

KIMBERLEY ABORIGINAL HEALTH PLANNING FORUM (KAHPF)¹

SUICIDE POSITION PAPER

ENDORSED BY KAHPF 20th MAY 2016

THE CURRENT KIMBERLEY SITUATION

Key characteristics of completed and attempted suicides and self-harm incidents in the Kimberley (Bala 2015):

- Very high and increasing incidence of suicide per capita², the majority being Aboriginal people and the majority of the deaths by hanging.
- Youth suicide rates per ABS-adjusted population are fairly equal across all Shires. Suicide rates are highest in October and higher in the wet season
- A more recent trend towards the younger end of the age distribution scale, and with increasing numbers of young women attempting and completing suicide.
- Most people that suicide do not have a diagnosed mental health condition. 71% of individuals who suicided between 2005 and 2014 had no previous engagement with Kimberley Mental Health and Drug Services (KMHDS).
- Multiple causes/triggers of suicide make it problematic to predict where future cluster(s) might occur.
- Suicidal thinking across the Kimberley is 10% higher than the rest of Australia and 20% higher in young women aged 15-24 in the Shires of Broome and Wyndham/East Kimberley.

UNDERLYING CAUSES OF SUICIDE IN THE KIMBERLEY

Risk models indicate that suicide risk arises from depression, hopelessness and opportunity which, in combination with proximal and immediate triggers, leads to suicidal acts (Christensen & Petrie 2013). The Mental Health Commission report *Suicide 2020* (MHC 2015) notes that the social determinants of suicide include violence, dysfunction, homelessness and poverty. Various studies have considered the impact of smoking marijuana on suicides, for example an American study (2009 Elements of Behaviours Health) which found that people who smoke marijuana before age 17 are 3.5 times more likely to attempt suicide as those who started smoking marijuana later in life. In addition, people who are dependent on marijuana have a higher risk of experiencing major depression and suicidal thoughts and behaviors.

Evidence from the N.T. (Robinson 2011) identifies the impact of alcohol misuse on parenting and family relationships noting *“the pattern of risk established in early childhood is compounded by ongoing stress within families related to alcohol and cannabis misuse by parents and young adults within many households, ongoing family violence and the failure of many youth to sustain social connection through education, work or other productive activity”*.

Unlike the European experience where depression is a major factor in suicides, the significance of

¹ See page 6 for more information on KAHPF.

² The Audit of Kimberley suicide data (Bala 2015) found 125 suicides occurred between 2005 and 2014. The male to female ratio was 3:1. The Kimberley rate is 20 times higher than the general Australian suicide rate.

untreated depression in the Kimberley situation is unknown as most of the completed suicides 2005-14 were by people not known to KMHDS. The Kimberley experience is that alcohol and other drug use/misuse, relationship difficulties and/or family conflict/violence often trigger a suicide or suicide attempt. However, alcohol and drug abuse are generally regarded as a strategy to mask underlying issues such as sexual abuse, rather than the cause of suicidal thinking per se.

Rather than mental illness or alcohol abuse, historical trauma and racism, economic disadvantage and cultural breakdown are implicated as the underlying causes of the high rates of Kimberley suicide. 96% of Aboriginal people in the Kimberley belong to a family where members of that family were removed (KAHPF 2012). Several reports, such as the WA Child Health Survey (TICHR 2002) and Working Together (Dudgeon et al 2014 pg. 99) document the enduring, trans-generational effects of colonialism and child removal on parenting and capacity to form relationships and confirm that **the cumulative effect of inter-generational trauma and grief, combined with social and economic disadvantage**, has resulted in high rates of psychological distress, trauma and abuse, substance abuse and self-harm.

Impaired family relationships are compounded by the poor living conditions that many families endure. In 2008 the WA Coroner noted the lack of State or Commonwealth leadership in response to the *"appallingly bad" living conditions, including a lack of basic education, poor health, unemployment and lower life expectancy that Kimberley Aboriginal people faced*. Overcrowding and homelessness continue to be problems of great concern, first raised by KAHPF more than 10 years ago. Although, under the National Partnership Agreement for Indigenous Housing the WA Housing Authority (through Commonwealth funding) has undertaken a substantial housing construction program in the Kimberley since 2010, overcrowding remains a significant problem, A spike in the number of children with Acute Rheumatic Fever (ARF) in 2013 followed by a dramatic increase in acute renal failure - diagnosed as Acute Post Streptococcal Glomerulonephritis or APSGN in 2014 are visible and quantifiable impacts of overcrowding and poor environmental health – the impact on the social and emotional wellbeing of young people living in these circumstances is less visible, but equally menacing.

Boredom and hopelessness are considered the underlying cause of many young people's drift towards risk-taking behaviour, alcohol/drug abuse and suicide ideation. The loss of cultural connection to country and traditional roles and activities leaves young people in limbo. The difference between the modern world they see on television/via social media and their restricted lives without jobs, income, opportunities or enough meaningful activities to fill the day impacts on self esteem and sense of wellbeing. Young people with FASD³ are particularly vulnerable in these circumstances as their condition is characterised by loss of impulse control and/or the ability to predict outcomes from their actions.

