SICK HEART OF A GENERATION

Indifference is at the core of this suicide epidemic

TRACY WESTERMAN

INDIGENOUS SUICIDE (per 100,000 people)

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2013-2017
MALE	26.5	27.5	35.4	33.5	28.6	35.7	34.8	39.6	39	39.6	30.7	37.8
FEMALE	9.2	8.2	8.5	14.7	11.8	12.9	13.1	13.1	11.8	11.9	10.8	12.6
PERSONS	17.8	17.7	21.1	23.9	20	24	23.8	25.9	25.1	25.5	20.5	24.9

Source: Australian Bureau of Statistics

Tracy Westerman

Indigenous Affairs Minister Nigel Scullion has allocated $134 million for indigenous suicide prevention. This crudely translates to $248,000 per death based on the suicide mortality rate — without adding state funding into the mix.

Despite this, and as a country facing a growing tragedy of generational indigenous child suicides, we still have no nationally accepted evidence-based programs across the spectrum of early intervention and prevention activities.

Staggeringly, funded programs are not required to demonstrate evidence of impact, nor are they required to demonstrate a measurable reduction in suicide and mental health risk factors.

So, given this, can governments truly claim they are funding suicide prevention? You cannot claim prevention if you aren't measuring risk. It's that simple.

In an area as complex as indigenous suicide, it is crucial that funding decisions unsupported by clinical and cultural expertise are challenged and redirected in the best way possible: towards the evidence. Report after report has pointed to the need for "evidence-based approaches", but has anyone questioned why this continues to remain elusive?

Perhaps we need to start with what constitutes evidence.

It doesn't mean attendance. This is not evidence of impact. It means measurable, outcome-based evidence — a reduction in suicide risk factors attributable to the intervention provided.

Without measurability there is no accountability. Without measurability we are failing to gather crucial evidence of what works to better inform current and future practitioners struggling to halt the intergenerational transmission of suicide risk.

Clinicians terrified

Up to 30 per cent of clinicians will experience the suicide death of a client in our clinical lifetime. It is complex, it is scary, and very few of us understand what it is like to feel as though you are holding someone's life in your hands.

I can tell you that, despite extensive training, suicide prevention challenges you at every level.

It challenges your core values about the right of people to choose death over life; it stretches you therapeutically despite your training in best practice; and it terrifies you that you have missed something long after you have left your at-risk client.

The nature of suicide risk is that it changes. Being able to predict and monitor it takes years of clinical expertise and well-honed clinical insight and judgment.

Throw culture into the mix and this becomes a rare set of skills held by few in this country. Indeed, back-to-back coronial inquiries, a 2016 parliamentary inquiry and 2018 Senate inquiry all concluded that not only are services lacking in remote and rural areas of Australia but culturally appropriate services were often non-existent.

Prevention focus

First, we need to recognise the significant societal contributors to escalating rates of child suicides.

And we need to start with changing the narrative on indigenous suicides.

The core driver is that indigenous suicide is badly understood and myths about so-called causes of suicide are portrayed as if they exist as a direct linear relationship.

Suicide risk factors are being incorrectly stated as suicide causes and this is critical to this whole issue. Alcohol, poverty, abuse, colonialisation — these are not causes. They are risk factors, not causes. It is vital we understand this distinction to ensure adequate prevention efforts.

So, what separates Person A, who has been abused and becomes suicidal, from Person B, who has been abused and does not? While this is an essential question, we do not have clear evidence of these critical causal pathways.

Once we establish a causal pathway, we can then focus on determining treatments of best practice to ensure that clinicians are focused in the best possible way to eliminate the established cause.

This can be done only through rigorous assessment of individual risk factors. Some of these risk factors will be static and historical, meaning they cannot be changed: you cannot change someone's date or place of birth, for example.

Other risk factors will be dynamic and changeable: we can work on changing anxiety and responses to trauma.

Once we have a comprehensive picture of an individual's risk factors, treatment is then determined as being effective based on a reduction in the symptoms attributable to the clinical intervention. Presenting poverty and colonialisation as causes offers little to clinicians, who need to focus therapeutic interventions on what is alterative and treatable.

It distracts us from the true causes of indigenous suicide that enable a genuine opportunity for prevention. Our people are not killing themselves because they are poor. They are killing themselves because of racism, trauma, most likely co-morbid with depression and alcohol and drug use, isolation and a lack of access to culturally competent clinicians and evidence-based programs.

A further danger in confusing causes with risk factors is that it also informs government approaches to this issue.

So, taking this example of alcohol, the government decided to solve suicides through establishing dry communities and restricting alcohol. There has not been a decrease in suicide in alcohol-restricted communities; in fact, the opposite is true. Suicide is so multidimensional and multifaceted that, unless you can undertake rigorous assessment, there is going to be an endless cycle of risk that is "predicted" only once a child dies by suicide.

The most distressing outcome of failing to understand suicide causes is it further stigmatises bereaved Aboriginal parents, inferring that most, if not all, are perpetrators or alcoholics.

Perpetuating such stereotypes contributes to a general lack of empathy for Aboriginal people bereaved by suicide. It is a "they did it to themselves" mentality that is not only inaccurate but also unhelpful and unkind.

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When non-indigenous children die by suicide, we rightly look for deficits in society or systems and how we need to "do better" as a society.

