Preventing Suicide among Indigenous Australians

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OVERVIEW

This chapter begins with an overview of the recent epidemiological trends in suicide and attempted suicide for Indigenous and non-Indigenous Australians and how this compares with the situation in other post-colonial English-speaking nations such as Canada, the USA and New Zealand. We then review qualitative studies exploring the meaning of suicide within the Indigenous community context, how these inform our understandings of suicidal behaviour and their value for informing preventive action. These highlight the individual, community or situational factors which appear to be associated with increased risk for suicide and suicidal behaviour. Life-course studies of individuals who develop suicidal behaviour or complete suicide are also considered to identify the specific situations and processes that trigger or escalate suicidal behaviour. Recent Australian and international data indicate certain social circumstances, particularly contexts of ‘bereavement overload’, where suicidal behaviours may become socially contagious, with ‘copy-cat’ suicidal behaviour. The chapter concludes with a discussion of what works in prevention, early intervention and post-vention including proactive bereavement support, containment of suicide clusters, as well as longer-term strategies for community healing following collectively experienced trauma.

WHAT IS THE CURRENT SITUATION IN AUSTRALIA?¹

Suicide is an extremely distressing event that can have profoundly disruptive effects on the family, friends and communities of those who take their own lives. While suicide is believed to have been a rare occurrence among the Indigenous peoples of Australia in pre-colonial times, since the late 1970s it has become increasingly prevalent and is now an issue of major concern for many Indigenous communities (Tatz, 1999; Elliot-Farrelly, 2004). Reducing suicide and suicidal behaviour among Indigenous Australians is now a public health priority for all Australian governments (SCRGSP, 2003, 2009).

The Australian Bureau of Statistics only reports Indigenous mortality data from those states and territories that have official records with reliable identification data for Indigenous people (Queensland, Western Australia, South Australia and the Northern Territory). The most recently available ABS data for these jurisdictions indicate that suicide was the leading cause of death from external causes for Indigenous males over the years 2001–05 (ABS, 2008).² In 2007,


² These data are based on ICD-10 codings X60-X84 in the Australian Institute of Health and Welfare (AIHW) National Mortality Database and reflect deaths based on the year of death registration. The combined data from these jurisdictions are used as an indication of the overall Australian Indigenous rates as reliable Indigenous death data are not presently available for NSW, Victoria, ACT and Tasmania.
suicide was the sixth leading cause of death among Indigenous Australians, with 3.7% of all deaths in Indigenous Australia being due to suicide. The rate of suicide in the Indigenous population is almost three times greater than that of the non-Indigenous population (3.7% compared to 1.3%) (Department of Health and Ageing, 2009). While suicide deaths account for a much higher proportion of all deaths among Indigenous people than non-Indigenous people, this also varies by state and territory. It is well recognised that Indigenous Australians experience disproportionate bereavement stress due to the higher overall rates of premature death. What is less well understood is that Indigenous Australians experience a substantially greater burden of bereavement stress because of the traumatic nature of suicide and its relative frequency as a cause of death.

The actual rates of Indigenous suicide are also believed to be significantly higher than the officially reported rates (Elliot-Farrelly, 2004). This is due to a number of factors including the misclassification of Indigenous status on death certificates and other data systems (ABS and AIHW, 1999), differences between jurisdictions in their coronial processes, the procedures around reportable deaths (i.e. deaths that must be reported to a coroner), and the strictness with which the legal criteria are applied in arriving at the official determination of the death being suicide (ABS, 2006; Harrison et al., 2001). To reduce these uncertainties there are presently discussions occurring between all Australian governments and the Australian Coroners’ Association to establish a nationally uniform coronial data system which can better inform preventive action through more reliable monitoring of trends and a more consistent understanding of the various factors associated with suicide.

The averaged suicide rates among Indigenous males for Queensland, Western Australia, South Australia and the Northern Territory were between three to four times higher than those of non-Indigenous males, with the highest rates among Indigenous men aged 25–34 years whose age-specific rate was more than 110 per 100,000 in comparison with around 30 per 100,000 for non-Indigenous men (ABS, 2008). However, differences in rates are evident between these jurisdictions. For example, within the Northern Territory, Measey et al. (2006) found that the suicide rates among the Indigenous males aged 45 or less increased by 800% over the period 1981–2002, while the rates for non-Indigenous males aged 65 or less increased by 30%. The all ages rate of suicides of Indigenous men in Western Australia increased by 700% from five per 100,000 in 1986 to 35 per 100,000 in 2002, while the comparable rates for non-Indigenous men remained essentially unchanged at around 21 per 100,000.