With reference to suicide among children ATISPEP (2015) reports that a range of biological, social and psychological factors and the cumulative impact of life stressors influence children's poor mental health and levels of toxic stress. Stress is a critical risk factor for children's poor physical, emotional and mental health. Research suggests that suicidal behaviour by younger children is often an impulsive reaction to a stressful event that has occurred within family or school – two environments that can present a number of stress risk factors. Vulnerability to stress from early childhood appears to be intensified by a number of precipitating circumstances that emerge in adolescence and trigger impulsive and emotionally heightened responses that can result in suicidal

³ The Fitzroy Valley prevalence study revealed 1 in 5 children with a FASD Diagnosis (NCHS).

behaviour. **Relationship breakdowns including disputes with family members, are amongst the most common precipitating factors reported for suicidal behaviour.** The untimely loss of family elders (often due to chronic diseases such as renal failure or diabetes) can compound the stress for young people and the family members that remain. Elders have a crucial role in keeping a family together. Anecdotal reports suggest there are now so many funerals that people have no time to heal and find the cumulative effects of grief and loss overwhelming.

PROTECTIVE FACTORS - THE IMPORTANCE OF FOSTERING RESILIENCE

The need to build the resilience of local Aboriginal people to protect themselves, their families and the wider family and community from suicide and enhance the capacity of all to cope with the issues and challenges that trigger suicide is a priority.

Recommendations

A holistic and across government/inter-sectoral approach led by local people's priorities is needed, including:

- Early intervention and longer term initiatives particularly those targeted at children and young people at risk due to neglect and/or family dysfunction (for example, interventions which enhance attachment and/or reduce the risk of adversity which makes children vulnerable to self-harm in later life)
- Support for groups, towns and remote communities wanting to implement alcohol bans or restrictions
- Delivery of consciousness raising campaigns which focus on life affirming/preserving strategies, including programmes which build cultural identity
- Greatly expanded delivery of culturally-validated locally-delivered resilience building programmes e.g. Alive and Kicking Goals and KEHLP⁴, and suicide prevention training e.g. AMHFA⁵ to create a critical mass of local people with the skills to help their families and communities
- Enhancing the capacity of local trainers, champions, mentors and natural helpers, and recognition of their key role in suicide prevention and case management of people at risk.

REDUCING RISK – ADDRESSING THE UNDERLYING CAUSES

As the Kimberley suicide situation is different from that in most other parts of Australia, nationally-framed solutions identified in national or whole-of-WA suicide strategies will not necessarily work. Local solutions are required which address the underlying causes of Kimberley suicide.

There is significant evidence that for effective long lasting change, solutions should be co-designed with Aboriginal families, communities and Aboriginal Community Controlled organisations. The role of Government is to provide an enabling environment for this to occur.

Potential solutions include:

⁴ KEHLP – Kimberley Empowerment and Healing Leadership Program

⁵ AMHFA – Aboriginal Mental Health First Aid

1. BUILDING/FOSTERING A SENSE OF CULTURAL CONNECTION

Evidence from Canada (Chandler 2012) suggests that the communities that take steps to preserve their cultural past and control their civic lives tend to have fewer suicides. It is therefore likely that a sense of identity and 'cultural continuity' can help Aboriginal people, and especially youth, to see that they have a future. This approach is supported by the Elders Report (Culture is Life 2014) which advocates that culture is an essential foundation for any Government attempt to improve Indigenous wellbeing – *that having access to cultural knowledge strengthens and reinforces a young person's sense of identity and helps protect them from feelings of hopelessness, isolation and being lost between two worlds.*

Recommendations:

Activities planned and led by local Aboriginal people including:

- Community level engagement focussing on people that are not currently engaged
- Interventions focused on cultural continuity, identity and/or language
- Resilience building programmes eg Alive and Kicking Goals
- Culturally appropriate employment e.g. land management, Ranger programmes, bush medicine.

2. ADDRESSING THE HOUSING SHORTAGE

The availability of adequate and functional housing, access to safe drinking water, a consistent electricity supply and an organised waste disposal system are basic elements that preserve and protect life. Yet many Kimberley households consist of 6 or more people, often of 3 or 4 generations, living in or on the verandas of a 3 bedroomed house. Young couples who want to establish their own home find it extremely difficult and are forced to live with family in overcrowded circumstances – exacerbating family tensions.

Recommendations

- Provide realistic levels of funding for the provision of the appropriate level of environmental health and municipal services in remote communities.
- Pass the revised Health Act (WA) to ensure an equitable level of health protection is available to Aboriginal communities. To effect this, it is essential that the provisions for binding the Crown are preserved and commenced. This would ensure there is a standard level of Authority available to protect basic health rights, such as housing standards, public buildings, food premises, waste water disposal, drinking water quality and waste disposal.
- Ensure construction of additional public housing continues so that the net public housing stock in the Kimberley continues to increase.

3. PROGRAMMES THAT STRENGTHEN FAMILY RELATIONSHIPS/PARENTING SKILLS

The 2012-2015 Kimberley Aboriginal Health Plan (KAHPF 2012) supported the finding of the WA Child Health Survey (TICHR 2005) that a strong family provides a major source of strength to Aboriginal people. It also noted the finding that a high number of families experienced extraordinary levels of stress, often witnessed by children, caused by deaths, violence, abuse, criminal activity and/or severe hardship.