When indigenous children die by suicide, we look for deficits in their families, in their culture. Why don't we have a more empathetic view of indigenous child suicides and for indigenous families bereaved by suicide?

Finding answers

Unfortunately the gaps are obvious and have been for decades.

First, universities need to set minimum standards of cultural competence as prerequisites in the degrees undertaken by those in the "helping professions".

Most would be lucky to have an hour of cultural training in their degrees and then are sent out to remote indigenous communities where cultural barriers are so significant they render the most gifted clinicians into paralysis.

I have developed a normed Aboriginal Mental Health Cultural Competency Profile, which has demonstrated the capacity to measure, support and improve cultural competency development. This is objective and measurable, and provides a useful method for educational institutions to set minimum standards.

Second, we need to assess and screen for early risk. My PhD resulted in the development of the Westerman Aboriginal Symptom Checklist, a culturally validated psychometric test to screen youth at risk.

Despite this, we do not have a widely accepted methodology to assess for suicide risk in indigenous people.

While the youth version (WASCY) and adult version (WASCA) have existed for two decades, and more than 25,000 clinicians have chosen to be accredited in it, access into high-risk areas is limited by the lack of wide-scale government rollout of the tool.

Third, we need to understand the causes of indigenous suicide. The priority needs to be to analyse the suicide death data to firmly establish causal pathways to suicide. If the suicide data were analysed in a way that determined "causal" pathways it would quite simply change the paradigm of this area.

The big-picture thinking is to use continuous suicide data (suicide risk factors that move and change) gathered by the WASCY and WASCA to determine causal pathways and co-variates (that is, impulsivity, depression and suicide risk) and determine whether a reduction in these factors reduces the overall suicide death rate.

This is complex but these two data sets will enable us to determine what risk factors are reducing the suicide death rate in more of an immediate, measurable and responsive way.

Access to this data is likely to take many more months to pass through several ethics committees, but we will self-fund this analysis to fast-track this vital information and to speed up crucial gaps in our knowledge in this area.

Fourth, we need to determine whether indigenous suicide is different. The WASCY has determined a different set of risk factors for indigenous suicide, finding among other things that up to 60 per cent of suicide risk is accounted for by impulsivity.

Those with impulse-control issues are likelier to have limited coping mechanisms that enable self-soothing specific to interpersonal conflict. This pattern often occurs with those who have trauma and attachment-related issues — the origins of which for Aboriginal families often lie in the forcible removal from primary attachment figures.

With the increasing evidence of the impacts of race-based trauma there is a need to address societal contributors to indigenous suicides. Thema Bryant-Davis and Carlota Ocampo, among others, have noted similar courses of mental illness between victims of violent crime and victims of racism.

In Australia, Yin Paradies has found that racism explains 30 per cent of depression and reduces Aboriginal life expectancy more than smoking.

Just as trauma frequently becomes a central organising principle in the psychological structure of the individual, trauma has become a central organising principle in the psychological structure of whole communities. This is known as "repetition compulsion", meaning individuals who have had a previous traumatic event are at increased risk for future trauma experiences.

Suicide "clusters" are an obvious and common consequence of trauma repetition compulsion.

From a suicide prevention perspective, racism manifests as a sense of hopelessness and helplessness, which has consistently been implicated in suicide risk. When the origin of this lies in racial identity it seems inherently "untreatable" as a core risk factor and unchallengeable as a core driver when a suicidal individual develops thought processes based on a belief they don't matter.

When those within the "system" and broader community show no visible sign of caring, this cognition then becomes increasingly ingrained through daily reinforcement.

The best I can do as a clinician is to assist my clients to develop healthy and robust cultural identity and develop the skills and resilience to manage racist events.

The WASCY provides a cultural resilience assessment that enables clinicians to "treat" factors that have been demonstrated to moderate or buffer suicide risk. This is crucial to prevention.

We are also about to publish on the impacts of a whole-of-community suicide intervention response to indigenous deaths.

This is the first evidence-based program to demonstrate a measurable reduction in suicide risk factors. It is crucial that these programs are widely available in high-risk communities.

Epigenetics tells us that racism impacts on Aboriginal people in the same way as a traumatic event. The fact most of our suicides are so impulsive makes absolute sense from a trauma perspective.

Finally, we turn to our political leadership. We look for guidance in what resonates in the conscience of our nation.

I wrote recently about the silence of our political leaders during the Fogliani coronial inquiry into the 13 deaths of indigenous children in the Kimberley.

Not a single question in the lower house of the West Australian parliament has been asked about the coroner's report, nor what was going to be done about it.

The ABC reported only nine of the 95 members of parliament have brought up the inquest in any way, in either chamber, this year.

Studies support that a "hierarchy of newsworthiness" exists in which "cultural proximity" to the audience plays a crucial role in the extent of empathy generated for victims. The more the audience relates to victims, the greater the newsworthiness.

If the broader community can't connect in a "this could happen to me or my family" manner, then there is less community outcry, and significantly less pressure on politicians to respond because, ultimately, they are very aware there will be little to no backlash about it.

When those who are mandated to care fail to respond your trauma becomes magnified. The silence of our political leaders has served to magnify the trauma of these families and in effect has become systemically perpetuated by them.

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