For purposes of comparison, the overall rates of suicide over the past three decades among Canadian First Nations people (i.e. Indians with registered and non-registered status, Metis and Inuit) have also been consistently higher than in the general population (Kirmeyer et al., 2007). In 2000 the overall First Nations suicide rate was 24 per 100,000, twice the general population rate of 12 per 100,000. However, the suicide rate within Inuit regions over the period 1998–2003 averaged 135 per 100,000—over 10 times the national rate. In the USA between 1998 and 1999, the rate of death by suicide for the American Indian population was 19.3 per 100,000, which is around 1.5 times the general population of 11.2 per 100,000. In New Zealand, similar overall rates of suicide were recorded for Maori and non-Maori up to 1987. But significant increases in Maori suicide have occurred subsequently, particularly among the age group 15–29 years. In 1999 the Maori male suicide rate of 26 per 100,000 was more than three times the general population rate of eight per 100,000 (Ferguson et al., 2004).

**Is Indigenous suicide different?**

Within each of the above-mentioned post-colonial nations, the increase in Indigenous suicide over recent decades has been largely a function of the dramatic increases among Indigenous men. Within the Indigenous Australian population there are now around five to six male suicides for each female suicide (see Figure 7.1). Female Indigenous Australians under the age of 25 years complete suicide at around five times the rate of their non-Indigenous counterparts (see Figure 7.2.). However, the rates of suicide among Indigenous women aged 45 and older are similar to, or lower than, those of non-Indigenous females (ABS, 2008).
While Indigenous and non-Indigenous males have higher rates of suicide deaths, females make many more non-fatal suicide attempts. Comparable data on hospital admissions for self-inflicted injury (suicide attempts) are not presently available for all Australian jurisdictions. However, the Western Australian data for the period 2001–05 provides an indication of the frequency of non-fatal self-harm injury of sufficient severity to warrant hospital admission. Figure 7.3 below shows the age and gender variation in self-harm injury hospital admissions for Indigenous and non-Indigenous people within that state (Health Department of Western Australia, 2007).
This shows a distinctly different age-specific pattern for Indigenous and non-Indigenous admissions. Among the 15–24-year age group, Indigenous females have about a 30% increased likelihood of intentional self-harm injury over Indigenous males; and both male and female Indigenous rates are around double those of their non-Indigenous counterparts. For those aged 25–44 years Indigenous males and females have very similar rates (8.5 and 9.0 per 1000 persons, respectively). These rates are two or three times higher than those of non-Indigenous males and females (two and three per 1000 persons, respectively). Finally, among the 45–64 age group, the Indigenous male admission rate is 3 per 1000 which is only marginally higher than among non-Indigenous males; while the Indigenous female rate drops to around 1 per 1000 which is similar to the rate for non-Indigenous females (1.3 per 1000).

Given the differences in the geographic distribution between Australia’s Indigenous and non-Indigenous populations, and the wide diversity of socioeconomic and cultural living circumstances, it is not surprising that there are significant regional variations in the occurrence of Indigenous suicide. Hunter (2001) has described how the far north of Queensland contains approximately half of the Indigenous people living in Queensland but accounted for almost two-thirds of Indigenous suicides. Three communities constituting less than 20% of the far north Queensland region’s Aboriginal and Torres Strait population accounted for 40% of the deaths by suicide. Furthermore, these communities contribute to this excess at different times with overlapping ‘waves’ of suicides, suggesting a condition of community risk that varies by location and time (Hunter et al., 1999).

