

# Aboriginal youth suicide

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## Introduction

Suicide (and self-harm) within the Aboriginal community has become one of the major social issues facing Western Australian health and welfare agencies. The increase in the numbers of deaths relating to suicide has led to both State and Commonwealth suicide and self-harm initiatives (Swan & Raphael, 1995).

Numbers of interdepartmental advisory committees and working parties have been established to address the issue. The Health Department of Western Australia<sup>1</sup> has investigated the prevalence of suicide and self-harm in both metropolitan and regional areas. This research has focused on both the Aboriginal and non-Aboriginal population and has illuminated a number of trends (these will be delineated below). It is important to note that the research thus far conducted by the Health Department of Western Australia has focused on risk factors associated with suicide. There is still much work to be undertaken in the area of translating such epidemiological information into practice. Recently in Western Australia, there have been initiatives that have placed greater emphasis on training and educating non-Aboriginal mental health and welfare professionals. This has also included the delivery of culturally sensitive programs to Aboriginal communities and professionals.

## Prevalence

- There has been no significant change in suicide rates in Western Australia since 1921. What has altered is the age at which suicide occurs. Since the mid-1960s there has been a steady trend of increasing suicide deaths for males aged 15-24 years (*Youth Suicide Prevention Manual*, 1998).
- In 1995 and 1996, for males aged 15-24 years, suicide was the third leading cause of death, accounting for 25% of all deaths. (*Youth Suicide Prevention Manual*, 1998).
- The pattern of suicide in Western Australia shows a steady increase for 15-19 year olds from 1986-1988, followed by a decrease for that age group, but an increase in the older 20-24 year olds.
- World Health Organisation figures place Australia's suicide rate among the highest third of the nations listed.

<sup>1</sup> Research has been conducted by the Health Department of Western Australia via the TVW Centre for Child Research and the Epidemiology Branch – Health Information Centre.



### *Urban-rural differences*

- In Western Australia, rural rates have increased by approximately 50% from 1986-1992. The rural rates have remained consistently higher since that time. The Western Australian data suggest that suicide rates are higher in smaller remote settlements of less than 4000 people (i.e. remote Aboriginal settlements).

## **Risk and protective factors for suicidal behaviours**

The effective prevention of suicide requires not only understanding of those *risk factors* which exist to increase an individual's vulnerability to suicide, but also an effective means by which these variables are able to be changed (Spence, 1998). The problem with such an approach is that many risk factors exist which cannot be easily altered.

An alternative or additional strategy for prevention of suicide has been to focus on building up *protective factors*, which have been shown to produce resilience to the development of suicide behaviours. For instance, an individual may possess particular risk factors implicated in suicidal behaviours, but not go on to engage in suicidal behaviours. This is considered to be the result of that same individual possessing certain protective factors, which ameliorate the effect of these factors.

Current research has therefore focused on identifying factors which are considered to act as protective and risk factors for the development of suicidal behaviours (Lambert, Knight, Taylor & Achenbach, 1994). Risk factors, which have been considered within the mainstream literature, have included:

- Effects of economic downturn include increased unemployment, increased poverty, reduced government services to country areas and decline of country towns increasing social isolation;
- Depression;
- Isolation, reduced access to essential services, including mental health services, and difficulty maintaining confidentiality in small country towns;
- Ready availability of firearms; and
- Australian cultural norms which make it more difficult for men to seek help, and the tendency for alcohol consumption to be the solution for anxiety and depression.

## **Risk and protective factors for suicidal behaviours in Aboriginal populations**

A considerable body of literature, both published and unpublished, has consistently argued that mainstream mental health services are not meeting the needs of Indigenous clients (Hunter, 1991a, 1991b; McKendrick et.al., 1990; Nurcombe, 1970). There exists a range of risk factors for suicidal behaviours, which are unique to Aboriginal people. These remain unrecognised within the literature and unattended in clinical practice. Interventions, which fail to address the negative effects of such risk factors, have limited chance of success. This is being reflected in the literature and in increased rates of suicide in Aboriginal communities.

Subsequently it is important that whilst there is a need to take account of those risk factors common to mainstream population, a separate analysis which takes account of those factors specific to Aboriginal populations and which have been implicated in the development of suicidal behaviours, must occur. These factors include disruption, forceful removal, substance abuse, social isolation, and cultural identity and racism.

## Disruption

A range of social-historical-political factors has been implicated in the development of much suicidal and self-harm behaviour amongst Aboriginal people. These include the forceful removal of Aboriginal children from their families and communities since European occupation of Australia and the continuation of this policy until 1972 in Western Australia (Kahn et.al., 1978). The centrality of trauma and grief associated with such separation have been repeatedly identified by Aboriginal and Torres Strait Islander people as one of the most critical issues affecting them (Swan & Raphael, 1995).