The dominant theory currently used in the study of infant and toddler behavior and in the field of infant mental health is attachment theory. The most important tenet of attachment theory is that an infant needs to develop a relationship with at least one primary caregiver for the child's

successful social and emotional development, and in particular for learning how to effectively regulate their feelings. Secure attachment is when children feel they can rely on their caregivers to attend to their needs for physical closeness, emotional support and protection. Infants raised in dysfunctional families characterised by lack of structure, unpredictability in everyday activities, frenetic activity, harsh parenting, bullying and/or abuse do not always develop this sense of attachment, which shapes how they respond to stress and the relationships they form as they mature (Dudgeon et al 2014 pg. 97).

Whilst the need to provide assessment, intervention and therapy services for the 0-5 aged group is recognised by KMHDS, the current resource level for the Kimberley Child and Adolescent Mental Health Service (CAMHS) does not enable this to occur.

Recommendations

- Resourcing for the extended roll out/delivery of culturally appropriate parenting programmes for example the “Hey Dad – for indigenous Dads, Pops and Uncles’ programme.
- Expansion of the current CAMHS workforce to enable the provision of infant mental health services.
- The employment of a Child Psychiatrist at KMHDS to provide clinical supervision and support to staff.
- Ongoing resourcing of early learning centres/0-4 programmes

4. SERVICES THAT MEET MEN’S NEEDS

Given that 75% of completed suicides in the Kimberley are by Aboriginal men, the provision of more support to men, particularly young men is required. Anecdotal evidence from across the Kimberley supports research findings from elsewhere which emphasise that:

- Men are not comfortable presenting at health services
- Men are not comfortable talking about their personal situation or feelings until a good deal of time has been spent on trust-building activities
- Men are unlikely to follow up on referrals without a good deal of support and encouragement to do so
- Men do not respond well to interventions by female workers.

There is therefore a need for much greater investment in providing services and programmes which operate in ways that men respond positively to.

Recommendations

- The development of a Business Case to support the establishment of more men’s wellbeing centres/support services across the region.
- Development of a strategy to employ more Aboriginal males in organisations providing family or SEWB support.

IMPROVING THE PRIMARY HEALTH RESPONSE

Evidence suggests that additional resources are needed to enhance the flexibility and capacity of counselling, social and emotional wellbeing and mental health services to effectively respond to critical incidences and to manage and support people at risk, including:

- Ongoing and improved cultural competency training and mentoring for practitioners

- Improved capacity to actively engage with young people
- Untied and flexible funding to respond to immediate client and community needs (e.g. for FTE and practical support)
- Better sharing of data leading to ongoing and improved local coordination and case management for people at risk of suicide/self harm - per recommendation 22 in the WA Ombudsman's report (2014).
- Review and monitoring of clinical referral pathways for people who attempt or threaten suicide including those discharged from hospitals and mental health services
- Appropriate easily-accessible after hours services and care – particularly for young men and preferably staffed by Aboriginal people per pg. 13 -14 in the Elders Report (Culture is Life 2014).

CONCLUSION

Suicide and self-harm are tragic symptoms not of mental illness, but of underlying inter-related social/historical/political factors which are not modifiable by the mental health interventions currently available in the Kimberley. To prevent further suicides a broad response which builds resilience and addresses causal factors, and is designed and implemented by local Aboriginal people, has to be the way forward.

In addition, it should be noted that it would be unproductive to consider suicide in isolation from other related issues such as child sexual abuse, alcohol abuse/other addictive behaviours, jealousy, family/domestic violence and incarceration in prison. All these issues have vastly elevated rates across the Kimberley, and this is no coincidence. They each share very similar or identical causes and feed into each other in a relentless and perpetual cycle.

The recommendations in this position paper therefore provide, in large measure, a template for a strategy with a wider remit of addressing not just the determinants of Aboriginal youth suicide, but this nexus of interconnected tragedies throughout the region. Any plan to reduce suicide has to target all of these issues, if there is to be any traction. Addressing these issues individually is destined to fail.

THE KIMBERLEY ABORIGINAL HEALTH PLANNING FORUM (KAHPF)

The Kimberley Aboriginal Health Planning Forum (KAHPF) was formed in 1998. The purpose of the Forum, which is attended by high level representatives from primary health service providers in the region, is to *“improve health outcomes for Aboriginal and Torres Strait Islander peoples in the Kimberley region of Western Australia through a co-ordinated approach to the planning and delivery of comprehensive primary health care services”*.

KAHPF membership includes the Kimberley Aboriginal Medical Services Council, Aboriginal Community Controlled Health Organisations from across the region, Alcohol and Drug Services from the region, the RFDS, WA Country Health Services, Boab Health Services, Kimberley Population Health, Kimberley Mental Health and Drug Service, Mens Outreach Service, Nirrumbuk Aboriginal Corporation, Rural Health West, the Kimberley Stolen Generation Aboriginal Corporation and WAPHA.

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