The mobility of Indigenous people between remote communities and regional centres, particularly in the more remote areas of northern and central Australia, is another difference. This means that these locations need to be considered part of a larger system when considering the occurrence of suicide and its impact on communities. The age distribution of the Australian Indigenous population is much lower than that of the non-Indigenous population because of higher adult-to-child ratios and shorter average life expectancy. This has important implications for understanding the psychological impact of suicide on families and the available community response capacity in terms of supports and services for treatment and prevention. It is also relevant to another distinct feature of Indigenous suicide: the phenomenon of ‘suicide clustering’. This is where an unusual number of suicides and episodes of suicidal behaviour occur in close proximity to one another (i.e. in time and/or place) within a particular community or region.
Hanssens and Hanssens’ (2007) investigation of Indigenous suicide in the Northern Territory from 1996 to 2005 suggests that ‘clusters’ of suicide (i.e. closely related in time and location) have been an enduring feature of Indigenous suicide in the Northern Territory over this period. Initial findings from this study found that 77% of Indigenous suicides were part of a cluster of suicides and this may have been a significant factor accounting for the escalating occurrence of Indigenous male suicide in the Territory over the past two decades. During the 10-year period of the initial stage of this study, suicide clusters were identified in both urban and rural health districts and regions and sub-regions of the Northern Territory. The Darwin region experienced 16 clusters within five communities; the Alice Springs region had 13 clusters within seven communities; the Katherine region had six clusters within five communities; East Arnhem had eight clusters within three communities; while the Barkly region had three clusters within two communities. The next stages of this study are investigating the mechanisms of ‘social contagion’. Previous overseas research using psychological autopsy interviewing methods suggests that ‘people who are vulnerable to suicide may cluster well before the occurrence of any overt suicidal stimulus’ (Joiner, 1999). Hanssens and Hanssens (2007) suggest that suicide in communities should be seen as a social issue with roots in the economic dispossession of Indigenous people: ‘when marginalized, unemployed Indigenous men experience severe negative events, including the suicidal behaviour of a member of the cluster, all members of the cluster are at increased risk of suicide.’

The first systematic Australian studies of Indigenous mental health and self-harming behaviours were based in medical anthropology, clinical epidemiology and sociological methods of enquiry (Cawte et al., 1968; Nurcombe et al., 1970; Brady et al., 1991). But the event that brought national attention to the growing problems of suicide among Indigenous Australians was the Royal Commission into Aboriginal Death in Custody (RCIADIC, 1991). The Commission's final report drew particular attention to the links between substance misuse and mental health disorders in the years and months before most of the deaths that it investigated. It also highlighted the disproportionate number of these deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children. The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion were all acknowledged by the Commission as contributing to the heightened risk of mental health problems, substance misuse and suicide. The Commission made several specific recommendations for improving police and custodial practice and providing adequate treatment for those with diagnosable disorders while in custody and in the 12 months following release from prison. Most of these practice recommendations were systematically implemented across all Australian jurisdictions over the following decade, with a resulting decline in deaths in custody. However, the Commission’s broader recommendations for Australian governments to address the underlying social, economic and political circumstances—including the overrepresentation of Aboriginal people in the justice system—received considerably less attention.

Hunter’s studies of Indigenous suicide in the Kimberley region of Western Australia and far north Queensland since the late 1980s have charted the historical impact of colonisation on the role of men in Indigenous society and the fairly recent emergence of suicidal behaviour as a sociocultural phenomenon (Hunter, 1991, 1993; Hunter et al., 1999). Hunter notes that willed or self-willed death associated with sorcery or physical debility in traditional Indigenous societies could be considered ‘suicide equivalent’ phenomena. These are very different from the disturbing increase in deaths by hanging of young men over recent decades. He argues that both phenomena are meaningful but in different ways: the former can be a socially understood and affirmed consequence of behaviour (transgression) or circumstance (debility), while the latter can be considered as a statement and communication that is meaningful in the particular intercultural political context of the then current Australian society and Indigenous communities of the 1990s. Understanding Indigenous suicide, therefore, demands a consideration of the historical context in which this change is located (Elliot-Farrelly, 2004; Hunter & Milroy, 2006).
An example of the importance of understanding historical context is Hunter’s discussion of the implications of the extension of drinking rights to Aboriginal people in the Kimberley in 1971 (Hunter 1991). This resulted in a sudden increase in Aboriginal deaths due to motor vehicle accidents and homicide. But it was the social disruption of alcohol on Kimberley communities that had its most potent effects on young adults, particularly unemployed men, who were already leading culturally dislocated lives in town camps. Almost 15 years after these developments there was a dramatic increase in suicide and self-destructive behaviours among young (mostly male) Aboriginal adults in the late 1980s. Hunter describes these young males as ‘the first generation to have grown up in an environment of widespread drinking and its social consequences’. This would suggest that alcohol was not the immediately contributing factor for suicide but rather it was the chaotic environment of childrearing that helped create the fundamental cause. This hypothesis would seem to be supported by another finding of this study, that a history of heavy drinking in the family was more predictive of suicides among incarcerated young Aboriginal men than these men’s own alcohol use. The challenge therefore for those seeking to address these problems is how to provide culturally appropriate treatments to alleviate individual suffering while at the same time facilitating community action to address the problems posed by the social worlds in which Aboriginal communities live.