## Forcible removal

People forcibly removed from their families, subsequently abused, institutionalised and raised to believe in their own cultural inferiority will frequently lack attachment, have low self esteem, and have difficulties relating to others. These factors increase the likelihood of suicidal behaviours (*Bringing Them Home Report: National Inquiry into the Separation of ATSI Children from their Families*, 1997).

John Bowlby (1951) first spoke of the importance of attachment to a primary caregiver in infancy. Research has since supported the notion that separation from a primary caregiver in childhood can lead to depression and suicide (Swan & Fagan, 1991; Morice, 1988); alcohol and drug use (Hunter, 1991d); lack of trust and intimacy; insecurity and lack of self esteem, feelings of worthlessness, delinquency and violence (*Bringing Them Home Report*, 1997).

The intergenerational effects of this experience have been profound. Many 'stolen generations' children are more likely to have 'problem' children, with 25% of boys and 33% of girls (of stolen generations parents) having substantial behaviour problems such as delinquency (Aboriginal Legal Service, 1995); substance usage (Reser, 1989a); self-harm (Hunter, 1991a) and suicidal behaviours (Swan & Raphael, 1995; Raphael, 1996; Sweney, 1995); difficulty with school (Gross, 1989) and in relating to their peers (Silverman, 1989).

## Substance-related problems

Alcohol abuse is simultaneously a health problem and a cause of other health problems and is at least in part mediated through a number of factors which increase an individual's vulnerability to mental disorders (Jones, 1972). Indeed, alcohol abuse is related to disorders of ideation and perception with data from the Northern Territory showing a 500% increase in hospital admission rates for ATSI males with a diagnosis of alcoholic psychosis between 1977 and 1982 (Hunter, 1988). Throughout the literature, chronic and acute alcohol usage is consistently associated with completed suicides (Hunter, 1988, 1991), depression (McKendrick et.al., 1991), and interpersonal violence (Hunter, 1988).

## Social isolation

Social isolation has also been identified as a major risk factor with most research indicating that the decrease of traditional social support networks are likely to mitigate the effects of stress and the engagement in suicidal behaviours (Hunter, 1988).

## Cultural identity and racism

Aboriginal people have been proposed to be psychologically vulnerable to suicidal behaviours as a result of devaluation in the Aboriginal sense of community (Durkheim, 1952; Huffine, 1989). Evidence also

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suggests that simple membership in an ethnic minority group contributes significantly to the relatively high rates of distress associated with suicidal behaviours (Ruth, 1990; Cawte, 1969). Studies have demonstrated that other Indigenous colonised cultures experience similar disproportionately high rates of suicide as Aboriginal people (Johnson, 1994; Berry & Kim, 1988).

## Protective factors

The question consistently arises in clinical work as to why some children who experience many risk factors do not develop pathology or suicide vulnerability. Whilst a variety of explanations may be proposed, much of the research is inconclusive and still in its early stages. However, the available literature indicates some mediation of the following variables in the development of psychological problems in young people. Tracy Westerman in the initial stages in her research has found a similar pattern amongst Aboriginal youth both in Perth and the Northwest. Those factors consistently cited include:

### *Individual temperament and coping skills*

It is clear that children are born with innate temperamental and conditionability to a range of life experiences (Spence, 1998). The extent to which these tendencies play a role in the maintenance and development of pathology remains unclear, as not all children with difficult temperaments will progress to show behavioural difficulties (Endler & Parker, 1990). However, those factors which have been identified within the literature as providing a protective barrier for high risk children include, having an easy early childhood temperament (Rutter et.al., 1975), high self esteem (Charman & Pervova, 1996) and internal locus of control (Werner, 1987).

Within the preliminary research, outcomes indicate that such temperaments include: a positive outlook on life; a will or determination to succeed despite adverse circumstances; the use of problem solving rather than emotion focused coping; and an adaptable personality which enables the child to shift between their traditional or culture of origin into mainstream culture with relative ease. Finally, having skills such as sporting ability as well as a strong sense of pride in their Aboriginal culture, as well as an internal locus of hope for a better future, are factors which have been considered to create as protection against risk factors highlighted above.

### *Family and external factors*

Further research outcomes suggest some support for the importance of attachment to a primary caregiver, or role model for those children who experience risk factors such as severe neglect, or adverse environmental and family circumstances. This has been supported by Toth and Cicchetti (1996) who demonstrated that children who were maltreated but displayed attachment to at least one parent or caregiver showed lower levels of depressive symptomatology than maltreated children who were poorly attached.

### *Conflict with peers*

Finally, research has also indicated that the level of positive external contact with peers has been linked with higher self esteem (Achenbach, 1987), lower levels of depressive symptomatology (Kendall et.al., 1990) and therefore may work to provide children with identified risk for mental ill health with a level of resilience against the development of suicidal behaviours.

## Aboriginal suicide in Western Australia

The process involved in providing accurate data as to the incidence and prevalence of Aboriginal youth suicide is problematic. Anecdotal evidence would suggest that there is an under-reporting of such deaths in statistical information. Suicide is often considered taboo within mainstream non-Aboriginal culture. However, it may assume different significance within the Aboriginal community due to the contrast in world view. A 'suicide' in an Aboriginal community may be attributed to spiritual factors, payback, a transgression of law or other cultural attributions.

