suicide risk is dose responsive – the more you talk about suicide without associated selected intervention or postvention responses (which often does not occur in remote communities), you effectively provide the 'script' for suicide when visual cues and reminders of a suicide death remain for those who have been bereaved.

More importantly, however, is that it has the consequence of linking Aboriginality and culture as a predisposing characteristic for suicide.

This is a dangerous representation given that the two constructs of hopelessness and helplessness are amongst the strongest predictors of suicide. Language needs to be accurate. Yes, Aboriginal people have a much higher suicide rate than non-Aboriginal Australians; however, there are also many communities that do not have suicides. We therefore need to understand why this pattern has emerged in these high risk communities and target those factors that increase vulnerability to suicides.

This has then led to the second area of concern – that being that there has been a failure to empirically validate the extent of the contribution of theoretically established Indigenous specific suicide risk factors (e.g. hopelessness; culture stress; acculturation etc.,) and which can therefore be the focus of sustained and targeted intervention. This is despite the fact that it has long been argued that there may be a different nature or set of risk and protective factors for Aboriginal suicide (Reser, 1991; Hunter, 1990; Tatz, 2000; Westerman, 2003; Hanssens, 2007, 2010) and that the research that is available is consistent in this argument. It has simply not been capitalised on or value added via targeted and strategic funding to develop a clearer research understanding of Aboriginal suicides.

It also means that intervention programs cannot be developed based upon a unique suicidality that has long been suggested.

The third area which has its implications in the first two points is that funding has not been strategic in not only ensuring the development of empirically based programs but in also ensuring communities have access to programs across the eight areas of suicide intervention and prevention activities. Until this occurs suicide funding will continue to fund crisis driven or standard treatment responses.

The fourth area of need is in ensuring that there is capacity for services to screen for early signs of suicide risk. This currently does not occur due to the lack of a widely accepted assessment methodology or psychometric test that enables this to occur. Early intervention therefore becomes an impossible scenario. In addition, the lack of a widely accepted measure of Indigenous suicide risk means that programs cannot be evaluated for their efficacy specific to a reduction in risk characteristics.

The building of an evidence base of 'what works' is the primary outcome of this lack of consistent methodology.

The fifth area of need is that the suicide prevention field has historically not focused on 'community capacity building' via the training of 'whole communities' in suicide prevention.

This involves upskilling of communities as suicide 'gatekeepers' and has been a strong focus of the work of IPS. Rather suicide prevention initiatives have historically focused upon the upskilling of service providers as a primary mechanism of reducing the suicide rate. Given the extent of suicide clusters in isolated and remote communities the reality is that there will often be an absence of service providers at times of risk. The upskilling of service providers, community and youth in combination is therefore a reality of prevention that is not 'common' in mainstream suicide intervention. However, it is also the case that Aboriginal people are exposed to suicide risk at a far greater level than the mainstream population. This means that the failure to provide established risk reduction skills in a psycho-educative manner (e.g. problem solving; conflict resolution; anger management;

effective communication) in combination with suicide warning signs etc., and links to external supports across whole communities is essential.

Related to this is that service providers often struggle with the application of cultural skills (and cultural competence) when operating from a predominantly mainstream or clinical 'headspace'.

This is based upon my personal experience of close to twenty years of training of well over 20,000 participants. The common theme with participants is that whilst mainstream programs clearly offer some value they often fail in their desire to increase the competence and confidence of service providers who are then left to deal with the combination of the complexity of suicide and the cultural interpretation of suicide as well as cultural barriers between clinical and client. Unfortunately, the government 'strategy' that seems to be favoured is one which is not targeted or responsive to these five areas of need. It is my view that programs that are evidence based and have a track record of measurable outcome will not be forthcoming until the above five areas are implemented. What remains is a constant rhetoric around the concept of 'too hard' or 'impossible to solve' and we are left with roundtable after roundtable followed by constant Inquiries. In the face of all of this, it is not difficult to understand therefore that the status quo has been maintained and that the issue has not been approached with the scientific rigour that it requires. .....and so the talk fest continues......

For an overview of the extensive achievements of IPS in Aboriginal suicide prevention please visit us at: http://indigenouspsychservices.com.au/services/aboriginal-cultural-competency-programs

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