As noted earlier, the variation of suicide by location and time in these remote regions of northern Australia suggests that socially mediated factors within communities provide a more pertinent explanation than the descriptive epidemiological conceptions of individual risk inferred from psychological autopsy studies and clinically based investigations of suicidal behaviour. Hunter and his co-authors observe that since different communities contribute to this excess (of suicide) at different times in ‘overlapping “waves” of suicides’, this phenomenon is more indicative of a condition of community risk rather than individual risk (Hunter et al., 1999).

Colin Tatz’s sociological analysis of the historical, political and social contexts of contemporary Aboriginal life explains the way in which the processes of ‘decolonisation’ have undermined the internal values of Aboriginal society and left many Aboriginal youth with a profound sense of frustration, alienation and distress (Tatz, 2001). He uses the term ‘decolonisation’ to refer to the devastating effects which the removal of direct government controls over Aboriginal affairs in 1972 had in many Aboriginal communities, particularly the inadequate infrastructure and services within what were essentially artificially created settlements. His analysis takes issue with the medicalisation of suicide as a mental health problem in much of the previous research and reports such as the Royal Commission into Aboriginal Deaths in Custody. This, he argues, has prevented the problem being examined and understood in a wider context.

Tatz further suggests that many of the mainstream social risk factors for suicide simply do not apply to Indigenous people and their communities. His studies of communities in New South Wales, the ACT and New Zealand identified the following community factors as being most relevant to explaining increases in suicide: lack of a sense of purpose in life; lack of recognised role models and mentors outside the context of sport; disintegration of the family; lack of meaningful support networks within the community; high community rates of sexual assault and drug and alcohol misuse; animosity and jealousy manifest in factionalism; the persistent cycle of grief due to the high number of deaths within communities; and poor literacy levels leading to social and economic exclusion and alienation.

Hunter and Milroy (2006) have more recently taken this a step further in understanding the underlying processes through which these broader historical, socioeconomic and community factors become internalised and how this can lead to the impulse of self-annihilation. They argue that Indigenous self-harm reflects vulnerability stemming from internal states informed by individual experience and collective circumstance. Most particularly, the way in which historical forces have impacted on the environment of family life appears critical in shaping individual identity, health and wellbeing:
Considering life as a narrative or story, the desire to end one’s personal story abruptly, prematurely and deliberately can [therefore] be seen to stem from the complex interplay of historical, political, social, circumstantial, psychological and biological factors that have already disrupted sacred and cultural continuity; disconnecting the individual from the earth, the universe and the spiritual realm—disconnecting the individual from the life affirming stories that are central to cultural resilience and continuity (Hunter & Milroy, 2006, p. 150).

**WHAT WORKS IN PREVENTION, EARLY INTERVENTION AND POST-VENTION?**

Current mainstream initiatives to reduce suicide and suicidal behaviour in Australia have largely been informed and supported by the National Suicide Prevention Strategy (NSPS), which commenced in 1999 and built upon and extended the initiatives of the former National Youth Suicide Prevention Strategy (NYSPS) to include all age groups. In July 2006, the Council of Australian Governments agreed to a National Action Plan on Mental Health 2006–2011, a key element of which was the expansion of the NSPS and funding of $62.4 million. The Australian Government provides NSPS funding for the development of national and community-based suicide prevention initiatives. The key objectives of the NSPS are to support national suicide prevention across the life-span; and develop and implement a strategic framework for whole-of-government and whole-community approaches to suicide prevention across all levels of government and business. Over the period 2008–09 the Australian Government has committed funding under the NSPS to projects that have strengthened emphasis on developing and implementing evidence-based suicide prevention in high-risk groups. It is also focusing on the development of strategies to address groups at highest risk, which include boosting the capacity of community organisations in rural areas; developing bereavement response services for families and friends who have been bereaved through suicide; and building the capacity of Indigenous communities to provide culturally appropriate suicide prevention activities.