- Data to describe trends amongst Aboriginal people are incomplete. The Western Australian data indicate that the number of recorded suicide deaths for Indigenous young people is disproportionate to those of non-Aboriginal (deaths in custody do not account for this disproportionate rate). The suicide rate within Aboriginal communities currently stands at 32 deaths per 100 000, compared to the mainstream rate of 16 per 100 000. The most vital aspect of these reported statistics is that whilst in mainstream communities there is evidence which indicates that the suicide rate is stabilising and in some instances decreasing, the rate of suicide in Aboriginal communities is continuing to rise at an alarming rate (Hillman et. al., 2000).
- A number of Aboriginal communities have expressed concern at the incidence of suicide and suicidal behaviour amongst their young.

## Strategies and interventions

Since 1989, one of the key foci of the Western Australia's Youth Suicide Advisory Committee has been aimed at Aboriginal youth suicide prevention. This committee is comprised of a number of representatives, including delegates from within Aboriginal communities, senior governmental representatives and non-government agencies.

General strategies aimed at reducing youth suicide within Western Australia include training and educating professionals and community based workers on the 'train the trainer' model, assistance to schools and isolated communities and the development of best practice procedures in providing for care of at-risk youth.

The number of State-funded initiatives includes:

- Training and implementation of a set of steps those educators can engage in once they have identified at-risk students. This would include strategies to implement within the school in the wake of a student suicide.
- Improving training accessed by workers who have regular contact with youth within the community to improve ability to manage and help at-risk youth.
- Liaising with media in the responsible reportage of youth suicide and related topics.
- Increasing the role of hospitals and health care providers in the follow-up of youth who have attempted suicide in order to offer needed support.

## Prevention of contagion – Aboriginal specific interventions

When working with Aboriginal communities there is a number of important issues to consider when interventions are the result of ideation regarding suicide, or as debriefing following a suicide attempt:

- The therapist is encouraged to research all possible triggers for the ideation/attempt/suicide. This is in particular relation to exploring any cultural reasons for the behaviour. There have been a number of occasions in which suicide has been the result of breaching cultural taboos. If this is the case, only Elders are able to intervene in these matters. The therapist must take a behind-the-scenes role and offer services offered only in deference to the Elders' (or communities') expressed consent.
- Due to the taboo surrounding suicide in Aboriginal communities, using the word suicide directly in a first session is not suggested. A preferred method is by beginning questions from peripheral, general discussion about mood (eg. Do you feel sad very often?), and then leading into behavioural responses to emotions (eg. What sorts of things do you do when you feel really sad?). If the client has not expressed suicidal and self-harmful intent the question should be expressed as: 'Have you ever felt so sad that you have tried to hurt yourself in some way?' If the client is happy to answer this sort of question, this usually provides the green light to talk to them about suicidal ideation. It is important to continue to gauge client responses (verbal and non-verbal) to initial questioning about suicide.
- The suicide data strongly support the role of contagion in completed and attempted suicides particularly among young Aboriginal males. A powerful approach has therefore been to use the group dynamic as a positive rather than negative dynamic. Similar to suicide watches, the 'surviving' group members are debriefed by the therapist and encouraged to make an agreement to 'watch out for each other' during the times when the therapist is not present. In groups which are functioning well, it is not uncommon for members to be able to identify those young people who they consider to be the most vulnerable, and make a special effort to be available to them. The therapist should remain highly visible and present in the aftermath of a suicide and assist group members to ventilate, debrief and support one another through this most critical period.

## Summary

With the alarming increase in Aboriginal suicide in Western Australia more needs to be done to incorporate epidemiological information into culturally sensitive work practice by non-Aboriginal professionals. Similarly, Western information and education should be provided to Aboriginal communities to amalgamate with culturally relevant belief systems. Once this is done idiosyncratic service delivery systems, which target the depressed and suicidal cohort of these communities, can be implemented. It is likely that such culturally derived, driven and implemented programs will be considerably more successful than current models of intervention.

A cautionary note: When working with Aboriginal people it is erroneous to assume that all Aboriginal people are homogeneous. It is suggested that each program delivered to this population be developed in conjunction with and driven by the local population. This will take into account different cultural beliefs and practices – it will also limit the potential of infringing on culturally sensitive processes. The authors recommend that non-Aboriginal professionals should always work with a cultural consultant (this person must be nominated by the community) and not take the expert role (Vicary & Andrews 2000; Tamasese & Waldegrave, 1994).

The authors would like to take the opportunity to point out that neither perceives themselves as experts in this field. Both are continuing their education on a daily basis as they work with Aboriginal communities and depressed and suicidal Aboriginal young people. The authors would like to acknowledge the support and encouragement shown to them by their Aboriginal teachers.

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