These strategies have been informed by current international research in suicide prevention, which highlights the importance of two sets of risk factors. The first are immediate (proximal) factors, such as an individual’s mental state, and precipitating circumstances, such as recent life stress events and heavy drug and alcohol use in the weeks and months preceding suicide. The second are longer-term (distal) factors, which have a cumulative effect from early childhood and through the life course. Clearly, different prevention strategies and interventions are required to counter the effects of each of these sets of causative influences.

**PREVENTIVE EARLY INTERVENTION FOR INDIVIDUALS IN DISTRESS**

Preventive early intervention for distressed individuals showing signs and symptoms of acute suicidal risk generally aims to interrupt the proximal risks for suicide and to stabilise and reduce their level of emotional arousal through physical containment, social support and/or clinical intervention, depending on the assessed level of risk. In communities with limited access to mental health practitioners, community workers may need to make an initial assessment of the risk of suicide or serious self-harm based on their knowledge of the person and their circumstances. This should wherever possible be done in consultation with others rather than making potentially life-and-death decisions alone. Telephone consultation with a mental health practitioner can help in reaching a considered decision about the level of monitoring or action needed to ensure safety: a) in the immediate future (e.g. over the next two hours); b) in the short-term (over the next two days); or c) in the longer term (e.g. over the next two weeks). Such assessments usually require speaking directly with the individual about their thoughts about ending their life or harming themselves.
A number of culturally appropriate training programs are now available to assist community workers and natural community helpers in making risk assessments of this kind, for example the *Gatekeeper Training Programme* (Ministerial Council for Suicide Prevention 2009), the Indigenous Psychological Services *Whole of Community Suicide Prevention Forums* (Indigenous Psychological Services, 2009) and the *Aboriginal Mental Health First Aid Training and Research Program, Suicidal Thoughts & Behaviours and Deliberate Self-Injury: Guidelines for providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person* (ORYGEN & beyondblue, 2008). (Further details about these programs are included in Chapter 21.) Training programs such as these aim to develop skills of engaging with highly distressed individuals, increase knowledge of mental health issues such as depression and psychotic behaviour that often underlie suicidal behaviour, and build understanding of the social and clinical supports that can help in reducing suicide risk and prevent crisis situations escalating. While some programs are designed for helping professionals, others are designed for community members with the aim of ensuring that communities have a number of key individuals who can be relied on as ‘gatekeepers’ to link and refer suicidally distressed individuals with the clinical or other supportive interventions they may need. Figure 7.4 below outlines some of the relevant issues covered in these programs and emphasises the importance of interrupting the escalating state of mental arousal, feelings of hopelessness, dread and agitation which typically precede fatal and non-fatal impulsive suicidal behaviour.

![Figure 7.4: Recognising and addressing proximal risks for suicide](source)

**LONGER-TERM PREVENTION PROMOTING RESILIENCE**

The current national policy framework for suicide prevention also has an increased emphasis on whole-of-population and strengths-based approaches to prevent individuals from becoming at risk in the first place. This is consistent with the evidence on Indigenous suicide reviewed earlier.
which suggests that the social and community determinants of Indigenous suicide contribute as much as, if not more than, individually based risk factors. Such universal approaches to prevention have been shown to be particularly effective in addressing issues that arise through multiple risk exposures over time or that are highly prevalent at lower levels of risk (Doll, 1997). Improved scientific knowledge of the early-life factors that promote emotional resilience in children and young people is also informing strengths-based policies and increased national investment in place-based (i.e. community) initiatives to better support the development of all children and young people, and equip them for managing the challenges of life in 21st-century Australia. Figure 7.5 provides a schematic overview of the key individual, family and community processes found to be most influential in shaping positive developmental outcomes in the Western Australian Aboriginal Child Health Survey (Zubrick et al., 2008).

![Figure 7.5: Developmental pathways to health, wellbeing and participation](image)

Other community-based strategies seek to strengthen protective factors (e.g. help-seeking) at the community and family level, and to reduce the ‘upstream’ risks (e.g. alcohol and other drug abuse) that increase the likelihood that an individual will respond to adverse life circumstances with impulsive suicidal behaviour. This is based on the evidence that stresses (such as social disadvantage, racism, family violence, mental health or behavioural problems, as well as traumatic events such as bereavements, relationship breakdown or trouble with the law) have a cumulative biological impact over time.

**PROACTIVE BEREAVEMENT SUPPORT AND CONTAINMENT OF SUICIDE CLUSTERS**

The high levels of bereavement suffered by Aboriginal and Torres Strait Islander families and communities are a growing concern for many communities. While suicide can be seen as an indicator of distress in communities, it is also the case that the personal tragedy of suicide has a wide impact affecting many people. As discussed earlier, it is not uncommon for Aboriginal
families and communities to be affected by numerous deaths and suicides within a fairly short period. Where there is little time to recover from one loss before another has occurred, whole families and communities can be left in a constant state of mourning, grief and bereavement. For some individuals, this can be accompanied by extended grief reactions such as shock, numbness and disbelief. Bereaved family, friends and other community members often see their own distress reflected in the predicament and actions of the deceased person. For more vulnerable individuals this may trigger their own suicidal thoughts and actions. Ripples of loss, grief and mourning after suicide can spread outwards through the community and to other communities, particularly where families are highly interconnected and there are strong cultural obligations with regard to funerals and observance of sorry business. This community distress and heightened awareness of suicide can be further exacerbated by unthinking or sensational media reporting, particularly graphic reporting of the actual methods of suicide.

A feature common to most communities that have experienced suicide clusters is that the level of bereavement stress appears to have overtaken the community’s usual resources for coping and containing suicidal behaviour. Without access to additional emergency support and outreach services to stabilise the situation, these communities have experienced a local ‘outbreak’ of suicidal behaviour and deaths (Silburn, 2007). The extremely distressing nature of such events highlights the need for developing and maintaining bereavement support and counselling expertise within communities and Indigenous community organisations. At the same time, the trauma and additional stresses associated with suicide may also require more specialised mental health intervention, as well as consultative back-up and proactive support for ‘front-line’ community workers.

Community healing approaches to prevention

It is in this context that the population data describing the intergenerational effects of forced removal on family breakdown, mental health problems and suicide among Australian Indigenous families affected by these past policies is of particular relevance (Silburn et al., 2006). Similar rates of social and mental health problems have occurred among Canadian Indigenous families affected by abuse and historical trauma that occurred with the residential school system. The Canadian Government’s support of Indigenous Healing Centers over the past decade has proved to be one of the most effective components of its overall national strategy in redressing the individual and collective trauma suffered by Indigenous peoples through these past policies. These Healing Centres offer a range of cultural strengthening activities, including traditional and spiritual healing practices as well as complementary and/or mainstream approaches to trauma recovery, health maintenance and rehabilitation services. The final report of the Canadian Indigenous Healing Foundation concluded that properly funded community-administered Indigenous Healing Centres have led to significant reductions in many of the most socially damaging problems (including suicide) in families and communities impacted by the residential schools system (Aboriginal Healing Foundation, 2006).

While Prime Minister Kevin Rudd’s 2008 apology to the Indigenous peoples of Australia for the harm and intergenerational suffering caused by the policies of forced removal and resettlement marked an important first step in the national reconciliation process, it also begs the question of what is needed in terms of reparation and restorative justice. Given the Canadian evidence of the value of communities being supported by a National Foundation supporting community healing initiatives, it was encouraging that on 13 February 2009, the first anniversary of the Motion of Apology to Australia’s Indigenous Peoples, the government announced the establishment of the Healing Foundation. The Foundation’s inaugural Board was appointed in late 2009.

In the meantime, several Australian communities have been developing community healing initiatives in response to the collective trauma of child abuse and multiple bereavements. In Western Australia, Darrell Henry has developed a promising three-level model of community healing through his therapeutic support of a number of Western Australian
Aboriginal communities recovering from suicide clusters (Henry, 2008). This integrated community healing model involves a strategic response to suicides and suicidal behaviour, which includes Aboriginal community people as the key ‘first-response’ service providers, has a primary focus on the whole issue for the community, and involves a whole-community approach.

This model recognises the essential and significant role of cultural work in Aboriginal communities. It involves actively supporting cultures and working with cultures using traditional practices such as being placed and ‘held’ through a formal community process with strong men and women for cultural, spiritual and personal learning. Successful examples of the cultural use of this process of ‘holding’ are described by McCoy (2008) in the context of the Kutjungka region in the south-east Kimberleys in Western Australia. Henry suggests that such healing practices could be further enabled by funding support such as going to country, re-created use of or development of rituals of healing such as the use of smoke, water, stones, leaves and plants to cleanse the spirit and clear aberrant and distorted spirits from the being. Importantly, this depends on the existent layers of natural helpers in the community, which is seen as fundamental to all other therapeutic work.

Henry’s next layer of helping involves Aboriginal para-professional workers acting as a bridge between community natural helpers and counsellors trained in mainstream generic counselling methods. They would include Aboriginal health and mental health workers as well as dedicated community counsellors who can provide counselling for shock and trauma; these would assist in managing critical responses to family violence and disclosures of abuse and so on. Counselling training is generally available, but at present there are few stable employment opportunities and limited career paths for such urgently needed community-based workers. While professional bodies such as the Australian Psychological Society have set guidelines for the assessment, diagnosis and treatment of Aboriginal people, including the use of cultural advisers in the interview process, Henry highlights the need for specialist training in adapting psychological and psychiatric methods for use with Aboriginal people. He suggests that this level of service could be improved by scholarships and personal support for tertiary training of Aboriginal people in the helping professions, by professional mentoring and co-working, and by specialist practitioner training delivered in communities.

Figure 7.6: Henry’s three-level model of community healing and helping
By integrating all three of these layers of helping, this community healing model brings together Aboriginal cultural, spiritual and community processes. This can lead to or regenerate a full spectrum of individual and community healing responses. This in turn can become a vehicle of cultural respect and revivification, at the same time presenting opportunities for strengthening social infrastructures and creating job potentials for long-term community residents with clear lines of professional development and mainstream support where required.

**CONCLUSION**

This review of the emergence of suicide and suicidal behaviour as major concerns within the Australian Indigenous population over the past several decades highlights the depth and complexity of the issues involved. There is clearly no quick or simple solution. What is required is acknowledgment of the level of distress that brings individuals to this point and the heavy toll that suicide takes on families, communities and society. Addressing the individual, community and sociopolitical and historical issues involved requires action on many fronts and on several levels. Linking and enabling these endeavours is vital to restorying the past and creating a future that includes the opportunities needed for individual and communal healing.

**Reflective exercises**

1. You are a counsellor in a local community health centre. A member of the local Aboriginal community has approached you because she is worried about her 17-year-old son who has been feeling *winyarn* (sad) for a long time. Over the past month she has noticed a marked change in her son's behaviour. She says he has been ‘flying off the handle’ over minor frustrations and become aggressive towards her when she has tried to ask him ‘what’s wrong?’ She has contacted you now because he has begun talking about killing himself over the past few days. Thinking about the issues discussed in this chapter:
   a. How would you go about engaging with this family?
   b. What would you need to consider when assessing his level of risk?
   c. Who would you consult when developing a plan of action?

2. In your conversations, counselling sessions or other interactions with Aboriginal or Torres Strait Islander people in your community, are you able to identify key narrative threads that indicate that they may be ‘disconnecting the individual from the life affirming stories that are central to cultural resilience and continuity’ (Hunter & Milroy, 2006, p. 150). If so can you describe some examples of this?

3. Thinking about Henry’s Community Healing Model as it might be applied in your own community (or the communities you work with) in the situation where there has been a high rate of suicide and suicidal behaviour over several years:
   a. How would you identify the natural helpers in your community (or the communities you work with)?
   b. What resources (or gaps) exist to support these natural helpers and to link them to the specialist, paraprofessional or traditional healers?
   c. What are the traditional healing practices in your community? Are you permitted to discuss them?
   d. How (if at all) are the traditional healers invited to participate in the mainstream programs and services designed to prevent suicide?

**References**


